Objectives

• Review the OASIS-D items and latest guidance
• Discuss assessment techniques to accurately answer OASIS items
• Learn how expansion of the One Clinician Rule will affect information gathering for OASIS-D
• Examine how the GG items compare and contrast with M1800s ADL items
• Identify how the OASIS-D GG and J items will be used in quality measurement for Home Health

Data Elements: Standardization

• The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 includes formulation of new Standardized Patient Assessment Data Elements (SPADEs): identical standards and definitions which will be utilized across all post-acute care providers
  • HH – Home Health (OASIS)
  • SNF—Skilled Nursing Facility (Minimum Data Set)
  • IRF—Inpatient Rehab Facility (Patient Assessment Instrument)
  • LTCH—Long Term Care Hospital (Continuity Assessment Record and Evaluation (CARE) Data Set)
Data Elements: Standardization

- Increase standardization with assessment item sets for all post acute settings to enable cross setting data collection, calculation of standardized quality measures, and interoperable data exchange.
- The eventual aim is to enable reporting quality outcomes and resource use between these settings.
- OASIS-C2 and OASIS-D changes designed to standardize data collection items across settings.

Uses of OASIS data

- Quality measures
- IMPACT Act measures
- Risk Adjustment
- Process measures
- HHCompare, STAR Rating
- QAPI
- Survey
- Potentially Avoidable Events
- Payment HHRG, VBP

OASIS Data Timepoints

OASIS data are collected at the following time points:

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

*visit required

Outcomes

- Health status changes between two or more time points - includes physiologic, functional, cognitive, emotional, and behavioral health.
- Changes that are intrinsic to the patient.
- Changes that result from care provided, or natural progression of disease and disability, or both.
- Outcomes are positive, negative, or neutral changes in health status.
OASIS-Based Outcomes

- OASIS data items are arranged from least impaired or independent, to most impaired or dependent.
- Except for GG-items
- The answer at SOC/ROC is compared to the answer at Transfer/DC to determine if there has been improvement, decline or stabilization on that particular outcome.

Tip: read responses from bottom up

Process Measures

- Process measures evaluate the rate of HHA use of specific evidence-based processes of care. The HH QRP process measures focus on high-risk, high-volume, problem-prone areas for home healthcare.
- Purpose of Process Measures
  - Whose score is it?
  - Why do we need a process?
  - Processes that promote good outcomes—known as best practices
  - Some require standardized validated tools

Potentially Avoidable Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Care for Injury Caused by Fall</td>
<td>Discharged to community needing wound care or medication assistance</td>
</tr>
<tr>
<td>Emergent Care for Wound Infections, Developing Wound Ulcers</td>
<td>Discharged to community needing wound care or medication assistance</td>
</tr>
<tr>
<td>Emergent Care for Improper Medication Administration, Medication Side Effects</td>
<td>Discharged to the community needing toileting assistance</td>
</tr>
<tr>
<td>Substantial Decline in 3 or more Activities of Daily Living</td>
<td>Development of Urinary Tract Infection</td>
</tr>
<tr>
<td>Substantial Decline in Mngt of Oral Medications</td>
<td>Increase in Number of Pressure Ulcers</td>
</tr>
<tr>
<td>Emergent Care for Hypo/Hyperglycemia</td>
<td>Discharged to the community with a healed stage 2 pressure ulcer</td>
</tr>
</tbody>
</table>

Home Health Compare

- Subset of OASIS-based quality performance
- 22 publicly reported measures
- Outcome measures that indicate how well HHAs assist patients in regaining or maintaining their ability to function
- Process measures that evaluate the rate of HHA use of specific evidence-based processes of care
Types of STAR Ratings

Quality of Patient Care STAR Ratings
• Formerly called the “Home Health Compare STAR ratings”
• Posted on HHCompare website since July 2015
• Based on OASIS data submitted by agencies for outcome and process measures and claims data for acute care hospitalization

Patient Survey STAR Ratings
• First posted on HHCompare January 28, 2016
• Based on Home Health Consumer Assessment of Healthcare Providers and Services (HHCAHPS) measures currently reported on HHCompare.

Outcome Measures
• Improvement in Ambulation
• Improvement in Bed Transferring
• Improvement in Bathing
• Improvement in Pain Interfering with Activity
• Improvement in Shortness of Breath
• Improvement in Management of Oral Medications

Process Measures
• Timely Initiation of Care
• Drug Education on all Medications Provided to Patient/Caregiver
• Influenza Immunization Received for Current Flu Season

Utilization Measure
• Acute Care Hospitalization (Claims-based)

Current Star Ratings
• Quality of Patient Care Star Ratings on Home Health Compare, January 2019 update

<table>
<thead>
<tr>
<th>Your agency</th>
<th>NE State Average</th>
<th>National Average</th>
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<tr>
<td>***</td>
<td>***1/2</td>
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Acute Care Hospitalization
• Uses Medicare claims based information
• The “ACH” and “ED Use without Hospitalization” measures evaluate patient admission to an acute care hospital and emergency department (without hospitalization), respectively, during the 60 days following the start of home health stay
• Planned hospitalizations are not counted
• OASIS based ACH rates will not be reported after 2019
**Current Scores**

- Claims-based Acute Care Hospitalization of patients receiving home care services

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<tr>
<th>Your agency</th>
<th>NE State Average</th>
<th>National Average</th>
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</thead>
<tbody>
<tr>
<td>16.1%</td>
<td>15.8%</td>
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**Risk Adjustment**

- Statistical **risk adjustment** uses analytic methods to separate the relationships of outcomes with care provided from the relationship of outcomes with natural progression of disease and disability.
- One of the major purposes of OASIS is to provide data items needed for risk adjustment.
  - **Risk adjustment compensates or controls for the potential influence of case mix variables (i.e., risk factors) that can affect outcomes.**

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**Home Health Resource Group**

- OASIS is the basis for payment
- HHRG produced through grouper software
  - Determined through certain OASIS responses
  - Three domains
    - Clinical Severity
    - Functional Status
    - Service utilization
- 45 HHRGs; 153 case mix weights
  - C1F1S1 to C3F3S5 for four different equations (five different groupings)
  - (five different C1F1S1s)

**Patient Driven Grouping Model (PDGM) proposed for 2020**

- Admission source: Community or Facility
- Episode Timing: early or late
- Clinical Grouping: based on primary diagnosis on claim (complex nursing, wounds, neuro rehab, MS rehab, behavioral, MMTA)
- Functional level: OASIS items M1800, M1810/20, M1830, M1840, M1850, M1860, M1033
- Comorbidity adjustment from secondary diagnoses on claim
Quality Assessment Performance Improvement - QAPI

- Program activities:
  - Goal: show measurable improvement in areas that will improve health outcomes, patient safety and quality of care
  - Focus: high risk, high volume, problem prone areas of care
  - Track and address patient incidents and adverse events
- Program data:
  - Must use quality indicator data from OBQI, PBQI and OBQM CASPER reports (may also use other sources in addition to CASPER reports)

Survey Prep

- “One button” Reports
  - OBQI
  - PBQI
  - OBQM
  - Patient Characteristics report
- OASIS data submission report

OASIS-D Changes

28 Removed Items
M0903, M1011, M1017, M1018, M1025, M1034, M1036, M1210, M1220, M1230, M1240, M1300, M1302, M1313, M1320, M1350, M1410, M1501, M1511, M1615, M1750, M1880, M1890, M1900, M2040, M2110, M2250, M2430

7 Revised Items
M1228, M1306, M1311, M1322, M1324, M2101, M2310

6 New Items
GG0100, GG0110, GG0130, GG0170, J1800, J1900

New Quality Measures

New standardized items support measurement domains mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), including new quality measures:

- New standardized items J1800, J1900 - Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF # 0674)
- New standardized items GG0130, GG0170a-b, d-s - Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
- Modification to OASIS item M1311 to support a new standardized pressure ulcer measure to replace the current standardized pressure ulcer measure. The new measure is Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

IMPACT Act

- New items added to OASIS for standardization to align with the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI), the Long-term Care Hospital assessment set, and the Minimum Data Set (MDS).
  - GG0100 Prior Function
  - GG0110 Prior Device Use
- Item removals, including the removal of data elements at different time points. This results in largely different assessment times by time point, reducing burden for HHAs. Details and calculations of data elements by timepoint are available in Appendix C of the OASIS-D Manual.

Resources for OASIS Accuracy

- OASIS-D data set
- OASIS-D Guidance Manual, Ch. 1 and Ch. 3
- CMS OASIS Static Q&As Category 1-4
  - Updated October 2018
- CMS Quarterly Q&As, resumed April 2018
- OASIS Considerations for PPS Patients
- WOCN Guidance for OASIS Wound Items
- OASIS Education Coordinator for your state

And remember...

*When guidance from two CMS resources conflicts – use the most recent.*

*When unable to find an exact answer – use clinical judgement.*

*If there’s no information in the Q&As – consider submitting a question to CMS*  
Homehealthqualityquestions@cms.hhs.gov
Quality Resources

- Home Health Quality Reporting Program website
- Spotlight and Announcements
- Home Health Quality measures, Star Measures
- OASIS data sets and Guidance Manuals
- HH Quality Reporting Training
- Home Health Quality Help Desk email:
  homehealthqualityquestions@cms.hhs.gov

OASIS Patient Populations

- Medicare and Medicaid patients, 18 years and older, receiving skilled services
  - Includes Medicare Advantage plans, Medicaid managed care plans
  - Except patients receiving maternity services, or care for pre- or postnatal conditions
  - Excludes patients receiving only personal care, homemaker, or chore services (not skilled services)
- HHAs may collect OASIS data on non-Medicare and non-Medicaid patients for payor request or agency use, BUT do not transmit the data to CMS

The Definition of an Episode Can Be Different

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

- Time period under consideration for each item usually day of assessment
- Day of assessment is the 24 hours immediately preceding the home visit and the time spent by the clinician in the home conducting the visit
- Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance.
  - Within the last 14 days
  - Prior to this current illness
  - Day of assessment and recent pertinent past
  - This payment episode (60 days)
  - At the time of or any time since the most recent SOC/ROC OASIS assessment
  - Last 5 days visits received prior to planned/unexpected DC
  - Collaboration

Conventions

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

Conventions

- Time periods for data collection:
  - SOC: 5 days
  - ROC: 48 hours (2 days)
  - Recert FU: days 56-60 of episode
  - Discharge: date of DC visit and 4 preceding calendar days
- New guidance: code pressure ulcers based on the first skin assessment (may not update even within the allowed time frame for the assessment)

Conventions

- “By midnight of the next calendar day” = by midnight tomorrow
- Twelve items allow a dash response
  - A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.
Conventions

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

Conventions

- Combine observation, interview, and other relevant strategies to complete OASIS data items as needed
  - However, when assessing physiologic or functional health status, direct observation is the preferred strategy – avoid a “recliner assessment”
- When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact and includes both verbal cues and supervision.

Conventions

- Understand the definitions of words as used in the OASIS, and what’s included and excluded in item
- Physician ordered restrictions are considered when determining ability
- The use of the term “specifically,” means scoring of the item should be limited to only the circumstances listed. The use of “for example,” means the clinician may consider other relevant circumstances or attributes when scoring the item
- CMS encourages a multidisciplinary approach to assessment

Expansion of the One Clinician Rule

- CMS is promoting a team approach to data collection, as present in other PAC settings
- Comprehensive assessment includes OASIS items and is part of legal HHA clinical record. While only the assessing clinician is responsible for accurately completing and signing comprehensive assessment, s/he may collaborate to collect data for all OASIS items, as agency policy allows. (per CoPs)
  - Signature is attestation that to the best of his/her knowledge, the document reflects the patient status as assessed, and supported as documented.
Expansion of the One Clinician Rule

• Collaboration may consider information from others such as patient, caregivers, physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to OASIS data collection. (per OASIS guidance effective 1/1/18)

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

• M0090 = last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including OASIS items. Must be within allowed assessment time frame

Details Re: Collaboration

• Other Agency Staff: LPN/LVN, PTA, COTA, MSW, HHA

• All must function within the scope of their practice and state licensure.

• Direct contact or other means: In-person, health care monitoring devices, video streaming, review of photograph, phone call, etc

• Clinical/patient assessment: Base responses on assessment by agency staff, and not directly on documentation from other care settings

• OASIS Quarterly Q&A April 2018

Collaboration Considerations

Need a way to identify what was actually collected by the clinician through assessment, and what was gathered from others via collaboration

• Who did you collaborate with?
• What information was shared?
• When did you discuss this information?
• How is this additional information going to be used to answer OASIS items?
• How is this collaboration going to be documented in the medical record?

Quiz

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

  a. RN visit only
  b. RN, PT, OT since all are qualified clinicians
  c. HHA, RN, PT because all 3 visits are within timeframe
  d. HHA, RN, PT and OT because collaboration is allowed
Quiz--OASIS Quarterly Q&A April 2018

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

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

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Timely Initiation of Care

• Conditions of Participation require the initial assessment to determine the patient’s eligibility for home care services and immediate care needs; and must be conducted either:
  • Within 48 hours of the date of referral OR
  • Within 48 hours of return home from inpatient facility OR
  • On the physician-ordered SOC or ROC date
• Initial assessment vs. SOC visit dates
• OASIS items used for measurement:
  • M0102 – Date of physician-ordered Start of Care (Resumption of Care)  
  • M0104 – Date of Referral  
  • M1005 – Inpatient Discharge Date (most recent)

---

M0102 Date of Physician-ordered SOC (or ROC)

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

- [ ] NA - No specific SOC date ordered by physician

• Time points: SOC, ROC
• Specifies date HH services are ordered to begin or resume IF the date was specified by the physician
• Mark NA if physician orders do not specify SOC/ROC date, or requested/revised SOC/ROC order received after originally ordered SOC/ROC date, or order for requested/revised SOC/ROC date received after the 48 hour time frame
M0102 Date of Physician-ordered SOC (or ROC)

• Must be a single specific date to initiate or resume care, not a range of dates
• If originally ordered SOC/ROC date is delayed due to patient condition or physician request (example: extended hospitalization), enter new ordered SOC/ROC date in M0102
• If specific SOC/ROC date not given and a specific SOC/ROC date beyond the 48 hours is requested, must receive order/approval for new date on or before the end of the 48 hour initial assessment time frame

M0104 Date of Referral

• Update/revise the M0104 date:
  • If SOC is delayed due to the patient’s condition or physician request, and agency received updated/revised information
  • If a hospitalist (or other referring physician) is not going to provide orders and follow the patient, this is not a valid “referral” for completion of M0104
  • The HHA must contact an alternate, or attending physician, and upon agreement from this following physician for referral and/or further orders, the HHA will note this as the referral date in M0104 (unless referral details are later updated or revised).

