Chapter 2 contains the following sets of OASIS items:

- All Items: This is the entire set of OASIS Items that are collected at any point in time during a home health episode of care. At any one point in time, only a subset of OASIS items is collected.
- Patient Tracking Sheet: This information is collected at Start of Care and updated as needed at subsequent time points. Note: Patient Tracking Sheet items are required to be included in the data submission record for each time point, although they are collected at Start of Care and only updated as needed at subsequent time points. Refer to the OASIS Data Specifications on the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/
 OASIS/Downloads/OASIS-C2-Data-Submission-Specs-v2-20-0-Draft.zip.
- Start of Care (SOC): This information is collected at Start of Care in addition to all OASIS items on the Patient Tracking Sheet.
- Resumption of Care (ROC): This information is collected at Resumption of Care in addition to M0032
 Resumption of Care Date on the Patient Tracking Sheet.
- Follow-Up (FU): This information is collected at Recertification and Other Follow-up.
- **Transfer (TRN):** This information is collected at Transfer to Inpatient Facility, with or without Discharge from Home Health Agency.
- **Discharge (DC):** This information is collected at discharge from home health agency other than Death at Home or Transfer to Inpatient Facility.
- **Death at Home (Death):** This information is collected when the patient dies while on service with the home health agency, and died somewhere other than an inpatient/outpatient facility or ED.

Home Health Patient Tracking Sheet

(M0010)	CMS Certification N	umber:															
(M0014)	Branch State:																
(M0016)	Branch ID Number:	Γ															
(M0018)	National Provider Identifier (NPI) for the attending physician who has signed the plan of care:																
								□ U	K -	- Un	kno	wn or	Not A	vail	able)	
(M0020)	Patient ID Number:																
(M0030)	Start of Care Date:	mo	nth .	/ da	У	/	yea	ır									
(M0032)	Resumption of Care			month	/[day]/[ear			□ N.	A - No	t Ap	plic	able	
(M0040)	Patient Name:			11011111		uay	, ,	, ,	Cui								
(First)		Ш,	[M I)					<u> </u>	_ast))						(S	uffix)
	Patient State of Res		` <i>Г</i>					,	•							,	,
(M0060)	Patient ZIP Code:					_ [
(M0063)	Medicare Number:	(inc	ludin	g suff	fix)								NA -	- No	o M	edica	are
(M0064)	Social Security Nur	nber:			- [-] UI	K – Ur	know	n or	Not	. Ava	ilable
(M0065)	Medicaid Number:												□ NA	- N	lo N	ledic	aid
(M0066)	Birth Date:	mo	nth	/ da	У	/	yea	r									
					•												
(M0069)	Gender																
Enter Co	ode 1 Male 2 Female																

(M0140)	Rac	e/Et	hnicity: (Mark all that apply.)
	1	-	American Indian or Alaska Native
	2	-	Asian
	3	-	Black or African-American
	4	-	Hispanic or Latino
	5	-	Native Hawaiian or Pacific Islander
	6	-	White
(M0150)	Cur	rent	Payment Sources for Home Care: (Mark all that apply.)
	0	-	None; no charge for current services
	1	-	Medicare (traditional fee-for-service)
	2	-	Medicare (HMO/managed care/Advantage plan)
	3	-	Medicaid (traditional fee-for-service)
	4	-	Medicaid (HMO/managed care)
	5	-	Workers' compensation
	6	-	Title programs (for example, Title III, V, or XX)
	7	-	Other government (for example, TriCare, VA)
	8	-	Private insurance
	9	-	Private HMO/managed care
	10	-	Self-pay
	11	-	Other (specify)
	UK	-	Unknown

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

Time Point	Items Used						
Start of Care	M0010-M0030, M0040-M0150, M1000-M1036, M1060-						
Start of care—further visits planned	M1306, M1311, M1320-M1410, M1600-M2003, M2010 M2020-M2250, GG0170						
Resumption of Care	M0032, M0080-M0110, M1000-M1036, M1060-M1306,						
Resumption of care (after inpatient stay)	M1311, M1320-M1410, M1600-M2003, M2010, M2020- M2250, GG0170						
Follow-Up	M0080-M0100, M0110, M1011, M1021- M1025, M1030,						
Recertification (follow-up) assessment Other follow-up assessment	M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200						
Transfer to an Inpatient Facility	M0080-M0100, M1041-M1056, M1501, M1511, M2005,						
Transferred to an inpatient facility—patient not discharged from an agency	M2016, M2301-M2410, M2430, M0903, M0906						
Transferred to an inpatient facility—patient							
discharged from agency							
Discharge from Agency — Not to an Inpatient Facility							
Death at home	M0080-M0100, M2005, M0903, M0906						
Discharge from agency	M0080-M0100, M1041-M1056, M1230, M1242, M1306-						
	M1342, M1400, M1501-M1620, M1700-M1720, M1740,						
	M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906						
CLINICAL RECORD ITEMS							
(M0080) Discipline of Person Completing Assessment							
Enter Code 1 RN							
····· - ··· 2 PI							
3 SLP/ST 4 OT							
(M0090) Date Assessment Completed:							
month day year							
(M0100) This Assessment is Currently Being Complete	ed for the Following Reason:						
Start/Resumption of Care	-						
Enter Code 1 Start of care—further visits planned							
	Resumption of care (after inpatient stay)						
	Follow-Up 4 Recertification (follow-up) reassessment [Go to M0110]						
5 Other follow-up [<i>Go to M0110</i>]							
Transfer to an Inpatient Facility							
	tient not discharged from agency [<i>Go to M1041</i>]						
	7 Transferred to an inpatient facility—patient discharged from agency [<i>Go to M1041</i>]						

<u>Discharge from Agency — Not to an Inpatient Facility</u>

Death at home [Go to M2005]

Discharge from agency [Go to M1041]

	care (resumption of care) date when the patient was referred for home health services, record the date
\$	specified. [Go to M0110, if date entered]
	month day year
	NA - No specific SOC date ordered by physician
	Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was eceived by the HHA.
	month day year
	Episode Timing: Is the Medicare home health payment episode for which this assessment will
	define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Cod	le 1 Early
	UK Unknown
	NA Not Applicable: No Medicare case mix group to be defined by this assessment.
PATIEN	Γ HISTORY AND DIAGNOSES
	From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all
t	hat apply.)
	1 - Long-term nursing facility (NF)
	2 - Skilled nursing facility (SNF/TCU) Short stay pouts heapital (IRRS)
	3 - Short-stay acute hospital (IPPS)4 - Long-term care hospital (LTCH)
	4 - Long-term care hospital (LTCH) 5 - Inpatient rehabilitation hospital or unit (IRF)
	6 - Psychiatric hospital or unit
	7 - Other (specify)
	NA - Patient was not discharged from an inpatient facility [Go to M1017]
(M1005) I	npatient Discharge Date (most recent):
(1011003)	inpatient discharge date (most recent).
	month day year
	UK - Unknown
	List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):
	Inpatient Facility Diagnosis ICD-10-CM Code
	a
	D
	c
(d
•	e
f	·
	NA - Not applicable (patient was not discharged from an inpatient facility) [Omit "NA" option on SOC,
	ROC]

Changed Medical Regimen Diagnosis a	(M1017)	Med	dical	es Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):							
b			<u>Cha</u>	nged Medical Regimen Diagnosis ICD-10-CM Code							
c. d. e. f. NA - Not applicable (no medical or treatment regimen changes within the past 14 days) (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: patient experienced an inpatient facility discharge or change in medical or treatment regimen within the ladays, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen within the ladays, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen within the ladays, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen in past 14 Days: 1 - Urinary incontinence 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days		a.									
d		b.									
e		C.									
NA - Not applicable (no medical or treatment regimen changes within the past 14 days) (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen within the past 14 that apply.) 1 - Urinary incontinence 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days		d.									
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NA - Not applicable (no medical or treatment regimen changes within the past 14 days) (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen within the past indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regiment along the inpatient stay or change in medical or treatment regiment regiment in past 14 days 1 - Urinary incontinence 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days		f.									
(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: patient experienced an inpatient facility discharge or change in medical or treatment regimen within the patient stay, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen within the patient stay or change in medical or treatment regimen within the patient stay or change in medical or treatment regimen that apply.) 1 - Urinary incontinence 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days	_										
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 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days 	(M1018)	pati day	ient s, in	experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 ndicate any conditions that existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen.							
 □ 3 - Intractable pain □ 4 - Impaired decision-making □ 5 - Disruptive or socially inappropriate behavior □ 6 - Memory loss to the extent that supervision required □ 7 - None of the above □ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days] 1	-	Urinary incontinence							
 □ 4 - Impaired decision-making □ 5 - Disruptive or socially inappropriate behavior □ 6 - Memory loss to the extent that supervision required □ 7 - None of the above □ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days] 2	-	Indwelling/suprapubic catheter							
 □ 5 - Disruptive or socially inappropriate behavior □ 6 - Memory loss to the extent that supervision required □ 7 - None of the above □ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days] 3	-	Intractable pain							
 G - Memory loss to the extent that supervision required T - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days] 4	-	Impaired decision-making							
☐ 7 - None of the above ☐ NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days] 5	-	Disruptive or socially inappropriate behavior							
□ NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days] 6	-	Memory loss to the extent that supervision required							
] 7	_	None of the above							
	_	1 NA	_	No inpatient facility discharge and no change in medical or treatment regimen in past 14 days							

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

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

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

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

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

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

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

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

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.
- Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis	s & (M1023) Other Diagnoses	(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)						
Column 1	Column 2	Column 3	Column 4					
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)					
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM					
(M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed					
a	a	a	a (
(M1023) Other Diagnoses	All ICD-10-C M codes allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed					
b	b	b	b					
c	c	c(c					
d	d	d(d(
e	e	e(e(
f	f	f(f					
(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply See OASIS Guidance Manual for a complete list of relevant ICD-10 codes. 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) 2 - Diabetes Mellitus (DM) (M1030) Therapies the patient receives at home: (Mark all that apply.)								
☐ 1 - Intraveno	us or infusion therapy (excludes	TPN)						
☐ 2 - Parentera	I nutrition (TPN or lipids)							
☐ 3 - Enteral nu canal) ☐ 4 - None of th	utrition (nasogastric, gastrostom) ne above	y, jejunostomy, or any other a	rtificial entry into the alimentar					

		Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for zation? (Mark all that apply.)
	1 -	History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
	2 -	Unintentional weight loss of a total of 10 pounds or more in the past 12 months
	3 -	Multiple hospitalizations (2 or more) in the past 6 months
	4 -	Multiple emergency department visits (2 or more) in the past 6 months
	5 -	Decline in mental, emotional, or behavioral status in the past 3 months
	6 -	Reported or observed history of difficulty complying with any medical instructions (for example,
		medications, diet, exercise) in the past 3 months
		Currently taking 5 or more medications
		Currently reports exhaustion
		Other risk(s) not listed in 1 - 8
	10 -	None of the above
(M1034) C	verall	Status: Which description best fits the patient's overall status?
Enter Code	9 0	The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
	1	The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
	2	The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
	3	The patient has serious progressive conditions that could lead to death within a year.
	UK	The patient's situation is unknown or unclear.
	nat app	ctors, either present or past, likely to affect current health status and/or outcome: (Mark all olly.) Smoking
П		Obesity
П		Alcohol dependency
		Drug dependency
		None of the above
	_	Unknown
· _		ta Vaccine Data Collection Period: Does this episode of care (SOC/ROC to large) include any dates on or between October 1 and March 31?
Enter Code	0	No <i>[Go to M1051]</i>
	1	Yes
	ifluenz eason?	a Vaccine Received: Did the patient receive the influenza vaccine for this year's flu
Enter Code	∌ 1	Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
	2	Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
	3	Yes; received from another health care provider (for example, physician, pharmacist)
	4	No; patient offered and declined
	5	No; patient assessed and determined to have medical contraindication(s)
	6	No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
	7	No; inability to obtain vaccine due to declared shortage
	8	No; patient did not receive the vaccine due to reasons other than those listed in responses $4-7$.

	eumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for mple, pneumovax)?	
Enter Code	0 No 1 Yes [<i>Go to M1501 at TRN; Go to M1230 at DC</i>]	
•	ason Pneumococcal Vaccine not received: If patient has never received the pneumococcal cination (for example, pneumovax), state reason:	
Enter Code	1 Offered and declined 2 Assessed and determined to have medical contraindication(s) 3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine 4 None of the above	
(M1060) Heig	ht and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater rou	nd up
inches	a. Height (in inches). Record most recent height measure since the most recent SOC/ROC	
pounds	b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, bef shoes off, etc.)	

