Fall Conference 2022
Wednesday, October 19, 2022
9:00am-3:00pm

1a. OASIS E Training

Presented by:

Objectives:

- Discuss the impact of the OASIS
- Discuss an overview of the new HH VBP program
- Describe structural changes, items additions, and deletions.
- Identify completion time consideration per OASIS time points.
- Explain new guidance for legacy OASIS items, such as ADLs and GG items.
- Explain guidance for new OASIS E items.
What does OASIS impact?

- OBQI
- OBQM (PAEs)
- PBQI
- IMPACT Act
- QAPI
- Risk adjustment
- Case mix acuity profile
- Care Compare, Star rating
- Enhanced survey activity
- Payment (PDGM)
- VBP
PDGM Items vs Star Ratings vs VBP Items

**PDGM (Payment)**
- M1033
- M1800*
- M1810*
- M1820*
- M1830*
- M1840*
- M1850*
- M1860*

**Star (Outcome/Process)**
- M0102/M0104
- M1860*
- M1850*
- M1830*
- M1400*
- M2020*
- ACH (Claims)

**VBP (Outcomes)**
- M1800*, M1810*, M1820*, M1830*, M1845*, M1870*
- M1840*, M1850*, M1860*
- M1400*
- M2020*
- M2420*

* Items included in Discharge OASIS also

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**OASIS Impact**

- Supports the need for home care
- Supports homebound status
- Provides an opportunity to evaluate the patient’s care needs and provide needed resources

- Get it RIGHT at the SOC!
- Paint an accurate picture!
- Capture the True Acuity at the SOC to hopefully reflect IMPROVEMENTS by discharge!
Data Elements: Standardization

- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 includes the formulation of new **Standardized Patient Assessment Data Elements (SPADEs):** identical standards and definitions which will be utilized across all post-acute care providers to enable cross setting data collection, *calculation of standardized quality measures*, and interoperable data exchange
  - HH – Home Health (OASIS)
  - SNF—Skilled Nursing Facility (Minimum Data Set)
  - IRF—Inpatient Rehab Facility (Patient Assessment Instrument)
  - LTCH—Long Term Care Hospital (Continuity Assessment Record and Evaluation (CARE) Data Set)

OASIS E will standardize Data Collection!

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Value Based Purchasing

VBP
Quality Outcome Measures used for VBP

Map to 6 National Quality Strategy (NQS) priority areas
- Clinical Quality of Care; Communication and Care coordination;
  Efficiency and Cost Reduction; Patient Safety; and Patient and Caregiver Centered Experience and Patient and Family Engagement
- Improvement in Dyspnea
- Discharged to Community
- Improvement in Management of Oral Medications
- Total Normalized Composite Change in Mobility (TNC Mobility)
- Total Normalized Composite Change in Self-Care (TNC Self-Care)
- Acute Care Hospitalization during the 1st 60 Days of Home Health Use (Claims-based)
- Emergency Department Use without Hospitalization During 1st 60 Days of Home Health (Claims Based)
- HH CAHPS Survey

Quality Measures in VBP — Claims and HHCAHPS Based

<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Type</th>
<th>Measure Title</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency &amp; Cost Reduction</td>
<td>Outcome</td>
<td>Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health (NQF0171)</td>
<td>CWF (Claims)</td>
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<tr>
<td></td>
<td></td>
<td>Emergency Department Use Without Hospitalization (NQF0173)</td>
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<tr>
<td>Patient &amp; Caregiver Centered</td>
<td>Outcome</td>
<td>Willingness to recommend the agency</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Experience</td>
<td></td>
<td>Communications between Providers and Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care of Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Care Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall Rating of Home Health Care</td>
<td></td>
</tr>
</tbody>
</table>
## Quality Measures in VBP – OASIS-based

<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Type</th>
<th>Measure Title</th>
<th>Data Source</th>
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</thead>
<tbody>
<tr>
<td>Clinical Quality of Care</td>
<td>Outcome</td>
<td>Improvement in Dyspnea</td>
<td>OASIS (M1400)</td>
</tr>
<tr>
<td>Communication &amp; Care Coordination</td>
<td>Outcome</td>
<td>Discharged to Community</td>
<td>OASIS (M2420)</td>
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<tr>
<td>Patient Safety</td>
<td>Outcome</td>
<td>Improvement in Management of Oral Medications (NQF0176)</td>
<td>OASIS (M2020)</td>
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<tr>
<td>Patient and Family Engagement</td>
<td>Composite Outcome</td>
<td>Total Normalized Composite Change in Self-Care</td>
<td>OASIS (M1800) (M1810) (M1820) (M1830) (M1845) (M1870)</td>
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<tr>
<td>Patient and Family Engagement</td>
<td>Composite Outcome</td>
<td>Total Normalized Composite Change in Mobility</td>
<td>OASIS (M1840) (M1850)(M1860)</td>
</tr>
</tbody>
</table>

## OASIS – Based Measures

- **25%**
  - TNC Change in Self-Care
    - M1800 Grooming
    - M1810 Upper Body Dressing
    - M1820 Lower Body Dressing
    - M1830 Bathing
    - M1845 Toilet Hygiene
    - M1870 Feeding/Eating

- **25%**
  - TNC Change in Mobility
    - M1840 Toilet Transferring
    - M1850 Bed Transferring
    - M1860 Ambulation

- **50%**
  - Other OASIS
    - M1400 Dyspnea
    - M2020 Oral Meds
    - M2420 D/C Community

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<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Category</th>
<th>May 2022 Large Cohort</th>
<th>May 2022 Small Cohort</th>
<th>Improvement in Management of Oral Meds</th>
<th>OASIS-based</th>
<th>93.361</th>
<th>96.291</th>
<th>73.580</th>
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<td>OASIS-based</td>
<td>96.651</td>
<td>99.357</td>
<td>Improvement in Dyspnea</td>
<td>OASIS-based</td>
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<td>99.357</td>
<td>82.042</td>
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<tr>
<td>Total Normalized Composite (TNC)</td>
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<td>2.522</td>
<td>Total Normalized Composite (TNC)</td>
<td>OASIS-based</td>
<td>2.349</td>
<td>2.522</td>
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<td>1.545</td>
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<td>Change in Self Care</td>
<td>OASIS-based</td>
<td>83.429</td>
<td>90.867</td>
<td>Total Normalized Composite (TNC)</td>
<td>OASIS-based</td>
<td>83.429</td>
<td>90.867</td>
<td>71.992</td>
<td>69.623</td>
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<tr>
<td>Change in Mobility</td>
<td>OASIS-based</td>
<td>6.099</td>
<td>2.186</td>
<td>Discharge to Community</td>
<td>OASIS-based</td>
<td>83.429</td>
<td>90.867</td>
<td>71.992</td>
<td>69.623</td>
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<td>Hospitalization</td>
<td>Claims-based</td>
<td>92.385</td>
<td>96.465</td>
<td>Acute Care Hospitalizations</td>
<td>Claims-based</td>
<td>8.976</td>
<td>4.597</td>
<td>15.058</td>
<td>13.598</td>
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<tr>
<td>Care of Patients</td>
<td>HHCAHPS-based</td>
<td>95.379</td>
<td>95.379</td>
<td>Communication Between Providers and</td>
<td>HHCAHPS-based</td>
<td>92.385</td>
<td>96.465</td>
<td>83.038</td>
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<tr>
<td>Patients</td>
<td>HHCAHPS-based</td>
<td>92.214</td>
<td>94.762</td>
<td>Specific Care Issues</td>
<td>HHCAHPS-based</td>
<td>92.214</td>
<td>94.762</td>
<td>83.651</td>
<td>83.224</td>
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<td>Overall Rating of Home Health Care</td>
<td>HHCAHPS-based</td>
<td>93.946</td>
<td>95.904</td>
<td>Overall Rating of Home Health Care</td>
<td>HHCAHPS-based</td>
<td>93.946</td>
<td>95.904</td>
<td>85.306</td>
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<td>Willingness to Recommend Agency</td>
<td>HHCAHPS-based</td>
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<td>Willingness to Recommend Agency</td>
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New Format and Sections

- When looking at OASIS E you will see that the structure and format have changed.
- New structure is following closely the structure of categories as in the MDS (Minimum Data Set) used in SNFs.
- As items are removed and added the Quality Reporting Items have also changed.
- Some items are almost the same items as OASIS D1 but with some changes such as their item numbers.
- Some items have part of the original item in OASIS D1 but have been changed to represent the needed element for the IMPACT/SPADE item. For example PHQ2 is now PHQ9.

New and Revised IMPACT items added for OASIS-E:

A1005 – A2124: New Identification Information items.

B0200 Hearing and B1300 Health Literacy added; M1200 changes to B1000-Vision with revised responses.

C0100 – C1310: New Cognitive Patterns items; BIMS and CAM used for assessment.

D0150 – D0160 New/revised Mood items; PHQ 2-9 added replacing M1730 with D0150.

D0700 Social Isolation item added.


K0520: New Swallowing and Nutritional Status items. M1030 Parenteral nutrition changes to K0520 and is revised.

N0415: New Medication items to identify specific high risk drug classes patient is taking.

O0110: Identifies special treatments, procedures, and programs patient uses (ie. chemotherapy, radiation, oxygen, suction, trach care, ventilator/BiPAP/CPAP, IV meds, transfusions, dialysis, etc).
This OASIS version reflects a net increase of 143 data elements (DE) across all time points (Table 1) from OASIS-D/D1.

### Table 1. Number of Data Elements Added and Removed for OASIS-E

<table>
<thead>
<tr>
<th>Time Point</th>
<th>#DE in OASIS-D (D1)</th>
<th>#DE added for OASIS-E</th>
<th>#DE removed for OASIS-E</th>
<th>Net change (+)</th>
<th>#DE in OASIS-E</th>
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<tbody>
<tr>
<td>SOC</td>
<td>158</td>
<td>59</td>
<td>14</td>
<td>45</td>
<td>203</td>
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<tr>
<td>ROC</td>
<td>131</td>
<td>49</td>
<td>8</td>
<td>41</td>
<td>172</td>
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<tr>
<td>FU</td>
<td>36</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>44</td>
</tr>
<tr>
<td>TOC</td>
<td>22</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>DAH</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>DC</td>
<td>97</td>
<td>51</td>
<td>2</td>
<td>49</td>
<td>146</td>
</tr>
<tr>
<td>Totals</td>
<td>444</td>
<td>168</td>
<td>25</td>
<td>143</td>
<td>596</td>
</tr>
</tbody>
</table>

### Table 2. Number of Data Elements at Each Level of Burden by Time Points for OASIS-E

<table>
<thead>
<tr>
<th>Level of Burden</th>
<th>SOC</th>
<th>ROC</th>
<th>FU</th>
<th>TOC</th>
<th>DAH</th>
<th>DC</th>
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</thead>
<tbody>
<tr>
<td>0.15</td>
<td>21</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>0.25</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>0.3</td>
<td>173</td>
<td>142</td>
<td>44</td>
<td>22</td>
<td>9</td>
<td>116</td>
</tr>
<tr>
<td>Total # DE</td>
<td>203</td>
<td>172</td>
<td>44</td>
<td>22</td>
<td>9</td>
<td>146</td>
</tr>
</tbody>
</table>
Projected Times per OASIS Time Point

**START OF CARE**
Estimated time spent per each OASIS-E SOC Assessment/Patient = 57.3 clinician minutes

**RESUMPTION OF CARE**
Estimated time spent per each OASIS-E ROC Assessment/Patient = 48 minutes

**FOLLOW UP**
Estimated time spent per each OASIS-E FU Assessment/Patient = 13.2 minutes

**TRANSFER OF CARE**
Estimated time spent per each OASIS-E TOC Assessment/Patient = 6.6 minutes

**DEATH AT HOME**
Estimated time spent per each OASIS-E DAH Assessment/Patient = 2.7 minutes

**DISCHARGE**
Estimated time spent per each OASIS-E DC Assessment/Patient = 40.2 minutes
OASIS Patient Populations

• Medicare and Medicaid patients, 18 years and older, receiving skilled services
  – Includes Medicare Advantage plans, Medicaid managed care plans
  – Except patients receiving maternity services, or care for pre- or postnatal conditions
  – Excludes patients receiving only personal care, homemaker, or chore services (not skilled services)

• HHAs may collect OASIS data on non-Medicare and non-Medicaid patients for payor request or agency use, BUT do not transmit the data to CMS

• Note: PDGM only applies to traditional Medicare FFS
• Note: VBP only applies to traditional Medicare FFS, however risk adjustment on OASIS and HHCAHPS comes from all Medicare and Medicaid

OASIS Collection and Transmission

• OASIS must be collected and transmitted for any patient with the following payors:
  1. Medicare (traditional fee-for-service)
  2. Medicare (HMO/managed care/Advantage plan)
  3. Medicaid (traditional fee-for-service)
  4. Medicaid (HMO/managed care)
OASIS Data Timepoints

OASIS data are collected at the following time points:

- Start of care*
- Resumption of care following inpatient facility stay*
- Follow up for Recertification within the last 5 days of each 60-day recertification period*
- Other Follow-up during home health episode of care*
- Discharge from home care*
- Transfer to inpatient facility.
  - With/without discharge from HHA
- Death at home.

*visit required

Comprehensive assessment updated or revised

- **Start of Care (RFA 1)** = First Billable Visit + 5 days
- **Follow-Up for RCT (RFA 4)** = Not less frequently than the last 5 days of every 60-day episode beginning with the SOC date (days 56-60)
- **Other Follow-Up (RFA 5)** = Within 2 days of a major decline or improvement in condition
- **Resumption of Care (ROC) (RFA 3)** = Within 48 hours of patient’s return home from an inpatient facility admission of 24 hours or more for reasons other than diagnostic tests (or within 48 hours of knowledge of return home)
- **Transfers (RFA 6, 7), Death at Home (RFA 8), Discharge from Agency (RFA 9)** = must be completed on, or within 48 hours of becoming aware of the transfer, discharge, or death date. At discharge, completed within 2 days (DC)
**Other Follow-Up PDGM Considerations**

- **Not required to update diagnoses. If only the diagnosis is changed, no need to complete an Other Follow-up**

- **SCIC:** Major improvement or decline in a patient’s condition that was not envisioned in the original POC.

- **If a significant change in condition occurs that was not anticipated and warrants a change in the POC, complete the Other Follow-Up.**

   - If completed before the start of a subsequent contiguous 30-day period and results in change in the functional level, the second 30-day claim would have a change in the case-mix group.

   - Do not update the current 30-day claim. Update the assessment completion date (M0090) on the second 30-day claim.

   - No M1021 & M1023 on OFU

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**General OASIS Conventions**
The Definition of an Episode Can Be Different

For OASIS purposes, a quality or care episode must have a beginning (a SOC or ROC assessment) and a conclusion (a Transfer, Discharge, or Death at Home assessment) to be considered a complete quality episode.

Conventions to note

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

• If patient’s ability/status varies on day of assessment, report patient’s “usual status” or what is true greater than 50% of the assessment time frame, unless the item specifies differently
  – Example, for M2020 Management of Oral Medications and M2030 Management of Injectable Medications, instead of “usual status” or “> 50% of the time,” consider the medication for which the most assistance is needed
  – Not the “average” ability over a time period

• Code pressure ulcers based on the first skin assessment (may not update even within the allowed time frame for the assessment)

• Code GG items as close to the SOC/ROC as possible.

Conventions

• Responses to items documenting a patient’s current status should be based on observation and report of the patient’s condition and ability at the time of the assessment, without referring back to prior assessments.
  – Several process items allow “look back” at documentation at the time of or at any time since the most recent SOC/ROC OASIS assessment

• Minimize the use of NA and Unknown responses.
• Some items allow a dash response. Indicates no information was available. CMS expects dash usage to be a rare occurrence.
Conventions

• Combine observation, interview, collaboration with other agency staff and other relevant strategies to complete OASIS data items as needed

• However, when assessing current physiologic or functional health status, **direct observation** is the preferred strategy – avoid a “recliner assessment”

• When an OASIS item refers to assistance, this means **assistance from another person** unless otherwise specified within the item. **Assistance is not limited to physical contact and includes both verbal cues and supervision.**

Conventions

• Understand the definitions of words as used in the OASIS, and what’s included and excluded in item

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

• The comprehensive assessment includes the OASIS items and is part of the patient’s legal HHA clinical record.
Conventions

• Section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a physician/practitioner, nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law. They can:

(1) order home health services;

(2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care),

(3) certify and re-certify that the patient is eligible for Medicare home health services.

Collaboration

• CMS is promoting a team approach to data collection, as present in other PAC settings

• Comprehensive assessment includes OASIS items and is part of legal HHA clinical record. While only the assessing clinician is responsible for accurately completing and signing comprehensive assessment, they may collaborate to collect data for all OASIS items, as agency policy allows. (per CoPs)

  – Signature is attestation that to the best of their knowledge, the document reflects the patient status as assessed, and supported as documented.
Collaboration

- Collaboration may consider information from others such as patient, caregivers, physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to OASIS data collection. (per OASIS guidance effective 1/1/18)
  - Must function within their own practice act
  - Direct contact or other means: in-person, health care monitoring devices, video streaming, review of photo, phone call, etc.
  - Clinical patient assessment: base responses on assessment by agency staff, and not directly on documentation from other care settings (Q&A April 2018)

- Collaboration must occur within the appropriate assessment timeframe and consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.

- M0090 = last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including OASIS items. Must be within allowed assessment time frame. If not, M0090 is late.

Collaboration Considerations

- Need a way to identify what was collected by the clinician through assessment, and what was gathered from others via collaboration
- Who did you collaborate with?
- What information was shared?
- When did you discuss this information?
- How is this additional information going to be used to answer OASIS items?
- How is this collaboration going to be documented in the medical record?
Updating the Assessment During the Timeframe

**Official Answer:**
- Each OASIS item should be considered individually and coded based on the guidance provided for that item.
- Unless otherwise specified in item guidance, information collected by the assessing clinician during the timeframe for the specified assessment type may be used to inform OASIS coding.
- Note item guidance does specify special rules for coding pressure ulcer/injury and GG Function items at SOC/Resumption of Care (ROC). To support consistency of data collection related to pressure ulcers/injuries and GG function data across all Post-Acute care (PAC) providers cross-setting guidance directs coding for pressure ulcers/injuries to be based on the “first skin assessment” and coding for GG0130 – Self-Care and GG0170 – Mobility items should be based on a functional assessment that occurs at or soon after the patient’s SOC/ROC, and reflect the patient’s baseline ability to complete the activity, prior to the benefit of services provided by your agency staff. (July 2021, Q&A #1)

How Does Day of Assessment Mesh with Collaboration?

- When collaboration is used, other agency staff may provide information to the assessing clinician on what he/she assessed during a visit conducted during the assessment timeframe. Each person collaborating may provide information that was collected utilizing the existing conventions, including the “day of assessment.” For example, if desired, the PT who visited on Wednesday may provide information that was relevant to the PT’s “day of assessment” (the 24 hours that proceeded the PT’s visit, and the time the PT was in the home) to the RN for consideration when coding the SOC/ROC assessment items. OASIS Q&A July 2019
Scenario

The aide who visited the patient on Monday, discovered the patient had been hospitalized for two days and discharged home on Sunday. The RN visits the patient on Tuesday to do the ROC assessment and the PT visits on Wednesday, and the OT visits the patient on Thursday. Based on the expanded collaboration allowed, could the nurse use information from the aide and the PT and OT visits to complete ROC OASIS items?

a. RN visit only
b. RN, PT, OT since all are qualified clinicians
c. HHA, RN, PT because all 3 visits are within timeframe
d. HHA, RN, PT and OT because collaboration is allowed

Answer--OASIS Quarterly Q&A April 2018

The aide who visited the patient on Monday, discovered the patient had been hospitalized for two days and discharged home on Sunday. The RN visits the patient on Tuesday to do the ROC assessment and the PT visits on Wednesday, and the OT visits the patient on Thursday. Based on the expanded collaboration allowed effective January 2018, could the nurse use information from the aide and the PT and OT visits to complete ROC OASIS items?

a. RN visit only
b. RN, PT, OT since all are qualified clinicians
c. HHA, RN, PT because all 3 visits are within timeframe
d. HHA, RN, PT and OT because collaboration is allowed
Date Item Definitions

• **M0030**: Start of Care Date – date first reimbursable service is provided
• **M0032**: Resumption of Care Date – date of first visit following an inpatient stay by patient receiving services from the HH agency
• **M0090**: Date Assessment Completed - last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including OASIS items (data collection completed)

Section A

Administrative Information and Patient Tracking
Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
(A1005) Ethnicity

Intent: Identification of patients self reported ethnicity and health trend data

- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and cross multiple post-acute care settings.

Response-specific instruction:
- Ask the patient to select the category or categories that most closely correspond to his or her ethnicity from the list in A1005.
- If the patient is unable to respond, a proxy response may be used – code all that apply + X
- **Check all that apply.**
- Only if the patient is unable to respond and no family member or significant other is available, medical record documentation may be used.
- Dash is **NOT** a valid response

(A1005) Ethnicity – **Scenario #1**

The patient had an acute CVA with mental status changes. During the SOC the patient is unable to respond to questions regarding their ethnicity. The patient’s spouse informs the nurse that they are Cuban.
(A1005) Ethnicity – Scenario Answer #1

- **Coding:** A1005, Ethnicity would be coded as D - Yes, Cuban and X – Patient unable to respond.
- **Rationale:** If a patient is unable to respond and the proxy provides the response, code both the proxy response and X - Patient unable to respond.

(A1005) Ethnicity - Scenario

The patient is admitted following a THA and declines to respond to questions regarding their ethnicity.
(A1005) Ethnicity – Scenario #2 **Answer**

**Coding:** A1005, Ethnicity would be coded as Y – Patient declines to respond.

**Rationale:** If a patient declines to respond to this item, then the only response option that should be coded is Y – Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1005, Ethnicity when a patient declines to respond.

---

(A1010) Race

*Intent: Identification of patient self-reported race data and health trend data*

- Collection of the race data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute care settings.

**Response-specific Instructions**

- Ask the patient to select the category or categories that most closely correspond to his or her race from the list in A1010, Race.
- If the patient is unable to respond, a proxy may be used – code all that apply + X
- **Check ALL that Apply!**
- If neither the patient nor a proxy is able to respond to this item use medical record documentation.
- Dash is NOT a valid response!
(A1010) Race – Scenario #1

The patient has severe dementia with agitation. During the SOC assessment the patient is unable to respond. The patient’s child informs the nurse that the patient is Korean and African American.

(A1010) Race – Scenario #1 Answer

• **Coding:** A1010 would be coded as B - Black or African American, H - Korean, and X – Patient unable to respond.

• **Rationale:** If a patient is unable to respond and the proxy provides the response, code both the proxy response and X – Patient unable to respond.
(A1010) Race – Scenario #2

The patient is admitted to the HHA following a recent CVA resulting in confusion and is unable to inform the assessing clinician which race applies to them. The proxy reports that none of the listed races apply to the patient.

Coding: A1010, Race would be coded as X, Patient unable to respond and Z, None of the above.

Rationale: If a patient is unable to respond, proxy input may be used to code A1010, Race. When a patient is unable to respond but proxy input can provide the necessary information, code both the information from the proxy input, in this case- Z, None of the above, and X, Patient unable to respond.
(M0150) Current Payment Sources for Home Care
Identifies payers who will be billed by your home health agency for services provided during the home health episode.

- Exclude pending payer sources.
- If the patient’s care is being reimbursed by multiple payers (for example, Medicare and Medicaid; private insurance and self-pay; etc.), include all sources.
- If one or more payment sources are known but additional sources are uncertain, mark only those that are known.

Dual Eligibility

“The Medicare-Medicaid dual eligible population is a unique and diverse group generally characterized as “high-risk” because dual eligible individuals have a combination of complex clinical and behavioral conditions that are compounded by poverty.”

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Duals with Multiple Conditions (physical or behavioral)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2+ Conditions</td>
<td>77%</td>
</tr>
<tr>
<td>3+ Conditions</td>
<td>60%</td>
</tr>
<tr>
<td>4+ Conditions</td>
<td>41%</td>
</tr>
<tr>
<td>5+ Conditions</td>
<td>25%</td>
</tr>
</tbody>
</table>

Dual status is a significant risk factor and one of the greatest predictors of poor health status/health outcomes!
(A1100) Language

**INTENT:** Identify inability to make needs known and to prevent isolation, depression and unmet needs due to language barrier. To ensure language barrier doesn’t interfere with accurate assessment.

**Assessment Steps:**
- Ask the patient’s preferred language that the patient primarily speaks or understands
- Ask patient if an interpreter is needed or wanted to communicate with doctor or staff
- If the patient is unable to respond, ask family member or significant other.
- If neither source available review record
- A1110A – Dash is a valid response
- A1110B – Dash is NOT a valid response (code 9 is unable to determine)

**Coding Tip:** American Sign Language (ASL) can be reported as preferred language.

*Social Determinant of Health (SDOH)*

---

(A110) Language

**Relevance to HHAs**

- More than 64 million people in the United States speak a language other than English at home, and nearly 40 million of those individuals have limited English proficiency (LEP).
- Individuals with LEP have been shown to receive worse care and have poorer health outcomes, including higher readmission rates.
- Communication with individuals with LEP is an important component of quality health care, which starts by understanding the population in need of language services.
- Unaddressed language barriers between a patient and provider care team negatively affects the ability to identify and address individual medical and non-medical care needs, to convey and understand clinical information, and to convey and understand discharge and follow-up instructions, all of which are necessary for providing high-quality care.
- Understanding the communication assistance needs of patients with LEP, including individuals who are deaf or hard of hearing, is critical for ensuring good outcomes.
(A1250) Transportation

**Intent:** to identify transportation needs

### Assessment Strategies:
- Ask patient if in **past 6 months to a year**, did transportation interfere with keeping medical and non-medical appointments, or getting things you need.
- Patient should be allowed to select more than one yes response.
- Proxy and medical record information may be used.
- Check all that apply.

*Social Determinant of Health (SDOH)*

---

(A1250) Transportation

**Relevance to HHAs**

- Transportation barriers can affect access to needed health care, causing missed appointments, delayed care, and unfilled prescriptions, all of which can have a negative impact on health outcomes.
- Access to transportation for ongoing health care and medication access needs, particularly for those with chronic diseases, is essential to successful chronic disease management.
- Adopting a data element to collect and analyze information regarding transportation needs across PAC settings would facilitate the connection to programs that can address identified needs.
Transfer of Health

Quality Measures & Meaningful Measures

- Poor communication and coordination across health care settings contribute to patient complications, hospital readmissions, emergency department visits, and medication errors.

