

**Outcome and ASsessment  
Information Set**

***OASIS-C1/ICD-10  
Guidance Manual***

***Revised: October 2015***

***Centers for Medicare & Medicaid Services***

## PREFACE

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This manual is an updated, streamlined version of the original OASIS-B1 Implementation Manual, originally published in 1999. The implementation manual is the first in a four-manual series on the Outcome and Assessment Information Set (OASIS), interpretation of the OASIS-based quality reports that CMS provides, and use of the reports for performance improvement. This manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS data. It includes both general data collection conventions and item-specific guidance, as well as links to quality-related resources for agencies. The original manual has been archived, and while it will still be accessible on the CMS web site ([Archived OASIS Information](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIArchivedOASISInformation.zip)<sup>1</sup>), it will not be updated to reflect current or future changes to the OASIS data set.

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

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

Input from the NQF, a nonprofit organization that endorses national consensus standards for measuring and publicly reporting on performance, has been especially valuable in guiding the evolution of OASIS and associated performance reports. NQF-endorsed voluntary consensus standards are widely viewed as the gold standard for measurement of health care quality. Once a measure is NQF-endorsed, it can be used by government agencies like CMS for public reporting and quality improvement. NQF has endorsed a number of OASIS-based quality measures for public reporting. Endorsed measures are periodically reviewed for continuing endorsement, and, as measure development continues, new or revised measures are submitted to NQF for review.

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<sup>1</sup> <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIArchivedOASISInformation.zip>

## REVISION HISTORY

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1. OASIS C Guidance Manual Original Publication: September 2009
2. Revision 1: December 2009
3. Revision 2: January 2011
4. Revision 3: January 2012
5. Revision 4: December 2012
6. OASIS-C1/ICD-9 Guidance Manual: June 2014

Note: Past revisions of the guidance manual have included an “errata” document that indicated where changes had occurred so that HHAs could replace only those manual pages that had changed. Because this revision is substantially more extensive than previous updates, this manual was intended to replace in its entirety the OASIS-C Guidance Manual and as such, changes to specific sections or pages were not tracked. However, there was a table included at the beginning of Chapter 3 that indicated which OASIS items and which item-by-item guidance sections had been revised.

7. OASIS-C1/ICD-9 Guidance Manual: January 2015

Changes in this version included a new Chapter 2, in which the “draft” notation was removed from the OASIS forms and the OMB number was added to each timepoint version. The footer date throughout the entire manual was changed to January 2015.

8. OASIS-C1/ICD-10 Guidance Manual: October 2015

This version of the manual includes changes required to incorporate the newly-implemented ICD-10-CM codes into both the guidance manual and the corresponding OASIS-C1 data set items. The footer was changed in all chapters, including those that did not have changes related to the implementation of ICD-10-CM.

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## CHAPTER 3 – OASIS ITEM GUIDANCE

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Chapter 3 contains item-by-item guidance for all OASIS items. For each data item, guidance is provided on the following topics:

- OASIS ITEM text.
- ITEM INTENT: Describes the rationale for collecting the information, in the context of outcome and process quality measurement, care planning, outcome risk adjustment, or prospective payment rate adjustment.
- TIME POINTS COMPLETED: Describes when the information is to be collected during the patient’s home health episode of care.
- RESPONSE-SPECIFIC INSTRUCTIONS: Describes how the clinician should decide which of the possible responses should apply. These instructions may not always provide definitive guidance for selecting responses in every case, because clinical judgment is often required to determine the most accurate response to a specific item.
- DATA SOURCES/RESOURCES: Describes the potential sources of information that should be accessed during the assessment to determine the most accurate response to this specific item. May include other clinicians, administrative records, online guidance regarding coding or other assessment guidelines, or standards promulgated by professional or accrediting organizations.

The following table is a copy of the table used in the prior version of this manual – OASIS-C1/ICD-9 Data Set and the corresponding changes that were made to Chapter 3 – OASIS-C1/ICD-9 Item Guidance. An “X” in a column indicates that a change had been made to the OASIS-C1/ICD-9 Data Set and/or the OASIS-C1/ICD-9 Guidance Manual. This table is included for information only.

Following this ICD-9 table, there is a table showing the changes made to the Data Set and Guidance Manual for OASIS-C1/ ICD-10

OASIS-C Item Number	OASIS-C1/ICD-9 Data Set					OASIS-C1/ICD-9 Guidance Manual			
	OASIS-C1/ICD-9 Item Number	New or Deleted Item	New Item Number	Item Wording Change	Skip Pattern Change	Item Intent	Time Points	Response-Specific Instructions	Data Sources/Resources
M0010	M0010								
M0014	M0014							X	
M0016	M0016								
M0018	M0018							X	
M0020	M0020					X			
M0030	M0030							X	
M0032	M0032							X	
M0040	M0040					X		X	
M0050	M0050								
M0060	M0060			X				X	
M0063	M0063								
M0064	M0064							X	
M0065	M0065								

OASIS-C Item Number	OASIS-C1/ICD-9 Data Set					OASIS-C1/ICD-9 Guidance Manual			
	OASIS-C1/ICD-9 Item Number	New or Deleted Item	New Item Number	Item Wording Change	Skip Pattern Change	Item Intent	Time Points	Response-Specific Instructions	Data Sources/Resources
M0066	M0066							X	
M0069	M0069								
M0080	M0080								
M0090	M0090							X	
M0100	M0100				X	X		X	
M0102	M0102					X		X	
M0104	M0104							X	
M0110	M0110								
M0140	M0140								
M0150	M0150			X		X		X	
<b>*Please note: Items to be Used at Specific Time Points has CHANGED. See OASIS-C1/ICD-9, page 3.</b>									
M0903	M0903							X	
M0906	M0906							X	
M1000	M1000			X	X	X		X	
M1005	M1005							X	
M1010	M1010								
M1012	M1012	DELETED							
M1016	M1016								
M1018	M1018					X		X	
M1020	M1020					X		X	
M1022	M1022					X		X	
M1024	M1024					X		X	
M1030	M1030							X	
M1032	M1033		X	X		X		X	
M1034	M1034								
M1036	M1036							X	
M1040	M1041		X	X	X	X		X	X
M1045	M1046		X	X		X		X	X
M1050	M1051		X	X		X		X	
M1055	M1056		X	X		X		X	
M1100	M1100			X				X	
M1200	M1200							X	
M1210	M1210					X		X	X
M1220	M1220								X
M1230	M1230			X				X	X
M1240	M1240			X		X		X	
M1242	M1242							X	X
M1300	M1300			X		X		X	
M1302	M1302					X		X	
M1306	M1306			X		X		X	
M1307	M1307			X		X		X	
M1308	M1308			X			X	X	
	M1309	NEW		X					
M1310		DELETED							
M1312		DELETED							
M1314		DELETED							
M1320	M1320			X		X		X	X
M1322	M1322					X		X	
M1324	M1324			X		X		X	
M1330	M1330			X		X		X	
M1332	M1332			X				X	

OASIS-C Item Number	OASIS-C1/ICD-9 Data Set					OASIS-C1/ICD-9 Guidance Manual			
	OASIS-C1/ICD-9 Item Number	New or Deleted Item	New Item Number	Item Wording Change	Skip Pattern Change	Item Intent	Time Points	Response-Specific Instructions	Data Sources/Resources
M1334	M1334			X				X	
M1340	M1340			X	X	X		X	X
M1342	M1342			X				X	X
M1350	M1350						X	X	
M1400	M1400			X					
M1410	M1410						X	X	
M1500	M1500			X		X		X	X
M1510	M1510			X	X			X	X
M1600	M1600								
M1610	M1610			X				X	
M1615	M1615								
M1620	M1620					X		X	
M1630	M1630							X	
M1700	M1700			X				X	
M1710	M1710							X	X
M1720	M1720							X	
M1730	M1730			X		X		X	
M1740	M1740			X					
M1745	M1745								
M1750	M1750								
M1800	M1800			X		X		X	
M1810	M1810					X		X	
M1820	M1820					X		X	
M1830	M1830			X		X		X	
M1840	M1840					X		X	
M1845	M1845					X		X	
M1850	M1850					X		X	
M1860	M1860			X		X		X	
M1870	M1870					X		X	
M1880	M1880			X		X		X	
M1890	M1890			X		X		X	
M1900	M1900			X		X			
M1910	M1910			X		X		X	
M2000	M2000			X				X	X
M2002	M2002							X	
M2004	M2004			X		X		X	
M2010	M2010								
M2015	M2015			X				X	
M2020	M2020					X		X	X
M2030	M2030					X		X	X
M2040	M2040			X		X		X	
M2100	M2102		X	X				X	
M2110	M2110			X		X	X		
M2200	M2200							X	
M2250	M2250			X		X		X	
M2300	M2300			X		X		X	
M2310	M2310			X		X		X	
M2400	M2400			X		X		X	X
M2410	M2410				X			X	
M2420	M2420							X	
M2430	M2430			X				X	
M2440		DELETED							



The following table shows the changes that have been made to the OASIS-C1/ICD-10 Data Set and the corresponding changes that have been made to Chapter 3 – OASIS-C1/ICD-10 Item Guidance in response to provisions in the Protecting Access to Medicare Act of 2014 (PAMA) and reflecting the new ICD-10 coding changes. Please note that items M1011, M1017, M1021, M1023, and M1025 replace items M1010, M1016, M1020, M1022, and there are corresponding changes to the guidance manual pages for those items. The change to M1000 only required the item text to be changed in this manual. No change was made to guidance. Current items M1320, M1340, M1350, M1510, and M2102 have had minor changes made to the Response-Specific Instructions.

OASIS-C1 ICD-9 Item Number	OASIS-C1/ICD-10 Data Set					OASIS-C1/ICD-10 Guidance Manual			
	OASIS-C1/ ICD-10 Item Number	New or Deleted Item	New Item Number	Item Wording Change	Skip Pattern Change	Item Intent	Time Points	Response- Specific Instructions	Data Sources/ Resources
M1000	M1000				X				
M1010	M1011		X	X		X	X	X	
M1016	M1017		X	X		X		X	
M1020	M1021		X	X		X		X	
M1022	M1023		X	X		X		X	
M1024	M1025		X	X		X		X	
M1320	M1320							X	
M1340	M1340							X	
M1350	M1350							X	
M1510	M1510							X	
M2102	M2102							X	

<b>OASIS ITEM</b>
(M0010) CMS Certification Number: _____
<b>ITEM INTENT</b>
Specifies the agency's Centers for Medicare & Medicaid Services (CMS) certification number (CCN/Medicare provider number).
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet)
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Enter the agency's CMS certification (Medicare provider) number, if applicable. If agency is not Medicare-certified, leave blank.</li> <li>• This is NOT the Provider's NPI number.</li> <li>• Preprinting this number on clinical documentation is allowed and recommended.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency administrator and billing staff</li> </ul>

<b>OASIS ITEM</b>
(M0014)    Branch State: __ __
<b>ITEM INTENT</b>
Specifies the State where the agency branch office is located.
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Enter the two-letter postal service abbreviation of the State in which the branch office is located. If a branch ID (not N or P) is entered in M0016, then M0014 cannot be blank.</li> <li>• Preprinting this abbreviation on clinical documentation is allowed and recommended.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency or branch administrator</li> </ul>

<b>OASIS ITEM</b>
(M0016) Branch ID Number: _____
<b>ITEM INTENT</b>
Specifies the branch identification code, as assigned by CMS. The identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Enter the Federal branch identification number specified for this branch as assigned by CMS.</li> <li>• If you are an HHA with no branches, enter "N" followed by 9 blank spaces.</li> <li>• If you are a parent HHA that has branches, enter "P" followed by 9 blank spaces.</li> <li>• Preprinting this number on clinical documentation is allowed and recommended.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency or branch administrator</li> </ul>

<b>OASIS ITEM</b>
<p><b>(M0018) National Provider Identifier (NPI)</b> for the attending physician who has signed the plan of care:                  _____ <input type="checkbox"/> <b>UK – Unknown or Not Available</b></p>
<b>ITEM INTENT</b>
Identifies the physician who will sign the Plan of Care
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet)
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• The NPI is a ten-digit numeric identifier that replaced the six-digit alphanumeric UPIN in 2007.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency medical records department</li> <li>• For more information see the link for NPI registry in Chapter 5 of this manual.</li> </ul>

<b>OASIS ITEM</b>
(M0020) Patient ID Number: _____
<b>ITEM INTENT</b>
Identifies the agency-specific patient identifier. This is the identification code the <b>agency</b> assigns to the patient and uses for record keeping purposes for this episode of care. The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (for example, from admission to discharge).
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet)
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• If there are fewer digits than spaces provided, leave spaces at the end blank.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency medical records department</li> </ul>



<b>OASIS ITEM</b>	
(M0032) Resumption of Care Date: ___ / ___ / ___	<input type="checkbox"/> NA – Not Applicable
month    day    year	
<b>ITEM INTENT</b>	
Specifies the date of the first visit following an inpatient stay by a patient receiving service from the home health agency.	
<b>TIME POINTS ITEM(S) COMPLETED</b>	
ROC The resumption of care date must be updated on the Patient Tracking Sheet whenever a patient returns to service following an inpatient facility stay.	
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>	
<ul style="list-style-type: none"> <li>• At start of care, mark “NA.”</li> <li>• The most recent resumption of care date should be entered.</li> <li>• If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.</li> <li>• Assessment strategies: If question exists as to the resumption of care date, clarify with the agency administrative staff.</li> </ul>	
<b>DATA SOURCES / RESOURCES</b>	
<ul style="list-style-type: none"> <li>• Agency administrative staff</li> </ul>	



<b>OASIS ITEM</b>
<p><b>(M0040) Patient Name:</b></p> <p>_____</p> <p>(First) _____ (MI) _____ (Last) _____ (Suffix)</p>
<b>ITEM INTENT</b>
Specifies the full name of the patient: first name, middle initial, last name, and suffix (for example, Jr., III, etc.).
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important.</li> <li>• If no suffix, leave blank. If middle initial is not known, leave blank.</li> <li>• The name entered should be exactly as it appears on the patient's Medicare or other insurance card.</li> <li>• The name entered should be the patient's legal name, even if the patient consistently uses a nickname.</li> <li>• The sequence of the names may be reordered (that is, last name, first name, etc.) in agency forms, if desired.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient's Medicare card, private insurance card, HMO identification card, etc.</li> </ul>

<b>OASIS ITEM</b>
(M0050) Patient State of Residence: __ __
<b>ITEM INTENT</b>
Specifies the State in which the patient is currently residing while receiving home care.
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>Enter the two-letter postal service abbreviation of the State in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>Clarify the exact (State) location of the residence with municipal, county, or State officials, if necessary.</li> </ul>

<b>OASIS ITEM</b>
(M0060) Patient ZIP Code: _____
<b>ITEM INTENT</b>
Specifies the ZIP code for the address at which the patient is currently residing while receiving home care.
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet); updated if change occurs during the episode.
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Enter the ZIP code for the address of the patient’s CURRENT residence, even if this is not the patient’s usual (or legal) residence.</li> <li>• Enter at least five digits (nine digits if known).</li> <li>• The patient’s ZIP code is used for <i>Home Health Compare</i> to determine places where your agency provided service. Be sure to use the ZIP code where the service is provided.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Verify the ZIP code with the local post office, if necessary.</li> </ul>

<b>OASIS ITEM</b>	
(M0063) Medicare Number: _____ (including suffix)	<input type="checkbox"/> NA – No Medicare
<b>ITEM INTENT</b>	
For Medicare patients only. Specifies the patient’s Medicare number, including any prefixes or suffixes. Use RRB number for railroad retirement program.	
<b>TIME POINTS ITEM(S) COMPLETED</b>	
SOC (Patient Tracking Sheet); updated if change occurs during the episode.	
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>	
<ul style="list-style-type: none"> <li>• Enter the number identified as “Claim No.” on the patient’s Medicare card. (NOTE: This may or may not be the patient’s Social Security number.)</li> <li>• If the patient does not have Medicare, mark "NA - No Medicare."</li> <li>• If the patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number if available. If not available, mark “NA - No Medicare.” Do <u>not</u> enter the HMO identification number.</li> <li>• Enter Medicare number (if known) whether or not Medicare is the primary payment source for this episode of care.</li> <li>• If there are fewer digits than spaces provided, leave spaces at the end blank.</li> </ul>	
<b>DATA SOURCES / RESOURCES</b>	
<ul style="list-style-type: none"> <li>• Patient’s Medicare card. Referral information may include the number, but it should be verified with the patient.</li> </ul>	

<b>OASIS ITEM</b>
<p><b>(M0064) Social Security Number:</b> _____ - ____ - _____</p> <p><input type="checkbox"/> <b>UK - Unknown or Not Available</b></p>
<b>ITEM INTENT</b>
<p>Specifies the patient’s Social Security number.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>SOC (Patient Tracking Sheet)</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Include all nine numbers. Mark “UK” if unknown or not available (for example, information cannot be obtained or patient refuses to provide information).</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient’s Social Security card, if available. Referral information may include the number, but it should be verified with the patient.</li> </ul>

<b>OASIS ITEM</b>	
(M0065) Medicaid Number: _____	<input type="checkbox"/> NA – No Medicaid
<b>ITEM INTENT</b>	
Specifies the patient's <u>Medicaid</u> number.	
<b>TIME POINTS ITEM(S) COMPLETED</b>	
SOC (Patient Tracking Sheet); updated if change occurs during the episode.	
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>	
<ul style="list-style-type: none"> <li>• Include all digits and letters. If patient does not have Medicaid coverage or Medicaid coverage is pending, mark "NA - No Medicaid."</li> <li>• If the patient has Medicaid, answer this item whether or not Medicaid is the payer source for the home care episode.</li> <li>• This number is assigned by an individual state and is found on the patient's Medicaid card.</li> </ul>	
<b>DATA SOURCES / RESOURCES</b>	
<ul style="list-style-type: none"> <li>• Patient's Medicaid card or other verifying documentation. Make sure that the coverage is still in effect, such as checking the expiration date. Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency.</li> <li>• Referral information may include the number, but it should be verified with the patient.</li> </ul>	

<b>OASIS ITEM</b>
(M0066) Birth Date:    ___ / ___ / _____ month    day        year
<b>ITEM INTENT</b>
Specifies the birth date of the patient, including month, day, and four digits for the year.
<b>TIME POINTS ITEM(S) COMPLETED</b>
SOC (Patient Tracking Sheet)
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient or caregiver report</li> <li>• Other legal documents (for example, driver’s license, state-issued ID card, etc.)</li> </ul>

<b>OASIS ITEM</b>
<p><b>(M0069) Gender:</b></p> <p><input type="checkbox"/> 1 - Male</p> <p><input type="checkbox"/> 2 - Female</p>
<b>ITEM INTENT</b>
<p>Specifies the gender of the patient.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>SOC (Patient Tracking Sheet)</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> </ul>



OASIS ITEM
<p><b>(M0140) Race/Ethnicity: (Mark all that apply.)</b></p> <p><input type="checkbox"/> 1 - American Indian or Alaska Native</p> <p><input type="checkbox"/> 2 - Asian</p> <p><input type="checkbox"/> 3 - Black or African-American</p> <p><input type="checkbox"/> 4 - Hispanic or Latino</p> <p><input type="checkbox"/> 5 - Native Hawaiian or Pacific Islander</p> <p><input type="checkbox"/> 6 - White</p>
ITEM INTENT
<p>Specifies the racial/ethnic groups or populations with which the patient is affiliated, as identified by the patient or caregiver. Office of Management and Budget (OMB) regulations state that "unknown" is not a permissible response for this item. The major purpose of this item is to track health disparities.</p>
TIME POINTS ITEM(S) COMPLETED
<p>SOC (Patient Tracking Sheet); updated if change occurs during the episode.</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Response 1 – American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.</li> <li>• Response 2 – Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</li> <li>• Response 3 – Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."</li> <li>• Response 4 – Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."</li> <li>• Response 5 – Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</li> <li>• Response 6 – White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/family interview</li> <li>• If the patient does not self-identify, referral information (including hospital or physician office clinical record data); observation</li> </ul>

OASIS ITEM
<p><b>(M0150) Current Payment Sources for Home Care: (Mark all that apply.)</b></p> <p><input type="checkbox"/> 0 - None; no charge for current services</p> <p><input type="checkbox"/> 1 - Medicare (traditional fee-for-service)</p> <p><input type="checkbox"/> 2 - Medicare (HMO/managed care/Advantage plan)</p> <p><input type="checkbox"/> 3 - Medicaid (traditional fee-for-service)</p> <p><input type="checkbox"/> 4 - Medicaid (HMO/managed care)</p> <p><input type="checkbox"/> 5 - Workers' compensation</p> <p><input type="checkbox"/> 6 - Title programs (for example, Title III, V, or XX)</p> <p><input type="checkbox"/> 7 - Other government (for example, TriCare, VA)</p> <p><input type="checkbox"/> 8 - Private insurance</p> <p><input type="checkbox"/> 9 - Private HMO/managed care</p> <p><input type="checkbox"/> 10 - Self-pay</p> <p><input type="checkbox"/> 11 - Other (specify) _____</p> <p><input type="checkbox"/> UK Unknown</p>
ITEM INTENT
<p>This item is limited to identifying payers to which any <b>services</b> provided during this home care episode and included on the Plan of Care will be billed by <b>your home health agency</b>.</p>
TIME POINTS ITEM(S) COMPLETED
<p>SOC (Patient Tracking Sheet) and updated when change occurs during the episode.</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Exclude "pending" payment sources.</li> <li>• Accurate recording of this item is important because assessments for Medicare and Medicaid patients are handled differently than assessments for other payers. If the patient's care is being reimbursed by multiple payers (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 those that are known.</li> <li>• Mark all current pay sources, whether considered primary or secondary.</li> <li>• Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full.</li> <li>• Select Response 2 if the payment source is a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C.</li> <li>• Select Response 3 if the patient is receiving services provided as part of a Medicaid waiver or home and community-based waiver (HCBS) program.</li> <li>• Select Response 6 if the patient is receiving services through one of the following programs: <ul style="list-style-type: none"> <li>- Title III - State Agency on Aging grants, which encourage State Agencies on Aging to develop and implement comprehensive and coordinated community-based systems of service for older individuals via Statewide planning and area planning. The objective of these services and centers is to maximize the informal support provided to older Americans to enable them to remain in their homes and communities. This program insures that elders receive the services they need to remain independent by providing transportation services, in-home services, and caregiver support services;</li> </ul> </li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M0150)**

- Title V - State programs to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for pregnant women, mothers, infants, and children, and children with special health care needs in providing health services for mothers and children who do not have access to adequate health care;
- Title XX - Social service block grants available to states to provide homemaking, chore service, home management or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.
- Select Response 7 if the patient is a member of a Tri-Care program, which replaced CHAMPUS.
- Select Response 10 if patient is self pay for all or part of the care (for example, copayments).

**DATA SOURCES / RESOURCES**

- Referral information regarding coverage. This can be verified with patient/caregiver.
- Copies of health insurance identification cards. The card(s) will provide the patient ID number as well as current status of coverage.

