



Department of Health
and Environment

www.kdheks.gov

Healthy Kansans living in safe sustainable
environments



Good Morning

Healthy Kansans living in a safe sustainable
environment



A stylized tropical illustration. On the left, a green palm tree stands on a green island. A green biplane with yellow wings and a red and white striped tail is flying towards the right. In the center-right, a yellow rectangular sign with a red border contains the text 'OASIS 2011' in blue. The background is a bright cyan sky with white clouds. The bottom of the image features a green grassy foreground.

OASIS 2011

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Perfect World



Healthy Kansans living in a safe sustainable
environment



Presented by

Lynn Searles, RN

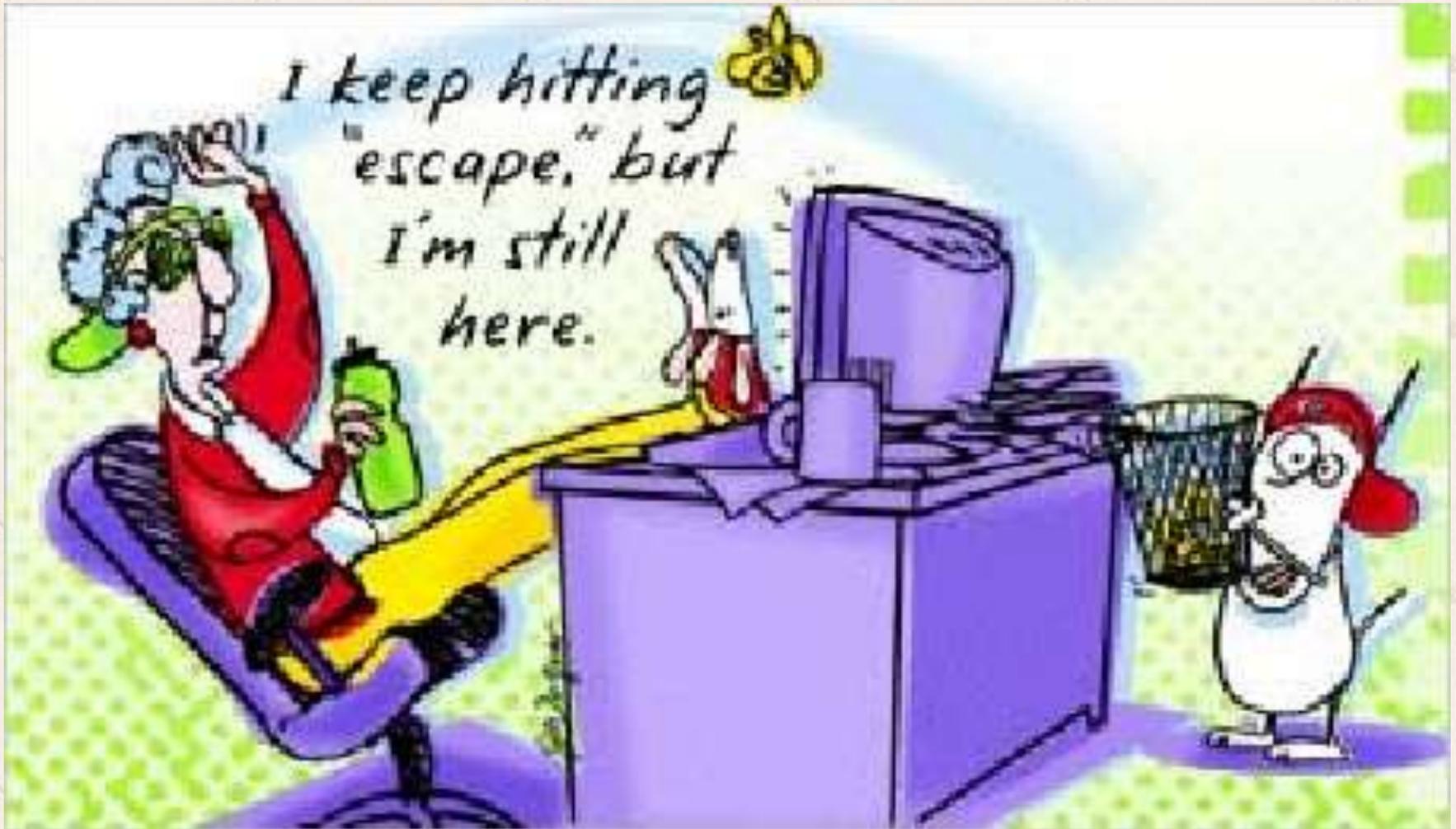
OASIS Education Coordinator

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- 1000 SW Jackson, Suite 200
- Topeka, KS 66612-1365
- 785-291-3552



PRIVATE DUTY/ATTENDANT CARE

- In Kansas, Private Duty and Private Duty Nursing are terms used by the healthcare industry for a variety of services from skilled nursing in a hospital to attendant care in the individual's home. However, the Kansas Department of Health and Environment who licenses hospitals, home health agencies etc has not defined "Private Duty." I am not aware of any State of Kansas department that has regulations for PDN.
- For Kansas Home Health Agencies who are Medicare providers, personal care attendant services are not recognized - See G233, CFR484.36(e). Regardless of whether or not the client can self-direct, if the services include "hands-on" personal care, the services would be considered home health aide services. The individual providing the services, at a minimum, must be a Kansas certified Home Health Aide or a Home Health Aide trainee who becomes Kansas certified within 90 days of hire. Regardless of payer source, if the services are not "hands-on" (ie housekeeping, errands, etc), neither Federal home health certification nor State home health licensure have regulations specifying qualifications for the individual providing those services. For individuals who provide "none hands-on" care, the agency is to determine the position qualifications.



Healthy Kansans living in safe sustainable environments

**Don't let life discourage
you;
everyone who got where
he is had to begin where
he was.**



Richard Evans

For a civil engineer, there's no such thing
as a "little mistake."



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Failure
is the opportunity to begin
again, more intelligently.



Henry Ford

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**Let's take
some of the
mystery out
of OASIS!**



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**We must
change with
the times or
we will
become
obsolete**



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Better

Buckle

Up!