What isn’t the M0104 date

• This does not include calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
• The date authorization was received from the patient’s payer is NOT the date of referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).
**M1005 Inpatient Discharge Date**

* (most recent)

- Time points: SOC, ROC
- Identifies the date of the most recent discharge from an inpatient facility (within past 14 days)

---

**Example 1**

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

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**Example 2: Patient Requests Delay**

**Physician Informed & New SOC Approved**

- M0030: Jan. 4
- M0102: Jan. 4
- M0104: skipped if date entered in
- M1005: skipped

**Physician Not Informed**

- M0030: Jan. 4
- M0102: NA
- M0104: Jan. 1
- M1005: skipped, no inpatient discharge in past 14 days

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**Can’t Find the Patient**

- Q23.11.2.2. M0102 & M0104. We received a referral for home care but were unable to reach the patient for several days. We notified the physician of the problem. When we finally reached the patient, he requested we start care a week after the original order date. We sent a fax to the MD 5 days after the original order was received requesting a delay in the SOC with a specific date 3 days from then. If we received the order back from the MD prior to that new date, how do we answer M0102, Physician-ordered SOC date and M0104, Date of Referral? [Q&A EDITED 04/15; ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #5]
Can’t Find the Patient

• A23.11.2.2. "If the originally ordered start of care is delayed due to the patient’s condition or physician request (e.g., extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician ordered start of care (resumption of care)."

• In order to report this new updated/revised physician’s ordered start of care date in M0102, it must have been received before the end of the 48 hour initial assessment time frame (or before the date of the previous physician’s ordered start of care date, if one was provided). If the order to extend the physician’s ordered start of care date is received after the 48 hour initial assessment time frame (or after the date of the previous physician’s ordered start of care date, if one was provided), report NA for M0102 and report the original referral date in M0104.

Current Scores

• Timely Initiation of Care

<table>
<thead>
<tr>
<th>Your agency</th>
<th>NE State Average</th>
<th>National Average</th>
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<tbody>
<tr>
<td></td>
<td>95.7%</td>
<td>94.3%</td>
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J1800: Any Falls Since SOC/ROC

Review: home health clinical record, visit notes, incident reports, other relevant clinical documentation (fall logs)
Interview: patient and/or family/caregivers about occurrence of falls since most recent SOC/ROC
J1800 Definition of Fall

- **Unintentional** change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).
- An **intercepted fall** occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.
- CMS understands that challenging a patient’s balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Unwitnessed Fall

- The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  - **Rationale:** This item addresses unwitnessed as well as witnessed falls.

Intercepted Fall

- An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  - **Rationale:** An intercepted fall is considered a fall.

Balance Training – Challenge Balance

- A patient is participating in balance retraining activities during a therapy visit. The therapist is intentionally challenging patient’s balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides minimal assistance to allow the patient to maintain standing.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 0, No.
  - **Rationale:** The patient’s balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated. When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall.
Unanticipated Fall During Therapy

- A patient is ambulating with a walker with the help of the physical therapist. The patient stumbles and the therapist has to bear some of the patient's weight in order to prevent a fall.
- **Coding:** J1800, Any Falls since SOC/ROC would be coded 1, Yes.
- **Rationale:** The patient’s stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.

<table>
<thead>
<tr>
<th>J1900 Definitions</th>
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<tbody>
<tr>
<td><strong>INJURY RELATED TO A FALL</strong></td>
</tr>
<tr>
<td><strong>NO INJURY</strong></td>
</tr>
<tr>
<td><strong>INJURY (EXCEPT MAJOR)</strong></td>
</tr>
<tr>
<td><strong>MAJOR INJURY</strong></td>
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<table>
<thead>
<tr>
<th>J1900: Number Falls Since SOC/ROC</th>
</tr>
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<tbody>
<tr>
<td><strong>CODING:</strong></td>
</tr>
<tr>
<td>0. None</td>
</tr>
<tr>
<td>1. One</td>
</tr>
<tr>
<td>2. Two or more</td>
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<tr>
<td><strong>A.</strong> No injury: No evidence of any injury noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.</td>
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<tr>
<td><strong>B.</strong> Injury (except major): Skin tears; abrasions; lacerations; superficial bruises; hematomas and sprains; or any fall-related injury that causes the patient to complain of pain.</td>
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<tr>
<td><strong>C.</strong> Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.</td>
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A “—” dash is a valid response for any row in this item

**Response Specific Instructions**

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

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

Coding:
- J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.
- J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.
- J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

Answer J1800 and J1900

- The patient fell at the doctor’s office and sustained a shoulder dislocation.
  - J1800 Any falls? And J1900?
- The patient fell at the hospital after transfer from home health, abrasion on forehead.
  - J1800 Any falls? And J1900?

### Jan. 2019 Q&A #31

- J1800 and J1900 reflect falls that occurred at any time during the quality episode, regardless of where the fall occurred. A fall that occurred at the doctor’s office during the HH quality episode would be reported. If a HH patient has a qualifying inpatient facility transfer (e.g. hospital or SNF), and falls in the facility, that fall would not be reported by the home health agency, as it did not occur within a HH quality episode (the fall would have occurred after the transfer and before the ROC).

### Info Obtained Later

- Mr. Norman fell and complained of severe pain in his hip. He went to the ER and was admitted. We completed the transfer OASIS the next day but information was not available until 4 days later that the hip is fractured. Since that knowledge was obtained after the timeframe, how should M1900 be coded?
- Since injuries can present themselves later than the time of the fall, or the agency may not learn of the level of injury until after the OASIS/assessment is completed, agencies are encouraged to correct errors as accurate information regarding fall-related injuries becomes known. Errors should be corrected following the agency’s correction policy and M0090 would not necessarily be changed. Jan. 2019 Q&A #32
Falls Quality Measure

- Reports the percentage of quality episodes in which the patient experiences one or more falls with major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness or subdural hematoma)
- Adopted for calendar year 2020 HH Quality Reporting Program, data for measure calculation submitted via OASIS Jan-Dec 2019
  - J1800 gateway item, J1900C data item for measure
- This measure is not risk-adjusted

Numerator = number of quality episodes in which J1900C is response 1 or 2

Denominator = All quality episodes except:

Occurrence of falls was not assessed (J1800 is dash “—”)  
Or  
Assessment indicates fall occurred AND the number of falls with major injury was not assessed (J1900C is dash “—”)

ADLs

Uses of ADL and IADL items

- Outcomes
- Risk Adjustment
- Payment
- Support Medicare eligibility
OASIS Assessment Conventions for ADL Items

• Identify \textit{ability}, not actual performance or willingness
• Assess patient’s ability to \textit{safely} complete the specified activities listed in the OASIS item and only those specific tasks
• Patient’s ability to access needed items and/or location where the task occurs is INCLUDED, unless specifically excluded in guidance
  • M1845 Toileting hygiene—excludes getting to the location where the toileting occurs
  • M1870 Feeding/Eating—excludes getting to location where meal is consumed and excludes transporting food to table
• Consider what the patient is able to do on the day of assessment; if ability varies over the 24 hour period, select the response that describes the patient’s ability more than 50% of the time
• If patient’s ability varies between multiple tasks included in the item, report ability to perform a majority of the included tasks, giving more weight to tasks that are performed more frequently

Conventions Specific to ADLs/IADLs

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

Bedfast Defined

• "Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed." If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time.
• The assessing clinician will have to use her/his judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as she/he is able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents him from tolerating the sitting position.

Conventions for ADL Items (con’t)

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

- What is the difference between “willingness” and “adherence” (which do not impact OASIS scoring) and “cognitive/mental/emotional/behavioral impairment” (which may impact OASIS scoring)?
- In absence of pathology, patients may make decisions about how and when they perform their activities of daily living that may differ from what the clinician determines to be acceptable. A patient may choose to shave and brush his teeth infrequently because he doesn’t value doing it at a frequency that the clinician deems as socially appropriate. There are differences in the frequency at which grooming or bathing is performed, or expected to be performed based on age, religion, culture and familial practices, and this is not necessarily indicative of pathology.

**Things to Remember**

- Patient 1 demonstrates that they can safely ambulate while using a walker, but then as a *matter of choice*, decides to walk without it.
- Patient 2 demonstrates that they can safely ambulate while using a walker, but then consistently walks without it, *forgetting* that they have a walker.
- For OASIS scoring, non-conformity or non-adherence should not automatically be considered indicative of a deeper psychological impairment. The assessing clinician will have to use clinical judgment to determine if the patient’s actions are more likely related to impairment, or to personal choice made in awareness of the potential related risk.

**Conventions Specific to ADLs/IADLs**

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

**M1800 Grooming**

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

*Proposed payment item in PDGM*
M1800 Grooming

- Patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment.
- Select the response that best describes the patient’s level of ability to perform the majority of grooming tasks.
- Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.

Assessment Tips for M1800

- Observe the patient get to the location where grooming takes place and where items are kept.
- Ask the patient to go through the motions involved in grooming: assess upper extremity range of motion, balance when bending over the sink.
- Observe patient’s appearance, hygiene and grooming to determine if patient has been able to do tasks on day of assessment; ask patient or caregiver if any assistance has been needed.
- Determine patient’s ability to perform a majority of grooming tasks safely, consider frequency.

Quiz

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

M1810/M1820 Dress Upper/Lower Body

Enter Code

- How can this score be improved by discharge?
M1810/M1820 Dressing

- Ability to obtain, put on, and remove upper body and lower body clothing.
- Assess ability to put on whatever clothing is routinely worn.
- Specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- Consider the clothing to be “routine” if:
  - It is what the patient usually wears and will continue to wear
  - Patient modifies the clothing worn due to a physical impairment and the new styles are expected to become the patient’s new routine clothing
  - There is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.

Environmental Modification

- If the environment is modified (e.g., the patient decides to start storing clothing in the dresser instead of hanging in the closet), and the patient can now access clothes from a location without anyone’s help, then this new arrangement could now represent the patient’s current status (e.g., clothing’s new “usual” storage area and patient’s ability). The appropriate score would be a “0” if the patient was also able to put on and remove a majority of his clothing items safely. Remember day of assessment.
  - Temporary storage because of weakness—1 (Patient could then work to gain independence in accessing clothing from its usual storage location, or decide to make long-term environmental modifications, and possibly achieve improvement in the outcome if successful.)
  - Permanent storage—0

Assessment Tips for M1810/M1820

- Ask the patient if he/she has difficulty dressing upper body.
- Observe the patient’s general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely.
- Opening and removing garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing.
- Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. The patient also can be asked to demonstrate the body motions involved in dressing.
M1830: Bathing

- If patient is able to bathe in the tub or shower with no assistance from another person for getting in/out of the tub or bathing any part of their body, choose Response 0 or 1
- Response 0 – no assistance from another person and no assistive devices are used; patient is totally independent in bathing
- Response 1 – no assistance from another person, and patient independent bathing with devices in the home and used correctly

M1830: Bathing

- If patient requires standby assistance to bathe safely in tub or shower or requires verbal cueing or reminders, then select Response 2 or 3, depending on whether the assistance needed is intermittent (“2”) or continuous (“3”).
- If patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, select “2”. If patient requires one, two, or all three types of assistance listed in Response 2, but not continuous presence of another person as in Response 3, then “2” is the best response.
**M1830: Bathing**

- The patient’s status should not be based on an assumption of a patient’s ability to perform a task with equipment they do not currently have.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower.
  - Responses 4, 5, or 6 would apply, depending on the patient’s ability to participate in bathing activities.

**M1830: Assessment Techniques**

- Use a combined interview and observation approach
- Does the patient have a functioning bath tub or shower? Sink?
- Ask the patient how they currently bathe, and what type of assistance is needed to wash entire body
- Do they have the necessary safety equipment in the home?
- Does the patient have medical restrictions that affect bathing?
- Observe the patient’s general appearance in determining if the patient has been able to bathe self independently and safely

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**M1830: Bathing**

- Response 4: patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water safely at a sink, or setting up a basin at the bedside, etc.
- Response 5: patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair, or on a commode
- Response 6: patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs

**M1830: Assessment Techniques**

- Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely
- Ask the patient to demonstrate the motions involved in bathing the entire body.
- Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower. The patient who only performs a sponge bath may be able to bathe in the tub or shower with assistance and/or a device.
- Consider safety: home setting, equipment, ability
- Score at SOC/ROC before you teach or get equipment
Examples

The patient’s tub is nonfunctioning or unsafe for use. His bath supplies are kept on the counter and patient bades himself at the sink without any additional help.
• M1830: ?
What if he can’t get to the sink and his wife has to set up a basin at the bedside for the patient to bathe himself?
• M1830: ?
The patient is ordered not to shower until 7 days after surgery when the sutures will be removed. When the nurse arrives, he is just getting out of the shower and his dressing is soaking wet. He showered without any assistance except his wife helped him get into the shower.
• M1830: ?

Examples

The patient is on physician-ordered bed rest.
• M1830 = ?

The patient chooses not to navigate the stairs to the tub/shower.
• M1830 = ?

Examples

The patient is on physician-ordered bed rest.
• M1830 = 5 or 6 depending on whether patient can participate in bathing himself in the bed.

The patient chooses not to navigate the stairs to the tub/shower, and sponge bathes at the sink in the kitchen.
• M1830 = 2 or 3. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower.
  • How much help does the patient need to get to the shower upstairs? Does she need help with bathing once she gets there? Continuous or intermittent assistance?

Example

The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.
• If due to fear, she refuses to enter the shower even with the assistance of another person; either Response 4, 5, or 6 would apply, depending on the patient’s ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then Response 3 would describe her ability.
Example

The patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on over the cast, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower.

• M1830: ?

Current Scores

• Improvement in Bathing

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M1840 Toilet Transferring

• Response 0 – can get to/from and on/off bathroom toilet without assistance, may use a device or not.

• Response 1 requires patient participation (effectively participate by contributing effort toward the completion of some of the included tasks)
  • If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders.
  • If the patient needs assistance getting to/from the toilet or with toiling transfer or both.
  • If the patient can independently get to the toilet, but requires assistance to get on and off the toilet.
M1840 Toilet Transferring

- A patient who is unable to get to/from the toilet or bedside commode, but is able to place and remove a bedpan/urinal independently, should be marked Response 3. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal.
- If the bedfast patient needs assistance to get on/off the bedpan, the appropriate M1840 Response is "4-Is totally dependent in toileting" even if they can place and remove the urinal.
- Emptying the bed pan is excluded from the item.

Assessment Tips for M1840

- Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc.
- Determine the level of assistance needed by the patient to safely get to and from and on and off the toilet or commode.
- Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

No Toilet

- In the absence of a toilet in the home, the assessing clinician would need to determine if the patient is able to use a bedside commode (Response 2), or if unable to use a bedside commode, if he is able to use a bedpan/urinal independently (Response 3). If the patient is not able to use the bedside commode or bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment, then Response 4 – totally dependent in toileting would be appropriate.

M1845 Toileting Hygiene

Majority of tasks doesn’t apply for this item - has to be able to manage both clothing and toilet hygiene for 0 and 1.
M1845 Toileting Hygiene

• Includes pulling clothes up or down, managing incontinence pads, adequately cleaning (wiping) the perineal area, ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies). Excludes managing ostomy equipment.