LIVING ARRANGEMENTS

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

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

SENSORY STATUS

(M1200) Visio	on (wi	th corrective lenses if the patient usually wears them):
Enter Code	0	Normal vision: sees adequately in most situations; can see medication labels, newsprint.
Ш	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.
	2	Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.
(M1210) Abil	ity to	Hear (with hearing aid or hearing appliance if normally used):
(WITZTO) ADII	l	
Enter Code	0 1	Adequate: hears normal conversation without difficulty. Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
	2	Severely Impaired: absence of useful hearing.
	UK	Unable to assess hearing.
(M1220) Und	erstaı	nding of Verbal Content in patient's own language (with hearing aid or device if used):
F	0	Understands: clear comprehension without cues or repetitions.
Enter Code	1	Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
	2	Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
	3	Rarely/Never Understands.
	UK	Unable to assess understanding.
(M1230) Spec	ech a	nd Oral (Verbal) Expression of Language (in patient's own language):
Enter Code	0	Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
	1	Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
	2	Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
	3	Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
	4	<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).
	5	Patient nonresponsive or unable to speak.
		atient had a formal Pain Assessment using a standardized, validated pain assessment opriate to the patient's ability to communicate the severity of pain)?
Enter Code	0	No standardized, validated assessment conducted
	1	Yes, and it does not indicate severe pain
	2	Yes, and it indicates severe pain
(M1242) Fred	uenc	y of Pain Interfering with patient's activity or movement:
Fintan Cada	0	Patient has no pain
Enter Code	1	Patient has pain that does not interfere with activity or movement
	2	Less often than daily
	3	Daily, but not constantly
	4	All of the time

INTEGUMENTARY STATUS

(M1300) Pres Ulce	ssure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure ers?
Enter Code	0 No assessment conducted [Go to M1306]
Enter Code	Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
	2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Doe	s this patient have a Risk of Developing Pressure Ulcers?
Enter Code	0 No
	1 Yes
	s this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated Instageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)
Enter Code	0 No [<i>Go to M1322</i>]
	1 Yes
	Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 sure Ulcers)
Enter Code	Was present at the most recent SOC/ROC assessment Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:
	NA No Stage 2 pressure ulcers are present at discharge

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

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

		rrent pressure ulcers that were nc o current pressure ulcer at a give	
		Enter Nu	ımber
a. Stage 2			
b. Stage 3			
c. Stage 4			
	or e: For pressure ulcers that are t a Stage 1 or 2 at the most rece	Unstageable due to slough/eschant SOC/ROC.	ar, report the number that are
d. Unstageabl	le – Known or likely but ble due to non-removable		
Unstageal bed by slo	e – Known or likely but ble due to coverage of wound ough and/or eschar.		
f. Unstageabl injury in e	e – Suspected deep tissue volution.		
,,			-
	us of Most Problematic Pressunt be observed due to a non-rem	re Ulcer that is Observable: (Expovable dressing/device)	ccludes pressure ulcer that
Enter Code	 Newly epithelialized Fully granulating Early/partial granulation Not healing NA No observable pressure 	ulcer	
local cool	lized area usually over a bony pro	re Ulcers: Intact skin with non-bla ominence. The area may be painf or. Darkly pigmented skin may not th persistent blue or purple hues.	ul, firm, soft, warmer, or
Enter Code	0 1 2 3 4 or more		
ulce		ed Pressure Ulcer that is Stagea non-removable dressing/device, co eep tissue injury.)	
Enter Code		icers or no stageable pressure ulc	ers
(M1330) Doe:	s this patient have a Stasis Ulcer	r?	
Enter Code	2 Yes, patient has observab		
	3 Yes, patient has unobserv non-removable dressing/d	able stasis ulcers ONLY (known b evice) [<i>Go to M1340</i>]	out not observable due to

(M1332) Curi	rent Number of Stasis Ulcer(s) that are Observable:
Enter Code	1 One 2 Two 3 Three 4 Four or more
(M1334) Stat	us of Most Problematic Stasis Ulcer that is Observable:
Enter Code	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340) Doe:	s this patient have a Surgical Wound?
Enter Code	 No [At SOC/ROC, go to M1350; At FU//DC, go to M1400] Yes, patient has at least one observable surgical wound Surgical wound known but not observable due to non-removable dressing/device [At SOC/ROC, go to M1350; At FU/DC, go to M1400]
(M1342) Stat	us of Most Problematic Surgical Wound that is Observable
Enter Code	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing
	s this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those cribed above, that is receiving intervention by the home health agency?
Enter Code	0 No 1 Yes
	ORY STATUS
(M1400) Whe	en is the patient dyspneic or noticeably Short of Breath ?
Enter Code	 Patient is not short of breath When walking more than 20 feet, climbing stairs With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
	 With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation At rest (during day or night)
·	piratory Treatments utilized at home: (Mark all that apply.)
□ 1	- Oxygen (intermittent or continuous)
	Ventilator (continually or at night)Continuous / Bi-level positive airway pressure
□ 3	

CARDIAC STATUS

			
	patie	nt ex	is in Heart Failure Patients: If patient has been diagnosed with heart failure, did the thibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, r weight gain) at the time of or at any time since the most recent SOC/ROC assessment?
F		0	No [Go to M2005 at TRN; Go to M1600 at DC]
Enter Co	ae	1	Yes
		2	Not assessed [Go to M2005 at TRN; Go to M1600 at DC]
		NA	Patient does not have diagnosis of heart failure [Go to M2005 at TRN; Go to M1600 at
			DC]
	indic actio	ative n(s)	lure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what has (have) been taken to respond? (Mark all that apply.)
	0		lo action taken
	1		Patient's physician (or other primary care practitioner) contacted the same day
	2		Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
	3		mplemented physician-ordered patient-specific established parameters for treatment
	4		Patient education or other clinical interventions
	5		Dbtained change in care plan orders (for example, increased monitoring by agency, change in visiting in the control of the con
ELIMINA			
(M1600)	Has	this p	atient been treated for a Urinary Tract Infection in the past 14 days?
Enter Co	do	0	No
Enter Cor	ue	1	Yes
		NA	Patient on prophylactic treatment
		UK	Unknown [<i>Omit "UK" option on DC</i>]
(M1610)	Urina	ary Ir	ncontinence or Urinary Catheter Presence:
F (0-	al .	0	No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]
Enter Co	ae	1	Patient is incontinent
		2	Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or
			suprapubic) [Go to M1620]
(M1615)	Whe	n doe	es Urinary Incontinence occur?
_		0	Timed-voiding defers incontinence
Enter Co	de	1	Occasional stress incontinence
		2	During the night only
		3	During the day only
		4	During the day and night

(M1620) Bowel Incontinence Frequency:				
Enter Code	Very rarely or never has bowel incontinenceLess than once weekly			
	2 One to three times weekly			
	3 Four to six times weekly			
	4 On a daily basis			
	5 More often than once daily			
	NA Patient has ostomy for bowel elimination			
	UK Unknown [Omit "UK" option on FU, DC]			
(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?				
Enter Code	0 Patient does <u>not</u> have an ostomy for bowel elimination.			
	Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen.			
	The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.			

NEURO/EMOTIONAL/BEHAVIORAL STATUS

		Functioning: Patient's current (day of assessment) level of alertness, orientation,
com		ension, concentration, and immediate memory for simple commands.
Enter Code	0	Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1	Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
	2	Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
	3	Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
	4	Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
(M1710) Whe	n Co	nfused (Reported or Observed Within the Last 14 Days):
	0	Never
Enter Code	1	In new or complex situations only
	2	On awakening or at night only
ш	3	During the day and evening, but not constantly
	4	Constantly
	NA	Patient nonresponsive
(M1720) Whe	n An	xious (Reported or Observed Within the Last 14 Days):
	0	None of the time
Enter Code	1	Less often than daily
	2	Daily, but not constantly
ш	3	All of the time
	NA	Patient nonresponsive

		sion Screening: Has the sion screening tool?	ne patient	been scree	ened for depr	ession, using a	standardize	d, validated	
	. 0								
Enter Code	1	Yes, patient was scr	eened usii	ng the PHO	Q-2©* scale.				
		Instructions for this have you been bot					weeks, ho	w often	
		PHQ-2©*	•	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond	
		a) Little interest or in doing things	pleasure	□0	<u></u> 1	□2	□3	□NA	
		b) Feeling down, depressed, or h	opeless?	□0	<u></u> 1	□2	□3	□NA	
	3	patient meets criteria	a for furthe eened with et criteria f	er evaluation In a differer For further o	n for depress at standardize evaluation for	sion. ed, validated ass depression.	essment ar	d the	
			*Copyrig	ht© Pfizer	Inc. All rights	reserved. Repr	oduced with	permission	1.
		ive, behavioral, and ps ved): (Mark all that app		symptoms	that are den	nonstrated <u>at lea</u>	ist once a w	<u>reek</u> (Repo	rted or
	1 - 2 - 3 - 4 - 5 - 7 -	Memory deficit: failure significant memory los Impaired decision-mak activities, jeopardizes significant disruption: yelli Physical aggression: apunches, dangerous minimum Disruptive, infantile, or Delusional, hallucinato None of the above behinder of the properties of the significant of the signi	s so that s ing: failure safety thro ng, threate aggressive aneuvers socially in ry, or para	upervision to perforn ugh action ening, exce or comba with wheel appropriat noid behav	is required n usual ADLs s essive profani tive to self an chair or other e behavior (ex vior	or IADLs, inabil ity, sexual refere d others (for exa r objects)	ity to appropences, etc.	priately stop	o
oth		ency of Disruptive Beha isruptive/dangerous sym							
Enter Code	0 1 2 3 4 5	Less than once a mo Once a month Several times each of Several times a wee	month ·k	ing Servic	e s at home n	provided by a gu	alified psvo	hiatric	
•	rse?	Salant 100017111g 1 Gyothe		9 001 110	o at nome p				
Enter Code	0	110							
	1	Yes							

ADL/IADLs

	rooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and ands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code	O Able to groom self unaided, with or without the use of assistive devices or adapted methods.
	1 Grooming utensils must be placed within reach before able to complete grooming activities.
	2 Someone must assist the patient to groom self.
	3 Patient depends entirely upon someone else for grooming needs.
	urrent Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including ndergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code	Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1 Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2 Someone must help the patient put on upper body clothing.
	3 Patient depends entirely upon another person to dress the upper body.
	urrent Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including indergarments, slacks, socks or nylons, shoes:
Enter Code	Able to obtain, put on, and remove clothing and shoes without assistance.
	1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
	2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
	3 Patient depends entirely upon another person to dress lower body.
	athing: Current ability to wash entire body safely. Excludes grooming (washing face, washing ands, and shampooing hair).
Enter Code	O Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	(b) to get in and out of the shower or tub, <u>OR</u>
	 (c) for washing difficult to reach areas. 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.
	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.
	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
	bilet Transferring: Current ability to get to and from the toilet or bedside commode safely <u>and</u> ansfer on and off toilet/commode.
Enter Code	0 Able to get to and from the toilet and transfer independently with or without a device.
Linter Code	1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.

inco	eting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or ntinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, des cleaning area around stoma, but not managing equipment.
Enter Code	Able to manage toileting hygiene and clothing management without assistance. Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. Someone must help the patient to maintain toileting hygiene and/or adjust clothing. Patient depends entirely upon another person to maintain toileting hygiene.
	sferring: Current ability to move safely from bed to chair, or ability to turn and position self in f patient is bedfast.
Enter Code	Able to independently transfer. Able to transfer with minimal human assistance or with use of an assistive device. Able to bear weight and pivot during the transfer process but unable to transfer self. Unable to transfer self and is unable to bear weight or pivot when transferred by another person. Bedfast, unable to transfer but is able to turn and position self in bed. Bedfast, unable to transfer and is unable to turn and position self.