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environments



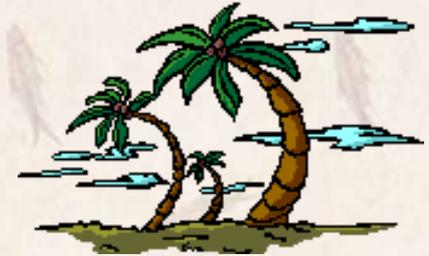
OASIS Tools

- OASIS C Manual (1/11)
- OCCB Quarterly Q & As (1/11)
- Errata Sheets (1/11)
- OASIS C form(s)
- HAVEN or other compliant software



RESOURCES

- **Iowa Foundation for Medical Care:** Help Desk 1-877-201-4721
- **Kansas Foundation for Medical Care:**
Help Desk 1-800-432-0770
- **OASIS Automation Coordinators** (Myers and Stauffer):
Help Desk 1-785-228-6770
- **CAHABA** 1-877-299-4500
- **HAVEN** Help Desk 1-877-201-4721
- **CMS OASIS Website:** www.cms.hhs.gov/oasis
- **CMS OCCB Q & As:** www.oasiscertificate.org
- **OBQI Manual:** www.cms.gov/HomeHealthQualityInits/Downloads/HHQIOBQIManual.pdf
- **HH Compare:** www.medicare.gov/HHCompare/Home.asp
- **QIES Technical Support Office:** www.qtso.com/hhdownload.html
- **MDCN:** Help Desk 1-800-905-2069
- **Language Line:** www.certifiedlanguages.com 1-800-225-5254
- **NPN Lookup:** www.npinumberlookup.org
- **Kansas Dept of Health and Environment:**
www.kdheks.gov/bhfr/state_ach_licensure_forms.html
1-785-291-3552 or lsearles@kdheks.gov



Latest Resources – April 2011

- **OASIS-C Guidance Manual – 01/2011 Update**
 - www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp
- **Errata Sheet – 01/2011**
 - www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp
- **OASIS Considerations Document – 11/2010 Update**
 - www.gtso.com/hhdownload.html
- **CMS OASIS Q&As – Categories 1,2,3, & 4 – 01/2011 Update**
 - www.gtso.com/hhdownload.html
- **CMS OCCB January 2011 Q&AS**
 - www.oasiscertificate.org

OASIS Certificate and Competency Board - Microsoft Internet Explorer provided by KDHE

http://oasiscertificate.org/main/

File Edit View Favorites Tools Help

OASIS Certificate and Competency Board

OCCB
OASIS Certificate & Competency Board

(337) 205-3196 | Contact Us

OASIS Job Board Login

ABOUT OCCB COS-C EXAM EXAM REGISTRATION RESOURCES COS-C'S EVENTS

OCCB'S 4TH ANNUAL CONFERENCE

Join us Nov. 11th
Hear from industry leaders, Quality OASIS-C...
Learn more and Register

- Resources Overview
- Q&A's & Core Docs
- OASIS Links
- Sponsors/Educators
- Job Board

EXAM REGISTRATION

Currently there are two exam methods: Paper & Pencil (P&P) and Computer Based Testing (CBT); Successful candidates will be awarded the COS-C designation.

REGISTER NOW

COS-C EXAM CALENDAR

Sept 22 - Syracuse, NY
Sept 24 - Miami, FL
Sept 29 - Wallingford, CT
Sept 29 - Okemos, MI

EXAM CALENDAR

NEWS & QUICK LINKS

[OASIS-C Core Documents](#) - Essential OASIS Resources
[OASIS ?](#) Email cmsoasisquestions@oasisanswers.com
[COS-C's](#) - Log in to access your certificate info!
Learn more about the new website....

VIEW MORE

OASIS Answers, Inc.
Content experts to CMS and the OCCB, OASIS Answers is an industry leader in OASIS education.

VIEW ALL SPONSORS & EDUCATORS

Done

start Lynn Searles - Inbox ... OASIS Certificate an... Microsoft PowerPoint ...

Internet 100% 2:39 PM

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Kansas Department of Health and Environment: State ACH Licensure Forms - Microsoft Internet Explorer provided by KDHE

http://www.kdheks.gov/bhfr/state_ach_licensure_forms.html

File Edit View Favorites Tools Help

Kansas Department of Health and Environment: State...

Links

[Mission](#)

[Elder Abuse Hotlines](#)

Forms: Application, Complaint and Related Forms for Health Care Providers

[Directory of KDHE Regulated Health Care Providers](#)

[Health Occupations Credentialing](#)

OASIS & Risk Management Training Information and Registration Forms

[State Regulations Enforced by BHF](#)

[Regulation Interpretation Manual \(.pdf\)](#)

[Links to Other Sites...](#)

[Submit Comments About Our Website](#)

State ACH Licensure Forms

Most files on this site require the [Adobe Acrobat Reader®](#) plug-in. For assistance with download, installation, or use of the plug-in, please contact [Adobe Systems, Inc.®](#)

Effective March 1, 2004 - All Adult Care Homes (i.e. home plus facilities and adult day care) are now managed by the Kansas Department of Health and Environment (KDHE) Licensure and Certification and Evaluation Commission. 503 S. Kansas Ave
Topeka, KS 66603-3404
Phone: 785-296-4986

This page makes available for direct download as PDF related forms and instructions for health care providers. It provides links to Medicare certification forms and related Medicare reimbursement. A general link to forms of the Administration) is as follows: <http://cms.hhs.gov/form> information can be found in the sections below. Please refer to state and federal regulations for definitions and other requirements. Licenses and Medicare certification forms for KDHE regulated providers are available for download at 1240.

Fee Payment

Submission of many of the state licensure forms by providers requires either check, money order or credit card payment at the time of submission to the Kansas Department of Health and Environment (KDHE).

KDHE currently accepts only the Discover/Novus credit cards.

http://www.kdheks.gov/bhfr/mds_oasis/index.html



Kansas Department of Health and Environment: State ACH Licensure Forms - Microsoft Internet Explorer provided by KDHE

http://www.kdheks.gov/bhfr/state_ach_licensure_forms.html

File Edit View Favorites Tools Help

Kansas Department of Health and Environment: State...

- [Medicare Learning Network Provider/Supplier Specific Information:](#)

Home Health Agencies:

State Licensure/Complaint Forms:

- [Application and Instructions for Home Health Agency License](#)
- [Agency Complaint Investigation Report Form \(NEW\)](#)
- [HHA Licensing Decision Tree](#)
- [Statement of Deficiencies and Plan of Correction Instructions - Health](#)

Medicare Certification Forms:

Use the following links to obtain information about Medicare fee-for-service provider/supplier enrollment.

- [Medicare Learning Network Provider/Supplier Specific Information:](#)

OASIS Training:

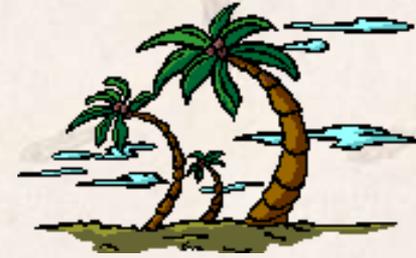
- [OASIS](#)

Other Provider Types Regulated by BHF but not requiring State Licensure:

- Comprehensive Outpatient Rehabilitation Facility
- End Stage Renal Disease (Dialysis) Facilities
- Hospice
- Outpatient Provider of Physical Therapy/Occupational Therapy/Speech Pathology Services
- Portable X-ray Facility

www.kdheks.gov/bhfr/state_ach_licensure-forms.html

OASIS



- Outcome and Assessment Information Set (**OASIS**) is a group of data elements that:
 - Represent **core items** of a comprehensive assessment for an adult home care patient;
 - and



- Form the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI)

Background



- **OASIS** is the key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is an integral part of the **Conditions of Participation** for Medicare-certified Home Health Agencies