- Communication has been cited as the third most frequent root cause in sentinel events, which The Joint Commission defines as a patient safety event that results in death, permanent harm, or severe temporary harm.

- Failed or ineffective patient handoffs are estimated to play a role in 20 percent of serious preventable adverse events.

- When care transitions are enhanced through care coordination activities, such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans and prevent medical errors.

Transfer of Health Information

Two companion measures:

1. Transfer of Health Information to the Provider–Post-Acute Care Measure.
   - Assess the timeliness of transfer of a reconciled med list to the next care setting when a patient is transferred or discharged from the current PAC setting to another provider.
   - Facilitates safer coordination of care.

2. Transfer of Health Information to the Patient–Post-Acute Care Measure.
   - Assess the timeliness of transfer of a reconciled med list to the patient, family, or caregiver when a patient is discharged from a PAC setting to a private home, ALF, or group home.
   - Guidance specifies that medication information is written in plain, easy-to-understand language.
   - Facilitates a safe, effective transition from care.

***New OASIS-E Items: A2120, A2121, A2122, A2123, A2124***
Medication Reconciliation and Management

- 80% of medication errors occur during handoffs between settings
- Med errors are usually related to the transmission of inaccurate discharge medication lists
- Med errors make up one-fifth of all adverse events
- One study showed 90% of patients experience at least one discrepancy in transition from hospital to home health
- Upon discharge to home patients are often faced with numerous medication changes, new med regimens, and follow-up details

Transfer of Health

Reconciled Medication List

- A reconciled medication list of the current prescribed and over-the-counter medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route to the patient at the time of discharge or transfer.
- Medications may also include but are not limited to total parenteral nutrition and oxygen.
- The current medications should include those that are (1) active, including those that will be discontinued after discharge, and (2) those held during the stay and planned to be continued/resumed after discharge.
- If deemed relevant to the patient’s care by the subsequent provider, medications discontinued during the stay may be included.
Transfer of Health

Reconciled Medication List

A reconciled medication list often includes important information about:

1. the patient - including their name, date of birth, information, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions, and
2. each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, any special instructions (e.g., crush medications); and, for any held medications, the reason for holding the medication and when medication should resume. This information can improve medication safety.

May also include the patient’s weight and date taken, height and date taken, preferred language, and ability to self-administer medication; when the last dose was; and when the final dose should be administered (e.g., end of treatment).

M2410 Impact on A2120 at Transfer - Info to Provider

Captures the percentage of patients with a timely transfer of health information (reconciled med list); not risk-adjusted

If RFA 6 or RFA 7 Completed
### M2420 Impact on A2121 at Discharge – Info to Provider

Captures the percentage of patients with a timely transfer of health information (reconciled med list); not risk-adjusted

- This is answered when M2420 is answered 2 or 3.
- Only skilled services from a certified HHA counts for 2.

#### A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No – Current reconciled medication list not provided to the subsequent provider</td>
<td>Skip to B1300, Health Literacy</td>
</tr>
<tr>
<td>1. Yes – Current reconciled medication list provided to the subsequent provider</td>
<td>Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider</td>
</tr>
</tbody>
</table>

#### A2122 Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

<table>
<thead>
<tr>
<th>Route of Transmission</th>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Electronic Health Record</td>
<td></td>
</tr>
<tr>
<td>B. Health Information Exchange Organization</td>
<td></td>
</tr>
<tr>
<td>C. Verbal (e.g., in-person, telephone, video conferencing)</td>
<td></td>
</tr>
<tr>
<td>D. Paper-based (e.g., fax, copies, printouts)</td>
<td></td>
</tr>
<tr>
<td>E. Other Methods (e.g., texting, email, CDs)</td>
<td></td>
</tr>
</tbody>
</table>

After completing A2122, skip to B1300, Health Literacy at Discharge

### A2123 & A2124 Med Reconciliation Items to PATIENT on D/C

Captures the percentage of patients with a timely transfer of health information (reconciled med list); not risk-adjusted. **COMPLETE if Response to M2420 is a 1, 4 or UK.**

#### A2123 Provision of Current Reconciled Medication List to Patient at Discharge

At the time of discharge, did your agency provide the patient's current reconciled medication list to the patient, family and/or caregiver?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No – Current reconciled medication list not provided to the patient, family and/or caregiver</td>
<td>Skip to B1300, Health Literacy</td>
</tr>
<tr>
<td>1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver</td>
<td>Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient</td>
</tr>
</tbody>
</table>

Dash is NOT a valid response

#### A2124 Route of Current Reconciled Medication List Transmission to Patient

Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

<table>
<thead>
<tr>
<th>Route of Transmission</th>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Electronic Health Record</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>E. Other Methods (e.g., texting, email, CDs)</td>
<td></td>
</tr>
</tbody>
</table>
A2122 & A2124 Same Guidance

Item Rationale
These items collect important data to monitor how medication lists are transmitted at transfer/discharge to the subsequent provider and at discharge to the patient, family, and caregiver.

A2122/A2124 Response Choice Definitions

- **Code A2122A/A2124A, Electronic Health Record**, if your agency has an EHR and used it to transmit or provide access to the reconciled medication list to the subsequent provider, patient, family, and/or caregiver. This would include situations where both the discharging and receiving provider have direct access to a common EHR system. This could also include providing the patient with direct access to their EHR medication information through a patient portal.

- **Checking this route does not require confirmation that the patient has accessed the medication list from the portal or the subsequent provider has accessed the common EHR system for the medication list.**

- **Code A2122B/A2124B, Health Information Exchange**, if your agency participates in a Health Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider, patient, family, and/or caregiver.
A2122/A2124 Response Choice Definitions

- **Code A2122C/A2124C, Verbal**, if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider, patient, family, and/or caregiver.

- **Code A2122D/A2124D, Paper-Based**, if the current reconciled medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using a paper-based method such as a printout, fax or efax.

- **Code A2122E/A2124E, Other Methods**, if the current reconciled medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using another method, not listed above (e.g., texting, email, CDs).

- **Dash** is **NOT** a valid response for this item.

Transfer of Health Scenario

The patient is being transferred from home health to an acute care hospital in the same healthcare system which uses the same electronic health record (EHR). The patient’s current reconciled medication list at the time of transfer from the agency is accessible to the subsequent acute care hospital staff admitting them and this is how the medication list is shared. The HHA did not notify the hospital of the med list in the EHR.
Transfer of Health **Answer**

**Coding:**
A2120 would be coded 1, Yes.
A2122 would be marked A, Electronic Health Record

**Rationale:** Having access to the patient’s medication list through the same EHR system is one way to transfer a medication list. This code of 1, Yes, is used for this passive means of transferring the medication list when the sending and receiving provider can access the same EHR system.

---

Transfer of Health **Scenario**

<table>
<thead>
<tr>
<th>A2124. Route of Current Reconciled Medication List Transmission to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate the route(s) of transmission of the current reconciled medication list to the patient, family, and/or caregiver.</td>
</tr>
</tbody>
</table>

**Route of Transmission**

A. Electronic Health Record  □
B. Health Information Exchange □
C. Verbal (e.g., in-person, telephone, video conferencing) □
D. Paper-based (e.g., fax, copies, printouts) □
E. Other Methods (e.g., texting, email, CDs) □

A patient will not be taking any prescribed or over-the-counter medications at the time of discharge. It is clearly verbally communicated to the patient and family, given in writing in the discharge packet and is part of the documentation available in the EHR that the patient can access.
Transfer of Health **Answer**

**Coding:**
A2123 would be coded 1, Yes
A2124 would be A, EHR, C, Verbal, and D, Paper-based

**Rationale:** Information confirming that the patient is not taking any medications at discharge is provided to the patient, family, and/or caregiver and meets the item intent of providing the patient’s current reconciled medication list to the patient, family, and/or caregiver for A2123. In A2124, all routes that the information is communicated should be marked.

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**M2420 Discharge Disposition**

**ITEM INTENT**
- Identifies where the patient resides after discharge from the home health agency.

**Why important?**
- Purpose of home care is to increase patient independence in self-care
- Goal is discharged to community
- Important in determining to whom the medication reconciliation list goes to for the TOH outcome
- Important in M2420 VBP outcome
Discharge to Community

**Measure Description:**
Percentage of home health episode after which patients remained at home.

**Numerator:**
Number of home health episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge.

**Denominator:**
Number of home health quality episodes ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.

**Exclusions:**
Home health quality episodes that end in patient death.

**OASIS Item:** (M2420) Discharge Disposition

---

M2420 Discharge Disposition

*Change Related to TOH*

**Changes per OASIS Q&As Jan 2020:**
- **Formal assistive services** refer to community-based services provided through organizations or by *paid helpers*. Examples: homemaking services under Medicaid waiver programs, personal care services provided by an HHA, paid assistance provided by an individual, and home-delivered meals provided by organizations like Meals-on-Wheels.
- **Informal services** are provided by friends, family, neighbors, or other individuals in the community for which *no financial compensation* is provided. Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members/friends/volunteer.
M2420 Discharge Disposition

Changes per OASIS Q&As Jan 2020:

- **Response 1** Patient remained in the community (**without formal assistive services**) if:
  - after discharge from your agency the patient remained in a non-inpatient setting,
  - **AND** either with no assistive services,
  - **Or** with ANY assistive services EXCEPT:
    - 1. Skilled services from another Medicare-certified home health agency, and/or

- **Response 2** Patient remained in the community (**with formal assistive services**) if:
  - after discharge from your agency the patient remained in a **non-inpatient** setting,
  - receiving **skilled services** from another **Medicare-certified home health agency**,(with or without other assistive services).
  - or when an agency completes a discharge and new SOC OASIS due to a pay source change for a patient.
Examples:

Response 1 = D/C
Home with:
- Meals on Wheels
- Private duty help
- Provider type programs
- Help from neighbors
- Nonskilled services
- No assist
- *Getting Dialysis 3 days a week*
- *Outpatient therapy*

Response 2 = D/C
Home with:
- Skilled services from another Medicare certified home care agency
- Also answered at DC if your agency is readmitting for Medicare certified skilled services

Response 3 = D/C
Home with:
- Non-institutional hospice

Discharge Disposition

*Change Related to M2420 Outcome -- Q&As October 2021*

Death at Home
- A patient dies less than 24 hours after being admitted to an inpatient facility, or,
- A patient dies in the emergency room (ER), or,
- A patient dies in outpatient surgery.

Transfer
- *A qualifying inpatient stay is defined as a patient being admitted to an inpatient facility for 24 hours or more for reasons other than diagnostic testing.*
Practice **Scenario #1**

- A patient being seen by ABC Home Care began to have difficulty breathing and 911 was called. The patient was treated in the ER and then held for a couple more hours that day for observation. During that time the patient expired. What assessment would the agency complete?

  - RFA6 Transfer
  - RFA 7 Transfer d/c from agency
  - RFA 8 Death at Home
  - RFA 9 Discharge from agency

**Answer Scenario #1**

- Before this guidance release we would have completed a Transfer, however now we will complete an RFA 8 Death at Home.

  - RFA6 Transfer
  - RFA 7 Transfer d/c from agency
  - **RFA 8 Death at Home**
  - RFA 9 Discharge from agency
Practice Scenario # 2

• Mr. C, a patient of ABC Home Health is sent to an SNF for respite care while the family goes on vacation. 5 days after his arrival he dies. Which OASIS should be completed?

- RFA6 Transfer
- RFA 7 Transfer d/c from agency
- RFA 8 Death at Home
- RFA 9 Discharge from agency

Answer Scenario # 2

• There is a Q&A that SNF respite is considered an inpatient transfer so RFA 7 Transfer d/c from the agency would have already been completed with admission to SNF for respite care.
Practice Scenario #3

• Patient is at the hairdresser and suddenly collapses and dies. She is a patient with ABC Home Health, what OASIS assessment should be completed?

- RFA6 Transfer
- RFA 7 Transfer d/c from agency
- RFA 8 Death at Home
- RFA 9 Discharge from agency

Answer Scenario #3

• Even though the patient was out of the home when the death occurred the agency would complete an RFA 8 Death at Home.

- RFA6 Transfer
- RFA 7 Transfer d/c from agency
- RFA 8 Death at Home
- RFA 9 Discharge from agency
Timely Initiation of Care

M0102 Date of Physician-ordered SOC (or ROC)

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

- Must be a single specific date to initiate or resume care, not a range of dates

Star Item

M0102/M0104 is based on SOC/ROC date; CoP is based on initial assessment

Item Intent: The date specified by a physician/allowed practitioner order to start home care services (that is, provide the first covered service), or resume home care services (that is provide the first visit following a qualifying inpatient stay) regardless of the type of services ordered (for example, therapy only).

- Must be a single specific date to initiate or resume care, not a range of dates
M0102 Date of Physician-ordered SOC (or ROC)

- *Mark NA if physician orders do not specify SOC/ROC date, or if the order to extend the physician’s ordered SOC/ROC date is received after the date of the previous order has passed.*
- If originally ordered SOC/ROC date is delayed due to patient condition or physician request (example: extended hospitalization), enter new ordered SOC/ROC date in M0102
- If a specific SOC/ROC date beyond the 48 hours is requested, must receive order/approval for new date **on or before** the end of the 48-hour initial assessment time frame

M0104 Date of Referral

- Specifies the most recent date that verbal, written, or electronic authorization to begin/resume home care was **received** by the home health agency
- General order to “Evaluate for Home Care services” (no discipline(s) specified) received from a physician who will be following the patient is valid referral date
- Skipped if date entered in M0102
M0104 Date of Referral

- If SOC is delayed due to the patient’s condition or physician request, and agency received updated/revised information
- If a hospitalist (or other referring physician) is not going to provide orders and follow the patient, this is not a valid "referral" for (the purpose of) completion of M0104
  - The HHA must contact an alternate, or attending physician, and upon agreement from this following physician for referral and/or further orders, the HHA will note this as the referral date in M0104 (unless referral details are later updated or revised).
  - *The clock doesn’t run until you find a provider that will sign the orders.*

What *isn’t* the M0104 date

- Calls from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
- Date authorization was received from the patient’s payer is NOT the date of referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).
- Date agency confirms a PDGM acceptable primary diagnosis for reimbursement.
M1005 Inpatient Discharge Date (most recent)

- Identifies the date of the most recent discharge from an inpatient facility (within past 14 days)

Timely Initiation of Care Star Calculation

**M items used:**
- (M0102) Date of Physician-ordered SOC/ROC
- (M0104) Date of Referral
- (M0030) SOC Date or
- (M0032) ROC Date
- (M0100) Reason for Assessment
- (M1000) Which Inpatient Facility discharged from
- (M1005) Inpatient Discharge Date

*Process Measure – not risk adjusted*

*Common Error: Not documenting a delay in care, not documenting physician confirmation/communication*
Timely Initiation of Care

Quality episodes where the SOC/ROC Date was:

1) Same as physician-ordered date
   \[ M_{0030} = M_{0102} \]
   or

2) Within 2 days of referral
   \[ M_{0030} \leq M_{0104} + 2 \text{ days} \] (if M0102 N/A)
   or

3) Within 2 days of Discharge
   \[ M_{0030} \leq M_{1005} + 2 \text{ days} \] (if M0102 N/A & M1005 > M0104)

Timely Initiation of Care

- Conditions of Participation require the initial assessment to determine the patient's eligibility for home care services and immediate care needs; and must be conducted either:
  - Within 48 hours of the date of referral OR
  - Within 48 hours of return home from inpatient facility OR
  - On the physician-ordered SOC or ROC date

- Initial assessment vs. SOC visit dates
**Practice Scenario #1**

- HH Agency gets a referral from the hospital on Mr. Smith on Feb. 1, with an anticipated DC date of Feb. 3.
- Agency checks hospital census report daily and sees Mr. Smith is still in the hospital end of day on Feb. 3 and there's no answer at his home number. Contact with hospital: patient has a UTI and they are keeping him another day or two to make sure he responds to antibiotic.
- Patient is discharged from hospital to home on **Feb. 7** and you find out about it when the family calls you.
- Agency does initial assessment and SOC visit on **Feb. 8**. How should the following be scored?
  - M0030
  - M0102
  - M0104
  - M1005

**Scenario Answer #1**

- HH Agency gets a referral from the hospital on Mr. Smith on Feb 1, with an anticipated DC date of Feb 3.
- Agency checks hospital census report daily and sees Mr. Smith is still in the hospital end of day on Feb 3 and there's no answer at his home number. Contact with hospital: patient has a UTI and they are keeping him another day or two to make sure he responds to antibiotic.
- Patient is discharged from hospital to home on **Feb 7**.
- Agency does initial assessment and SOC visit on **Feb 8**.
  - M0030 – Feb 8
  - M0102 – NA
  - M0104 – Feb 3 (updated info received?)
  - M1005 – Feb 7

Meet criteria for timely initiation of care?
**Scenario #2: Patient Requests Delay**

- A referral is received by the agency from a physician office on March 1. The agency calls the patient to set up the initial visit and the patient requests a delay in the SOC visit to March 4 because his daughter can be there that day and she wants to be there.

- Problem: March 4 is outside the 48-hour time period allowed for the initial assessment/SOC visit.

- How will you score this?

**Scenario #2 Answer: Patient Requests Delay**

<table>
<thead>
<tr>
<th>Physician/NPP Not Informed</th>
<th>Physician/NPP Informed &amp; New SOC Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>• M0030: March 4</td>
<td>• M0030: March 4</td>
</tr>
<tr>
<td>• M0102: NA</td>
<td>• M0102: March 4</td>
</tr>
<tr>
<td>• M0104: March 1</td>
<td>• M0104: skipped if date entered in M0102</td>
</tr>
<tr>
<td>• M1005: skipped, no inpatient discharge in past 14 days</td>
<td>• M1005: skipped</td>
</tr>
</tbody>
</table>

*This requires that the order be received prior to or on March 3*
Scenario #3

• The patient has been on service with the agency for several weeks, goes into the hospital and doesn’t call the agency to let them know. When the RN makes her next visit on April 10, she finds out the patient was hospitalized April 1 and came home April 5. She determines that the inpatient stay met the criteria for a Transfer. She calls the physician to obtain any new orders at the visit on April 10 and provides care that is billable.

  • M0032
  • M0102
  • M0104
  • M1005

Scenario #3 Answer

• The patient has been on service with the agency for several weeks, goes into the hospital and doesn’t call the agency to let them know. When the RN makes her next visit on April 10, she finds out the patient was hospitalized April 1 and came home April 5. She determines that the inpatient stay met the criteria for a Transfer. She calls the physician to obtain any new orders at the visit on April 10 and provides care that is billable.

  • M0032 = April 10
  • M0102 = NA
  • M0104 = April 10 (verbal authorization for care)
  • M1005 = April 5

What is the M0090 date?
Section B: Hearing, Speech, Vision

The items in this section assess the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.

<table>
<thead>
<tr>
<th>Section B</th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B0200 Hearing</td>
<td>X</td>
<td></td>
<td></td>
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<td>New Item</td>
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<tr>
<td>M1200 Vision</td>
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<tr>
<td>B1000 Vision</td>
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<tr>
<td>B1300 Health Literacy</td>
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<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>New Item</td>
</tr>
</tbody>
</table>

SOC ROC ROC FUF TRF DCD DAH
B0200 Hearing

Item Intent: Identifies the patient’s ability to hear (with assistive devices, if they are used).

- Addresses reversible causes of hearing loss
- Identify the need and benefit of assistive hearing devices
- Identify other communication strategies for individuals with hearing loss not corrected by hearing device
- Hearing impairments can be mistaken for cognitive impairment
- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.

B0200 – Hearing Response Choices

Ability to hear (with hearing aid or hearing appliances if normally used)

0. Adequate - no difficulty in normal conversation, social interaction, listening to TV

1. Minimal difficulty – Patient hears conversational levels but difficulty with quiet listening conditions or when not 1 on 1 situations. Hearing adequate if environmental adjustments made such as background noise.

2. Moderate difficulty - speaker has to increase volume and speak distinctly. Patient able to compensate with speaker adjusts tonal quality and volume or speaks directly; or patient can hear only when speaker’s face is visible.

3. Highly impaired - absence of useful hearing. Patient only hears some sounds and fails to respond when volume and tonal quality changes. There is no comprehension of conversational speech.

Dash IS a valid response
B0200 Hearing

**Assessment Tips:**

- Reduce background noise
- Ensure patient is using normal assistive hearing devices if applicable.
  - Some patients choose to use amplifiers, microphones, and headphones instead of hearing aids
- Interview patient about different situations (e.g., using telephone, watching TV, conversations, attending activities)
- Use observation of conversations with others
- Use best communication methods for this patient such as, louder voice, face patient, use gestures, speak slower, take patient to quieter area.

B1000 Vision

**SOC assessment**

- Dash IS a valid response

**Item Intent:**
Identifies the patient’s ability to see objects nearby in their environment, in adequate light, and with glasses or other visual appliances. *Other visual appliances includes magnifying glass.*
B1000 Vision

Assessment Tips

- Ensure customary visual appliance for close vision is in place like glasses and/or magnifying glass
- Ensure Adequate lighting—lighting that is sufficient or comfortable for a person with normal vision to see fine detail
- Use variety of print sizes, read pill bottle, newspaper etc
- If patient unable to read, use pictures to assess vision
- If patient is not able to communicate well, do not assume patient response 4, do eyes follow objects?

B1300 – Health Literacy

Response-Specific Instructions

- This item is intended to be a patient self-report item. No other source should be used to identify the response.
- Ask the patient, “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?”

Dash is NOT a valid response
B1300 – Health Literacy - **Scenario**

When asked how often they need help when reading the instructions provided by their doctor, the patient reports that they never need help. The patient’s son is present and shares that a family member must always accompany the patient to doctors’ visits and that the patient often needs someone to explain the written materials to them multiple times before they understand, providing examples of needing to frequently explain to the patient why they are on a special diet and why and how to take some of their medications.

**B1300 – Health Literacy – Scenario Answer**

**Coding:** B1300, Health Literacy is coded as Code 0, Never.

**Rationale:** The patient indicated they never need help reading instructions from their doctor or pharmacist. **B1300, health literacy is intended to be a patient self-report item and no other sources, including proxy/caregivers, should be used to identify the response to this item.**
Health Literacy Definition

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

(National Academy of Sciences, Engineering, and Medicine, 2015).

9 out of 10
Adults lack health literacy needed to manage their own care

Impact of Health Literacy

Similar to language barriers, low health literacy can interfere with provider/patient communication

- Inability to understand treatment plans
- Inability to understand medication regimen
- Worse health outcomes
- Lower knowledge about health
- Receipt of fewer preventive services
- Higher medical costs
- More frequent ER visits
Visualizing Health Project

*The benefits of risk reduction example*

- This image presents a risk estimate to a patient, and more importantly, it also shows them how much that risk could be reduced.

- It uses an icon array display, which research has shown is a particularly effective type of graphic at showing risk, but which needed new thinking about how to show risk reduction.

http://www.vizhealth.org/gallery/

---

Improving Health Literacy

- Make sure teaching is in language and literacy level that patient understands
- Don’t use jargon – use terms and language the pt and cg understand
- Determine patients learning style
- Teach using preferred learning methods
  - Teach and Reteach (Teachback)
- Breakdown into smaller teaching segments if need
- Do not assume pts are knowledgeable or have retained info
- Evaluate understanding using teach back techniques
- Materials available in large font, simple language, uncluttered and easy to read
### Section C

#### Cognitive Patterns

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SOC</th>
<th>ROC</th>
<th>FU</th>
<th>TRF</th>
<th>DC</th>
<th>DAH</th>
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<tbody>
<tr>
<td>C0100</td>
<td>BIMS Interview Attempted</td>
<td></td>
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<td></td>
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<tr>
<td>C0200</td>
<td>BIMS: Repetition of Three Words</td>
<td>X</td>
<td>X</td>
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<tr>
<td>C0300</td>
<td>BIMS: Temporal Orientation</td>
<td>X</td>
<td>X</td>
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<tr>
<td>C0400</td>
<td>BIMS: Recall</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>C0500</td>
<td>BIMS: Summary Score</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>C1310</td>
<td>Signs/Symptoms of Delirium</td>
<td>X</td>
<td>X</td>
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<td>M1700</td>
<td>Cognitive Functioning</td>
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<tr>
<td>M1710</td>
<td>When Confused</td>
<td>X</td>
<td>X</td>
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<tr>
<td>M1720</td>
<td>When Anxious</td>
<td>X</td>
<td>X</td>
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</tr>
</tbody>
</table>

- X: Present
- New Item: New item added to the checklist.
Cognition and SPADE Research

CMS has identified several data elements as applicable for cross-setting use in the standardized assessment of cognitive impairment.

1. The BIMS
2. The Confusion Assessment Method (CAM)


www.mdapp.co/psychiatry Start practicing now!!

Brief Interview for Mental Status Screening Tool (BIMS)

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Assessment of repetition and recall with and without prompting
- Assessment of temporal orientation
- Results in cognitive function score
- Not designed to diagnose dementia or cognitive impairment
- Identifies cognitively impaired who may be at risk for decline
- Cognitive impairment is also associated with re-hospitalization among elderly patients receiving home health care
BIMS Rationale:

- Cognitively intact patients may appear to be cognitively impaired because of extreme frailty, hearing impairment, or lack of interaction.
- Some patients may appear to be more cognitively intact than they are.
- When cognitive impairment is incorrectly diagnosed or missed appropriate communication, worthwhile activities and therapies may not be offered.
- An abrupt change in cognitive status may indicate delirium and maybe the only indication of a potentially life-threatening illness.
- A decline in mental status may also be associated with a mood disorder.
- Awareness of possible impairment may be important for maintaining a safe environment and providing safe, comprehensive discharge planning.

C0100 – Should Brief Interview for Mental Status Conducted?

- Determine attention, orientation, and ability to register and recall information.
- Complete if patient is at least sometimes understood
- If patient communicates with American Sign Language
- If patient uses interpreter and interpreter present
- Most patients will be able to attempt BIMS
- Dash IS a valid response option but CMS does not expect to see
BIMS : C0200- C0500

The purpose of BIMS:
1. Establish cognitive baseline.
2. Establish the ability to understand and participate in treatment.
3. Ensure safety of the patient.
4. Identify resources needed upon discharge.

C0200 – Repetition of Three Words

- The inability to repeat three words on first attempt may indicate: a memory impairment, a hearing impairment, a language barrier, or inattention that may be a sign of delirium or another health issue.
- Nonsensical responses should be coded as zero.
- **Score number of words repeated on 1st attempt only**
- After first attempt repeat words with cues to help with recall for later.
- If patient's primary method of communications is writing, then it can be administered in writing.