Section GG: FUNCTIONAL ABILITIES and GOALS - SOC/ROC

	GO170C) Mobility	<i>50</i> /1100		
	Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at			
	SOC/ROC, code the reason.			
	de the patient's discharge goal using the 6-point scale. Do not	use codes 07, 0	9, or 88 to co	de discharge
goa				
	ding:	1.	2.	
	ety and Quality of Performance – If helper assistance is	SOC/ROC	Discharge	
	uired because patient's performance is unsafe or of poor quality,	Performance	Goal	
	re according to amount of assistance provided.	Ne	1.	
	ivity may be completed with or without assistive devices.	Ψ Enter Codes	s in Boxes♥	
06	Independent – Patient completes the activity by him/herself with no assistance from a helper.			Lying to
05	Setup or clean-up assistance – Helper SETS UP or CLEANS			Sitting on
03	UP; patient completes activity. Helper assists only prior to or			Side of Bed:
	following the activity.			The ability to
04	Supervision or touching assistance – Helper provides			safely move
٠.	VERBAL CUES or TOUCHING/STEADYING assistance as			from lying on
	patient completes activity. Assistance may be provided			the back to
throughout the activity or intermittently.				sitting on the
03	Partial/moderate assistance – Helper does LESS THAN HALF			side of the bed
	the effort. Helper lifts, holds or supports trunk or limbs, but			with feet flat on
provides less than half the effort. the floor, and				the floor, and with no back
02	Substantial/maximal assistance – Helper does MORE THAN			
	HALF the effort. Helper lifts or holds trunk or limbs and provides			support.
0.4	more than half the effort.			
υı	Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or			
	more helpers is required for the patient to complete the activity.			
If a	ctivity was not attempted, code reason:			
07	Patient refused			
09	Not applicable			
88	Not attempted due to medical condition or safety concerns			

		on/Locomotion: Current ability to walk safely, once in a standing position, or use a r, once in a seated position, on a variety of surfaces.
Enter Code	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3	Able to walk only with the supervision or assistance of another person at all times.
	4	Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
	5	Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
	6	Bedfast, unable to ambulate or be up in a chair.
		or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to so feating, chewing, and swallowing, not preparing the food to be eaten.
Futur Code	0	Able to independently feed self.
Enter Code	1	Able to feed self independently but requires:
		(a) meal set-up; <u>OR</u>
		(b) intermittent assistance or supervision from another person; OR
		(c) a liquid, pureed or ground meat diet.
	2	<u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
	3	Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4	<u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5	Unable to take in nutrients orally or by tube feeding.
		bility to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat meals safely:
Enter Code	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).
	1	<u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
	2	Unable to prepare any light meals or reheat any delivered meals.
		Use Telephone: Current ability to answer the phone safely, including dialing numbers, ively using the telephone to communicate.
	0	Able to dial numbers and answer calls appropriately and as desired.
Enter Code	1	Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
	2	Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
	3	Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
	4	Unable to answer the telephone at all but can listen if assisted with equipment.
	5	Totally unable to use the telephone.
	NA	Patient does not have a telephone.

his/h	r Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to er most recent illness, exacerbation, or injury.
Enter Code	Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) Independent Needed Some Help Dependent
Enter Code	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	 d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent
	this patient had a multi-factor Falls Risk Assessment using a standardized, validated ssment tool?
Enter Code	 No. Yes, and it does not indicate a risk for falls. Yes, and it does indicate a risk for falls.
MEDICATIO	<u>DNS</u>
(M2001) Drug	
med	Regimen Review: Did a complete drug regimen review identify potential clinically significant ication issues?
Enter Code	
Enter Code (M2003) Media	cation issues? 0 No - No issues found during review [<i>Go to M2010</i>] 1 Yes - Issues found during review
Enter Code (M2003) Media	O No - No issues found during review [Go to M2010] 1 Yes - Issues found during review 9 NA - Patient is not taking any medications [Go to M2040] cation Follow-up: Did the agency contact a physician (or physician-designee) by midnight of ext calendar day and complete prescribed/recommended actions in response to the identified
Enter Code (M2003) Media the na poten Enter Code (M2005) Media pres	O No - No issues found during review [Go to M2010] 1 Yes - Issues found during review 9 NA - Patient is not taking any medications [Go to M2040] cation Follow-up: Did the agency contact a physician (or physician-designee) by midnight of ext calendar day and complete prescribed/recommended actions in response to the identified tial clinically significant medication issues? 0 No
Enter Code (M2003) Media the na poten Enter Code (M2005) Media pres	O No - No issues found during review [Go to M2010] 1 Yes - Issues found during review 9 NA - Patient is not taking any medications [Go to M2040] Cation Follow-up: Did the agency contact a physician (or physician-designee) by midnight of ext calendar day and complete prescribed/recommended actions in response to the identified tial clinically significant medication issues? O No 1 Yes ication Intervention: Did the agency contact and complete physician (or physician-designee) cribed/recommended actions by midnight of the next calendar day each time potential clinically
Enter Code (M2003) Media the na poten Enter Code (M2005) Med pres signi Enter Code	O No - No issues found during review [Go to M2010] 1 Yes - Issues found during review 9 NA - Patient is not taking any medications [Go to M2040] Cation Follow-up: Did the agency contact a physician (or physician-designee) by midnight of ext calendar day and complete prescribed/recommended actions in response to the identified tial clinically significant medication issues? O No 1 Yes Ication Intervention: Did the agency contact and complete physician (or physician-designee) cribed/recommended actions by midnight of the next calendar day each time potential clinically ficant medication issues were identified since the SOC/ROC? O No

NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about

special precautions associated with all high-risk medications

Νo

Yes

0

1

Enter Code

how and when to report problems that may occur?

rec car	ent SO e provi	aregiver Drug Education Intervention: At the time of, or at any time since the most DC/ROC assessment, was the patient/caregiver instructed by agency staff or other health der to monitor the effectiveness of drug therapy, adverse drug reactions, and significant ts, and how and when to report problems that may occur?
Enter Code	0 1 NA	No Yes Patient not taking any drugs
reli Ex	ably an	nent of Oral Medications: Patient's current ability to prepare and take <u>all</u> oral medications and safely, including administration of the correct dosage at the appropriate times/intervals. injectable and IV medications. (NOTE: This refers to ability, not compliance or ss.)
Enter Code	0	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1	Able to take medication(s) at the correct times if:
ш		(a) individual dosages are prepared in advance by another person; <u>OR</u>
		(b) another person develops a drug diary or chart.
	2	Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	3	<u>Unable</u> to take medication unless administered by another person.
	NA	No oral medications prescribed.
injed	ctable n	ent of Injectable Medications: Patient's current ability to prepare and take <u>all</u> prescribed medications reliably and safely, including administration of correct dosage at the etimes/intervals. Excludes IV medications.
Enter Code	0	Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
	1	Able to take injectable medication(s) at the correct times if:
		(a) individual syringes are prepared in advance by another person; <u>OR</u>
		(b) another person develops a drug diary or chart.
	2	Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
	3	<u>Unable</u> to take injectable medication unless administered by another person.
	NA	No injectable medications prescribed.
		dication Management: Indicate the patient's usual ability with managing oral and medications prior to his/her most recent illness, exacerbation or injury.
Enter Code	a.	Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code	b.	Injectable medications Injectable medications Independent Needed Some Help Dependent NA Not Applicable

CARE MANAGEMENT

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

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

THERAPY NEED AND PLAN OF CARE

(M2200)	herapy Need: In the home health plan of care for the Medicare payment episode for which this as ill define a case mix group, what is the indicated need for therapy visits (total of reasonable and ne hysical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no isits indicated.)	cessary
([Number of therapy visits indicated (total of physical, occupational and speech-language parcombined).	:hology
	IA - Not Applicable: No case mix group defined by this assessment.	
(M2250)	lan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of ca	re include

(M2250) Plan of Care Synopsis: (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	□0	1	□NA Physician has ch establish patient-	specific is patient. Agency ized clinical sible for all care
b.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	□0	□1	NA Patient is not dial lower legs due to acquired conditionamputee).	
C.	Falls prevention interventions	□0	□1	□NA Falls risk assessi patient has no ris	
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	<u></u> 0	<u></u> 1	no symptoms of o has some sympto but does not mee	depression es patient has: 1) depression; or 2) oms of depression et criteria for further ression based on
e.	Intervention(s) to monitor and mitigate pain	□0	<u></u> 1	□NA Pain assessment has no pain.	indicates patient
f.	Intervention(s) to prevent pressure ulcers	□0	<u></u> 1		sk assessment) indicates patient eveloping pressure
g.	Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	□0	<u></u> 1	□NA Patient has no pr has no pressure moist wound hea	

EMERGENT CARE

(M2301)			ent Care: At the time of or at any time since the most recent SOC/ROC assessment has the utilized a hospital emergency department (includes holding/observation status)?
		0	No [<i>Go to M2401</i>]
Enter Co	de	1	Yes, used hospital emergency department WITHOUT hospital admission
		2	Yes, used hospital emergency department WITH hospital admission
		U	K Unknown [<i>Go to M2401</i>]
(M2310)			n for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or hospitalization)? (Mark all that apply.)
	1	-	Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
	2	-	Injury caused by fall
	3	-	Respiratory infection (for example, pneumonia, bronchitis)
	4	-	Other respiratory problem
	5	-	Heart failure (for example, fluid overload)
	6	-	Cardiac dysrhythmia (irregular heartbeat)
	7	-	Myocardial infarction or chest pain
	8	-	Other heart disease
	9	-	Stroke (CVA) or TIA
	10	-	Hypo/Hyperglycemia, diabetes out of control
	11	-	GI bleeding, obstruction, constipation, impaction
	12	-	Dehydration, malnutrition
	13	-	Urinary tract infection
	14	-	IV catheter-related infection or complication
	15	-	Wound infection or deterioration
	16	-	Uncontrolled pain
	17	-	Acute mental/behavioral health problem
	18	-	Deep vein thrombosis, pulmonary embolus
	19	_	Other than above reasons

☐ UK - Reason unknown

$\frac{\text{DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE}{\text{ONLY}}$

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

	Plan / Intervention	No	Yes	Not App	olicable
a.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	□0	<u></u> 1	□NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b.	Falls prevention interventions	0 0	<u></u> 1	□NA	Every standardized, validated multi- factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
C.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	_0	_1	□NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d.	Intervention(s) to monitor and mitigate pain	□0	<u></u> 1	□NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e.	Intervention(s) to prevent pressure ulcers	O	<u></u> 1	□NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f.	Pressure ulcer treatment based on principles of moist wound healing	<u></u> 0	1	□NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(M2410) To w	/hich I	Inpatient Facility has the patient been admitted?			
Enter Code	1	Hospital [Go to M2430]			
	2	Rehabilitation facility [<i>Go to M0903</i>]			
	3	Nursing home [Go to M0903]			
	4	Hospice [<i>Go to M0903</i>]			
	NA	No inpatient facility admission [Omit "NA" option on TRN]			
· /	(M2420) Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)				
Fintair Code	1	Patient remained in the community (without formal assistive services)			
Enter Code	2	Patient remained in the community (with formal assistive services)			
	3	Patient transferred to a non-institutional hospice			
	4	Unknown because patient moved to a geographic location not served by this agency			
	UK	Other unknown [Go to M0903]			

(M2430)	Rea	son	for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)			
	1	-	Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis			
	2	-	Injury caused by fall			
	3	-	Respiratory infection (for example, pneumonia, bronchitis)			
	4	-	Other respiratory problem			
	5	-	Heart failure (for example, fluid overload)			
	6	-	Cardiac dysrhythmia (irregular heartbeat)			
	7	-	Myocardial infarction or chest pain			
	8	-	Other heart disease			
	9	-	Stroke (CVA) or TIA			
	10	-	Hypo/Hyperglycemia, diabetes out of control			
	11	-	Gl bleeding, obstruction, constipation, impaction			
	12	-	Dehydration, malnutrition			
	13	-	Urinary tract infection			
	14	-	IV catheter-related infection or complication			
	15	-	Wound infection or deterioration			
	16	-	Uncontrolled pain			
	17	-	Acute mental/behavioral health problem			
	18	-	Deep vein thrombosis, pulmonary embolus			
	19	-	Scheduled treatment or procedure			
	20	-	Other than above reasons			
	UK	-	Reason unknown			
(M0903)		e of	Last (Most Recent) Home Visit: / /			
(M0906)		cha 	rge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.			