Regulations

- **Conditions of Participation:**
 - Require HHAs to collect **OASIS** data, and
 - Require HHAs to report **OASIS** to their State survey agency

CoP and Regulatory Compliance

- Determined by surveys/audits
 - Licensure/Certification
 - Eligibility to provide services
 - Fiscal Intermediary
 - Reimbursement



Licensure/Certification Survey Process

- After initial, unannounced
- Home Visits, Staff interview, Record and Policy Review
- Statement of Deficiencies (CMS-2567)



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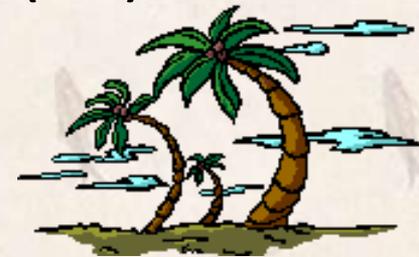
FY2010 OASIS Citations

- G323 – Transmittal of OASIS Data at least monthly (2)
- G330 – Comprehensive patient assessment (regardless of payer) (2)
- G331 – Initial RN assessment to determine immediate patient needs and for Medicare patients, eligibility and homebound status (1)
- G332 – Initial assessment visit within 48 hours of referral/return home from hospital or on physician-ordered SOC date (1)
- G334 – Completion of comprehensive assessment within 5 calendar days after SOC (2)
- G337 – Comprehensive drug regimen review of all meds (7)
- G338 – Update of comprehensive assessment - significant change (1)
- G339 – Update of comprehensive assessment – last 5 days of cert period - recert (1)
- G342 – Incorporation of OASIS Items in agency's own assessment (1)



FY 2010 Top Four Other HH Citations and Other Stats

- G158 – Care follows written plan of care established and periodically reviewed by a physician (21)
- G145 – Written summary to physician q 60 days (13)
- G229 – Home Health Aide Supervision q 2 weeks (13)
- H0115 – Personnel Record content (13)
- 50 surveys
- Teams: 1 – 7 surveyors
- 2472.25 on-site survey hours (49.4 hrs/survey)



OASIS - C



- **Effective 1/1/10**
- OASIS – item revisions tested to insure no impact on the payment algorithm
- No referring to prior assessment – limited exceptions
- SOC day 0
- i.e. = only in these circumstances
- e.g. = for example
- One calendar day = until the end of the next calendar day
- Current = time of assessment and preceding 24 hours
- Prior = status before this current (most recent) illness, exacerbation, or injury
- If discharged from inpt within past 14 days – consider all relevant procedures during that ENTIRE inpt stay
- “Value Based Purchasing”
- **Exceptions to every rule** = Read your manual and Q & As

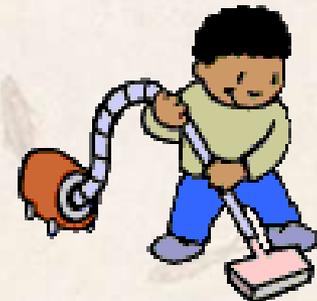
DATA COLLECTION CONVENTIONS

- #1 – in most cases, report what is true on the day of assessment UNLESS different time period has been indicated in the item or related guidance
 - Prior to this current illness, exacerbation or injury
 - Since the last OASIS
- #2 – pt's ability or status varies – report usual or what is true 50% of the assessment time frame
- #4 (no #3) – current status without referring back to prior assessment (exceptions)
- #5 – combine observations, interview, and other relevant strategies
- #13 – only one clinician takes responsibility for accurately completing comprehensive assessment (collaboration when appropriate)

Everyone completing OASIS must have access to an OASIS manual.

OASIS – When Required (G320 & G330)

- Required
 - Medicare billed
 - Medicaid billed (includes Wellness monitoring through a waiver program)
- Exceptions
 - Medicare/Skilled Medicaid not billed
 - Maternity services
 - Under the age of 18
 - Housekeeping or chore services only
 - Personal care services only



Numbering System

Clinical Record Items M0080 – M0110

Patient Tracking Items M0010 – M0150

Patient History and Diagnoses M1000s

Living Arrangements M1100s

Sensory Status M1200s

Integumentary Status M1300s

Respiratory Status M1400s

Cardiac Status M1500s

Elimination Status M1600s

Neuro/Emotional/Behavioral Status M1700s

ADLs/IADLs M1800s + M1900s

Medications M2000s

Care Management M2100s

Therapy Need and Plan of Care M2200

Emergent Care M2300s

Data Collected at Transfer/Discharge M2400s,

M0903+M0906



Time Required for OASIS – C*

- SOC/ROC: 20 – 125 minutes, average 49.61 minutes
- Recert: 10 – 75 minutes, average 33.45 minutes
- Transfer: 2 – 40 minutes, average 17.44 minutes
- DC: 8 – 80 minutes, average 26.31 minutes



*68 RNs and PTs, 370 OASIS-C assessments on 183 pts, 177 full OASIS-C assessments

Items to be Used at Specific Time Points

Items to be Used at Specific Time Points

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



OASIS TIME LINE

- **Initial Assessment** must be done within **48 HOURS** from date of referral, patient's return home, or on the physician ordered SOC (Admission) G 332
- **Comprehensive Assessment (SOC OASIS)** must be completed **within 5 days of the SOC Date** G 334



OASIS TIME LINE

- **Follow-up Assessment** must be completed between days **56 and 60** of the current episode to start another episode G 339
- **Resumption Of Care (ROC)** must be done within 48 hours of return home from inpatient facility G 340

Reporting OASIS information

G323:

Transmit data **AT LEAST**
monthly



Electronically transmit to ensure confidentiality

- **G323**



COMPREHENSIVE ASSESSMENT (Standard)



- Data collected on **MULTIPLE ASPECTS** of the patient and the environment

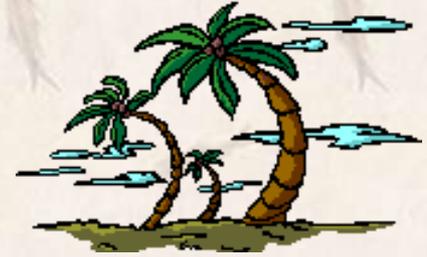
HOW IS DATA COLLECTED?



- **Interaction** – with patient/family
- **Observation** – of patient/environment
- **Measurement** – of vital signs, etc.