Dash IS a valid response

Many examples in guidance
BIMS Repetition and Category Cues--

**Say to the patient**

I am going to say 3 words for you to remember. Please repeat the words after I have said all three. The words are sock, blue, and bed. Now please tell me the three words.

**All three correct**

- That's right. The words are sock, something to wear; blue, a color; and bed, a piece of furniture.
- The words may be in any order.
- The words may be according to category, e.g., shirt, shoe, sock or any context.

**Recalled two or fewer words**

- Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the 3 words.

**Unable to recall all 3 words**

- Repeat the words one more time.

---

**Examples C0200**

- Clinician: I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now please tell me the three words.

- Patient: Bed, sock, blue.

- Clinician: That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture.

Score?
Examples C0200

• Clinician: I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now please tell me the three words.
• Patient: Bed, sock, black.
• Clinician: Let me say the three words again. The words are sock, something to wear; blue, a color; and bed, a piece of furniture.
• Patient: Oh, that's right. Bed, sock, blue.
• Score?

Examples C0200

• Clinician: I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are sock, blue, and bed. Now please tell me the three words.
• Patient: What were those words again?
• Clinician: Let me say the three words again. The words are sock, something to wear; blue, a color; and bed, a piece of furniture.
• Patient: Oh, that's right. Bed, sock, blue.
• Score?
C0300 – Temporal Orientation

- The ability to place oneself in correct time.
- For BIMS, it is the ability to indicate the correct date in current surroundings.
- Patient **allowed 30 seconds to answer without any hints** from assessor.
- A lack of temporal orientation may lead to decreased communication or participation in activities.
- Not being oriented may be frustrating or frightening.
- Interviewer should reorient the patient if necessary to reduce anxiety.

Stop here if not complete

If 0 is chosen, document whether:
- Refused to answer
- Nonsensical
- Provided incorrect answer

Current day is day 1

If 0 is chosen, document whether:
- Refused to answer
- Nonsensical
- Provided incorrect answer
Stopping the BIMS Before it is Complete

Stop the interview after completing (C0300C) “Day of the Week” if:
• All responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR
• There has been no verbal or written response to any of the questions up to this point, OR
• There has been no verbal or written response to some questions up to this point and for all others, the patient has given a nonsensical response.

If the interview is stopped, do the following:
• Code “-” (dash) in C0400A, C0400B, and C0400C.
• Code 99 in the summary score in C0500.
  ➢ If all responses to C0200, C0300A, C0300B, and C0300C are 0 because answers are incorrect, continue interview. For example, red, chair, shoe, 1954, December.

C0400 Recall

• Allow 5 seconds for spontaneous recall of each word.
• For any word that is not correctly recalled after 5 seconds, provide a category cue. Category cues should be used only after the patient is unable to recall one or more of the three words.
• Allow up to 5 seconds after category cueing for each missed word to be recalled.

Dash IS a valid response
**BIMS Recall and Category Cues**

<table>
<thead>
<tr>
<th>Say to the patient</th>
<th>2 – Yes; no cue required</th>
<th>1 – Yes: after cueing</th>
<th>0 – No; could not recall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let's go back to an earlier question. What were those three words that I asked you to repeat?</td>
<td>Patient remembers the word spontaneously without cueing.</td>
<td>Patient requires the category cue to remember the word.</td>
<td>Cannot recall even after cue</td>
</tr>
<tr>
<td>• Allow 5 seconds for spontaneous recall.</td>
<td>• The words may be in any order.</td>
<td>• Something to wear; (allow 5 seconds)</td>
<td>Chooses not to answer</td>
</tr>
<tr>
<td></td>
<td>• On the first try the patient names multiple items in a category, including the correct word, e.g., shirt, shoe, sock</td>
<td>• A color; (allow 5 seconds)</td>
<td>Nonsensical answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A piece of furniture. (allow 5 seconds)</td>
<td>Names multiple items in a category even if one is correct.</td>
</tr>
</tbody>
</table>

**BIMS Important Definitions**

**Nonsensical Response**

- Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.

**Complete Interview**

- The BIMS interview is considered complete if the patient attempted and provided relevant answers to at least four of the questions included in C0200 – C0400C.

- Relevant answers do not have to be correct but do need to be related to the question.
BIMS Coding Tip

- Nonsensical responses, incorrect answers, and questions the patient chooses not to answer should be coded as zero.
  - Code refusals as incorrect/no answer or could not recall.

- The assessing clinician should track the reason for coding answers as zero because this information will be used later for the coding of the summary score in C0500.

If 0 is chosen, document whether:
- Refused to answer
- Nonsensical
- Provided incorrect answer

Place “-” in A, B, and C if assessment was stopped after C0300.
• Select “99” (incomplete) if there are any dashes, 4 or more responses with no answer or nonsensical answers.

• Total each score if “99” does not apply. Count all incorrect responses as 0 in determining the total score (00-15).

Scenario BIMS

Mrs. D is easily understood and is given the words sock, blue and bed. She initially remembers all three in the correct sequence. The day of assessment is Friday June 11th, 2023. When asked the day of the week Mrs. D says Sunday. When asked for the month and year she stated it was May 2019. When the assessor asks for Mrs. D to give her the 3 words again, she could say sock, but when they got to the next word she was drawing a blank until the nurse said it’s a color. She then stated the third word was chair. What would correct responses be for the BIMS items?
Scenario Answer

- C0100 should BIMS be conducted – Yes, the assessment is conducted since Mrs. D is understandable.
- C0200 Repetition of words is yes, she recalls all the terms. (3)
- C0300 Temporal Orientation –
  A. Correct Year – Response 1. Patient missed year by 4 yrs. Stating it was 2019 not 2023. (1)
  B. Correct Month – Response 1 missed correct month by a month. (1)
  C. Day of the week – Incorrect (0)
- C0400 Recall –
  A. Able to recall sock – response 2 – yes (2)
  B. Able to recall blue – Yes after cue for “a color” (1)
  C. Able to recall bed – No- could not recall stated chair not bed. (0)

C0500 Total Score – add the scores from C0200 – C0400 for a score of 8/15 (Moderately Impaired)

How much longer will the BIMS take?

CMS has calculated through testing that the time to complete in the HHA setting, after we become familiar with the BIMS assessment, will be about 2 ½ minutes additionally to the OASIS assessment.
CAM
Confusion Assessment Method

DELIRIUM
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.

C1310 A-D Signs and Symptoms of Delirium

CAM - Confusion Assessment Method

- Helpful in distinguishing delirium and reversible confusion from other types of cognitive impairment.
- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection of delirium is essential to identify and treat or eliminate the cause.
- Observation, not interview model
- Will be used in all PAC settings
- Delirium is associated with increased mortality, functional decline, development or worsening of incontinence, behavior problems, withdrawal from activities, rehospitalizations, and increased length of stay.
- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.

C1310A - Acute Onset of Mental Status Change

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Is there evidence of an acute change in mental status from the patient’s baseline?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

- **Code 0, No**: if there is no evidence of acute mental status change from the patient’s baseline.
- **Code 1, Yes**: if the patient has an alteration in mental status observed or reported or identified that represents an acute change from baseline.

- Examples of Acute Change in Mental Status:
  - Normally alert pt is lethargic
  - Sudden agitation, talking to dead people, tearing clothes off
  - Disoriented to time, person, place
  - Normally loud patient is lethargic, inattentive
CAMS Tips

- Assess for change in mental status, inattention, disorganized thinking and altered level of consciousness. Evidence can be found during the patient interview, in the medical record, and/or from family or staff reports of these issues during the assessment period.

- If a patient is diagnosed with a communication impairment or is receiving mechanical ventilation, the patient should be offered, if appropriate, alternative means of communication such as an electronic device (smart phone, tablet, laptop, etc.), writing, pointing, nodding, or using cue cards to assess the patient’s mental status.

CMS Definitions

FLUCTUATION

- The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of an interview/discussion or the assessment period. Fluctuating behavior may be noted by staff or family or documented in the medical record.
C1310B - Inattention

B. Inattention - Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

- Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).
- Assess separately from level of consciousness
- An additional step to identify difficulty with attention is to ask the patient to count backwards from 20.

C1310B - Inattention

B. Inattention - Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

- Code 0, behavior not present, if the patient remains focused during the assessment and all other sources agree that the patient was attentive during other activities.
- Code 1, behavior continuously present, does not fluctuate, if the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary. All sources must agree that inattention was consistently present to select this code.
- Code 2, behavior present, fluctuates, if inattention is noted during the assessment or any source reports that the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied or if information sources disagree in assessing level of attention.
- Dash is a valid response for this item. Dash indicates “no information.” CMS expects dash use to be a rare occurrence.
C1310C – Disorganized Thinking

- **Code 0, behavior not present**, if all sources agree that the patient’s thinking was organized and coherent, even if answers were inaccurate or wrong.
- **Code 1, behavior continuously present, does not fluctuate**, if, during the assessment and according to other sources, the patient’s responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the patient unpredictably switched from subject to subject.
- **Code 2, behavior present, fluctuates**, if, during the assessment or according to other data sources, the patient’s responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.
- **Dash** is a valid response for this item. Dash indicates “no information.” CMS expects dash use to be a rare occurrence.

C1310D - Altered Level of Consciousness

- **Code 0, behavior not present**, if all sources agree that the patient was alert and maintained wakefulness during conversation, interview(s), and activities.
- **Code 1, behavior continuously present, does not fluctuate**, if, during the assessment and according to other sources, the patient was consistently lethargic, stuporous, vigilant, or comatose.
- **Code 2, behavior present, fluctuates**, if, during the assessment or according to other sources, the patient’s level of consciousness varied. For example, the patient was at times alert and responsive, while at other times the patient was lethargic, stuporous, or vigilant. Code as fluctuating if information sources disagree.
- **Dash** is a valid response for this item. Dash indicates “no information.” CMS expects dash use to be a rare occurrence.
CAM Assessment Scoring

- Delirium is often misdiagnosed as dementia
- Delirium is a mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

CAM Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 OR Item B, C or D = 2  **AND** Item B = 1 OR 2

**AND EITHER** Item C = 1 OR 2 OR Item D = 1 OR 2

<table>
<thead>
<tr>
<th>C1310. Signs and Symptoms of Delirium (from CAM®)</th>
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<tbody>
<tr>
<td>Code after completing Brief interview for Mental Status and reviewing medical record.</td>
</tr>
<tr>
<td>A. Acute Onset of Mental Status Change</td>
</tr>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
</tbody>
</table>

**Coding:**
- 0. Behavior not present
- 1. Behavior continuously present, does not fluctuate
- 2. Behavior present, fluctuates (comes and goes, changes in severity)

B. Inattention – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

C. Disorganized thinking – Was the patient’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

D. Altered level of consciousness – Did the patient have altered level of consciousness, as indicated by any of the following criteria?
  - vigilant – started easily to any sound or touch
  - lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch
  - stuporous – very difficult to arouse and keep aroused for the interview
  - comatose – could not be aroused
Scenario - CAM – C1310 Signs and Symptoms of Delirium

• At the SOC visit Mr. Arnie was explaining in detail how he sets up his meds and then suddenly started talking about Santa Claus and the presents the grandkids received. When you redirected Mr. Arnie, he began to focus on telling the nurse again about how he sets up medications, and within 10 seconds he was tracing the edges of his buttons and silent. When you called his name, he jumped and was startled. How will you score Mr. Arnie for item C1310? His caregiver says he’s been like that since he came from the hospital.

Scenario Answer

CAM – C1310 Signs and Symptoms of Delirium

A. Acute Onset of Mental Status Change – 1. Yes

B. Inattention – 2 Behavior present, fluctuates. Mr. Arnie is redirected to focus back on medication management, but within 10 seconds is distracted and tracing edges of his buttons.

C. Disorganized thinking – 2 Behavior present, fluctuates. The patient goes from talking coherently about medication management to Santa Clause.

D. Altered level of consciousness – 2 Behavior present, fluctuates...patient vigilant and easily startled
Section D: Mood

This section contains items that address mood distress. The presence of indicators does not automatically mean that the patient has a diagnosis of depression or other mood disorders.

<table>
<thead>
<tr>
<th></th>
<th>Section D</th>
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</thead>
<tbody>
<tr>
<td>M1730</td>
<td>Depression Screening</td>
</tr>
<tr>
<td>D0150</td>
<td>Patient Mood Interview</td>
</tr>
<tr>
<td>D0160</td>
<td>Total Severity Score</td>
</tr>
<tr>
<td>D0700</td>
<td>Social Isolation</td>
</tr>
</tbody>
</table>
Depression and Home Health Population

- Depression is common among HH patients.
- 9.2 percent of HH patients screened positive for signs and symptoms of depression.
- Hospitalization rate for depressed patients was more than twice as high as the rate for non-depressed patients during the first two weeks of home care.
- Depression has also been associated with an increased risk of falls, psychological & physical distress, decreased participation in therapy and activities, decreased functional status, and poorer outcomes!

D0150 PHQ-2 to 9
SOC, ROC, D/C

Item Intent:

- To identify and record the presence or absence of specific clinical mood indicators.
- Clinicians should recognize these indicators, report them to provider and consider them when developing the patient’s individualized care plan.
PHQ-2 to 9 Assessment Tips:

- Conduct the interview in a private setting.
- If interpreter is used, that person just needs to translate and not attempt to determine intent behind answers.
- Be sure patient can hear you. If hearing impaired, make sure hearing assistive devices are being used. Minimize background noise.
- If administer PHQ2-9 on paper, make sure font is large enough for visually impaired individuals.
- Patient may respond to question verbally, by pointing or writing answers
- Record patient’s responses as they are stated regardless of whether the assessor attributes symptoms to something other than mood. Further evaluation of clinical relevance should be explored.

PHQ-2 to 9 Assessment Tips (cont.):

- Explain reason for assessment.
  - **Suggested language:** “I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care.”

- Explain response choices. May use cue cards.
- Read each item as written
- Do not provide definitions, meaning is based on the patient’s perceptions.
- Each question must be asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question
PHQ-2 to 9 Assessment Tips (cont.):

- Ask the first two questions (D0150A D0150B) of the Patient Mood Interview (PHQ-2 to 9).
  "Over the last 2 weeks, have you been bothered by any of the following problems?"
  - D0150A Little Interest or pleasure in doing things
  - D0150B Feeling down, depressed or hopeless

- Determine Symptom Presence
- Determine Symptom Frequency

Coding Instructions for Column 1: Symptom Presence

- **Code 0**, no: if patient indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- **Code 1**, yes: if patient indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9**, no response: if the patient was unable or chose not to complete the assessment, responded nonsensically and/or the agency was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.
- **Dash** indicates “no information.”
Coding Instructions for Column 2: Symptom Frequency

D0150 Coding Tips:
Select only one frequency response per item.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Column 1 Presence</th>
<th>Column 2 Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms not present</td>
<td>0 (no)</td>
<td>0 (never)</td>
</tr>
<tr>
<td>Unable to complete/respond</td>
<td>9 (No response)</td>
<td>(blank)</td>
</tr>
<tr>
<td>Yes, symptom present, but unable to quantify</td>
<td>1 (yes)</td>
<td>(blank)</td>
</tr>
<tr>
<td>Difficulty selecting between 2 frequencies</td>
<td>1 (yes)</td>
<td>Choose the highest</td>
</tr>
<tr>
<td>Different responses for different parts of a single item</td>
<td>1 (yes)</td>
<td>Choose the highest</td>
</tr>
</tbody>
</table>
**No Patient Mood Interview**

**Question 2**: My agency forgot to complete the Patient Mood Interview when completing the patient’s Discharge assessment. How should D0150 - Patient Mood Interview (PHQ-2 to 9) and D0160 - Total Severity Score be coded? What if the agency only missed asking 1 of the symptom presence (Column 1 of D0150) questions?

**Answer 2**: When the agency misses asking the patient one or more of the symptom presence questions from D0150 - Patient Mood Interview (PHQ-2 to 9) code Column 1: Symptom Presence with a dash (–) and leave Column 2: Symptom Frequency blank.

If no assessment is conducted for Symptom Presence, enter a dash (–) in Column 1 and skip Column 2 in each row of D0150A-I, then code 99 for D0160 - Total Severity Score.

A dash (–) is a valid response for D0150 Column 1: Symptom Presence. A dash (–) is not a valid response for D0150 Column 2: Symptom Frequency or D0160 - Total Severity Score. Q&A July 2022

---

**Determining whether to complete the PHQ-9 – additional items C thru I?** *(Q&A July 2022)*

Depends on the patient’s responses to the PHQ-2 (D0150A and D0150B).

- If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue.
  - If both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ-2 and skip D0160 - Total Severity Score.
  - If both D0150A2 and D0150B2 are coded 0 or 1, then end the PHQ-2 and enter the sum of D0150A2 and D0150B2 in D0160 - Total Severity Score.
- For all other scenarios, proceed to ask the remaining seven questions (D0150C through D0150I) of the PHQ-9 and complete D0160 - Total Severity Score.
Interviewing Tips and Techniques:

**D0150**

- Repeat the question if you think the question has been misunderstood or misinterpreted. Do not interpret for the patient.
- Some patients may be eager to talk and stray from topic. Gently guide discussion back
  - Example: “That’s interesting, now I need to know….”
- Validate your understanding of patient’s response by asking for clarification.
- If patient has difficulty selecting a response, start by offering a single response.
- Explore noncommittal responses.
  - Example:
    - “What do you mean?”
    - “Tell me more about that?”
    - “Give me an example”

Interview Tips (cont.):

**D0150**

- Patients may give long responses that might require interviewer to narrow down
  - Example:
    - D0150E Poor Appetite or Overeating. Patient responds “the food is always cold, and it just doesn’t taste like it does at home. The Doctor won’t let me have salt.”
    - Possible response to narrow answer: “You’re telling me the food isn’t what you usually eat? How often would you say that you have been bothered by poor appetite or overeating in the last 2 weeks?”
D150 Coding Tips:

Item D150I: Thoughts that you would be better off dead, or hurting yourself some way

- Newer clinicians may feel uncomfortable with this question
- Interviewers often feel this item may upset the patient, it’s too personal or that it is giving the patient inappropriate ideas.

- It has been found that most patients who have such feelings appreciate an opportunity to express it.
- Asking about self-harm does NOT plant the idea, it does give provider better understanding of patient’s current status.
- The best technique is to ask question openly without any hesitation.
- If patient confirms this question have follow-up questions and process set up to initiate immediate intervention if needed.

D0160 Total Severity Score

• The PHQ9 total score is a way for health care professionals to easily identify and track symptoms of depression and how they might change over time.

• Remember: The score does not diagnose a mood disorder but can be communicated to physician or responsible mental health specialist for follow-up.

• The score can provide further information on the severity of symptoms.
Coding Instructions:

- Maximum score of 27
- PHQ9 is considered successfully completed if 7 of the 9 items have responses.
- If 3 or more items are left blank, PHQ9 is deemed *incomplete* and should be scored as “99”
- Enter score as a 2-digit number.
- Dash is NOT a valid response (Q&A July 2022)

Scoring Rules for D0160

- If only the PHQ-2 is completed because both D0150A2 and D0150B2 are less than 2 (but not blank), add the numeric scores from these two frequency items and enter the value in D0160.
- *If PHQ-2 to 9 is complete with a value of 0, 1, 2 or 3 in each item in column 2 → D0160 is the sum of the scores in column 2.*
Scoring Rules for D0160 – When items are skipped, dashed or missing from Column 2

- If the number of missing items in Column 2 is equal to **one**, then compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0160.

- If the number of missing items in Column 2 is equal to **two**, then compute the simple sum of the seven items in Column 2 that have non-missing values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0160.

- If the number of missing items in Column 2 is equal to **three or more**, then item D0160 must equal [99].

---

PHQ9 Score Interpretation

*Responses may be interpreted as follows:*

- **Major Depressive Syndrome** is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period.

- **Minor Depressive Syndrome** is suggested if, of the 9 items, (1) feeling down, depressed or hopeless (D0150B), (2) trouble falling or staying asleep, or sleeping too much (D0150C), or (3) feeling tired or having little energy (D0150D) are identified at a frequency of half or more of the days (7-11 days) during the look-back period.

- In addition, PHQ-2 to 9 **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
  - 0-4: minimal depression
  - 5-9: mild depression
  - 10-14: moderate depression
  - 15-19: moderately severe depression
  - 20-27: severe depression
D0700 Social Isolation

Social Determinant of Health

- Social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

- Dash is not a valid response

Social Isolation

- **Social isolation**: Studies indicate that “belonging” – whether to a large extended family, a network of friends, a social or volunteer organization, or a faith community – is related to longer life and better health, as well as to community participation.

  - Poorer outcomes
  - Frequent hospital readmissions
  - Increased medication non-adherence
  - Higher mortality rate
  - Decreased quality of care
Section E

Behavior

Section E: Behavior – No changes

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### Section F: Preferences for Customary Routine Activities – No Changes

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181
### Section G: Functional Status

### Section GG: Functional Abilities and Goals

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</table>
GG0100
Prior Functioning: Everyday Activities

INTENT:
• This item identifies the patient’s usual ability with everyday activities, prior to the current illness, exacerbation or injury.

Assessment Steps:
Review medical records for prior functioning, interview patient/family/caregivers.
GG0100 Prior Functions: Everyday Activities

Coding Tips:

- Record Patient’s usual prior ability for self-care, ambulation, stair climbing, functional cognition
- Code 3, Independent, if the patient completed ALL the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- Code 2, Needed Some Help, if the patient needed partial assistance from another person to complete ANY of the activities.
- Code 1, Dependent, if the helper completed ALL the activities for the patient or the assistance of two or more helpers was required for the patient to complete the activities. Q July 2021

Mark Code 8, Unknown if there is no information about the patient’s ability available after an attempt to interview the patient or family and after reviewing the patient’s clinical record.

Code 9, Not Applicable, if the activities were not applicable to the patient prior the current illness, exacerbation or injury.

Dash “—” If didn’t attempt to find out patient’s prior abilities in these areas (not assessed) – should be a rare occurrence
Scooting Up or Down the Stairs

• Completing the stair activity for GG0100C Stairs indicates that a patient went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift), and/or with or without some level of assistance. “By any safe means” may include a patient scooting up/down stairs on buttocks. Stairs include internal or external without a defined number.
• Stairs do NOT include a ramp.

What is the timeframe?

• If patient had an acute CVA 8 weeks ago and then patient is hospitalized for CHF exacerbation, would the prior function continue to be before the CVA or just for the CHF exacerbation?
  – each individual patient’s unique circumstances
  – Clinical professional judgement
• Clinicians should use clinical judgment within these parameters in determining the time frame that is considered "prior to the current illness, exacerbation, or injury."
GG0110 Prior Device Use

INTENT:
• This item identifies the patient’s use of devices and aids immediately prior to the current illness, exacerbation, or injury to align treatment goals.

Assessment Steps:
Review medical record for prior devices. Interview patient, family and caregivers.
GG0110 Prior Device Use

• Interview patient or family or review the patient’s clinical record describing the patient’s use of prior devices and aids.

• GG0110C - Mechanical lift, any device a patient or caregiver requires for lifting or supporting the patient’s bodyweight. Examples include, but are not limited to:
  – Stair lift, Hoyer lift, Bathtub lift, sit-to-stand lift, stand assist, electric recliner, and full-body style lifts
  – Use clinical judgment

• GG0110D - Walker, All types of walkers. Examples include, but are not limited to:
  – Pick-up walker, Hemi-walker, Rolling walker, Platform walker
  – Knee scooter (not a scooter) Q&A 4/19

GG0110 Practice Scenario

• Mr. C has bilateral lower extremity neuropathy secondary to his diabetes. Prior to this current episode, he used a cane. Today, he is using a walker.

• **Answer:** Z None of the above. He did not use the walker prior to the current episode, and cane is not an option on the responses.
**Scenario GG0110**

Mr. D uses a transport chair but doesn’t have a wheelchair and never has, how will GG0110 be scored?

**Answer GG0110**

The intent of GG0110 – Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient’s unique circumstances and use clinical judgment to determine how prior device use applies for each individual patient.

CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use. (Jan. 2021, Q&A #4)
**Scenario** GG0100 Electric Recliner

Mrs. A has a lift recliner that brings her to a standing position. How will GG0110 be scored

Examples include, but are not limited to: stair lift, Hoyer lift, bathtub lift, sit-to-stand lift, chair lift and electric recliner, if required. (Oct. 2019, Q&A #29)

---

**G vs GG**
TNC - Calculating Raw Change

**Episode Level**

- For each TNC measure: CMS calculates the raw change score for each applicable OASIS item at the episode level.
- Difference between the patient’s status at SOC/ROC and the patient’s status at discharge.
- **Example:** If the patient goes from a “3” on bathing at start or resumption of care to a “0” on bathing at discharge, the raw change score for the episode is “3”.
- CMS does this calculation for each of the 6 OASIS items used to calculate TNC Change in Self-Care and the 3 OASIS items used to calculate TNC Change in Mobility.
- *Patients who are fully independent at SOC or ROC ARE included in the calculations.*
- Patients who are fully independent can either remain the same or worsen. If the patient worsens, the episode will earn a negative change score.

---

**TNC Raw Change Values**

- Mr. E was admitted to home care following surgery for the removal of his gallbladder. Upon initial assessment, he was marked a 3 (requires assistance at all times) for ambulation. At discharge, Mr. E is moving around well with little pain and is marked a 1 (requires a one-handed device but no assistance for M1860).
- What is his raw score?
TNC - Compute Normalized Change

Episode Level

• For each TNC measure: CMS normalizes episode Raw Change by dividing the raw score by the maximum possible change (number of item responses) for that OASIS item.
• The maximum possible range of episode level raw change scores for TNC Change in Self-Care is “-6” to “+6”, and for TNC Change in Mobility is “-3” to “+3”.
• This is applied to each applicable OASIS item in the TNC measures to fit scores into a range of “-1” and “+1” for all nine OASIS items.
• CMS expects few patients to achieve the max Normalized Change scores of “-1” or “+1” during their episode of care. Typically, patients may achieve smaller amounts of proportional change during their episode of care.

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Maximum Possible Change</th>
<th>Normalized Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example Normalization Change

• Let’s normalize Mr. E’s Raw score of 2 for M1860 in the previous example.