• Focus is on the patient’s ability to access needed supplies and implements, and manage hygiene and clothing once at the location where toileting occurs. The ability to access the toilet or bedside commode, transfer on and off the bedpan and to use the urinal are excluded from consideration when assessing the patient’s toileting hygiene ability.

• The word “assistance” in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.

M1845 Toileting Hygiene

• Response 0 if the patient is independent in managing toileting hygiene and managing clothing.

• Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.

• If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, select Response 2.

M1850 Transferring

• Identifies the patient’s ability to safely transfer from bed (current sleeping surface) to chair (and chair to bed), or position self in bed if bedfast.

• For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface.
M1850 Transferring

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

- The need for assistance with gait may impact the Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed.

M1850 Transferring

- If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), assess the patient’s ability to move from the supine position on their current sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.

- Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is dependent. If standby human assistance were necessary to assure safety, then a different response level would apply.

M1850 Transferring

- Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete task.

- Select Response 1 if:
  - Patient transfers either with minimal human assistance (but not device), or with the use of a device (but no human assistance)
  - Patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing or reminders
  - Patient requires another person to position the wheelchair by the bed and apply the brakes to lock the wheelchair for safe transfer from bed to chair

M1850 Transferring

- Response 2 - Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).

- Select Response 2 if:
  - Patient requires more than minimal assistance (more than 25% of the effort to transfer comes from another person helping)
  - Patient requires both minimal human assistance and an assistive device to be safe
  - Patient can bear weight and pivot, but requires more than minimal human assist,
M1850 Transferring

• The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.
• A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer.

M1850 Transferring

• If the patient is bedfast, select Response 4 or 5, depending on the patient’s ability to turn and position self in bed.
• Bedfast refers to being confined to the bed, either per physician restriction or due to a patient’s inability to tolerate being out of the bed. Responses 4 and 5 do not apply for the patient who is not bedfast.
• The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed.

M1850 Assessment Techniques

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

Current Scores

• Improvement in Bed Transferring

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M1860 Ambulation/Locomotion

- Identifies the patient’s ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces.
- Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence.
- Assess patient’s ability to ambulate; endurance is not included in this item.
- Patient may use a wheelchair 75% of the time due to distances and endurance, and ambulates 25% of the time – that patient has the ability to ambulate.
- The patient that is only able to take a few steps to complete the transfer to and from a wheelchair is NOT able to functionally ambulate, that patient is chairfast.
- The patient that stays in bed watching TV all day and gets up to walk to the table for meals has the ability to ambulate – he just chooses to stay in bed most of the time; that doesn’t make him bedfast.

**M1860 Ambulation/Locomotion**

- Response 0: patient can safely walk on any surface in their environment, including stairs, **without any device or any human assistance AT ALL**.
  - If you mark this response, better document why the patient is homebound!
- Response 1: Safe on all surfaces and stairs **with a one-handed device – NO HUMAN ASSISTANCE NEEDED AT ALL FOR ANY SURFACE**.
  - Includes all kinds of canes, as long as they only require one hand to use safely and correctly.
- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, select Response 2 or Response 3, depending on whether **assistance required is intermittent (“2”) or continuous (“3”)**.
  - If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces, select Response 2 (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).
M1860 Ambulation/Locomotion

- If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with the supervision or assistance should be reported, unless the patient is chairfast.
- Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance.
  - A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self.
  - Wheelchair may be powered or manual version.

M1860 Ambulation/Locomotion Example

A patient is able to ambulate independently with a walker, but he chooses to not use the walker, therefore is not safe. Response #2, or Response #3?

- Report the patient’s physical and cognitive ability, not their actual performance, adherence or willingness to perform an activity. If observation shows the patient is able to ambulate independently with a walker, without human assistance, select Response 2 for M1860.
- However, if the patient forgets to use the walker due to memory impairment, that impacts his ability. The clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, M1860 would be a “3”. If patient only needed assistance intermittently, the correct response would be a “2”.

Patient safely ambulates with a quad cane in all areas of the home except her bedroom and bathroom where she has shag carpet that tangles in the prongs of the cane. In those rooms, she switches to a walker to ambulate safely. The patient does not require any human assistance.

- M1860: 2
M1860 Ambulation/Locomotion

• Patient has no device in home and is not safe ambulating even with assistance from another person all the time.
• “5-Chairfast, unable to ambulate and is unable to wheel self”.
• Patient ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home.
• If the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, she would be scored a "2" for M1860 if she needs two hands to use the stair lift and a "1" if she only needs one hand to safely use the stair lift.

Knee Scooter

• If a patient is safely using a knee scooter to facilitate non-weight bearing on one lower extremity, what response would be selected for M1860 - Ambulation?
• To determine the accurate response for M1860, the assessing clinician must determine if the knee scooter will be considered an assistive device for the purpose of ambulation. If the assessing clinician determines the knee scooter is an assistive device, then the clinician must determine if the patient is safe without the assistance of another person and assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.

How safe are they?

Patient is wheelchair bound and cannot ambulate but can wheel self. Patient also has advanced dementia or cognitive decline and although the patient can wheel self independently, he/she is unable to do so with any purpose, (i.e., patient could not follow simple instructions to get to another room, or could not self-evacuate in the event of an emergency). What response should be selected?

• The assessing clinician must consider the non-ambulatory patient’s ability to safely use the wheelchair, given the patient’s current physical and mental/emotional/cognitive status, activities permitted, and the home environment.
• In the scenario, the patient’s advanced dementia/cognitive decline is noted as a concern because the patient is unable to wheel self with purpose. Other than addressing safety on surfaces the patient would routinely encounter in their environment, CMS guidance does not detail specific criteria regarding patient ambulation or wheelchair use (i.e., how far the patient must walk, or wheel self; or if they use ambulation or wheelchair mobility with specific purpose, regularity, or efficiency). It is left to the judgment of the assessing clinician to determine the patient’s ability (i.e., does the patient’s mental status impacted his/her safety?) and select a response accordingly.
M1860 Assessment Techniques

• Observe the patient walk a reasonable distance
  • Does patient use a device? Correctly and safely? What type?
  • Does patient use walls or furniture for support?
  • Does patient demonstrate loss of balance or other actions that suggest additional support is needed for safe ambulation?
  • Does the patient demonstrate safe gait pattern?
• Observe the patient’s ability and safety on stairs
  • If chairfast, does the patient have a wheelchair? Power or manual? Do the brakes work properly? Can the patient demonstrate ability to wheel the chair independently? Across the floor? Through doorways? Up/down entrance ramp?

Current Scores

• Improvement in Ambulation/Locomotion

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GG Functional Abilities and Goals

• Alignment with standardized sections in other PAC instruments
• “Patient” instead of “Resident” (as in the original)
• “SOC/ROC” instead of “admission”
• Full assessment timeframe to complete data collection and assessments
  • SOC = 5 days
  • ROC = 2 days
  • Recert FU = days 56-60
  • Other FU = 2 days
  • DC = last visit + 4 calendar days preceding last visit
GG Item Time Points

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GG0130 and GG0170 Time Periods

- SOC/ROC: functional assessment at or soon after SOC (5 days) or ROC (2 days), prior to start of therapy services if possible (baseline)
- Follow-Up: functional assessment within the time period for Recert FU (days 56-60) or Other FU (2 days)
- Discharge: functional assessment at or close to the time of discharge, including the last 5 days of care (the date of the discharge visit plus the 4 preceding calendar days)

GG Item Conventions

- Assess patient status based on direct observation
- Consider reports by patient/family/caregiver
- Observe patient perform activity as independently as possible, while remaining safe
- Consider the amount of assistance needed for safety
- Device use doesn’t affect response choice
- If performance varies during assessment time period, report the “usual status”
- Majority of tasks does not apply. In situations where the patient’s prior ability varied between the listed GG activities, group all activities together and code based on patient’s ability considering all activities together.

Jan. 2019 Q&A #8

The “majority of tasks” convention that applies to the M1800 ADL/IADL items does not apply to the GG Prior Functioning, Self-care and Mobility items. In situations where the patient’s prior ability varied between the listed GG activities, group all activities together and code based on patient’s ability considering all activities together. For example, for GG0100, if a patient completed all the activities by him/herself, with/without an assistive device, with no assist from a helper, code as 3-independent. If a patient needed partial assistance from another person to complete any of the activities, code as 2-needed some help. If a helper completed all the activities for the patient because the patient could not assist, code as 1-dependent.

For the GG0130 and GG0170 activities that include multiple activities (e.g. upper body dressing for a patient who wears an undershirt, blouse and sweater), code using the 6-point scale based on the patient’s ability to complete all relevant tasks.
GG0100 response tips

- **Unknown** = If no information about the patient’s prior ability is available after attempt to interview patient/family and after reviewing the patient’s clinical record (patient can’t recall, no family to ask, no access to prior clinical record)
- **Dash “—”** = If didn’t attempt to find out patient’s prior abilities in these areas (not assessed)

When to Code Not Applicable

- The patient uses a walker for ambulation but uses a stair lift for the stairs.
- C Stairs would be coded Not Applicable (9)
- Rationale: Mr. S is not able to go up and down stairs; he uses a stair lift. So, he did not perform this activity prior to the current illness, exacerbation or injury.
  - Walking and scooting on bottom is counted, but not stair lifts.
  - A stair lift is not a portable device.

What is the timeframe?

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

- Interview patient or family or review the patient’s clinical record describing the patient’s use of prior devices and aids.
- GG0110C - Mechanical lift, any device a patient or caregiver requires for lifting or supporting the patient’s bodyweight. Examples include, but are not limited to:
  - Stair lift
  - Hoyer lift
  - Bath tub lift
- GG0110D - Walker, All types of walkers. Examples include, but are not limited to:
  - Pick-up walker
  - Hemi-walker
  - Rolling walker
  - Platform walker

Example

- Mr. C has bilateral lower extremity neuropathy secondary to his diabetes. Prior to this current episode, he used a cane. Today, he is using a walker.
- Answer Z None of the above. He did not use the walker prior to the current episode, and cane is not an option on the responses.

CMS Q&A Feb 2019 “Understanding OASIS Function M and GG Item Coding”

- The intention is not for the codes on the GG and M items to be duplicative or always “match”
- Each OASIS item should be considered individually and coded based on guidance specific to that item
- There are differences between items that have the same or similar names
  - What is included or excluded in the activity
  - What coding instructions apply to the activity, i.e. differing conventions related to assistive device use
**GG0130 and GG0170 Responses**

- **06** Independent: no assistance from another person
- **05** Set-up/Clean-up assistance: assistance from ONE other person before and/or after the activity but not during the actual performance of the activity
- **04** Supervision/touching assistance: verbal/non-verbal cueing or touching/steadying/contact guard assistance from ONE person
- **03** Partial/moderate assistance: physical assistance from ONE person who provides LESS than half the effort of the activity
- **02** Substantial/maximal assistance: physical assistance from ONE person who provides MORE than half the effort of the activity
- **01** Dependent: physical assistance from ONE person who provides ALL the effort to complete the activity, OR patient requires the assistance of TWO or MORE persons to complete the activity

**Jan. 2019 Q&A #29**

Q29: For “05. Setup or clean-up assistance,” can you please clarify if this “or” statement means that this answer should not be selected if the caregiver provides assistance before and after a task?

A29: Select Code 05, Setup or clean-up assistance when a helper provides only setup and/or clean-up assistance, prior to and/or following the activity, but not during the activity. If the only help a patient needs to complete an activity is for a helper to retrieve an assistive device or adaptive equipment, then code 05

**Reason Not Attempted Codes**

- **07** Patient refused
  - Pt refused to attempt activity, unable to get info from cg
- **09** Not applicable
  - Pt couldn’t perform activity at assessment AND couldn’t perform activity prior to current illness/injury
- **10** Not attempted due to environmental limitations
  - Ex: lack of equipment, indoor/outdoor weather
- **88** Not attempted due to medical condition or safety concerns
  - Pt couldn’t perform activity at assessment BUT could perform activity prior to current illness/injury
  - Dash “—” Item not assessed

**Danger of the Dash “—”**

- Dash allowed on all GG items at all time points
  - No info available, or can’t assess for reason other than 07, 09, 10, or 88
  - Should be the response of last resort!
  - Modified time periods
  - Expansion of One Clinician Rule allows more collaboration with others
  - Four responses for reason not assessed
  - A dash response does not provide “positive credit” for this quality measure Application of Percent of Long-term Care Hospital Patients with Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
88 vs 01

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

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

07 Patient Refused

- When completing GG0130 or GG0170 and a patient refuses to perform an activity, combine general observation, interview of patient/caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all GG items, as needed. Code 07, Patient refused, when assessment/discussion of the activity is attempted, the patient refuses, and no other Performance or Activity not attempted code is applicable. January 2019

GG0130 Self-Care SOC/ROC

<table>
<thead>
<tr>
<th>GG0130: Self-Care</th>
<th>SOC/ROC Performance</th>
<th>Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code the patient’s usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities may be completed with or without assistive devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. SOC/ROC</td>
<td>2. Discharge Goal</td>
</tr>
<tr>
<td>Eating:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral hygiene:</td>
<td>A. The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.</td>
<td></td>
</tr>
<tr>
<td>Toileting hygiene:</td>
<td>B. The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not the dressing.</td>
<td></td>
</tr>
<tr>
<td>Shower/bathe self:</td>
<td>C. The ability to bathe self, including washing hair, drying body by using towel.</td>
<td></td>
</tr>
<tr>
<td>Upper body dressing:</td>
<td>D. The ability to dress and undress above the waist, including fasteners, if applicable.</td>
<td></td>
</tr>
<tr>
<td>Activity D is “Wash Upper Body”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower body dressing:</td>
<td>E. The ability to dress and undress below the waist, including fasteners; does not include footwear.</td>
<td></td>
</tr>
<tr>
<td>Putting on/taking off footwear:</td>
<td>F. The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.</td>
<td></td>
</tr>
</tbody>
</table>

Notice there is no D

<table>
<thead>
<tr>
<th>1. SOC/ROC Performance</th>
<th>2. Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Eating:</td>
<td>The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.</td>
</tr>
<tr>
<td>B. Oral hygiene:</td>
<td>The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to invert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them.</td>
</tr>
<tr>
<td>C. Toileting hygiene:</td>
<td>The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not the dressing.</td>
</tr>
<tr>
<td>D. Shower/bathe self:</td>
<td>The ability to bathe self, including washing hair, drying body by using towel.</td>
</tr>
<tr>
<td>E. Upper body dressing:</td>
<td>The ability to dress and undress above the waist, including fasteners, if applicable.</td>
</tr>
<tr>
<td>F. Lower body dressing:</td>
<td>The ability to dress and undress below the waist, including fasteners; does not include footwear.</td>
</tr>
<tr>
<td>G. Putting on/taking off footwear:</td>
<td>The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.</td>
</tr>
</tbody>
</table>
**Contrast and Compare**

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

**GG0130A Eating**

- **88**—If the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN due to a new (recent-onset) medical condition.
- **09**—If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, injury or exacerbation.
- If the patient eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code eating based on the amount of assistance the patient requires to eat and drink by mouth.