M0010

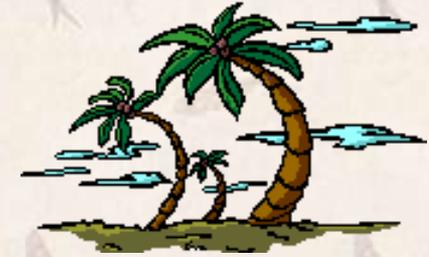


- **(M0010) C M S Certification Number**



Chapter 3: A-1

M0014



- (M0014) Branch State



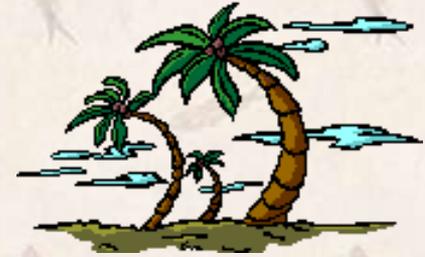
Chapter 3: A-2



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M0016



- **(M0016) Branch I D Number**

Chapter 3: A-3

M0018

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

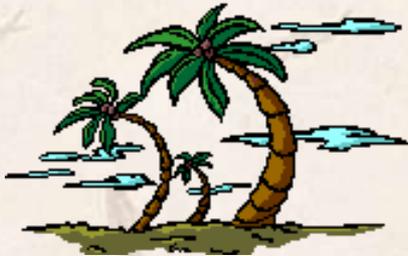
UK – Unknown or Not Available

<http://www.npinumberlookup.org/>

Chapter 3: A-4)

M0020

- **(M0020) Patient I D Number**
-

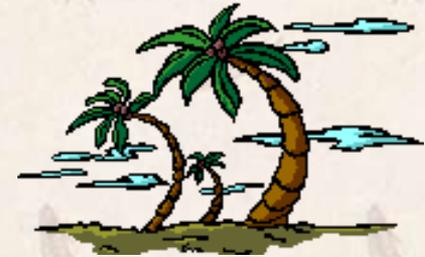


Chapter 3: A-5

M0030

- **(M0030) Start of Care Date:**

___/___/_____
month / day / year



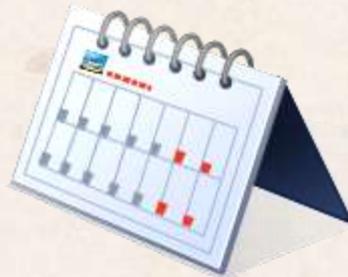
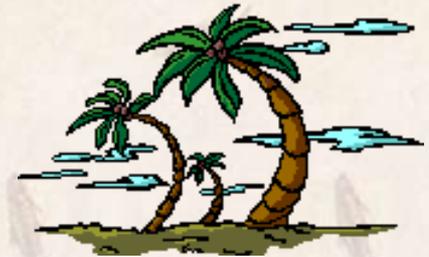
Chapter 3: A-6

M0032

- **(M0032) Resumption of Care Date:**

___/___/_____
month / day / year

NA - Not Applicable



Chapter 3: A- 7

M0040

- **(M0040) Patient Name:**

(First)

(M I)

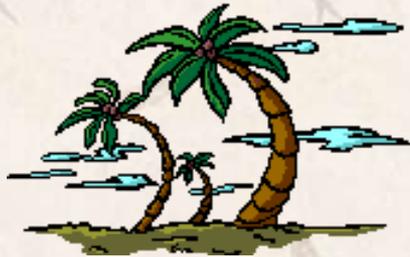
(Last)

(Suffix)

Chapter 3: A-8

M0050

- **(M0050) Patient State of Residence**



Chapter 3: A-9

M0060

- **(M0060) Patient Zip Code**

Chapter 3: A-10



M0063

- **(M0063) Medicare Number:**

_____ (including suffix)

NA – No Medicare

MEDICARE HEALTH INSURANCE

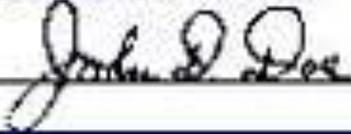
SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN D. DOE

MEDICARE CLAIM NUMBER
123-45-6789A

SEX
MALE

IS ENTITLED TO
HOSPITAL INSURANCE (PART A) **1/1/95**
MEDICAL INSURANCE (PART B) **1/1/95**

SIGN HERE 

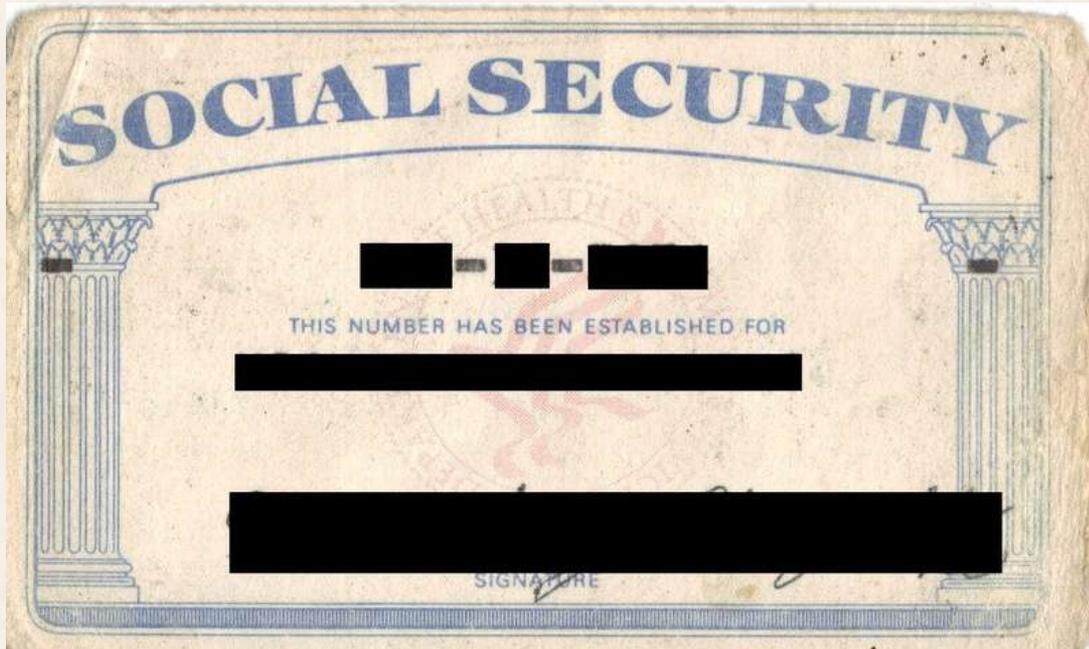
Chapter 3: A-11

M0064

- **(M0064) Social Security Number**

____ - ____ - _____

UK – Unknown or Not Available



Chapter 3: A-12

M0065

- **(M0065) Medicaid Number**

NA – No Medicaid

Chapter 3: A-13



M0066

- **(M0066) Birth Date:**

___/___/_____
month / day / year



Chapter 3: A-14

M0069

Chapter 3: A-15

- **(M0069) Gender:**

- 1 - Male
- 2 - Female



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M0140

• (M0140) Race/Ethnicity: (Mark all that apply.)