<table>
<thead>
<tr>
<th>Raw score 2</th>
<th>Max Possible Change 6</th>
<th>Normalized change 0.33</th>
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</table>
## TNC – Calculation with Positive Outcomes

*Episode Level*

<table>
<thead>
<tr>
<th>Composite Measure</th>
<th>Activity (OASIS Item)</th>
<th>Status at SOC</th>
<th>Status at DC</th>
<th>Maximum Possible Change</th>
<th>Raw Change</th>
<th>Normalized Change</th>
<th>Sum of Normalized Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TNC Change in Mobility</strong></td>
<td><strong>Ambulation (M1860)</strong></td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>3</td>
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<td></td>
<td><strong>Toilet Transferring (M1840)</strong></td>
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<td>0</td>
<td>4</td>
<td>2</td>
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<tr>
<td></td>
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<td>5</td>
<td>2</td>
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<tr>
<td><strong>TNC Change in Self-Care</strong></td>
<td><strong>Grooming (M1800)</strong></td>
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<td>3</td>
<td>2</td>
<td>0.667</td>
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<tr>
<td></td>
<td><strong>Lower Body Dressing (M1820)</strong></td>
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<td>3</td>
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## TNC – Calculation with Negative Outcomes

*Episode Level*

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<th>Composite Measure</th>
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<th>Status at SOC</th>
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<th>Raw Change</th>
<th>Normalized Change</th>
<th>Sum of Normalized Change</th>
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<tr>
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</tbody>
</table>

*A value of “0” indicates a status of most independent for each OASIS item. The value for most dependent status varies by OASIS item and is equal to the item’s “Maximum Possible Change.”*
**TNC – Sum of Normalized Change**

*Episode Level—Calculate the Normalized Change for Mr E for each item and sum for self-care and mobility.*

1. **Self-care**
   - M1800 Norm. Change
   - M1810 Norm. Change
   - M1820 Norm. Change
   - M1830 Norm. Change
   - M1845 Norm. Change
   - M1870 Norm. Change

2. **Mobility**
   - M1840 Normalized Change
   - M1850 Normalized Change
   - M1860 Normalized Change

3. **Step 3**

4. **Sum of Normalized Change**

---

**Total Normalized Change**

- **Agency Level**

- **Step 4**

- **Now add all “Sum of Normalized Change” together for each applicable OASIS item for each quality episode per patient and divide by # of quality episodes.**

- **HHA Observed**

- **Then Risk Adjust**
TNC Raw Change Values Example #2

- Nancy Nurse is new to the agency and admitted Mrs. B and scored her 1 (needs assistive device only) for bathing, not realizing that walking to the bathroom is included in the item. At discharge, a nurse that has OASIS training for years responded with a 2 (requires intermittent assistance) for bathing.
- What is Mrs. B’s raw score?

Example #2 Normalization Change

- Let’s normalize Mrs. B’s Raw score of -1 for M1830 in the previous example.
OASIS Assessment Conventions for ADL Items

- Identify *ability*, not actual performance or willingness
- Assess patient’s ability to *safely* complete the specified activities listed in the OASIS item
- Consider what the patient is able to do on the day of assessment; if ability varies over the 24 hour period, select the response that describes the patient’s ability more than 50% of the time
- Assess only for the specific tasks included in the item
- If patient’s ability varies between multiple tasks included in the item, report ability to perform a majority of the included tasks, giving more weight to tasks that are performed more frequently
OASIS Assessment Conventions for ADL Items (con’t)

• Consider medical restrictions when determining ability
• Do not assume the patient would be able to safely use equipment that is not in the home at the time of assessment
• While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient’s ability to perform a task
• Response scales present the most optimal (independent) level first, then proceed to less optimal (most dependent) levels. Read the responses from the bottom up!
• “Assistance” means help from another human being
• Service animals are considered “devices” not “assistance”

Conventions Specific to ADLs/IADLs

• Ability can be temporarily or permanently limited by:
  – physical impairments (for example, limited range of motion, impaired balance)
  – emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  – sensory impairments, (for example, impaired vision or pain)
  – environmental barriers (for example, accessing grooming aids, mirror and sink, stairs, narrow doorways, location where dressing items are stored).
    • Environmental barriers may be different dependent on the tasks.
Conventions Specific to ADLs/IADLs

- Assessment Strategies
  - Observation/demonstration is the *preferred method*
  - Patient/caregiver interview
  - Physical assessment
  - Nutritional assessment
  - Physician orders
  - Plan of Care
  - Referral information
  - Review of past health history
- Document any inconsistencies

GG Item Conventions

- Assess patient status based on direct observation if possible
- Consider reports by patient/family/caregiver within the time period under consideration, (e.g., reporting on the patient’s ability to complete the activity within the past 24 hours)
- Observe patient perform activity as independently as possible, while remaining safe (you may be the assistant)
- Consider the amount of assistance needed for safety
- Level of assistance needed to complete the activity safely, not based on the availability of such assistance
GG Item Conventions

• **Device use doesn’t affect response choice**

• If performance varies during assessment time period, report the “usual status”

• **Majority of tasks does not apply. In situations where the patient’s ability varied between listed GG activities, group all activities together, code based on patient’s ability considering all activities together.** January 2019

• **The intention is not for the codes on the GG and M items to always “match.”** February 2019

Consistency not required between M and GG Items

• There are differences between items that have the same or similar names; CMS does not necessarily expect them to match. Coding differences may be a result of:
  – What is included/excluded in the activity
  – Differing conventions related to assistive device use

• Each item should be considered individually and coded based on the guidance provided for that item

• **There will be variances between M1800s and GG items**
GG0130 and GG0170 Responses

• **06 Independent**: no assistance from another person

• **05 Set-up/Clean-up assistance**: assistance from ONE other person before and/or after the activity but not during the actual performance of the activity

• **04 Supervision/touching assistance**: verbal/non-verbal cueing or touching/steadying/contact guard assistance from ONE person

• **03 Partial/moderate assistance**: physical assistance from ONE person who provides LESS than half the effort of the activity

• **02 Substantial/maximal assistance**: physical assistance from ONE person who provides MORE than half the effort of the activity

• **01 Dependent**: physical assistance from ONE person who provides ALL the effort to complete the activity, OR patient requires the assistance of TWO or MORE persons to complete the activity

Reason Not Attempted Codes

• **07 Patient refused**
  - Pt refused to attempt activity, unable to get info from cg

• **09 Not applicable**
  - Pt couldn't perform activity at assessment AND couldn't perform activity prior to current illness/injury (09=baseline)

• **10 Not attempted due to environmental limitations**
  - Ex: lack of equipment, indoor/outdoor weather

• **88 Not attempted due to medical condition or safety concerns**
  - Pt couldn’t perform activity at assessment BUT could perform activity prior to current illness/injury (88=brand new state)

• **Dash “—”** indicates that no information is available, and/or an item could not be assessed

Due to standardization across PAC settings, CMS hoped to use GG items for Functional status, however, were unable to due to the large percentage of “Activity Not Attempted” codes.
OASIS GG ITEM FREQUENCIES BY RESPONSE TYPE IN CY 2021 GG0130

- Eat: 0.6%
- Oral Hygiene: 0.2%
- Toileting Hygiene: 0.3%
- Shower/bathe self: 40%
- Upper Body Dressing: 39.1%
- Lower Body Dressing: 39.1%
- Footwear: 39.5%

□ % of Periods with Responses ANA (07, 09, 10, 88, -, skipped or not collected at FU
□ % Periods with responses 01 to 06

OASIS GG ITEM FREQUENCIES BY RESPONSE TYPE CY2021 GG0170

- Roll Left to Right: 2.4%
- Sit to Lying: 2.4%
- Lying to Sitting: 2.9%
- Chair Transfer: 5.1%
- Toilet Transfer: 3.1%
- Car Transfer: 4%
- Walk 10 ft: 56.8%
- Walk 50 ft/2 turns: 16.7%
- Walk 150 ft: 30.2%
- Walk 10 ft, uneven: 68%
- 1 step/curb: 46.6%
- 4 steps: 44.7%
- 12 steps: 60%
- Picking up object: 84%
- Wheel 50 ft: 56.1%
- Wheel 150 ft: 79.2%

□ % Periods with responses 01 to 08
□ % Periods with responses ANA 07,09,10,88, -, skip, not collected at FU
Danger of the Dash “—”

- Dash allowed on all GG items at all time points
  - No info available, or can’t assess for reason other than 07, 09, 10, or 88
- Should be the response of last resort!
  - Modified time periods
  - Collaboration with others
  - Four responses for reason not assessed
- A dash response does not provide “positive credit” for this quality measure

Application of Percent of Long-term Care Hospital Patients with Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Response 88 vs 01

- What if the patient cannot perform the task at the present time due to a new condition, and a caregiver provides all the effort in completing the task for the patient. Should the patient be scored:
  - 88 Not attempted due to medical condition or safety concerns
  - OR
  - 01 Dependence: physical assistance from ONE person who provides ALL the effort to complete the activity, OR patient requires the assistance of TWO or MORE persons to complete the activity

Code the reason activity was not attempted if:
- A patient does not attempt the activity AND
- A helper does not complete the activity AND
- Patient’s usual status cannot be determined based on pt/caregiver report

The caregiver cannot walk for the patient.
At Risk for Falls Means...

- The MACH 10 identifies the patient at risk for falls. We’ve been told that we have to mark the M1800s and the GG items with at least supervision required. This instruction doesn’t always seem to be consistent with general assessment observations, and if also used at discharge, limits the ability to show improvement my patients have made. Is there some specific instruction that has been provided that requires this directed coding?

- Identifying that a patient is at risk for falls is only one criterion to consider when determining the type and amount of assistance needed for a patient to safely complete functional activities. There is no CMS guidance that requires that a patient scored as "at risk" for falls must be coded as needing supervision (or greater assistance) for any or all of the function OASIS items. Although a patient may meet the MAHC-10’s “at risk for falls” threshold, (e.g., due to age, 3+ diagnoses, age-related vision impairment, and poly-pharmacy), additional assessment findings (like the patient wears glasses to correct vision impairment, and sits while completing dressing activities) may allow the patient to safely complete some activities without supervision or assistance.

- Even if a patient is determined to be at risk for falls, each OASIS item should be considered individually and coded based on the item specific guidance and OASIS conventions that apply to each item.

Compare and Contrast

EXAMPLE: Patient can brush teeth and wash hands without assistance or set up, but requires some assistance with hair care, washing face, shaving and trimming nails.

<table>
<thead>
<tr>
<th>(M1800)</th>
<th>Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>Able to groom self unaided, with or without the use of assistive devices or adapted methods.</td>
</tr>
<tr>
<td>0</td>
<td>Grooming utensils must be placed within reach before able to complete grooming activities.</td>
</tr>
<tr>
<td>1</td>
<td>Someone must assist the patient to groom self.</td>
</tr>
<tr>
<td>2</td>
<td>Patient depends entirely upon someone else for grooming needs.</td>
</tr>
</tbody>
</table>

GG01308

| B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
|---------|----------------------------------------------------------------------------------------------------------------------------------|
| 06. Independent – Patient completes the activity by him/herself with no assistance from a helper. |

CMS OASIS Q&A February 2019
**Contrast and Compare**

**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently feed self.</td>
</tr>
<tr>
<td>1</td>
<td>Able to feed self independently but requires:</td>
</tr>
<tr>
<td></td>
<td>(a) meal set-up; OR</td>
</tr>
<tr>
<td></td>
<td>(b) intermittent assistance or supervision from another person; OR</td>
</tr>
<tr>
<td></td>
<td>(c) a liquid, pureed or ground meat diet.</td>
</tr>
<tr>
<td>2</td>
<td>Unable to feed self and must be assisted or supervised throughout the meal/snack.</td>
</tr>
<tr>
<td>3</td>
<td>Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.</td>
</tr>
<tr>
<td>4</td>
<td>Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.</td>
</tr>
<tr>
<td>5</td>
<td>Unable to take in nutrients orally or by tube feeding.</td>
</tr>
</tbody>
</table>

**GG0170**

**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.

*If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (c urb)*

**06. Independent** – Patient completes the activity by him/herself with no assistance from a helper.
GG0130A Eating—Example of 88 vs 09

• **88**—If the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN due to a new (recent-onset) medical condition.

• **09**—If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, injury or exacerbation.

• If the patient eats and drinks by mouth and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code eating based on the amount of assistance the patient requires to eat and drink by mouth.

Difference between 09 and 88

• ALS patient with J tube feedings many years

• Bowel rest for pancreatitis, NPO for 1 week on TPN. Support advancing back to regular diet
GG0130 Self-Care SOC/ROC

<table>
<thead>
<tr>
<th>SOC/ROC Performance</th>
<th>Discharge Goal</th>
</tr>
</thead>
</table>

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them.

C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

D. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

E. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.

F. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.

G. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

No Row D: Activity D is “Wash Upper Body”

M1800 Grooming

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

Enter Code

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

3 points

- **Excludes** bathing, shampooing hair, and toileting hygiene.
- **Includes** getting to the area where grooming takes place and accessing grooming aids, sink, or mirror.
Assessment Tips for M1800

• Observe the patient get to the location where grooming takes place and where items are kept.

• Ask the patient to go through the motions involved in grooming: assess upper extremity range of motion, balance when bending over the sink.

• Observe patient’s appearance, hygiene and grooming to determine if patient has been able to do tasks on day of assessment; ask patient or caregiver if any assistance has been needed.

• Determine patient’s ability to perform a majority of grooming tasks safely, consider frequency.

Set-up or Assistance?

• OASIS guidance says ability to access the location and items needed to complete grooming tasks are considered in M1800, so if patient needs to be assisted to the bathroom for safety, or needs grooming items placed within reach, then could complete the tasks with no further assistance, score a “1” for grooming. Some clinicians refer to M1800 “1” for grooming as “set up”. My concept of set up means doing things like opening the toothpaste tube and putting toothpaste on the toothbrush, not just placing an item within reach.

• If patient needs assistance to open and/or set up grooming items (i.e. put toothpaste on toothbrush, opening the top of the toothpaste tube), is this considered providing access to items and scored as a “1”, or is it considered providing assistance and scored a “2” as long as the majority of the grooming tasks required this assistance?
Set-up or Assistance?

- Each OASIS item should be considered individually and coded based on guidance provided for that item. Response 1 for M1800 relates to patient access of “utensils” needed for grooming (e.g., accessing grooming aids, mirror, sink). Response 1 for M1800 is placing grooming items within reach and is **not to be considered the same as Response 05-Set-up or Clean-up assistance for GG0130** items which includes assistance a helper provides only prior to or following the activity, but not during the activity.

- For example, putting toothpaste on the toothbrush and opening the top of the toothpaste goes beyond placing the items within reach and would be considered providing assistance for M1800 **Response 2**. CMS Q&A July 2019

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Contrast and Compare

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them.</td>
</tr>
</tbody>
</table>

**Oral hygiene only – even if no teeth**

*Do not consider* assistance provided to get to or from the bathroom to score Oral Hygiene.

*Do consider* assistance needed to get to area for scoring Grooming.

---

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

1. Able to groom self unaided, with or without the use of assistive devices or adapted methods.
2. Grooming utensils must be placed within reach before able to complete grooming activities.
3. Someone must assist the patient to groom self.
4. Patient depends entirely upon someone else for grooming needs.
Score M1800 and GG0130B

- Mr. Kingsley's wife helps him to the bathroom because of his unsteady gait. Once there, he sits on the stool in front of the sink and completes his grooming by himself (everything he needs is kept on the counter). When he's finished, he calls for his wife who helps him back to his recliner.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Grooming: Current ability to tend safely to personal hygiene needs (specifically, washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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</tr>
<tr>
<td>1</td>
<td>Grooming utensils must be placed within reach before able to complete grooming activities.</td>
</tr>
<tr>
<td>2</td>
<td>Someone must assist the patient to groom self.</td>
</tr>
<tr>
<td>3</td>
<td>Patient depends entirely upon someone else for grooming needs.</td>
</tr>
</tbody>
</table>

Score M1800 and GG0130B

- Mr. Plack requires steadying assistance to get to the bathroom. His wife applies the toothpaste to the toothbrush for him and leaves. Mr. Plack then is able to brush his teeth at the sink without assistance. When he is done brushing his teeth, combing his hair and washing his hands, his wife provides steadying assistance so that he can ambulate back to his chair.

- Independent – Patient completes the activity by him/herself with no assistance from a helper.
- Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
- Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
M1810/M1820 Dress Upper/Lower Body

**M1810 Dressing Upper Body**

- Identifies the patient’s ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing.

- **Includes**: ability to manage zippers, buttons, and snaps if these are routinely worn. Prosthetic, orthotic, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items/tasks.

- **Excludes**: wound dressings

- Enter the response that best describes the patient’s level of ability to perform the majority of upper body dressing tasks.

- Collaborate!
M1820 Dressing Lower Body

- Identifies the patient’s ability to **dress lower body**, including the ability to **obtain, put on, and remove lower body clothing**.

- **Includes**: All lower body clothing routinely worn: undergarments, pants, shoes and socks. Prosthetic, orthotic, AFO or other support devices for lower body, as well as anti-embolism stockings should be considered as lower body dressing items/tasks. (Excludes: wound dressing)

- In cases where a patient’s ability is different for various dressing lower body tasks, enter the response that best describes the patient’s level of ability to perform the **majority** of dressing lower body tasks

- Collaborate!

Considerations

Clothing is considered “routinely worn” if:

- Clothing is what patient usually wears and will continue to wear
- Patient made a change in clothing to styles that are expected to become the patient’s new everyday style of dress
- No reasonable expectation that the patient could return to previous style of dress
- No specified time frame at which the modified clothing style will become the routine clothing – use clinical judgement
Assessment Tips for M1810/M1820

• Ask the patient if he/she has difficulty dressing upper body. Includes getting to where clothing items are stored and accessing items, including orthotics, prosthetics, etc.

• Opening and removing garments during the physical assessment of heart, lungs, and extremities provides opportunity to evaluate spinal flexion, joint range of motion, shoulder and arm strength, coordination, and manual dexterity needed for dressing. The patient also can be asked to demonstrate the body motions involved in dressing.

• Observe the patient’s general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely.

Contrast and Compare

What is routinely worn

Need assist getting clothes out: 05

Clothing items PLUS compression wraps, prosthetics, collars, etc.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.</td>
</tr>
<tr>
<td>1</td>
<td>Able to dress upper body without assistance if clothing is laid out or handed to the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Someone must help the patient put on upper body clothing.</td>
</tr>
<tr>
<td>3</td>
<td>Patient depends entirely upon another person to dress the upper body.</td>
</tr>
</tbody>
</table>
Contrast and Compare

G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.

H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.

If footwear is not safe for mobility, then code the appropriate “activity not attempted” code. October 2019 Q&A 34

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to obtain, put on, and remove clothing and shoes without assistance.</td>
</tr>
<tr>
<td>1</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>2</td>
<td>Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.</td>
</tr>
<tr>
<td>3</td>
<td>Patient depends entirely upon another person to dress lower body.</td>
</tr>
</tbody>
</table>

Lower Body vs Footwear

- If clothing items or supportive devices cover both the leg and foot, do not score for both GG0130G and GG0130H
  - If an item covers all or part of the foot (even if it extends up the leg), it is considered footwear for GG0130H
  - If an item goes on the lower body and does not cover any part of the foot, it is considered a lower body dressing item for GG0130G
Score GG0130 F and G

- Ms. Moana wears a muumuu and has gone commando for a year or more because she has a hard time handling her underwear.
- If Ms. Moana doesn’t wear underwear or any other lower body garment, score GG0130F according to how much assistance she needs to put on her muumuu and score GG0130G with the appropriate activity not attempted code.
- October 2019 Q&A 32

Fastening the Bra or Pants

- Can dress upper body but needs help with fastening bra.
- Score GG0130F according to type and amount of assistance required to complete ENTIRE upper body dressing activity. NOT based on majority of tasks.
- If helper provides LESS THAN HALF of the effort then score 03, Partial/moderate assistance.
- If helper provides MORE THAN HALF of the effort then score 02, Substantial/maximal assistance.
- Same guidance applies to lower body dressing, i.e. pants.
- October 2019 Q&A 33
When is set-up?

- If a patient is independent with dressing but requires supervision to gather her clothes from the closet and take them to the bed before she can get dressed, is she “independent” for dressing, “supervision” for dressing” or “set-up” for dressing?
- The intent of the items GG0130F and GG0130G is the patient’s ability to dress and undress above the waist (GG0130F) and below the waist (GG0130G); including fasteners, if applicable.
- It is not the type of assistance that is provided that determines the 05 Setup/Clean-up code but rather when (related to the completion of the activity) the needed assistance is provided.
- If the assistance provided is necessary only before or after the activity is completed, and no assistance is needed during the completion of the activity, select Code 05 Setup/Clean-up.
- Jan 2020 Q&A

Status at Time of Assessment

- OASIS guidance has been to score SOC/ROC before any teaching or intervention. Would this include scoring a patient’s ability before the PT cues?
- Is the PT intervening/teaching or just acting as caregiver to determine amount of assistance needed?
- When coding GG0130 and GG0170 items, if patient requires only verbal cueing to complete the activity, code 04 supervision or touching assistance would be the correct choice. Coding of GG items should be based on patient’s true baseline. Assessing clinician may need to use clinical judgement to differentiate between verbal cueing and therapeutic intervention. July 2019 Q&A #18
M1830 Bathing

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

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

**Score:** 2

Focus on ability to access tub/shower first

**Can access tub/shower**

- Response 0 thru 3
  - All these answers mean they can safely access tub/shower with or without assistance. How much assistance needed during process determines which response. Managing the water is not included.

**Cannot access tub/shower**

- Responses 4 or 5
  - Unable to safely access tub/shower even with assistance. Whether they can bath outside tub/shower determines which response 4 or 5. Response 4 requires independence with running water.
M1830: Assessment Techniques

• Check referral orders: does patient have medical restrictions that affect bathing?
• Use combination of interview and observation
• Assess environmental barriers, available safety equipment, functioning tub/shower/sink
• Ask the patient how they currently bathe, and what type of assistance is needed to wash entire body
• Observe patient get to location where bathing occurs or access water in basin/sink
• Observe the patient’s general appearance in determining if the patient has been able to bathe self independently and safely

M1830: Assessment Techniques

• Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely
• Ask the patient to demonstrate the motions involved in bathing the entire body.
• Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower. The patient who only performs a sponge bath may be able to bathe in the tub or shower with assistance and/or a device.
• Consider safety: home setting, equipment, ability
• Score at SOC/ROC before you teach or get equipment
M1830 Bathing (considering not unable-6)

• If the only assistance needed is:
  – Getting to the bathroom (2-Intermittent assistance)
  – Getting water protection sleeve on (2-Intermittent assistance)

• Fear of falling
  – Able to get into tub with assistance then 2 or 3
  – Refuses to get into tub then 4 or 5

• Uses shower for storage
  – If not functional, then 4 or 5
  – If functional, assess ability to bathe in shower or tub

• Tub or shower unsafe, then 4 or 5

Contrast and Compare

Location does not matter.

Not included
Scenario M1830 and GG0130E

- Mrs. Nance needs her daughter to help her in and out of the tub, she can sit on her shower chair to wash her chest, arms, perineal area and upper legs. Her daughter returns to assist her with her back, lower legs and feet. Mrs. Nance then can rinse and dry herself off.

05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

Answer M1830 and GG0130E

**Note:** The table on the page appears to be related to the scenario but it is not fully legible in the provided image. It seems to relate to the bathing ability of a patient, possibly indicating different levels of assistance needed for different tasks. The specific details are not fully transcribed due to the image quality.
Scenario Ms. Wyatt

- Ms Wyatt bathes with a plastic tub which the caregiver sets up for her with soap, water, wash cloths and towels. She then bathes by herself. Prior to her hip replacement she hired a contractor to remove her old tub and replace it with a walk-in shower, complete with a built-in ledge for sitting while bathing, grab bars and a hand-held shower. The shower has not been completed at this point. Should her performance be coded 05, Set-up or clean-up assistance as the only help she requires is setting up the basin or 10, Not attempted due to environmental limitations since she is NOT bathing in a tub/shower?
- What if the caregiver returns to replace the water for rinsing?
- Bonus: What would her score be in M1830 Bathing?

Practice Answers

- Ms Wyatt bathes w/ plastic tub which caregiver sets up for her w/ soap, water, wash cloths and towels. She then bathes by herself. Prior to THR she hired a contractor to remove her old tub and replace it with a walk-in shower, but the work has not been completed at SOC. Should her performance be coded 05, Set-up or clean-up assistance as the only help she requires is setting up the basin or 10, Not attempted due to environmental limitations since she is NOT bathing in a tub/shower? 05 Set-up or clean up
- What if the caregiver returns to replace the water for rinsing? 03 Partial assist
- Bonus: What would her score be in M1830 Bathing? 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
### M1840 Toilet Transferring

**Includes ability to safely:**

- Get to the toilet/commode
  - via ambulation or wheelchair
- Transfer on and off the toilet/commode
- Return to starting location

**Excludes:**

- Hygiene
- Management of clothing

If ability varies over time, enter the response describing the patient's **ability more than 50%** of the time period under consideration.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to get to and from the toilet and transfer independently with or without a device.</td>
</tr>
<tr>
<td>1</td>
<td>When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.</td>
</tr>
<tr>
<td>2</td>
<td>Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).</td>
</tr>
<tr>
<td>3</td>
<td>Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.</td>
</tr>
<tr>
<td>4</td>
<td>Is totally dependent in toileting.</td>
</tr>
</tbody>
</table>
Assessment Tips for M1840

• Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc.

• Determine the level of assistance needed by the patient to safely get to and from and on and off the toilet or commode.

• Consider environmental barriers/limitations

• Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

M1840 vs GG0170F

M1840 Toilet Transferring

• 0 Able to get to and from the toilet and transfer independently with or without a device.

• 1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. Patient has to participate.

• 2 Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

• 3 Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.

• 4 Is totally dependent in toileting or equipment is not in the home.

GG0170F Toilet Transfer

• Only assesses on and off toilet and commode
M1840 Toilet Transferring

*Patient uses both BSC and Toilet*

Is patient using the BSC for convenience? Or, for example, is there a safety factor at night that indicates the need for BSC use?

- What is patient’s usual status for the assessment time frame?
- Time frame is measured in hours—not # of times to bathroom/BSC

**Example:**

Patient awake from 6 am – 9 pm and is safe to go to bathroom
During nighttime 9 pm – 6 am, patient must use BSC for safety
15 hours = bathroom; 9 hours = BSC
Usual status = 15 > 9, therefore bathroom is usual status
Cat 4 Q143.1

GG0170F Toilet Transfer

- Does not include getting to/from the toilet or BSC
- Can assess with a BSC if patient has equipment
- Does not consider bedpan or urinal use
- Toileting hygiene and clothing management are not considered part of the toilet transfer activity
Scenario GG1070F and M1840

- Mrs. Murry is on bedrest due to a new medical complication. She uses a bedpan for bladder and bowel elimination and can transfer on and off.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>F. Toilet transfer: The ability to get on and off a toilet or commode.</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.</th>
</tr>
</thead>
<tbody>
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<td>0</td>
<td>Able to get to and from the toilet and transfer independently with or without a device.</td>
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<td>1</td>
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<td>Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).</td>
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<td>3</td>
<td>Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.</td>
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<td>4</td>
<td>Is totally dependent in toileting.</td>
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</table>

Answer GG0170F and M1840

- Mrs. Murry is on bedrest due to a new medical complication. She uses a bedpan for bladder and bowel elimination.