**Difference between 09 and 88**

- ALS patient with J tube feedings many years
- Bowel rest for pancreatitis, NPO for one week with TPN. Support advancing back to regular diet

**GG0130A Eating**

Mr. Richards is unable to eat or drink by mouth since he had a stroke 1 week ago. He receives nutrition and hydration through a G-tube, which is administered by a helper. SLP is ordered for swallowing therapy, but has not yet performed their evaluation.

Did the activity of eating occur? No. New or old problem? New CVA
Quiz

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

Contrast and Compare

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

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

Quiz

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

Contrast and Compare

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

Enter Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to manage toileting hygiene and clothing management without assistance.</td>
</tr>
<tr>
<td>1</td>
<td>Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Someone must help the patient to maintain toileting hygiene and/or adjust clothing.</td>
</tr>
<tr>
<td>3</td>
<td>Patient depends entirely upon another person to maintain toileting hygiene.</td>
</tr>
</tbody>
</table>
Jan. 2019 Q&A #10

Q10: Does GG0130C Toileting Hygiene, that includes clothing adjustment before and after voiding, also include pads and incontinence briefs? Does this item include the safe retrieval of the supplies needed to perform the hygiene task?

A10: Toileting hygiene includes managing undergarments, clothing and incontinence products, and performing perineal hygiene. If the patient can complete toileting hygiene and clothing management tasks only after a helper retrieves or sets up supplies necessary to perform included tasks, code 05 – setup or clean-up.

In situations where a definitive answer to an assessing clinician’s question is not contained in published CMS OASIS guidance, the clinician may have to rely on clinical judgement to determine how to code the item, ensuring that the response coded does not conflict with current guidance.

Jan. 2019 Q&A #11

Q11: Does GG0130E Shower/Bathe Self only apply to the patient that can use a shower or tub? If this includes sponge bathing does it include the ability to safely retrieve the needed supplies?

A11: The activity being assessed is “the ability to bathe self, including washing, rinsing and drying self...” Code the item based on the patient’s ability to bathe him/herself, regardless of where the bathing takes place. If the patient can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks, code 05 – setup or clean-up assistance.

Quiz

- Mrs. Nance can, while sitting on the shower chair, wash her chest, arms, perineal area and upper legs. Her daughter assists her with her back, lower legs and feet. Mrs. Nance then can rinse and dry herself off. Her daughter helps her in and out.
Practice

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

- What if the caregiver returns to replace the water for rinsing?

- Bonus: What would her score be in M1830 Bathing?

Practice Answers

- Code the item based on the patient’s ability to bathe herself, regardless of where the bathing takes place. Your patient bathes at the sink and only requires assistance for setting up and filling the plastic tub she uses for bathing. If no other assistance is required while the patient washes, rinses and dries off her body, select Code 05 Set-up/Clean-up.

- If the patient requires any assistance at any time during the bathing activities of washing, rinsing, drying (for instance needs someone to refresh the tub of water for rinsing), Code 03 Partial/moderate assistance, one person provides less than half the effort of the activity

- Bonus: What would her score be in M1830 Bathing?

Contrast and Compare

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

- Contrast and Compare

Jan. 2019 Q&A #12

GG0130F Upper Body Dressing includes the ability to dress and undress above the waist, including fasteners, if applicable.

If the patient can complete upper body dressing tasks only after a helper retrieves or sets up clothing or devices necessary to perform the included tasks, code 05 – setup or clean-up assistance.

If donning and doffing an elastic bandage, or an orthosis or prosthesis occurs while the patient is dressing/undressing the upper body, then count the elastic bandage/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the patient needs when coding the upper body dressing item.
Jan. 2019 Q&A #12 (con’t)

Assess ability to put on whatever clothing is routinely worn. If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing. The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient’s new routine clothing.

Jan. 2019 Q&A #13

- GG0170G Lower Body Dressing includes: “The ability to dress and undress below the waist, including fasteners; does not include footwear.”
- If donning and doffing an elastic bandage, a stump/shrinker or an orthosis or prosthesis occurs while the patient is dressing/undressing the lower body, then count the elastic bandage/shrinker/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the patient needs when coding the lower body dressing item.
- If the patient can complete lower body dressing tasks only after a helper retrieves or sets up clothing/devices necessary to perform the included tasks, code 05 – Setup or clean-up assistance.

Jan. 2019 Q&A #13 (con’t)

- Note that while some types of clothing, wraps or supportive devices may cover both the lower leg/lower body and the foot, the patient’s ability to put them on/take them off should not be considered for both GG0130G Lower Body Dressing and GG0130H Footwear. In order to assist in determining which activity the piece of clothing-wrap/orthotic/prosthetic should apply to, consider items that cover all or part of the foot (even if it extends up the leg, like a sock or ankle foot orthosis) as footwear. Consider items that go on the lower body (excluding items that cover all or part of the foot) as lower body dressing items.
Jan. 2019 Q&A #14

• GG0130H includes: “The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.”
• If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the patient is putting on/taking off footwear, then consider the elastic bandage/elastic stocking/orthotic/prosthesis when determining the amount of assistance the patient needs to put on/take off footwear.
• Example of footwear may include: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).

Jan. 2019 Q&A #14 (con’t)

• If the patient can complete the tasks of putting on/taking off footwear, and only needs a helper to retrieve or set up footwear/devices necessary to perform the included tasks, code 05 – Setup or clean-up assistance.
• Note that while some types of clothing, wraps or supportive devices may cover both the lower leg/lower body and the foot, the patient’s ability to put them on/take them off should not be considered for both GG0130G Lower Body Dressing and GG0130H Footwear. In order to assist in determining which activity the piece of clothing-wrap/orthotic/prosthetic should apply to, consider items that cover all or part of the foot (even if it extends up the leg, like a sock or ankle foot orthosis) as footwear. Consider items that go on the lower body (excluding items that cover all or part of the foot) as lower body dressing items.

Response Specific Instructions

SOC/ROC

Code the patient’s functional status based on a functional assessment that occurs at or soon after the patient’s SOC/ROC.

The SOC/ROC function scores are to reflect the patient’s SOC/ROC baseline status and are to be based on observation of activities, to the extent possible.

When possible, the assessment should occur prior to the start of therapy services to capture the patient’s true baseline status. This is because therapy interventions can affect the patient’s functional status.

Discharge Goal

• For the Home Health (HH) Quality Reporting Program (QRP) a minimum of one self-care or mobility goal must be coded. However, agencies may choose to complete more than one self-care or mobility discharge goal.
• Code the patient’s discharge goal(s) using the 6-point scale. Use of the activity not attempted codes (07, 09, 10 or 88) is permissible to code discharge goal(s) but this should be rare. If the patient is expected to be able to perform the activity by discharge, make an estimate of ability after treatment. Use of a dash is permissible for any remaining self-care or mobility goals that were not assessed.
Goals should be established as part of the patient’s care plan. Licensed clinicians can establish a patient’s discharge goal(s) at the time of SOC/ROC based on
- Patient’s prior medical condition/level of function
- SOC/ROC assessment of self-care, mobility status
- Discussions with the patient and family
- Professional judgment, the profession’s practice standards
- Expected treatments, patient motivation to improve
- Anticipated length of stay, and the discharge plan

GG0130 and GG0170 DC Goal
- Expected to make functional progress by discharge, the response reported for Discharge Goal will be higher (more independent) than the SOC/ROC Performance response.
- Not expected to make progress during the home health episode, but it is expected that the patient would be able to maintain his/her SOC functional level, the Discharge Goal response will be the same as the patient’s SOC Performance response.
- If a patient with a progressive neurological condition is expected to rapidly decline, and that skilled therapy services may slow the decline of function, the Discharge Goal would be lower (more dependent) than the SOC/ROC Performance response.
- If the assessing clinician does not establish a Discharge Goal for the patient’s mobility task, may enter a dash (“–”) for Column 2-Discharge Goal.

GG0130 Self-Care at Discharge

GG0130 Self-Care at Follow-Up
Response Specific Instructions at Discharge

- Discharge Performance: The discharge time period under consideration includes the last 5 days of care. This includes the date of the discharge visit plus the four preceding calendar days.
- Code the patient’s functional status based on a functional assessment that occurs at or close to the time of discharge.
- Any of the reason not attempted codes may be used at DC, including the dash.

GG0170 Mobility

GG0170 Mobility SOC/ROC

Code the patient’s usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal(s) using the 6-point scale. Use of codes 09, 10, or 88 is permissible to code discharge goal(s).

Categorize
Safety and Quality of Performance - If help is needed because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. Independent - Patient completes the activity from/farthest with no assistance from a helper.
05. Setup or clean-up assistance - Helper sets up or cleans up patient’s area prior to activity. Helper assists only prior to or following the activity.
04. Supervision or non-touching assistance - Helper provides verbal cues and/or indirect standing and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides more than half the effort.
01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. Patient refused
09. Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
11. Not attempted due to medical conditions or safety concerns

Skip
Skip Patterns

- Even in situations where activity performance is coded with an “activity not performed” code or skipped, a discharge goal may still be reported. Use of a dash is permissible for any remaining self-care or mobility goals where a discharge goal was not established.
- For example, the patient may be scored an 88 at SOC/ROC but the DC goal can be scored as well.
- Dashing (IMHO)
GG0170A Roll Left to Right (Instructions and at least one example for each line)

- The activity includes the patient rolling to both the left and to the right while in a lying position,
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.
- For example, if a clinician determines that a patient’s new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns.
- For example, if a clinician determines that a patient’s preferred slightly elevated resting position is “lying” for that patient.

Example

- At SOC, the physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side. He then instructs him how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. R completes the activity without physical assistance from a helper. Mr. R was moving about in bed without difficulty prior to hospitalization. The therapist expects Mr. R will roll left and right by himself by discharge.

  - Coding: GG0170A, Roll left and right, SOC Performance would be coded 04, Supervision or touching assistance. Discharge Goal would be coded 06, Independent.
  - Rationale: At SOC, the physical therapist provides verbal cues (i.e., instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back. The physical therapist does not provide any physical assistance. After assessment and considering his current condition, the therapist expects Mr. R will be independently rolling left and right at discharge.

GG0170B Sit to Lying

- The activity includes the ability to move from sitting on side of bed to lying flat on the bed
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness/injury, code 88, Not attempted due to medical condition or safety concerns.
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, and could not perform the activity prior to the current illness, exacerbation or injury, code 09, Not applicable.
- For GG0170B, Sit to lying, clinical judgment should be used to determine what is considered a “lying” position for the patient. For example, a clinician could determine that a patient’s preferred slightly elevated resting position is “lying” for that patient.
GG0170C Lying to Sitting on Bed

- The activity includes patient transitions from lying on the back to sitting on the side of the bed with feet flat on the floor, and sitting upright with no back support (person or object providing support).
- If a patient’s feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment (if applicable), or a foot stool is required to accommodate foot placement on the floor/footstool.
- Clinician judgement should be used to determine what is considered a “lying” position for the patient.

Jan. 2019 Q&A #15

Q15: For GG0170C Lying to sitting on side of bed, how would a patient with below-knee amputation (BKA) be coded to perform lying to sitting position with feet on the floor?

A15: If any patient can perform the activity independently and safely, sitting on the side of the bed with no back support, and their feet do not touch the floor, they can be scored as a 06, Independent. For a BKA patient, the score would be based on the amount of assistance required to complete the activity. If the patient was able to safely complete the activity independently, moving from lying to sitting on the side of the bed with one foot touching the floor or not, with no back support, the patient would be scored as a 06, Independent. Please be aware that a BKA patient can wear lower extremity prosthetic(s) with attached “foot” to complete this activity.

GG0170C Lying to Sitting on Bed

- If the patient sleeps in an electric recliner (which we are assessing as the patient’s bed), and the patient pushes a button for the chair to return to a sitting position, is this considered assistance?
- If patients are able to use an assistive device themselves, the response code entered on the OASIS would be coded as a 06, Independent.

Jan. 2019 Q&A #17

Quiz

- The patient uses a belt around his feet in order to swing his feet/legs off the bed and go from lying to sitting on the side of the bed. Someone had to hand the belt to the patient. What is the score?

[OASIS codes:]

O6. Independent – Patient completes the activity by himself/herself with no assistance from a helper.
O5. Setup or clean-up assistance – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
O4. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
O3. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
Jan. 2019 Q&A #16

Q16: For GG0170 Lying to sitting on side of bed, if a patient uses a belt to pull himself from lying to sitting on the side of the bed, but someone had to hand the belt to the patient, would that still be considered independent?

A16: For GG0170C, the use of an assistive device does not affect the scoring of the measure if the patient is able to perform the activity independently. If the patient requires a caregiver to hand him the assistive device to perform the activity, this would be scored as **Code 05, Setup or clean-up assistance**, because the patient requires setup assistance prior to performing the activity.

GG0170D Sit to Stand

- The activity includes the patient coming to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- If the only help a patient needs to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis, then enter code 05, Setup or clean-up assistance.

GG0170E Chair/Bed to Chair

- The activity begins with the patient sitting (in a chair, wheelchair, or at the edge of the bed) and transferring to sitting in a chair, wheelchair, or at the edge of the bed (to a different sitting surface).
- Sit to lying and lying to sitting are not assessed as part of GG0170E.
- While the need for assistance with ambulation may impact the M1850 Transferring item (which is specifically a transfer to and from the bed), the need for assistance with ambulation would not impact the code selected for GG0170E which simply reflects a transfer between any two sitting surfaces. Jan. 2019 Q&A #18
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and two helpers are needed to assist with a mechanical lift transfer, then code 01, Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer.

GG0170D and GG0170E

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

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<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D. Sit to stand:</strong> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</td>
<td></td>
</tr>
<tr>
<td><strong>E. Chair/bed-to-chair transfer:</strong> The ability to transfer to and from a bed to a chair (or wheelchair).</td>
<td></td>
</tr>
</tbody>
</table>
GG0170F Toilet Transfer

• Does not include getting to/from the toilet or BSC
• Can assess with a BSC if patient has equipment
• Toileting hygiene and clothing management are not considered part of the toilet transfer activity

GG0170G Car Transfer

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

GG0170F Toilet Transfer

• At SOC, Mrs. Murry is on bedrest due to a new medical complication. She uses a bedpan for bladder and bowel elimination. The assessing clinician expects she will return to independent use of the bathroom toilet once the current medical condition resolves.
Car Transfer Practice
• Ms Melvin walks to the car with her walker. Her son opens the car door for her. She places her hands on the car door and the handle inside the car and sits in the car. The son folds her walker and places it in the car. When getting out of the car, Ms Melvin rises to a standing position by using the car door and the door sill. Her son sets up the walker so that she can ambulate.