- 1 - American Indian or Alaska Native
- 2 - Asian
- 3 - Black or African-American
- 4 - Hispanic or Latino
- 5 - Native Hawaiian or Pacific Islander
- 6 - White



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M0150



- **(M0150) Current Payment Sources for Home Care:
(Mark all that apply.)**

- 0 - None; no charge for current services
- 1 - Medicare (traditional fee-for-service)
- 2 - Medicare (HMO/managed care/Advantage plan)
- 3 - Medicaid (traditional fee-for-service)
- 4 - Medicaid (HMO/managed care)
- 5 - Workers' compensation
- 6 - Title programs (e.g., Title III, V, or XX)
- 7 - Other government (e.g., TriCare, VA, etc.)
- 8 - Private insurance
- 9 - Private HMO/managed care
- 10 - Self-pay
- 11 - Other (specify) _____
- UK - Unknown

Chapter 3: A-17



M0080

- **(M0080) Discipline of Person Completing Assessment:**

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

Chapter 3: B-1



M0090

- **(M0090) Date Assessment Completed:**

___/___/_____
month / day / year



Chapter 3: B-2



M0100

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

Start/Resumption of Care

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

Follow-Up

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

Transfer to an Inpatient Facility

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

Discharge from Agency — Not to an Inpatient Facility

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

Chapter 3: B-3

M0102

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

__ __ / __ __ / __ __ __ __

(Go to M0110, if date entered)

month / day / year

- NA – No specific SOC date ordered by physician

Chapter 2: B-5



M0104

- **(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



Chapter 3: B-6

M0110

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

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

Chapter 3: B-7

M1000 Inpatient Facility DC

- **(M1000)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**

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

Chapter 3: C-1

M1005

- **(M1005) Inpatient Discharge Date (most recent):**

___/___/_____

month / day / year

UK - Unknown



Chapter 3: C-3

M1010 Inpatient Diagnosis

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

Inpatient Facility Diagnosis

ICD-9-C M Code

a. _____

___ - ___ - ___ . ___ - ___

b. _____

___ - ___ - ___ . ___ - ___

c. _____

___ - ___ - ___ . ___ - ___

d. _____

___ - ___ - ___ . ___ - ___

e. _____

___ - ___ - ___ . ___ - ___

f. _____

___ - ___ - ___ . ___ - ___

Chapter 3: C-4

M1012 Inpatient Procedure

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

<u>Inpatient Procedure</u>	<u>Procedure Code</u>
a. _____	____ - ____ . ____ - ____
b. _____	____ - ____ . ____ - ____
c. _____	____ - ____ . ____ - ____
d. _____	____ - ____ . ____ - ____

- NA - Not applicable
- UK - Unknown

M1016

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

	<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-C M Code</u>
a.	_____	___ . ___
b.	_____	___ . ___
c.	_____	___ . ___
d.	_____	___ . ___
e.	_____	___ . ___
f.	_____	___ . ___

- NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

Chapter 3: C-6

M1018

- **(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:** If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

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

Chapter 3: C-7

M1020/1022/1024

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

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

Column 1: Enter the description of the diagnosis.

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

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

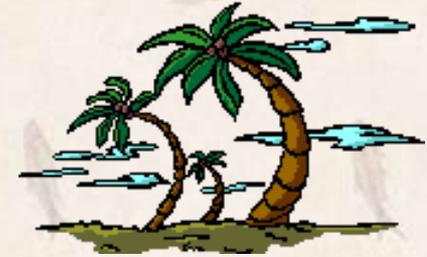
- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring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

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

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

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

(Form on next page)



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

M1020/1022/1024

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

M1020/1022/1024

- Code each row according to the following directions for each column:
- Column 1: Enter the description of the diagnosis.
- Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;
Rate the degree of symptom control for the condition listed in Column 1 using the following scale:
 - 0 - Asymptomatic, no treatment needed at this time
 - 1 - Symptoms well controlled with current therapy
 - 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
 - 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
 - 4 - Symptoms poorly controlled; history of re-hospitalizations

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

M1020/1022/1024

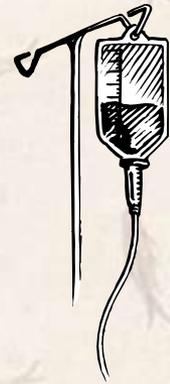
- Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.
- Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

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

M1030 Therapies at Home

- **(M1030) Therapies the patient receives at home: (Mark all that apply.)**

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



Chapter 3: C-12

M1032

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

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

Chapter 3: C-13

M1034

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

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

Chapter 3: C-14

M1036

- **(M1036) Risk Factors**, either present or past, likely to affect current health status and/or outcome:
(Mark all that apply.)

Chapter 3: C-15

- 1 - Smoking
- 2 - Obesity
- 3 - Alcohol dependency
- 4 - Drug dependency
- 5 - None of the above
- UK - Unknown



The Breakfast Club

M1040

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

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

Chapter 3: C-16



M1045

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

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

Chapter 3: C-17 - 18

M1050

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

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

Chapter C-19

M1055

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

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

Chapter 3: C-20 - 21

M1100

Chapter 3: D-1 - 3



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

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

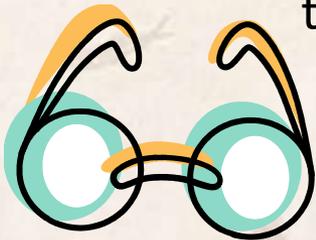


M1200



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

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



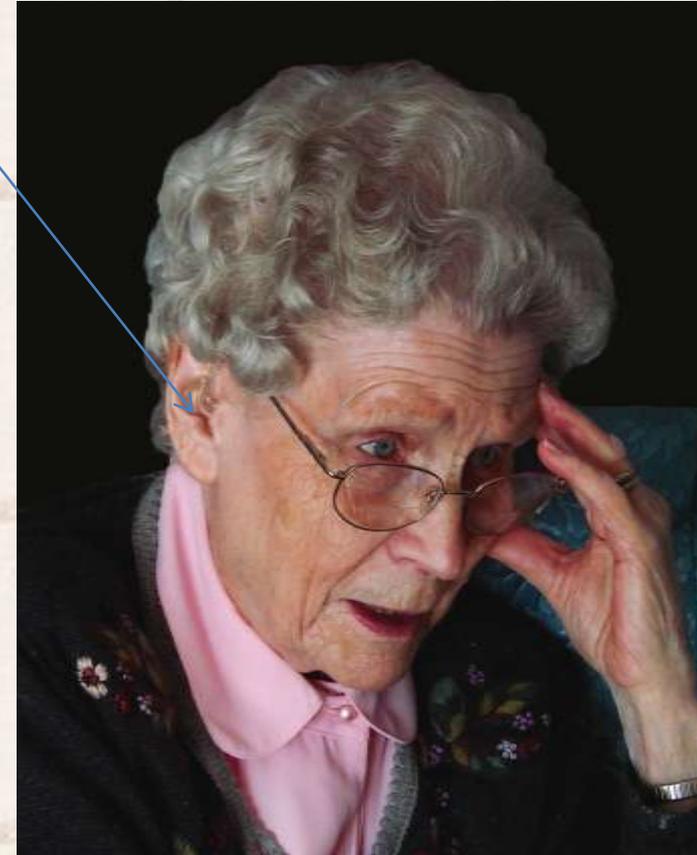
Chapter 3: E - 1

M1210 Hearing

- **(M1210) Ability to Hear** (with hearing aid or hearing appliance if normally used):