<b>OASIS ITEM</b>
<p><b>(M0080) Discipline of Person Completing Assessment:</b></p> <p><input type="checkbox"/> 1-RN    <input type="checkbox"/> 2-PT    <input type="checkbox"/> 3-SLP/ST    <input type="checkbox"/> 4-OT</p>
<b>ITEM INTENT</b>
<p>Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient’s home at the specified OASIS time point or the clinician reporting the transfer to an inpatient facility or death at home.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>All</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, while care coordination and consultation are needed, only one individual actually completes and records the assessment.</li> <li>• According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments.</li> <li>• LPNs, PTAs, COTAs, MSWs, and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment or collect OASIS data.</li> <li>• When both the RN and qualified therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency policy</li> <li>• Conditions of Participation</li> </ul>



OASIS ITEM
<p><b>(M0100) This Assessment is Currently Being Completed for the Following Reason:</b></p> <p><b><u>Start/Resumption of Care</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 – Start of care—further visits planned</li> <li><input type="checkbox"/> 3 – Resumption of care (after inpatient stay)</li> </ul> <p><b><u>Follow-Up</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 4 – Recertification (follow-up) reassessment [<i>Go to M0110</i>]</li> <li><input type="checkbox"/> 5 – Other follow-up [<i>Go to M0110</i>]</li> </ul> <p><b><u>Transfer to an Inpatient Facility</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 6 – Transferred to an inpatient facility—patient not discharged from agency [<i>Go to M1041</i>]</li> <li><input type="checkbox"/> 7 – Transferred to an inpatient facility—patient discharged from agency [<i>Go to M1041</i>]</li> </ul> <p><b><u>Discharge from Agency — Not to an Inpatient Facility</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 8 – Death at home [<i>Go to M0903</i>]</li> <li><input type="checkbox"/> 9 – Discharge from agency [<i>Go to M1041</i>]</li> </ul>
ITEM INTENT
<p>Identifies the “time point” - reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.</p>
TIME POINTS ITEM(S) COMPLETED
<p>All</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Mark only one response.</li> <li>• Response 1: This is the start of care comprehensive assessment. A Plan of Care is being established, whether or not further visits will be provided after the start of care visit. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required.</li> <li>• Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests. Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is marked. When a patient is discharged from an inpatient facility <b>and</b> care is resumed within the last 5 days of the episode (that is, a recertification assessment is due), a ROC assessment, rather than a recertification assessment, is completed.</li> <li>• Response 4: This comprehensive follow-up assessment is conducted during the last five days of the 60-day certification period and is completed to continue the patient’s services for an additional 60 day episode of care.</li> <li>• Response 5: This comprehensive assessment is conducted due to a major decline or improvement in patient’s health status occurring at a time <u>other than</u> during the last five days of the episode. This assessment is done to re-evaluate the patient’s condition, allowing revision to the patient’s care plan as appropriate.</li> <li>• Response 6: This “Transfer to an Inpatient Facility” OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests with the expectation that home health care will be resumed following inpatient discharge; thus the patient is not discharged from the agency. (When the patient resumes care, a Resumption of Care comprehensive assessment is conducted.) This response <u>does not</u> require a home visit; a telephone call may provide the information necessary to complete the required data items. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0100)**

- Response 7: This “Transfer to an Inpatient Facility” OASIS is only completed when the home care patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) and the agency does NOT anticipate the patient will be returning to care. The patient is discharged from the agency. This response does NOT require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.
- Response 8: Data regarding patient death anywhere other than death in an emergency department or inpatient facility. A patient who dies **before** being treated in an emergency department or before being admitted to an inpatient facility would have this response marked. Note the “skip pattern” included in the response. A home visit is not required to mark this response; the information necessary to complete the data items may be obtained by telephone.
- Response 9: This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. This response includes transfer and **discharge** to another home health agency or an in-home hospice. A patient visit is required to complete this assessment. Note the “skip pattern” present in the response. The Discharge OASIS is not required when only a single visit is made in a care episode (SOC/ROC and TRF/DC).
- Assessment strategies: Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

**DATA SOURCES / RESOURCES**

- Agency case manager or other care team provider
- Clinical record
- Hospital or other health care provider information regarding transfer to inpatient facility or death at home

<b>OASIS ITEM</b>
<p><b>(M0102) Date of Physician-ordered Start of Care (Resumption of Care):</b> 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.</p> <p style="text-align: center;">             ___/___/____ [ Go to M0110, if date entered ]              month / day / year           </p> <p><input type="checkbox"/> NA - No specific SOC date ordered by physician</p>
<b>ITEM INTENT</b>
<p>Specifies the date that home care services are ordered to begin, if the date was specified by the physician. The item refers to the order to start home care services (that is, provide the first covered service), regardless of the type of services ordered (for example, therapy only).</p>
<b>TIME POINT ITEM(S) COMPLETED</b>
<p>Start of care Resumption of care</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• If the originally ordered start of care is delayed due to the patient’s condition or physician request (for example, extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician-ordered start of care (resumption of care). For example, a patient discharged home on May 15 but for whom the physician orders home care to begin May 20 for a specified order (for example, PT or administration of a subcutaneous drug), would have a physician-ordered start of care date of May 20.</li> <li>• If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.</li> <li>• Mark “N/A” if the initial orders did not specify a SOC date.</li> <li>• Because the SOM requires a visit within 48 hours of resumption of care following hospitalization, mark "N/A" if the physician orders a ROC date that extends beyond 2 calendar days of the inpatient facility discharge.</li> <li>• In order to be considered a physician-ordered SOC date, the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment visit) must be conducted within 48 hours of the referral or within 48 hours of the patient’s return home from the inpatient facility.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Physician orders to initiate home care or resume home care following inpatient facility stay.</li> </ul>



<b>OASIS ITEM</b>
<p><b>(M0104) Date of Referral:</b> Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.</p> <p style="text-align: center;">             ____ / ____ / _____              month / day / year           </p>
<b>ITEM INTENT</b>
<p>Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin home care was <b>received</b> by the home health agency.</p>
<b>TIME POINT ITEM(S) COMPLETED</b>
<p>Start of care Resumption of care</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• If start of care is delayed due to the patient’s condition or physician request (for example, extended hospitalization), then the date the agency received <b>updated/revised</b> referral information for home care services to begin would be considered the date of referral. This does not refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.</li> <li>• The date authorization was received from the patient’s payer is NOT the date of the referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).</li> <li>• If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.</li> </ul>
<b>DATA SOURCES/ RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency referral form</li> <li>• Agency records specifying the date the referral was received by the agency</li> <li>• Hospital or nursing home discharge information</li> </ul>

OASIS ITEM
<p><b>(M0110) Episode Timing:</b> Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?</p> <p><input type="checkbox"/> 1 - Early</p> <p><input type="checkbox"/> 2 - Later</p> <p><input type="checkbox"/> UK - Unknown</p> <p><input type="checkbox"/> NA - Not Applicable: No Medicare case mix group to be defined by this assessment.</p>
ITEM INTENT
Identifies the placement of the current Medicare PPS payment episode in the patient’s current sequence of adjacent Medicare PPS payment episodes.
TIME POINT ITEM(S) COMPLETED
Start of care Resumption of care Follow-up
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• A “sequence of adjacent Medicare home health payment episodes” is a continuous series of Medicare PPS payment episodes, regardless of whether the same home health agency provided care for the entire series.             <ul style="list-style-type: none"> <li>- Low utilization payment adjustment (LUPA ) episodes (less than 5 total visits) are counted.</li> <li>- “Adjacent” means that there was no gap between Medicare-covered episodes of more than 60 days.</li> <li>- Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as <i>gap</i> days when counting the sequence of Medicare payment episodes.</li> </ul> </li> <li>• “Early” includes the only PPS episode in a single episode case OR the first or second PPS episode in a sequence of adjacent PPS episodes. <b>Select Response 1 – Early – if the episode of care you are assessing the patient for is the patient’s first or second episode of care</b> in a current sequence of adjacent Medicare home health PPS payment episodes.</li> <li>• “Later” means the third or later PPS episode in a sequence of adjacent episodes. <b>Select Response 2 – Later – if this episode is the third or later episode of care</b> in a current sequence of adjacent Medicare home health PPS payment episodes.</li> <li>• Select the “UK - Unknown” response if the placement of this PPS payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as selecting the “Early” response.</li> <li>• Enter “NA” if no Medicare case mix group is to be defined for this episode.</li> <li>• If the patient needs a case mix code for billing purposes (a HIPPS code), a response other than “NA” is required to generate the code. Some payment sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (continued for OASIS ITEM M0110)**

- Assessment strategies: Consult all available sources of information to code this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of a sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence.

**DATA SOURCES / RESOURCE**

- Medicare systems, such as Health Insurance Query for Home Health (HIQH).
- Manual calculations. Note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. A sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of the sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).

OASIS ITEM
<p><b>(M1000)</b> From which of the following <b>Inpatient Facilities</b> was the patient discharged within the past 14 days? <b>(Mark all that apply.)</b></p> <p><input type="checkbox"/> 1 - Long-term nursing facility (NF)</p> <p><input type="checkbox"/> 2 - Skilled nursing facility (SNF / TCU)</p> <p><input type="checkbox"/> 3 - Short-stay acute hospital (IPP S)</p> <p><input type="checkbox"/> 4 - Long-term care hospital (LTCH)</p> <p><input type="checkbox"/> 5 - Inpatient rehabilitation hospital or unit (IRF)</p> <p><input type="checkbox"/> 6 - Psychiatric hospital or unit</p> <p><input type="checkbox"/> 7 - Other (specify) _____</p> <p><input type="checkbox"/> NA - Patient was not discharged from an inpatient facility [<i>Go to M1017</i>]</p>
ITEM INTENT
<p>Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care. The purpose of this item is to establish the patient's recent health care history before formulating the Plan of Care. This determination must be made with sufficient accuracy to allow appropriate care planning. For example, the amount and types of rehabilitation treatment the patient has received and the type of institution that delivered the treatment are important to know when developing the home health Plan of Care.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Mark all that apply. For example, patient may have been discharged from both a hospital <u>and</u> a rehabilitation facility within the past 14 days.</li> <li>• An inpatient facility discharge that occurs on the day of the assessment does fall within the 14-day period.</li> <li>• The term “past 14 days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included.</li> <li>• Facility type is determined by the facility's state license.</li> <li>• If the patient was discharged from a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care, select Response 1 - Long-term nursing facility.</li> <li>• Response 2 – Skilled nursing facility means a (a) Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit or (b) transitional care unit (TCU) within a Medicare-certified nursing facility.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1000)**

Determine responses to the questions below. If all three of the criteria below apply, select Response 2:

- 1) Was the patient discharged from a Medicare-certified skilled nursing facility? If yes;
  - 2) While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If yes; and
  - 3) Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to admission to home health care? yes.
- Response 3 – Short-stay acute hospital applies to most hospitalizations.
  - Response 4 – Long-term care hospital, applies to a hospital that has an average inpatient length of stay of greater than 25 days.
  - Response 5 – Inpatient rehabilitation hospital or unit (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital.
  - Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) should be considered Response 7 – Other.
  - If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 3), a skilled nursing bed under Medicare Part A (Response 2), or a nursing bed at a lower level of care (Response 1). The referring hospital can answer this question regarding the bed status.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Physician
- Referral Information
- For Medicare patients, Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

OASIS ITEM
<p><b>(M1005) Inpatient Discharge Date</b> (most recent):</p> <p style="text-align: center;">_ _ / _ _ / _ _ _ _ month / day / year</p> <p><input type="checkbox"/> UK - Unknown</p>
ITEM INTENT
Identifies the date of the <u>most recent</u> discharge from an inpatient facility (within past 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• The term “past 14 days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included.</li> <li>• Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility.</li> <li>• If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Referral information</li> <li>• For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.</li> </ul>

<b>OASIS ITEM</b>															
<p><b>(M1011)</b> List each <b>Inpatient Diagnosis</b> and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center; border-bottom: 1px solid black;"><u>Inpatient Facility Diagnosis</u></th> <th style="width: 50%; text-align: center; border-bottom: 1px solid black;"><u>ICD-10-CM Code</u></th> </tr> </thead> <tbody> <tr> <td>a. _____</td> <td>_____ . _____</td> </tr> <tr> <td>b. _____</td> <td>_____ . _____</td> </tr> <tr> <td>c. _____</td> <td>_____ . _____</td> </tr> <tr> <td>d. _____</td> <td>_____ . _____</td> </tr> <tr> <td>e. _____</td> <td>_____ . _____</td> </tr> <tr> <td>f. _____</td> <td>_____ . _____</td> </tr> </tbody> </table> <p><input type="checkbox"/> NA - Not applicable (patient was not discharged from an inpatient facility) [ Omit “NA” option on SOC, ROC ]</p>		<u>Inpatient Facility Diagnosis</u>	<u>ICD-10-CM Code</u>	a. _____	_____ . _____	b. _____	_____ . _____	c. _____	_____ . _____	d. _____	_____ . _____	e. _____	_____ . _____	f. _____	_____ . _____
<u>Inpatient Facility Diagnosis</u>	<u>ICD-10-CM Code</u>														
a. _____	_____ . _____														
b. _____	_____ . _____														
c. _____	_____ . _____														
d. _____	_____ . _____														
e. _____	_____ . _____														
f. _____	_____ . _____														
<b>ITEM INTENT</b>															
<p>Identifies diagnosis(es) for which patient was actively receiving treatment in an inpatient facility within the past 14 days. This list of diagnoses is intended to include only those diagnoses that required active treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis.</p>															
<b>TIME POINTS ITEM(S) COMPLETED</b>															
<p>Start of care Resumption of care Follow-up</p>															
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>															
<ul style="list-style-type: none"> <li>• “Actively treated” should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition.</li> <li>• The term “past 14 days” is the two-week period immediately preceding the start/resumption of care or follow-up. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any diagnoses related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported.</li> <li>• If a diagnosis was not treated during an inpatient admission, it should not be listed. (Example: The patient has a long-standing diagnosis of “osteoarthritis,” but was treated during hospitalization only for “peptic ulcer disease.” Do <u>not</u> list “osteoarthritis” as an inpatient diagnosis.)</li> <li>• No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.</li> <li>• No V, W, X, Y, or Z codes. List the underlying diagnosis.</li> <li>• It is not necessary to fill in every line (a-f) if the patient had fewer than six inpatient diagnoses.</li> <li>• Select “NA” at follow-up if the patient was not discharged from an inpatient facility within the past 14 days.</li> </ul>															
<b>DATA SOURCES / RESOURCES</b>															
<table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="width: 50%; vertical-align: top; padding-right: 20px;"> <ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.)</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Physician</li> <li>• The current ICD-10-CM List of Codes and Descriptions and the ICD-10-CM Official Guidelines for Coding and Reporting should be the source for coding (see Chapter 5 for link).</li> </ul> </td> </tr> </tbody> </table>		<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Physician</li> <li>• The current ICD-10-CM List of Codes and Descriptions and the ICD-10-CM Official Guidelines for Coding and Reporting should be the source for coding (see Chapter 5 for link).</li> </ul>												
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Physician</li> <li>• The current ICD-10-CM List of Codes and Descriptions and the ICD-10-CM Official Guidelines for Coding and Reporting should be the source for coding (see Chapter 5 for link).</li> </ul>														

<b>OASIS ITEM</b>														
<p><b>(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days:</b> List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black; padding: 5px;"><u>Changed Medical Regimen Diagnosis</u></th> <th style="text-align: left; border-bottom: 1px solid black; padding: 5px;"><u>ICD-10-CM Code</u></th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">a. _____</td> <td style="padding: 5px;">_____ . _____</td> </tr> <tr> <td style="padding: 5px;">b. _____</td> <td style="padding: 5px;">_____ . _____</td> </tr> <tr> <td style="padding: 5px;">c. _____</td> <td style="padding: 5px;">_____ . _____</td> </tr> <tr> <td style="padding: 5px;">d. _____</td> <td style="padding: 5px;">_____ . _____</td> </tr> <tr> <td style="padding: 5px;">e. _____</td> <td style="padding: 5px;">_____ . _____</td> </tr> <tr> <td style="padding: 5px;">f. _____</td> <td style="padding: 5px;">_____ . _____</td> </tr> </tbody> </table> <p><input type="checkbox"/> NA - Not applicable (no medical or treatment regimen changes within the past 14 days)</p>	<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-10-CM Code</u>	a. _____	_____ . _____	b. _____	_____ . _____	c. _____	_____ . _____	d. _____	_____ . _____	e. _____	_____ . _____	f. _____	_____ . _____
<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-10-CM Code</u>													
a. _____	_____ . _____													
b. _____	_____ . _____													
c. _____	_____ . _____													
d. _____	_____ . _____													
e. _____	_____ . _____													
f. _____	_____ . _____													
<b>ITEM INTENT</b>														
<p>Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days. The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks.</p>														
<b>TIME POINTS ITEM(S) COMPLETED</b>														
<p>Start of care Resumption of care</p>														
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>														
<ul style="list-style-type: none"> <li>• No surgical codes - list the underlying diagnosis.</li> <li>• No V, W, X, Y, or Z codes - list the appropriate diagnosis.</li> <li>• Response to this item may include the same diagnoses as M1011 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.</li> <li>• Mark "NA" if no medical or treatment regimen changes were made within the past 14 days OR all changes in the medical or treatment regimen were made because a diagnosis improved.</li> <li>• The term "past 14 days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any diagnoses requiring medical or treatment regimen change on or after August 6 and prior to the HHA admission would be reported.</li> </ul>														
<b>DATA SOURCES / RESOURCES</b>														
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Physician orders</li> <li>• Referral information</li> <li>• The current ICD-10-CM List of Codes and Descriptions and the ICD-10-CM Official Guidelines for Coding and Reporting should be the source for coding (see Chapter 5 for link).</li> </ul>														



OASIS ITEM
<p><b>(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:</b> If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. <b>(Mark all that apply.)</b></p> <p><input type="checkbox"/> 1 - Urinary incontinence</p> <p><input type="checkbox"/> 2 - Indwelling/suprapubic catheter</p> <p><input type="checkbox"/> 3 - Intractable pain</p> <p><input type="checkbox"/> 4 - Impaired decision-making</p> <p><input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior</p> <p><input type="checkbox"/> 6 - Memory loss to the extent that supervision required</p> <p><input type="checkbox"/> 7 - None of the above</p> <p><input type="checkbox"/> NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days</p> <p><input type="checkbox"/> UK - Unknown</p>
ITEM INTENT
Identifies existence of condition(s) <u>prior to</u> medical regimen change or inpatient stay within past 14 days.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select Response 7 – None of the above – if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and none of the indicated conditions existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen.</li> <li>• Select Response “NA” if no inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be marked “NA.”</li> <li>• Select Response “Unknown” if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and it is unknown whether the indicated conditions existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen.</li> <li>• The term “past 14 days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Referral information (for example, history and physical)</li> </ul>

**OASIS ITEM**

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

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

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

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

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

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

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

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

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

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

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

(Form on next page)

<b>OASIS ITEM (M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses (cont'd)</b>			
<b>(M1021 Primary Diagnosis &amp; (M1023) Other Diagnoses)</b>		<b>(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)</b>	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-C M / Symptom Control Rating	Description/ ICD-10-C M	Description/ ICD-10-C M
<b>(M1021) Primary Diagnosis</b>	<b>V, W, X, Y codes NOT allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>
a. _____	a. _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____ (_____._____)	a. _____ (_____._____)
<b>(M1023) Other Diagnoses</b>	<b>All ICD-10-C M codes allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>
b. _____	b. _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (_____._____)	b. _____ (_____._____)
c. _____	c. _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (_____._____)	c. _____ (_____._____)
d. _____	d. _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (_____._____)	d. _____ (_____._____)
e. _____	e. _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (_____._____)	e. _____ (_____._____)
f. _____	f. _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (_____._____)	f. _____ (_____._____)
<b>ITEM INTENT</b>			
<p>M1021: the intent of this item is to accurately report and code the patient's primary home health diagnosis and document the degree of symptom control for that diagnosis. The patient's primary home health diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care.</p> <p>M1023: the intent of this item is to accurately report and code the patient's secondary home health diagnoses and document the degree of symptom control for each diagnosis. Secondary diagnoses are comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient's Plan of Care, or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis.</p> <p>M1025 (OPTIONAL): the intent of this item is to provide the agency with the option of documenting a resolved underlying condition in Columns 3 and 4, if a Z-code is reported as a primary or secondary diagnosis in Columns 1 and 2, and the underlying condition is no longer active.</p>			
<b>TIME POINTS ITEM(S) COMPLETED</b>			
Start of care Resumption of care Follow-up			

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1021/1023/1025)**

- HHA clinicians and coders must comply with the ICD-10-CM Official Guidelines for Coding and Reporting when assigning primary and secondary diagnoses to the OASIS items M1021 and M1023. See Chapter 5 for link.
  - The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for care in all health care settings. The ICD-10-CM is based on the ICD-10, the international classification of disease published by the World Health Organization (WHO).
  - The ICD-10-CM Official Guidelines for Coding and Reporting were developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself and should be used as a companion document to the official version of the ICD-10-CM List of Codes and Descriptions.
  - Adherence to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). It is expected that each agency will ensure that diagnoses and ICD-10-CM codes reported in the OASIS data set meet these guidelines.
- Identifying the patient's Primary and Secondary Home Health Diagnoses
  - The assessing clinician is expected to complete the patient's comprehensive assessment and understand the patient's overall medical condition and care needs before selecting and assigning diagnoses.
  - The determination of the patient's primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.
  - As noted in the Item Intent, the patient's primary diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care. The primary diagnosis may or may not relate to the patient's most recent hospital stay, but must relate to the skilled services (skilled nursing, physical therapy, occupational therapy, and speech language pathology) rendered by the HHA.
  - As noted in the Item Intent, the secondary diagnoses include coexisting conditions actively addressed in the patient's Plan of Care, and any comorbid conditions having the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis. The secondary diagnoses may or may not be related to a patient's recent hospital stay, but must have the potential to impact the skilled services provided by the HHA.
  - Diagnoses may change during the course of the home health stay due to a change in the patient's health status or a change in the focus of home health care. At each required OASIS time point, the clinician must assess the patient's clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.
  - Only current medical diagnoses should be reported as primary or secondary diagnoses in M1021 and M1023. Diagnoses should be excluded if they are resolved or do not have the potential to impact the skilled services provided by the HHA. An example of a resolved condition is cholecystitis following a cholecystectomy.
  - In addition to following the ICD-10-CM Official Guidelines for Coding and Reporting, selection of home health diagnoses must be performed in compliance with Medicare's rules and regulations for coverage and payment to ensure provider compliance with Section 1862(a)(1)(A) of the Social Security Act. Section 1862(a)(1)(A) excludes provider services from Medicare coverage and payment that "are not reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1021/1023/1025)**

- Reporting Primary and Secondary Diagnoses in M1021 and M1023
  - At each required OASIS time point, the assessing clinician should enter the patient's current primary and secondary diagnoses in Column 1 of M1021 and M1023. Complete Column 1 from top to bottom, leaving any blank entries at the bottom.
  - The order that secondary diagnoses are entered should be determined by the degree that they impact the patient's health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is "controlled with difficulty," this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled."
- Reporting ICD-10-CM Codes in Column 2 of M1021 and M1023
  - The assessing clinician can enter the actual numeric ICD-10-CM codes for each diagnosis listed in Column 1 and 2 of M1021 and M1023, once the assessment is completed and the diagnosis is entered in Column 1. Alternatively, a coding specialist in the agency may enter the actual numeric ICD-10-CM codes in Column 2, as long as the assessing clinician has determined the primary and secondary diagnoses in Column 1.
  - The correct process for selecting an ICD-10-CM code using the Alphabetic Index and the Tabular List is described in the ICD-10-CM Official Guidelines for Coding and Reporting. Follow the official conventions and instructions provided within the ICD-10-CM List of Codes and Descriptions and the Official Guidelines to code each row in Column 2.
  - Each ICD-10-CM code must be entered at its highest level of specificity (diagnosis codes only - no surgical or procedure codes allowed).
  - ICD-10-CM does not allow external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) to be reported in M1021 (Primary Diagnosis) but they may be reported in M1023 (Secondary Diagnoses).
  - Also note that when a Z-code is reported in Column 2, the code for the underlying condition may be entered in Column 2, as long as it is a current on-going condition that has a potential to impact the skilled services provided by the HHA. See the ICD-10-CM Official Guidelines for Coding and Reporting for complete instructions on code assignment and sequencing related to the use of Z-codes and use of multiple coding for a single condition (such as manifestation/etiology pairs).
- Reporting the Symptom Control Rating in Column 2 of M1021 and M1023
  - At each required time point, the assessing clinician should record the symptom control ratings for each primary and secondary diagnosis in column 2 of M1021 and M1023.
  - Assessing degree of symptom control includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.
  - Choose one value that represents the degree of symptom control appropriate for each diagnosis using the scale provided in the M1021/M1023 instructions.