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

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

CLINICAL RECORD ITEMS

(M0080) Disci	pline of Person Completing Assessment
Enter Code	1 RN 2 PT 3 SLP/ST 4 OT
(M0090) Date	Assessment Completed:
mo	onth day year
(M0100) This	Assessment is Currently Being Completed for the Following Reason:
Enter Code	Start/Resumption of Care Start of care—further visits planned Resumption of care (after inpatient stay) Follow-Up
	4 Recertification (follow-up) reassessment [<i>Go to M0110</i>]
	5 Other follow-up [<i>Go to M0110</i>]
	Transfer to an Inpatient Facility
	6 Transferred to an inpatient facility—patient not discharged from agency [Go to M1041]
	7 Transferred to an inpatient facility—patient discharged from agency [Go to M1041]
	Discharge from Agency—Not to an Inpatient Facility
	8 Death at home [Go to M2005]
	9 Discharge from agency [Go to M1041]

(M0102)	Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
	month day year [Go to M0110, if date entered]
	NA – No specific SOC date ordered by physician
(M0104)	Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
	month day year
(M0110)	Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Co	1 Early 2 Later UK Unknown NA Not Applicable: No Medicare case mix group to be defined by this assessment.
	Not Applicable. No Medicare case thix group to be defined by this assessment.
PATIEN	IT HISTORY AND DIAGNOSES
(M1000)	From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)
	1 - Long-term nursing facility (NF)
	2 - Skilled nursing facility (SNF/TCU)
	3 - Short-stay acute hospital (IPPS)
	4 - Long-term care hospital (LTCH)
	5 - Inpatient rehabilitation hospital or unit (IRF)
	6 - Psychiatric hospital or unit
	7 - Other (specify)
	NA - Patient was not discharged from an inpatient facility [Go to M1017]
(M1005)	Inpatient Discharge Date (most recent):
	UK - Unknown
(M1011)	List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):
	Inpatient Facility Diagnosis ICD-10-CM Code
	a
	b
	c
	d
	e
	f

(M1017)	Medical	ses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring d medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):
	Cha	nged Medical Regimen Diagnosis ICD-10-CM Code
	a	
	b	
	ı	
	Conditi patient of days, in (Mark a	Not applicable (no medical or treatment regimen changes within the past 14 days) ions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 dicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimentall that apply.)
		Urinary incontinence
		Indwelling/suprapubic catheter
	3 -	Intractable pain
	4 -	Impaired decision-making
	5 -	Disruptive or socially inappropriate behavior
	6 -	Memory loss to the extent that supervision required
	7 -	None of the above
	NA	No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
	UK	Unknown

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

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

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

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

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

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

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

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

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.
- Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis	s & (M1023) Other Diagnoses	(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)		
Column 1	Column 2	Column 3	Column 4	
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)	
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM	
(M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed	
a	a.	a	a	
(M1023) Other Diagnoses	All ICD-10-C M codes allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed	
b	b.	b	b	
с	c	c	c	
d	d d	d(d	
e	e	e(e(
f	f. 0 1 2 3 4	f(f(
See OASIS Guidance 1 - Periphera 2 - Diabetes I (M1030) Therapies the pati 1 - Intravenou 2 - Parentera	•	relevant ICD-10 codes. ripheral Arterial Disease (PAI I that apply.)	0)	

(M1033)			Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for ization? (Mark all that apply.)
	1	_	History of falls (2 or more falls—or any fall with an injury—in the past 12 months)
	2	_	Unintentional weight loss of a total of 10 pounds or more in the past 12 months
	3	_	Multiple hospitalizations (2 or more) in the past 6 months
	4	_	Multiple emergency department visits (2 or more) in the past 6 months
	5	_	Decline in mental, emotional, or behavioral status in the past 3 months
	6	-	Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
	7	-	Currently taking 5 or more medications
	8	-	Currently reports exhaustion
	9	-	Other risk(s) not listed in 1–8
	10	-	None of the above
(M1034)	Ove	rall	Status: Which description best fits the patient's overall status?
Enter Co	ode	0	The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
		1	The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
		2	The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
		3	The patient has serious progressive conditions that could lead to death within a year.
		U	K The patient's situation is unknown or unclear.
(M1036)	Risk that		ctors, either present or past, likely to affect current health status and/or outcome: (Mark all
П	1		Smoking
	2	_	Obesity
	3		Alcohol dependency
П	4	_	Drug dependency
_	5	_	None of the above
	UŁ	(-	Unknown
(M1060) I	Heigh	ıt aı	nd Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up
inches		а	. Height (in inches). Record most recent height measure since the most recent SOC/ROC
pounds		b.	. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

LIVING ARRANGEMENTS

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

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

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):				
Enter Code	0	Normal vision: sees adequately in most situations; can see medication labels, newsprint.		
	1	Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.		
	2	Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.		
(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):				
Enter Code	0	Adequate: hears normal conversation without difficulty.		
	1	Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.		
	2	Severely Impaired: absence of useful hearing.		
	UK	Unable to assess hearing.		
(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):				
Enter Code	0	Understands: clear comprehension without cues or repetitions.		
	1	Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.		
	2	Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.		
	3	Rarely/Never Understands.		
	UK	Unable to assess understanding.		

(M1230) Spee	ech and Oral (Verbal) Expression of Language (in patient's own language):
Enter Code	Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
	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).
	Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
	3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
	4 <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).
	5 Patient nonresponsive or unable to speak.
	this patient had a formal Pain Assessment using a standardized, validated pain assessment tool ropriate to the patient's ability to communicate the severity of pain)?
F., t O I.	No standardized, validated assessment conducted
Enter Code	1 Yes, and it does not indicate severe pain
	2 Yes, and it indicates severe pain
(M1242) Freq	uency of Pain Interfering with patient's activity or movement:
- · · · ·	0 Patient has no pain
Enter Code	1 Patient has pain that does not interfere with activity or movement
	2 Less often than daily
	3 Daily, but not constantly
	4 All of the time
INTEGUME	NTARY STATUS
(M1300) Pres	sure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?
Enter Code	0 No assessment conducted [Go to M1306]
Litter Code	1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
	2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does	this patient have a Risk of Developing Pressure Ulcers?
F., t O I.	
Enter Code	0 No
	1 Yes
	s this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as ageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)
Enter Code	
Linter Code	0 No [<i>Go to M1322</i>]
	1 Yes

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

		Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot d due to a non-removable dressing/device)
Enter Code	0 1 2 3 NA	Newly epithelialized Fully granulating Early/partial granulation Not healing No observable pressure ulcer
area	a usually opared t	umber of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized y over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as o adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones appear with persistent blue or purple hues.
Enter Code	0 1 2 3 4 or 1	more
that	cannot	ost Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer be staged due to a non-removable dressing/device, coverage of wound bed by slough nar, or suspected deep tissue injury.)
Enter Code	1 2 3 4 NA	Stage 1 Stage 2 Stage 3 Stage 4 Patient has no pressure ulcers or no stageable pressure ulcers
(M1330) Doe	es this p	atient have a Stasis Ulcer ?
Enter Code	0 1 2 3	No [Go to M1340] Yes, patient has BOTH observable and unobservable stasis ulcers Yes, patient has observable stasis ulcers ONLY Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-
		removable dressing/device) [Go to M1340]

(M1332) Curre	ent Number of Stasis Ulcer(s) that are Observable:
Enter Code	1 One 2 Two 3 Three 4 Four or more
(M1334) Statu	s of Most Problematic Stasis Ulcer that is Observable:
Enter Code	 Fully granulating Early/partial granulation Not healing
(M1340) Does	this patient have a Surgical Wound?
Enter Code	 No [go to M1350] Yes, patient has at least one observable surgical wound Surgical wound known but not observable due to non-removable dressing/device [go to M1350]
(M1342) Statu	s of Most Problematic Surgical Wound that is Observable
Enter Code	 Newly epithelialized Fully granulating Early/partial granulation Not healing
	this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those ribed above, that is receiving intervention by the home health agency?
Enter Code	0 No 1 Yes
	DRY STATUS
(M1400) When	n is the patient dyspneic or noticeably Short of Breath ?
Enter Code	 Patient is not short of breath When walking more than 20 feet, climbing stairs With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation At rest (during day or night)
(M1410) Resp	 Ventilator (continually or at night) Continuous / Bi-level positive airway pressure

ELIMINATION STATUS

(M1600) Has	this patient been treated for a Urinary Tract Infection in the past 14 days?
Enter Code	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown
(M1610) Urin	ary Incontinence or Urinary Catheter Presence:
Enter Code	 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] Patient is incontinent Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [Go to M1620]
(M1615) Whe	n does Urinary Incontinence occur?
Enter Code	 Timed-voiding defers incontinence Occasional stress incontinence During the night only During the day only During the day and night
(M1620) Bowe	I Incontinence Frequency:
Enter Code	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown
last	omy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or ment regimen?
Enter Code	 Patient does <u>not</u> have an ostomy for bowel elimination. Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

		Functioning: Patient's currentsion, concentration, and imme				, orientation	,
Enter Code	0	Alert/oriented, able to focus ar independently.	nd shift atte	ntion, compre	ehends and reca	alls task dire	ections
	1	Requires prompting (cuing, reconditions.	petition, rei	minders) only	under stressful	or unfamilia	ır
	2	Requires assistance and some involving shifting of attention) distractibility.					
	3	Requires considerable assista to shift attention and recall dire				d oriented o	r is unable
	4	Totally dependent due to disturb vegetative state, or delirium.	ırbances sı	ıch as consta	nt disorientation	ı, coma, per	sistent
(M1710) Whe	n Cor	nfused (Reported or Observe	d Within th	ne Last 14 Da	ıys):		
Enter Code	0	Never					
Enter Code	1	In new or complex situations of	only				
	2	On awakening or at night only					
	3	During the day and evening, b	ut not cons	stantly			
	4	Constantly					
		Patient nonresponsive					
(M1720) Whe	n Anx	cious (Reported or Observed	Within the	Last 14 Day	s):		
Enter Code	0	None of the time					
Enter Gode	1	Less often than daily					
	2	Daily, but not constantly					
	3	All of the time					
		Patient nonresponsive					
		on Screening: Has the patient n screening tool?	been scree	ened for depre	ession, using a s	standardize	d, validated
Futou Codo	0	No					
Enter Code	1	Yes, patient was screened usi	ng the PHO	Q-2©* scale.			
		Instructions for this two-ques				weeks, how	w often
		have you been bothered by a	any of the f	ollowing probl	ems?"	Moorly	
		DUG 60#		Several	More than half	Nearly every day	NA
		PHQ-2©*	Not at all	days	of the days	12 – 14	Unable to
		a)	0 - 1 day	2 - 6 days	7 – 11 days	days	respond
		a) Little interest or pleasure in doing things	O	<u> </u>	□2	□3	□NA
		b) Feeling down, depressed, or hopeless?	□0	<u></u> 1	□2	□3	□NA
	2	Yes, patient was screened wit patient meets criteria for further				essment an	d the
	3	Yes, patient was screened wit patient does not meet criteria				essment an	d the
		*Copyrig	ıht© Pfizer	Inc. All rights	reserved. Repro	oduced with	permission.

	gnitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> eported or Observed): (Mark all that apply.)
□ 1	- Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
□ 2	- Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
□ 3	- Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
□ 4	- Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
□ 5	- Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
□ 6	- Delusional, hallucinatory, or paranoid behavior
□ 7	- None of the above behaviors demonstrated
	equency of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or er disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
Enter Code	0 Never
Linter Code	1 Less than once a month
	2 Once a month
_	3 Several times each month
	4 Several times a week
	5 At least daily
•	his patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric se?
Enter Code	
	0 No
	1 Yes
ADL/IADL	<u> </u>
	coming: Current ability to tend safely to personal hygiene needs (specifically: washing face and nds, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods.
Enter Code	1 Grooming utensils must be placed within reach before able to complete grooming activities.
	2 Someone must assist the patient to groom self.
	3 Patient depends entirely upon someone else for grooming needs.
	rrent Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments, lovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code	Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1 Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2 Someone must help the patient put on upper body clothing.
	3 Patient depends entirely upon another person to dress the upper body.

(M1820) Curre slack	ent Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, s, socks or nylons, shoes:
Enter Code	Able to obtain, put on, and remove clothing and shoes without assistance. Able to dress lower body without assistance if clothing and shoes are laid out or handed to
	the patient.
	2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
(111000) D (1	3 Patient depends entirely upon another person to dress lower body.
	ing: Current ability to wash entire body safely. <u>Excludes</u> grooming (washing face, washing ls, and shampooing hair).
Enter Code	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
Enter Code	With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, OR
	(b) to get in and out of the shower or tub, <u>OR</u>
	(c) for washing difficult to reach areas.
	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.
	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.
	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
(M1840) Toile on ar	t Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer and off toilet/commode.
F4 01-	Able to get to and from the toilet and transfer independently with or without a device.
Enter Code	When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.
incor	t ing Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or ntinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes area around stoma, but not managing equipment.
Enter Code	Able to manage toileting hygiene and clothing management without assistance.
Enter Code	Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
ш	2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3 Patient depends entirely upon another person to maintain toileting hygiene.
	sferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if nt is bedfast.
Fintan Cada	0 Able to independently transfer.
Enter Code	1 Able to transfer with minimal human assistance or with use of an assistive device.
	2 Able to bear weight and pivot during the transfer process but unable to transfer self.
	3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4 Bedfast, unable to transfer but is able to turn and position self in bed.
	5 Bedfast, unable to transfer and is unable to turn and position self.