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

Chapter 3: E-2



M1220

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

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

Chapter 3: E-3

M1230

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

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

Chapter 3: E-4

M1240 Pain Assessment

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

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

Chapter 3: E-5



M1242

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

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



Chapter 3: E-6

M1300

- **(M1300) Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers?**
 - 0 - No assessment conducted [***Go to M1306***]
 - 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
 - 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

Chapter 3: F-1

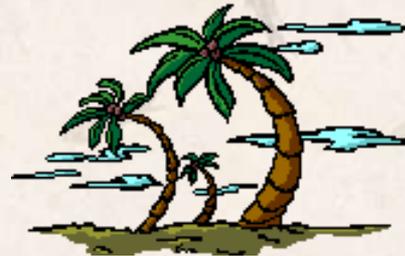
M1302

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

0 - No

1 - Yes

Chapter 3: F-2



M1306

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

0 - No [*Go to M1322*]

1 - Yes



Chapter 3: F-3 - 4

M1307

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

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

2 - Developed since the most recent SOC/ROC assessment:
record date pressure ulcer first identified:

___ / ___ / _____

month / day / year

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

Chapter 3: F-4 - 5

M1308

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

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

Chapter 3: F-7 -9

Directions for M1310, M1312, and M1314

- If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.
- **(M1310) Pressure Ulcer Length:** Longest length “head-to-toe”
__ | __ | . | __ | (cm)
- **(M1312) Pressure Ulcer Width:** Width of the same pressure ulcer; greatest width perpendicular to the length
| __ | __ | . | __ | (cm)
- **(M1314) Pressure Ulcer Depth:** Depth of the same pressure ulcer; from visible surface to the deepest area
| __ | __ | . | __ | (cm)

Chapter 3: F-10 - 11

M1320

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

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



Chapter 3: F-12

M1322

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

0 1 2 3 4 or more

Chapter 3: F-13

M1324

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

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

Chapter 3: F-14

M1330

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

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



Chapter 3: F-15

M1332

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

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

Chapter 3: F-16

M1334

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

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

Chapter 3: F-17



M1340



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

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



Chapter 3: F-18 - 19

M1342

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

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

Chapter 3: F-20

M1350

- **(M1350)** Does this patient have a **Skin Lesion** or **Open Wound**, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

0 - No

1 - Yes

Chapter 3: F-21

M1400 Dyspnea

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

Chapter 3: G-1

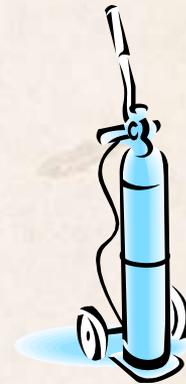


- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation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

M1410

- **(M1410) Respiratory Treatments** utilized at home: **(Mark all that apply.)**

- 1 - Oxygen (intermittent or continuous)
- 2 - Ventilator (continually or at night)
- 3 - Continuous / Bi-level positive airway pressure
- 4 - None of the above



Chapter 3: G-2

M1500

- **(M1500) Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?
 - 0 - No [*Go to M2004 at TRN; Go to M1600 at DC*]
 - 1 - Yes
 - 2 - Not assessed [*Go to M2004 at TRN; Go to M1600 at DC*]
 - NA - Patient does not have diagnosis of heart failure [*Go to M2004 at TRN; Go to M1600 at DC*]

Chapter 3: H-1

M1510

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

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

Chapter 3: H-2

M1600 UTI Treatment

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

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

Chapter 3: I-1

M1610

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

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

Chapter 3: I-2 - 3

M1615

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

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

Chapter 3: I-4

M1620

- **(M1620) Bowel Incontinence Frequency:**

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

Chapter 3: I-5

M1630

- **(M1630) Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?
 - 0 - Patient does not have an ostomy for bowel elimination.
 - 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
 - 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Chapter 3: I-6

M1700

- **(M1700) Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
 - 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
 - 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
 - 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
 - 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
 - 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Chapter 3: J-1



M1710

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

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

Chapter 3: J-2

M1720

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

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

Chapter 3: J-3

M1730

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

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

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

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

Chapter 3: J-4 - 5

M1740

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

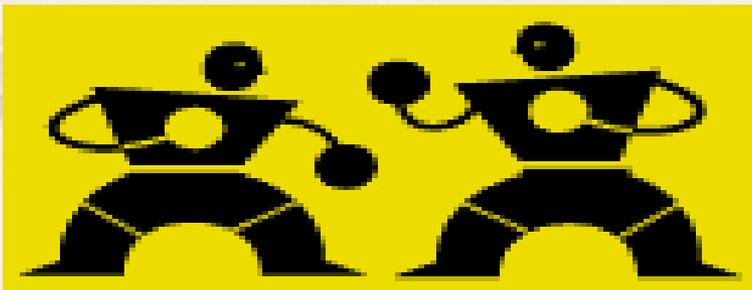
- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, in-ability to appropriately stop activities, jeopardizes safety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

Chapter 3: J-6

M1745

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

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



M1750

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

- 0 - No
- 1 - Yes

Chapter 3: J-8



Scenario A

Mrs. Aziz was admitted to your agency for care following an ORIF of the left femur. She has a long standing diagnosis of schizophrenia. Her husband reported that she had not had hallucinations or delusions for the last 3 years, but her anti-psychotic medications were not administered routinely during her hospitalization and for two weeks now, she has been hearing the **“voices”** again almost every day instructing her to do things that put her in great danger. Her medication regimen was restarted 6 days ago and he is hoping she will be better soon as it is exhausting supervising her closely around-the-clock. During the assessment, you note the patient can't remember where she left her reading glasses and that her hair needed shampooing. Mrs. Aziz reports she only likes her hairdresser to care for her hair and she has an appointment next week.

When you call into the physician's office to report the patient's condition and obtain orders, you find out Mrs. Aziz's attending physician is on vacation. The covering physician was uncomfortable ordering the psych nurse evaluation you requested and stated you should check back in 6 days when her attending is back from vacation. You agree.

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

- A) 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
 - 6 - Delusional, hallucinatory, or paranoid behavior

- B) 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
 - 6 - Delusional, hallucinatory, or paranoid behavior

- C) 6 - Delusional, hallucinatory, or paranoid behavior

- D) 7 – None of the above behaviors demonstrated

Which of the following represents accurate OASIS scoring for **M1750, Is this patient receiving**

Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

- A) 0 – No because there is no order for psychiatric nursing services at the time the SOC assessment was completed.
- B) 0 – No because the first psych nurse visit will not occur during the 5 days after SOC
- C) 1 – Yes because the assessing clinician asked for the referral
- D) 1 – Yes because the assessing clinician will hold the assessment until she gets the orders from the attending in 6 days.

M1800

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

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



Chapter 3: K-1

M1810 Upper Body Dressing

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

Chapter 3: K-2 - 3

M1820 Lower Body Dressing

- **(M1820) Current Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
 - 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
 - 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
 - 2 - Someone must help the patient put on under-garments, slacks, socks or nylons, and shoes.
 - 3 - Patient depends entirely upon another person to dress lower body.