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1021/1023/1025)**

- M1025 (OPTIONAL)
  - If a Z-code is reported in Column 2 and the underlying condition for the Z-code is resolved, then the resolved condition may be reported in Columns 3 and 4 at the agency's discretion.
  - If an agency chooses to report a diagnosis in Columns 3 and 4, then the instructions that accompany items M1021/M1023/M1025 in the OASIS-C1 data set should be followed to code each row in Column 3 and/or 4. If a diagnosis and ICD-10-CM code is entered in Columns 3 and/or 4, it must be placed in the same row as the corresponding Z-code. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1025.
- Refer to the ICD-10-CM Official Guidelines for Coding and Reporting for instructions on multiple coding for a single condition (such as manifestation/etiology pairs).

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-10-CM List of Codes and Descriptions and the ICD-10-CM Official Guidelines for Coding and Reporting should be the source for coding (see Chapter 5 for link).
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history.

OASIS ITEM	
<p><b>(M1030) Therapies</b> the patient receives <u>at home</u>: <b>(Mark all that apply.)</b></p> <p><input type="checkbox"/> 1 - Intravenous or infusion therapy (excludes TPN)</p> <p><input type="checkbox"/> 2 - Parenteral nutrition (TPN or lipids)</p> <p><input type="checkbox"/> 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)</p> <p><input type="checkbox"/> 4 - None of the above</p>	
ITEM INTENT	
<p>Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy <b>at home</b>, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• This item addresses only therapies administered at home, defined as the patient’s place of residence. Exclude therapies administered in outpatient facilities or by any provider outside the home setting.</li> <li>• If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment (for example, the IV will be started at this visit or a specified subsequent visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.</li> <li>• Select Response 1 if a patient receives intermittent medications or fluids via an IV line (including heparin or saline flushes). If IV catheter is present but not active (for example, site is observed only or dressing changes are provided), do <u>not</u> mark Response 1.</li> <li>• Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump.</li> <li>• Select Response 1 if the patient receives hemodialysis or peritoneal dialysis in the home.</li> <li>• Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (for example, weight gain), but those parameters are not met on the day of the assessment.</li> <li>• An irrigation or infusion of the bladder is not included when completing M1030, Therapies at Home.</li> <li>• Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does <u>not</u> apply. A flush of a feeding tube does <u>not</u> provide nutrition.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li style="width: 50%;">• Patient/caregiver interview</li> <li style="width: 50%;">• Review of past health history</li> <li style="width: 50%;">• Physician orders</li> <li style="width: 50%;">• Physical assessment</li> <li style="width: 50%;">• Referral information</li> </ul>	

OASIS ITEM
<p><b>(M1033) Risk for Hospitalization:</b> Which of the following signs or symptoms characterize this patient as at risk for hospitalization? <b>(Mark all that apply.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)</li> <li><input type="checkbox"/> 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months</li> <li><input type="checkbox"/> 3 - Multiple hospitalizations (2 or more) in the past 6 months</li> <li><input type="checkbox"/> 4 - Multiple emergency department visits (2 or more) in the past 6 months</li> <li><input type="checkbox"/> 5 - Decline in mental, emotional, or behavioral status in the past 3 months</li> <li><input type="checkbox"/> 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months</li> <li><input type="checkbox"/> 7 - Currently taking 5 or more medications</li> <li><input type="checkbox"/> 8 - Currently reports exhaustion</li> <li><input type="checkbox"/> 9 - Other risk(s) not listed in 1 - 8</li> <li><input type="checkbox"/> 10 - None of the above</li> </ul>
ITEM INTENT
Identifies patient characteristics that may indicate the patient is at risk for hospitalization.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select all Responses 1-9 that apply.</li> <li>• If Response 10 is selected, none of the other responses should be selected.</li> <li>• Response 1 includes witnessed and reported (unwitnessed) falls.</li> <li>• In Response 5, decline in mental, emotional, or behavioral status refers to significant changes occurring within the past 3 months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization. In Response 7, medications include OTC medications.</li> <li>• Response 9 - Other risk(s), may be selected if the assessing clinician finds characteristics other than those listed in Responses 1-8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Review of health history</li> <li>• Referral information</li> <li>• Physical assessment</li> </ul>



OASIS ITEM
<p><b>(M1034) Overall Status:</b> Which description best fits the patient's overall status? <b>(Check one)</b></p> <p><input type="checkbox"/> 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).</p> <p><input type="checkbox"/> 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).</p> <p><input type="checkbox"/> 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.</p> <p><input type="checkbox"/> 3 - The patient has serious progressive conditions that could lead to death within a year.</p> <p><input type="checkbox"/> UK - The patient's situation is unknown or unclear.</p>
ITEM INTENT
Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Use information from other providers and clinical judgment to select the response that best identifies the patient's status.</li> <li>• Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy.</li> <li>• A "Do Not Resuscitate" order does not need to be in place for Responses 2 or 3.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Review of health history</li> <li>• Referral information</li> <li>• Physical assessment</li> <li>• Advance Directive</li> </ul>

OASIS ITEM
<p><b>(M1036) Risk Factors</b>, either present or past, likely to affect current health status and/or outcome: <b>(Mark all that apply.)</b></p> <p><input type="checkbox"/> 1 - Smoking</p> <p><input type="checkbox"/> 2 - Obesity</p> <p><input type="checkbox"/> 3 - Alcohol dependency</p> <p><input type="checkbox"/> 4 - Drug dependency</p> <p><input type="checkbox"/> 5 - None of the above</p> <p><input type="checkbox"/> UK - Unknown</p>
ITEM INTENT
Identifies specific factors that may exert a substantial impact on the patient's health status, response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select all Responses 1-4, that apply.</li> <li>• If Response 5 is selected, none of the other responses should be selected.</li> <li>• CMS does not provide a specific definition for each of these factors.</li> <li>• Amount and length of exposure should be considered when responding (for example, smoking one cigarette a month may not be considered a risk factor).</li> <li>• Care providers should use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past.</li> <li>• For determination of obesity, consider using Body Mass Index guidelines.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Review of past health history</li> <li>• Physical assessment</li> <li>• Links to Body Mass Index guidelines for obesity can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M1041) Influenza Vaccine Data Collection Period:</b> Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?</p> <p><input type="checkbox"/> 0 - No [ Go to M1051 ]</p> <p><input type="checkbox"/> 1 - Yes</p>
ITEM INTENT
Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 and March 31).
TIME POINTS ITEM(S) COMPLETED
Transfer to inpatient facility Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• A care episode is one that includes both SOC/ROC and Transfer/Discharge. Therefore, when completing this item at Transfer or Discharge, only go back to the most recent SOC or ROC to determine if the patient was receiving home health agency services on or between October 1 through March 31.</li> <li>• If no part of the care episode (from SOC/ROC to Transfer or Discharge) occurred during the time period from October 1 and March 31, mark “No.”</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Clinical record and calendar</li> </ul>

OASIS ITEM
<p><b>(M1046) Influenza Vaccine Received:</b> Did the patient receive the influenza vaccine for this year's flu season?</p> <p><input type="checkbox"/> 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)</p> <p><input type="checkbox"/> 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)</p> <p><input type="checkbox"/> 3 - Yes; received from another health care provider (for example, physician, pharmacist)</p> <p><input type="checkbox"/> 4 - No; patient offered and declined</p> <p><input type="checkbox"/> 5 - No; patient assessed and determined to have medical contraindication(s)</p> <p><input type="checkbox"/> 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine</p> <p><input type="checkbox"/> 7 - No; inability to obtain vaccine due to declared shortage</p> <p><input type="checkbox"/> 8 - No; patient did not receive the vaccine due to reasons other than those listed in Responses 4 - 7.</p>
ITEM INTENT
<p>For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year's flu season, and if not, the reason why. This item meets National Quality Forum (NQF) standards for harmonization of influenza measures across care settings.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to an inpatient facility Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Complete if Response 1 for M1041 is selected. Select only one response.</li> <li>• Select Response 1 if your agency provided the influenza vaccine to the patient during this episode of care (SOC/ROC to Transfer/Discharge).</li> <li>• Select Response 2 if your agency provided the flu vaccine for this year's flu season prior to this home health episode, (for example, if the SOC/ROC for this episode was in winter, but your agency provided the vaccine for the current flu season during a previous home health episode in the fall when the vaccine for the current flu season became available). <ul style="list-style-type: none"> <li>– You may select Response 2 if a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year's flu season.</li> </ul> </li> <li>• Select Response 3 if the patient or caregiver reports (or there is documentation in the clinical record) that the patient received the influenza vaccine for the current flu season from another provider. The provider can be the patient's physician, a clinic, or health fair providing influenza vaccines, etc.</li> <li>• Responses 1 or 2 or 3 may be selected even if the flu vaccine for this year's influenza season was provided prior to October 1 (that is, flu vaccine was made available early).</li> <li>• Select Response 4 if the patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine.</li> <li>• Note: It is not required that the agency offered the vaccine. Select Response 4 only if the patient was offered the vaccine and he/she refused.</li> <li>• Select Response 5 if the influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1046)**

- Select Response 6 if age/condition guidelines indicate that influenza vaccine is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current influenza age/condition guidelines is posted to the CDC website (see link in Chapter 5). It is the agency's responsibility to make current guidelines available to clinicians.
- Select Response 7 only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- Select Response 8 only if the patient did not receive the vaccine due to a reason other than Responses 4-7.

**DATA SOURCES / RESOURCES**

- Clinical record
- Patient/caregiver interview
- Physician or other health care provider
- A link to CDC Guidelines can be found in Chapter 5 of this manual.

<b>OASIS ITEM</b>
<p><b>(M1051) Pneumococcal Vaccine:</b> Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes [ Go to M1500 at TRN; Go to M1230 at DC ]</p>
<b>ITEM INTENT</b>
Identifies whether the patient has ever received the pneumonia vaccine.
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Transfer to an inpatient facility</p> <p>Discharge from agency - not to an inpatient facility</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Select Response 1 if the patient has ever received the pneumococcal vaccine.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Clinical record</li> <li>• Patient/caregiver interview</li> </ul>

OASIS ITEM
<p><b>(M1056) Reason Pneumococcal Vaccine not received:</b> If patient has never received the pneumococcal vaccination, state reason:</p> <p><input type="checkbox"/> 1 - Offered and declined</p> <p><input type="checkbox"/> 2 - Assessed and determined to have medical contraindication(s)</p> <p><input type="checkbox"/> 3 - Not indicated; patient does not meet age/condition guidelines for pneumococcal vaccination</p> <p><input type="checkbox"/> 4 - None of the above</p>
ITEM INTENT
Explains why the patient has never received the pneumococcal vaccination.
TIME POINTS ITEM(S) COMPLETED
Transfer to an inpatient facility Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Response 1 should be selected if the patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine.</li> <li>• Response 2 should be selected if pneumococcal vaccine administration is medically contraindicated for this patient. Medical contraindications include anaphylactic hypersensitivity to component(s) of the vaccine, acute febrile illness, bone marrow transplant within past 12 months, or receiving course of chemotherapy or radiation therapy within past 2 weeks.</li> <li>• Select Response 3 if CDC age/condition guidelines indicate that pneumococcal vaccination is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current pneumococcal vaccination age/condition guidelines are posted to the CDC's website (see link in Chapter 5). It is the agency's responsibility to make current guidelines available to clinicians.</li> <li>• Response 4 should be selected only if the agency did not provide the vaccine due to a reason other than Responses 1 - 3.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Clinical Record</li> <li>• A link to CDC Guidelines for pneumococcal vaccine administration can be found in Chapter 5 of this manual.</li> </ul>

**OASIS ITEM**

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

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

**ITEM INTENT**

This item identifies, using the care provider's professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s) (other than home health agency staff) to provide in-person assistance.

**TIME POINTS ITEM(S) COMPLETED**

Start of care  
Resumption of care

**RESPONSE—SPECIFIC INSTRUCTIONS**

- To answer this question:
  - **First, determine living arrangement** – whether the patient lives alone, in a home with others, or in a congregate setting.
  - **Second, determine availability of assistance** – how frequently caregiver(s) are in the home and available to provide assistance if needed.
  - **Only one response should be marked.** Select the appropriate row (a, b, or c) to reflect the patient's living situation, then select the one response in the column that best describes the availability of in-person assistance at the time of the OASIS assessment.
- **Living Arrangement**
  - Select a response from **Row a** if the patient lives alone in an independent (non-assisted) setting. For example, the patient lives alone in a home, in their own apartment, or in their own room at a boarding house. A patient with only live-in paid help is considered to be living alone. A patient who normally lives alone but temporarily has a caregiver staying in the home to provide assistance is considered to be living alone. A patient who lives alone but can obtain emergency help by phone or life-line, is still living alone.
  - Select a response from **Row b** if the patient lives with others in an independent (non-assisted) setting. For example, the patient lives with a spouse, family member or another significant other in an independent (non-assisted) setting. A patient who normally lives with others but is occasionally alone because caregiver(s) are traveling out of town is still considered to be living with others.



**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100)**

- Select a response from **Row c** if the patient lives in an “assisted living” setting (assistance, supervision and/or oversight are provided as part of the living arrangement). For example, the patient lives alone or with a spouse or partner in an apartment or room that is part of an assisted living facility, residential care home, or personal care home.
- If the patient has recently changed their living arrangement due to their condition, report the usual living arrangement prior to the illness, injury or exacerbation for which the patient is receiving care, unless the new living arrangement is expected to be permanent.
- **Availability of Assistance**
  - Identify the frequency with which any in-person assistance is available:
    - **Around the clock** means there is someone available in the home to provide assistance to the patient 24 hours a day.
    - **Regular daytime** means someone is in the home and available to provide assistance during daytime hours every day with infrequent exceptions.
    - **Regular nighttime** means someone is in the home and available to provide assistance during nighttime hours every night with infrequent exceptions.
    - **Occasional/short-term assistance** means someone is available to provide in-person assistance only for a few hours a day or on an irregular basis, or may be only able to help occasionally.
    - **No assistance available** means there is no one available to provide any in-person assistance.
  - Clinical judgment must be used to determine which hours constitute "regular daytime" and "regular nighttime" based on the patient's specific activities and routines. No hours are specifically designated as daytime or nighttime.
  - Availability of assistance refers to in-person assistance provided in the home of the patient. It includes any type of in-person assistance, including but not limited to ADLs and IADLs. If a person is in an assisted living or congregate setting with a call-bell that summons help, this is considered in-person assistance.
  - The caregiver(s) need not live in the home with the patient, but assistance via telephone is not included in this question.
  - This item documents the time caregiver(s) are in the home and available without regard to the amount or types of assistance the patient requires, or whether the caregiver(s) are able to meet all or only some of the patient's needs. Adequacy of caregiver assistance for different types of needs is captured in M2100.
  - Use your professional judgment to determine if someone will be available to provide any assistance to the patient. If a person is living in the patient's home but is **completely unable to or unwilling to provide any assistance** to the patient, do not count them as a caregiver.
  - Availability of assistance refers to the expected availability and willingness of caregiver(s) for this upcoming care episode.
- **Examples:**
  - Patient lives alone in her own apartment. Since her discharge from the hospital, her two daughters alternate staying with her during the day and night so that one of them is always there, except for the times when one goes out to run an errand or pick up a child at day care. Response = 01 (*Patient still considered to be living alone, since daughters are only staying there temporarily. Daughters are providing round-the-clock care, even if one occasionally needs to be out of the house for brief periods.*)
  - Patient lives alone in her home but her son and daughter-in-law live across the street. They bring the patient dinner every night and are available around the clock by telephone. Response = 04 (*Son and daughter-in-law are not there to provide in-person assistance consistently, day or evening, even if they live across the street and are available by phone.*)

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100)**

- Patient lives with her daughter who works during the day but is home every evening and sleeps there every night. A paid aide comes in 3 days a week to assist with ADLs. Daughter has back problems that prevent her from lifting patient, but she assists the patient with dressing every morning and takes the patient to doctor's appointments. Response = 08 (*Patient lives in a home with others who are available every night to offer in-person assistance. Even if the daughter can't meet all of patient's needs, she is available all night.*)
- Patient lives with her husband who has significant cognitive and functional impairments, is wheelchair bound, and is unable to provide the patient with any assistance. A member of the church comes by one evening a week and brings groceries. Response = 09 (*Patient lives in a home with another person who is there 24 hours but is unavailable to provide assistance. Caregiver from church provides occasional assistance.*)
- Patient lives alone in an apartment that is part of an ALF. The apartment does not have a call-bell but her contract with the ALF includes having a home health aide assist her with ADLs 2 hours every morning. Her son also comes over occasionally to assist with bills, groceries, and errands. Response = 14 (*Patient is living in a congregate setting; one caregiver is available to assist for some part of every day on a regular basis, but not all day, another caregiver offers occasional assistance.*)

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Physical assessment
- Observation
- Referral information
- Assisted Living Facility agreement or contract

OASIS ITEM
<p><b>(M1200) Vision</b> (with corrective lenses if the patient usually wears them):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.</li> <li><input type="checkbox"/> 1 - Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.</li> <li><input type="checkbox"/> 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.</li> </ul>
ITEM INTENT
Identifies the patient's ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Follow-up
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• “Nonresponsive” means that the patient is not <u>able</u> to respond.</li> <li>• As specified within the OASIS question, only assess functional vision with corrective lenses if the patient usually wears corrective lenses.</li> <li>• A magnifying glass (as might be used to read newsprint) is <u>not</u> an example of corrective lenses.</li> <li>• Reading glasses (including "grocery store" reading glasses) <u>are</u> considered to be corrective lenses.</li> <li>• Assessment strategies: In the health history interview, ask the patient about vision problems (for example, cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered.</li> <li>• Be sensitive to requests to read, as patient may not be able to read though vision is adequate.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral information (for example, history and physical)</li> </ul>

OASIS ITEM
<p><b>(M1210) Ability to Hear</b> (with hearing aid or hearing appliance if normally used):</p> <p><input type="checkbox"/> 0 - Adequate: hears normal conversation without difficulty.</p> <p><input type="checkbox"/> 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.</p> <p><input type="checkbox"/> 2 - Severely Impaired: absence of useful hearing.</p> <p><input type="checkbox"/> UK - Unable to assess hearing.</p>
ITEM INTENT
Identifies the patient's ability to hear spoken language and other sounds (for example, alarms).
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>Hearing is evaluated with the patient wearing hearing aids or devices if he/she usually uses them.</li> <li>Select the "UK" response if the patient is not <u>able</u> to respond or if the patient's condition makes it impossible to assess hearing (for example, severe dementia, schizophrenia, unconscious).</li> <li>If evaluating ability to hear with hearing aids, be sure that the devices are in place, turned on, and that the hearing aids are working (for example, batteries are functional).</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>Patient/caregiver interview</li> <li>Observation</li> <li>Physical assessment</li> <li>Referral information (for example, history and physical)</li> </ul>

OASIS ITEM
<p><b>(M1220) Understanding of Verbal Content</b> in patient's own language (with hearing aid or device if used):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Understands: clear comprehension without cues or repetitions.</li> <li><input type="checkbox"/> 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.</li> <li><input type="checkbox"/> 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.</li> <li><input type="checkbox"/> 3 - Rarely/Never Understands</li> <li><input type="checkbox"/> UK - Unable to assess understanding.</li> </ul>
ITEM INTENT
<p>Identifies the patient's functional ability to comprehend spoken words and instructions in the patient's primary language. Both hearing and cognitive abilities may impact a patient's ability to understand verbal content.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• The "UK" response should be selected if the patient is not <u>able</u> to respond or if it is otherwise impossible to assess understanding of spoken words.</li> <li>• For patients whose primary language differs from the clinician's, an interpreter may be necessary.</li> <li>• If a patient can comprehend lip reading, they have the ability to understand verbal content, even if they are deaf.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral information (for example, history and physical)</li> <li>• Interpreter</li> </ul>

OASIS ITEM
<p><b>(M1230) Speech and Oral (Verbal) Expression of Language</b> (in patient's own language):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.</li> <li><input type="checkbox"/> 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).</li> <li><input type="checkbox"/> 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.</li> <li><input type="checkbox"/> 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.</li> <li><input type="checkbox"/> 4 - <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).</li> <li><input type="checkbox"/> 5 - Patient nonresponsive or unable to speak.</li> </ul>
ITEM INTENT
Identifies the patient's physical and cognitive ability to communicate with words in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Discharge from agency – not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Augmented speech (for example, a trained esophageal speaker, use of an electrolarynx) <b>is</b> considered verbal expression of language.</li> <li>• Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?</li> <li>• Select Response 5 for a patient who communicates entirely nonverbally (for example, by sign language or writing) or is unable to speak.</li> <li>• "Nonresponsive" means that the patient is not <u>able</u> to respond.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral information (for example, history and physical)</li> <li>• Interpreter</li> </ul>

OASIS ITEM
<p><b>(M1240)</b> Has this patient had a formal <b>Pain Assessment</b> using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?</p> <p><input type="checkbox"/> 0 - No standardized, validated assessment conducted</p> <p><input type="checkbox"/> 1 - Yes, and it does not indicate severe pain</p> <p><input type="checkbox"/> 2 - Yes, and it indicates severe pain</p>
ITEM INTENT
<p>Identifies if a standardized, validated pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care</p> <p>Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• A standardized, validated tool is one that 1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.); and 2) includes a standard response scale (for example, a scale where patients rate pain from 0-10). The standardized, validated tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond. Severe pain is defined according to the scoring parameters specified for the tool being used. CMS does not endorse a specific tool.</li> <li>• If the standardized, validated tool does not define levels of "severe" pain, then the agency or care provider should use the level(s) of pain identified in the tool that best reflect the concept of "severe."</li> <li>• Select Response 0 if such a tool was not used to assess pain.</li> <li>• Select Response 1 or 2 based on the pain reported at the time the standardized, validated tool was administered, per the tool's instructions.</li> <li>• In order to select Response 1 or 2, the pain assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the allowed time frame (that is, within five days of SOC and within two days of discharge from the inpatient facility at ROC).</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physical assessment</li> <li>• Clinical record</li> <li>• A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include visual analog scales, the Wong-Baker FACES Pain Rating Scale, numerical scales, and the Memorial Pain Assessment Card. Links to these and other assessment tools can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M1242) Frequency of Pain Interfering</b> with patient's activity or movement:</p> <p><input type="checkbox"/> 0 - Patient has no pain</p> <p><input type="checkbox"/> 1 - Patient has pain that does not interfere with activity or movement</p> <p><input type="checkbox"/> 2 - Less often than daily</p> <p><input type="checkbox"/> 3 - Daily, but not constantly</p> <p><input type="checkbox"/> 4 - All of the time</p>
ITEM INTENT
Identifies frequency with which pain interferes with patient's activities, with treatments if prescribed.
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Responses are arranged in order of least to most interference with activity or movement.</li> <li>• Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete. Include all activities (for example, sleeping, recreational activities, watching television), not just ADLs.</li> <li>• When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk). Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (for example, frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (for example, FACES). The patient's treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation of nonverbal indications of pain</li> <li>• Physical assessment</li> <li>• Referral information (for example, history and physical)</li> <li>• Standardized, validated pain assessment tools. Links to these tools can be found in Chapter 5 of this manual.</li> </ul>