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<td>4</td>
<td>Is totally dependent in toileting.</td>
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</table>
Contrast and Compare

Perineal hygiene around catheter

M1845 Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after voiding or having a bowel movement. If managing an ostomy, includes cleaning area around stoma, but not managing equipment.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to manage toileting hygiene and clothing management without assistance.</td>
</tr>
<tr>
<td>1</td>
<td>Able to manage toileting hygiene and clothing management without assistance if supplies/implments are laid out for the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Someone must help the patient to maintain toileting hygiene and/or adjust clothing.</td>
</tr>
<tr>
<td>3</td>
<td>Patient depends entirely upon another person to maintain toileting hygiene.</td>
</tr>
</tbody>
</table>

Includes ability to safely:

• Pull Clothing Up/Down
• Clean/wipe the perineal area
• Provide hygiene related to catheters
• Clean around stomas used for urinary or bowel elimination
• Access needed supplies to maintain hygiene

Excludes:

• Getting to toilet
• Transferring on/off toilet

If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
M1845 Toileting Hygiene

Assessment strategies

A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item.

- **Ask** the patient if he/she has any difficulty managing toileting hygiene or adjusting clothing/incontinence pads
- **Ask** the patient if he/she has any difficulty with managing catheter hygiene or cleaning around their stoma
- **Observe** the patient during toilet hygiene if possible or activities similar that would mimic balance, strength, dexterity, ROM needed to complete task safely
- **Observe** for signs of unsafe/non-hygienic practices (soiled clothing, stool under nails, incontinence issues, smell of urine/stool)
- **Determine** the level of assistance needed by the patient to safely maintain perineal hygiene, adjust clothing/incontinence pads before and after toileting, clean around stoma, clean around foley if present

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

<table>
<thead>
<tr>
<th>OASIS Response Choice</th>
<th>Simplified</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 -Able to manage toileting hygiene and clothing management <strong>without assistance</strong>.</td>
<td>No Human Assist Independent</td>
</tr>
<tr>
<td>1 -Able to manage toileting hygiene and clothing management <strong>without assistance if supplies/implements are laid out</strong> for the patient.</td>
<td>No Human Assist Items placed within reach</td>
</tr>
<tr>
<td>2 -<strong>Someone must help</strong> the patient to maintain toileting hygiene and/or adjust clothing.</td>
<td>Human Assist (VC, SBA, Physical) Intermittent or Continuous</td>
</tr>
<tr>
<td>3 -Patient <strong>depends entirely</strong> upon another person to maintain toileting hygiene.</td>
<td>Dependent</td>
</tr>
</tbody>
</table>
Toileting Hygiene

- Patient wears a Thoracic-Lumbar-Sacral Orthosis (TLSO) brace, can pull pants and underwear up/down without help but insists on removing the brace while sitting on the commode prior to cleaning herself, and requires assist to don/doff the brace, then can pull up her clothing.

- Code GG0130C based on the type and amount of assistance to complete the entire activity including cleansing the peri-area and adjusting any clothing relevant to the patient (TLSO is considered a dressing item). If in the assessing clinician’s judgement, patient requires a helper to provide less than half the effort to complete the entire activity, code 03 (partial/moderate assist); if the patient needs a helper to provide more than half the effort to complete the entire activity, code 02 (substantial/maximum assistance). July 2020

M1850 Transferring

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently transfer.</td>
</tr>
<tr>
<td>1</td>
<td>Able to transfer with minimal human assistance or with use of an assistive device.</td>
</tr>
<tr>
<td>2</td>
<td>Able to bear weight and pivot during the transfer process but unable to transfer self.</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>
</tbody>
</table>

3 pts

7 pts

3 pts

6
M1850 Transferring:

For most patients M1850 transferring includes:
• transfer from a supine position in bed to a sitting position
• then some type of standing, stand-pivot, or sliding board transfer to a chair
• and back into bed from the chair or sitting surface.
• The need for assistance with gait may impact score if the closest sitting surface in patient’s environment is not next to the bed

• If there is no chair in the patient’s bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient’s ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient’s environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.

M1850 Transfer

OASIS Definitions

Minimal Human Assistance:

- Includes any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance
- Individual assisting is contributing less than 25% of the total effort required to perform the transfer
- Patient requires guidance for initiation, balance, and/or stability
- Patient is assuming >75% of own body weight

Able to Bear Weight

- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities

Bedfast

Refers to being confined to the bed, either per physician restriction or due to a patient’s inability to tolerate being out of the bed for any length of time.
M1850 Assessment Techniques

• Observe the patient lie down on their back in bed or on their usual sleeping surface. Assistance needed?
• Observe the patient rise to a sitting position on the side of the bed. Assistance needed?
• Identify the nearest sitting surface and observe patient perform some type of transfer to that surface. The transfer may involve standing and taking a few steps to the chair or bench or bedside commode, a stand-pivot, or a sliding board transfer. Assistance needed? What type of assistance? How much assist? By whom?
• Observe patient transfer back onto the bed from the sitting surface.

GG0170A Roll left & right, GG0170B Sit to Lying

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.</td>
<td></td>
</tr>
<tr>
<td>B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.</td>
<td></td>
</tr>
</tbody>
</table>

• GG0170A: while lying supine, rolls to both left and right
• GG0170B: moves from sitting on side of bed to lying flat on bed
• If patient unable to lie flat due to medical restriction or condition, but could previously, code 88
• Use clinical judgement to determine patient’s “lying position” (could be slightly elevated head of bed, as long as patient can still turn to side)
GG0170C Lying to Sitting

C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.

- Note reference to feet flat on the floor has been removed!
- If patient able to use assistive device without help, code 06
- If patient sleeps in recliner (as their bed) and can push a button for the chair to return to a sitting position, code 06
- If caregiver must hand assistive device to patient, who can then perform the activity, code 05

GG0170D Sit to Stand

D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.

- From any of the three surfaces (chair, wheelchair, bed) applicable to patient’s environment
- If the only help a patient needs to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis, code 05
GG0170E Chair/Bed to Chair

• Activity begins with patient sitting (in a chair, wheelchair, or at the edge of the bed) and transferring to a different sitting surface (chair, wheelchair, or bed).
• Sit to lying and lying to sitting are not assessed as part of GG0170E.
• While the need for assist with ambulation may impact M1850 Transferring item (which is specifically a transfer to and from the bed), the need for assistance with ambulation would not impact the code selected for GG0170E which simply reflects a transfer between any two sitting surfaces.
• If 2 people assist with hoyer lift transfer, code 01 even if patient assists with any part of the chair/bed-to-chair transfer.

Scenario GG0170D and GG0170E, M1850

• Mr. B admitted to HH for complete quadriplegia from an injury 1 year ago and has been unable to bear weight in standing since the injury. At SOC, he is transferred from his bed into a wheelchair with assist of two people using a patient lift that does not require him to come to a standing position.
**Answer** GG0170D and GG0170E, M1850

- Mr. B admitted to HH for complete quadriplegia from an injury 1 year ago and has been unable to bear weight in standing since the injury. At SOC, he is transferred from his bed into a wheelchair with assist of two people using a patient lift that does not require him to come to a standing position.

<table>
<thead>
<tr>
<th>Q9</th>
<th>D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>E. Chairbed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).</td>
</tr>
</tbody>
</table>

M1850 = 3

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**M1860 Ambulation/Locomotion**

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

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

Enter Code

7 pts

6 pts

17

20 pts
OASIS Definitions

**Assistance:**
- When an OASIS item refers to assistance, this means assistance from another person.
- Is not limited to physical contact
- Includes verbal cues
- Includes supervision

**Bedfast:**
Refers to being confined to the bed, either per physician restriction or due to a patient’s inability to tolerate being out of the bed for any length of time.

**Chairfast:**
A patient who is not safe ambulating even with the combination of continuous assistance and a device is chairfast.

**Day of Assessment:**
Is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.

Scoring Considerations

- **Ambulatory** Responses 0, 1, 2 or 3
  - Ambulates safely alone or with assistance (stand-by to max)

- **Chairfast** Responses 4 or 5
  - Unable to make patient safe with combination of device and assistance
  - Can only take 1-2 steps to transfer

- **Bedfast** Response 6
  - Medically restricted to bed or unable to tolerate being out of bed

“Usual Status > 50% of the Time” does not apply when determining if patient is Ambulatory vs Chairfast vs Bedfast

Examples:
- Spends most of the day in bed ≠ Bedfast
- Uses wheelchair 80% and ambulates 20% ≠ Chairfast
M1860 Ambulation/Locomotion

This item identifies the patient’s ability and type of assistance needed to safely ambulate or propel self in a wheelchair on a variety of surfaces given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform Ambulation. Ability can be temporarily or permanently limited by:

- **physical impairments** (for example, limited range of motion, impaired balance);
- **emotional/cognitive/behavioral impairments** (for example, memory deficits, impaired judgment, fear);
- **sensory impairments** (for example, impaired vision, pain);
- **environmental barriers** (for example, stairs, narrow doorways, unsafe flooring).

M1860 Assessment Techniques

Observe the patient walk a reasonable distance, if safe

- Consider all surfaces in patient’s environment, assess on steps if routinely used
- Does patient use a device? Correctly and safely? What type?
- Does patient use walls or furniture for support?
- Does patient demonstrate loss of balance or other actions that suggest additional support is needed for safe ambulation?
- Does the patient demonstrate safe gait pattern?

If chairfast, does the patient have a wheelchair?

- Power or manual? Do the brakes work properly?
- Can the patient demonstrate ability to wheel the chair independently and as directed? Across the floor? Through doorways? Up/down entrance ramp? Safely?
- Check feet/lower legs for bruises, abrasions
Assessment Techniques M1860

- Do not assume patient would be able to safely use equipment that is not available in-home day of assessment.
- Consider environmental barriers, available equipment, amount of supervision / assistance that patient should have to ambulate/locomote safely in home.
- Caregiver availability is not considered: it is not does the patient have a caregiver present to help, but should the patient have a caregiver to be safe.

GG0170I through GG0170L

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If SOC/ROC performance is coded 07, 09, 10 or 86, skip to GG0170M, 1 step (curb)</td>
<td></td>
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</tr>
<tr>
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<tr>
<td>J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.</td>
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<tr>
<td>K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.</td>
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<td></td>
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</tr>
<tr>
<td>L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Use of assistive device(s) and adaptive equipment (cane or leg brace) does not affect coding of activity
- 90-degree turns may be same or different directions
- If environment does not allow a walk of 150 ft without turns, may demonstrate ability to walk 150 ft with turns
Rest Breaks While Walking

- For GG0170K, walking 150 feet, the patient is not allowed to sit down and rest during the 150 ft walk. May pause to catch a breath, but not sit down.
- May determine response based on patient or caregiver/family report of patient’s ambulation into the home when coming back from the hospital the day before (within the assessment time frame). March 2019 QRP Training
- Additional info: The patient walking 50 feet takes a standing rest break. How would he be coded?
- May take a standing rest break. If he needs to sit to rest during a GG walking activity, consider the patient unable to complete the walking activity

Two Helpers—What is the Difference?

- If the patient requires two helpers to carry him 10 feet from the bed to the chair, would this be coded 01- Dependent for GG0170I Walk 10 feet?
- The walking activities cannot be completed without some level of patient participation. A helper cannot entirely complete a walking activity for a patient.
- When the therapist must provide contact guard assist to the patient during ambulation and there is a second person helping to manage an oxygen tank (or IV pump tubing), how are the GG walking items scored?
- If two helpers are required to assist the patient to safely walk, (one to provide support to the patient and a second to manage necessary equipment to allow the safe walk), code 01 – Dependent, as two helpers are required for the patient to safely complete the activity. Jan 2020 Q&A
**Scenario**

- Mr. Bradford is recovering from a stroke and even with hands-on assistance and his walker is only able to walk 30 feet (PT is providing less than half the effort). Mr. Bradford reports that he could walk 50 ft without assistance prior to the stroke. Mr. Bradford’s care plan includes muscle strengthening and gait training. The therapist believes that he will be able to walk the 50 feet with 2 turns by discharge with the assistance of a caregiver for verbal cues and contact guard assist on the turns. Mr. Bradford couldn’t walk 150 ft prior to stroke.

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If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb) |   |
| J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns. |   |
| K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. |   |

**Quiz Answers**

- Mr. Bradford is recovering from a stroke and even with hands-on assistance and his walker is only able to walk 30 feet (PT is providing less than half the effort). Mr. Bradford reports that he could walk 50 ft without assistance prior to the stroke. Mr. Bradford’s care plan includes muscle strengthening and gait training. The therapist believes that he will be able to walk the 50 feet with 2 turns by discharge with the assistance of a caregiver for verbal cues and contact guard assist on the turns. Mr. Bradford couldn’t walk 150 ft prior to stroke.

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<tbody>
<tr>
<td>03</td>
<td>04</td>
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<tr>
<td>88</td>
<td>04</td>
</tr>
<tr>
<td>09</td>
<td>09</td>
</tr>
</tbody>
</table>
GG0170M through GG0170O

- GG0170M = gateway item, watch the skip pattern
- Skip pattern is for performance only – could have a DC goal even if not able to do today
- Use of device(s) or adaptive equipment (railing or cane) does not affect coding of activity
- If level of assistance different for going up or down steps, code based on usual status (i.e. it’s 50/50, so code more dependent portion of activity)
- Includes on feet, or bumping/scooting on their buttocks, if safe

<table>
<thead>
<tr>
<th></th>
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<th>M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N. 4 steps: The ability to go up and down four steps with or without a rail. If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>O. 12 steps: The ability to go up and down 12 steps with or without a rail.</td>
</tr>
</tbody>
</table>

Patient in WC going up Step Scenario

- Mrs. B is not ambulatory but can get up and down a curb in her wheelchair by herself, how would I code GG0170M 1 step?
Patient in WC going up Step **Answer**

- A wheelchair-bound patient may be able to complete the activity of going up and down stairs (including 1 step/curb) in a wheelchair. He would be coded using the 6-point scale if the activity is completed, or coded with one of the “activity not completed” codes if the activity does not get completed, or coded with a dash if no information is available. A patient getting up and down a curb in a wheelchair with no assistance would be coded 06 – Independent.

- Jan. 2019 Q&A #25

**GG0170M One Step or Curb Scenario**

When we assess GG0170M using a curb and the patient is not able to perform due to medical/safety reasons, are we then required to assess using a single step?
GG0170M One Step or Curb Answer

No. There is no requirement to assess a patient going up and down both a curb and a step. However, coding GG0170M with a 07, 09, 10 or 88 when a patient is unable to go up and down a curb (due to no railing) results in skipping GG0170N-O (4 and 12 steps). Providers may want to consider assessing patient’s ability to go up and down 1 step in order to capture performance codes of 06-01 for one or more of the other stair items if the patient can complete the activities with a railing. July 2020

No Car and No 12 Steps

• How do we assess GG0170 activities such as a car transfer or 12 steps if the patient does not have a car or a flight of stairs?

• If the car transfer activity (GG0170G) or the stair activities (GG0170M, N and O) are not completed because no car or stairs are available, and the patient’s status cannot be determined based on patient or caregiver report, enter Code 10, Not attempted due to environmental limitations.

• Note that assessing clinicians can use professional clinical judgment to determine if a car transfer, or stair activity, or other GG self-care or mobility activity, may be assessed using a similar activity as an acceptable alternative. For example, for item GG0170O, 12 Stairs, the combination of going up and down 4 stairs 3 times consecutively is an acceptable alternative to meet the intention of this activity.

• Jan. 2019 Q&A #28
With or Without Railings

A patient has one step with no railing to enter the home and his flight of 12 stairs to his bedroom has two railings. Using the railings, he can go up and down the flight of stairs independently. However, he requires assistance to go up and down the one step in and out of his home because there is no railing to use. How would GG0170M - 1 Step (curb) be coded?

If a patient's performance going up/down a curb is different than his performance going up/down one step with a railing, code GG0170M - 1 step (curb) based on the activity with which the patient needs the most assistance. CMS Q&A July 2019

Stick with the Original Answer

• On admission a patient was not able to go up and down steps secondary to safety deficits. PT completed their evaluation 2 days later and after providing education regarding the safety deficits and how to correctly ascend/descend the stairs, patient was then able to ascend and descend some steps. Do we code 88 – not attempted due to medical conditions or safety concerns since patient was unsafe on admission? Or do we code based on how the patient performed on steps at the PT evaluation even though the patient had received interventions by agency staff in order to complete the activity?

• The Intent of the GG0170 stair items is to determine the amount of assistance required by a patient to go up and down the stairs, by any safe means. At Admission, the mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff. "Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.

• In your scenario if the patient was not able to go up and down the stairs prior to the benefit of services provided by the agency, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, use the appropriate activity not attempted code.

Jan 2020 Q&A#18
GG0170Q through GG0170S

- GG0170Q = gateway item, watch skip pattern
- Turns are 90 degrees, may be in the same direction or different directions
- Should be at the patient's ability level (not jeopardizing patient's safety)
- May use different types of wheelchair for longer distances

GG0170Q Use of Wheelchair/Scooter

- Intent of the wheelchair mobility item is to assess the ability of patients who are learning how to self-mobilize using a wheelchair, those who require assistance from a helper to mobilize using a wheelchair/scooter, and those who require a helper to push them in a wheelchair. October 2019 Q&A 37
- Use clinical judgment to determine if the patient's use of a wheelchair is for self-mobilization due to the patient's medical condition or safety.
- Answer 0 – No if at the time of assessment the patient does not use a wheelchair or scooter under any conditions.
**Courtesey WC Use**

- Patient reports he uses a courtesy wheelchair to doctor appointments due to long distance from car to office, and hospital policy required him to leave in a wheelchair the day before. How do I score w/c use, especially if he doesn’t own a wheelchair?

- Code 0 – No would only be used if at the time of the assessment, patient does not use a wheelchair under any condition. *Although it is infrequent, your patient uses a wheelchair, so GG0170Q would be 1 – Yes*

- If a patient does not complete the wheelchair activities during home visit, determine the patient’s abilities based on the patient’s performance of similar activities during the assessment, or on patient and/or caregiver report. If you are unable to observe the activity, and usual status cannot be determined based on patient and/or caregiver report or on assessment of similar activities, then select the appropriate activity not attempted code.

- Jan 2020 Q&A#19

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**April 2020 Q&A #15 clarifies the confusion!**

- **QUESTION 15:** According to the guidance manual, the intent of GG0170Q – Does the patient use wheelchair and/or scooter is to assess the ability of patients who SELF-mobilize with a wheelchair/scooter or those who are learning to SELF-mobilize. The answer from the January 2020 Quarterly Q&As makes it sound like the item’s intent is to code based on whether or not the patient is using a wheelchair or scooter at all, regardless if they self-mobilize. Please clarify.

- **ANSWER 15:** At times, CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance. The January 2020 Quarterly OASIS Q&As represent more recent OASIS guidance than the OASIS Guidance Manual dated January 2, 2019, therefore, utilize the more recent guidance presented in January 2020, Question #20. *Only code GG0170Q - Does the patient use a wheelchair and/or scooter? as “0 – No” if at the time of the assessment the patient does not use a wheelchair or scooter under any condition.*
Wheelchair Use Changes

- Patient does not use a w/c at SOC, GG0170Q = No. During the episode, patient begins using a w/c. Is it appropriate to go back to the SOC and change GG0170Q to Yes and add corresponding goals, even though the w/c use occurred after the SOC assessment time period ended?

- At the time of the SOC assessment, if the patient does not use a w/c under any condition, response No is correct. Following the SOC assessment time period, if the patient begins to use a w/c under any condition, there is no need to update the SOC performance or discharge goals for GG0170Q-S on the SOC assessment. The gateway wheelchair item (GG0170Q) might not be the same on the SOC and DC assessments.

Scenario GG0170Q and GG0170R

- At SOC, Mrs. Burns is unable to bear any weight on right leg due to recent fracture. Nurse observes as caregiver provides steadying assistance when transferring her from bed into wheelchair. Once in the wheelchair, Mrs. Burns propels herself safely using left leg and arms about 60 feet down the hall and makes two turns without any physical assist or supervision.
**Answer GG0170Q and GG0170R**

- At SOC, Mrs. Burns is unable to bear any weight on right leg due to recent fracture. Nurse observes as caregiver provides steadying assistance when transferring her from bed into wheelchair. Once in the wheelchair, Mrs. Burns propels herself safely using left leg and arms about 60 feet down the hall and makes two turns without any physical assist or supervision.

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<tr>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>1. Yes → Continue to GG0170R, Wheel 50 feet with two turns.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.</th>
</tr>
</thead>
<tbody>
<tr>
<td>RR1. Indicate the type of wheelchair or scooter used.</td>
</tr>
<tr>
<td>1. Manual</td>
</tr>
<tr>
<td>2. Motorized</td>
</tr>
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</table>

**Scenario GG0170Q, GG0170R, GG0170S**

- For longer distances Mrs. Burns uses a motorized scooter. She requires assistance getting on/off scooter, but once she is seated she can propel it 400 feet to dining room without further assistance.

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<td>SS1. Indicate the type of wheelchair or scooter used.</td>
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**Answer** GG0170Q, GG0170R, GG0170S

- For longer distances Mrs. Burns uses a motorized scooter. She requires assistance getting on/off scooter, but once she is seated she can propel it 400 feet to dining room without further assistance.

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<tr>
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</tr>
<tr>
<td>2.</td>
<td>Motorized</td>
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</tbody>
</table>

**GG0170G Car Transfer**

- The activity includes transferring in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
- Does not include opening or closing the car door, or fastening seat belt.
- If the patient is not able to attempt car transfers (for example because no car is available, or there are weather or other environmental constraints), and the patient’s usual status cannot be determined based on patient or caregiver report, enter code 10 Not attempted due to environmental limitations.
- If at the time of the assessment the patient is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.
- Consider interview of patient/family re: trip home from hospital if it was within the day of assessment time frame.
Car Transfer **Scenario**

Ms Melvin walks to the car with her walker. Her son opens the car door for her. She places her hands on the car door and the handle inside the car and sits in the car. The son folds her walker and places it in the car. When getting out of the car, Ms Melvin rises to a standing position by using the car door and the door sill. Her son sets up the walker so that she can ambulate. She does not require the walker to complete the transfer. Jan. 2019 Q&A #27

06. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

Car Transfer **Answer**

Ms Melvin walks to the car with her walker. Her son opens the car door for her. She places her hands on the car door and the handle inside the car and sits in the car. The son folds her walker and places it in the car. When getting out of the car, Ms Melvin rises to a standing position by using the car door and the door sill. Her son sets up the walker so that she can ambulate. She does not require the walker to complete the transfer. Jan. 2019 Q&A #27
Mr. Rose **Scenario**

- Mr. Rose is a paraplegic and transfers into a van by manipulating his wheelchair up a ramp and then after positioning the wheelchair, he is able to hook the front tethers while his caregiver completes the other 3 tethers. How should I code Mr. Rose on car transfers?
- The car transfer activity focuses on transferring into and out of a car or van **seat**. If he is seated in a wheelchair, then the appropriate “activity not attempted” code would be used.

Mr. Rose **Answer**

- When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe. At admission, the self-care or mobility performance code is to reflect the patient’s baseline ability to complete the activity prior to benefit of services provided by your agency staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and then coding based on the type and amount of assistance that was required prior to the benefit of services provided by your agency staff.

- Communicating the activity request (e.g., “Can you stand up from the toilet?”) would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (e.g., “Push down on the grab bar”, etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code.
• Assuming the verbal cues were only required prior to the activity, were provided prior to the benefit of services, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues fit the definition for 05 – Setup or clean-up assistance.

• Example: prior to the "Picking up an item from the floor" activity, the therapist needed to cue the patient on where to place their hand for stability; then the patient completed all of the activity safely and without any assistance or additional cues. Score = 05 - Setup

• Example: the OASIS Guidance Manual indicates via an example for bed to chair transfers, that “locking chair brakes” prior to the transfer is 05 – Setup, as long as no further assistance was required during the activity. Could a verbal cue reminding a patient to lock wheelchair brakes prior to the initiation of the transfer be considered 05 - Setup as well, as long as no further cueing or touching was provided during the activity? Yes, score = 05 – Setup, if all cues were prior to the activity. April 2020 Q&A #10
## Section H: Bowel and Bladder

### Section H

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<th>ROC</th>
<th>FU</th>
<th>TRF</th>
<th>DC</th>
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317

## Section I

### Active Diagnosis

318
Section I: Active Diagnoses

<table>
<thead>
<tr>
<th>Section I</th>
<th></th>
<th>SOC</th>
<th>ROC</th>
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</table>

What does that mean that M1021 and M1023 aren’t going to be on Recert/Other FU?

- OASIS item is no longer used for payment. The claim is used for payment.
- Only the first six are transmitted to iQIES. The purpose is risk adjustment.
- There is no risk adjustment on Recerts or Other Follow-Ups.
- The diagnosis list on the Recert and the Other Follow-Up still need to go onto the POC and the claim. (The M1021/M1023 have been optional on the Recert and OFU since OASIS D1.)
### M1028 Active Diagnoses-Comorbidities and Co-existing Conditions

**Item Intent:**
- Identifies whether Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) or Diabetes are **present and active** diagnoses.
- It has been determined that these diagnoses affect a patient’s outcomes and risk for pressure ulcer worsening or development.
- This item requires a provider confirmation of these diagnoses.