Chapter 3: K-4 -5

M1830



Chapter 3: K-6 -7

- **(M1830) Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
(a) for intermittent supervision or encouragement or reminders, OR
(b) to get in and out of the shower or tub, OR
(c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.



M1840



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

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

Chapter 3: K-8 - 9

M1845



- **(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.

Chapter 3: K-10 - 11

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

M1850

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

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.





M1860

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

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



Chapter 3: K-14 - 15

Healthy Kansans living in safe sustainable environments



M1870

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

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



Chapter 3: K-16 - 17

M1880 Plan & Prepare Light Meals

- (M1880) Current **Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:

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





M1890 Telephone Use



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

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

Chapter 3: K-20

M1900

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

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

M1910

- **(M1910)** Has the patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?
 - 0 - No multi-factor falls risk assessment conducted.
 - 1 - Yes, and it does not indicate a risk for falls.
 - 2 - Yes, and it indicates a risk for falls.

Chapter 3: K-22 - 23



M2000

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

0 - Not assessed/reviewed [

Go to M2010]

1 - No problems found during

review [***Go to M2010***]

2 - Problems found during

review

NA - Patient is not taking any medications

[***Go to M2040***]

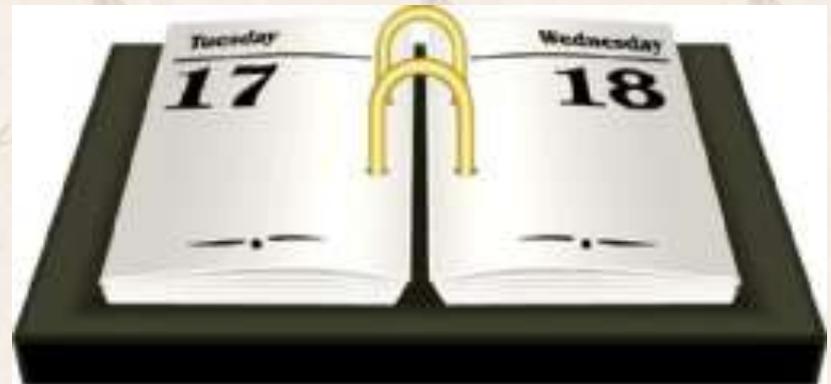


Chapter 3: L-1

M2002

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

- 0 - No
- 1 - Yes



Chapter 3: L-2

M2004

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

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

Chapter 3: L-4

M2010

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

- 0 - No
- 1 - Yes
- NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

Chapter 3: L-1-5 - 6

M2015

- **(M2015) Patient/Caregiver Drug Education Intervention:**
Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects and how and when to report problems that may occur?
 - 0 - No
 - 1 - Yes
 - NA - Patient not taking any drugs

Chapter 3: L-7

M2020



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

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.
- 3 - Unable to take medication unless administered by another person.
- NA - No oral medications prescribed.

Chapter 3: L-8 - 9

Scenario B

Mrs. Cooper is unable to swallow pills. She takes three meds daily, two small pills sublingually from the bottles routinely stored next to her chair and a potassium chloride extended release formulation for liquid suspension that must be mixed with cold water and consumed immediately. Mrs. Cooper has problems with balance and requires someone to walk with her at all times in order to ambulate safely. Her daughter usually mixes the potassium suspension in the kitchen and walks it quickly into the living room to the patient before it becomes too thick to drink.

Which of the following represents accurate OASIS scoring for M2020 Management of Oral Medications?

M2020 Management of Oral Medications: Patient's current ability to prepare and take all oral

medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

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

B) 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.

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

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

M2030

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

- 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.



Chapter 3: L-10 - 11

M2040

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na

Chapter 3: L-12

M2100 Types & Sources of Assistance

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

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



Chapter 3: M-1 - 2

Scenario C

Mr. Nair, who lives with his son, needs help with all ADLs and IADLs. The Happy Hill Adult Day Care van transports him up every morning of the week to the center where he eats all his meals, receives needed supervision and socialization. Mr. Nair's son states he will do many things for his dad at night after work, like setting up and transporting him to the physician office appointments, but he won't bathe him or cook for him. The med tech at the day care center administers his medications as the son is working at noon when meds are prescribed to be administered.

What are the appropriate responses would be appropriate for M2100, Types and Sources of Assistance, Rows a, b, c, & g?

- A) a - 1, b - 1, c - 1, g - 1
- B) a - 1, b - 1, c - 0, g - 5
- C) a - 3, b - 3, c - 0, g - 1
- D) a - 3, b - 3, c - 3, g - 1

M2110 ADL/ IADL Assistance

- **(M21101) How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

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

Chapter 3: M-3

M2200

Chapter 3: N-1 - 2



- **(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.

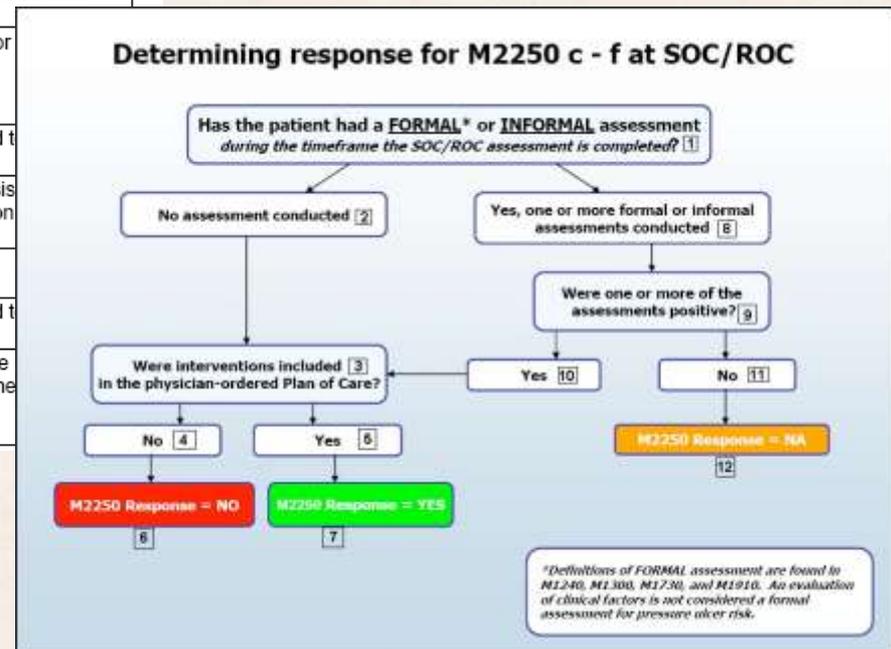


M2250

- **(M2250) Plan of Care Synopsis:** (Check only one box in each row.) Does the physician-ordered plan of care include the following: Chapter 3: N-3 - 5

Plan / Intervention	No	Yes	Not Applicable
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not diabetic or amputee
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not assessed for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient has no diagnosis symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not assessed for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient has no pressure need for moist wound he