OASIS ITEM
<p><b>(M1300) Pressure Ulcer Assessment:</b> Was this patient assessed for <b>Risk of Developing Pressure Ulcers?</b></p> <p><input type="checkbox"/> 0 - No assessment conducted [<i>Go to M1306</i>]</p> <p><input type="checkbox"/> 1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool</p> <p><input type="checkbox"/> 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)</p>
ITEM INTENT
<p>Identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. CMS does not require the use of standardized, validated tools, nor does it endorse one particular tool.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care</p> <p>Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select Response 0 if the patient was not assessed for pressure ulcer risk.</li> <li>• In order to select Response 1 or 2, the pressure ulcer risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.</li> <li>• Select Response 1 if the patient's risk for pressure ulcer development was clinically assessed, but no formal pressure ulcer screening tool was used.</li> <li>• Select Response 2 only if the patient was screened using a standardized, validated screening tool. This is defined as a tool that 1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities); and 2) includes a standard response scale. The tool must be appropriately administered per the tool's instructions.</li> <li>• If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, select Response 2.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical Assessment</li> <li>• Referral documentation</li> <li>• Physician</li> <li>• See link in Chapter 5 of this manual to the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale</li> </ul>

OASIS ITEM
<p><b>(M1302)</b> Does this patient have a <b>Risk of Developing Pressure Ulcers?</b></p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p>
ITEM INTENT
<p>Identifies if the patient is at risk for developing pressure ulcers. This item should be skipped if Response 0 was selected for M1300 (no pressure ulcer risk assessment).</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care</p> <p>Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• If pressure ulcer risk was assessed using a standardized, validated screening tool, use the scoring parameters specified for the tool to identify if a patient is at risk for developing pressure ulcers. If the evaluation was based on clinical factors (without a validated standardized screening tool), then the agency or care provider may define what constitutes risk.</li> <li>• A validated standardized screening tool is a tool that 1) has been scientifically tested and evaluated with a population with characteristics similar to the patient who is being evaluated and shown to be effective in identifying people at risk for developing pressure ulcers; and 2) includes a standard response scale. The standardized, validated tool must be appropriately administered per the tool's instructions.</li> <li>• If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, select Response 1-Yes, if either assessment is positive for risk.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical Assessment</li> <li>• Referral documentation</li> <li>• Physician</li> <li>• Standardized, validated pressure ulcer risk tools include the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale. Links can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M1306)</b> Does this patient have at least one <b>Unhealed Pressure Ulcer at Stage II or Higher</b> or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)</p> <p><input type="checkbox"/> 0 - No [<i>Go to M1322</i>]</p> <p><input type="checkbox"/> 1 - Yes</p>
ITEM INTENT
Identifies the presence or absence of Unstageable or unhealed <b>Stage II or higher</b> pressure ulcers only.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• The NPUAP definition of pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.</li> <li>• Select Response 0 – No, if the only pressure ulcer(s) is/are Stage I OR if a former Stage II pressure ulcer has healed AND the patient has no other pressure ulcers.</li> <li>• Select Response 1 – Yes, if the patient has an unhealed Stage II, OR a Stage III, OR Stage IV pressure ulcer at any healing status level OR if the patient has an Unstageable ulcer(s), defined as:             <ul style="list-style-type: none"> <li>- Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (for example, patient report of discomfort, past history of skin breakdown in the same area), but that are unobservable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath.</li> <li>- Pressure ulcers that the care provider suspects may be present based on clinical assessment, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures.</li> <li>- Suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.</li> </ul> </li> <li>• In 2004, based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it was determined that Stage I and Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface, known as epithelialization.</li> <li>• Stage III and IV (full thickness) pressure ulcers heal through a process of contraction, granulation, and epithelialization. They can never be considered "fully healed" but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.</li> </ul>

**DATA SOURCES / RESOURCES (cont'd for OASIS Item M1306)**

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Other resources can be found in Chapter 5 of this manual.

OASIS ITEM	
<p><b>(M1307)</b> The <b>Oldest Stage II Pressure Ulcer</b> that is present at discharge: (Excludes healed Stage II Pressure Ulcers)</p> <p><input type="checkbox"/> 1 - Was present at the most recent SOC/ROC assessment</p> <p><input type="checkbox"/> 2 - Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ___/___/____ month / day / year</p> <p><input type="checkbox"/> NA - No Stage II pressure ulcers are present at discharge</p>	
ITEM INTENT	
<p>The intent of this item is to a) identify the oldest Stage II pressure ulcer that is present at the time of discharge and is not fully epithelialized, b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage II pressure ulcers while under the care of the agency.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Discharge from agency – not to inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>Do not reverse stage pressure ulcers.</li> <li>Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage II (partial thickness) pressure ulcers can heal through epithelialization (the process of regeneration of the epidermis across a wound surface).</li> <li>Select Response 1 if the oldest Stage II pressure ulcer was already present when the SOC/ROC assessment was completed.</li> <li>Select Response 2 if the oldest Stage II pressure ulcer was first identified since the most recent SOC/ROC visit (that is, since the last time the patient was admitted to home care or had a resumption of care after an inpatient stay).</li> <li>If Response 2 is selected, specify the date of onset. Use two digits to indicate the month (for example, May is 05), single-digit dates should begin with 0, and use four digits to indicate the year (for example, May 4, 2014 would be 05/04/2014).</li> <li>Select Response “NA” if the patient has no Stage II pressure ulcers at the time of discharge, or all Stage II pressure ulcers have healed.</li> <li>An ulcer that is suspected of being a Stage II, but is Unstageable, should <u>not</u> be identified as the “oldest Stage II pressure ulcer.” For this item, Unstageable refers to pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (for example, patient report of discomfort, past history of skin breakdown in the same area), but that are unobservable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>Patient/caregiver interview</li> <li>Observation</li> <li>Physical assessment</li> </ul>	<ul style="list-style-type: none"> <li>Clinical Record</li> <li>Consult published guidelines of NPUAP for additional clarification and/or resources for training. Other resources can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM															
<p><b>(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:</b> (Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)</p>															
<table border="1"> <thead> <tr> <th style="width: 75%;">Stage Descriptions—unhealed pressure ulcers</th> <th style="width: 25%;">Number Currently Present</th> </tr> </thead> <tbody> <tr> <td>a. <b>Stage II:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.</td> <td style="text-align: center;">___</td> </tr> <tr> <td>b. <b>Stage III:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</td> <td style="text-align: center;">___</td> </tr> <tr> <td>c. <b>Stage IV:</b> Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</td> <td style="text-align: center;">___</td> </tr> <tr> <td>d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device</td> <td style="text-align: center;">___</td> </tr> <tr> <td>d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.</td> <td style="text-align: center;">___</td> </tr> <tr> <td>d.3 Unstageable: Suspected deep tissue injury in evolution.</td> <td style="text-align: center;">___</td> </tr> </tbody> </table>	Stage Descriptions—unhealed pressure ulcers	Number Currently Present	a. <b>Stage II:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___	b. <b>Stage III:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___	c. <b>Stage IV:</b> Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___	d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device	___	d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	___	d.3 Unstageable: Suspected deep tissue injury in evolution.	___	
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d.3 Unstageable: Suspected deep tissue injury in evolution.	___														
ITEM INTENT															
<p>Identifies the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Stage I pressure ulcers are <u>not</u> reported in this item.</p>															
TIME POINTS ITEM(S) COMPLETED															
<p>Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility</p>															
RESPONSE—SPECIFIC INSTRUCTIONS															
<ul style="list-style-type: none"> <li>• Report the number of Stage II or higher pressure ulcers that are present on the current day of assessment.                         <ul style="list-style-type: none"> <li>– Mark a response for each row of this item: a, b, c, d1, d2, and d3. If there are NO ulcers at a given stage, enter "0" for that stage.</li> </ul> <p>Stage I ulcers are not reported in this item.</p> </li> <li>• <b>Stage II ulcers</b> <ul style="list-style-type: none"> <li>– Stage II ulcers that have healed are not reported in this item.</li> <li>– Stage II pressure ulcers are described as "partial thickness" ulcers. Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface known as epithelialization.</li> </ul> </li> </ul>															

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1308)**

- **Stage III and IV ulcers**
  - Stage III and IV ulcers are described as “full thickness” ulcers. Stage IV ulcers involve full thickness skin loss with extensive destruction accompanied by tissue necrosis with damage to muscle, bone, tendon, or joint capsule. Stage III and IV (full thickness) pressure ulcers close through a process of granulation, contraction, and epithelialization. They can never be considered “fully healed” but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.
  - A closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage. Reverse staging of granulating Stage III and Stage IV pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. For example, if a pressure ulcer is Stage III at SOC and is granulating at the follow-up visit, the ulcer remains a Stage III ulcer.
  - A previously closed Stage III or Stage IV pressure ulcer **that is currently open again** should also be reported at its worst stage.
  - If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient’s physician) to determine the stage of the wound at its worst. An ulcer’s stage can worsen, and this item should be answered appropriately if this occurs.
- A muscle flap, skin advancement flap, or rotational flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply) performed to surgically replace a pressure ulcer is a surgical wound. It should not be reported as a pressure ulcer on M1308.
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) remains a pressure ulcer and should not be reported as a surgical wound on M1342. Until the graft edges completely heal, the grafted pressure ulcer should be reported on M1308 as d.1 (Unstageable) pressure ulcer. The number of pressure ulcers meeting these definitions should be counted to determine the response to d.1. Once the graft edges heal, the closed Stage III or Stage IV pressure ulcer would continue to be regarded as a pressure ulcer at its worst stage.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1342.
- Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (for example, patient report of discomfort, past history of skin breakdown in the same area), but that are Unstageable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath should be reported as d.1 (Unstageable).
- Response d.2 refers to pressure ulcers that the care provider suspects may be present based on clinical assessment findings, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures. The number of pressure ulcers meeting this definition should be counted to determine the response to d.2.
- Response d.3 refers to a suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure ulcers meeting this definition should be counted to determine the response to d.3. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

**DATA SOURCES / RESOURCES (cont'd for OASIS Item M1308)**

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Resources and links can be found in Chapter 5 of this manual.
- See Chapter 5 of this manual for NPUAP staging illustrations.



OASIS ITEM	
<b>(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:</b>	
<b>Instructions for a – c:</b> For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter “0” if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	—
b. Stage III	—
c. Stage IV	—
<b>Instructions for d:</b> For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter “0” if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	—
ITEM INTENT	
This item documents the number of pressure ulcers that are new or have “worsened” (increased in numerical stage) since the most recent Start or Resumption of Care assessment. Definitions of pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel (NPUAP).	
TIME POINTS ITEM(S) COMPLETED	
Discharge	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• Review the history of each current pressure ulcer. Specifically, compare the current stage of the pressure ulcer to the stage of that ulcer at the most recent SOC/ROC to determine whether the pressure ulcer currently present is new or worsened when compared to the presence or stage of that pressure ulcer at the most recent SOC/ROC.</li> <li>• For definitions of pressure ulcer stages, see M1308 and the NPUAP staging system.</li> <li>• For pressure ulcers that are currently Stage II, III or IV (rows a, b and c):                             <ul style="list-style-type: none"> <li>– Mark a response for each row of this item: a, b, and c. If there are NO ulcers at a given stage, enter “0” for that stage/row.</li> <li>– Report the number of current pressure ulcers at each stage that are new or have worsened since the most recent SOC/ROC assessment.</li> <li>– For pressure ulcers that are currently Stage II, III or IV, “worsening” refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of I-IV (the NPUAP staging system) at the time of discharge in comparison to the most recent SOC/ROC assessment.</li> </ul> </li> </ul>	






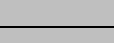

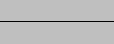


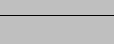
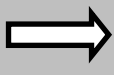
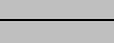

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1309)**

- For row a: Stage II. Enter the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage II, that were not present or were a Stage I at most recent SOC/ROC. Enter "0" if there are no current Stage II pressure ulcers or no Stage II pressure ulcers that have worsened since most recent SOC/ROC.
- For row b: Stage III. Enter the number of current pressure ulcers at discharge whose deepest anatomical stage is Stage III, that were not present or were a Stage I or II at the most recent SOC/ROC. Enter "0" if there are no current Stage III pressure ulcers or no Stage III pressure ulcers that have worsened since most recent SOC/ROC.
- For row c: Stage IV. Enter the number of current pressure ulcers at discharge whose deepest anatomical stage is Stage IV, that were not present or were at Stage I, II, or III at the most recent SOC/ROC. Enter "0" if there are no current Stage IV pressure ulcers or no Stage IV pressure ulcers that have worsened since most recent SOC/ROC.
- For pressure ulcers that are currently Unstageable due to coverage of wound bed by slough or eschar, row d:
  - Pressure ulcers that are Unstageable due to slough or eschar are those in which the wound bed is not visible due to some degree of necrotic tissue or scabbing that the clinician believes may be obscuring the visualization of bone, muscle, tendon or joint capsule (Stage IV structures). Note that if a Stage IV structure is visible, the pressure ulcer is not considered Unstageable – it is a Stage IV even if slough or eschar is present.
  - For pressure ulcers that are currently Unstageable due to slough or eschar, "worsening" refers to a pressure ulcer that was either not present or was a Stage I or II pressure ulcer at the most recent SOC/ROC and is now Unstageable due to slough or eschar. Pressure ulcers that are currently Unstageable due to presence of slough or eschar and were Stage III or IV at the most recent SOC/ROC are not considered worsened.
  - Enter "0" if
    - there are currently no pressure ulcers that are Unstageable due to slough or eschar.
    - all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC.
- See the following page for a reporting algorithm.
- Reverse staging of pressure ulcers is NOT an appropriate clinical practice according to NPUAP. A closed Stage III or Stage IV pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. A previously closed Stage III or Stage IV pressure ulcer that breaks down again should be staged at its worst stage.
- Pressure ulcers that were Unstageable for any reason at the most recent SOC/ROC cannot be reported as new or worsened.
- Pressure ulcers that are Unstageable at discharge due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath cannot be reported as new or worsened.
- Suspected deep tissue injuries in evolution that are present at SOC/ROC or discharge cannot be reported as new or worsened.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Resources and links can be found in Chapter 5 of this manual. A link to NPUAP staging illustrations can be found in Chapter 5.

<b>OASIS ITEM</b>
<b>Reporting algorithm for M1309</b>

CURRENT STAGE <i>at Discharge</i>	<i>Look back to most recent SOC/ROC</i>	PRIOR STAGE <i>at most recent SOC/ROC</i>		REPORT AS <i>NEW OR WORSENE</i> D?
a. Stage II <i>at discharge</i>	<i>If same pressure ulcer at most recent SOC/ROC was:</i>	<b>Not present</b>		<b>YES</b>
		Stage I		NO
		Stage II Stage III Stage IV		NA (reverse staging not allowed)
		Unstageable		NO
b. Stage III <i>at discharge</i>	<i>If same pressure ulcer at most recent SOC/ROC was:</i>	<b>Not present</b>		<b>YES</b>
		Stage I Stage II		<b>YES</b>
		Stage III		NO
		Stage IV		NA (reverse staging not allowed)
c. Stage IV <i>at discharge</i>	<i>If same pressure ulcer at most recent SOC/ROC was:</i>	<b>Not present</b>		<b>YES</b>
		Stage I Stage II Stage III		<b>YES</b>
		Stage IV Unstageable		NO
d. Unstageable due to slough or eschar <i>at discharge</i>	<i>If same pressure ulcer at most recent SOC/ROC was:</i>	<b>Not present</b>		<b>YES</b>
		Stage I Stage II		<b>YES</b>
		Stage III Stage IV Unstageable		NO

OASIS ITEM
<p><b>(M1320) Status of Most Problematic Pressure Ulcer that is Observable:</b> (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Newly epithelialized</li> <li><input type="checkbox"/> 1 - Fully granulating</li> <li><input type="checkbox"/> 2 - Early/partial granulation</li> <li><input type="checkbox"/> 3 - Not healing</li> <li><input type="checkbox"/> NA - No observable pressure ulcer</li> </ul>
ITEM INTENT
<p>Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage II or higher. Please note, Stage I pressure ulcers are not considered for this item.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Determine which pressure ulcer(s) are observable: <ul style="list-style-type: none"> <li>– Includes all Stage II or higher pressure ulcers that are not covered with a non-removable dressing or device, even if Unstageable</li> <li>– When determining the healing status of a pressure ulcer for answering M1320, the presence of necrotic tissue does NOT make the pressure ulcer “NA – No observable pressure ulcer.”</li> </ul> </li> <li>• Determine which observable pressure ulcer is most problematic: <ul style="list-style-type: none"> <li>– “Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.</li> <li>– If the patient has only one observable pressure ulcer, that ulcer is the most problematic.</li> </ul> </li> <li>• Utilize the WOCN guidance to determine status of the most problematic observable pressure ulcer: <ul style="list-style-type: none"> <li>– Response 0 – Newly Epithelialized: wound bed completely covered with new epithelium, no exudate, no avascular tissue (eschar and/or slough); no signs or symptoms of infection.</li> <li>– Response 1 – Fully Granulating: wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open</li> <li>– Response 2 – Early/Partial Granulation: wound with ≥25% of the wound bed covered with granulation tissue; &lt;25% of the wound bed covered with avascular tissue (eschar and/or slough); may have dead space; no signs or symptoms of infection; wound edges open.</li> <li>– Response 3 – Not Healing: wound with ≥25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.</li> </ul> </li> <li>• Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for a Stage II ulcer is 3 – Not Healing.</li> <li>• Since a suspected Deep Tissue Injury in evolution does not granulate and would not be covered with new epithelial tissue, the only appropriate response for a suspected Deep Tissue Injury is 3 – Not Healing.</li> <li>• A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 – Early/Partial Granulation if necrotic or avascular tissue covers &lt;25% of the wound bed, or Response 3 - Not Healing, if the wound has ≥25% necrotic or avascular tissue.</li> </ul>

<b>RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1320)</b>	
<ul style="list-style-type: none"><li>• Reference the WOCN document, “Guidance on OASIS-C1 Integumentary Items” and CMS OASIS Q&amp;As (links in Chapter 5) for complete guidance on selecting a response for M1320</li></ul>	
<b>DATA SOURCES / RESOURCES</b>	
<ul style="list-style-type: none"><li>• Observation</li><li>• Physical Assessment</li><li>• Referral documentation</li></ul>	<ul style="list-style-type: none"><li>• Review of health history</li><li>• Physician</li><li>• Additional resources for the WOCN and NPUAP can be found in Chapter 5 of this manual.</li></ul>

<b>OASIS ITEM</b>
<p><b>(M1322) Current Number of Stage I Pressure Ulcers:</b> Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.</p> <p><input type="checkbox"/> 0      <input type="checkbox"/> 1      <input type="checkbox"/> 2      <input type="checkbox"/> 3      <input type="checkbox"/> 4 or more</p>
<b>ITEM INTENT</b>
<p>Identifies the presence and number of Stage I pressure ulcers.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• NPUAP defines a Stage I pressure ulcer as follows: “Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.”</li> <li>• Further description: The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical Assessment</li> <li>• See Chapter 5 of this manual for more information regarding NPUAP staging illustrations.</li> </ul>

OASIS ITEM	
<p><b>(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable:</b> (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)</p> <p> <input type="checkbox"/> 1 - Stage I  <input type="checkbox"/> 2 - Stage II  <input type="checkbox"/> 3 - Stage III  <input type="checkbox"/> 4 - Stage IV  <input type="checkbox"/> NA - Patient has no pressure ulcers or no stageable pressure ulcers                 </p>	
ITEM INTENT	
<p>Identifies the stage of the most problematic stageable pressure ulcer. Definitions of pressure ulcer stages derived from the National Pressure Ulcer Advisory Panel.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of Care Resumption of Care Follow-up Discharge from agency - not to an inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• Determine which pressure ulcer(s) are stageable or Unstageable. A pressure ulcer is considered Unstageable if:                     <ul style="list-style-type: none"> <li>– it is covered with a non-removable dressing or device that cannot be removed such as a cast,</li> <li>– it is a suspected deep tissue injury in evolution, or</li> <li>– the wound bed is obscured by some degree of necrotic tissue or scabbing AND no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible. Note that if a Stage IV structure is visible, the pressure ulcer is reportable as a Stage IV even if slough or eschar is present.</li> </ul> </li> <li>• Determine which stageable pressure ulcer is the most problematic.                     <ul style="list-style-type: none"> <li>– “Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.</li> <li>– If the patient has only one stageable pressure ulcer, then that ulcer is the most problematic.</li> </ul> </li> <li>• Mark the response that most accurately describes the stage of the most problematic stageable pressure ulcer using the definitions of stage in M1308 that were derived from the National Pressure Ulcer Advisory Panel (NPUAP) staging system.                     <ul style="list-style-type: none"> <li>– Select “NA” if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.</li> <li>– Reverse staging of pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. If a pressure ulcer is Stage IV at SOC and is granulating at the follow-up visit, the ulcer remains a Stage IV ulcer. A closed Stage III or Stage IV pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. However, an unhealed active ulcer at a lower stage may be the most problematic ulcer. A previously closed Stage III or Stage IV pressure ulcer that breaks down again should be staged at its worst stage.</li> </ul> </li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral documentation</li> <li>• Review of health history</li> <li>• Physician</li> <li>• See Chapter 5 of this manual for links to published guidelines of NPUAP, NPUAP staging illustrations, and WOCN guidelines.</li> </ul>	

OASIS ITEM	
<p><b>(M1330)</b> Does this patient have a <b>Stasis Ulcer</b>?</p> <p><input type="checkbox"/> 0 - No [<i>Go to M1340</i>]</p> <p><input type="checkbox"/> 1 - Yes, patient has BOTH observable and unobservable stasis ulcers</p> <p><input type="checkbox"/> 2 - Yes, patient has observable stasis ulcers ONLY</p> <p><input type="checkbox"/> 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [<i>Go to M1340</i>]</p>	
ITEM INTENT	
<p>Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.</p> <p>Stasis ulcers DO NOT include arterial lesions or arterial ulcers.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency – not to inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• A response of “Yes” identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs).</li> <li>• It is important to differentiate stasis ulcers from other types of skin lesions, and only report stasis ulcers in this item.</li> <li>• Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.</li> <li>• Select Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a cast or dressing/device (for example, Unna boot) that cannot be removed. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.</li> <li>• Select Response 3 ONLY if the patient has a reported stasis ulcer that cannot be observed because of a cast or dressing/device (for example, Unna boot) that cannot be removed, and has no observable stasis ulcers. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician</li> <li>• Physician’s orders</li> <li>• Referral information</li> <li>• Review of health history</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• A link to the Clinical Fact Sheet – Quick Assessment of Leg Ulcers can be found in Chapter 5 of this manual.</li> </ul>	