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Diabetes Mellitus (DM)</td>
</tr>
<tr>
<td></td>
<td>3. None of the above</td>
</tr>
</tbody>
</table>

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### CMS Definition – Active Diagnosis

- Active diagnoses are diagnoses that have a **direct relationship** to the patient’s **current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death** at the time of assessment.
- Do not include diseases or conditions that have been resolved or do not affect the patient’s current functional, cognitive, or mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
M1028 Active Diagnoses-Comorbid Conditions

Coding Instructions (check all that apply)

**Code 1, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD),** if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), indicated by any of the following diagnosis codes:

Codes that start with the first 4 characters of:
- **I70.2**, Atherosclerosis of native arteries of the extremities
- **I70.3**, Atherosclerosis of unspecified type of bypass graft(s) of the extremities
- **I70.4**, Atherosclerosis of autologous vein bypass graft(s) of the extremities
- **I70.5**, Atherosclerosis of nonautologous biological bypass graft(s) of the extremities
- **I70.6**, Atherosclerosis of nonbiological bypass graft(s) of the extremities
- **I70.7**, Atherosclerosis of other type of bypass graft(s) of the extremities
- **I70.91**, Generalized atherosclerosis
- **I70.92**, Chronic total occlusion of artery of the extremities

Codes that start with the first 3 characters of:
- **I73**, Other peripheral vascular diseases

**Code 2, Diabetes Mellitus (DM),** if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any of the following diagnosis codes:

Codes that start with the first 3 characters of:
- **E08**, Diabetes mellitus due to underlying condition
- **E09**, Drug or chemical induced diabetes mellitus
- **E10**, Type 1 diabetes mellitus
- **E11**, Type 2 diabetes mellitus
- **E13**, Other specified diabetes mellitus

*Note: Diabetic PVD will now be captured under both PVD and Diabetes per the February 2017 release of the CMS OASIS Q&As*
### Section J: Health Conditions

<table>
<thead>
<tr>
<th>Item</th>
<th>Section J</th>
</tr>
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<tbody>
<tr>
<td>M1033</td>
<td>Risk for Hospitalization</td>
</tr>
<tr>
<td>J0510</td>
<td>Pain Effect on Sleep</td>
</tr>
<tr>
<td>M1242</td>
<td>Frequency of Pain Interfering w/ Activity</td>
</tr>
<tr>
<td>J0520</td>
<td>Pain Interfering w/ Therapy</td>
</tr>
<tr>
<td>J0530</td>
<td>Pain Interfering w/ Activity</td>
</tr>
<tr>
<td>J1800</td>
<td>Any Falls since SOC/ROC</td>
</tr>
<tr>
<td>J1900</td>
<td>Number of Falls since SOC/ROC</td>
</tr>
<tr>
<td>M1910</td>
<td>Falls Risk Assessment</td>
</tr>
<tr>
<td>M1400</td>
<td>Dyspnea</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</table>
Reminders regarding Deleted Items

- CoPs require a comprehensive assessment.
- Falls risk assessment incorporated into your OASIS comprehensive assessment.
- Wound assessment incorporated into your OASIS comprehensive assessment.
  - Documentation to indicate healing status
  - Covered by dressing
  - Stage
- Dyspnea assessment incorporated into your OASIS comprehensive assessment.

Pain Interference

J0510, J0520, J0530
Pain Definition

- Any type of physical pain or discomfort in any part of the body.
- It may be localized to one area or maybe more generalized.
- It may be acute or chronic, continuous or intermittent, or occur at rest or with movement.
- Pain is very subjective;
- Pain is whatever the experiencing person says it is and exists whenever he or she says it does.

Pain Interference

Item Rationale:

Health-Related Quality of Life impact:
- The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown, and infections.
- Pain significantly adversely affects a person’s quality of life and is tightly linked to depression, diminished self-confidence, and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired patients.
- Some older adults limit their activities to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management!
- The lookback period on these items is 5 days!
**J0510 Pain Effect on Sleep**

**Scenario J0510 Pain Effect on Sleep**

"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night"

Mrs. D. responds, “I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby.”
Answer J0510 Pain Effect on Sleep

"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night"

**Coding:** J0510 would be coded 1 rarely or not at all

**Rationale:** Mrs. D. reports no sleep problems related to pain but did have pain during the day. Zero can only be used if the patient reports zero pain in the last 5 days

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Scenario J0510 Pain Effect on Sleep

"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night"

Miss G. responds, “Yes, the back pain makes it hard to sleep. I have to ask for extra pain medicine every night, and I still wake up several times during the night because my back hurts so much. My arthritis hurts more when I am laying down”
**Answer J0510 Pain Effect on Sleep**

"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night"

**Coding:** J0510 would be coded 4 almost constantly.

**Rationale:** The patient reports pain-related sleep problems that happen daily, frequently waking up and taking extra meds to try to help but her pain is always worse at night.

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**J0520 Pain Interference with Therapy Activities**

- Intent: to determine how often the patient has had pain caused them to limit their participation in rehab therapy sessions
- **5 day look back period**
- Response 0 is chosen if the pt has not had rehab therapy in the last 5 days
- Responses 1 through 4 are with increasing frequency – select based on patient response
- Response 8 is used if patient is unable to answer for some reason
- Dash is NOT a valid response

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**SOC ROC D/C**
Rehabilitation Therapy

- Special healthcare service or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment.

- Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.

- Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present.

J0530 Pain Interference with Day-to-Day Activities

- Intent: to determine how often the patient has had pain caused them to limit their day-to-day activities (excludes rehab therapy sessions)

- Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management!

- 5 day look back period

- Responses 1 through 4 are with increasing frequency – select based on pt response

- Response 8 is used if pt is unable to answer for some reason

- Dash is NOT a valid response
**Scenario J0530 Pain Interference with Day-to-Day Activities**

"Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?"

Ms. L. responds, “A little, I had some pain on Wednesday, and walking distances like that make my knees hurt more, so I did not go shopping.”

**Answer J0530 Pain Interference with Day-to-Day Activities**

"Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?"

**Coding**: J0530 would be coded 2 Occasionally.

**Rationale**: Ms. L. reports pain that limits the distances she can walk. She does not attempt to go shopping frequently, but occasionally.
Scenario J0530 Pain Interference with Day-to-Day Activities

"Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?"

Mr. Q. responds, “I don’t like painful activities.” Interviewer repeats question and Mr. Q. responds, “I designed a plane one time.”

Answer J0530 Pain Interference with Day-to-Day Activities

"Over the past 5 days, how often you have limited your day-to-day activities (excluding rehabilitation therapy session) because of pain?"

Coding: J0530 would be coded 8, unable to answer.
Rationale: patient has provided a nonsensical answer to the question.
M1033 Risk for Hospitalization

If 4 or more except 8, 9 & 10 are marked – Increases the functional score

<table>
<thead>
<tr>
<th>M1033. Risk for Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which of the following signs or symptoms characterize this patient as at risk for hospitalization?</td>
</tr>
<tr>
<td>□ 1. History of falls (2 or more falls – or any fall with an injury – in the past 12 months)</td>
</tr>
<tr>
<td>□ 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months</td>
</tr>
<tr>
<td>□ 3. Multiple hospitalizations (2 or more) in the past 6 months</td>
</tr>
<tr>
<td>□ 4. Multiple emergency department visits (2 or more) in the past 6 months</td>
</tr>
<tr>
<td>□ 5. Decline in mental, emotional, or behavioral status in the past 3 months</td>
</tr>
<tr>
<td>□ 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months</td>
</tr>
<tr>
<td>□ 7. Currently taking 5 or more medications</td>
</tr>
<tr>
<td>□ 8. Currently reports exhaustion</td>
</tr>
<tr>
<td>□ 9. Other risk(s) not listed in 1-8</td>
</tr>
<tr>
<td>□ 10. None of the above</td>
</tr>
</tbody>
</table>
M1033—1 History of Falls

- Any fall in the last 12 months, with or without an injury, whether witnessed or unwitnessed.
  - 2 or more falls occurred OR
  - A single fall resulting in ANY injury
- Fall—an unintentional change in position coming to rest on the ground, floor, or the next lowest surface (such as a bed or chair).
- Falls resulting from an overwhelming force and falls resulting from therapeutic balance retraining are considered falls. Intercepted falls are not included for M1033.
- October 2019 Q&A #16

History of Falls

Identifying Documentation that Supports a Recommendation

- Documentation supports multiple falls and/or recurrent falls within the time frame
- Examples of supporting documentation for recommendation:
  - Patient had fall from w/c with head injury in September
  - Vertigo and UTI resulted in fall
  - Fall with a painful wrist
  - MD notes patient fell and strained her back requiring NSAIDS for pain
  - Patient or caregiver reports patient has fallen without an injury twice in the past 5 weeks
M1033—2 Weight Loss

- Unintentional weight loss of a total of 10 pounds or more in the past 12 months
  - Key: *unintentional* – often patients don’t realize they have lost the weight
- When weighing the patient for M1060, ask patient and family/caregiver if this is usual weight, any changes (gain or loss) of 10 pounds or more in the last year? Has patient been dieting during that time?

M1033—3-Hospitalization

- Only acute inpatient hospital stays in last 6 months
  - No LTCHs or inpatient psych hospitalizations
- Hospitalization = being admitted for 24 hours or more to an *inpatient* acute bed for more than diagnostic testing. Observation stays are *not* included.
- If discharged from the acute hospital and then readmitted later that day to the acute hospital, that counts as two hospitalizations.
M1033—4-Multiple ED Visits

- Response 4 - Two or more ED trips in the last 6 months
- Hospital emergency departments only (as defined in M2301)
- Includes all visits to ED whether instructed to go by physician, agency or patient/family decision

M2301 Emergent Care

- **Excludes** urgent care services not provided in a hospital emergency department, including care provided at doctor's office, care provided by an ambulance crew, or care received in urgent care facilities.
- **Includes** holding and observation only in the hospital emergency department setting
- If a patient went to a hospital ED, was "held" for observation, then released
- Time period that a patient can be "held" can vary
- If the patient went thru ED to be admitted, count both as an ED visit and a hospitalization

M1033—5-Decline in Mental...

- Response 5 – Significant changes in mental, emotional or behavioral status in past 3 months
- Patient, family, caregiver or physician has noted a decline regardless of the cause
- Anything that may impact the patient’s ability to remain safely in the home, increase likelihood of hospitalization
  - May be temporary or permanent
  - Physician consultation or treatment may or may not have occurred
Decline in Mental, Emotional or Behavioral Status

**Identifying Documentation that Supports a Recommendation**

- Documentation supports decline/worsening status
- Investigate when:
  - Change in anxiety/depression medication
  - Difficulty with self management
  - HH orders for med management -- ? due to cognitive decline
  - Condition exacerbates dementia/anxiety
- Examples of supporting documentation for recommendation:
  - Increased anxiety and depression
  - Has severe anxiety with new medication
  - Hospital stay for altered mental status

Difficulty Complying with Any Medical Instructions

**M1033 Response 6 Guidance**

- Time frame: Past 3 months
- Reported or observed
- Compliance difficulty examples:
  - Medications
    - Missing medication(s)
    - Non-compliant with ordered medication(s)
    - Unable to afford medications
  - Diet
    - Not following prescribed diet
    - Requires diet teaching
    - Unable to afford food
  - Exercise
    - HEP noncompliance
    - Unable to perform prescribed exercise due to pain
Difficulty Complying with Any Medical Instructions

Identifying Documentation that Supports a Recommendation

• The patient does not have needed equipment in the home--glucometer, C-pap, walker, blood pressure cuff, scale, etc.
• Noncompliant with CPAP use
• Not following weight bearing restrictions
• Patient left inpatient/ED AMA
• Missed medical or dialysis appointments
• Investigate when:
  – Patient denies a medical condition/diagnosis
  – Caregiver provides care when patient refuses

Currently Taking 5 or More Medications

M1033 Response 7 Guidance

• Time frame: Day of Assessment
• Includes prescribed and OTC medications, any route
• Noncompliance is not a factor
• Nutritional supplements, vitamins and homeopathic and herbal products are included
• Examples: Tylenol, multivitamins, TUMS, TPN, O2

Identifying Documentation that Supports a Recommendation

• Med profile lists ≥ 5 medications
• Compare physician/DC med list with home health med list
M1033 – 8 and 9

• These do not provide any case-mix points in PDGM scoring (only responses 1-7 count)
• Response 8 – Currently reports exhaustion
• Response 9 – Other risk(s) not listed in 1-8
  – Anything that might potentially increase the risk of hospitalization
  – Slower movement during sit to stand and walking
  – Ex: dialysis treatment, terminal diagnosis, low literacy, blindness, unstable caregiver, limited financial resources, unsafe environment, etc.

None of the Above

M1033 Response 10 Guidance

• If Response 10 is selected, none of the other responses should be selected.
• Would be used *infrequently*
Falls
J1800, J1900

Assessment Steps:
• Review home health clinical record, incident reports and any other relevant clinical documentation (for example, fall logs)
• Interview patient and/or caregiver about occurrence of falls

Coding Instructions:
• Code 0, no: if patient has not had any fall since most recent SOC/ROC
• Code 1, yes: if patient has fallen since most recent SOC/ROC
• A Dash is a valid response, but CMS expects this to be a rare occurrence.
J1800 Definition of Fall

FALL:
• Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).

INTERCEPTED FALL:
• An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this IS still considered a fall.

Therapeutic Loss of Balance:
• NOTE: CMS does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Definition of a fall different with each item

M1033 Risk of Hospitalization
• Any fall in the last 12 months, with or without an injury, whether witnessed or unwitnessed.
  – 2 or more falls occurred OR
  – A single fall resulting in ANY injury
• Fall—an unintentional change in position coming to rest on the ground, floor, or the next lowest surface (such as a bed or chair).
• Falls resulting from an overwhelming force and falls resulting from therapeutic balance retraining are considered falls. Intercepted falls are not included for M1033.

October 2019 Q&A #16

J1800 Any falls since most recent SOC/ROC
• Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).
• An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this IS still considered a fall.
• CMS does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.
Unwitnessed Fall Scenario

- The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

Unwitnessed Fall Answer

- The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  - **Rationale:** This item addresses unwitnessed as well as witnessed falls.
Intercepted Fall **Scenario**

- An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.

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**Intercepted Fall Answer**

**Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.  
**Rationale:** An intercepted fall is considered a fall.
Balance Training – Challenge Balance **Scenario**

- A patient is participating in balance retraining activities during a therapy visit. The therapist is intentionally challenging patient’s balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides minimal assistance to allow the patient to maintain standing.

Balance Training – Challenge Balance **Answer**

**Coding:** J1800, Any Falls since SOC/ROC, would be coded 0, No.

**Rationale:** The patient’s balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated. When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall.
Unanticipated Fall During Therapy **Scenario**

A patient is ambulating with a walker with the help of the physical therapist. The patient stumbles and the therapist has to bear some of the patient’s weight in order to prevent a fall.

Unanticipated Fall During Therapy **Answer**

- A patient is ambulating with a walker with the help of the physical therapist. The patient stumbles and the therapist has to bear some of the patient’s weight in order to prevent a fall.

  - **Coding**: J1800, Any Falls since SOC/ROC would be coded 1, Yes.
  - **Rationale**: The patient’s stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.
J1900: Number of Falls Since SOC/ROC Assessment

**Identifies the number of falls a patient had since the most recent SOC/ROC, AND fall related injury.**

Outcome is % of quality episodes in which the patient experiences one or more falls with **major injury**

### Coding:

- 0. None
- 1. One
- 2. Two or more

### Enter Codes in Boxes

- A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
- B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain
- C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

### Response Specific Instructions

- Review record and interview patient/family to determine the number of falls that occurred since the most recent SOC/ROC and identify the level of fall-related injury for each fall.
- Code falls no matter where the fall occurred, IF it occurred during the quality episode.
- Code each fall only once.
  - If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.
J1900 Definitions

- **INJURY RELATED TO A FALL** Any documented or reported injury that occurred as a result of or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

- **NO INJURY** No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.

- **INJURY (EXCEPT MAJOR)** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.

- **MAJOR INJURY** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Answer J1800 and J1900

- The patient fell at the doctor's office and sustained a shoulder separation.
  - J1800 Any falls? And J1900?
- The patient fell at the hospital after transfer from home health.
  - J1800 Any falls? And J1900?
Example

Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes. The first describes an event during which Mr. G tripped on the bathroom rug and almost fell but caught himself against the sink. The RN assessment identified no injury. The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

Coding:
- J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.
- J1900B, Injury (except major), would be coded 1, one injury (except major) fall since the most recent SOC/ROC.
- J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.
- Rationale: The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

Info Obtained Later

- Mr. Norman fell and complained of severe pain in his hip. He went to the ER and was admitted. We completed the transfer OASIS the next day but information was not available until 4 days later that the hip is fractured. Since that knowledge was obtained after the timeframe, how should M1900 be coded?
- Since injuries can present themselves later than the time of the fall, or the agency may not learn of the level of injury until after the OASIS/assessment is completed, agencies are encouraged to correct errors as accurate information regarding fall-related injuries becomes known. Errors should be corrected following the agency’s correction policy and M0090 would not necessarily be changed.
M1400 Dyspnea

Improvement in Dyspnea

**Measure Description:**
Percentage of home health quality episodes during which the patient became less short of breath or dyspneic.

**Numerator:**
The number of home health quality episodes where the discharge assessment indicates less dyspnea at discharge than at the start (or resumption) of care.

**Denominator:**
The number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.

**Exclusions:**
Home health quality episodes for which the patient, at start/resumption of care, was not short of breath at any time, episodes that end with inpatient facility transfer or death.

**OASIS Item (M1400)** When is the patient dyspneic?
M1400 Shortness of Breath

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient is not short of breath</td>
</tr>
<tr>
<td>1</td>
<td>When walking more than 20 feet, climbing stairs</td>
</tr>
<tr>
<td>2</td>
<td>With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)</td>
</tr>
<tr>
<td>3</td>
<td>With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation</td>
</tr>
<tr>
<td>4</td>
<td>At rest (during day or night)</td>
</tr>
</tbody>
</table>

Item intent and instructions:

- Identifies the level of exertion/activity that results in a patient’s dyspnea or shortness of breath
- May be observed during assessment or reported by the patient or family/caregiver
- Day of assessment – time in home and 24h preceding

M1400 Assessment Techniques

- Assess with activity if safe for patient to demonstrate
- If patient uses oxygen **continuously**, assess **with** oxygen
- If the patient uses oxygen **intermittently**, assess **without** the use of oxygen
- If oxygen used at night due to positional dyspnea, report level of exertion that causes dyspnea without oxygen
- Sleep apnea ≠ dyspnea
- Ask about any shortness of breath in past 24 hours
  - Don’t answer solely based on **patient’s** report of dyspnea - observation and interview
M1400 Shortness of Breath

Chairfast or bedbound patient:

- Evaluate the level of exertion required to produce shortness of breath
- The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest
  - Response 0
    - Patient has not been short of breath during the day of assessment
  - Response 1 (When walking more than 20 feet...)
    - Appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient).
  - Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.
  - Remember the EXAMPLES – are not absolutes!

M1400 Shortness of Breath

- Assess and report what caused the patient to experience dyspnea on the day of the assessment.
- The examples included in Responses 2 and 3 are used to illustrate the degree of effort represented by the terms moderate and minimal.
- Response 3 - With minimal exertion or agitation includes the examples of eating, talking or performing other ADLs. The reference to other ADLs means activities of daily living that only take minimal effort to perform like grooming.
Scenario

• The patient is not short of breath sitting in her chair at rest. When the SN asked her to walk into the bedroom, she became short of breath and had to stop and catch her breath after rising from her chair and ambulating a few feet. After catching her breath in the bedroom, the SN helped her remove her shirt to assess breath sounds. The patient became short of breath attempting to put her arm in the sleeve of her shirt when getting re-dressed.

Answer

• The patient is not short of breath sitting in her chair at rest. When the SN asked her to walk into the bedroom, she became short of breath and had to stop and catch her breath after rising from her chair and ambulating a few feet. After catching her breath in the bedroom, the SN helped her remove her shirt to assess breath sounds. The patient became short of breath attempting to put her arm in the sleeve of her shirt when getting re-dressed.
Mr Mays with his positional dyspnea

- Mr Mays walks around without his oxygen and is not short of breath but when he lays down at night he has to get his oxygen on to get enough air.

- Since the patient’s supplemental oxygen use is not continuous, M1400 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be “4 – At rest (during day or night).” It would be important to include further clinical documentation to explain the patient’s specific condition.

Another Scenario

- Patient sleeps with 2 pillows or in recliner and currently not short of breath at rest and otherwise not SOB

- How will you score M1400?
Another Scenario Answer

• Patient sleeps with 2 pillows or in recliner and currently not short of breath at rest and otherwise not SOB

• Environmental modifications: If patient restricts an activity to remain free of dyspnea, can be a “0”
  – Key: did the patient make the modification BEFORE the SOC visit?
Section K Swallowing/Nutritional Status
New Nutritional Approaches Item

<table>
<thead>
<tr>
<th>Section K</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1060 Height and Weight</td>
</tr>
<tr>
<td>K0520 Nutritional Approaches</td>
</tr>
<tr>
<td>M1030 Therapies Received at Home</td>
</tr>
<tr>
<td>M1870 Feeding or Eating</td>
</tr>
</tbody>
</table>

**SOC/ROC FU TRF DC DAH**

**K0520 two different versions: SOC/ROC and D/C**

<table>
<thead>
<tr>
<th>SOC/ROC</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0520. Nutritional Approaches</td>
</tr>
<tr>
<td>1. On Admission</td>
</tr>
<tr>
<td>Check all of the nutritional approaches that apply on admission</td>
</tr>
<tr>
<td>A. Parenteral/IV feeding</td>
</tr>
<tr>
<td>B. Feeding tube (e.g., nasogastric or abdominal (PEG))</td>
</tr>
<tr>
<td>C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)</td>
</tr>
<tr>
<td>D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)</td>
</tr>
<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>

**Discharge**

| K0520. Nutritional Approaches |
| 4. Last 7 days |
| Check all of the nutritional approaches that were received in the last 7 days |
| 5. At discharge |
| Check all of the nutritional approaches that were being received at discharge |
| A. Parenteral/IV feeding |
| B. Feeding tube (e.g., nasogastric or abdominal (PEG)) |
| C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids) |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) |
| Z. None of the above |

A & B replace M1030
K0520 Nutrition Approaches

**Item Rationale**

**Health-related Quality of Life**
- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual’s sense of dignity and self-worth as well as diminish pleasure from eating.
- The patient’s clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the patient and family members to establish nutritional support goals that balance the patient’s preferences and overall clinical goals.

**Planning for Care**
- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

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**CMS Definitions for K0520 Responses**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PARENTERAL/IV FEEDING</strong></td>
<td><strong>FEEDING TUBE</strong></td>
<td><strong>MECHANICALLY ALTERED DIET</strong></td>
<td><strong>THERAPEUTIC DIET</strong></td>
</tr>
<tr>
<td>• Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).</td>
<td>• Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.</td>
<td>• A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.</td>
<td>• A therapeutic diet is a diet intervention ordered by a health care practitioner provides food/nutrition via oral, enteral and parenteral routes as part of the treatment for a disease or clinical condition to modify, eliminate, decrease, or increase certain micro- and macro- nutrients in the diet.</td>
</tr>
</tbody>
</table>

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K0520A Tips

**Parenteral/IV feeding**— includes parenteral or IV fluids provided for nutrition or hydration. Includes additional fluid intake specifically addressing a documented nutrition or hydration need. Excludes fluids provided solely to maintain access and patency.

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN) either continuous or intermittent.
- Hypodermoclysis and subcutaneous ports in hydration therapy
- IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

The following items are **NOT** to be coded in K0520A:

- IV Medications—Code these when appropriate in O0100H, IV Medications.
- IV fluids used to reconstitute and/or dilute medications for IV administration.
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
- IV fluids administered solely as flushes.
- Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

K0520B Tips

**Feeding Tube**

- Code only feeding tubes used to deliver nutritive substances and/or hydration during the time period under consideration.

**Enteral Feeding Formulas:**

- Should be coded to K0520B Feeding Tube whether NG tube, Peg tube, G-tube, J-tube etc.
- Should not be coded as a mechanically altered diet K0520C.
- Should only be coded as K0520D, Therapeutic Diet when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.
**K0520C Tips**

*Mechanically Altered Diet*

- **MECHANICALLY ALTERED DIET** A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Codes to K0520C
- does not code to therapeutic diet K0520D automatically, only if meets definition of therapeutic as well
- May be seen in patients with dysphagia, cognitive impairment or missing/loose teeth
- Includes: soft solids, pureed foods, ground meat, thickened liquids

**K0520D Tips**

*Therapeutic Diets*

- Therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, *supplements* (whether taken with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are **being administered as part of a therapeutic diet to manage problematic health conditions** (e.g. supplement for protein-calorie malnutrition).
- Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.
**Scenario K0520 SOC**

Pt is admitted to home care and is on peg tube feedings. The enteral formula is a diabetic formula selected to provide proper nutrition without spiking glucose levels.

- **B Feeding Tube** would be marked for the enteral feeding
- **D Therapeutic Diet** would also be marked due to the enteral feeding being a diabetic formula which is considered a therapeutic diet.

**Scenario K0520 SOC**

Pt is admitted to home care with a history of CVA causing dysphagia and pt is also Diabetic. Diet ordered is for 1800 calorie Diabetic diet with thickened liquids and ground meat.

- **C Mechanically Altered Diet** should be marked for the thickened liquids and ground meat
- **D Therapeutic Diet** should be marked due to Diabetic diet being ordered.
Scenario K0520 Discharge

Pt is being discharged from Home Care. Pt was on Tube feeding for the last 2 weeks along with a Diabetic diet with thickened liquids. Pt is now taking enough orally to discontinue the tube feeds at discharge and will continue with the diabetic diet with thick liquids.

- K0520-4 Last 7 Days will have B, C and D marked
- K0520-5 At Discharge will have only C and D marked

M1870 Feeding or Eating

Item intent and instruction

- **Identifies** the patient’s ability to feed self, including eating, chewing, and swallowing food
- **Excludes** patient’s ability to prepare food items and transport to the table
- Willingness and adherence are not the focus of this item
- Dash is NOT a valid response
Response Specific Instructions

Response 0

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Feeding or Eating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently feed self.</td>
</tr>
<tr>
<td>1</td>
<td>Able to feed self independently but requires:</td>
</tr>
<tr>
<td></td>
<td>(a) meal set-up; OR</td>
</tr>
<tr>
<td></td>
<td>(b) intermittent assistance or supervision from another person; OR</td>
</tr>
<tr>
<td></td>
<td>(c) a liquid, pureed or ground meat diet.</td>
</tr>
<tr>
<td>2</td>
<td>Unable to feed self and must be assisted or supervised throughout the meal/snack.</td>
</tr>
<tr>
<td>3</td>
<td>Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.</td>
</tr>
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</tr>
<tr>
<td>5</td>
<td>Unable to take in nutrients orally or by tube feeding.</td>
</tr>
</tbody>
</table>

- 100% independent in feeding self meals and snack SAFELY including task of:
  - Eating
  - Chewing
  - Swallowing
- Does not require ANY supervision or set up
- Item responses are based on assistance needed to feed the patient once food is placed in front of them.
- This response does not include assistance needed for preparation of food items or transportation to the table.