Jan. 2019 Q&A #27
Q27: At the time of the assessment the patient requires a walker to ambulate to the car. Once there, her daughter opens the car door for her. The patient is able to position herself and place her hands correctly to safely lower herself into the car. Her daughter then shuts her door, folds her walker and places it in the backseat. When they arrive at their destination her daughter retrieves her walker from the back, opens the car door and sets up her walker within reach. The patient is able to safely exit the car and come to a standing position at her walker. Would closing/opening/placing the walker be considered 05, Set up and clean up for GG0170G since all the walker "maintenance" occurs prior to and after the activity, or should it be totally disregarded for this item?

A27: You describe a caregiver who folds the walker and places it in back seat after the patient transfers into the car, then retrieves the walker and sets it up for the patient prior to the patient transferring out of the car. If the patient requires the set up (or clean-up) of this walker in order to complete the car transfer, and no assistance is needed during the completion of the activity, select Code 05 Set-up/Clean-up. If the patient does not require the walker when completing the transfer, then Code 06 - Independent.
• The activity is restricted to the transfer and does not include getting to or from the vehicle.

GG0170I through GG0170L
• Use of assistive device(s) and adaptive equipment (cane or leg brace) does not affect coding of activity
• 90 degree turns may be same or different directions
• If environment does not allow a walk of 150 ft without turns, may demonstrate ability to walk 150 ft with turns
• If not able to attempt walking on uneven surface due to not available or weather limits access, and not able to gather info from patient/family, code 10 not attempted due to environmental limitations

Jan. 2019 Q&A # 20, 21
Q20: For GG0170J Walk 50 feet with 2 turns, do the turns need to be consecutive?
A20: For the activity of ambulating 50 feet with two turns, the turns can occur at any time during the 50-foot walk.

Q21: If an HHA is able to ‘walk a patient 150 feet with two 90-degree turns’ (GG0170K), can they use the observed assessment information to also give a response to the 50-foot walk question (GG0170J) and the 10-foot walk question (GG0170I), or must all three walks be performed individually?
A21: The activities are coded on OASIS separately. The assessing clinician can use clinical judgement to determine how the actual patient assessment is conducted.
When combining OASIS activities in the patient assessment, consider where one activity ends and another begins, then code based on the amount of assistance needed for each distance.
From March QRP Training

• For GG0170K, walking 150 feet, the patient is not allowed to sit down and rest during the 150 ft walk. May pause to catch a breath, but not sit down.
• May determine response based on patient or caregiver/family report of patient’s ambulation into the home when coming back from the hospital the day before (within the assessment time frame).

Quiz

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

GG0170M through GG0170O

• GG0170M = gateway item, see skip pattern
• Skip pattern is for performance only – could have a DC goal even if not able to do today
• Use of device(s) or adaptive equipment (railing or cane) does not affect coding of activity
  • If stair lift is used, do not consider as a device.
• If level of assistance different for going up or down steps, code based on usual status (i.e. it’s 50/50, so code more dependent portion of activity)

Jan. 2019 Q&A #23

Q23: According to Chapter 3 coding guidance in some instances (GG0170I Walk 10 feet, GG0170M 1 step, GGG0170N 4 steps) we are instructed to Skip to another item if an "activity not attempted code" is used in the SOC/ROC performance column. To clarify, when we do that should we also leave the discharge goal blank or "dash" it? If we feel that we could establish an accurate discharge goal anyway, should we truly skip setting a discharge goal?

A23: Even in situations where activity performance is coded with an “activity not performed” code or skipped, a discharge goal may still be reported. Use of a dash is permissible for any remaining self-care or mobility goals where a discharge goal was not established.
Jan. 2019 Q&A #24

Q24: For GG0170N 4 steps and GG0170O 12 steps is “The ability to go up and down steps...” limited to referring to a patient that walks up and down the steps on their feet, or do we also consider those that may take a stair lift, or even those that may ascend/descend stairs on their buttocks?

If a patient independently uses their stair lift – are they to be scored as 06 Independent, or 09 Not applicable?

A24: For GG0170: Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without portable assistive devices and/or with or without some level of assistance.

06 – Independent would be coded if the stair activity of a patient going up and down steps (1, 4, or 12) is completed by any safe means (e.g., walking on their feet, scooting on their bottom), with or without a portable assistive device, and with no set-up assistance or assistance during the stair activity.

• The use of non-portable assistive devices (such as a stair lift with a track attached to the wall) would not be considered “completing the stair activity.” A patient that is not able to go up and down the stairs, with or without assistance, without the use of a non-portable stair lift would be coded with the appropriate “activity was not attempted” code.

Jan. 2019 Q&A #25, 26

Q25: If my non-ambulatory patient can get up and down a curb in his wheelchair by himself, how would I code GG0170M 1 step?

A25: A wheelchair-bound patient may be able to complete the activity of going up and down stairs (including 1 step/curb) in a wheelchair. He would be coded using the 6-point scale if the activity is completed, or coded with one of the “activity not completed” codes if the activity does not get completed, or coded with a dash if no information is available. A patient getting up and down a curb in a wheelchair with no assistance would be coded 06 – Independent.

Q26: My patient has one step into his home that I can observe. His living environment is without other steps. For 4 steps and 12 steps would I code the dash or 10–environmental limitation?

A26: In the situation provided, a performance code may be determined for GG0170M 1 Step (Curb), but Code 10, Not attempted due to Environmental Limitations, may need to be reported for GG0170N – 4 Steps, or GG0170O – 12 Steps unless the patient’s usual status can be determined based on patient or caregiver report or by clinical judgment and assessment of the patient status in a similar activity.

Jan. 2019 Q&A #28

Q28: How do we assess GG0170 activities such as a car transfer or 12 steps if the patient does not have a car or a flight of stairs?

A28: If the car transfer activity (GG0170G) or the stair activities (GG0170M, N and O) are not completed because no car or stairs are available, and the patient’s status cannot be determined based on patient or caregiver report, enter Code 10, Not attempted due to environmental limitations.

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

GG0170P Picking up Object

• Tests balance and leg strength
• If at time of assessment patient is unable to complete the activity (ex: unable to stand), and could not stand to perform this activity prior to current illness, code 09 not applicable
GG0170P Picking up Object

• Mrs. Cosgrove was admitted after a hip replacement. She ambulates with a walker. She drops the hairbrush out of her walker basket and asks her son to fetch her reacher. Mrs. C stoops slightly while holding onto the walker and uses her reacher to pick up the hairbrush safely.

GG0170Q through GG0170S

- GG0170Q = gateway item, see skip pattern

GG0170Q Use of Wheelchair/Scooter

• Intent of the wheelchair mobility item is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or patients who used a wheelchair prior to admission.
• Use clinical judgment to determine if the patient’s use of a wheelchair is for self-mobilization due to the patient’s medical condition or safety.
• If the patient is ambulatory and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport within a larger living facility (assisted living facility or apartment complex), or for community mobility outside the home (for instance to a physician appointment or to dialysis), enter code 0 – No for GG0170Q Does the patient use a wheelchair/scooter, and skip all remaining wheelchair questions.

GG0170R and GG0170S

• Turns are 90 degrees, may be in the same direction or different directions
• Should be at the patient’s ability level (not jeopardizing patient’s safety)
• May use different types of wheelchair for longer distances
GG0170Q and GG0170R

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

GG0170Q, GG0170R, GG0170S

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

**Functional Quality Measure**

- “Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function”

- Reports the percent of episodes with a SOC/ROC and a DC functional assessment and a treatment goal that addresses function; the treatment goal proves that a care plan with a goal has been established for the patient, and documentation of a goal for one functional item reflects the care plan addresses function.

- Not risk-adjusted

**Numerator**

- number of quality episodes with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal at SOC/ROC, and valid numeric score or reason not attempted score for each of the functional assessment items on the DC assessment.

**Denominator**

- All quality episodes (no measure – specific exclusions, all OASIS patients)

NOTE: for HH episodes ending in a qualifying admission to an inpatient facility (Transfer) or Death at Home, the discharge functional status data would not be required for the episode to be included in the numerator (just need a valid numeric score or reason not attempted code for SOC/ROC and a valid numeric score for at least one self-care or mobility goal on the SOC/ROC assessment).
**Jan. 2019 Q&A #30**

Q30: The response-specific instructions in the OASIS Guidance Manual for GG0130 and GG0170 state that the QRP only requires coding a minimum of one self-care or mobility discharge goal. If an agency decides to establish a discharge goal for just one functional activity, how would the other remaining activities be coded?

A30: Effective January 1, 2019, select activities from GG0130 and GG0170 are used to calculate the quality measure Application of Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631).

The activities utilized in the measure are:

- GG0170. Mobility Items (GG0170B. Sit to lying, GG0170C. Lying to sitting on side of bed, GG0170D. Sit to stand, GG0170E. Chair/bed-to-chair transfer, GG0170F. Toilet transfer, GG0170J. Walk 50 feet with two turns, GG0170K. Walk 150 feet, GG0170R. Wheel 50 feet with two turns, GG0170S. Wheel 150 feet).

Per the measure specifications, the numerator is met when, for a home health quality episode, valid codes are reported for the SOC/ROC performance AND for the Discharge performance for all of the listed functional activities AND, at SOC/ROC, a valid numeric score is coded for a discharge goal for at least one of the listed self-care or mobility activities.

As outlined in the Guidance Manual, agencies may choose to complete more than one self-care or mobility discharge goal, including reporting a discharge goal for all collected GG0130 and GG0170 items. A dash is a valid response for any activity where a discharge goal is not established, including for an activity that is skipped due to the skip pattern.

Pressure Ulcer Defined

- A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure. NPUAP
- Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. (CMS)
- NOT pressure ulcers: Serum filled blisters that are caused by shoes rubbing against the foot
  - If the cause of a wound is solely a friction force which leads to visible skin impairment, such as the serum filled blister cited in the scenario, it would NOT be categorized as a pressure ulcer. The 2009 International NPUAP-EPUAP Pressure Ulcer Prevention and Treatment Clinical Practice Guideline eliminated reference to friction as a factor in pressure ulcer development. (January 2016)
  - Does not include mucosal pressure ulcers 4bQ98.2.2.

Stage 1 Pressure INJURY

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage 2 Pressure Ulcer/Injury

- Partial-thickness skin loss with exposed dermis
  The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister not solely from friction
- Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.
- These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.
- This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (Marsi), or traumatic wounds (skin tears, burns, abrasions).
Stage 2 or DTI?

- Examine the area surrounding an intact blister (stage 2 pressure ulcer) for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister demonstrates signs of tissue damage (e.g. color change, tenderness, bogginess/firmness, warmth or coolness), these characteristics suggest a deep tissue injury (DTI) instead of a stage 2 pressure ulcer.

<table>
<thead>
<tr>
<th>Stage 2</th>
<th>DTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pink red wound bed</td>
<td>Dark wound bed</td>
</tr>
<tr>
<td>Serum filled blister</td>
<td>Blood filled blister</td>
</tr>
</tbody>
</table>

Stage 3 Pressure Ulcer/Injury

- Full-thickness skin loss, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.
- Slough and/or eschar may be visible
- The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur.
- Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed
- If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury

- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer
- Slough and/or eschar may be visible
- Epibole (rolled edges), undermining and/or tunneling often occur
- Depth varies by anatomical location
- If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury

Stage 4 Staging Tips

- Stage based on previous documentation; do not reverse stage
- Exposed bone, tendon or muscle + Slough or eschar = Still a stage 4
- Unstageable (even if previously staged)
Unstageable

- Known or likely but not stageable due to non-removable dressing or device
  - Includes those that are sutured
- Known or likely but not stageable due to coverage of wound bed by slough and/or eschar (no stage 4 structures can be visualized)
  - A scab is not the same as eschar (removed from Q&A)
- Suspected deep tissue injury in evolution.

Unstageable: Non-removable dressing

Non-removable dressing/device includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Every effort should be made to assess the wound if possible, unless there is clear direction that the dressing/device should not be removed.

Unstageable: Eschar Slough

Slough: Non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

Eschar: Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Deep Tissue Injury

- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.
- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.
- Intact skin or blood-filled blister

Intact skin or blood-filled blister

The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.

Thin blister over dark wound bed
Basics Regarding Pressure Ulcers

National Pressure Ulcer Advisory Panel (NPUAP), has determined that:

• Stage 1 and stage 2 (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface, known as epithelialization.

• Stage 3 and 4 (full thickness) pressure ulcers heal through a process of contraction, granulation, and epithelialization. They can never be considered "fully healed" but they can be considered “closed” when they are fully granulated and the wound surface is covered with new epithelial tissue.

Updated Guidance - NPUAP

• NPUAP updated terminology for staging (Pressure ulcer now pressure injury)

• Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP.

• When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.

Closed Stage 3 and 4 Ulcer/Injury

• Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins).

• Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.

Closed Stage 3 and 4 Ulcer/Injury

• Agencies should be aware that the patient is at higher risk of having the site of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue.

• Tensile strength of the skin overlying a closed full thickness pressure ulcer is only 80% of normal skin tensile strength.

• Agencies should pay careful attention that preventative measures are put into place that will mitigate the re-opening of a closed ulcer.
**M1306: Revised Item**

<table>
<thead>
<tr>
<th>(M1306)</th>
<th>Does this patient have at least one Unhealed Pressure Ulcer Injury at Stage 2 or Higher or designated as Unstageable? (Excludes Stage 1 pressure ulcers and all healed pressure ulcers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>0 No [Go to M1322 at SOC/ROC/FU, Go to M1324 at DC]</td>
</tr>
<tr>
<td>1 Yes</td>
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</tr>
</tbody>
</table>

No—Stage 1 and all ‘healed’ ulcers
Yes—Stage 2 or higher and unstageables

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**M1306 Synopsis**

**NO**

- Stage 1 pressure ulcers.
- Healed Stage 2 pressure ulcers (once epithelialized no longer considered a pressure ulcer)
- Healed Stage 3 pressure ulcers (healed for the purposes of scoring OASIS—continue to be at risk)
- Healed Stage 4 pressure ulcers (healed for the purposes of scoring OASIS—continue to be at risk)

**YES**

- Stage 2 pressure ulcers
- Stage 3 Unhealed
- Stage 4 Unhealed
- Unstageable
  - presence of non-removable dressing/device
  - presence of necrotic tissue that obscures visualization of stage 4 structures (bone, muscle, tendon or joint capsule)
  - presence of eschar/slough
  - Suspected deep tissue injury in evolution

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**M1306**

- Mr. Ross has been on service before and it took several months to heal up his stage 4 ulcer. Mr. Ross is being admitted back to your agency. The assessing clinician notes the shiny pink divot on the right hip.
- Only ulcer is a closed stage 4—then answer to M1306 is NO. (Note skip pattern.)
  - OASIS response—no pressure ulcer
  - Clinical documentation—epithelialized stage 4 ulcer located at right hip
  - Code according to stage? Up to you...