<b>OASIS ITEM</b>
<p><b>(M1332) Current Number of Stasis Ulcer(s) that are Observable:</b></p> <p><input type="checkbox"/> 1 - One</p> <p><input type="checkbox"/> 2 - Two</p> <p><input type="checkbox"/> 3 - Three</p> <p><input type="checkbox"/> 4 - Four or more</p>
<b>ITEM INTENT</b>
<p>Identifies the number of visible (observable) stasis ulcers.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency – not to inpatient facility</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• All stasis ulcers except those that are covered by a non-removable dressing/device or cast are considered observable.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Observation</li> <li>• Physical Assessment</li> <li>• Review of health history</li> <li>• Physician</li> <li>• Referral information</li> </ul>

OASIS ITEM	
<p><b>(M1334) Status of Most Problematic Stasis Ulcer that is Observable:</b></p> <p><input type="checkbox"/> 1 - Fully granulating</p> <p><input type="checkbox"/> 2 - Early/partial granulation</p> <p><input type="checkbox"/> 3 - Not healing</p>	
ITEM INTENT	
<p>Identifies the degree of healing present in the most problematic, observable stasis ulcer. The “most problematic” ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency – not to inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• Determine which stasis ulcers are observable. Includes all stasis ulcers that are not covered with a non-removable dressing/device or cast</li> <li>• Determine which observable stasis ulcer is the most problematic.                             <ul style="list-style-type: none"> <li>– “Most problematic” may be based on healing status, size, difficulty in accessing for treatment, etc., depending on the specific situation.</li> <li>– If the patient has only one observable stasis ulcer, that ulcer is the most problematic.</li> </ul> </li> <li>• Utilize the WOCN guidance to determine status of the most problematic observable stasis ulcer:                             <ul style="list-style-type: none"> <li>– Response 1 – Fully Granulating: Mark 1 when a stasis ulcer has a wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open</li> <li>– Response 2 – Early/Partial Granulation: Mark 2 when ≥ 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, &lt;25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.</li> <li>– Response 3 – Not Healing: Mark 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.</li> </ul> </li> <li>• Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Observation</li> <li>• Physical Assessment</li> <li>• Review of health history</li> <li>• To determine healing status of the stasis ulcer, further resource links can be found in Chapter 5 of this manual.</li> </ul>	

OASIS ITEM
<p><b>(M1340)</b> Does this patient have a <b>Surgical Wound</b>?</p> <p><input type="checkbox"/> 0 - No [<i>At SOC/ROC, go to M1350; At FU//DC, go to M1400</i>]</p> <p><input type="checkbox"/> 1 - Yes, patient has at least one observable surgical wound</p> <p><input type="checkbox"/> 2 - Surgical wound known but not observable due to non-removable dressing/device [<i>At SOC/ROC, go to M1350; At FU/DC, go to M1400</i>]</p>
ITEM INTENT
Identifies the presence of a wound resulting from a surgical procedure.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.</li> <li>• If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one observable surgical wound.</li> <li>• Select Response 2 if the only surgical wound(s) is/are not observable. A wound is considered not observable if it is covered by a dressing/device (such as a cast) which is not to be removed <b>per physician order</b>.</li> <li>• For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item.</li> <li>• A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound.</li> <li>• A muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.</li> <li>• Debridement or the placement of a skin graft does not create a surgical wound, as these are treatments performed to an existing wound. The wound would continue to be defined as the type of wound previously identified.</li> <li>• A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound. A bowel ostomy being allowed to close on its own is excluded as a surgical wound.</li> <li>• All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. Examples include cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc. These may be reported in M1350 if the home health agency is providing intervention specific to the ostomy.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1340)**

- Orthopedic pin sites, central line sites (centrally-inserted venous catheters), stapled or sutured incisions, and wounds with drains are all considered surgical wounds. Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.
- A PICC line (peripherally-inserted venous catheter), either tunneled or non-tunneled, is NOT a surgical wound, as it is peripherally inserted.
- Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for the purpose of this item.
- For additional guidance on questions related to surgical wounds, please see Q&As for M1340.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.
- See Chapter 5 of this manual for resource links.

OASIS ITEM
<p><b>(M1342) Status of Most Problematic Surgical Wound that is Observable</b></p> <p><input type="checkbox"/> 0 - Newly epithelialized</p> <p><input type="checkbox"/> 1 - Fully granulating</p> <p><input type="checkbox"/> 2 - Early/partial granulation</p> <p><input type="checkbox"/> 3 - Not healing</p>
ITEM INTENT
Identifies the degree of healing present in the most problematic, observable surgical wound.
TIME POINTS ITEM(S) COMPLETED
Start of Care Resumption of Care Follow-up Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Determine which surgical wounds are observable               <ul style="list-style-type: none"> <li>- Includes all surgical wounds (as defined in M1340 guidance) that are not covered with a non-removable dressing/device or cast</li> <li>- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and no longer a surgical wound.</li> </ul> </li> <li>• Identify the most problematic observable surgical wound.               <ul style="list-style-type: none"> <li>- The “most problematic” surgical wound may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on the specific situation.</li> <li>- If the patient has only one observable surgical wound, that wound is the most problematic.</li> </ul> </li> <li>• Determine status of the most problematic surgical wound using WOCN guidance:               <ul style="list-style-type: none"> <li>- The clinician must first assess if the wound is healing entirely by primary intention (well-approximated with no dehiscence), or if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing).</li> <li>- Surgical wounds healing by <b>primary intention</b> (approximated incisions) do not granulate, therefore the only appropriate responses would be Response 0 - Newly epithelialized or Response 3 - Not healing. If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. Epithelialization is regeneration of the epidermis across a wound surface. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.) If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing exclusively by primary intention.</li> </ul> </li> </ul>

<b>RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1342)</b>		
<ul style="list-style-type: none"> <li>- <b>Secondary Intention:</b> If it is determined that there is incisional separation, healing will be by secondary intention. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."</li> <li>- Response 0 – Newly epithelialized: Select 0 when the wound bed has completely covered with new epithelium; no exudate; no avascular tissue (eschar and/or slough); no signs or symptoms or infection. Epithelialization is characterized by "Epidermal resurfacing" and means the opening created during the surgery is covered by epithelial cells. If epidermal resurfacing has occurred completely, the correct response in the OASIS would be "Newly epithelialized" until 30 days have passed without complication, at which time it is no longer a reportable surgical wound.</li> <li>- Select Response 0 – Newly epithelialized for implanted venous access devices and infusion devices when the insertion site is healed and without signs and symptoms of infection.</li> <li>- Response 1 – Fully Granulating: Select 1 when a surgical wound has a wound bed filled with granulation tissue to the level of the surrounding skin; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open</li> <li>- Response 2 – Early/Partial Granulation: Select 2 when <math>\geq 25\%</math> of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <math>&lt; 25\%</math> of the wound bed is covered with avascular tissue); no signs or symptoms of infection; wound edges open.</li> <li>- Response 3 – Not Healing: Select 3 when wound has <math>\geq 25\%</math> avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.</li> </ul>		
<b>DATA SOURCES / RESOURCES</b>		
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Referral documentation</li> <li>• Review of health history</li> <li>• Physician</li> <li>• CMS OASIS Q&amp;As can be accessed through the CMS OASIS web page.</li> </ul>	<ul style="list-style-type: none"> <li>• Links to the Wound, Ostomy, and Continence Nurses' guidelines are provided in Chapter 5 of this manual.</li> </ul>

OASIS ITEM	
<p><b>(M1350)</b> Does this patient have a <b>Skin Lesion</b> or <b>Open Wound</b> (excluding bowel ostomy), other than those described above, <u>that is receiving intervention</u> by the home health agency?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p>	
ITEM INTENT	
Identifies the presence or absence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.	
TIME POINTS ITEM(S) COMPLETED	
Start of care Resumption of care	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• A lesion is a broad term used to describe an area of pathologically altered tissue. All alterations in skin integrity are considered to be lesions. Examples of lesions include but are not limited to sores, skin tears, burns, ulcers, rashes, edema, and persistent redness without a break in the skin.</li> <li>• Certain open wounds/lesions are not included in this item. These include:               <ul style="list-style-type: none"> <li>- bowel ostomies (which are reported in OASIS item M1630)</li> <li>- wounds resulting from cataract surgery, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach</li> <li>- tattoos, piercings, and other skin alterations unless ongoing assessment and/or clinical intervention by the home health agency is a part of the planned/provided care</li> <li>- any other skin lesions or open wounds that are <u>not</u> receiving clinical intervention from the home health agency. "Receiving clinical assessment or intervention from the home health agency" means the lesion is being clinically assessed on an ongoing basis as indicated on the home health agency's Plan of Care (for example, wound measurements for a traumatic laceration)</li> </ul> </li> <li>• Response 0 – "No" should be selected if:               <ul style="list-style-type: none"> <li>- the patient does not have any open wounds/skin lesions (as defined above), or</li> <li>- all of the patient's open wounds/skin lesions are pressure ulcers, stasis ulcers and/or surgical wounds, which are addressed in other OASIS-C1 Integumentary Items.</li> <li>- the patient's open wounds/skin lesions are <u>not</u> receiving clinical intervention from the home health agency (as defined above)</li> </ul> </li> <li>• Response 1 – "Yes" should be selected for all types of other open wounds/skin lesions that are part of the agency's planned/provided care but are NOT addressed in other OASIS-C1 Integumentary Items. Examples include but are not limited to:               <ul style="list-style-type: none"> <li>- burns, diabetic ulcers, cellulitis, abscesses, edema, wounds caused by trauma of various kinds</li> <li>- PICC line and peripheral IV sites</li> <li>- non-bowel ostomies (for example, tracheostomies, thoracostomies, urostomies, jejunostomies, gastrostomies) if clinical interventions (for example, cleansing, dressing changes, assessment) are being provided by the home health agency during the care episode</li> </ul> </li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Referral documentation</li> <li>• Review of health history</li> <li>• Physician</li> </ul>

OASIS ITEM
<p><b>(M1400)</b> When is the patient dyspneic or noticeably <b>Short of Breath</b>?</p> <p><input type="checkbox"/> 0 - Patient is not short of breath</p> <p><input type="checkbox"/> 1 - When walking more than 20 feet, climbing stairs</p> <p><input type="checkbox"/> 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)</p> <p><input type="checkbox"/> 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation</p> <p><input type="checkbox"/> 4 - At rest (during day or night)</p>
ITEM INTENT
Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• If the patient uses oxygen continuously, select the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, mark the response based on the patient's shortness of breath WITHOUT the use of oxygen.               <ul style="list-style-type: none"> <li>– The response is based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.</li> </ul> </li> <li>• The responses represent increasing severity of shortness of breath.</li> <li>• For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. Response 0 would apply if the patient has not been short of breath during the day of assessment. Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient). See Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Observation</li> <li>• Physical assessment</li> <li>• Patient/caregiver interview</li> <li>• Review of health history</li> </ul>



<b>OASIS ITEM</b>
<p><b>(M1410)</b> Respiratory Treatments utilized at home: <b>(Mark all that apply.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 - Oxygen (intermittent or continuous)</li> <li><input type="checkbox"/> 2 - Ventilator (continually or at night)</li> <li><input type="checkbox"/> 3 - Continuous / Bi-level positive airway pressure</li> <li><input type="checkbox"/> 4 - None of the above</li> </ul>
<b>ITEM INTENT</b>
Identifies any of the listed respiratory treatments being used by this patient in the home.
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Start of care</p> <p>Resumption of care</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Excludes any respiratory treatments that are not listed in the item (for example, does not include nebulizers, inhalers).</li> <li>• Response 3 reflects both CPAP and BiPAP.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physician's orders</li> <li>• Referral information</li> <li>• Review of health history</li> </ul>

OASIS ITEM
<p><b>(M1500) Symptoms in Heart Failure Patients:</b> If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?</p> <p><input type="checkbox"/> 0 - No [<i>Go to M2004 at TRN; Go to M1600 at DC</i>]</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> 2 - Not assessed [<i>Go to M2004 at TRN; Go to M1600 at DC</i>]</p> <p><input type="checkbox"/> NA - Patient does not have diagnosis of heart failure [<i>Go to M2004 at TRN; Go to M1600 at DC</i>]</p>
ITEM INTENT
<p>Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of or at any time since the previous OASIS assessment.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to inpatient facility</p> <p>Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select Response options 0, 1, or 2 if the patient has a diagnosis of heart failure, regardless of whether the diagnosis is documented elsewhere in the OASIS assessment.</li> <li>• Select “NA” if the patient does not have a diagnosis of heart failure.</li> <li>• If the patient has a diagnosis of heart failure, select Response 1 – Yes, to report symptoms associated with heart failure even if there are other co-morbidities that also could produce the symptom (for example, dyspnea in a patient with pneumonia and heart failure).</li> <li>• Consider any new or ongoing heart failure symptoms that occurred at the time of or at any time since the previous OASIS assessment</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Review of clinical record including physical assessment data, weight trends, and clinical notes using HHA systems put into place to accomplish such a review (for example, flow sheets, reports from electronic health record data) at the time of, or at any time since, the previous OASIS assessment.</li> <li>• A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M1510) Heart Failure Follow-up:</b> If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the previous OASIS assessment, what action(s) has (have) been taken to respond? <b>(Mark all that apply.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - No action taken</li> <li><input type="checkbox"/> 1 - Patient's physician (or other primary care practitioner) contacted the same day</li> <li><input type="checkbox"/> 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)</li> <li><input type="checkbox"/> 3 - Implemented physician-ordered patient-specific established parameters for treatment</li> <li><input type="checkbox"/> 4 - Patient education or other clinical interventions</li> <li><input type="checkbox"/> 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)</li> </ul>
ITEM INTENT
<p>Identifies actions the home health care providers took in response to symptoms of heart failure that occurred at the time of or at any time since the previous OASIS assessment. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to an inpatient facility Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Include any actions that were taken <b>in response to Heart Failure symptoms</b> at least one time at the time of or at any time since the previous OASIS assessment.</li> <li>• If the interventions are not completed as outlined in this item, select Response 0 – No action taken. However, in this case, the care provider should document rationale in the clinical record.</li> <li>• If Response 0 is selected, none of the other responses should be selected.</li> <li>• Response 1 includes communication to the physician or primary care practitioner made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the <i>same day</i>. Same day means by the end of <i>this</i> calendar day. In many situations, other responses also will be marked that indicate the action taken as a result of the contact (that is, any of Responses 2-5).</li> <li>• Response 2 should be selected when the patient exhibits symptoms of heart failure that require immediate attention in an emergency room and is advised to do so by agency staff. It is not selected when a patient is educated to go to the ER or call 911 based on pre-established parameters.</li> <li>• Response 3 would be the best response for a situation in which either the home care clinician reminds the patient to implement or is aware that the patient is following physician-established parameters for treatment.</li> <li>• Response 4 includes "Patient education," referring to the effective sharing of pertinent heart failure-related information to increase patient knowledge, skill, and responsibility. Simply providing a patient with printed materials regarding heart failure without assessment of their understanding of the content should not be considered patient education.</li> <li>• Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms can be reported.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Review of clinical record at the time of or at any time since the previous OASIS assessment.</li> <li>• Physician-ordered home health Plan of Care.</li> <li>• Examples of standard clinical guidelines can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M1600)</b> Has this patient been treated for a <b>Urinary Tract Infection</b> in the past 14 days?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p> <p><input type="checkbox"/> NA - Patient on prophylactic treatment</p> <p><input type="checkbox"/> UK - Unknown <i>[Omit "UK" option on DC]</i></p>
ITEM INTENT
Identifies treatment of urinary tract infection during the past 14 days.
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• The term “past 14 days” is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any treatment for a UTI occurring on or after August 6 would be considered.</li> <li>• Unknown is not an option at discharge from agency.</li> <li>• Select Response 0 – No, if patient has not been treated for a UTI within the past two weeks, including if the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago.</li> <li>• Select Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.</li> <li>• Select Response 1 – Yes, if the patient is on prophylactic treatment <u>and</u> develops a UTI.</li> <li>• Select Response “NA” – if the patient is on prophylactic treatment to prevent UTIs.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician orders</li> <li>• Review of health history</li> <li>• Referral information</li> <li>• Physician</li> <li>• Medication list</li> </ul>

OASIS ITEM
<p><b>(M1610)</b> Urinary Incontinence or <b>Urinary Catheter Presence:</b></p> <p><input type="checkbox"/> 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) <b>[Go to M1620]</b></p> <p><input type="checkbox"/> 1 - Patient is incontinent</p> <p><input type="checkbox"/> 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) <b>[Go to M1620]</b></p>
ITEM INTENT
Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select Response 0 if the patient has anuria or an ostomy for urinary drainage (for example, an ileal conduit), or if the patient has a urinary diversion that is pouched (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma</li> <li>• Select Response 1 if the patient is incontinent at any time (including “occasionally,” “only when I sneeze,” “sometimes I leak a little bit,” etc.).</li> <li>• Select Response 1 if the patient is incontinent or is dependent on a timed-voiding program. Timed voiding is defined as scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Time voiding is a compensatory strategy; it does not cure incontinence.</li> <li>• Select Response 2 if a catheter or tube is utilized for drainage (even if catheterizations are intermittent).</li> <li>• Select Response 2 if the patient requires the use of a catheter for urinary drainage for any reason (for example, retention, post-surgery, incontinence). Select Response 2 and follow the skip pattern if the patient is <u>both</u> incontinent and requires a urinary catheter.</li> <li>• Select Response 2 if a catheter was inserted during the comprehensive assessment.</li> <li>• A leaking urinary drainage appliance is not incontinence.</li> <li>• A catheter solely utilized for irrigation of the bladder or installation with an antibiotic is not reported in this item.</li> <li>• If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent.</li> <li>• Assessment strategies: Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.</li> </ul>

<b>DATA SOURCES / RESOURCES (cont'd for OASIS Item M1610)</b>
<ul style="list-style-type: none"><li>• Patient/caregiver interview</li><li>• Observation</li><li>• Physical assessment</li><li>• Physician orders</li><li>• Review of health history</li><li>• Referral information</li></ul>

OASIS ITEM
<p><b>(M1615) When does Urinary Incontinence occur?</b></p> <p><input type="checkbox"/> 0 - Timed-voiding defers incontinence</p> <p><input type="checkbox"/> 1 - Occasional stress incontinence</p> <p><input type="checkbox"/> 2 - During the night only</p> <p><input type="checkbox"/> 3 - During the day only</p> <p><input type="checkbox"/> 4 - During the day and night</p>
ITEM INTENT
Identifies when the urinary incontinence occurs.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select Response 0 if timed-voiding defers incontinence. Timed voiding determines the patient's pattern for voiding and schedules toileting to prevent episodes of leaking. The patient can self-schedule toileting or the caregiver can prompt or bring the patient to the toilet. Timed voiding is a compensatory strategy; it does not cure incontinence. If timed voiding does not defer incontinence, do not select Response 0.</li> <li>• Select Response 1 – Occasional stress incontinence - when the patient is unable to prevent escape of relatively small amounts of urine when coughing, sneezing, laughing, lifting, moving from sitting to standing position, or other activities (stress), which increase abdominal pressure.</li> <li>• If urinary incontinence happens with regularity or in other circumstances than those described in the definition of stress incontinence, determine when the incontinence usually occurs and select Response 2, 3, or 4 as appropriate.</li> <li>• Select Response 2 – During the night only – when the patient's incontinence occurs while the patient is sleeping at night.</li> <li>• Select Response 3 – During the day only – when the patient's incontinence occurs while the patient is up/awake during the day. Includes incontinence during daytime naps.</li> <li>• Select Response 4 – During the day and night – when the patient is incontinent when sleeping at night and up/awake during the day.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Review of health history</li> <li>• Referral information</li> </ul>

OASIS ITEM
<p><b>(M1620) Bowel Incontinence Frequency:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Very rarely or never has bowel incontinence</li> <li><input type="checkbox"/> 1 - Less than once weekly</li> <li><input type="checkbox"/> 2 - One to three times weekly</li> <li><input type="checkbox"/> 3 - Four to six times weekly</li> <li><input type="checkbox"/> 4 - On a daily basis</li> <li><input type="checkbox"/> 5 - More often than once daily</li> <li><input type="checkbox"/> NA - Patient has ostomy for bowel elimination</li> <li><input type="checkbox"/> UK - Unknown <i>[Omit "UK" option on FU, DC]</i></li> </ul>
ITEM INTENT
<p>Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does <u>not</u> address treatment of incontinence or constipation (for example, a bowel program).</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Responses are arranged in order of least to most frequency of bowel incontinence.</li> <li>• Response 4 – On a daily basis – indicates that the patient experiences bowel incontinence once per day.</li> <li>• Response “NA” is used if patient has an ostomy for bowel elimination.</li> <li>• Unknown is not an option at follow-up or discharge.</li> <li>• Assessment strategies: Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient’s responses to these items may make you aware of an as yet unidentified problem that needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Review of health history</li> <li>• Referral information</li> </ul>



OASIS ITEM
<p><b>(M1630) Ostomy for Bowel Elimination:</b> Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?</p> <p><input type="checkbox"/> 0 - Patient does <u>not</u> have an ostomy for bowel elimination.</p> <p><input type="checkbox"/> 1 - Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen.</p> <p><input type="checkbox"/> 2 - The ostomy was <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.</p>
ITEM INTENT
Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or caused a change in medical treatment plan.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Follow-up
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Applies to any type of ostomy for bowel elimination (for example, colostomy, ileostomy). This item only addresses bowel ostomies, not other types of ostomies (for example, urinary ostomies, tracheostomies).</li> <li>• If an ostomy has been reversed, then the patient does <u>not</u> have an ostomy at the time of assessment.</li> <li>• If patient does not have an ostomy for bowel elimination, select Response 0 – Patient does <u>not</u> have an ostomy for bowel elimination.</li> <li>• If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or necessitated a change in the medical or treatment regimen within the last 14 days.</li> <li>• The term “last 14 days” is the two-week period immediately preceding the start/resumption of care or follow-up assessment. This means that for purposes of counting the 14-day period, the date of admission/assessment is day 0 and the day immediately prior to the date of admission/assessment is day 1. For example, if the patient’s SOC date is August 20, any ostomy related to an inpatient stay or requiring medical or treatment regimen change that occurred on or after August 6 would be considered.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Physician orders</li> <li>• Review of health history</li> <li>• Referral information</li> <li>• Physician</li> <li>• Supplies list</li> </ul>

OASIS ITEM
<p><b>(M1700) Cognitive Functioning:</b> Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</li> <li><input type="checkbox"/> 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.</li> <li><input type="checkbox"/> 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.</li> <li><input type="checkbox"/> 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.</li> <li><input type="checkbox"/> 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</li> </ul>
ITEM INTENT
Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Discharge from agency - not to inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Responses progress from no impairment to severely impaired. Consider the degree of impairment.</li> <li>• Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.</li> <li>• Consider the amount of supervision and care the patient has required due to cognitive deficits.</li> <li>• Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., <u>will</u> have various degrees of cognitive dysfunction.</li> <li>• Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy <u>may</u> have cognitive deficits.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Links to cognitive assessment tools can be found in Chapter 5 of this manual.</li> <li>• Review of past health history</li> <li>• Physician</li> </ul>