Section GG: FUNCTIONAL ABILITIES and GOALS - SOC/ROC

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

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

	g or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code	Able to independently feed self. Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. Unable to feed self and must be assisted or supervised throughout the meal/snack. Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. Unable to take in nutrients orally or by tube feeding.	
	Ability to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered afely:	
Enter Code	 (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). <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. Unable to prepare any light meals or reheat any delivered meals. 	
	to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and <u>ely</u> using the telephone to communicate.	
Enter Code	Able to dial numbers and answer calls appropriately and as desired. Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. Able to answer the telephone only some of the time or is able to carry on only a limited conversation. Unable to answer the telephone at all but can listen if assisted with equipment. Totally unable to use the telephone.	
	IA Patient does not have a telephone.	

	Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her recent illness, exacerbation, or injury.
Enter Code	 a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	 d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent
(M1910) Has t tool?	this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment
Enter Code	 No. Yes, and it does not indicate a risk for falls. Yes, and it does indicate a risk for falls.
MEDICATIO	
	Regimen Review: Did a complete drug regimen review identify potential clinically significant cation issues?
Enter Code	 No – No issues found during review [Go to M2010] Yes – Issues found during review NA – Patient is not taking any medications [Go to M2040]
next c	cation Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the alendar day and complete prescribed/recommended actions in response to the identified potential significant medication issues?
Enter Code	0 No 1 Yes
preca	ent/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special autions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and a to report problems that may occur?
Enter Code	No Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

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

CARE MANAGEMENT

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

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

THERAPY NEED AND PLAN OF CARE

(M2200)	Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)
([Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
	NA - Not Applicable: No case mix group defined by this assessment.

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

	Plan / Intervention	No	Yes	Not App	olicable
a.	Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<u></u> 0	<u></u> 1	□NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	□0	□1	□NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
C.	Falls prevention interventions	□ 0	□1	□NA	Falls risk assessment indicates patient has no risk for falls.
d.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	<u></u> 0	_1	□NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
e.	Intervention(s) to monitor and mitigate pain	□0	□1	□NA	Pain assessment indicates patient has no pain.
f.	Intervention(s) to prevent pressure ulcers	□0	<u></u> 1	□NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g.	Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	□0	<u></u> 1	□NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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

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

CLINICAL RECORD ITEMS

	
(M0080) Disci	ipline of Person Completing Assessment
Enter Code	1 RN 2 PT 3 SLP/ST 4 OT
(M0090) Date	Assessment Completed:
mo	onth day year

(M0100) This As:	sessment is Currently Being Completed for the Following Reason:
Enter Code 1 3 Fc 4 5 Tr 6 7	Start of care—further visits planned Resumption of care (after inpatient stay) Dillow-Up Recertification (follow-up) reassessment [Go to M0110] Other follow-up [Go to M0110] ransfer to an Inpatient Facility Transferred to an inpatient facility—patient not discharged from agency [Go to M1041] Transferred to an inpatient facility—patient discharged from agency [Go to M1041] ischarge from Agency — Not to an Inpatient Facility Death at home [Go to M2005] Discharge from agency [Go to M1041]
start of codate specific date specific month NA - (M0104) Date of	[Go to M0110, if date entered] No specific SOC date ordered by physician Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was by the HHA.
case mix	
From whall that a	ich of the following Inpatient Facilities was the patient discharged within the past 14 days? (Markapply.) Long-term nursing facility (NF) Skilled nursing facility (SNF/TCU) Short-stay acute hospital (IPPS) Long-term care hospital (LTCH) Inpatient rehabilitation hospital or unit (IRF) Psychiatric hospital or unit Other (specify) Patient was not discharged from an inpatient facility [Go to M1017]

(M1005)	Inpatient Discharge Date (most recent):	
	UK - Unknown	
(M1011)		code at the level of highest specificity for only those by having a discharge date within the last 14 days (no V,
	Inpatient Facility Diagnosis	ICD-10-CM Code
	a	
	b	
	C	
	d	
	e	
	f	
	codes): Changed Medical Regimen Diagnosis a. b. c. d.	past 14 days (no V, W, X, Y, or Z codes or surgical ICD-10-CM Code
	e	
	f	
	NA - Not applicable (no medical or treatment	regimen changes within the past 14 days)
(M1018)	this patient experienced an inpatient facility disch	nimen Change or Inpatient Stay Within Past 14 Days: If narge or change in medical or treatment regimen within the diprior to the inpatient stay or change in medical or
	1 - Urinary incontinence	
	3 1 1	
	!	
	1	
	7 11 1	
	6 - Memory loss to the extent that supervisi	on required
	7 - None of the above	
		ange in medical or treatment regimen in past 14 days
	UK - Unknown	

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

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

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

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

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

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

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

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

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.
- Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis	s & (M1023) Other Diagnoses	(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)			
Column 1	Column 2	Column 3	Column 4		
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)		
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM		
(M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed		
a	a.	a)	a(
(M1023) Other Diagnoses	All ICD-10-C M codes allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed		
b	b.	b)	b		
С	c	c(c		
d	d	d(d		
e	e.	e(e		
f	f. 0 1 2 3 4	f	f		
See OASIS Guida 1 - Peripheral 2 - Diabetes I (M1030) Therapies the pati 1 - Intravenou 2 - Parentera	•	t of relevant ICD-10 codes. ripheral Arterial Disease (PAI I that apply.) TPN)	0)		

	for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for bitalization? (Mark all that apply.)
□ 1	- History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
_ 2	
_ _ 3	
_ _ 4	
_ □ 5	
_ _ 6	
□ 7	- Currently taking 5 or more medications
□ 8	- Currently reports exhaustion
□ 9	- Other risk(s) not listed in 1–8
□ 10	- None of the above
(M1034) Ove	rall Status: Which description best fits the patient's overall status?
Enter Code	The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
	1 The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
	2 The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
	3 The patient has serious progressive conditions that could lead to death within a year.
	UK The patient's situation is unknown or unclear.
	Factors, either present or past, likely to affect current health status and/or outcome: (Mark all apply.)
□ 1	- Smoking
□ 2	- Obesity
□ 3	- Alcohol dependency
□ 4	- Drug dependency
□ 5	- None of the above
☐ UK	- Unknown
(M1060) Heigh	nt and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up
inches	a. Height (in inches). Record most recent height measure since the most recent SOC/ROC
pounds	b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weigh consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

LIVING ARRANGEMENTS

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

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

SENSORY STATUS

(M1200) Visio	n (wit	th corrective lenses if the patient usually wears them):
Enter Code	0	Normal vision: sees adequately in most situations; can see medication labels, newsprint.
	1	Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
	2	Severely impaired: cannot locate objects without hearing or touching them, or patient
		nonresponsive.
(M1210) Abili	ty to I	Hear (with hearing aid or hearing appliance if normally used):
	0	Adequate: hears normal conversation without difficulty.
Enter Code	1	Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
	2	Severely Impaired: absence of useful hearing.
	UK	Unable to assess hearing.
(M1220) Unde	erstan	nding of Verbal Content in patient's own language (with hearing aid or device if used):
Fintan Cada	0	Understands: clear comprehension without cues or repetitions.
Enter Code	1	Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
	2	Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
	3	Rarely/Never Understands.
	UK	Unable to assess understanding.
(M1230) Spee	ch ar	nd Oral (Verbal) Expression of Language (in patient's own language):
Enter Code	0	Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
	1	Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
	2	Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
	3	Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
	4	<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).
	5	Patient nonresponsive or unable to speak.

` '	his patient had a formal Pain Assessment using a standardized, validated pain assessment tool opriate to the patient's ability to communicate the severity of pain)?
Enter Code	 No standardized, validated assessment conducted Yes, and it does not indicate severe pain Yes, and it indicates severe pain
(M1242) Freq	uency of Pain Interfering with patient's activity or movement:
Enter Code	 Patient has no pain Patient has pain that does not interfere with activity or movement Less often than daily Daily, but not constantly All of the time

INTEGUMENTARY STATUS

(M1300) Pres	sure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?
Enter Code	0 No assessment conducted [Go to M1306]
	Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
	Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does	this patient have a Risk of Developing Pressure Ulcers?
Enter Code	0 No 1 Yes
	this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as ageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)
Enter Code	0 No [<i>Go to M1322</i>] 1 Yes

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

	tatus of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot e observed due to a non-removable dressing/device)
Enter Cod	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable pressure ulcer
	urrent Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized rea usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as
C	ompared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones nly it may appear with persistent blue or purple hues.
Enter Cod	0 1
	2
	3
(M1324) S	4 or more tage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer
th	nat cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)
Enter Cod	1 Stage 1
	2 Stage 2
	3 Stage 3 4 Stage 4
	NA Patient has no pressure ulcers or no stageable pressure ulcers
(M1330) D	oes this patient have a Stasis Ulcer ?
	0 No [<i>Go to M1340</i>]
Enter Cod	e e 1 Yes, patient has BOTH observable and unobservable stasis ulcers
	2 Yes, patient has observable stasis ulcers ONLY
	3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-
	removable dressing/device) [<i>Go to M1340</i>]
(M1332) C	urrent Number of Stasis Ulcer(s) that are Observable:
	1 One
Enter Cod	e 2 Two
	3 Three
	4 Four or more
(M1334) S	tatus of Most Problematic Stasis Ulcer that is Observable:
Enter Cod	e 1 Fully granulating
	2 Early/partial granulation
	3 Not healing
(M1340) D	oes this patient have a Surgical Wound?
.	0 No [<i>go to M1350</i>]
Enter Cod	e
	2 Surgical wound known but not observable due to non-removable dressing/device [<i>go to</i>
	M1350]

(M1342) Stat	us of Most Problematic Surgical Wound that is Observable
Enter Code	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing
	s this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those cribed above, that is receiving intervention by the home health agency?
Enter Code	0 No 1 Yes
RESPIRAT	ORY STATUS
(M1400) Whe	n is the patient dyspneic or noticeably Short of Breath ?
Enter Code	 Patient is not short of breath When walking more than 20 feet, climbing stairs With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation At rest (during day or night)
□ 1 □ 2 □ 3 □ 4	 Continuous / Bi-level positive airway pressure None of the above
	ON STATUS this matient has a treated for a Universe Treat Infaction in the most 14 days?
Enter Code	this patient been treated for a Urinary Tract Infection in the past 14 days? O No 1 Yes NA Patient on prophylactic treatment UK Unknown
(M1610) Urin	ary Incontinence or Urinary Catheter Presence:
Enter Code	 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] Patient is incontinent Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [Go to M1620]
(M1615) Whe	n does Urinary Incontinence occur?
Enter Code	0 Timed-voiding defers incontinence 1 Occasional stress incontinence 2 During the night only 3 During the day only 4 During the day and night

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(M1620) Bowel Incontinence Frequency:			
Enter Code	0 Very rarely or never has bowel incontinence		
	1 Less than once weekly		
	2 One to three times weekly		
	3 Four to six times weekly		
	4 On a daily basis		
	5 More often than once daily		
	NA Patient has ostomy for bowel elimination		
	UK Unknown		
(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?			
Enter Code	0 Patient does <u>not</u> have an ostomy for bowel elimination.		
Enter Code	Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen.		
	2 The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.		