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**M1311 Current Number of Unhealed Pressure Ulcers**

- SOC/ROC

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**M1311: Current Number of Unhealed Pressure Ulcers**

**IMPACT Act Item**

<table>
<thead>
<tr>
<th>(M1311)</th>
<th>Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Number</td>
<td></td>
</tr>
</tbody>
</table>

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

Follow-up

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

The First Skin Assessment

- Report pressure ulcer/injury stage (or unstageable) based on the *first skin assessment*
- Do NOT change OASIS coding if the ulcer/injury increases in numerical stage (i.e. worsens) or becomes stageable or unstageable within the assessment time period
  - If a pressure ulcer identified on the SOC date increases in numerical stage within the 5 day assessment time period, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311x1 on the SOC OASIS.
- Skin assessment should be completed as close to the actual time of the SOC/ROC as possible

Determining Present on Admission

- For the OASIS, “Present on Admission” and “Present at SOC/ROC” have equivalent meanings
  - Stage identified at first skin assessment
  - At discharge
    - If unstageable at SOC/ROC = first time numerically stageable
  - Discharge: For each pressure ulcer, determine whether that pressure ulcer was present at that same site and at the same stage at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
OASIS-D New Guidance

- Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is unstageable due to slough and/or eschar at DC, should be considered new and not coded as present at the most recent SOC/ROC for M1311x2
- If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing/device, that pressure ulcer/injury should be considered new, and not be coded as present at the most recent SOC/ROC for M1311x2

Cannot Change Assessment on M1311

- Example: Pressure ulcer is assessed as covered with eschar and slough at SOC. Ulcer is debrided on Day 3 of episode and ulcer is staged at 4.
- M1311 CANNOT be updated to stage 4 on the SOC assessment.

Non-Removable Dressing at SOC

- If the pressure ulcer is identified as a Stage 3 in the SNF documentation but is under a dressing that cannot be removed at the SOC, for M1311 do I identify a Stage 3 or unstageable pressure ulcer due to non-removable dressing?
- The only way you can report a pressure ulcer as unstageable due to non-removable dressing/device is by having documentation that there is indeed an ulcer underneath the dressing/device. In this case, since there is documentation of a Stage 3 pressure ulcer under the non-removable dressing/device, you would report the ulcer as unstageable due to non-removable dressing/device. Once the dressing is removed, the ulcer would need to be assessed and staged. The SOC M1311 response of unstageable due to non-removable dressing/device should not be changed to Stage 3, since that was the pressure ulcer’s status when first assessed upon admission.

Rationale

- If the initial skin assessment completed on admission to home health services identifies a pressure ulcer, the stage of the pressure ulcer as identified on that initial clinical assessment is what should be reported on the SOC OASIS. Any subsequent changes in numerical staging would be reported on subsequent OASIS assessments. Therefore, if an unstageable pressure ulcer is identified as part of the initial skin assessment at SOC, this ulcer should be reported as unstageable on the SOC OASIS, regardless of whether it is subsequently debrided and stageable after the initial skin assessment (i.e., by Day 2).
**Cannot Change Assessment on M1311**

- Example: Pressure ulcer assessed as covered with a non-removable dressing at SOC. Patient returns to clinic on day 3 and nurse documents on day 4 that it is a stage 3.
- M1311 CANNOT be updated to stage 3.

**Only applies to pressure ulcers...**

If a patient has a non-removable dressing on when the assessing clinician admits, could a different clinician report the wound status to the assessing clinician if the dressing is removed within the assessment time frame?

The answer to this question is dependent on the type of wound involved

**Pressure Ulcers:** To support consistency of data collection related to pressure ulcers across all post-acute care (PAC) providers, cross-setting guidance states that for pressure ulcers, the first clinical skin assessment is the assessment used to complete the SOC OASIS pressure ulcer items.

**Applies only to pressure ulcers**

A pressure ulcer that is known to be present but that is covered with a non-removable dressing at the admission visit would be reported as Unstageable due to a non-removable dressing/device, even if the ulcer becomes observable by the 2nd visit. The guidance to assess and report the pressure ulcer stage and status as close to SOC/ROC as possible applies to all OASIS pressure ulcer items.

**Surgical Wounds:** OASIS guidance allows the agency to use any skin assessment conducted during the assessment time frame to code the OASIS surgical wound items. Guidance does not limit coding to only data from the first clinical skin assessment. For example, when a patient has a surgical wound under a non-removable dressing at the admission visit, and the dressing is changed the next day by a different nurse, the assessing clinician may report the surgical wound as non-observable based on the his/her admission visit, or may collaborate with the second nurse for information to code the surgical wound items based on observation after the dressing was removed.

**When did the skin assessment occur?**

We are seeking clarification regarding the reporting of pressure ulcers on the OASIS that are not identified on the initial visit. If a clinician conducts an initial assessment to meet the immediate needs of the patient and does not document the presence of a pressure ulcer and a pressure ulcer is found 2 days later when the comprehensive assessment is performed, is the pressure ulcer reported on the OASIS?
When did the skin assessment occur?

The OASIS pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the SOC or ROC date as possible. **If the first time a skin assessment could be done is on the second home health visit, and a pressure ulcer is identified during that assessment, then it should be reported on OASIS, as that would represent the initial skin assessment.**

If a skin assessment was conducted on the SOC visit and no pressure ulcer was identified, then a subsequent skin assessment was conducted on the second visit and a pressure ulcer was identified, the pressure ulcer would not be reported on the OASIS at that time point, since the pressure ulcer status should be based on the first skin assessment conducted at the SOC/ROC time points.

Answering M1311

- At SOC/ROC and FU, enter a response for the following rows of this item: A1, B1, C1, D1, E1, F1 for the number of pressure ulcers identified the day of assessment.
- Example: At SOC, in B1, enter the number of Stage 3 pressure ulcers that are observed at the first skin assessment completed during the SOC assessment timeframe. Enter 0 if no Stage 3 pressure ulcers are observed.
- At Discharge, enter a response for each row of this item: A1, A2, B1, B2, C1, C2, D1, D2, E1, E2, F1, F2, unless directed to skip.

Answering M1311 at Discharge

- If ulcer/injury was present and stageable (1,2,3,4) at most recent SOC/ROC, compare stage assessed at discharge to the stage of the SAME ulcer at SOC/ROC.
  - Report in Row 2 only the pressure ulcer/injuries from Row 1 that were present at the most recent SOC/ROC AND at the same stage.
- If ulcer/injury was present and unstageable at SOC/ROC, find the first documentation ulcer/injury became stageable: this is the “Present at the most recent SOC/ROC” stage for comparison to stage at discharge.
- Any numerically stageable pressure ulcer/injury at SOC/ROC that is unstageable due to slough/eschar at discharge is considered new and not considered present at the most recent SOC/ROC.

NEW in OASIS-D

Mr M

- Mr M was assessed to have a Stage 3 ulcer at SOC. He is being discharged today as he is being placed in a facility that specializes in pressure ulcers. The assessing clinician documents a ‘Stage 3, now unstageable due to eschar and slough.’
- How should M1311 be answered at DC?
  a. B1 = 1; B2 = 2; All others 0 or skipped
  b. E1 = 1; E2 = 0; All others 0 or skipped
  c. E1 = 1; E2 = 1; All others 0 or skipped
  d. E1 = 1; B1 = 0; B2 = 0; All others 0 or skipped
Stage 2 Example

- Example: At Discharge, report in M1311A1 the number of Stage 2 pressure ulcers that are observed on the current day of assessment.
- If no Stage 2 pressure ulcers are observed, enter 0 in A1 and skip A2.
- If at least one Stage 2 pressure ulcer is observed, and reported in A1, enter in A2 the number of these Stage 2 pressure ulcers that were observed at the same stage at the most recent SOC/ROC.

Stage 3 and 4

- If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
- A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer. A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer. Do NOT reverse stage.
- If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the highest numerical stage of the wound. The clinician should make every effort to contact previous providers (including patient’s physician) to determine the highest numerical stage of the pressure ulcer.

Flaps, Grafts, Debridement

- A pressure ulcer treated with any kind of flap or graft is considered a surgical wound until 30 days after complete re-epithelialization.
- A pressure ulcer that has been debrided is still a pressure ulcer.
- Previously closed (healed) stage 3 or 4 pressure ulcer that re-opens is reported at its worse stage.

The pressure ulcer at ROC was covered by a nonremovable dressing. The first documentation noted of stage during the episode is stage 2. At discharge the pressure ulcer is stage 3.
At SOC, patient has three small stage 2 pressure ulcers on sacrum.

At DC, sacral area is assessed: two of the stage 2 pressure ulcers have merged, and the third ulcer has increased to a stage 3.

Ms. P

Ms. P continued

• At the SOC, Ms. P was admitted with a diagnosis of cerebrovascular accident with right hemiparesis and assessed to have a 1 cm x 1 cm x < 0.1 cm Stage 2 pressure ulcer on her coccyx.

• Ms. P continued to decline at home, with decreased appetite, frequent transient ischemic attacks, and a wish not to be hospitalized again. After a palliative care consult, the patient and family agreed to hospice care.

• Upon discharge from home care, Ms. P was noted to have a pressure ulcer completely covered with eschar on her left heel and a Stage 3 pressure ulcer 3 cm x 2 cm x 0.4 cm on her coccyx.
**Revised Quality Measure**

- M1311 will be used to calculate the revised Quality Measure for pressure ulcers: Percentage of Patients with Change in Skin Integrity, aligning with the IMPACT Act measure Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
  - Reports the percentage of quality episodes with reports of Stage 2-4 pressure ulcers or unstageable pressure injuries/ulcers due to eschar/slough, non-removable dressing/device or deep tissue injury, that were not present or were at a lesser stage on admission
- OASIS Discharge information will be compared back to the SOC/ROC information

**Pressure Ulcer Quality Measure**

**Numerator** = number of quality episodes in which assessment at DC indicates one or more new or worsened Stage 2-4 or unstageable pressure ulcer/injuries compared to SOC/ROC assessment

**Denominator** = All quality episodes except:
- End in Death at Home or Transfer to Inpatient Facility
- No assessment completed at BOTH SOC/ROC and DC
- DC assessment does not have usable response for M1311a-f

**Current Scores**

- Number of Patients with new or worsened pressure ulcers

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<th>Your agency</th>
<th>NE State Average</th>
<th>National Average</th>
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<tbody>
<tr>
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<td>0.4%</td>
<td>0.4%</td>
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**M1322: Revised Item**

- Recognize that although Stage 1 pressure ulcers are closed (intact skin), they would not be considered healed.

![Removed from DC]
“Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.

A pressure ulcer is considered Unstageable if:
- it is covered with a non-removable dressing or device, such as a cast, that cannot be removed, or
- it is a suspected deep tissue injury in evolution, or
- the wound bed is obscured by some degree of necrotic tissue AND no bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible.
  - Note that if a Stage 4 structure is visible, the pressure ulcer is reportable as a Stage 4 even if slough or eschar is present.

If a pressure ulcer is stage 4 at SOC and is granulating at the follow-up visit, the ulcer remains a stage 4 ulcer.

A closed stage 3 or stage 4 pressure ulcer is no longer to be regarded as a pressure ulcer at its worst stage.

A previously closed stage 3 or stage 4 pressure ulcer that breaks down again should be staged at its worst stage.

In order to stage the pressure ulcer as a stage 4, bone, muscle, tendon, or joint capsule (stage 4 structures) must be visible. A pressure ulcer that has some degree of necrotic tissue (eschar or slough) or scabbing present that the clinician believes may be obscuring the visualization of stage 4 structures cannot be staged, even if it was previously stageable.
M1330 Does this patient have a Stasis Ulcer?

Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis. Stasis ulcers DO NOT include arterial lesions or arterial ulcers. Response 3—Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

M1332 Current Number of Stasis Ulcers

Counting Stasis Ulcers

- If areas of venous stasis ulceration are contiguous and developed at the same time, the entire area would be counted as one stasis ulcer. If the patient had a venous stasis ulcer and then later developed another venous stasis ulcer, and eventually the wound margins met, it would be counted as two ulcers, as long as it remains possible to differentiate one ulcer from another based on wound margins. Depending on the timing and progression, it may be difficult for the clinician to know that a current ulcer was once two ulcers, and/or where one ulcer ends and another begins for assessment/reporting purposes. It would be up the assessing clinician to determine the number of stasis ulcers in situations where multiple ulcers may have merged together.

Mixed Arterial and Venous Disease

- Mixed ulcers—mark as stasis ulcers
- In a situation where the patient has a mixture of venous stasis and arterial disease, the wound appearance and characteristics will often help the physician determine if the ulcer is venous, arterial, or mixed.
- Venous stasis ulcer, or a mixed arterial and venous ulcer mark in M1330.
- Arterial and it is receiving clinical assessment or intervention from the home health agency, the assessing clinician would document the wound in the clinical skin assessment (January 2016).
Trauma Wound or Stasis Ulcer?

• Our patient’s lower extremity wound originated as a trauma wound due to a fall. The patient also has diagnoses of venous insufficiency and stasis dermatitis. The physician stated the wound is not healing due to the venous insufficiency. Is there a point in time when the wound is no longer classified as a traumatic wound and considered a stasis ulcer for M1330?

• Ulcers caused by inadequate circulation in the area affected. The healing process of other types of wounds, e.g. traumatic wounds, surgical wounds, burns, etc., may be impacted by the venous insufficiency, but it would not change the traumatic or surgical wound into a venous stasis ulcer.

Healing Status

- Fully Granulating: wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open.

- Early/Partial Granulation: wound with ≥25% of the wound bed covered with granulation tissue; <25% of the wound bed covered with avascular tissue (eschar and/or slough); may have dead space; no signs or symptoms of infection; wound edges open.

- Not Healing: wound with ≥25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

M1334 Status of Most Problematic Stasis Ulcer

1. Determine which stasis ulcers are observable
2. Determine which stasis ulcer is most problematic, then
3. Determine and report healing status

M1340 Surgical Wound

- Does this patient have a Surgical Wound?
  - Enter Code
    - 0 No [Go to M1400]
    - 1 Yes, patient has at least one observable surgical wound
    - 2 Surgical wound known but not observable due to non-removable dressing device [Go to M1400]
**M1340 Surgical Wound**

- Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.
- If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one observable surgical wound.
- Response 2 if the only surgical wound(s) is/are not observable. A wound is considered not observable if it is covered by a dressing/device (such as a cast) which is not to be removed per physician order.
  - This response can be updated during the timeframe.
- A surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item.