OASIS ITEM	
<b>(M1710) When Confused (Reported or Observed Within the Last 14 Days):</b>	
<input type="checkbox"/> 0 - Never <input type="checkbox"/> 1 - In new or complex situations only <input type="checkbox"/> 2 - On awakening or at night only <input type="checkbox"/> 3 - During the day and evening, but not constantly <input type="checkbox"/> 4 - Constantly <input type="checkbox"/> NA - Patient nonresponsive	
ITEM INTENT	
Identifies the time of day or situations when the patient experienced confusion, if at all.	
TIME POINTS ITEM(S) COMPLETED	
Start of care Resumption of care Discharge from agency - not to inpatient facility	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>This item may not relate directly to Item M1700. Assess specifically for confusion in the last 14 days.</li> <li>The term “last 14 days” is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any confusion occurring on or after August 6 would be considered.</li> <li>Select Response 0 if the patient had no confusion in the last 14 days. Responses 1-4 are selected if the patient has experienced confusion and each response represents a worsening of confusion frequency. Response 1 is selected when the patient’s confusion is isolated to a new or a complex situation; for example, the patient became confused when a new caregiver was introduced or when a procedure was performed the first time. Responses 2, 3, &amp; 4 are selected when confusion occurs without the stimulus of a new or complex situation, or when confusion that initially presented with a new or complex situation persists days after the new or complex situation becomes more routine. Responses 2, 3 &amp; 4 differ from each other based on the time when the confusion occurred. Response 2 is selected if the confusion only occurred when the patient was awakening from a sleep or during the night. Response 3 is selected if the confusion occurs during the day and evening, but is not constant. If confusion was not constant, but occurred more often than just upon awakening or at night, select Response 3.</li> <li>“Nonresponsive” means that the patient is unable to respond or the patient responds in a way that you cannot make a clinical judgment about the patient’s level of orientation. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any confusion during the last 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, select “NA – Patient nonresponsive.”</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>Patient/caregiver interview</li> <li>Observation</li> <li>Physical assessment</li> <li>Review of recent (last 14 days) health history</li> <li>Physician</li> <li>Links to a resource for patients with Alzheimer’s disease or dementia can be found in Chapter 5 of this manual.</li> </ul>	

<b>OASIS ITEM</b>
<p><b>(M1720) When Anxious (Reported or Observed Within the Last 14 Days):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - None of the time</li> <li><input type="checkbox"/> 1 - Less often than daily</li> <li><input type="checkbox"/> 2 - Daily, but not constantly</li> <li><input type="checkbox"/> 3 - All of the time</li> <li><input type="checkbox"/> NA - Patient nonresponsive</li> </ul>
<b>ITEM INTENT</b>
<p>Identifies the frequency with which the patient has felt anxious within the last 14 days.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Start of care                      Resumption of care                      Discharge from agency - not to inpatient facility</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• Anxiety includes:                             <ul style="list-style-type: none"> <li>- Worry that interferes with learning and normal activities,</li> <li>- Feelings of being overwhelmed and having difficulty coping, or</li> <li>- Symptoms of anxiety disorders.</li> </ul> </li> <li>• Responses appear in order of increasing frequency of anxiety.</li> <li>• “Nonresponsive” means that the patient is unable to respond or the patient responds in a way that you can’t make a clinical judgment about the patient’s level of anxiety. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any anxiety during the last 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, select “NA – Patient nonresponsive.”</li> <li>• The term “last 14 days” is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient’s SOC date is August 20, any anxiety occurring on or after August 6 would be considered.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral information</li> <li>• Review of recent (last 14 days) health history</li> <li>• Physician</li> <li>• Links to standardized anxiety screening tools can be found in Chapter 5 of this manual.</li> </ul>

<b>OASIS ITEM</b>					
<p><b>(M1730) Depression Screening:</b> Has the patient been screened for depression, using a standardized, validated depression screening tool?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes, patient was screened using the PHQ-2©* scale.</p>					
<p>Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"</p>					
<b>PHQ-2©*</b>	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
<p><input type="checkbox"/> 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.</p> <p><input type="checkbox"/> 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.</p>					
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<b>ITEM INTENT</b>
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Identifies if the home health agency screened the patient for depression using a standardized, validated depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized, validated tool. This item is used to calculate process measures to capture the agency’s use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

<b>TIME POINTS ITEM(S) COMPLETED</b>
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Start of care  
Resumption of care

<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
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- Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others as allowed by the standardized, validated tool’s administration instructions.
- To meet the definition of “standardized, validated,” the depression screening tool must 1) have been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.) and 2) include a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and communication deficits and appropriately administered per the tool’s instructions.
- If a standardized, validated depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression.
  - In order to select Responses 1, 2 or 3, the standardized, validated depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment (specifically, within five days of SOC or within two days of discharge from the inpatient facility at ROC).

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1730)**

- Select Response 0 if a standardized, validated depression screening was not conducted.
  - If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be selected.
- Select Response 1 if the PHQ-2© is completed, and mark the appropriate responses in rows a and b. Please note that the PHQ-2© instructions indicate that the patient is interviewed, not family or others. If the patient scores three points or more on the PHQ-2©, then further depression screening is indicated.
  - If the PHQ-2© is not used to assess the patient, you may choose to administer a different standardized, validated depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment.
- Select Response 2 if the patient is screened with a different standardized, validated assessment AND the tool indicated the need for further evaluation.
- Select Response 3 if the patient is screened with a different standardized, validated assessment BUT the tool indicates no need for further evaluation.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- A link with more information on the PHQ–2© can be found in Chapter 5 of this manual.
- There are many depression screening tools available. Links to several tools can be found in Chapter 5 of this manual.

OASIS ITEM
<p><b>(M1740) Cognitive, behavioral, and psychiatric symptoms</b> that are demonstrated <u>at least once a week</u> (Reported or Observed): (Mark all that apply.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required</li> <li><input type="checkbox"/> 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions</li> <li><input type="checkbox"/> 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.</li> <li><input type="checkbox"/> 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)</li> <li><input type="checkbox"/> 5 - Disruptive, infantile, or socially inappropriate behavior (<b>excludes</b> verbal actions)</li> <li><input type="checkbox"/> 6 - Delusional, hallucinatory, or paranoid behavior</li> <li><input type="checkbox"/> 7 - None of the above behaviors demonstrated</li> </ul>
ITEM INTENT
<p>Identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Behaviors may be observed by the clinician or reported by the patient, family, or others.</li> <li>• Include behaviors which are severe enough to:                         <ul style="list-style-type: none"> <li>- make the patient unsafe to self or others,</li> <li>- cause considerable stress to the caregivers, or</li> <li>- require supervision or intervention.</li> </ul> </li> <li>• If Response 7 is selected, none of the other responses should be selected.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Physical assessment</li> <li>• Referral information</li> <li>• Physician</li> <li>• Links to standardized cognitive screening tools can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed):</b> Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.</p> <p> <input type="checkbox"/> 0 - Never  <input type="checkbox"/> 1 - Less than once a month  <input type="checkbox"/> 2 - Once a month  <input type="checkbox"/> 3 - Several times each month  <input type="checkbox"/> 4 - Several times a week  <input type="checkbox"/> 5 - At least daily </p>
ITEM INTENT
Identifies frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur.</li> <li>Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver.</li> <li>Behaviors can be observed by the clinician or reported by the patient, family, or others.</li> <li>Examples of disruptive/dangerous behaviors include sleeplessness, “sun-downing,” agitation, wandering, aggression, combativeness, getting lost in familiar places, etc.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>Patient/caregiver interview</li> <li>Observation</li> <li>Physical assessment</li> <li>Referral information</li> <li>Review of past health history</li> <li>Physician</li> <li>Links to additional information sources can be found in Chapter 5 of this manual.</li> </ul>



<b>OASIS ITEM</b>
<p><b>(M1750)</b> Is this patient receiving <b>Psychiatric Nursing Services</b> at home provided by a qualified psychiatric nurse?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p>
<b>ITEM INTENT</b>
<p>Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation, certification, or experience.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Start of care</p> <p>Resumption of care</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Observation</li> <li>• Referral information</li> <li>• Physician orders/Plan of Care</li> <li>• Clinical record</li> <li>• HHAs may elect to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefit Policy Manual for additional information</li> </ul>

OASIS ITEM	
<p><b>(M1800) Grooming:</b> 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).</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.</li> <li><input type="checkbox"/> 1 - Grooming utensils must be placed within reach before able to complete grooming activities.</li> <li><input type="checkbox"/> 2 - Someone must assist the patient to groom self.</li> <li><input type="checkbox"/> 3 - Patient depends entirely upon someone else for grooming needs.</li> </ul>	
ITEM INTENT	
<p>Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments, (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, accessing grooming aids, mirror and sink).</li> </ul>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of care Resumption of care Discharge from agency – not to an inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The grooming scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is currently able to do.</li> <li>• Grooming includes several activities. The frequency with which selected activities are performed (such as washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.</li> <li>• In cases where a patient's ability is different for various grooming tasks, select the response that best describes the patient's level of ability to perform the majority of grooming tasks.</li> <li>• Response 2 includes standby assistance or verbal cueing.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Observation/demonstration is the preferred method</li> <li>• Patient/caregiver interview</li> </ul>	<ul style="list-style-type: none"> <li>• Physical assessment</li> <li>• Environmental assessment</li> </ul>

OASIS ITEM
<p><b>(M1810)</b> Current <b>Ability to Dress Upper Body</b> safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.</li> <li><input type="checkbox"/> 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.</li> <li><input type="checkbox"/> 2 - Someone must help the patient put on upper body clothing.</li> <li><input type="checkbox"/> 3 - Patient depends entirely upon another person to dress the upper body.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn. The intent of the item is to identify the patient's <b>ABILITY</b>, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely dress the upper body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, location where dressing items are stored)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• 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.</li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The ability to dress upper body scale presents the most independent level first then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• In cases where a patient's ability is different for various upper body dressing tasks, pick the response that best describes the patient's level of ability to perform the majority of upper body dressing tasks.</li> <li>• If the patient requires standby assistance (a "spotter") to dress <u>safely</u> or requires verbal cueing/reminders, select Response 2.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1810)**

- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- 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 difficulty dressing upper body. Observe the patient's general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient also can be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

**DATA SOURCES / RESOURCES**

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM
<p><b>(M1820)</b> Current <b>Ability to Dress Lower Body</b> safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to obtain, put on, and remove clothing and shoes without assistance.</li> <li><input type="checkbox"/> 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.</li> <li><input type="checkbox"/> 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.</li> <li><input type="checkbox"/> 3 - Patient depends entirely upon another person to dress lower body.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to dress lower body, including the ability to obtain, put on, and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely dress the lower body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, location where dressing items are stored)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Prosthetic, orthotic, or other support devices applied to the lower body (for example, lower extremity prosthesis, ankle-foot orthosis [AFO], or TED hose) should be considered as lower body dressing items/tasks.</li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The ability to dress lower body scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• In cases where a patient's ability is different for various dressing lower body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing lower body tasks.</li> <li>• If the patient requires standby assistance (a "spotter") to dress <u>safely</u> or verbal cueing/reminders, select Response 2.</li> <li>• If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1820)**

- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

**DATA SOURCES / RESOURCES**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM
<p><b>(M1830) Bathing:</b> Current ability to wash entire body safely. <b><u>Excludes grooming (washing face, washing hands, and shampooing hair).</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.</li> <li><input type="checkbox"/> 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.</li> <li><input type="checkbox"/> 2 - Able to bathe in shower or tub with the intermittent assistance of another person: <ul style="list-style-type: none"> <li>(a) for intermittent supervision or encouragement or reminders, <u>OR</u></li> <li>(b) to get in and out of the shower or tub, <u>OR</u></li> <li>(c) for washing difficult to reach areas.</li> </ul> </li> <li><input type="checkbox"/> 3 - Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.</li> <li><input type="checkbox"/> 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> 6 - Unable to participate effectively in bathing and is bathed totally by another person.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to bathe entire body and the assistance that may be required to <u>safely</u> bathe, including transferring in/out of the tub/shower. The intent of the item is to identify the patient's <b>ABILITY</b>, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely bathe, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, location of tub/shower, wash basin/sink)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Specifically excludes washing face and hands, and shampooing hair.</li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The bathing scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1830)**

- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then select Response 2 or Response 3, depending on whether the assistance needed is intermittent (“2”) or continuous (“3”).
- If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, select Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response.
- The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have.
- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.
  - For Response 4, the patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water at the sink, or setting up a basin at the bedside, etc.
  - Select Response 5 if the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair, or on a commode.
- Select Response 6 if the patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs or if patient has a functioning tub or shower.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance in determining if the patient has been able to bathe self independently and safely. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower with assistance and/or a device. Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.

**DATA SOURCES / RESOURCES**

- Observation/demonstration is the preferred method.
- Patient/caregiver interview
- Physical assessment
- Environmental assessment



OASIS ITEM
<p><b>(M1840) Toilet Transferring:</b> Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to get to and from the toilet and transfer independently with or without a device.</li> <li><input type="checkbox"/> 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.</li> <li><input type="checkbox"/> 2 - <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).</li> <li><input type="checkbox"/> 3 - <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.</li> <li><input type="checkbox"/> 4 - Is totally dependent in toileting.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to <u>safely</u> get to and from and transfer on and off the toilet or bedside commode. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform toilet transferring, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, location of toilet or bedside commode)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Excludes personal hygiene and management of clothing when toileting.</li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The toilet transferring scale presents the most optimal level first, then proceeds to less optimal toileting methods. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• If the patient can get to and from the toilet during the day independently, but uses the commode at night for convenience, select Response 0.</li> <li>• If the patient requires standby assistance to get to and from the toilet <u>safely</u> or requires verbal cueing/reminders, select Response 1.</li> <li>• If the patient needs assistance getting to/from the toilet or with toileting transfer or both, then Response 1 is the best option.</li> <li>• If the patient can independently get to the toilet, but requires assistance to get on and off the toilet, select Response 1.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1840)**

- A patient who is unable to get to/from the toilet or bedside commode, but is able to place and remove a bedpan/urinal independently, should be marked Response 3. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal.
- Assessment Strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely get on and off the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

**DATA SOURCES / RESOURCES**

- Observation/demonstration is the preferred method.
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM
<p><b>(M1845) Toileting Hygiene:</b> 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.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to manage toileting hygiene and clothing management without assistance.</li> <li><input type="checkbox"/> 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.</li> <li><input type="checkbox"/> 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.</li> <li><input type="checkbox"/> 3 - Patient depends entirely upon another person to maintain toileting hygiene.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to manage personal hygiene and clothing when toileting. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform toileting hygiene, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, location of hygiene/clothing management supplies/implements)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area.</li> <li>• Toileting hygiene includes the patient's ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).</li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The toileting hygiene scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• This item refers the patient's ability to manage personal hygiene and clothing with or without assistive devices. The word "assistance" in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.</li> <li>• Select Response 0 if the patient is independent in managing toileting hygiene and managing clothing.</li> </ul>

<b>RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1845)</b>
<ul style="list-style-type: none"><li>• Select Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.</li><li>• If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, select Response 2.</li><li>• Response 2 includes standby assistance or verbal cueing.</li></ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"><li>• Observation/demonstration is the preferred method</li><li>• Patient/caregiver interview</li><li>• Physical assessment</li><li>• Environmental assessment</li></ul>

OASIS ITEM
<p><b>(M1850) Transferring:</b> Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to independently transfer.</li> <li><input type="checkbox"/> 1 - Able to transfer with minimal human assistance or with use of an assistive device.</li> <li><input type="checkbox"/> 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.</li> <li><input type="checkbox"/> 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.</li> <li><input type="checkbox"/> 4 - Bedfast, unable to transfer but is able to turn and position self in bed.</li> <li><input type="checkbox"/> 5 - Bedfast, unable to transfer and is unable to turn and position self.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely transfer, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, location of current sleeping surface and a sitting surface)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface. <ul style="list-style-type: none"> <li>- 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.</li> </ul> </li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The transferring scale presents the most optimal level first, then proceeds to less optimal levels of transferring. Read each response carefully to determine which one best describes what the patient is able to do.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1850)**

- 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 (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities). If the patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing/reminders, select Response 1.
- For Response 1, “minimal human assistance” could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.
  - In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.
- If the patient transfers either with minimal human assistance (but not device), or with the use of a device (but no human assistance), select Response 1. If the patient requires both minimal human assistance and an assistive device to transfer safely, select Response 2.
- If the patient can bear weight and pivot, but requires more than minimal human assist, Response 2 should be marked.
- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.
- If the patient is bedfast, select Response 4 or 5, depending on the patient's ability to turn and position self in bed. Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for safe transfer from bed to chair.

**DATA SOURCES / RESOURCES**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM
<p><b>(M1860) Ambulation/Locomotion:</b> Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).</li> <li><input type="checkbox"/> 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.</li> <li><input type="checkbox"/> 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.</li> <li><input type="checkbox"/> 3 - Able to walk only with the supervision or assistance of another person at all times.</li> <li><input type="checkbox"/> 4 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.</li> <li><input type="checkbox"/> 5 - Chairfast, unable to ambulate and is <u>unable</u> to wheel self.</li> <li><input type="checkbox"/> 6 - Bedfast, unable to ambulate or be up in a chair.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely ambulate or use a wheelchair, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or pain)</li> <li>- environmental barriers (for example, stairs, narrow doorways, unsafe flooring)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence.</li> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment.</li> <li>• The ambulation/locomotion scale presents the most optimal level first, then proceeds to less optimal mobility abilities. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to <u>safely</u> ambulate, select Response 2 or Response 3, depending on whether the assistance required is intermittent ("2") or continuous ("3").</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1860)**

- If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces, select Response 2 (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).
- If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters (for example, Response 2 is appropriate if a walker is required for safe ambulation in the hallway and living room, even if there are some situations in the home where a cane provides adequate support.)
- If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with the supervision or assistance should be reported, unless the patient is chairfast.
- Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, or demonstrates loss of balance or other actions that suggest a need for additional support for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

**DATA SOURCES / RESOURCES**

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment



OASIS ITEM
<p><b>(M1870) Feeding or Eating:</b> Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to independently feed self.</li> <li><input type="checkbox"/> 1 - Able to feed self independently but requires: <ul style="list-style-type: none"> <li>(a) meal set-up; <u>OR</u></li> <li>(b) intermittent assistance or supervision from another person; <u>OR</u></li> <li>(c) a liquid, pureed or ground meat diet.</li> </ul> </li> <li><input type="checkbox"/> 2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.</li> <li><input type="checkbox"/> 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.</li> <li><input type="checkbox"/> 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.</li> <li><input type="checkbox"/> 5 - Unable to take in nutrients orally or by tube feeding.</li> </ul>
ITEM INTENT
<p>Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or hearing, pain)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• This item <u>excludes</u> evaluation of the preparation of food items, and transport to the table. Respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him. Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.</li> <li>• The patient's ability may change as the patient's condition improves or declines, or as medical restrictions are imposed or lifted. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The feeding/eating scale presents the most optimal level first, then proceeds to less optimal feeding/eating abilities. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• Meal "set-up" (Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. -- all of which are special adaptations of the meal for the patient.</li> <li>• Select Response 2 if the patient is either unable to feed themselves and/or must be assisted or supervised while eating.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1870)**

- If a tube is being used to provide all or some nutrition, select Responses 3 or 4, depending on the patient's ability to take in nutrients orally. If a patient is being weaned from tube feeding, Responses 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, select Responses 0, 1, or 2. This is true, even if the tube remains in place, unused for a period of time.
- Responses 4 and 5 include non-oral intake.
- Response 5 is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may be the case for patients who receive all nutrition intravenously (such as TPN) or for patients who are receiving only intravenous hydration.

**DATA SOURCES / RESOURCES**

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

OASIS ITEM
<p><b>(M1880)</b> Current <b>Ability to Plan and Prepare Light Meals</b> (for example, cereal, sandwich) or reheat delivered meals safely:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission).</li> <li><input type="checkbox"/> 1 - <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.</li> <li><input type="checkbox"/> 2 - Unable to prepare any light meals or reheat any delivered meals.</li> </ul>
ITEM INTENT
<p>Identifies the patient's physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform light meal planning and preparation, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision, pain)</li> <li>- environmental barriers (for example, location of cooking appliances, food and meal prep supplies)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment.</li> <li>• In cases where a patient's ability is different for various light meal preparation tasks, pick the response that best describes the patient's level of ability to perform the majority of light meal preparation tasks.</li> <li>• Response 0 indicates that during the day of assessment, the patient has the consistent physical and cognitive ability to plan and prepare meals.</li> <li>• Response 1 indicates that during the day of assessment, the patient has inconsistent ability to prepare light meals (for example, can't prepare breakfast due to morning arthritic stiffness, but can prepare other meals throughout day).</li> <li>• Response 2 indicates patient does not have the ability to prepare light meals at any point during the day of assessment.</li> <li>• While nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when selecting a response.</li> <li>• When a patient's prescribed diet consists either partially or completely of enteral nutrition, the clinician must assess the patient's ability to plan and prepare their prescribed diet, including their knowledge of the feeding amount and ability to prepare the enteral feeding, based on product used. Note that the ability to set up, monitor and change the feeding equipment is excluded from M1880, as it is addressed on row "e" of M2102.</li> </ul>

**DATA SOURCES / RESOURCES (cont'd for OASIS Item M1880)**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Environmental assessment

OASIS ITEM	
<p><b>(M1890) Ability to Use Telephone:</b> Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to dial numbers and answer calls appropriately and as desired.</li> <li><input type="checkbox"/> 1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.</li> <li><input type="checkbox"/> 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.</li> <li><input type="checkbox"/> 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.</li> <li><input type="checkbox"/> 4 - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment.</li> <li><input type="checkbox"/> 5 - Totally unable to use the telephone.</li> <li><input type="checkbox"/> NA - Patient does not have a telephone.</li> </ul>	
ITEM INTENT	
<p>Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely use the telephone, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited range of motion, impaired balance)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision or hearing, pain)</li> <li>- environmental barriers (for example, phone type/features, size of numbers)</li> </ul>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is <i>able to do</i> on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.</li> <li>• The telephone use scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.</li> <li>• Ability to use telephone identifies the patient's ability to safely answer the phone, dial a number, and effectively use the telephone to communicate. If a speech impaired patient can only communicate using a phone equipped with texting functionality, select Response 1 - Able to use a specially adapted telephone.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Observation/demonstration is the preferred method</li> <li>• Patient/caregiver interview</li> </ul>	<ul style="list-style-type: none"> <li>• Physical assessment</li> <li>• Environmental assessment</li> </ul>

<b>OASIS ITEM</b>			
<p><b>(M1900) Prior Functioning ADL/IADL:</b> Indicate the patient’s usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. Check only <u>one</u> box in each row.</p>			
<b>Functional Area</b>	<b>Independent</b>	<b>Needed Some Help</b>	<b>Dependent</b>
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
<b>ITEM INTENT</b>			
<p>Identifies the patient’s functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient’s prior ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items.</p>			
<b>TIME POINTS ITEM(S) COMPLETED</b>			
<p>Start of Care Resumption of Care</p>			
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>			
<ul style="list-style-type: none"> <li>• For each functional area, select a response.</li> <li>• “Independent” means that the patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper.</li> <li>• “Needed some help” means that the patient contributed effort but required help from another person to accomplish the task/activity safely.</li> <li>• “Dependent” means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort.</li> <li>• “Self-care” refers specifically to grooming, dressing, bathing, and toileting hygiene. Medication management is not included in the definition of self-care for M1900 as it is addressed in a separate question (M2040).</li> <li>• “Ambulation” refers to walking (with or without assistive device). Wheelchair mobility is not directly addressed in this item. A patient who is unable to ambulate safely (even with devices and/or assistance), but is able to use a wheelchair (with or without assistance) would be reported as “Dependent” in Ambulation for M1900.</li> <li>• “Transfer” refers specifically to tub, shower, commode, and bed to chair transfers.</li> <li>• “Household tasks” refers specifically to light meal preparation, laundry, shopping, and phone use.</li> <li>• If the patient was previously independent in some self-care tasks (or some transfers, or some household tasks), but needed help or was completely dependent in others, pick the response that best describes the patient’s level of ability to perform the majority of included tasks.</li> </ul>			
<b>DATA SOURCES / RESOURCES</b>			
<ul style="list-style-type: none"> <li style="width: 50%;">• Patient/caregiver interview</li> <li style="width: 50%;">• Review of past health history</li> <li style="width: 50%;">• Referral information</li> <li style="width: 50%;">• Physician</li> </ul>			

OASIS ITEM
<p><b>(M1910)</b> Has this patient had a multi-factor <b>Falls Risk Assessment</b> using a standardized, validated assessment tool?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes, and it does not indicate a risk for falls.</p> <p><input type="checkbox"/> 2 - Yes, and it does indicate a risk for falls.</p>
ITEM INTENT
<p>Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. The multi-factor falls risk assessment must include at least one standardized, validated tool that 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elders, noninstitutionalized adults with disabilities, etc.) and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered per the tool's instructions.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care</p> <p>Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of a specific tool.</li> <li>• For Responses 1 and 2, an agency may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria as described in the item intent. Alternatively, an agency may incorporate several tools as long as one of them meets the criteria as described in the item intent. For example, a physical performance component (for example, Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (for example, OASIS items for cognitive status, vision, incontinence, ambulation, transferring).</li> <li>• Use the scoring parameters specified in the tool to identify if a patient is at risk for falls. Select Response 1 if the standardized, validated response scale rates the patient as no-risk, low-risk, or minimal risk. Select Response 2 if the standardized, validated response scale rates the patient as anything above low/minimal-risk. If the tool does not provide various levels, but simply has a single threshold separating those "at risk" from those "not at risk," then the patient scoring "at risk" should be scored as Response 2.</li> <li>• In order to select Response 1 or 2, the falls risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.</li> <li>• Select Response 0 if: <ul style="list-style-type: none"> <li>– a standardized, validated multi-factor falls risk screening was NOT conducted by the home health agency,</li> <li>– a standardized, validated multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame,</li> <li>– a standardized, validated multi-factor falls risk screening was conducted during the assessment time frame, but NOT by the assessing clinician.</li> <li>– the patient is not able to participate in tasks required to allow the completion and scoring of the standardized, validated assessment(s) that the agency chooses to utilize.</li> </ul> </li> </ul>

**DATA SOURCES / RESOURCES (cont'd for OASIS Item M1910)**

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment
- Referral information
- Review of past health history
- Several links to guidelines listing Falls Risk Assessment factors can be found in Chapter 5 of this manual.