NEURO/EMOTIONAL/BEHAVIORAL STATUS

		ONAL BLITATIONAL OTATOS		
		Functioning: Patient's current (day of assessment) level of alertness, orientation, ension, concentration, and immediate memory for simple commands.		
Enter Code	Enter Code 0 Alert/oriented, able to focus and shift attention, comprehends and recalls task direction independently.			
	1	Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.		
	2	Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.		
	3	Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.		
	4	Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.		
(M1710) Whe	n Co	nfused (Reported or Observed Within the Last 14 Days):		
	0	Never		
Enter Code	1	In new or complex situations only		
	2	On awakening or at night only		
	3	During the day and evening, but not constantly		
	4	Constantly		
	NA	Patient nonresponsive		
(M1720) Whe	(M1720) When Anxious (Reported or Observed Within the Last 14 Days):			
	0	None of the time		
Enter Code	1	Less often than daily		
	2	Daily, but not constantly		
	3	All of the time		
	NA	Patient nonresponsive		

		on Screening: Has the patient n screening tool?	been scree	ened for depre	ession, using a	standardize	d, validated
	0	No					
Enter Code	1	Yes, patient was screened usi	ng the PHC	Q-2©* scale.			
		Instructions for this two-ques have you been bothered by a				weeks, how	w often
		PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
		a) Little interest or pleasure in doing things	0	1	□2	□3	□NA
		b) Feeling down, depressed, or hopeless?	□0	<u></u> 1	□2	□3	□NA
	2	Yes, patient was screened with patient meets criteria for further				essment an	d the
	3	Yes, patient was screened with patient does not meet criteria f				essment an	d the
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		, behavioral, and psychiatric s or Observed): (Mark all that		that are dem	nonstrated <u>at lea</u>	ıst once a w	<u>/eek</u>
□ 1		lemory deficit: failure to recogn ours, significant memory loss so				ecall events	of past 24
□ 2	- In	npaired decision-making: failure ctivities, jeopardizes safety thro	to perform	n usual ADLs		ity to appro	priately stop
□ 3	- V	erbal disruption: yelling, threate	ening, exce	essive profani	ty, sexual refere	ences, etc.	
□ 4		hysical aggression: aggressive bjects, punches, dangerous ma					self, throws
□ 5	- D	isruptive, infantile, or socially in	appropriate	e behavior (e :	xcludes verbal	actions)	
□ 6	- D	elusional, hallucinatory, or para	noid behav	/ior			
□ 7	- N	one of the above behaviors der	nonstrated				
		y of Disruptive Behavior Sym ptive/dangerous symptoms tha					
Futou Codo	0	Never					
Enter Code	1	Less than once a month					
	2	Once a month					
	3	Several times each month					
	4	Several times a week					
	5	At least daily					
(M1750) Is the		ent receiving Psychiatric Nurs	ing Servic	es at home p	rovided by a qu	alified psycl	niatric
Enter Code							
	0	No					
	1	Yes					

ADL/IADLs

	poming: Current ability to tend safely to personal hygiene needs (specifically: washing face and dds, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code	0 Able to groom self-unaided, with or without the use of assistive devices or adapted methods.
Enter Code	1 Grooming utensils must be placed within reach before able to complete grooming activities.
	2 Someone must assist the patient to groom self.
	3 Patient depends entirely upon someone else for grooming needs.
	rent Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments, overs, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code	O Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1 Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2 Someone must help the patient put on upper body clothing.
	3 Patient depends entirely upon another person to dress the upper body.
	rent Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, cks, socks or nylons, shoes:
Ft O!-	0 Able to obtain, put on, and remove clothing and shoes without assistance.
Enter Code	1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
ш	2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
	3 Patient depends entirely upon another person to dress lower body.
	thing: Current ability to wash entire body safely. <u>Excludes</u> grooming (washing face, washing nds, and shampooing hair).
Enter Code	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
Enter Code	1 With the use of devices, is able to bathe self in shower or tub independently, including
	getting in and out of the tub/shower. 2 Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	(b) to get in and out of the shower or tub, <u>OR</u>
	(c) for washing difficult to reach areas.
	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.
	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.
	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
	let Transferring: Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer and off toilet/commode.
Fintair Carla	0 Able to get to and from the toilet and transfer independently with or without a device.
Enter Code	When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.

incor	ntinen	Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or ce pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes rea around stoma, but not managing equipment.
Enter Code	0 1	Able to manage toileting hygiene and clothing management without assistance. Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
		Someone must help the patient to maintain toileting hygiene and/or adjust clothing. Patient depends entirely upon another person to maintain toileting hygiene. ng: Current ability to move safely from bed to chair, or ability to turn and position self in bed if bedfast.
Enter Code	0 1 2 3 4 5	Able to independently transfer. Able to transfer with minimal human assistance or with use of an assistive device. Able to bear weight and pivot during the transfer process but unable to transfer self. Unable to transfer self and is unable to bear weight or pivot when transferred by another person. Bedfast, unable to transfer but is able to turn and position self in bed. Bedfast, unable to transfer and is unable to turn and position self.

Section GG: FUNCTIONAL ABILITIES and GOALS - SOC/ROC

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

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

		r Eating: Current ability to feed self-meals and snacks safely. Note: This refers only to the <u>eating</u> , <u>chewing</u> , and <u>swallowing</u> , <u>not preparing</u> the food to be eaten.
Enter Code	0 1 2 3 4 5	Able to independently feed self. Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. Unable to feed self and must be assisted or supervised throughout the meal/snack. Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. Unable to take in nutrients orally or by tube feeding.
	ent Ab s safel	ility to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered ly:
Enter Code	1 2	 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission). Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. Unable to prepare any light meals or reheat any delivered meals.
		Jse Telephone: Current ability to answer the phone safely, including dialing numbers, and using the telephone to communicate.
Enter Code	0 1 2 3	Able to dial numbers and answer calls appropriately and as desired. Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. Able to answer the telephone only some of the time or is able to carry on only a limited
	4 5 NA	conversation. Unable to answer the telephone at all but can listen if assisted with equipment. Totally unable to use the telephone. Patient does not have a telephone.

	Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her recent illness, exacerbation, or injury.
Enter Code	 a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	 b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code	 d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent
(M1910) Has t tool?	his patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment
Enter Code	 No. Yes, and it does not indicate a risk for falls. Yes, and it does indicate a risk for falls.
MEDICATIO	<u>NS</u>
	Regimen Review: Did a complete drug regimen review identify potential clinically significant cation issues?
Enter Code	 No - No issues found during review [Go to M2010] Yes - Issues found during review NA - Patient is not taking any medications [Go to M2040]
next	cation Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the calendar day and complete prescribed/recommended actions in response to the identified potential ally significant medication issues?
Enter Code	0 No 1 Yes
preca	nt/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special autions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and to report problems that may occur?
Enter Code	 No Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

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

CARE MANAGEMENT

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

(such	es and Sources of Assistance: Determine the ability and willingness of non-agency caregivers as family members, friends, or privately paid caregivers) to provide assistance for the following ities, if assistance is needed. Excludes all care by your agency staff.				
Enter Code	g. Advocacy or facilitation of patient's participation in appropriate medical care (for example, transportation to or from appointments)				
	 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 not likely to provide assistance OR it is unclear if they will provide assistance Assistance needed, but no non-agency caregiver(s) available 				
,	Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home h agency staff)?				
Enter Code	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received				
	5 No assistance received UK Unknown				

THERAPY NEED AND PLAN OF CARE

(M2200)	Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)
([Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
	NA - Not Applicable: No case mix group defined by this assessment.

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

Plan / Intervention		No	Yes	Not Ap	plicable
a.	Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<u></u> 0	1	□NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<u></u> 0	1	□NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
C.	Falls prevention interventions	□0	□1	□NA	Falls risk assessment indicates patient has no risk for falls.
d.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	<u></u> 0	<u></u> 1	□NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
e.	Intervention(s) to monitor and mitigate pain	□0	□1	□NA	Pain assessment indicates patient has no pain.
f.	Intervention(s) to prevent pressure ulcers	□0	<u></u> 1	□NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g.	Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	□0	_1	□NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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

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

CLINICAL RECORD ITEMS

(MOOOO) DISCI	pline of Person Completing Assessment
Enter Code	1 RN 2 PT 3 SLP/ST 4 OT
	Assessment Completed: / / / /
(M0100) This	Assessment is Currently Being Completed for the Following Reason:
Enter Code	Start/Resumption of Care 1 Start of care—further visits planned 3 Resumption of care (after inpatient stay) Follow-Up 4 Recertification (follow-up) reassessment [Go to M0110] 5 Other follow-up [Go to M0110] Transfer to an Inpatient Facility 6 Transferred to an inpatient facility—patient not discharged from agency [Go to M1041] 7 Transferred to an inpatient facility—patient discharged from agency [Go to M1041] Discharge from Agency — Not to an Inpatient Facility 8 Death at home [Go to M2005] 9 Discharge from agency [Go to M1041]

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

PATIENT HISTORY AND DIAGNOSES

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

Inpatient Facility Diagnosis	ICD-10-CM Code
a	
b	
C	
d	
e	
f	

☐ NA - Not applicable (patient was not discharged from an inpatient facility)

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

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

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

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

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

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

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

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

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.
- Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosi	s & (M1023) Other Diagnoses	(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)		
Column 1	Column 2	Column 3	Column 4	
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)	
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM	
M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed	
3	a.	a)	a(
M1023) Other Diagnoses	All ICD-10-C M codes allowed	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed	
D	b.	b	b	
o	c	c(c	
1	d d	d(d	
e	e	e(e(
:	f	f(f	
☐ 1 - Intraveno	ient receives <u>at home</u> : (Mark al us or infusion therapy (excludes Il nutrition (TPN or lipids) utrition (nasogastric, gastrostom	TPN)	artificial entry into the alimenta	
canal) 4 - None of the above				

SENSORY STATUS

(M1200) Visio	n (with corrective lenses if the patient usually wears them):
Enter Code	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.
	1 Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
	2 Severely impaired: cannot locate objects without hearing or touching them, or patient
	nonresponsive.
(M1242) Freq	uency of Pain Interfering with patient's activity or movement:
Enter Code	0 Patient has no pain
	1 Patient has pain that does not interfere with activity or movement
	2 Less often than daily
	3 Daily, but not constantly
	4 All of the time

INTEGUMENTARY STATUS

(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)		
Enter Code	0 No [<i>Go to M1322</i>] 1 Yes	

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

		umber of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized		
	area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones			
		appear with persistent blue or purple hues.		
Enter Code	0			
Enter Code	1			
	2			
	3			
		more		
		Nost Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer to be staged due to a non-removable dressing/device, coverage of wound bed by slough		
		har, or suspected deep tissue injury.)		
	1	Stage 1		
Enter Code	2	Stage 2		
	3	Stage 3		
ш	4	Stage 4		
	NA	Patient has no pressure ulcers or no stageable pressure ulcers		
(M1330) Doe	es this p	patient have a Stasis Ulcer?		
F (0)	0	No <i>[Go to M1340]</i>		
Enter Code	1	Yes, patient has BOTH observable and unobservable stasis ulcers		
	2	Yes, patient has observable stasis ulcers ONLY		
	3	Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-		
		removable dressing/device) [Go to M1340]		
(M1332) Cur	rent N	umber of Stasis Ulcer(s) that are Observable:		
,	1	One		
Enter Code	2	Two		
	3	Three		
ш	4	Four or more		
(M1334) Stat	tus of l	Most Problematic Stasis Ulcer that is Observable:		
Enter Code	1	Fully granulating		
	2	Early/partial granulation		
ш	3	Not healing		
(M1340) Doe	es this p	patient have a Surgical Wound?		
Enter Code	0	No <i>[go to M1400]</i>		
Enter Code	1	Yes, patient has at least one observable surgical wound		
	2	Surgical wound known but not observable due to non-removable dressing/device <i>[go to</i>		
<u>—</u>	4			
(114040)	4	M1400]		
(M1342) Stat		Most Problematic Surgical Wound that is Observable		
Enter Code	0	Newly epithelialized		
	1	Fully granulating		
	2	Early/partial granulation		
	3	Not healing		

RESPIRATORY STATUS

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

ELIMINATION STATUS

(M1610) Urinary Incontinence or Urinary Catheter Presence:			
Enter Code	 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] Patient is incontinent Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [Go to M1620] 		
(M1620) Bowe	el Incontinence Frequency:		
last	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination omy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or timent regimen?		
Enter Code	 Patient does <u>not</u> have an ostomy for bowel elimination. Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen. 		

ADL/IADLs

M1810) Current Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:		
Enter Code	O Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.	
	Able to dress upper body without assistance if clothing is laid out or handed to the patient.	
	2 Someone must help the patient put on upper body clothing.	
	3 Patient depends entirely upon another person to dress the upper body.	

	rrent Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, cks, socks or nylons, shoes:
Enter Code	O Able to obtain, put on, and remove clothing and shoes without assistance. Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. Patient depends entirely upon another person to dress lower body.
	thing: Current ability to wash entire body safely. <u>Excludes</u> grooming (washing face, washing has, and shampooing hair).
Enter Code	O Able to bathe self in shower or tub independently, including getting in and out of tub/shower. With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 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. 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. Unable to participate effectively in bathing and is bathed totally by another person.
	let Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer and off toilet/commode.
Enter Code	O Able to get to and from the toilet and transfer independently with or without a device. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. Is totally dependent in toileting.
	nsferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if ient is bedfast.
Enter Code	O Able to independently transfer. Able to transfer with minimal human assistance or with use of an assistive device. Able to bear weight and pivot during the transfer process but unable to transfer self. Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	 Bedfast, unable to transfer but is able to turn and position self in bed. Bedfast, unable to transfer and is unable to turn and position self.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.				
Enter Code	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).		
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.		
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.		
	3	Able to walk only with the supervision or assistance of another person at all times.		
	4	Chairfast, unable to ambulate but is able to wheel self independently.		
	5	Chairfast, unable to ambulate and is <u>unable</u> to wheel self.		
	6	Bedfast, unable to ambulate or be up in a chair.		
(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.				
Enter Code	0	Able to independently take the correct medication(s) and proper dosage(s) at the correct times.		
	1	Able to take injectable medication(s) at the correct times if:		
		(a) individual syringes are prepared in advance by another person; OR		
		(b) another person develops a drug diary or chart.		
	2	Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection		
	3	<u>Unable</u> to take injectable medication unless administered by another person.		
	NA	No injectable medications prescribed.		