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**Surgical Wounds**

**Surgical Wounds**

- Pressure ulcers with muscle flaps or skin grafts (break down during healing—non healing surgical wound)
  - Also can be a pressure ulcer and surgical wound at the same time
- Any ulcer with skin graft
- Excised pressure ulcers
- Dialysis cath exit sites (AV fistulas, AV shunts)*

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**Not A Surgical Wound**

- Pressure ulcers sutured closed
- Paracentesis

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**Surgical Wounds**

- Implanted infusion devices*
- ON-Q catheter sites
- Implanted pumps*
- Cardiac cath by cutdown
- VANTAS implanted device*
- Electrodesication and curettage
- MammoSite® breast brachytherapy

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**Not surgical wounds**

- PICC line (tunneled and non-tunneled) *Unless* inserted centrally
- Cardiac cath by needle puncture
- Toenail removal
- Cryosurgery

---

**Surgical Wound**

- I&D with drain
- Excision
- Wound with drain even after drain pulled
- Shave, punch or excisional biopsy
- Repair of a internal trauma
- Take down of ostomy
- Burn with a skin graft

---

**Not Surgical Wounds**

- I&D without drain
- I&D of foot ulcer with biopsy of bone 2nd Q 2015
- Removal of a callus
- Repair of a traumatic laceration
- Thoracotomy or any wound ending is ostomy
  - Surgical incision to insert chest tube
Surgical Wounds

- Pacemakers and internal defibrillators until epithelialized for 30 days
- LVAD
- VP shunts and burr holes
- Donor site for grafts
- Laparoscopic surgery, arthroscopy, and other minimally invasive surgery/procedure
- Kyphoplasty by open approach

Not Surgical Wounds

- Pacemakers and internal defibrillators once epithelialized for 30 days
- Retention sutures, staple sites
- Kyphoplasty by percutaneous approach
- Cataract surgery
- Gynecological surgery via vaginal approach
- Mucous membranes (dental)

Central venous catheters or central lines are those with the catheter tip located in the superior vena cava. Central lines can be peripherally inserted (i.e., basilic or cephalic vein in upper arm, or femoral vein in the groin) or centrally inserted (i.e., internal jugular vein in the neck, or subclavian or axillary vein in the chest).

Central lines that are centrally inserted (as in the internal jugular example) ARE considered surgical wounds for M1340 because of the central insertion, even if the type of catheter inserted into the central vein was intended to be inserted peripherally.

Central lines that are peripherally inserted are not considered surgical wounds.

4bQ105.9.1.

M1342 Status of Most Problematic Surgical Wound

1. Determine which surgical wounds are observable
2. Determine which observable surgical wound is most problematic, then
3. Determine and report healing status

Primary Intention

- The clinician must first assess if the wound is healing entirely by:
  - primary intention (well-approximated with no dehiscence), or
  - if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing).

Surgical wounds healing by primary intention (approximated incisions) do not granulate, therefore the only appropriate responses would be Response 0 - Newly epithelialized or Response 3 - Not healing.
Primary Intention

• Re-epithelialized? Epithelialization is regeneration of the epidermis across a wound surface. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.)

• If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing exclusively by primary intention.

Healing by Primary Intention

Epithelial Resurfacing

Does not include the appearance of the sutures

Scab adhering

Healing by Secondary Intention

Healing by primary intention

Healing by secondary intention

Secondary Intention
Secondary Intention

- If it is determined that there is incisional separation, healing will be by secondary intention. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."
- Response 0 — Newly epithelialized:
  - Completely covered with new epithelium; no exudate; no avascular tissue (eschar and/or slough); no signs or symptoms of infection.
  - Epithelialization is characterized by "Epidermal resurfacing" and means the opening created during the surgery is covered by epithelial cells. If epidermal resurfacing has occurred completely, the correct response in the OASIS would be "Newly epithelialized" until 30 days have passed without complication, at which time it is no longer a reportable surgical wound.

Healing Status

- **Primary intention**: healing will be by primary intention, and "Fully granulating" may be reported as "Not healing," "Early/partial granulation," and eventually "Newly epithelialized."

- **Fully Granulating**: wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open.

- **Early/Partial Granulation**: wound with ≥25% of the wound bed covered with granulation tissue; <25% of the wound bed covered with avascular tissue (eschar and/or slough); may have dead space; no signs or symptoms of infection; wound edges open.

- **Not Healing**: wound with ≥25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

Healing Status—Venous Access Devices

- When a needle is inserted and removed from an implanted venous access device, it is possible that the skin that was pierced by the needle could have a resulting wound that would heal by secondary intention. Usually, with good access technique and current needle technology there will be no perceptible wound.
- Response 0 — Newly epithelialized for implanted venous access devices and infusion devices when the insertion site is healed and without signs and symptoms of infection.

Healing Status—Venous Access Devices

- Occasionally, if there was an extremely large bore needle or traumatic entry or removal, there may be a resulting wound that heals by secondary intention. In this situation, the accessing clinician would rely on the WOCN’s OASIS Wound Guidance document to determine the healing status. Note that a scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "Not healing". 4bQ112.6.
- Some sites, because they are being held open by a line or needle, cannot fully granulate and may remain "non-healing" while the line or needle is in place. 4bQ112.6.1.
Current Scores

• Number of Patients whose surgical wounds healed or got better

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<tr>
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<td>86.5%</td>
<td>91.2%</td>
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M1320 & M1350 are gone!

• M1320 – Status of most problematic pressure ulcer
  • Assessment of granulation, eschar/slough, s/sx of infection, closed wound edges, etc. are key to treatment plan and healing pressure ulcers
• M1350 - Documentation of other wounds or alterations in skin integrity/pathology
  • Wound assessment, identification of etiology, development of treatment plan, documentation of measurements, response to treatment interventions
• Clinical assessment should still include healing status, documentation of closed stage 3 & 4.

Medication Measure Calculations

• Lots of uses for OASIS medication items:
  • End-result outcome measure: M2020
  • IMPACT Act measures: M2001, M2003, M2005
  • VBP measures: M2020, M2016
  • HH Star measure: M2016 in 2018, to be replaced by M2020 in 2019
• No changes in Drug Regimen Review (CoP same), but guidance refined to promote cross-setting alignment
Defining Clinically Significant

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

Three levels of significance

- Drug regimen review activities we can address ourselves without physician intervention
- Drug regimen review activities we need to address with the physician, but not necessary by midnight of next calendar day
- Those issues which require physician input asap
  - Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.
M2001—Not Just Med Rec

- Drug regimen review includes:
  - medication reconciliation,
  - a review of all medications a patient is currently using
  - review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
- Drug regimen review includes all medications:
  - prescribed and over the counter (including TPN and herbals),
  - administered by any route (oral, topical, inhalant, pump, injection, intravenous and via enteral tube).

M2001 Collaboration in 2018

- Change in One Clinician Rule guidance effective Jan. 1, 2018 expands allowance for collaboration
- Collaboration allowed: assessing clinician evaluates patient status (for example, presence of potential ineffective drug therapy or patient nonadherence), and another clinician (in the office) assists with review of the medication list (for example, possible duplicate drug therapy or omissions). Information must be communicated to the author of the assessment so the appropriate response for M2001 may be entered. Agency P&P will determine process and how it is documented.
- The M0090 date—the date the assessment is completed—would be the date the two clinicians collaborated and the assessment was completed.

M2003

- SOC
- ROC

Definition: “Physician contact”

- Contact with physician is defined as communication to the physician or physician-designee (made by telephone, voicemail, electronic means, fax, or any other means) that appropriately conveys the message of patient status. Communication can be directly to/from the physician or physician-designee, or indirectly through physician’s office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.
M2003 Response YES

- Two-way communication AND completion of the prescribed/recommended actions must have occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified
- Timely reporting of potential clinically significant medication issue(s) with no new orders or instruction in response (still 2 way communication)
- Multiple potential clinically significant medication issues identified—**all** must be communicated to the physician/physician-designee, with completion of **all** prescribed/recommended actions occurring by midnight of the next calendar day.

M2003 Response NO

- If two potential clinically significant medication issues are identified at the SOC/ROC, both are communicated timely to physician/designee who provides a recommended action for each issue (for example, patient education for one medication, and a new dosage for another), both recommended actions could have been addressed by midnight of the next calendar day, but only one was addressed.
- If a potential clinically significant medication issue was identified, and the clinician attempted to communicate with the physician, but did not receive communication back from the physician/physician designee until after midnight of the next calendar day.
Midnight Comes Early at ROC

• ROC OASIS must be completed within 48 hours of patient discharge from facility or the agency being aware of the patient being discharged from a facility, or on the physician-ordered ROC date. If the OASIS assessment is done on the second day (hours 25–48) and a medication issue is identified, does the clinician still have until midnight of the following day to resolve the issue, or does the issue need to be resolved before the 48th hour is complete?

• M2003, Medication Follow-up must also be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Conditions of Participation regarding the completion of the comprehensive assessment. If a medication problem is identified at SOC or ROC, physician communication and completion of prescribed/recommended actions must occur by midnight of the next calendar day after identification and before the end of the allowed assessment timeframe.

Example

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<td></td>
<td>Physician did not respond</td>
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</table>

Each time that an issue is found and rises to the level which requires physician intervention, was the physician notified, and did the physician respond (each time).

Use Your Judgment

• How do we answer this item for a compliant degenerative joint disease patient who was noted to have pain symptoms of 4/10 (per patient) on SOC, who already is on a new narcotic analgesic during the past week?

• With this symptom, can we answer “0 = No, no issues found during review” if we think this issue does not necessitate notifying the physician by midnight of the next business day?

• A potential clinically significant medication issue is an issue that in the care provider’s clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.
Dash

• There may be times because of an agency process that the drug regimen review is not completed within the assessment timeframe. Would that be an instance when a dash is used?
• A dash is expected to be a rare occurrence and indicates that no information is available and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged, or dies before assessment of the item could be completed. Agencies must ensure that their processes are not a barrier to complete a drug regimen review within the given timeframe and should adjust their processes to ensure that a drug regimen review is completed as required.

Physician does not respond

If we are unable to resolve a medication issue before midnight of the next calendar day due to no physician reply, how is that reflected within the reporting structure for M2003 and M2005? How does it differentiate a no physician reply vs. no agency action? Moreover, what are the implications, if any, for the agency and/or the physician for a pattern of non-adherence to this best practice?

• M2001 does not offer the option of “Drug regimen review not done.” To answer M2003 and M2005, the review must be done. M2003 asks if the physician was contacted and the actions completed. If no issues were identified, there is no need to contact the physician; if issues were found, the communication and response are both needed.
• Selecting “No” for M2003 and M2005 indicates that the best practice of identifying a medication issue, reporting it to the physician, and completing the recommended/prescribed actions possible by midnight of the next calendar day was not accomplished. The item response choices for M2003 and M2005 do not identify the reason why the best practice was not met.

DRR Quality Measure

• “Drug Regimen Review Conducted with Follow-up for Identified Issues”
• Reports the percentage of patient care episodes in which a DRR was conducted at SOC/ROC, and timely follow up with a physician occurred each time potential and actual clinically significant med issues were identified throughout that care episode
• Process measure: not risk adjusted

DRR Quality Measure

**Numerator** = number of episodes in the denominator where the medical record contains documentation of DRR conducted at SOC/ROC with all potential clinically significant med issues identified during the course of care and followed up with a physician or physician designee

**Denominator** = All complete quality episodes (with a discharge, transfer or death at home assessment during the reporting period)
Items Included in Quality Measure

• M2001 Drug Regimen Review
• M2003 Medication Follow-up
• M2005 Medication Intervention
• If a dash “—” is entered for any of these three items:
  • The quality episode will not be included in numerator
  • The quality episode will be included in denominator

Current Scores

• Physician-recommended actions to address medication issues completed timely

<table>
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<td>92.3%</td>
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High Risk Drugs Defined

• High-risk medications are those identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously.
  • Institute for Safe Medication Practices (High Alert Med List)
  • JCAHO, etc.
• Examples of high risk meds that could have a severe negative impact on patient safety and health
  • Hypoglycemics
  • Anticoagulants
M2010 High Risk Drug Education

- Response “0”
  - Interventions were not completed as outlined in this item.
  - Clinician should document rationale in the clinical record, unless the patient takes no high risk drugs (see Response NA)
- Response “1”
  - High risk meds are prescribed and education was provided
  - ALF—staff are considered caregivers; may or may not be appropriate to educate those administering medications 4b-Q161.3
  - Education can be over the phone 4b-Q161.4

M2010 Patient/Caregiver High Risk Drug Education

- Educate on high risk meds first
  - Unrealistic to expect that pt education on all meds can occur on admission
  - Remember the timeframe
  - Others can provide the education, but who has to mark the data item? 4b-Q161.4
  - Does not require a list of high risk meds educated on; there would be documentation in the record 3rdQ 2014

M2016 Medication Education

- Identify if clinicians instructed the patient and/or caregiver(s) on ALL medications
  - ALF staff are considered caregivers 4b-Q162.3, 162.4
  - Education can occur over the phone 4b-Q161.4
  - How to manage meds effectively and safely through knowledge of:
    - Medication effectiveness
    - Potential side effects
    - Drug interactions or adverse effects
    - When to contact the appropriate care provider

Still important to reduce ACH!
M2016 Patient/Caregiver Drug Education Intervention

- No--
  - Interventions are not completed as outlined in this item
  - Care provider should document rationale in the clinical record
- Yes—
  - Includes education by any agency staff
  - Has to be all 4 components
- NA—
  - Patient takes no prescription or OTC medications

M2016 Example

Mr. Walt’s ROC was completed October 8. The SN documented education on all of the patient’s meds (high risk and non-high risk) was completed at that time.

Mr. Walt is transferred to the hospital on October 10. How will you complete M2016? 4b-Q162.2

M2016 Example

- M2016 would be “Yes” if, at the time of or since the most recent SOC or ROC OASIS assessment, the patient and/or caregivers were educated regarding ALL their medications (not just the high risk medications), including how and when to report problems that may occur. If this specified education was accomplished for all medications at the time of the ROC assessment, the appropriate response for M2016 would be “Yes.”
- If review of the documentation on the ROC visit showed the clinician taught only some of the medications, or taught only some of the information on medication effectiveness, potential side effects, adverse drug reactions, and who and what to report about problems, then the appropriate response for M2016 would be “No.”

M2016 Patient/Caregiver Drug Education Intervention

- If assessment of the patient/caregiver’s baseline knowledge reveals the patient received the education from the pharmacist, you can include this education in M2016.
  - This would require that the pharmacist educated the patient/caregiver to monitor the effectiveness of all drug therapy (prescribed, as well as all OTC), drug reactions, and side effects, and how and when to report problems that may occur to the appropriate care provider.
- **Note that just including written materials in the bag with the medications at the time the medication is dispensed may not provide the specified education.** The education of the patient may also be a collaborative effort, in which the pharmacist may provide part of the education, with other healthcare providers. 4b-Q162.
M2016 Q&A

- Mrs. Washington was opened to home care on Jan. 1, and agency staff provided complete education on all medications during the first certification period. Mrs. Washington was recertified for home care services with a follow-up for recert on Feb. 26. At the recert visit, documentation of the Drug Regimen Review stated the patient had no new medications.
- At the discharge assessment visit on March 28, look-back at visit documentation showed there was no education in the second certification period because the patient had no new medications and there was no need to re-teach on all medications. How do you answer M2016 at Discharge?
- M2016 = Yes

Current Scores

- Patient/family educated on all medications

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<td>98.2%</td>
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M2020 Management of Oral Medications

- Includes all prescribed and OTC oral meds included on the POC
- Excludes topical, injectable and IV meds
- Excludes inhalation meds and sublingual meds
- Excludes swish and expectorate meds
- Meds given per gastrostomy or other tube are not considered po
- Does not include filling/reordering
- Swallowed and absorbed through GI system!
M2020 Management of Oral Medications

• If patient’s ability to manage oral meds varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

• If the medication is ordered prn, and on the day of assessment the patient needed a reminder for this prn, then the patient would be a "2".