OASIS ITEM
<p><b>(M2000) Drug Regimen Review:</b> Does a complete drug regimen review indicate potential clinically significant medication issues (for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance [non-adherence])?</p> <p><input type="checkbox"/> 0 - Not assessed/reviewed [<i>Go to M2010</i>]</p> <p><input type="checkbox"/> 1 - No problems found during review [<i>Go to M2010</i>]</p> <p><input type="checkbox"/> 2 - Problems found during review</p> <p><input type="checkbox"/> NA - Patient is not taking any medications [<i>Go to M2040</i>]</p>
ITEM INTENT
<p>Identifies if a review of the patient's medications indicated the presence of potential clinically significant problems. This item captures information for calculation of a process measure to identify best practices related to medications.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care</p> <p>Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>Includes all medications, prescribed and over the counter, administered by any route (for example, oral, topical, inhalant, pump, injection).</li> <li>If portions of the drug regimen review (for example, identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2000 may be selected. Collaboration in which the assessing clinician evaluates patient status (for example, presence of potential ineffective drug therapy or patient nonadherence), and another clinician (in the office) assists with review of the medication list (for example, possible duplicate drug therapy or omissions) does not violate the requirement that the comprehensive patient assessment is the responsibility of and must be ultimately completed by one clinician. Agency policy and practice will determine this process and how it is documented. The M0090 date – the date the assessment is completed – would be the date the two clinicians collaborated and the assessment was completed.</li> <li>The definition of a problem for Responses 1 and 2 includes the following: <ul style="list-style-type: none"> <li>Potential clinically significant medication issues include 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), nonadherence (regardless of whether the nonadherence is purposeful or accidental) or impairment or decline in an individual's mental or physical condition or functional or psychosocial status.</li> </ul> <p><b>Note:</b> Medication interaction is the impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.</p> </li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2000)**

**Note:** Adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeable with ADR, however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

In addition to the guidance provided above:

- Select Response 1 – no problems found – when (as applicable):
  - Patient's list of medications from the inpatient facility discharge instructions matches the medications the patient shows the clinician at the SOC/ROC assessment visit.
  - Assessment shows that diagnoses/symptoms for which patient is taking medications are adequately controlled (as able to be assessed within the clinician's scope of practice).
  - Patient possesses all medications prescribed.
  - Patient has a plan for taking medications safely at the right time.
  - Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
- Select Response 2 – problems found – when (as applicable):
  - Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
  - Assessment shows that diagnoses/symptoms for which patient is taking medications are NOT adequately controlled (as able to be assessed within the clinician's scope of practice).
  - Patient seems confused about when/how to take medications indicating a high risk for medication errors.
  - Patient has not obtained medications or indicates that he/she will probably not take prescribed medications because of financial, access, cultural, or other issues with medications.
  - Patient has signs/symptoms that could be adverse reactions from medications.
  - Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed 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.
- If a medication related problem is identified and resolved by the agency staff by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem.

**DATA SOURCES / RESOURCES**

- Patient assessment, specifically the drug regimen review as required by Conditions of Participation ( §484.55)
- Clinical record
- Communication notes
- Medication list
- Discussions with other agency staff responsible for completing drug regimen review.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information such as indications and precautions, dosage, monitoring or adverse consequences.
- Physician's Drug Reference (PDR) or other clinical medication handbook or software intended to provide warning of severity levels of risk for medication review.
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.
- Several online resources for evaluating drug reactions, side effects, interactions, etc., can be found in Chapter 5 of this manual.

OASIS ITEM	
<p><b>(M2002) Medication Follow-up:</b> Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes</p>	
ITEM INTENT	
<p>Identifies if potential clinically significant problems identified through a medication review were addressed with the physician within one calendar day following identification of medication issue(s).</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Start of Care</p> <p>Resumption of Care</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> <li>• Complete if Response 2 for M2000 is selected.</li> <li>• Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen.</li> <li>• Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status.</li> <li>• Select Response 1 – Yes, only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions.                         <ul style="list-style-type: none"> <li>- In order to select Response 1, the two-way communication AND reconciliation (or plan to resolve the problem) must be completed by the end of the next calendar day after the problem was identified and before the end of the allowed time frame (that is, within five days of SOC, within two days of discharge from the inpatient facility at ROC).</li> </ul> </li> <li>• If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record.</li> <li>• If a medication related problem is identified and resolved by the agency staff without physician involvement by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem.</li> <li>• If agency staff other than the clinician responsible for completing the SOC/ROC OASIS contacted the physician to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2002 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and must ultimately be completed by one clinician.</li> </ul>	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> <li>• Clinical record</li> <li>• Communication notes</li> <li>• Plan of Care</li> </ul>	<ul style="list-style-type: none"> <li>• Medication list</li> <li>• Discussions with other agency staff responsible for completing drug regimen review</li> </ul>

OASIS ITEM
<p><b>(M2004) Medication Intervention:</b> If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?</p> <p> <input type="checkbox"/> 0 - No  <input type="checkbox"/> 1 - Yes  <input type="checkbox"/> NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment                 </p>
ITEM INTENT
<p>Identifies if potential clinically significant problems such as adverse effects or drug reactions identified at the time of or at any time since the previous OASIS assessment were addressed with the physician.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to inpatient facility</p> <p>Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen.</li> <li>Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status.</li> <li>Select Response 1 – Yes, only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions.</li> <li>If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record.</li> <li>If agency staff other than the clinician responsible for completing the transfer or discharge OASIS contacted the physician to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the transfer or discharge OASIS assessment so that the appropriate response for M2004 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician.</li> <li>If the last OASIS assessment completed was the SOC or ROC, and a clinically significant problem was identified at that SOC or ROC visit, the problem (and/or related physician communication) would be reported at both the SOC/ROC (on M2002) and again at Transfer or Discharge (on M2004), since the time frame under consideration for M2004 is at the time of or at any time since the previous OASIS assessment.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>Clinical record</li> <li>Communication notes</li> <li>Medication list</li> <li>Plan of Care</li> <li>Discussions with other agency staff responsible for completing drug regimen review</li> </ul>

OASIS ITEM
<p><b>(M2010) Patient/Caregiver High-Risk Drug Education:</b> Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?</p> <p> <input type="checkbox"/> 0 - No  <input type="checkbox"/> 1 - Yes  <input type="checkbox"/> NA - Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications </p>
ITEM INTENT
<p>Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations (Institute for Safe Medication Practices, JCAHO, etc.) as having considerable potential for causing significant patient harm when they are used erroneously.</p> <p>This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select Response 0 – No, if the interventions are not completed as outlined in this item. However, in this case, the care provider should document rationale in the clinical record unless the patient is not taking any drugs.</li> <li>• Select Response 1 – Yes, if high-risk medications are prescribed and education was provided.</li> <li>• High-risk medications should be identified based on one or more authoritative sources.</li> <li>• If patient/caregiver is fully knowledgeable about special precautions associated with high-risk medications, select "NA."</li> <li>• If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of and ultimately must be completed by one clinician.</li> </ul>

**DATA SOURCES / RESOURCES (cont'd for OASIS Item M2010)**

- Clinical record
- Communication notes
- Medication list
- Plan of Care
- Discussions with other agency staff responsible for educating patient/caregivers on medications.
- Sources to identify high-risk medications for the purposes of responding to this item can include the ISMP High Alert Medication List, Beer's Criteria, Joint Commission's High Alert Medication lists, or other authoritative resources. Links to resources for identifying high-risk medications can be found in Chapter 5 of this manual.

OASIS ITEM
<p><b>(M2015) Patient/Caregiver Drug Education Intervention:</b> At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?</p> <p> <input type="checkbox"/> 0 - No  <input type="checkbox"/> 1 - Yes  <input type="checkbox"/> NA - Patient not taking any drugs </p>
ITEM INTENT
<p>Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.</p> <p>Drug education interventions for M2015 should address all medications the patient is taking – prescribed and over-the-counter – by any route.</p> <p>Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to an inpatient facility</p> <p>Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record.</li> <li>• The timeframe should be considered at the time of or at any time since the previous OASIS assessment.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Review of clinical record including teaching guidelines, flow sheets, clinical notes, etc.</li> <li>• Medication list</li> <li>• Plan of Care</li> <li>• Discussions with other agency staff responsible for educating patient/caregivers on medications</li> <li>• Links to a resource for drug information can be found in Chapter 5 of this manual.</li> </ul>

OASIS ITEM
<p><b>(M2020) Management of Oral Medications:</b> <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <b><u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</b></p> <p><input type="checkbox"/> 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</p> <p><input type="checkbox"/> 1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.</p> <p><input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</p> <p><input type="checkbox"/> 3 - <u>Unable</u> to take medication unless administered by another person.</p> <p><input type="checkbox"/> NA - No oral medications prescribed.</p>
ITEM INTENT
<p>This item is intended to identify the patient's ability to take <b>all</b> oral (p.o.) medications reliably and safely at <b>all</b> times. 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 take oral medications, 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 medication management. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited manual dexterity)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision, pain)</li> <li>- environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Includes all prescribed and OTC (over-the-counter) medications that the patient is currently taking and are included on the Plan of Care.</li> <li>• Excludes topical, injectable, and IV medications.</li> <li>• Only medications whose route of administration is p.o. should be considered for this item. Medications given per gastrostomy (or other) tube are <u>not</u> administered p.o., but are administered "per tube."</li> <li>• If the patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of this, select Response 0.</li> <li>• Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to 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 and orally ingest it at the correct times.</li> </ul>



**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2020)**

- Select Response 1 if the patient is independent in oral medication administration if another person must prepare individual doses (for example, place medications in a medi-planner or other device) and/or if another person in the home must modify the original medication container to enable patient access (for example, removing childproof lids, marking labels for the visually impaired or those who cannot read), or if someone in the home must develop a drug diary or chart which the patient relies on to take medications appropriately.
- Select Response 2 if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (for example, setting up a “planner device”) and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered “assistance” or “reminders.”)
- If a medication is ordered PRN and the medication is needed by the patient on the day of assessment—and the patient needed a reminder to take this PRN medication on the day of assessment, select Response 2. If the patient did not need any PRN medications on the day of the assessment and therefore no reminders were necessary, assess the patient's ability on all of the medications taken on the day of assessment.
- Select Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner, were adequate assistance for the patient to take all medications safely.
- If the patient's ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

**DATA SOURCES / RESOURCES**

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.

OASIS ITEM
<p><b>(M2030) Management of Injectable Medications:</b> <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. <b>Excludes IV medications.</b></p> <p><input type="checkbox"/> 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.</p> <p><input type="checkbox"/> 1 - Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.</p> <p><input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection</p> <p><input type="checkbox"/> 3 - <u>Unable</u> to take injectable medication unless administered by another person.</p> <p><input type="checkbox"/> NA - No injectable medications prescribed.</p>
ITEM INTENT
<p>This item is intended to assess the patient's ability to take <b>all</b> injectable medications reliably and safely at <b>all</b> times. 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. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (for example, limited manual dexterity)</li> <li>- emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)</li> <li>- sensory impairments (for example, impaired vision, pain)</li> <li>- environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Excludes IV medications, infusions (for example, medications given via a pump), and medications given in the physician's office or other settings outside the home.</li> <li>• Includes one-time injections administered in the home.</li> <li>• Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.</li> <li>• Select Response 0 if the patient sets up her/his own individual doses and is able to take the correct medication in the correct dosage at the correct time as a result of this,.</li> <li>• Select Response 1 for a patient independent in injectable medication administration if another person must prepare individual doses <b>and/or</b> if another person must develop a drug diary or chart.</li> <li>• Select Response 2 if reminders to take medications are necessary, regardless of the whether the patient is independent or needs assistance in preparing individual doses and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")</li> <li>• Select Response 3 if the physician ordered the RN to administer an injection in the home.</li> </ul>

<b>RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2030)</b>
<ul style="list-style-type: none"> <li>• If the patient’s ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.</li> <li>• PRN injectables, ordered and included on POC, are to be considered when determining the patient's ability to manage injectable medications. If the PRN medication was not needed during the assessment timeframe, use clinical judgment and make an inference regarding the patient's ability by asking them to describe and demonstrate the steps for administration and needle disposal, considering the patient's cognitive and physical status as well as any other barriers.</li> <li>• Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Observation/demonstration is the preferred method</li> <li>• Patient/caregiver interview</li> <li>• Physical assessment</li> <li>• Cognitive assessment</li> <li>• Environmental assessment</li> <li>• CMS OASIS Q&amp;As can be accessed through the CMS OASIS web page.</li> <li>• Chapter 5 of this manual has a link to the OASIS Q&amp;As.</li> </ul>

OASIS ITEM				
<p><b>(M2040) Prior Medication Management:</b> Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury. Check only <b>one</b> box in each row.</p>				
	<b>Independent</b>	<b>Needed Some Help</b>	<b>Dependent</b>	<b>Not Applicable</b>
a. Oral medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA
ITEM INTENT				
<p>Identifies the patient's ability to manage all prescribed oral and injectable medications prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.</p>				
TIME POINTS ITEM(S) COMPLETED				
<p>Start of Care Resumption of Care</p>				
RESPONSE—SPECIFIC INSTRUCTIONS				
<ul style="list-style-type: none"> <li>• A care episode is not the same as a payment episode. The care episode begins with the most recent SOC or ROC and ends with a Transfer or Discharge. For example, if a patient is resuming home care services after a recent inpatient admission, report the patient's ability to manage medications prior to the most recent illness, exacerbation or injury that is the cause of this resumption of home care services.</li> <li>• Includes all prescribed and OTC (over-the-counter) oral medications and all prescribed injectable medications that the patient was taking prior to most recent illness, and are included on the Plan of Care.</li> <li>• For each functional area (oral medications and injectable medications), select a response.</li> <li>• If the patient's prior ability to manage oral or injectable medications varied from medication to medication, consider the medication for which the most assistance was needed when selecting a response.</li> <li>• "Independent" means that the patient completed the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper or reminders from another person. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")</li> <li>• "Needed some help" means that the patient required some help from another person to accomplish the task/activity.</li> <li>• "Dependent" means that the patient was incapable of performing any of the task/activity. For oral medications, this means that the patient was capable only of swallowing medications that were given to her/him. For injectable medications, this means that someone else must have prepared and administered the medication.</li> <li>• Select Response "NA" if there were no oral medications (row a) or no injectable medications (row b) used.</li> </ul>				
DATA SOURCES / RESOURCES				
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> <li>• Referral information</li> <li>• Review of past health history</li> <li>• Physician</li> </ul>				

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

<b>ITEM INTENT (Cont'd for OASIS Item M2102)</b>	
Identifies ability and willingness of the caregiver(s) (other than home health agency staff) to provide categories of assistance needed by the patient.	
<b>TIME POINTS ITEM(S) COMPLETED</b>	
Start of care Resumption of care Discharge from agency – not to an inpatient facility	
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>	
<ul style="list-style-type: none"> <li>• At SOC/ROC, report what is known on the day of assessment regarding ability and willingness of caregivers to provide help in the various categories of assistance for the upcoming episode of care. At Discharge, report what is known on the day of the discharge assessment regarding the ability and willingness of caregivers to provide assistance to the patient at the time of the discharge.</li> <li>• For each row a-g, select one description of caregiver assistance.</li> <li>• If patient needs assistance with any aspect of a category of assistance (such as needs assistance with some IADLs but not others), consider the aspect that represents the most need and the availability and ability of the caregiver(s) to meet that need.</li> <li>• If more than one response in a row applies, (for example, the caregiver(s) provides the assistance but also needs training or assistance), select the response that represents the greatest need (“caregiver(s) needs training/supporting services to provide assistance”).</li> <li>• Select Response 3 if             <ul style="list-style-type: none"> <li>- Caregiver(s) are not likely to provide care due to an unwillingness and/or inability on the part of the caregiver(s); AND/OR if there is a reluctance on the part of the caregiver(s) to provide care.</li> </ul> </li> <li>• Row a – ADLs include basic self-care activities such as the examples listed.</li> <li>• Row b – IADLs include activities associated with independent living necessary to support the ADLs such as the examples listed.</li> <li>• Row c – Medication administration refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.</li> <li>• Row d – Medical procedures/treatments include procedures/treatments that the physician or physician-designee has ordered for the purpose of improving health status. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.             <ul style="list-style-type: none"> <li>- Devices such as T.E.D hose, prosthetic devices, orthotic devices, or other supports that have a medical and/or therapeutic impact should be considered medical procedures/treatments, not as ADL/dressing items in Row a.</li> </ul> </li> <li>• Row e – Management of equipment refers to the ability to safely use medical equipment as ordered. Examples of medical equipment include oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies, continuous passive motion machine, wheelchair, hoist lift, etc.</li> <li>• Row f – Supervision and safety includes needs related to the ability of the patient to safely remain in the home. This category of assistance needs includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits. Such assistance may range from calls to remind the patient to take medications, to in-person visits to ensure that the home environment is safely maintained, to the need for the physical presence of another person in the home to ensure that the patient doesn’t wander, fall, or for other safety reasons (for example, leaving the stove burner on).</li> <li>• Row g – Advocacy or facilitation of patient’s participation in appropriate medical care includes taking patient to medical appointments, following up with filling prescriptions, or making subsequent appointments, etc.</li> </ul>	
<b>DATA SOURCES / RESOURCES (Cont'd for OASIS Item M2102)</b>	
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> </ul>	<ul style="list-style-type: none"> <li>• Review of previous health history</li> </ul>

OASIS ITEM
<p><b>(M2110) How Often</b> does the patient receive <b>ADL or IADL assistance</b> from any caregiver(s) (other than home health agency staff)?</p> <p><input type="checkbox"/> 1 - At least daily</p> <p><input type="checkbox"/> 2 - Three or more times per week</p> <p><input type="checkbox"/> 3 - One to two times per week</p> <p><input type="checkbox"/> 4 - Received, but less often than weekly</p> <p><input type="checkbox"/> 5 - No assistance received</p> <p><input type="checkbox"/> UK - Unknown</p>
ITEM INTENT
<p>Identifies the frequency of the assistance with ADLs (for example, bathing, dressing, toileting, transferring, ambulating, feeding) or IADLs (for example, medication management, meal preparation, housekeeping, laundry, shopping, financial management) provided by any non-agency caregivers.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Responses are arranged in order of most to least assistance received from caregivers.</li> <li>• Note that this question is concerned broadly with ADLs and IADLs, not just the ones specified in other OASIS items. ADLs are defined as the tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet. Instrumental activities of daily living (IADL) are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone.</li> <li>• Select the response that reports how often the patient receives assistance with any ADL or IADL.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver interview</li> </ul>

OASIS ITEM
<p><b>(M2200) Therapy Need:</b> In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? <b>(Enter zero ["000"] if no therapy visits indicated.)</b></p> <p>( _ _ _ ) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).</p> <p><input type="checkbox"/> NA - Not Applicable: No case mix group defined by this assessment.</p>
ITEM INTENT
<p>Identifies the total number of therapy visits (physical, occupational, or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group, and only applies to payers utilizing a payment model based on case mix group assignment.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s), and (b) be reasonable and necessary to the treatment of the patient's illness or injury. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.</li> <li>• Report a number that is "zero filled and right justified." For example, 11 visits should be reported as "011."</li> <li>• Answer "000" if no therapy services are needed.</li> <li>• Once patient eligibility has been confirmed and the Plan of Care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the Plan of Care. The sequence of visits performed by the disciplines must be dictated by the individual patient's Plan of Care. For example, an eligible patient in an initial 60-day episode that has both physical therapy and occupational therapy orders in the Plan of Care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with 42 CFR 409.43 (f).</li> <li>• For multidisciplinary cases - Nursing and Therapy may collaborate to answer this item correctly. The PT, OT, and/or SLP are responsible to communicate the number of visits ordered by the physician to the RN completing this item. Coordination of patient care is specified in the Conditions of Participation (42 CFR 484.14).</li> <li>• When a patient is discharged home from an inpatient facility admission in the last five days of a certification period (the requirement to complete a Resumption of Care assessment overlaps with the requirement to complete a Recertification assessment), CMS allows the agency to complete a single ROC assessment to meet the requirements of both timepoints. In such cases, the total number of therapy visits planned for the upcoming 60-day episode should be reported in M2200.</li> </ul>



<p><b>RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2200)</b></p>
<ul style="list-style-type: none"> <li>• Answer “NA” (Not Applicable) when this assessment will <u>not</u> be used to determine a case mix group for Medicare, or other payers using a Medicare PPS-like model. Usually, the “NA” response will be checked for patients whose payment source is not Medicare fee-for-service (that is, M0150, Response 1 is not checked), or for an assessment that will <u>not</u> be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response other than “NA” – Not Applicable is required to generate the case mix code.</li> <li>• Assessment strategies: When the assessment and care plan are complete, review the Plan of Care to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services <u>are</u> ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. As noted in item intent above, the Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.</li> </ul>
<p><b>DATA SOURCES / RESOURCES</b></p>
<ul style="list-style-type: none"> <li>• Physician’s orders</li> <li>• Referral information</li> <li>• Plan of Care</li> <li>• Clinical record</li> </ul>

OASIS ITEM			
<b>(M2250) Plan of Care Synopsis:</b> (Check only <u>one</u> box in each row.) Does the physician-ordered plan of care include the following:			
Plan / Intervention	No	Yes	Not Applicable
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

ITEM INTENT
<p>Identifies if the physician-ordered home health Plan of Care incorporates specific best practices. Included in the physician-ordered Plan of Care means that the patient condition has been discussed and there is agreement as to the Plan of Care between the home health agency staff and the physician.</p> <p>This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item 2250)**

- Select “Yes” if the Plan of Care contains orders for best practice interventions as specified in each row, based on the patients needs.
  - The physician Plan of Care includes all additional orders as an extension of the original Plan of Care.
- “Yes” is an appropriate response if the intervention is in the Plan of Care even if the assessment indicated the intervention was not applicable.
- This question can be answered “Yes” prior to the receipt of signed orders if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the Plan of Care. Assuming all other OASIS information is completed, the Date Assessment Completed (M0090) then becomes the date of the communication with the physician to establish the Plan of Care that includes interventions listed in M2250.
- If “NA” criteria does not apply, select “No” if orders for interventions have been requested but not authorized by the end of the comprehensive assessment time period, unless otherwise indicated in rows d & g. This means Plan of Care orders must be in place within five days for SOC in order to respond “Yes.” For ROC, the Plan of Care orders must be in place within two days of inpatient discharge, or within two days of becoming aware of an inpatient discharge, in order to respond “Yes” to M2250.
- After reviewing physician orders for home health care and conducting a comprehensive assessment of the patient, the Plan of Care should be developed as required by Conditions of Participation: 484.14 Standard: Plan of Care. If the physician refers the patient under a Plan of Care that cannot be completed until after an initial visit and eligibility has been determined, the physician is consulted to approve additions or modification to the original plan.
- If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (within five days of SOC, within two days of discharge from the inpatient facility at ROC). For example, if the RN identifies falls risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient’s Plan of Care includes interventions to prevent falls risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.
- For each row a-g, select one response.
- Row a: If the physician-ordered Plan of Care contains specific clinical parameters relevant to the patient’s condition that, when out of specified range, would indicate that the physician should be contacted, select “Yes.” The parameters may be ranges and may include temperature, pulse, respirations, blood pressure, weight, wound measurements, pain intensity ratings, intake and output measurements, blood sugar levels, or other relevant clinical assessment findings. Select “NA” if the physician chooses not to identify patient-specific parameters and the agency will use standardized guidelines that are made accessible to all care team members.
- If the Plan of Care includes specific parameters ordered by the physician for this specific patient or after reviewing the agency’s standardized parameters with the physician, s/he agrees they would meet the needs of this specific patient, select “Yes.” If there are no patient-specific parameters on the Plan of Care and the agency will not use standardized physician notification parameters for this patient, select “No.” If the agency uses their own agency standardized guidelines, which the physician has NOT agreed to include in the Plan of Care for this particular patient, select “NA.”
- Row b: If the physician-ordered Plan of Care contains both orders for a) monitoring the skin of the patient’s lower extremities for evidence of skin lesions AND b) patient education on proper foot care, select “Yes.” If the physician-ordered Plan of Care contains orders for only one (or none) of the interventions, select “No” unless “NA” applies. Select “NA” if the patient does not have a diagnosis of diabetes mellitus or is a bilateral amputee or is missing lower legs due to a congenital or acquired condition.