THERA	PY NEED AND PLAN OF CARE
(M2200)	Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)
([Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
	NA - Not Applicable: No case mix group defined by this assessment year.

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

Time Point		Items Used	
	re—further visits planned	M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170	
<u> </u>	on of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-	
·	, , ,	M2250, GG0170	
Recertifica	tion (follow-up) assessment w-up assessment	M0080-M0100, M0110, M1011, M1021-M1025, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200	
Transfer to an	Inpatient Facility	M0080-M0100, M1041-M1056, M1501, M1511, M2005,	
discharged Transferre	d to an inpatient facility—patient not d from an agency d to an inpatient facility—patient d from agency	M2016, M2301-M2410, M2430, M0903, M0906	
Discharge fro	m Agency — Not to an Inpatient Facility		
Death at h Discharge	ome from agency	M0080-M0100, M2005, M0903, M0906, M0080-M0100,M1041-M1056, M1230, M1242, M1306- M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906	
	RECORD ITEMS ipline of Person Completing Assessment	:	
	4		
Enter Code	1 RN 2 PT 3 SLP/ST 4 OT		
	(M0090) Date Assessment Completed:		
(M0100) This	Assessment is Currently Being Complete	ed for the Following Reason:	
Enter Code	Start/Resumption of Care		
Enter code	1 Start of care—further visits planned 3 Resumption of care (after inpatient stay)		
	Follow-Up	lay)	
	4 Recertification (follow-up) reassessm	nent [<i>Go to M0110</i>]	
	5 Other follow-up [<i>Go to M0110</i>]		
	Transfer to an Inpatient Facility		
		patient not discharged from agency [Go to M1041]	
	1	patient discharged from agency [Go to M1041]	
	Discharge from Agency — Not to an Inc	natient Facility	
	Discharge from Agency — Not to an Ing 8 Death at home [Go to M2005]	patient Facility	

PATIENT HISTORY AND DIAGNOSES

	renza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to sfer/Discharge) include any dates on or between October 1 and March 31?	
Enter Code	0 No <i>[Go to M1051]</i> 1 Yes	
(M1046) Influ	enza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?	
Enter Code	Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)	
	Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)	
	3 Yes; received from another health care provider (for example, physician, pharmacist)	
	4 No; patient offered and declined	
	5 No; patient assessed and determined to have medical contraindication(s)	
	6 No; not indicated - patient does not meet age/condition guidelines for influenza vaccine	
	7 No; inability to obtain vaccine due to declared shortage	
	8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4–7.	
	umococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, umovax)?	
Enter Code	0 No 1 Yes [<i>Go to M1501</i>]	
(M01056) Reas	son Pneumococcal Vaccine not received: If patient has never received the pneumococcal ination (for example, pneumovax), state reason:	
Enter Code	1 Offered and declined	
Enter Code	2 Assessed and determined to have medical contraindication(s)	
	Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine	
	4 None of the above	
CARDIAC STATUS		
exhib	ptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient bit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or ht gain) at the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code	0 No [<i>Go to M2005</i>]	
Enter code	1 Yes	
	2 Not assessed [<i>Go to M200</i> 5]	
	NA Patient does not have diagnosis of heart failure [<i>Go to M2005</i>]	

in	ndicative	ilure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what has (have) been taken to respond? (Mark all that apply.)	
	0 - 1	No action taken	
	1 - 1	Patient's physician (or other primary care practitioner) contacted the same day	
	2 - 1	Patient advised to get emergency treatment (for example, call 911 or go to emergency room)	
	3 - 1	mplemented physician-ordered patient-specific established parameters for treatment	
	4 - 1	Patient education or other clinical interventions	
		Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)	
MEDICAT	<u> </u>		
pr	rescribe	on Intervention: Did the agency contact and complete physician (or physician-designee) d/recommended actions by midnight of the next calendar day each time potential clinically t medication issues were identified since the SOC/ROC?	
Enter Code	e 0 1 9	No Yes NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications	
So pr	OC/RO	Caregiver Drug Education Intervention: At the time of, or at any time since the most recent C assessment, was the patient/caregiver instructed by agency staff or other health care to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side and how and when to report problems that may occur?	
Enter Code	1	No Yes A Patient not taking any drugs	
EMERGENT CARE			
		At Care: At the time of or at any time since the most recent SOC/ROC assessment has the ilized a hospital emergency department (includes holding/observation status)?	
Enter Code	0	No [<i>Go to M2401</i>]	
	1	Yes, used hospital emergency department WITHOUT hospital admission	
	2	Yes, used hospital emergency department WITH hospital admission	
	Uł	Unknown [<i>Go to M2401</i>]	

(M2310)			for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or hospitalization)? (Mark all that apply.)
	1	-	Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
	2	-	Injury caused by fall
	3	-	Respiratory infection (for example, pneumonia, bronchitis)
	4	-	Other respiratory problem
	5	-	Heart failure (for example, fluid overload)
	6	-	Cardiac dysrhythmia (irregular heartbeat)
	7	-	Myocardial infarction or chest pain
	8	-	Other heart disease
	9	-	Stroke (CVA) or TIA
	10	-	Hypo/Hyperglycemia, diabetes out of control
	11	-	GI bleeding, obstruction, constipation, impaction
	12	-	Dehydration, malnutrition
	13	-	Urinary tract infection
	14	-	IV catheter-related infection or complication
	15	-	Wound infection or deterioration
	16	-	Uncontrolled pain
	17	-	Acute mental/behavioral health problem
	18	-	Deep vein thrombosis, pulmonary embolus
	19	-	Other than above reasons
	UK	-	Reason unknown

<u>DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE</u> <u>ONLY</u>

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

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

(M2410) To w	hich l	Inpatient Facility has the patient been admitted?
Enter Code	1	Hospital [<i>Go to M2430</i>]
	2	Rehabilitation facility [Go to M0903]
	3	Nursing home [Go to M0903]
	4	Hospice [<i>Go to M0903</i>]

(M2430)	Rea app		for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that
	1	-	Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
	2	-	Injury caused by fall
	3	-	Respiratory infection (for example, pneumonia, bronchitis)
	4	-	Other respiratory problem
	5	-	Heart failure (for example, fluid overload)
	6	-	Cardiac dysrhythmia (irregular heartbeat)
	7	-	Myocardial infarction or chest pain
	8	-	Other heart disease
	9	-	Stroke (CVA) or TIA
	10	-	Hypo/Hyperglycemia, diabetes out of control
	11	-	GI bleeding, obstruction, constipation, impaction
	12	-	Dehydration, malnutrition
	13	-	Urinary tract infection
	14	-	IV catheter-related infection or complication
	15	-	Wound infection or deterioration
	16	-	Uncontrolled pain
	17	-	Acute mental/behavioral health problem
	18	-	Deep vein thrombosis, pulmonary embolus
	19	-	Scheduled treatment or procedure
	20	-	Other than above reasons
	UK	-	Reason unknown
(M0903)		e of	Last (Most Recent) Home Visit: / /
(M0906)		non	rge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient. / /

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

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

CLINICAL RECORD ITEMS

<u></u>			
(M0080) Disc	pline of Person Completing Assessment		
Enter Code	1 RN 2 PT 3 SLP/ST 4 OT		
	Assessment Completed: / / / onth day year		

(M0100) This	Assessment is Currently Being Completed for the Following Reason:
	Start/Resumption of Care
Enter Code	1 Start of care—further visits planned
	3 Resumption of care (after inpatient stay)
	Follow-Up
	4 Recertification (follow-up) reassessment [<i>Go to M0110</i>]
	5 Other follow-up [Go to M0110]
	Transfer to an Inpatient Facility
	6 Transferred to an inpatient facility—patient not discharged from agency [<i>Go to M1041</i>]
	7 Transferred to an inpatient facility—patient discharged from agency [Go to M1041]
	Discharge from Agency—Not to an Inpatient Facility
	8 Death at home [Go to M2005]
	9 Discharge from agency [Go to M1041]
	enza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to
Tran	sfer/Discharge) include any dates on or between October 1 and March 31?
F (0)	
Enter Code	0 No [Go to M1051]
	1 Yes
(M1046) Influ	enza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?
,	
Enter Code	Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
	Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
	3 Yes; received from another health care provider (for example, physician, pharmacist)
	4 No; patient offered and declined
	5 No; patient assessed and determined to have medical contraindication(s)
	6 No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
	7 No; inability to obtain vaccine due to declared shortage
	8 No; patient did not receive the vaccine due to reasons other than those listed in responses
	4–7.
	umococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example,
priec	ımovax)?
Enter Code	O No
	0 No
	1 Yes [Go to M1230]
(M1056) Reas	son Pneumococcal Vaccine not received: If patient has never received the pneumococcal
	ination (for example, pneumovax), state reason:
	1 Offered and declined
Enter Code	
	Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
	4 None of the above

(M1230) Spee	ch ar	nd Oral (Verbal) Expression of Language (in patient's own language):
Enter Code	0	Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
Ш	1	Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
	2	Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
	3	Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
	4	Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).
	5	Patient nonresponsive or unable to speak.
(M1242) Frequ	uency	of Pain Interfering with patient's activity or movement:
Enter Code	0	Patient has no pain
Enter Code	1	Patient has pain that does not interfere with activity or movement
	2	Less often than daily
	3	Daily, but not constantly
	4	All of the time

INTEGUMENTARY STATUS

,	s this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as tageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)
Enter Code	0 No [<i>Go to M1322</i>] 1 Yes
(M1307) The Ulce	Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure ers)
Enter Code	Was present at the most recent SOC/ROC assessment Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:
	NA No Stage 2 pressure ulcers are present at discharge

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

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

Instructions for a-c: Indicate the number of current pressure ulcers that were not present or were at a lesser stage at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.			
		Enter Number	
a. Stage 2			
b. Stage 3			
c. Stage 4			
	or e: For pressure ulcers that are Unstageable due to slougl a Stage 1 or 2 at the most recent SOC/ROC.	n/eschar, report the number that are	
		Enter Number	
d. Unstageab removable	ole—Known or likely but Unstageable due to non- dressing.		
	ole—Known or likely but Unstageable due to coverage of I by slough and/or eschar.		
f. Unstageab	ole—Suspected deep tissue injury in evolution.		
	us of Most Problematic Pressure Ulcer that is Observab oserved due to a non-removable dressing/device)	le: (Excludes pressure ulcer that cannot	
Enter Code	0 Newly epithelialized		
Enter odde	Fully granulating Early/partial granulation		
	3 Not healing		
	NA No observable pressure ulcer		
(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.			
Enter Code	0		
	3		
	4 or more		
(M1324) Stag	e of Most Problematic Unhealed Pressure Ulcer that is	Stageable: (Excludes pressure ulcer	
	cannot be staged due to a non-removable dressing/device, or eschar, or suspected deep tissue injury.)	coverage of wound bed by slough	
Fustan Oada	1 Stage 1		
Enter Code	2 Stage 2		
	3 Stage 3		
	4 Stage 4		
	NA Patient has no pressure ulcers or no stageable pres	ssure ulcers	

(M1330) Does this patient have a Stasis Ulcer?			
Enter Code	0 No [<i>Go to M1340</i>]		
Enter Code	1 Yes, patient has BOTH observable and unobservable stasis ulcers		
	2 Yes, patient has observable stasis ulcers ONLY		
	Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [Go to M1340]		
(M1332) Curre	ent Number of Stasis Ulcer(s) that are Observable:		
F 1 0 1	1 One		
Enter Code	2 Two		
	3 Three		
	4 Four or more		
(M1334) Statu	s of Most Problematic Stasis Ulcer that is Observable:		
Foton Oods	1 Fully granulating		
Enter Code	2 Early/partial granulation		
	3 Not healing		
	3 Not realing		
(M1340) Does	this patient have a Surgical Wound?		
Enter Code	0 No [go to M1400]		
	1 Yes, patient has at least one observable surgical wound		
	2 Surgical wound known but not observable due to non-removable dressing/device		
	[go to M1400]		
(M1342) Statu	s of Most Problematic Surgical Wound that is Observable		
	0 Newly epithelialized		
Enter Code	1 Fully granulating		
	2 Early/partial granulation		
	3 Not healing		
DECDIDATO	NOV STATUS		