Response 1

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

<table>
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</tr>
</tbody>
</table>

- Able to feed self but requires:
  - Meal set up: activities such as cutting up food, mashing a potato, adding milk, sugar to cereal or tea, arranging food for easy access, and opening food packing OR
  - Intermittent assist or supervision OR
  - Specialty consistency like ground meat, pureed
- If ability varies choose response describing the patient’s ability more than 50% of the time period under consideration.
Response Specific Instructions

**Response 2**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.</th>
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• Correct choice if patient is either unable to feed themselves without **assistance or supervision** during the process.
• Assistance can be supervision, SBA or physical assistance
• Examples:
  -- Pt who is a fed by caregiver
  -- Pt who requires **continuous** supervision due to aspiration risk or cognitive status
• If patient is weaning from any type of tube for feeding (i.e. peg, nasogastric, etc) but the tube is still in and no nutrition if provided by tube, then answer response 0, 1, or 2 as appropriate.

Response Specific Instructions

**Response 3**

<table>
<thead>
<tr>
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• Response 3 patient taking **BOTH oral food AND feeding via tube**
• Depending on patient’s ability to get some nutrition orally. If weaning from tube feeding 3 or 4 will apply until no nutrition being provided via tube.
• Example: patient with malabsorption who takes oral food but also gets tube feeding as a supplement
Response Specific Instructions

**Response 4**

- Depending on patient’s ability to get some nutrition orally. If weaning from tube feeding 3 or 4 will apply until no nutrition being provided via tube.
- Response 4 no Oral intake - either unable to physically or orders for nothing by mouth
- Response 4 fed via gastric tube only

<table>
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<tr>
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<td>4</td>
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**Response 5**

- Response 5 is best response if patient UNABLE take in oral nutrients or nutrition by tube feeding.
- This might be the case for TPN delivery of nutrition.

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Score M1870

• Ms Hangry has difficulty seeing on her left side since her stroke. She can feed herself, but her caregiver has to remind her occasionally to look at her entire plate while eating so that she sees all the food.

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</tbody>
</table>

Score GG0130A

• Ms Hangry has difficulty seeing on her left side since her stroke. She can feed herself, but her caregiver has to remind her occasionally to look at her entire plate while eating so that she sees all the food.

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
GG0130A Eating

- Patient unable to eat or drink by mouth since a stroke 1 week ago. He receives nutrition and hydration through a G-tube, which is administered by a helper.

M1870 Feeding or Eating

- Quadriplegic patient cannot raise arms to get food into his mouth from the plate, helper feeds him, he can chew and swallow safely while eating.
GG0130A Eating

• Quadriplegic patient cannot raise arms to get food into his mouth from the plate, helper feeds him, he can chew and swallow safely while eating.

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

• Because patient swallows safely without assist, coding is based only on type and amount of assistance needed to bring food and/or liquid to the mouth. **Code 01** – dependent, because helper provides all the effort to bring food/liquid to the mouth.

GG0130A July 2019 Q&A #16 Rationale

• Intent of GG0130A is to assess patient’s ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once meal is placed before patient.
  – If patient does not have a swallowing problem, coding is based only on the type and amount of assist needed to bring food and/or liquid to the mouth. When patient swallows safely without assist, exclude swallowing from consideration when coding GG0130A.
  – If patient requires helper assist (e.g. supervision or cueing) due to a swallowing problem, code based on type and amount of assist required for feeding **and** safe swallowing.
Uses Non-Dominant Hand

- Mrs. Wright had a stroke affecting her dominant hand. At admission, she is able to use her unaffected, non-dominant hand to feed herself, only requiring set-up assistance. However, when asked by the OT to perform eating with her affected dominant hand, she required substantial/max assist. How should I score?

- Allow patient to complete the activity as independently as possible, as long as they are safe.
- Jan. 2020 Q&A #12

If safe using non-dominant hand, = 05  
If high risk of spills (hot foods, etc) = 02  
Score on M1870 = 1

M1870 Feeding/Eating—Refuses a Feeding Tube

- Patient has been medically advised to obtain a feeding tube due to his inability to safely take in oral nutrition due to risk (and recent history) of aspiration. Patient continues to eat against medical advice and refused alternate nutrition. Would M1870 be answered as a 2 or a 5? The patient has the motor skills to bring the food to his mouth, but is unsafe swallowing.

- The intent of M1870 is to identify the patient’s ABILITY to feed him/herself, including the process of eating, chewing and swallowing food given current physical and mental-emotional-cognitive status, activities permitted and environment; not necessarily actual performance. In this case, patient is feeding himself orally and is at risk for aspiration due to unsafe swallowing.
  - Response 2: if patient can complete the activities **safely** with constant supervision throughout the meal (reminder to chin-tuck, etc.)
  - Response 5: unable to take in nutrients orally or by tube feeding – best response if patient cannot **safely** take in nutrients orally and does not have a tube feeding.
# Section M: Skin Conditions

<table>
<thead>
<tr>
<th>Section M</th>
<th>SOC</th>
<th>ROC</th>
<th>FU</th>
<th>TRF</th>
<th>DC</th>
<th>DAH</th>
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<td>M1340 Presence of Surgical Wound</td>
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<td>M1342 Status of Most Problematic Surgical Wound</td>
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<td></td>
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</table>
### Section N: Medications

<table>
<thead>
<tr>
<th>Section N</th>
<th>Description</th>
<th>SOC</th>
<th>ROC</th>
<th>FU</th>
<th>TRF</th>
<th>DC</th>
<th>DAH</th>
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</thead>
<tbody>
<tr>
<td>N0415</td>
<td>High Risk Drug Classes</td>
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<tr>
<td>M2001</td>
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<td>M2005</td>
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<td>M2016</td>
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<tr>
<td>M2020</td>
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<tr>
<td>M2030</td>
<td>Management of Injectable Meds</td>
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<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **New Item**: X X X
- **Removed**: Removed
- **Removed at FU**: Removed at FU
N0415 – High-Risk Drug Classes

Section N – Medications

This item identifies if the patient is taking any prescribed medications in the specified drug classes and whether the indication was noted for all medications in the drug class.

**N0415: High-Risk Drug Classes: Use and Indication**

<table>
<thead>
<tr>
<th>SOC/ROC and Discharge</th>
<th>1. Is taking</th>
<th>2. Indication Noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes</td>
<td></td>
<td>Check all that apply</td>
</tr>
<tr>
<td>2. Indication noted</td>
<td>If Column 1 is checked, check if there is an indication noted for all medications in the drug class</td>
<td></td>
</tr>
</tbody>
</table>

A. Antipsychotic
B. Anticoagulant
C. Antibiotic
D. Opioid
E. Antiplatelet
F. Hypoglycemic (including insulin)
G. None of the Above

N0415 High-Risk Drug Class Considerations

- Patients taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- The standardized assessment of high-risk medication use and ensuring that indications are noted in the medical record are important steps toward overall medication safety within and between PAC provider settings.
- About 50% of medication errors happen at setting transitions.
- More common in adults over 65 years of age.
Definition: Adverse Drug Reaction

Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment.

The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

N0415 High-Risk Drug Classes

- Adverse drug events (ADEs) may be caused by medication errors such as drug omissions, errors in dosage, and errors in dosing frequency.
- Six medication class responses are considered at higher risk for adverse events.
  - Antipsychotic
  - Anticoagulant
  - Antibiotic
  - Opioid
  - Antiplatelet
  - Hypoglycemic
N0415 High-Risk Drug Classes

**Column 1**: Determine if the patient is taking any prescribed medications in any of the drug classes

**Column 2**: If Column 1 is checked, review documentation to determine if there is a documented indication noted for all medications in the drug class.

<table>
<thead>
<tr>
<th>SDC/RDC and Discharge</th>
<th>N0415. High-Risk Drug Classes: Use and Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is taking</td>
<td>Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes</td>
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<tr>
<td></td>
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<tr>
<td>A. Antipsychotic</td>
<td>□</td>
</tr>
<tr>
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</tr>
<tr>
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<td>□</td>
</tr>
<tr>
<td>H. Opioid</td>
<td>□</td>
</tr>
<tr>
<td>L. Antipruritic</td>
<td>□</td>
</tr>
<tr>
<td>J. Hypoglycemic (including insulin)</td>
<td>□</td>
</tr>
<tr>
<td>Z. None of the Above</td>
<td>□</td>
</tr>
</tbody>
</table>

**Data Sources**: medical record, H&P, D/C summary, med list, progress notes, transfer documents, etc.

---

N0415 High-Risk Drug Classes

- Code a medication that is part of a patient’s current drug regimen, even if it was not taken on the day of assessment.
- Include newly prescribed medications that are part of the current drug regimen, even if the medication is not yet in the home and/or the first dose has not been taken.
- A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the OASIS and are included as long as it is part of the patient’s current drug regimen.
N0415 High-Risk Drug Class Considerations

- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. Some drugs, especially combo drugs, fall into multiple categories.
- Code meds regardless of route (PO, IM, SQ, etc.)
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA and their composition is not standardized. Therefore, they should not be counted as medications for N0415– BUT SHOULD STILL BE ON MED LIST!

N0415 High-Risk Drug Class Considerations

- Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
- Dash is a valid response for this item. But should be a rare occurrence.
- Get familiar with these 6 drug classes!
N0415 High-Risk Drug Class Considerations

- Following resources provide information on medications:
  - Global RPh Drug Reference, https://globalrph.com/drugs/a/
  - The above resource list is not all-inclusive, and the use of these resources is not required.

Scenario #1

Pt is taking insulin for diabetes with hyperglycemia per the physician’s note. Pt is also ordered Plavix, but the medical record does not indicate why the pt is taking it.

- Mark all meds the patient is taking from the high-risk drug classes in column 1 and only mark column 2 if the indication is noted.
Scenario #2

Pt is taking insulin for diabetes, Plavix due to a recent stent, and is on Wellbutrin for depression per physician notes. The patient is also on tramadol for RA per notes, and on a Duragesic patch, but no documentation of why the patch is needed.

- Mark all meds the patient is taking ONLY from the high-risk drug classes and only mark column 2 if the indication is noted for ALL drugs in the class that the patient is on.

M2001 Drug Regimen Review

Item intent: Identifies if review of the patient’s medications indicated any potential or actual clinically significant medication issues.

<table>
<thead>
<tr>
<th>(M2001)</th>
<th>Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>0 - No issues found during review [Go to M2102]</td>
</tr>
</tbody>
</table>

This item is included in the calculation of: Process Measure

Coding instructions:
Code 0 if no clinically significant issues identified.
Code 1 if one or more issues identified.
Code 9 if patient is not taking any medications at the time of the review.
A dash ( - ) is a valid response for this item but the use of a dash should be a rare occurrence.
(M2001) Drug Regimen Review

- Complete a drug regimen review on admission or as close to actual SOC/ROC as possible to identify any potential or actual significant issues.
- Review the medical records from other facilities, recent H & P, transfer/discharge records, medication records and discharge medication lists.
- Includes all medications, prescribed and over the counter, administered by any route. Includes TPN and Oxygen, as well.
- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.
- The drug regimen review is part of the comprehensive patient assessment. The comprehensive patient assessment is the responsibility of and must ultimately be completed by one clinician, but collaboration is allowed. Agency policy and practice will determine this process and how it is documented.
- Drug regimen review is required by the Conditions of Participation
- Completed at SOC and ROC

IMPORTANT CMS DEFINITIONS

DRUG REGIMEN REVIEW

-The drug regimen review in Post-Acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE

-A clinically significant medication issue is a potential or actual issue that, in the clinician’s professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).
Defining Clinically Significant

Potential or actual clinically significant medication issues may include but are not limited to:

- adverse reactions to medications (such as a rash),
- ineffective drug therapy (analgesic that does not reduce pain),
- side effects (potential bleeding from an anticoagulant),
- drug interactions (serious drug-drug, drug-food and drug-disease interactions),
- duplicate therapy (generic name and brand name equivalent drugs are both prescribed),
- omissions (missing drugs from an ordered regimen),
- dosage errors (either too high or too low), and
- nonadherence (regardless of whether the nonadherence is purposeful or accidental).

Examples of Potential or Actual Significant Medication Issues

- Patient’s list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
- Assessment shows that diagnoses/symptoms for which the patient is taking medications are NOT adequately controlled.
- Patient seems confused about when/how to take medications indicating a high risk for medication errors.
- Patient has not obtained medications or indicates that s/he will not take prescribed medications because of financial, access, cultural, or other issues with medications.
- Patient has signs/symptoms that could be adverse reactions from medications.
- Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications.
- Patient has a complex medication plan with medications prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high.
Three levels of significance

DRUG REGIMEN REVIEW ACTIVITIES WE CAN ADDRESS OURSELVES WITHOUT PHYSICIAN INTERVENTION

DRUG REGIMEN REVIEW ACTIVITIES WE NEED TO ADDRESS WITH THE PHYSICIAN, BUT NOT NECESSARY BY MIDNIGHT OF NEXT CALENDAR DAY

-THOSE ISSUES WHICH REQUIRE PHYSICIAN INPUT ASAP

-ANY CIRCUMSTANCE THAT DOES NOT REQUIRE THIS IMMEDIATE ATTENTION IS NOT CONSIDERED A POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE.

M2001 Scenario

During the comprehensive assessment visit to Mr. K., the PT reviews all the patient’s medications and identifies no problems except that the patient’s newly prescribed pain medication is not in the home. The daughter, Nancy, states they were only going to pick it up from the pharmacy if “the pain got bad enough.” The PT reviews the physician’s instructions for the new medication with the Mr. K and Nancy; they agree the medication should be on hand, and to follow physician’s instructions for administration. Prior to the PT leaving the home, the daughter has gone to the drugstore and returned with the medication.

Answer: M2001 would be coded 0, No – No issues found during review. In the PT’s professional judgment, this did not require provider contact by midnight of the next calendar day, to resolve, it does not meet the criteria for a potential or actual clinically significant medication issue.
M2001 Scenario

During the SOC comprehensive assessment, Nurse Nancy completes all elements of the DRR except for checking for drug-drug interactions.

**Answer:** M2001, enter a dash, “–”
When any element is not assessed, the DRR is considered incomplete.

---

M2003 Medication Follow-up

<table>
<thead>
<tr>
<th>M2003. Medication Follow-up</th>
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</thead>
<tbody>
<tr>
<td>Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. No</th>
<th>1. Yes</th>
</tr>
</thead>
</table>

**ITEM INTENT**
- Identifies **if potential or actual** clinically significant medication issues identified through the drug regimen review were **communicated to the physician** (or physician-designee) **AND** to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

**TIME POINTS ITEM(S) COMPLETED**
- Start of care
- Resumption of care
M2003 Medication Follow-up

Assessment steps:
• Determine for EACH clinically significant medication issue identified at the SOC or ROC:
  • Two-way communication between clinician and physician AND
  • All physician/provider prescribed/recommended actions were completed
  • BOTH by midnight of the next calendar day.

Coding instructions:
• Code 0 NO - if physician was NOT contacted and/or recommended actions were NOT completed by midnight the next day for each significant medication issue identified.
• Code 1 YES - if physician was both contacted AND the prescribed action was completed by midnight the next day for each issue identified.
• A dash (–) is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Tip:
• If the physician prescribes/recommends an action that cannot be completed by midnight of the next calendar day, code 1, Yes, if steps have been taken in order to complete the action.

Examples of by midnight of the next calendar day:
• A clinically significant medication issue is identified at 10:00 AM on February 12th and physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on February 13th.
• A clinically significant medication issue is identified at 10:00 PM on February 12th physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on February 13th.
Important CMS Definitions

CONTACT WITH PHYSICIAN/ PHYSICIAN DESIGNEE
• Communication to the physician/physician-designee to convey an identified potential or actual clinically significant medication issue, AND a response from the physician/physician-designee to acknowledge receipt and/or convey prescribed/recommended actions in response to the medication issue.
• Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status.
• Communication can be directly to/from the physician or physician-designee, or indirectly through physician’s office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.

MEDICATION FOLLOW-UP
• The process of contacting a physician/physician-designee to communicate the identified medication issue and, to the extent possible, completing all physician/physician-designee prescribed/recommended actions by midnight of the next calendar day (at the latest).

M2003 Response YES

• Two-way communication AND completion of the prescribed/recommended actions must have occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.
• Timely reporting of potential clinically significant medication issue(s) with no new orders or instruction in response (still 2-way communication).
• Multiple potential clinically significant medication issues identified-- all must be communicated to the physician/physician-designee, with completion of all prescribed/recommended actions occurring by midnight of the next calendar day.
M2003 Response YES

- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.

- Examples of recommended actions that would take longer than the allowed time to complete might include:
  - physician instruction to agency staff to continue to monitor the issue over the weekend and call if problem persists
  - physician instructs the patient to address the concern with his PCP on a visit that is scheduled in two days

- The actual type of actions recommended should be considered in determining if the agency has taken whatever actions are possible by midnight of the next calendar day.

M2003 Response NO

- If two potential clinically significant medication issues are identified at the SOC/ROC, both are communicated timely to physician/designee who provides a recommended action for each issue (for example, patient education for one medication, and a new dosage for another), both recommended actions could have been addressed by midnight of the next calendar day, but only one was addressed.

- If a potential clinically significant medication issue was identified, and the clinician attempted to communicate with the physician, but did not receive communication back from the physician/physician designee until after midnight of the next calendar day
M2001/M2003 Scenario

During the SOC visit, the RN completes a drug regimen review and identifies that the patient is taking two antihypertensives; one which was newly prescribed during her recent hospital stay, and another that she was taking prior to her hospitalization. During the home visit, the RN contacts the physician’s office, and leaves a message with office staff providing notification of the potential duplicative drug therapy and a request for clarification. The next day, the RN returns to the home to complete the comprehensive assessment and again contacts the physician from the patient’s home. The physician’s office nurse reports to the agency and patient that the physician would like the patient to continue with only the newly prescribed antihypertensive and discontinue the previous medication.

Answer:
M2001, Drug Regimen Review, would be coded 1, Yes, Issues (clinically significant) found during review. M2003, Medication Follow-up, would be coded 1, Yes. As the clinically significant issue was communicated to the physician and the prescribed/recommended action was completed by midnight of the next calendar day.
Mr. Derma Scenario

• Mr. Derma was just started on antibiotics and when the nurse visits, he notices a new itchy rash. He considered that a potential clinically significant med issue and contacted the physician the same day. The next morning the dr. called. He had ordered a different antibiotic for Mr. Derma and asked that Mr. Derma be told to discontinue the first antibiotic. He was called and the son went to the pharmacy to get the new med. The next day the patient says he is less itchy and uncomfortable, but the rash is still present, although not as severe. How do I code M2003?

M2003 = 1-Yes. It is not necessary for the rash to be resolved, as long as the physician communication and completion of the prescribed/recommended actions were completed.

October 2019
# M2005 Medication Intervention

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
<tr>
<td>9.</td>
<td>NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications</td>
</tr>
</tbody>
</table>

This item is included in the calculation of: **Process Measure**

**ITEM INTENT**

- Identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

### Assessment steps:

- The time frame for this item is from date of last SOC/ROC through discharge.
- Review medical record to Determine for **EACH** clinically significant medication issue identified at OR since the SOC or ROC was there:
  1. Two-way communication between clinician and physician **AND**
  2. All physician/NPP prescribed/recommended actions were completed **BOTH** by midnight of the next calendar day.

### Coding instructions:

- Code 0 NO - if physician was not contacted and/or recommended actions were not completed by midnight the next day for each significant medication issue identified since admission to home care.
- Code 1 YES - if physician was both contacted AND the prescribed action was completed by midnight the next day for each issue identified since admission to home care.
- Code 9 N/A - if there were no potentially or clinically significant medication issues identified since SOC/ROC or patient is not taking any medications.
- A dash (--) value is a valid response for this item. CMS expects dash use to be a rare occurrence.
Example

Each time that an issue is found and rises to the level which requires physician intervention, was the physician notified, and did the physician respond (each time).

Use Your Judgment

- How do we answer this item for a degenerative joint disease patient who was noted to have pain symptoms of 4/10 (per patient) on SOC, who already is on a new narcotic analgesic during the past week?
- With this symptom, can we answer “0 = No, no issues found during review” if we think this issue does not necessitate notifying the physician by midnight of the next business day?
- A potential clinically significant medication issue is an issue that in the care provider’s clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.
Dash

• There may be times because of an agency process that the drug regimen review is not completed within the assessment timeframe. Would that be an instance when a dash is used?

• A dash is expected to be a rare occurrence and indicates that no information is available and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged, or dies before assessment of the item could be completed. Agencies must ensure that their processes are not a barrier to complete a drug regimen review within the given timeframe and should adjust their processes to ensure that a drug regimen review is completed as required.

Physician does not respond

• If we are unable to resolve a medication issue before midnight of the next calendar day due to no physician reply, how is that reflected within the reporting structure for M2003 and M2005? How does it differentiate a no physician reply vs. no agency action? Moreover, what are the implications, if any, for the agency and/or the physician for a pattern of non-adherence to this best practice?

• To answer M2003 and M2005 ask if the physician was contacted, and the actions completed. If no issues were identified, there is no need to contact the physician; if issues were found, the communication and response are both needed.

• Selecting "No" for M2003 and M2005 indicates that the best practice of identifying a medication issue, reporting it to the physician, and completing the recommended/prescribed actions possible by midnight of the next calendar day was not accomplished. The item response choices for M2003 and M2005 do not identify the reason why the best practice was not met.
M2005 Scenario

During the Discharge assessment visit, the RN reviews the patient’s medication list and confirms that no potential clinically significant medication issues are present. In reviewing the clinical record, there is documentation that a drug regimen review was conducted at SOC, and no potential clinically significant medication issues were identified. There is no other documentation to indicate that potential or actual clinically significant medication issues occurred during the episode of care.

- **Answer**: M2005: **ENTER Response 9 (NA)** – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications.
- This item is reported as NA because there is documentation that the agency looked for potential clinically significant medication issues via completion of a drug regimen review and that no potential or actual clinically significant medication issues were identified at any time during the episode, from SOC through Discharge.

M2005 Scenario

During the SOC comprehensive assessment, the RN completes the drug regimen review and identifies a potential clinically significant medication issue. On that day of admission, the RN calls and leaves a message with the physician’s office related to the medication issue. The physician does not return her call until after midnight of the next calendar day. No other medication issues arise during the episode, and the patient is discharged from home health.
Answers:

At SOC: M2001: ENTER Response 1 – Yes – Issues found during review.

M2003: ENTER Response 0 – No.

At DC: M2005: enter Response 0 – No.

Rationale: Because an issue identified was determined by the clinician to be clinically significant, warranting physician contact by midnight of the next calendar day, it meets the criteria for a clinically significant medication issue (1 – Yes for M2001). While the clinician initiated communication with the physician, the required two-way communication did not occur until after midnight of the next calendar day, resulting in 0 – No responses for M2003 and M2005.

Items Included in Quality Measure

- M2001 Drug Regimen Review
- M2003 Medication Follow-up
- M2005 Medication Intervention

- If a dash “—” is entered for any of these three items:
  - The quality episode will not be included in numerator
  - The quality episode will be included in denominator

Danger of the Dash!
Management of Oral Meds

**Used in Calculations:**
- Outcome Measure
- Risk Adjustment
- VBP
- Star Ratings
- Potentially Avoidable Event

**Improvement in Management of Oral Meds**

**Measure Description:**
Percentage of home health quality episodes during which the patient improved ability to take their medicines correctly (by mouth).

**Numerator:**
The number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in taking oral medications correctly at discharge than at the start (or resumption) of care.

**Denominator:**
The number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.

**Exclusions:**
Home health quality episodes for which the patient, at start/resumption of care, was able to take oral medications correctly without assistance or supervision, episodes that end with inpatient facility transfer or death, or *patient is nonresponsive*, or the patient has no oral medications prescribed.

**OASIS item:** (M2020) Management of Oral Medications
(M1700, M1710, M1720 used to risk adjust)
Management of Oral Meds

Item Intent:
• This item is intended to identify the patient’s ability to PREPARE and TAKE all oral (p.o.) medications reliably and safely, including administration of correct dosage, at correct times and intervals, on the day of assessment.
• Refers to ABILITY, not compliance or willingness

Choosing a Response:
• Day of Assessment: time spent in the home by the clinician and preceding 24h
• Response choice is PRIOR to any teaching or intervention by the agency
• Consider limitations and barriers: Physical, Mental/emotional, SDOH, activity restrictions, environment, sensory

M2020 Management of Oral Meds

The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

– physical impairments (for example, limited manual dexterity);

– emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);

– sensory impairments (for example, impaired vision, pain);

– environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).
M2020 Management of Oral Meds

Includes assessment of the patient’s ability to:
• Obtain the medication from where it is routinely stored
• Read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications)
• Open the container
• Select the pill/tablet or milliliters of liquid
• Orally ingest it at the correct times.

M2020 Management of Oral Medications

Includes: all prescribed, and OTC oral meds included on the POC swallowed and absorbed through GI system!!

Excludes:
• Topical, injectable and IV meds
• Inhalation meds and sublingual meds (Oct 2012)
• Swish and expectorate meds (Jan 2013)
• Meds given per gastrostomy or other tube 4b-Q167.8
• Does not include filling/reordering 4b-Q166
M2020 Management of Oral Medications

Response 0: Able to take independently all oral meds and proper doses at correct times

- Patient takes every med correctly from bottles, And/or
- Sets up her/his own ‘planner device’ and is able to take the correct med in the correct dosage at the correct time, every time
- Able to access usual medication location without assist
- A patient who can take their meds by themselves when dispensed by the pharmacy in blister paks.

Response 1: Patient is able to take meds at correct time, but requires:

- Another person to prepare individual doses in advance (e.g., sets up a planner device, and does NOT need reminders)
- Another person must modify original med container for access
- And/or another person to develop a drug diary/chart which the patient relies on to take meds appropriately
M2020 Management of Oral Medications

Response 2: Able to take med at correct times if given reminders

• Patient requires another person to provide **reminders** at the time the med is taken, regardless of whether meds taken from bottles or planner or whether he needs help preparing the doses, AND all oral meds have been taken correctly day of assessment
• Reminders to take PRN meds
• Reminders from a device that the patient can set up independently are not considered “assist” or “reminders”

M2020 Management of Oral Medications

Response 3: Unable to take meds unless administered by another person

• Unable to take unless administered by another person
• Patient who didn’t understand how to take med
• Patient who wasn’t able to take med at correct time even though reminded
• Patient who was unable to safely swallow oral med on day of assessment
• If medication **not in the home**, you cannot make assumptions about patient’s ability to take the med
• Patient requires someone to assist them to walk to the location where meds are **routinely stored**, or someone must retrieve the medications and bring them to the patient, or bring a beverage to swallow pills
• Planner filled **incorrectly, missed doses**
M2020 Assessment Techniques

- **Ask** the patient to gather all medications. Is the patient able to access the medications where they are kept in the home?
- **Verify** all ordered medications are in the home.
- **Ask** the patient to explain how he/she takes each medication: time of day, number of pills/tabs, relative to food or other medications.
- **Ask** the patient to demonstrate how to take a pill out of a med bottle (can he/she get the lid off, remove a small pill from the bottle, etc.). If patient uses a med planner, observe if he/she can open compartments and remove pills. Check compartments from day before to see if any pills remain that should have been taken.