April 2010 Q & As





M2300

- **(M2300) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?
 - 0 - No [***Go to M2400***]
 - 1 - Yes, used hospital emergency department WITHOUT hospital admission
 - 2 - Yes, used hospital emergency department WITH hospital admission
 - UK - Unknown [***Go to M2400***]

Chapter 3: O-1 - 2

M2310

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

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

Chapter 3: O-3 - 4

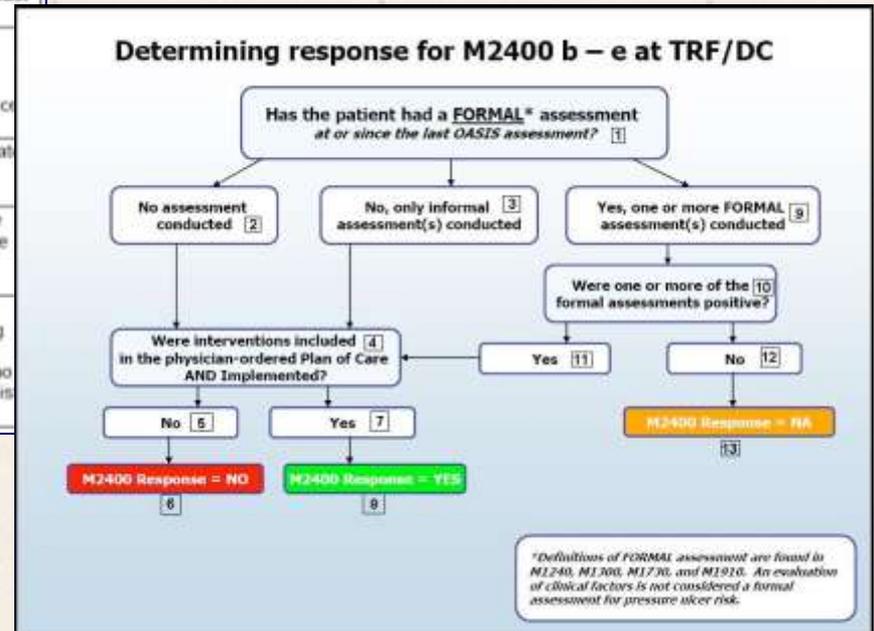
M2400

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

Chapter 3: P-1 - 3

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

April 2010 Q & As

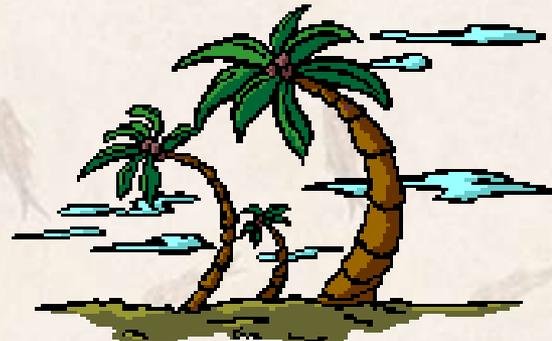


M2410 Inpatient Facility Admission

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

- 1 - Hospital [**Go to M2430**]
- 2 - Rehabilitation facility [**Go to M0903**]
- 3 - Nursing home [**Go to M2440**]
- 4 - Hospice [**Go to M0903**]
- NA - No inpatient facility admission [Omit "NA" option on TRN]

Chapter 3: P-4



M2420

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

- 1 - Patient remained in the community (without formal assistive services)
- 2 - Patient remained in the community (with formal assistive services)
- 3 - Patient transferred to a non-institutional hospice
- 4 - Unknown because patient moved to a geographic location not served by this agency
- UK - Other unknown [**Go to M0903**]

Chapter 3: P-5

Scenario D

You are completing the Discharge comprehensive assessment on Mr. Mendez, who has chronic renal failure. Reviewing the chart, you note that the patient visited the local hospital emergency department two weeks ago after being bitten by his grandchild's dog. He required 4 sutures and was started on a prophylactic antibiotic. While in the ED, the physician noted an irregular heart rate related to an elevated potassium level and instructed the patient to further restrict foods containing potassium and follow up with his PCP in one week. Mr. Mendez is being discharged as he is no longer homebound. He will continue to live in his home, receiving support from friends and church members who cook meals, help with housekeeping and transport him to the dialysis center when needed.

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

A) 6 – Cardiac dysrhythmia (irregular heartbeat)

B) 6 – Cardiac dysrhythmia (irregular heartbeat)
19 – Other than above reasons

C) 19 – Other than above reasons

D) 6 – Cardiac dysrhythmia (irregular heartbeat)
15 – Wound infection or deterioration
19 – Other than above reasons

(M2420) Discharge Disposition: Where is the patient after discharge from your agency?

- A) 1 - Patient remained in the community (without formal assistive services)
- B) 2 - Patient remained in the community (with formal assistive services)
- C) 4 - Unknown because patient moved to a geographic location not served by this agency
- D) UK - Other unknown

M2430

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

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

[*Go to M0903*]

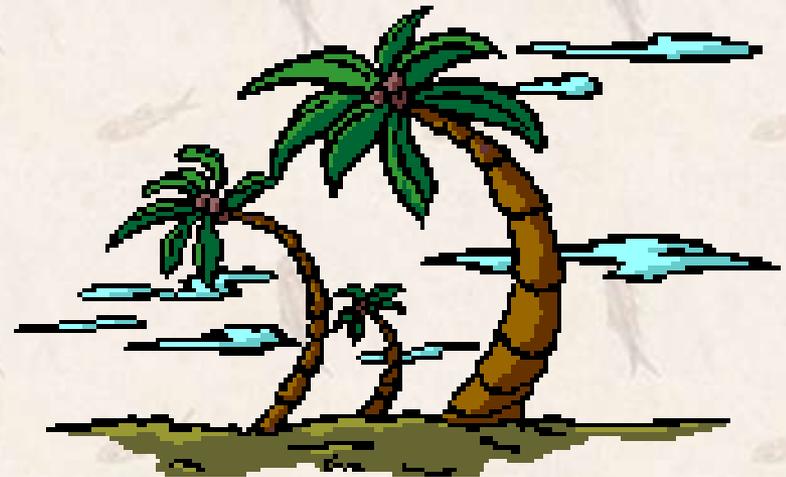
Chapter 3: P-6

M2440 Reason for Nursing Home Admission

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

Chapter 3: P-7

- 0 - Therapy services
- 1 - Respite care
- 2 - Hospice care
- 3 - Permanent placement
- 4 - Unsafe for care at home
- 5 - Other
- UK - Unknown [*Go to M0903*]



M0903

- **(M0903) Date of Last (Most Recent) Home Visit:**

___/___/_____
month / day / year



Chapter 3: P-8

M0906

Chapter 3: P-9

- **(M0906) Discharge/Transfer/Death Date:**
Enter the date of the discharge, transfer, or death (at home) of the patient.

___/___/_____
month / day / year



**The Winds of change
bring a new day**



Healthy Kansans living in safe sustainable
environments





QUESTIONS??



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environments



THANK YOU!

Travel Safe 😊



Kansas

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