RESPIRATORY STATUS

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

CARDIAC STATUS

exhi	ptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient bit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or ht gain) at the time of or at any time since the most recent SOC/ROC assessment?
Enter Code	0 No [Go to M1600] 1 Yes 2 Not assessed [Go to M1600] NA Patient does not have diagnosis of heart failure [Go to M1600]
indic	t Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms ative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what in(s) has (have) been taken to respond? (Mark all that apply.)
□ 0	- No action taken
□ 1	- Patient's physician (or other primary care practitioner) contacted the same day
□ 2	- Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
□ 3	- Implemented physician-ordered patient-specific established parameters for treatment
□ 4	- Patient education or other clinical interventions
□ 5	- Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)
ELIMINATIO	
(M1600) Has	this patient been treated for a Urinary Tract Infection in the past 14 days?
Enter Code	0 No 1 Yes NA Patient on prophylactic treatment
(M1610) Urina	ary Incontinence or Urinary Catheter Presence:
Enter Code	 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] Patient is incontinent Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [Go to M1620]
(M1615) Whe	n does Urinary Incontinence occur?
Enter Code	Timed-voiding defers incontinence Cocasional stress incontinence During the night only During the day only During the day and night
(M1620) Bowe	I Incontinence Frequency:
Enter Code	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis
	5 More often than once daily

NA Patient has ostomy for bowel elimination

NEURO/EMOTIONAL/BEHAVIORAL STATUS

			Functioning: Patient's current (day of assessment) level of alertness, orientation, ension, concentration, and immediate memory for simple commands.
Enter Co	de	0	Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
		1	Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
		2	Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
		3	Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
		4	Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
(M1710)	Whe	n Co	nfused (Reported or Observed Within the Last 14 Days):
Enter Co	do	0	Never
Enter Co	ue	1	In new or complex situations only
		2	On awakening or at night only
		3	During the day and evening, but not constantly
		4	Constantly
/M4720\	\//bo	NA n An	Patient nonresponsive xious (Reported or Observed Within the Last 14 Days):
(1011720)	vvne		• •
Enter Co	de	0	None of the time
		1 2	Less often than daily
		3	Daily, but not constantly All of the time
		NA	Patient nonresponsive
		(Ma - N	behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported rk all that apply.) Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
	2	- lı	mpaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
	3		/erbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
	4		Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
	5	- [Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
	6	- [Delusional, hallucinatory, or paranoid behavior
	7	- N	None of the above behaviors demonstrated
	othe safet	r disrı	cy of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or uptive/dangerous symptoms that are injurious to self or others or jeopardize personal
Enter Co	de	0	Never
	40	1	Less than once a month
		2	Once a month
		3	Several times each month
		4	Several times a week
		5	At least daily

ADL/IADLs

	oming: Current ability to tend safely to personal hygiene needs (specifically: washing face and ls, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code	 Able to groom self-unaided, with or without the use of assistive devices or adapted methods. Grooming utensils must be placed within reach before able to complete grooming activities. Someone must assist the patient to groom self.
	Someone must assist the patient to groom sen. Patient depends entirely upon someone else for grooming needs.
(M1810) Curre	ent Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments,
	vers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code	O Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1 Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2 Someone must help the patient put on upper body clothing.
	3 Patient depends entirely upon another person to dress the upper body.
	ent Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, as, socks or nylons, shoes:
Enter Code	Able to obtain, put on, and remove clothing and shoes without assistance.
Enter Code	Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
	2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
	3 Patient depends entirely upon another person to dress lower body.
	ing: Current ability to wash entire body safely. <u>Excludes</u> grooming (washing face, washing ls, and shampooing hair).
Fintair Carla	0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
Enter Code	With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, OR
	(b) to get in and out of the shower or tub, OR
	(c) for washing difficult to reach areas.
	Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
	4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
	t Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer and off toilet/commode.
Enter Code	Able to get to and from the toilet and transfer independently with or without a device. When reminded, assisted, or supervised by another person, able to get to and from the toilet
	and transfer. 2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.				
F + 0	, 0	Able to manage toileting hygiene and clothing management without assistance.		
Enter Code	de 1	Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.		
ш	2	Someone must help the patient to maintain toileting hygiene and/or adjust clothing.		
	3	Patient depends entirely upon another person to maintain toileting hygiene.		
		erring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if s bedfast.		
Enter Coo	0	Able to independently transfer.		
Elliel Coc	1 1	Able to transfer with minimal human assistance or with use of an assistive device.		
	2			
	3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.		
	4	Bedfast, unable to transfer but is able to turn and position self in bed.		
	5	,		
		ntion/Locomotion: Current ability to walk safely, once in a standing position, or use a nair, once in a seated position, on a variety of surfaces.		
Enter Coo	de 0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).		
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.		
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.		
	3	Able to walk only with the supervision or assistance of another person at all times.		
	4	Chairfast, unable to ambulate but is able to wheel self independently.		
	5	Chairfast, unable to ambulate and is <u>unable</u> to wheel self.		
	6	,		
		g or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the of <u>eating</u> , <u>chewing</u> , and <u>swallowing</u> , <u>not preparing</u> the food to be eaten.		
Enter Cod	0	Able to independently feed self.		
	1	Able to feed self independently but requires:		
		 (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet. 		
	2			
	3	Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.		
	4	<u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.		
	5	Unable to take in nutrients grally or by tube feeding		

` '	ent Ab s safe	ility to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered ly:
Enter Code	0	(a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
		(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission).
	1	<u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
	2	Unable to prepare any light meals or reheat any delivered meals.
		Jse Telephone: Current ability to answer the phone safely, including dialing numbers, and using the telephone to communicate.
France Code	0	Able to dial numbers and answer calls appropriately and as desired.
Enter Code	1	Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
	2	Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
	3	Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
	4	<u>Unable</u> to answer the telephone at all but can listen if assisted with equipment.
	5	Totally unable to use the telephone.
	NA	Patient does not have a telephone.

MEDICATIONS

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?			
Enter Code	 No Yes NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications 		
SOC, provi	nt/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent ROC assessment, was the patient/caregiver instructed by agency staff or other health care der to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side is, and how and when to report problems that may occur?		
Enter Code	0 No 1 Yes NA Patient not taking any drugs		

reliat Excl	oly and	ent of Oral Medications: Patient's current ability to prepare and take all oral medications d safely, including administration of the correct dosage at the appropriate times/intervals. injectable and IV medications. (NOTE: This refers to ability, not compliance or ss.)	
Enter Code	0	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.	
	1	Able to take medication(s) at the correct times if:	
		(a) individual dosages are prepared in advance by another person; <u>OR</u>	
		(b) another person develops a drug diary or chart.	
	2	Able to take medication(s) at the correct times if given reminders by another person at the appropriate times	
	3	<u>Unable</u> to take medication unless administered by another person.	
	NA	No oral medications prescribed.	
(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.			
Enter Code	0	Able to independently take the correct medication(s) and proper dosage(s) at the correct times.	
	1	Able to take injectable medication(s) at the correct times if:	
		(a) individual syringes are prepared in advance by another person; OR	
		(b) another person develops a drug diary or chart.	
	2	Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection	
	3	Unable to take injectable medication unless administered by another person.	
	NA	No injectable medications prescribed.	

CARE MANAGEMENT

(such	s and Sources of Assistance: Determine the ability and willingness of non-agency caregivers as family members, friends, or privately paid caregivers) to provide assistance for the following ties, if assistance is needed. Excludes all care by your agency staff.
Enter Code	 a. ADL assistance (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area
	1 Non-agency caregiver(s) currently provide assistance
	Non-agency caregiver(s) need training/ supportive services to provide assistance Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	4 Assistance needed, but no non-agency caregiver(s) available
Enter Code	 IADL assistance (for example, meals, housekeeping, laundry, telephone, shopping, finances) No assistance needed –patient is independent or does not have needs in this area
	1 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</u> to provide assistance OR it is <u>unclear</u> if they will provide assistance
	4 Assistance needed, but no non-agency caregiver(s) available
Enter Code	 c. Medication administration (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area
	1 Non-agency caregiver(s) currently provide assistance
	Non-agency caregiver(s) need training/ supportive services to provide assistance Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	4 Assistance needed, but no non-agency caregiver(s) available

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

EMERGENT CARE

(M2301)			ent Care: At the time of or at any time since the most recent SOC/ROC assessment has the utilized a hospital emergency department (includes holding/observation status)?	
		0	No [<i>Go to M2401</i>]	
Enter Co	ode	1	Yes, used hospital emergency department WITHOUT hospital admission	
		2		
		U	IK Unknown [<i>Go to M2401</i>]	
(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply.)				
	1	-	Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis	
	2	-	Injury caused by fall	
	3	-	Respiratory infection (for example, pneumonia, bronchitis)	
	4	-	Other respiratory problem	
	5	-	Heart failure (for example, fluid overload)	
	6	-	Cardiac dysrhythmia (irregular heartbeat)	
	7	-	Myocardial infarction or chest pain	
	8	-	Other heart disease	
	9	-	Stroke (CVA) or TIA	
	10	-	Hypo/Hyperglycemia, diabetes out of control	
	11	-	GI bleeding, obstruction, constipation, impaction	
	12	-	Dehydration, malnutrition	
	13	-	Urinary tract infection	
	14	-	IV catheter-related infection or complication	
	15	-	Wound infection or deterioration	
	16	-	Uncontrolled pain	
	17	-	Acute mental/behavioral health problem	
	18	-	Deep vein thrombosis, pulmonary embolus	
	19	-	Other than above reasons	
	UK	-	Reason unknown	

<u>DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE</u> <u>ONLY</u>

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

	Plan / Intervention	No	Yes	Not Applicable	
a.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	□0	<u></u> 1	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).	
b.	Falls prevention interventions	□0	<u></u> 1	NA Every standardized, validated multi- factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.	
C.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	O	<u></u> 1	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.	
d.	Intervention(s) to monitor and mitigate pain	□0	□1	□NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.	
e.	Intervention(s) to prevent pressure ulcers	□0	□1	□NA Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.	
f.	Pressure ulcer treatment based on principles of moist wound healing	□0	□1	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.	
(M2	2410) To which Inpatient Facility has the	patient b	een admi	itted?	
Er	nter Code 1 Hospital [Go to M2430] 2 Rehabilitation facility [G] 3 Nursing home [Go to M 4 Hospice [Go to M0903] NA No inpatient facility adm 2420) Discharge Disposition: Where is answer.)	Go to M096 10903] I hission the patier	03] It after dis	scharge from your agency? (Choose only one	
Er	nter Code 2 Patient remained in the 3 Patient transferred to a	communi non-instite ent moved	ty (with four	out formal assistive services) pormal assistive services) pospice pographic location not served by this agency	
(MC	(M0903) Date of Last (Most Recent) Home Visit: month day year				
(MC	9906) Discharge/Transfer/Death Date: I month day year	Enter the	date of th	ne discharge, transfer, or death (at home) of the patient	

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

Time Point		Items Used
Start of Care Start of care—further visits planned		M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
	n of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Recertifica	tion (follow-up) assessment w-up assessment	M0080-M0100, M0110, M1011, M1021-M1025, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Transfer to an Inpatient Facility Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency		M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
	m Agency — Not to an Inpatient Facility	
Death at h	omefrom agency	M0080-M0100, M2005, M0903, M0906 M0080-M0100, M1041-M1056, M1230, M1242, M1306- M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906
	ECORD ITEMS	
Enter Code	pline of Person Completing Assessmen RN PT SLP/ST OT	
	Assessment Completed: / /	
(M0100) This	Assessment is Currently Being Complet	ted for the Following Reason:
Enter Code		nent [<i>Go to M0110</i>] patient not discharged from agency [<i>Go to M1041</i>] patient discharged from agency [<i>Go to M1041</i>]
	8 Death at home [Go to M2005] 9 Discharge from agency [Go to M104	

MEDICATIONS

, ,	rescribed/recommended actions by midnight of the next calendar day each time potential clinically ignificant medication issues were identified since the SOC/ROC?	
Enter Code O No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications		
(M0903) Date of Last (Most Recent) Home Visit:		
(M0906) [Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.	