M2020 Assessment Techniques

- If the patient has sensory deficits (impaired vision, pain, neuropathy), manual dexterity deficits, or cognitive/memory deficits, **assess** how patient takes medications safely.
- **Assess** environmental barriers or ask if the patient is able to access a beverage to swallow oral meds.
- **Ask** if the patient has difficulty swallowing large pills or other problems with ingesting medications.
- For patients that live in an ALF, assess vision, strength, manual dexterity and cognitive status, and use clinical judgement to determine ability to take correct dosage at the right time.
This item is intended to assess the patient’s ability to take all injectable medications **reliably** and **safely** on the day of assessment.

The intent of the item is to identify the patient’s ABILITY, not necessarily actual performance. “Willingness” and “adherence” are not the focus of these items.

These items address the patient’s ability to safely manage injectable medications, given the current **physical** and **mental/emotional/cognitive status**, **activities permitted**, and **environment**.

**Coding Instructions:**

- **Includes** assessment of the patient’s ability to **obtain** the medication from where it is routinely stored, **read** the label, **draw up** the correct dose accurately using aseptic technique, **inject** in an appropriate site using correct technique, and **dispose** of the syringe properly.

- If the patient’s ability varies, consider the medication for which the most assistance is needed when selecting a response.

- PRN injectables, ordered and included on POC, are to be considered when determining the patient's ability to manage injectable medications.

- **Excludes** IV medications, infusions, and medications given in the physician’s office or other settings outside the home.

- **Includes** one-time injections administered in the home.
M2030 Management of Injectable Medications

- **Code 0 – Independent** - If the patient sets up her/his own individual doses and is able to take the correct medication in the correct dosage at the correct time.

- **Code 1** – Able to take at correct times **IF**: another person prepares individual doses or syringes in advance, and/or the original container is modified by another to enable access and/or if another person develops a drug diary or chart.

- **Code 2** - If **reminders** to take medications are necessary

- **Code 3** - **UNABLE** to take injectable medication unless administered by another person, if the physician ordered the RN to administer injection in the home, the pt does not have physical or cognitive ability to take all injectable meds correctly, or even with reminders pt requires assist (or the medication not in home.)

- **Dash** – is **NOT** a valid response

Scenario Practice

M2020/M2030
M2020/M2030 – **Scenario #1**

*Meds not in the Home*

- **Mr. M** cannot demonstrate his ability to take oral or injectable medications, (ex: *medications are not in the home*) how are codes for M2020 - Management of Oral Medications, and M2030 - Management of Injectable Medications determined?

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M2020/M2030 – **Answer #1**

*Meds not in the home*

In situations where one or more medications that the patient is currently taking and are listed on the Plan of Care are **not available to the patient**, preventing the patient from being able to demonstrate their ability to manage **oral or injectable medications**, the assessing clinician could **code using assessment strategies other than direct observation**. The assessing clinician would rely on their assessment of the complexity of the patient’s overall drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility, along with any other relevant barriers, and use clinical judgment to determine the patient’s current ability. In selecting a code, the clinician may use information gathered by report and/or observation, including details about when and how the patient accesses and administers their medications.

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**Jan 2022 Q&As**

Includes:
- Chooses not to fill. Cognitively intact
- Can’t afford meds
- Problem w/Pharmacy for M2030
M2020 Scenario #2

At SOC Mrs. F has only 2 prescribed PO medications: Tamiflu 30 mg daily for 7 days and Ativan 0.5 mg, take 1/2 tab at bedtime as needed. At discharge three weeks later, the Tamiflu has ended two weeks earlier, and the only medication patient was prescribed to take was the PRN Ativan. However, the patient has not taken or needed Ativan for the past week.

How should M2020 - Management of Oral Medications be coded?

M2020 Scenario #2 Answer:

M2020 reports a patient's ability on the day of the assessment (24 hours preceding the visit and time spent in home for the visit), to take the correct oral medications at all the correct times. PRN oral medications that are not needed on day of assessment, are not included in M2020. If the patient did not need any PRN medications on the day of the assessment, assess the patient’s ability on all of the medications taken on the day of assessment. (Q&A 7/19, Q&A #12)
Mr. S resides in an ALF with around-the-clock assistance. The ALF staff administer the medications to the patient per facility policy. If the assessing clinician determines that Mr. S could administer his own medications if allowed to.

How should M2020 and M2030 be answered?

A: When a patient who could likely otherwise self administer medications is being given medication at an assisted living facility due to facility policy, use clinical assessment strategies to determine if the patient could safely self-administer medications and how. [Category 4, Q164.1]

M2020 refers to the patient’s ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient’s vision, strength, and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility’s requirement.
M2020 Scenario #4

- Mr.C is unable to reorder her prescriptions with the physician. How should M2020 be scored?

M2020 Scenario #4 Answer

Do not consider refilling and obtaining medications from the pharmacy when scoring M2020. [Category 4, Q166]
M2020 Scenario #5

Mr. P has an automated medication dispenser. The nurse sets up the dispenser that has a flashing light and audible verbal message reminding the patient to take his medications. The dispenser will also send an alert to a caregiver if the patient does not respond.

How should M2020 be scored?

M2020 Scenario #5 Answer

A patient with an automated medication dispenser that requires set up and programming by another individual as well as reminders and dispensing by the device, should be scored as "2" for M2020. [Category 4, Q167.5]

If the patient successfully and independently programs/manages the device and takes all oral medications appropriately on the day of assessment, the patient would be scored a "0".
Practice Scenario #6

In late March Mr. F suffered a fall with a right hip fracture. He had a total hip replacement and transferred to rehab. He began homecare on April 1st. Prior to the hip fracture, he was not taking any medications except his antihypertensives. He was independent at home. He is now on oral pain medications and Aspirin post-operatively. At the SOC, he is able to ambulate with a rolling walker on level surfaces, but is unable to do stairs. He has two stairs separating his living area from his kitchen where his medications are stored.

Answer #6:

- **Response 3** – Unable to take medication unless administered by another person
- Q&A167.5.3 … If the medications were routinely stored in the kitchen and/or the water was not available for the patient to self-administer and the patient required someone to assist them to the location where the meds were stored and or to water, the appropriate score would be a "3".
Practice Scenario #7

Mrs. D’s discharge summary lists several new medications, including Lasix. She has all of her medications in the home, but states she is not going to fill the Lasix prescription because it makes her get up to the bathroom too often. She has no cognitive impairments and understands what the Lasix is for, but state she will not take it. Her daughter has set up a med box for her. She is able to easily access the med box and keeps a bottle of water with it. She has been taking all of the other medications as prescribed without additional assistance.

Answer #7:

**M2020 Response 1-** Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person

Q&A167.5.2.1 If a patient who is cognitively intact chooses not to take medications, and therefore does not have them delivered or picked up, the patient’s non-adherent behavior would not impact their ability to manage oral medications when selecting a response for M2020.

Response specific instructions: Enter Response 1 if the patient is independent in oral medication administration if another person must prepare individual does (for example, place medications in a medi-planner or other device)…
Practice Scenario #8

Mr. G was recently diagnosed with pneumonia. He has a gastrostomy and his medications are crushed to be given via the G-tube. He is able to use his inhaler and nebulizer and he has a PICC line for IV antibiotics.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Management of Oral Medications: Patient’s current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</td>
</tr>
<tr>
<td>1</td>
<td>Able to take medication(s) 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) another person develops a drug diary or chart.</td>
</tr>
<tr>
<td>2</td>
<td>Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</td>
</tr>
<tr>
<td>3</td>
<td>Unable to take medication unless administered by another person.</td>
</tr>
<tr>
<td>NA</td>
<td>No oral medications prescribed.</td>
</tr>
</tbody>
</table>

Answer #8

**M2020 Response NA**- No oral medications prescribed

Response specific instructions: Medications administered by other routes, including sublingual, buccal, swish and expectorate, or administered per gastrostomy (or other) tube are not to be considered for this item.

Q&A 167.5.4 Medications given per an inhaler or sublingually are not considered when answering M2020. When you assess M2020 consider those medications which are administered per the oral (p.o.) route. P.O. medications are swallowed and absorbed through the GI system. Sublingual medications are absorbed through the mucosal membranes under the tongue.
## Section O: Special Treatments, Procedures and Programs

<table>
<thead>
<tr>
<th>Item</th>
<th>SOC</th>
<th>ROC</th>
<th>FU</th>
<th>TRF</th>
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</tbody>
</table>

- **O0110**: Special Treatments, Procedures, Programs (New Item)
- **M1041**: Flu Vaccine Data Collection Period
- **M1046**: Flu Vaccine Received
- **M1051**: Pneumococcal Vac
- **M1056**: Reason PPV Not Received
- **M2200**: Therapy Need

- Removed
- Removed at FU
### O0110 Intent and Considerations

The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient.

- The treatments, procedures, and programs listed can have a profound effect on an individual’s health status, self-image, dignity, and quality of life.
- Items marked in O0110 should be addressed in the patients plan of care.
- Check **ALL** that apply!
- Check treatments, programs and procedures performed by others and/or that the patient performed themselves independently or after set-up by agency.
- Check items performed in the home and in other settings like a dialysis center.
- Do not code services that were provided solely in conjunction with a surgical (pre and post op) or diagnostic procedure such as IV medications.
- **Code O0110Z1, None of the above**, if none of the above treatments, procedures, or programs apply.
- **Dash IS** a valid response for this item.

### SOC/ROC

**O0110: Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that apply on admission.

#### Cancer Treatments

- **A1. Chemotherapy**
- **A2. IV**
- **A3. Oral**
- **A4. Other**

#### Radiation

- **B1. Radiation**

#### Respiratory Therapies

- **C1. Oxygen Therapy**
- **C2. Continuous**
- **C3. Inhemiport**
- **C4. High-concentration**

#### D1. Sedation

- **D2. Scheduled**
- **D3. As needed**

#### E1. Tracheotomy Care

- **E2. Invasive Mechanical Ventilator (ventilator or respirator)**
- **E3. Non-invasive Mechanical Ventilator**
- **E4. BIPAP**
- **E5. CPAP**

#### Other

- **H1. IV Medications**
- **H2. Vasovactive medications**
- **H3. Antibiotics**
- **H4. Anticoagulation**
- **H5. Other**

#### I2. Hemodialysis

- **I3. Peritoneal dialysis**
- **I4. IV Access**
- **I5. Peripheral**
- **I6. Mid-line**
- **I7. Central (e.g., PICC, tunneled, port)**

**None of the above:**

- **Z1. None of the above**
O0110 Cancer Treatments

Check ALL that Apply – May check A1 AND routes given!

<table>
<thead>
<tr>
<th>SOC/ROC</th>
<th>a. On Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>O0110. Special Treatments, Procedures, and Programs</td>
<td>Check all that apply</td>
</tr>
<tr>
<td>Check all of the following treatments, procedures, and programs that apply on admission.</td>
<td></td>
</tr>
<tr>
<td>Cancer Treatments</td>
<td></td>
</tr>
<tr>
<td>A1. Chemotherapy</td>
<td></td>
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<tr>
<td>A2. IV</td>
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<tr>
<td>A3. Oral</td>
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<tr>
<td>A10. Other</td>
<td></td>
</tr>
<tr>
<td>B1. Radiation</td>
<td></td>
</tr>
</tbody>
</table>

O0110 Cancer Treatments - Chemotherapy Coding Tips

**Code O0110A1, Chemotherapy**, if any type of chemotherapy medication administered as an antineoplastic for cancer treatment given by any route in this item.

- **Code O0110A2, Chemotherapy, IV**, if chemotherapy administered intravenously.
- **Code O0110A3, Chemotherapy, Oral**, if chemotherapy administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered enterally (e.g., feeding tube/PEG).
- **Code O0110A10, Chemotherapy, Other**, if chemotherapy administered in a way other than intravenously, enterally, or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).

• Each medication should be evaluated to determine its **reason for use** before coding it here.

• Medications coded here are those **actually used for cancer treatment**.

• Hormonal and other agents administered to **prevent** the recurrence or slow the growth of cancer **should not be coded** in this item, as they are not considered chemotherapy for the purpose of coding.
O0110 Cancer Treatments - Chemotherapy Coding Tips

O0110A, Chemotherapy

- **Example**: Ms. K was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **Example**: Megestrol Acetate is classified as an antineoplastic drug. It has a side effect of appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item.

O0110 Cancer Treatments - Radiation Coding Tips

O0110B1, Radiation

- Code intermittent radiation therapy, as well as radiation administered via radiation implant
O0110 Respiratory Therapy

Check ALL that Apply!

<table>
<thead>
<tr>
<th>Respiratory Therapies</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>C1. Oxygen Therapy</td>
<td></td>
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<td>C2. Continuous</td>
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<td>C3. Intermittent</td>
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<tr>
<td>C4. High-concentration</td>
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<tr>
<td>D1. Suctioning</td>
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<tr>
<td>D3. As needed</td>
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<tr>
<td>E1. Tracheostomy Care</td>
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<tr>
<td>F1. Invasive Mechanical Ventilator (ventilator or respirator)</td>
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<tr>
<td>G1. Non-invasive Mechanical Ventilator</td>
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<tr>
<td>G2. BiPAP</td>
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<tr>
<td>G3. CPAP</td>
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</tbody>
</table>

**O0110 Respiratory Treatments – Oxygen Therapy Coding Tips**

- **Code O0110C1 Oxygen Therapy** if continuous or intermittent oxygen is used via mask, cannula, etc., Including Bi-level Positive Airway Pressure (BiPAP), or Continuous Positive Airway Pressure (CPAP) here.
- Do not code hyperbaric oxygen for wound therapy in this item.

- **Code O0110C2, Oxygen Therapy, Continuous**, if oxygen therapy is continuously delivered for ≥ 14 hours per day.

- **Code O0110C3, Oxygen Therapy, Intermittent**, if oxygen therapy is delivered intermittently (< 14 hours continuously).
O0110 Respiratory Treatments – Oxygen Therapy Coding Tips

- **Code O0110C4, Oxygen Therapy, High concentration**, if oxygen is delivered via a high-concentration delivery system at a concentration that exceeds FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow-rate of 4 liters per minute).
  - A high-concentration delivery system can include either high or low-flow systems (e.g., simple face masks, partial and non-rebreather masks, face tents, venturi masks, aerosol masks, high-flow cannula or masks).
  - These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%.
  - Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO2 greater than 40%.

O0110 Respiratory Therapy – Suctioning Coding Tips

- **Code O0110D1, Suctioning – ONLY** if tracheal and/or nasopharyngeal suctioning is performed.
  - Do **not** code oral suctioning here.
  - This item may be coded if the patient performs his/her own tracheal and/or nasopharyngeal suctioning.

- **Code O0110D2, Suctioning, Scheduled**, if suctioning is scheduled.
  - Scheduled suctioning is performed when the patient is assessed to clinically benefit from regular interventions, such as every hour.
  - Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of agency-based clinical standards, protocols, and guidelines.

- **Code O0110D3, Suctioning, As needed**, if suctioning is performed on an as-needed basis, as opposed to regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted, or a sudden desaturation occurs from a mucus plug.
O0110 Respiratory Therapy – Tracheostomy Care Coding Tips

• **Code O0110E1, Tracheostomy care**
  – If cleansing of the tracheostomy and/or cannula is performed.
  – This item may be coded if the patient performs his/her own tracheostomy care or receives assistance.

O0110 Respiratory Therapy – Invasive Mechanical Ventilation Coding Tips

• **Code O0110F1, Invasive Mechanical Ventilator (ventilator or respirator)** if any type of electrically or pneumatically powered *closed-system mechanical ventilator support device* is used to ensure adequate ventilation in the patient who is or who may become (such as during weaning attempts) **unable to support his or her own respiration**.

• During invasive mechanical ventilation the pt’s breathing is controlled by the ventilator.

• Patients receiving closed-system ventilation include those patients’ receiving ventilation via an *endotracheal tube* (e.g., nasally or orally intubated) or **tracheostomy**.

• A patient who is currently in process of being weaned off a respirator or ventilator, should also be coded here.

• Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.
**O0110 Respiratory Therapy – Invasive Mechanical Ventilation Example**

**Example:** Mrs. T is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day, because a previous injury she lacks ability to breathe on her own. O0110F1 should be checked, as Mrs. T is using an invasive mechanical ventilator because she is unable to initiate spontaneous breathing on her own and the ventilator is controlling her breathing. Would also mark all the appropriate oxygen boxes, depending on oxygen orders.

**O0110 Respiratory Therapy – Non-invasive Mechanical Ventilation Coding Tips**

- **Code O0110G1, Non-invasive Mechanical Ventilator (BiPAP/CPAP)** if any type of respiratory device is used that prevents airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.
  - The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual.
  - If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here.
  - This item may be coded if the patient places or removes his/her own BiPAP/CPAP mask/device.

- **Code O0110G2, BiPAP,** if the non-invasive mechanical ventilator support was BiPAP.

- **Code O0110G3, CPAP,** if the non-invasive mechanical ventilator support was CPAP.
O0110 Respiratory Therapy – Non-invasive Mechanical Ventilation Example

Example: Mr. J has sleep apnea and requires a CPAP device to be worn when sleeping. His wife sets-up the water receptacle and humidifier element of the machine. Mr. J puts on the CPAP mask and starts the machine prior to falling asleep. Check boxes O0110G1 (Non-invasive Mechanical Ventilator) and O0110G3 (CPAP) as Mr. J is able to breathe on his own and wears the CPAP mask when he is sleeping to manage his sleep apnea. Would also mark any oxygen therapy being administered.

O0110 Other –IV Medications - Coding Tips

O0110H1 IV Medications

• Code any drug or biological given IV push, Epidural pump or drip through central or peripheral port.

• Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently, and they involve continuous administration of a substance.

• Mark ALL that Apply
O0110 Other – IV Medications - Coding Tips

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H1. IV Medications</td>
<td></td>
</tr>
<tr>
<td>H2. Vasoactive medications</td>
<td></td>
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<tr>
<td>H3. Antibiotics</td>
<td></td>
</tr>
<tr>
<td>H4. Anticoagulation</td>
<td></td>
</tr>
<tr>
<td>H10. Other</td>
<td></td>
</tr>
</tbody>
</table>

**O0110H1 IV Medications**

- Do **NOT** code flushes to keep IV access or port patent
- Do **NOT** code IV fluids without meds here.
- Do **NOT** code Subcutaneous pumps here.
- Do **NOT** include IV medications given with dialysis or chemotherapy.
- Do **NOT** code Dextrose 50% and/or Lactated Ringers given IV – these are not considered meds

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**O0110 Other – IV Medications Coding Tips**

**O0110H1 IV Medications (see previous)**

- **Code O0110H2, Vasoactive medications**, if at least one of the IV medications was a vasoactive medication.
  - **Check O0110H1 IV Medications, AND O0110H2, Vasoactive Medications** if the patient is receiving any intravenous vasoactive medications such as vasopressors and inotropes. Examples of vasopressors and inotropes that may be used in homecare include but are not limited to dobutamine, milrinone, and dopamine.
- **Code O0110H3, Antibiotics**, if at least one of the IV medications was an antibiotic.
- **Code O0110H4, Anticoagulation**, if at least one of the IV medications was an **IV** anticoagulant. Do **NOT** include subcutaneous administration of anticoagulant medications.
- **Code O0110H10, Other**, if at least one of the IV medications was not an **IV** vasoactive medication, **IV** antibiotic, or **IV** anticoagulant. Examples include **IV** analgesics (e.g., morphine) and **IV** diuretics (e.g., furosemide).

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O0110 Other – IV Medications **Scenario**

**Example:** Mr. C was admitted to Home Care after an acute myocardial infarction. During the hospital admission, it was discovered that he has severe multi-valve regurgitation and end-stage heart failure. He is currently receiving intravenous milrinone via a PICC to enhance his heart’s contractility.

O0110 Other – IV Medications **Answer**

**Example:** Mr. C was admitted to Home Care after an acute myocardial infarction. During the hospital admission, it was discovered that he has severe multi-valve regurgitation and end-stage heart failure. He is currently receiving intravenous milrinone via a PICC to enhance his heart’s contractility.

- Coding: O0110H1, IV Medications, and O0110H2, Vasoactive medications, would be checked. As well as O0110O1 IV Access and O0110O4 Central IV access
- Rationale: Mr. C is receiving intravenous milrinone, which is a vasoactive medication (inotrope) used for the treatment of heart failure – both O0110H1 and H2 are needed, as well as both O0110O1 and O2.
O0110 Other – Transfusions Coding Tips

• Code O0110I1 Transfusions
  – If blood or any blood product (platelets, synthetic blood products) are administered directly into the bloodstream.
  – Do not code those given during dialysis or chemotherapy.

O0110 Other – Dialysis Coding Tips

• Code O0110J1 Dialysis
  – if peritoneal or renal/hemodialysis occurs in the home or at a facility.
  – IV medications and transfusions given during dialysis are considered part of dialysis and are NOT to be coded under items K0520A (Parenteral/IV feeding), O0110H1 (IV medications), or O0110I1 (transfusions).
  – This item is also checked if the patient performs their own dialysis.

• Code O0110J2, Hemodialysis, if the dialysis was hemodialysis (renal). In hemodialysis the patient’s blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.

• Code O0110J3, Peritoneal dialysis, if the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.
O0110 Other - IV Access Coding Tips

• **Code O0110O1, IV Access**, if a catheter is inserted into a vein for a variety of clinical reasons, including long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.

• **Code O0110O2, Peripheral**, if IV access is peripheral access (catheter is placed in a peripheral vein) and remains peripheral.

• **Code O0110O3, Midline**, if IV access is midline access. Midline catheters are inserted into the antecubital (or other upper-arm) vein and do not reach all the way to a central vein such as the superior vena cava.

• **Code O0110O4, Central (e.g., PICC, tunneled, port)**, if IV access is centrally located (e.g., peripherally inserted central catheter [PICC], tunneled, port).

• Select **ALL** that Apply

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Special Treatments, Procedures and Programs

• Resource intensity captured
• Potential for complications identified
• Offers interoperability between PAC settings
• Reflection of intensity of care
• Care planning
**O0110 Scenario**

Mr. T. is admitted to homecare with an exacerbation of COPD and Pneumonia caused by resistant pseudomonas. He is on continuous oxygen at 4L NC. He has a central line in his right chest, that will be used for the IV Antibiotics for the next 6 weeks. Mr. T. also has a history of OSA and ESRD. He wears CPAP at night and his wife manages his peritoneal dialysis at home.

What all would you mark in O0110 for Mr T.?

---

### SOC/ROC

**O0110: Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that apply on admission.

<table>
<thead>
<tr>
<th>Cancer Treatments</th>
<th>a. On Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Chemotherapy</td>
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</tr>
<tr>
<td>A2. IV</td>
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</tr>
<tr>
<td>A3. Oral</td>
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<tr>
<td>A10. Other</td>
<td></td>
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<tr>
<td>B1. Radiation</td>
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</tbody>
</table>

**Respiratory Therapies**

<table>
<thead>
<tr>
<th>C1. Oxygen Therapy</th>
<th>☑</th>
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<tbody>
<tr>
<td>C2. Continuous</td>
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<td>C4. High-concentration</td>
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<td>D2. Scheduled</td>
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<td>G3. CPAP</td>
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**Other**

<table>
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<td>H10. Other</td>
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<td>J1. Transfusions</td>
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<td>J1. Dialysis</td>
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<tr>
<td>O1. IV Access</td>
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<td>O4. Central (e.g., PICC, tunneled, port)</td>
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</tbody>
</table>

**None of the Above**

| F1. None of the Above | ☑   |
**Scenario Mrs Crane**

Mrs. Crane was diagnosed with left upper lobe lung cancer two months ago. She has a port in her left chest and is receiving chemo and radiation therapy. She was admitted to the hospital with a local port infection in her left chest; pus and redness at the site. She has developed sepsis due to the port. MD states MSSA was identified in the blood cultures as the cause of sepsis. The port was removed and she will receive IV antibiotics for the sepsis and port infection via PICC line and the chest wound will be packed at home. Nursing will also be teaching regarding the PICC line and changing the dressing weekly while receiving IV antibiotics. Mrs. Crane uses O2 during her waking hours and says she wears it from 7am to 9:30pm every day. Chemo will resume after the scheduled new port insertion next week. Radiation continues.

### SOC/ROC

<table>
<thead>
<tr>
<th>00110. Special Treatments, Procedures, and Programs</th>
<th>a. On Admission Check all that apply</th>
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<td>D3. As needed</td>
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<td>E1. Tracheostomy Care</td>
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<tr>
<td>F1. Invasive Mechanical Ventilator (ventilator or respirator)</td>
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<td>G1. Non-Invasive Mechanical Ventilator</td>
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<td>G2. BIPAP</td>
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<td>G3. CPAP</td>
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<td>Other</td>
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<td>H1. IV Medications</td>
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<td>H2. Vasoactive medications</td>
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<td>H3. Antibiotics</td>
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<td>H4. Anticoagulation</td>
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<td>H10. Other</td>
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<td>J1. Transfusions</td>
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<td>J1. Dialysis</td>
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<td>J2. Hemodialysis</td>
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<td>J3. Peritoneal dialysis</td>
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<tr>
<td>O1. IV Access</td>
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<td>O2. Peripheral</td>
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<td>O3. Mid-line</td>
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<td>O4. Central (e.g., PICC, tunneled, port)</td>
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<tr>
<td>E1. None of the Above</td>
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Why is M2200 Therapy Need still there?

- Some payers still using a former PPS-like payment model.
- No longer on Recert/FU.
- Estimate how many therapy visits (all therapies) the patient needs in the next 60 days OR NA Not Applicable is a valid response
- Dash is NOT a valid response

Section Q
Participation in Assessment and Goal Setting
Section Q: Participation in Assessment and Goal Setting

<table>
<thead>
<tr>
<th>Section Q</th>
<th>M2401</th>
<th>Intervention Synopsis</th>
<th>SOC</th>
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<th>FU</th>
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Questions

LisaSelman-Holman@McBeeAssociates.com

Visit Us at McBeeAssociates.com
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