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item 2250)**

- Row c: If the physician-ordered Plan of Care contains specific interventions to reduce the risk of falls, select “Yes.” Environmental changes and strengthening exercises are examples of possible fall prevention interventions. If the Plan of Care does not include interventions for fall prevention, mark “No” unless “NA” applies. Select “NA” if an informal or formal falls risk assessment indicates no risk for falls, or if the response scale of a standardized, validated falls risk assessment tool rates the patient as no risk or low/minimal-risk. If the tool does not provide various levels, but simply has a single threshold separating those “at risk” from those “not at risk,” then patient scoring “not at risk” should be scored as “NA,” (unless fall prevention orders are present). If more than one falls risk assessment was completed by the assessing clinician, all must be negative in order to select “NA.”
- Row d: If the physician-ordered Plan of Care contains orders for further evaluation or treatment of depression, AND/OR if the physician has been notified about a positive depression screen, select “Yes.” Examples of interventions for depression may include new or existing medications, adjustments to already-prescribed medications, psychotherapy, or referrals to agency resources (for example, social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the patient has no diagnosis of depression AND does not meet criteria for further evaluation based on a formal or informal depression assessment, select “NA” (unless the physician has been notified about a positive depression screen, or orders for further evaluation or treatment of depression are present). If more than one depression screen was completed by the assessing clinician, all must be negative in order to select “NA.”
- Row e: If the physician-ordered Plan of Care contains interventions to monitor AND mitigate pain, select “Yes.” Examples of interventions to mitigate pain include medication, massage, visualization, and biofeedback. If the physician-ordered Plan of Care contains orders for only one (or none) of the interventions (for example, pain medications but no monitoring plan), select “No,” unless “NA” applies. If the clinician completed a formal or informal assessment that indicated the patient has no pain, select “NA” (unless orders for further monitoring and mitigating pain are present). If more than one pain assessment was completed by the assessing clinician, all must be negative in order to select “NA.”
- Row f: If the physician-ordered Plan of Care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown, select “Yes.” Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the clinician completed a formal or informal assessment that indicated the patient is not at risk for pressure ulcers, select “NA” (unless orders for interventions to reduce pressure on areas of skin at risk for breakdown are present). If more than one pressure ulcer risk assessment was completed by the assessing clinician, all must be negative in order to select “NA.”
- Row g: If the physician-ordered Plan of Care contains orders for pressure ulcer treatments based on principles of moist wound healing (for example, moisture retentive dressings) OR if such orders have been requested from the physician, select “Yes.” If the patient has no pressure ulcers OR no pressure ulcers needing moist wound healing treatments per physician, select “NA” (unless orders for pressure ulcer treatments based on principles of moist wound healing are present).
  - Moist wound healing treatment is any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, unna boots, medicated creams/ointments.

**DATA SOURCES / RESOURCES**

- Plan of Care
- Physician’s orders
- Clinical record
- Communication notes
- See Chapter 5 of this manual for links to additional resources.

OASIS ITEM
<p><b>(M2300) Emergent Care:</b> At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?</p> <p><input type="checkbox"/> 0 - No [<i>Go to M2400</i>]</p> <p><input type="checkbox"/> 1 - Yes, used hospital emergency department WITHOUT hospital admission</p> <p><input type="checkbox"/> 2 - Yes, used hospital emergency department WITH hospital admission</p> <p><input type="checkbox"/> UK - Unknown [<i>Go to M2400</i>]</p>
ITEM INTENT
<p>Identifies whether the patient was seen in a hospital emergency department at the time of or at any time since the previous OASIS assessment. Responses to this item include the entire period at or since the last time OASIS data were collected, including use of hospital emergency department that results in a qualifying hospital admission, necessitating Transfer OASIS data collection. This item includes current events.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to an inpatient facility - with or without agency discharge</p> <p>Discharge from agency</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• This item <b>excludes</b> urgent care services not provided in a hospital emergency department, including doctor's office visits scheduled less than 24 hours in advance, care provided by an ambulance crew without transport, or care received in urgent care facilities. This item only includes holding and observation in the emergency department setting.</li> <li>• An urgent care facility is defined as a freestanding walk-in clinic (not a department of a hospital) for patients in need of immediate medical care. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician offices. For example, X-ray facilities allow for treatment of minor fractures and foreign bodies, such as nail gun injuries. Most urgent care centers offer extended hours in evenings and on weekends for patients to receive treatment when their personal physician is not available.</li> <li>• If a patient went to a hospital emergency department, regardless of whether the patient/caregiver independently made the decision to seek emergency department services or was advised to go the emergency department by the physician, home health agency, or other health care provider, then Response 1 or 2 should be selected depending on whether or not a hospital admission occurred.</li> <li>• If a patient went to a hospital emergency department, was "held" at the hospital for observation, then released, the patient did receive emergent care. The time period that a patient can be "held" without admission can vary. "Holds" can be longer than 23 hours but emergent care should be reported regardless of the length of the observation "hold." An OASIS transfer assessment is not required if the patient was never actually admitted to an inpatient facility.</li> <li>• If a patient went to a hospital emergency department and was subsequently admitted to the hospital, select Response 2. An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more for reasons other than diagnostic testing).</li> <li>• If a patient is admitted to the hospital for a stay requiring an OASIS Transfer, Response 0 – No, should only be marked if the patient was directly admitted to the hospital (was not treated or evaluated in the emergency room), and had no other emergency department visits at or since the last OASIS assessment.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2300)**

- Select Response 1 for a patient who, at the time of or at any time since the previous OASIS assessment was collected, accessed a hospital emergency department that did not result in an admission to the hospital.
- If a patient utilized a hospital emergency department more than once at the time of or at any time since the previous OASIS assessment, select Response 2 if any emergency department visit at or since the last OASIS assessment resulted in hospital admission. If no admission, select Response 1.
- In Responses 1 and 2, "hospital admission" is defined as admission to a hospital where the stay is for 24 hours or longer, for reasons other than diagnostic testing.
- A patient who dies in a hospital emergency department is considered to have been under the care of the emergency department, not the home health agency. In this situation, a Transfer assessment, not an assessment for "Death at Home," should be completed. For M2300, select Response 1 - Yes, used hospital emergency department WITHOUT hospital admission.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Physician
- Hospital emergency department staff

OASIS ITEM
<p><b>(M2310) Reason for Emergent Care:</b> For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? <b>(Mark all that apply.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis</li> <li><input type="checkbox"/> 2 - Injury caused by fall</li> <li><input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis)</li> <li><input type="checkbox"/> 4 - Other respiratory problem</li> <li><input type="checkbox"/> 5 - Heart failure (for example, fluid overload)</li> <li><input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat)</li> <li><input type="checkbox"/> 7 - Myocardial infarction or chest pain</li> <li><input type="checkbox"/> 8 - Other heart disease</li> <li><input type="checkbox"/> 9 - Stroke (CVA) or TIA</li> <li><input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control</li> <li><input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction</li> <li><input type="checkbox"/> 12 - Dehydration, malnutrition</li> <li><input type="checkbox"/> 13 - Urinary tract infection</li> <li><input type="checkbox"/> 14 - IV catheter-related infection or complication</li> <li><input type="checkbox"/> 15 - Wound infection or deterioration</li> <li><input type="checkbox"/> 16 - Uncontrolled pain</li> <li><input type="checkbox"/> 17 - Acute mental/behavioral health problem</li> <li><input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus</li> <li><input type="checkbox"/> 19 - Other than above reasons</li> <li><input type="checkbox"/> UK - Reason unknown</li> </ul>
ITEM INTENT
Identifies the reasons for which the patient sought and/or received care in a hospital emergency department.
TIME POINTS ITEM(S) COMPLETED
Transfer to an inpatient facility - with or without agency discharge Discharge from agency
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• This item does not address urgent care services not provided in a hospital emergency department, including doctor's office visits scheduled less than 24 hours in advance, care provided by an ambulance crew without transport, or care received in urgent care facilities.</li> <li>• If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses. For example, if a patient received care for a fall at home and was found to have medication side effects, mark both responses.</li> <li>• Response 2 should be selected when the patient sought care in the hospital emergency department for an injury caused by a fall, regardless of where the fall occurred.</li> <li>• Select Response 19 if a patient seeks emergent care in the hospital emergency department for a new wound that was not the result of a fall.</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2310)**

- If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out (for example, patient was sent to ED for suspected DVT but diagnostic testing and evaluation were negative for DVT).
- If the reason is not included in the choices, select Response 19 - Other than above reasons.
- If the patient has received emergent care in a hospital emergency department multiple times since the last time OASIS data were collected, include the reasons for all visits.

**DATA SOURCES / RESOURCES**

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Physician
- Hospital emergency department



**OASIS ITEM**

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

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

**ITEM INTENT**

Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided during the home health care episode (at the time of or at any time since the previous OASIS assessment). "Included in the physician-ordered Plan of Care" means that the patient condition was discussed and there was agreement as to the Plan of Care between the home health agency staff and the patient's physician.

This item is used to calculate process measures to capture the use of best practices. The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.

The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in OASIS items for M1240, M1300, M1730, and M1910.

TIME POINTS ITEM(S) COMPLETED (cont'd for OASIS Item M2400)
Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select "Yes" if the physician-ordered Plan of Care includes the specified best practice interventions as specified in each row, at the time of or at any time since the previous OASIS assessment, and there is evidence of implementation in the clinical record. If orders are present and implemented, "Yes" may be selected even if the formal assessment was not conducted, or did not suggest a need for the particular intervention.</li> <li>• Select "No" if the interventions are not on the Plan of Care OR if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless "NA" applies.</li> <li>• Select "NA" if the plans/interventions specified in the row are not applicable for this patient. See guidance on selecting "NA" for each row below.</li> <li>• Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2400. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the Plan of Care prior to the end of the allowed assessment time frame, the RN may select "Yes" for row b of M2400. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the comprehensive assessment.</li> <li>• For each row a-f, select one response.</li> <li>• For rows b, c, e, and f, the intervention specified in the first column must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected.</li> <li>• For rows a and d, <b>BOTH</b> of the interventions specified in the first column must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected.</li> <li>• For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select "NA."  <ul style="list-style-type: none"> <li>— An evaluation of clinical factors is not considered a formal assessment for M1300 pressure ulcer risk.</li> </ul> </li> <li>• Row a: If the physician-ordered Plan of Care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." If the physician-ordered Plan of Care contains orders for only one of the interventions and/or only one type of intervention (monitoring or education) or no intervention is documented in the clinical record, select "No," unless "NA" applies. Select "NA" if the patient does not have a diagnosis of diabetes mellitus or is missing lower legs due to congenital or acquired condition (bilateral amputee).</li> <li>• Row b: If the physician-ordered Plan of Care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Environmental changes, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the Plan of Care does not include interventions for fall prevention, and/or there is no documentation in the clinical record that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If all formal multi-factor falls risk assessments conducted at the time of or at any time since the previous OASIS assessment indicates the patient was not at risk for falls (if a single-threshold assessment is used), or at low, minimal, or no risk for falls (if a multi-threshold tool is used), select "NA" (unless orders for fall prevention are present and were implemented).</li> </ul>

**RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2400)**

- Row c: If the physician-ordered Plan of Care contains interventions for evaluation or treatment of depression and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Interventions for depression may include new medications, adjustments to already-prescribed medications, psychotherapy or referrals to agency resources (for example, social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the Plan of Care does not include interventions for treating depression and/or if no interventions related to depression are documented in the clinical record at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If every standardized, validated assessment conducted at the time of or any time since the previous OASIS assessment indicates patient did not meet criteria for further evaluation of depression AND patient did not have diagnosis of depression, select "NA" (unless orders for further evaluation or treatment of depression are present and were implemented).
- Row d: If the physician-ordered Plan of Care contains interventions to monitor AND mitigate pain and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to mitigate pain severity. If the physician-ordered Plan of Care contains orders for only one of the interventions (for example, pain medications but no pain monitoring plan) and/or only one type of intervention (for example, administering pain medications but no pain monitoring) or no interventions were documented at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If every standardized, validated pain assessment conducted at or since the last OASIS assessment was negative for pain, select "NA" (unless orders for monitoring and mitigating pain are present and were implemented).
- Row e: If the physician-ordered Plan of Care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the Plan of Care does not include interventions to prevent pressure ulcers and/or no interventions were documented in the clinical record at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers, select "NA" (unless orders for interventions to reduce pressure on areas of skin at risk for breakdown are present and were implemented).
- Row f: If the physician-ordered Plan of Care contains orders for pressure ulcer treatments based on principles of moist wound healing (for example, moisture retentive dressings) and the clinical record contains documentation that these interventions were performed at the time of or at any time since the previous OASIS assessment, select "Yes." If the Plan of Care does not contain orders for pressure ulcer treatments based on principles of moist wound healing and/or no pressure ulcer treatments based on principles of moist wound healing were documented at the time of or at any time since the previous OASIS assessment, select "No," unless "NA" applies. If patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated per physician, select "NA" (unless orders for pressure ulcer treatments based on principles of moist wound healing are present and were implemented).

**DATA SOURCES / RESOURCES**

- |                       |                                                                                                                                        |
|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| • Plan of Care        | • Communication notes                                                                                                                  |
| • Physician's orders  | • Home Health Conditions of Participation                                                                                              |
| • Clinical record     | • Guidance on each particular item for the Plan of Care and intervention can be found in other item-by-item tips within this document. |
| • Clinical assessment |                                                                                                                                        |

OASIS ITEM
<p><b>(M2410)</b> To which <b>Inpatient Facility</b> has the patient been admitted?</p> <p><input type="checkbox"/> 1 - Hospital [<i>Go to M2430</i>]</p> <p><input type="checkbox"/> 2 - Rehabilitation facility [<i>Go to M0903</i>]</p> <p><input type="checkbox"/> 3 - Nursing home [<i>Go to M0903</i>]</p> <p><input type="checkbox"/> 4 - Hospice [<i>Go to M0903</i>]</p> <p><input type="checkbox"/> NA - No inpatient facility admission [<i>Omit "NA" option on TRN</i>]</p>
ITEM INTENT
Identifies the type of inpatient facility to which the patient was admitted.
TIME POINTS ITEM(S) COMPLETED
Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• If the patient was admitted to more than one facility, indicate the facility type to which the patient was admitted first (for example, the facility type that they were transferred to from their home).</li> <li>• When a patient dies in a hospital emergency department, the RFA 7 - Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to select Response 1 – Hospital for M2410, even though the patient was not admitted to the inpatient facility.</li> <li>• Admission to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital is considered a rehabilitation facility admission.</li> <li>• Admission to inpatient drug rehabilitation is considered an inpatient admission. Select Response 1 – Hospital, whether it was a freestanding drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital.</li> <li>• Admission to a skilled nursing facility (SNF), an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a nursing facility (NF) is a nursing home admission</li> <li>• When completing a Transfer, select Response 1, 2, 3, or 4. "NA" should be omitted from this item for transfer.</li> <li>• When completing a Discharge from agency – Not to an Inpatient Facility, select Response "NA."</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient family interview (for agency discharge)</li> <li>• Telephone contact with caregiver or family if patient was transferred</li> <li>• Facility</li> </ul>

OASIS ITEM
<p><b>(M2420) Discharge Disposition:</b> Where is the patient after discharge from your agency? <b>(Choose only one answer.)</b></p> <p><input type="checkbox"/> 1 - Patient remained in the community (without formal assistive services)</p> <p><input type="checkbox"/> 2 - Patient remained in the community (with formal assistive services)</p> <p><input type="checkbox"/> 3 - Patient transferred to a non-institutional hospice</p> <p><input type="checkbox"/> 4 - Unknown because patient moved to a geographic location not served by this agency</p> <p><input type="checkbox"/> UK - Other unknown [<i>Go to M0903</i>]</p>
ITEM INTENT
Identifies where the patient resides after discharge from the home health agency.
TIME POINTS ITEM(S) COMPLETED
Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services.</li> <li>• Formal assistive services refers to community-based services provided through organizations or by paid helpers. Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels. <ul style="list-style-type: none"> <li>– Therapy services provided in an outpatient setting would not be considered formal assistance.</li> </ul> </li> <li>• 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 (specifically, meals not provided by the church organization itself, but by individual volunteers).</li> <li>• Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.</li> </ul>
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> <li>• Patient/caregiver/family interview</li> <li>• Physician</li> <li>• Community resources</li> </ul>

OASIS ITEM
<p><b>(M2430) Reason for Hospitalization:</b> For what reason(s) did the patient require hospitalization? <b>(Mark all that apply.)</b></p> <p><input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis</p> <p><input type="checkbox"/> 2 - Injury caused by fall</p> <p><input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis)</p> <p><input type="checkbox"/> 4 - Other respiratory problem</p> <p><input type="checkbox"/> 5 - Heart failure (for example, fluid overload)</p> <p><input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat)</p> <p><input type="checkbox"/> 7 - Myocardial infarction or chest pain</p> <p><input type="checkbox"/> 8 - Other heart disease</p> <p><input type="checkbox"/> 9 - Stroke (CVA) or TIA</p> <p><input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control</p> <p><input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction</p> <p><input type="checkbox"/> 12 - Dehydration, malnutrition</p> <p><input type="checkbox"/> 13 - Urinary tract infection</p> <p><input type="checkbox"/> 14 - IV catheter-related infection or complication</p> <p><input type="checkbox"/> 15 - Wound infection or deterioration</p> <p><input type="checkbox"/> 16 - Uncontrolled pain</p> <p><input type="checkbox"/> 17 - Acute mental/behavioral health problem</p> <p><input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus</p> <p><input type="checkbox"/> 19 - Scheduled treatment or procedure</p> <p><input type="checkbox"/> 20 - Other than above reasons</p> <p><input type="checkbox"/> UK - Reason unknown</p>
ITEM INTENT
Identifies the specific condition(s) necessitating hospitalization.
TIME POINTS ITEM(S) COMPLETED
Transfer to inpatient facility - with or without agency discharge
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Select all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 17 would be marked. As another example, if a patient requires hospitalization for both heart failure and pneumonia, both Response 3 and Response 5 would be selected.</li> <li>• Response 2 should be selected if patient is hospitalized for an injury caused by a fall, regardless of where the fall occurred.</li> <li>• Response 20 should be selected if the patient is hospitalized for a new wound that is not the result of a fall.</li> <li>• If the reason is not included in the choices, select Response 20 “Other than above reasons.”</li> </ul>

**DATA SOURCES / RESOURCES (cont'd for OASIS Item M2430)**

- Telephone contact with patient/caregiver/family
- Facility discharge planner or case manager
- Physician
- Insurance case manager

<b>OASIS ITEM</b>
<p><b>(M0903) Date of Last (Most Recent) Home Visit:</b></p> <p style="text-align: center;">             ___ ___ / ___ ___ / ___ ___ ___ ___              month / day / year           </p>
<b>ITEM INTENT</b>
<p>Identifies the last or most recent home visit by any agency provider that is included on the Plan of Care.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Transfer to an inpatient facility - with or without agency discharge            Death at home            Discharge from agency</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• If the date or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.</li> <li>• If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist.</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Clinical record</li> </ul>



<b>OASIS ITEM</b>
<p><b>(M0906) Discharge/Transfer/Death Date:</b> Enter the date of the discharge, transfer, or death (at home) of the patient.</p> <p style="text-align: center;">             ____ / ____ / ____              month / day / year           </p>
<b>ITEM INTENT</b>
<p>Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.</p>
<b>TIME POINTS ITEM(S) COMPLETED</b>
<p>Transfer to an inpatient facility - with or without agency discharge            Death at home            Discharge from agency</p>
<b>RESPONSE—SPECIFIC INSTRUCTIONS</b>
<ul style="list-style-type: none"> <li>• If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2014 = 05/04/2014). Enter all four digits for the year.</li> <li>• The date of discharge is determined by agency policy or physician order.</li> <li>• The transfer date is the actual date the patient was admitted to an inpatient facility.</li> <li>• The death date is the actual date of the patient’s death at home. Exclude death occurring in an inpatient facility or in an emergency department, as both situations would result in Transfer OASIS collection and would report the date of transfer. Include death that occurs while a patient is being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).</li> </ul>
<b>DATA SOURCES / RESOURCES</b>
<ul style="list-style-type: none"> <li>• Agency policy or physician order</li> <li>• Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.</li> </ul>