• If on the day of assessment, the patient did not need any prn medications, therefore no reminders, then assess the patient's ability on all of the medications taken on the day of assessment.

M2020 Management of Oral Medications

• Assess patient’s ability to take medications reliably and safely at all times
• Identifies patient’s ability, not willingness or compliance or actual performance
• Ability can be temporarily or permanently limited by:
  • Physical impairments (e.g. limited manual dexterity)
  • Emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
  • Sensory impairments, (e.g., impaired vision, pain)
  • Environmental barriers (e.g. access to kitchen or medication storage area, stairs, narrow doorways)

M2020 Management of Oral Medications

• Response 0
  • Patient sets up her/his own ‘planner device’ and is able to take the correct med in the correct dosage at the correct time
• Response 1
  • Patient is independent in oral med administration, but requires
    • Another person to prepare individual doses (e.g., sets up a planner device)
    • And/or another person to develop a drug diary or chart which the patient relies on to take meds appropriately
• Response 2
  • Patient requires another person to provide reminders at the time the med is taken
  • What about a device that provides reminders?
    • Who sets up the device? 4b-Q167.5
Examples of Response 3

- Patient who didn’t understand how to take med
- Patient who wasn’t able to take med at correct time even though reminded
- Patient who was unable to safely swallow oral med on day of assessment
- If medication not in the home, you cannot make assumptions about patient’s ability to take the med
- Patient requires someone to assist them at medication administration time to walk to the location where meds are routinely stored, or someone must retrieve the medications and bring them to the patient

M2020 Assessment Techniques

- Ask the patient to gather all medications. Is the patient able to access the medications where they are kept in the home?
- Verify all ordered medications are in the home.
- Ask the patient to explain how he/she takes each medication: time of day, number of pills-tabs, relative to food or other medications
- Ask the patient to demonstrate how to take a pill out of a med bottle (can he/she get the lid off, remove a small pill from the bottle, etc.). If patient uses a med planner, observe if he/she can open compartments and remove pills. Check compartments from day before to see if any pills remain that should have been taken.
- If the patient has sensory deficits (impaired vision, pain, neuropathy), manual dexterity deficits, or cognitive/memory deficits, assess how patient takes medications safely.
- Assess environmental barriers or ask if the patient is able to access a beverage to swallow oral meds.
- Ask if the patient has difficulty swallowing large pills or other problems with ingesting medications.
- For patients that live in an ALF, assess vision, strength, manual dexterity and cognitive status, and use clinical judgement to determine ability to take correct dosage at the right time

Current Scores

- Improvement in ability to take oral medications

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No M1900, M2040, M2110

- Prior Functioning ADL/IADLs, Prior Medication Management and frequency patient needs assistance, are considerations for:
  - Setting discharge goals
  - Planning interventions to achieve goals
  - Assessing needed resources for additional help after agency discharge

**Care Planning and Emergent Care**

M2102: Revised Item

At SOC and ROC, report what is known on the day of assessment regarding ability and willingness of non-agency caregivers to provide assistance for the upcoming episode of care.
Comparing ADL items to M2102

- We have a patient, who at discharge is able to bathe in the shower with assist of her daughter, however she prefers to sponge bathe at the sink and is able to do so independently now. The clinician has marked response 2 for M1830 to reflect her ability to perform safely. Question: should the clinician answer M2102a (caregiver assistance with ADLs) Response 1, reflecting assistance needed for showering as answered in M1830, or can the clinician choose response 0 – no assistance needed because the patient is able to sponge bathe independently and safely. The patient is able to do all other ADLs independently. The clinician’s documentation in the clinical record reports patient’s preference with bathing.
- Our software system does give a warning if the response for M2102a is not consistent with the M18xx ADL questions/responses.

Medicare’s Answer

- M1830 addresses the patient’s ability to bathe in the shower or tub, not actual performance, regardless of where or how the patient currently bathes. Willingness and adherance are not the focus of the item. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and Response 1, 2, or 3 should be selected. In the scenario cited, the appropriate response for M1830 is “2”.
- M2102 is based on the ability and willingness of the caregiver(s) (other than home health agency staff) to provide the assistance needed by the patient to perform ADLs, including bathing. The item does not specify the bathing must be in the tub or shower. In the scenario cited, the assessing clinician has determined the patient to be independent in all ADLs, including bathing. Therefore, a response of "0" for M2102a. would be appropriate.

M2102 Generally

- If more than one response in a row applies, (for example, the caregiver(s) provides the assistance but also needs training or assistance), select the response that represents the greatest need (“caregiver(s) needs training/supporting services to provide assistance”).
- Response 3 if:
  - “Caregiver(s) not likely to provide” indicates that the caregiver(s) has indicated an unwillingness to provide assistance, or that the caregiver(s) is/are physically and/or cognitively unable to provide needed care.
  - “Unclear if caregiver(s) will provide” indicates that the caregiver(s) may express willingness to provide care, but their ability to do so is in question or there is reluctance on the part of the caregiver(s) that raises questions as to whether the caregiver will provide the needed assistance.

M2102 Assistance Needed

If patient needs assistance with any aspect of a category of assistance (such as needs assistance with some ADLs but not others), consider the aspect that represents the most need and the availability and ability of the caregiver(s) to meet that need.
- Row a – ADL assistance (for ex: transfer/ambulation, bathing, dressing, toileting, eating/feeding)
M2102 Medications and Procedures/Treatments

- Row c – Medication administration refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.
- Row d – Medical procedures/treatments include procedures/treatments that the physician or physician-designee has ordered for the purpose of improving health status. Ex: wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.
- Devices such as TED hose, prosthetic devices, orthotic devices, or other supports that have a medical and/or therapeutic impact should be considered medical procedures/treatments, not as ADL/dressing items in Row a.

M2102 ‘4’ Not Used Generally

- M2102. How is "Assistance needed, but no Caregiver(s) available" defined? Would it apply to a son who assists with ADLs safely and independently, but is unwilling to assist with medication administration?
- "4 - Assistance needed, but no non-agency caregiver(s) available" means the patient has no one involved in providing any level of care to them at all. In your example, the patient has a son who is providing some level of caregiver assistance; therefore, Response 4 would not be an appropriate response.
- If the son was willing and able to assist with ADLS, the appropriate responses for Row a would be "1- Non-agency caregiver(s) currently provide assistance". If the son was unwilling to assist with medication administration, the appropriate responses for Row c, Medication administration would be "Response “3 – Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance” because this response is defined as including situations where the caregiver is unwilling or unable to provide the needed care. 4b Q170.12.

M2102f. Q&A #8 July 2018

A8: The OASIS Guidance Manual states that M2102f should focus on supervision and safety necessary due to cognitive or mental health issues. The OASIS Guidance does not indicate a specific diagnosis is required. The need for supervision and safety due to cognitive or mental health issues may be based on the clinical judgement of the assessing clinician or others contributing to the comprehensive assessment.

A9 also notes: the response on M2102f would not necessarily be reflected on responses to the diagnosis items M1021/M1023, cognitive items M1740/M1745, depression screen M1730 or fall risk assessment M1910. Each OASIS item should be considered individually, based on guidance for that item.

No M2250 or M2430

- M2250 Plan of Care Synopsis deleted from SOC and ROC, but M2401 still part of Transfer, Discharge and Death at Home time points
  - Will need to assess risk factors with a FORMAL assessment to code NA on M2401
    - Example: M1300 is deleted, however your formal assessment is the Braden or Norton.
  - Will need to obtain orders for needed interventions to address any risk factors identified, and implement those interventions to code “yes” on M2401
- M2430 Reason for Hospitalization on Discharge or Transfer
  - How to track this information for QAPI projects to reduce ACH?
M2310: Revised Item

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

- Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- Hypo/Hyperglycemia, diabetes out of control
- Other than above reasons
- Reason unknown

M2310 Reason for Emergent Care

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

- Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- Hypo/Hyperglycemia, diabetes out of control
- Other than above reasons
- Reason unknown

M2301 Emergent Care

- Identifies whether the patient was seen in a hospital emergency department at the time of or at any time since the most recent SOC/ROC OASIS assessment. Responses to this item include the entire period at or since the last time SOC/ROC OASIS data were collected, including use of hospital emergency department that results in a qualifying hospital admission, necessitating Transfer OASIS data collection. *This item includes current events.*
M2301 Emergent Care

- Response 1 or 2—Yes
  - Patient went to a hospital emergency department, regardless of whether the patient/caregiver independently made the decision to seek emergency department services or was advised to go the emergency department by the physician, home health agency, or other health care provider
  - Response 2—Yes with admission
  - Patient went to a hospital emergency department and was subsequently admitted to the hospital
  - An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more for reasons other than diagnostic testing).

- What if a patient went to a hospital emergency department, was “held” at the hospital for observation, then released?
  - The patient did receive emergent care.
  - The time period that a patient can be "held" without admission can vary
  - An OASIS transfer assessment is not required if the patient was never actually admitted to an inpatient facility.

M2310 Reason for Emergent Care

- Emergency Room only
- If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses (include why even though not diagnosed)
  - If a patient received care for hypoglycemia and was found to have medication side effects, mark both responses.
  - Improper medication administration, regardless of who (patient, caregiver, or medical staff) administered the med improperly. 4b-Q181.5

Dies in the ER

- A patient who dies in a hospital emergency department is considered to have been under the care of the emergency department, not the home health agency. In this situation, a Transfer assessment, not an assessment for "Death at Home," should be completed. For M2301, select Response 1 - Yes, used hospital emergency department WITHOUT hospital admission.
M2310 Reason for Emergent Care

• If the reason is not included in the choices, mark Response 19 - Other than above reasons.
• If Pt received emergent care in a hospital ED multiple times since the last time OASIS data were collected, include the reasons for all visits.
• Include both the reasons care was sought and care received. 4b-Q181.5.1

M2401 Process Measures

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<tbody>
<tr>
<td>a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>0</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>b. Falls prevention interventions</td>
<td>0</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>c. Depression intervention(s) such as medication, referral for other treatment or a monitoring plan for current treatment</td>
<td>0</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>d. Interventions to monitor and mitigate pain</td>
<td>0</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>e. Interventions to prevent pressure ulcers</td>
<td>0</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>f. Pressure ulcer treatment based on principles of moist wound healing</td>
<td>0</td>
<td>1</td>
<td>NA</td>
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Current Scores

- Urgent, unplanned use of hospital Emergency Department without admission to the hospital

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<td>11.8%</td>
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M2401

Select No when at the time of or since the most recent SOC/ROC assessment an order for the criteria of a best practice intervention(s): 1. Has not been obtained and/or 2. Has not been implemented and NA does not apply.

2401 Intervention Synopsis

• Ordered, attempted and not provided because of documented lack of need for the education—May still answer yes

• Attempt was made to educate and the patient refused or otherwise declined to receive the needed instruction with no further attempt—Should not be reported as being implemented.

• Multiple orders for interventions. Can we respond "Yes" to M2401 d if pain mitigation orders were implemented but not completed prior to discharge?

• May answer "Yes" if there is evidence that the required assessment component was implemented AND evidence that at least one of the pain mitigation orders were implemented. 4bQ182.7.
Neuro/Emotional/Behavioral Items

Different time frames – different questions

- M1700 Cognitive Functioning
  - Day of assessment ONLY
- M1710 When Confused
  - Last 14 days
- M1720 When Anxious
  - Last 14 days
- M1730 Depression Screening
  - PHQ-2 is last 2 weeks
- M1740 Cognitive, Behavioral & Psychiatric Symptoms
  - Relevant past, multiple times, at least once a week
- M1745 Frequency of Disruptive Behavior Symptoms
  - Relevant past, “less than once a month” could require look back more than the past month

M1700 Cognitive Functioning

Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., will have various degrees of cognitive dysfunction.

Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.
M1700 Cognitive Functioning

- Consider:
  - Patient’s signs/symptoms of cognitive dysfunction over the past 24 hours.
  - Amount of supervision and care the patient has required due to cognitive deficits
  - Level of cognitive functioning including:
    - Alertness
    - Orientation
    - Comprehension
    - Concentration
    - Immediate memory for simple commands

M1710 When Confused

- Assess specifically for confusion in the past 14 days.
- If it is reported that the patient is “occasionally” confused, identify situation(s) in which confusion has occurred within the last 14 days, if at all.
- Report any episodes of confusion that occurred during the past 14 days, without regard to the cause of potential relevance of the confusion to this episode of care.

What is the difference in what is measured in M1700 – Cognitive Functioning and M1710- When Confused?

- M1710 may not relate directly to Item M1700
- M1700 – Level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands on the day of assessment (at the time of the assessment and in the preceding 24 hours).
- M1710, When Confused, is intended to identify the time of day or situations when the patient experienced confusion, if at all, during the past 14 days (Day of assessment and prior 14 days).

M1700 – Cognitive Functioning and M1710- When Confused

- If a patient is demonstrating confusion on the day of the assessment, it would be reported both in M1700 and M1710. If a patient was NOT confused on the day of assessment, but had experienced confusion during the prior 14 days, it would only be reported in M1710.
- If a patient has a cognitive impairment on the day of the assessment, that does NOT result in confusion, e.g.; forgetfulness, learning disabilities, concentration difficulties, decreased intelligence, it would only be reported in M1700.
M1720 When Anxious

Anxiety includes:
- Worry that interferes with learning and normal activities
- Feelings of being overwhelmed and having difficulty coping
- Symptoms of anxiety disorders

Non-Responsive

- “Nonresponsive” means that the patient is unable to respond or the patient responds in a way that you cannot make a clinical judgment about the patient’s level of orientation. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any confusion/anxiety during the past 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, enter “NA – Patient nonresponsive.”
- This applies to M1710 and M1720.

Nonresponsive M1710/M1720

- “Nonresponsive” means that the patient is unable to respond or the patient responds in a way that you can’t make a clinical judgment about the patient’s level of orientation. Examples at 4b-Q124.1
- Can still report confusion or anxiety during the past 14 days—ask the caregiver or other source
- Nonresponsive pulls the patient from 16 quality measures, 2 PAE, & 1 process measure because may not expect to improve. Home Health Quality Measures Tables, 2018
- If not expected to improve, Nonresponsive is a good response.

M1730 Depression Screening

- Instructions for this two-question test. Ask patient: “Over the last two weeks, how often have you been bothered by any of the following problems?”
- Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.
- Copyright © 2018. All rights reserved. Reproduced with permission.
M1730 Depression Screening

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

M1730 Depression Screening

- When evaluating the patient, the clinician must first assess whether the PHQ-2 is the appropriate depression screening tool. If the PHQ-2 is appropriate (the patient appears to be cognitively and physically able to respond), then the instrument may be used.
- If, however, the patient is unable to answer the specific PHQ-2 questions when asked by the assessing clinician, e.g. the patient can’t quantify how many days they have experienced the problems, the clinician can report in M1730 that the PHQ-2 was administered (Response 1), and select N/A - Unable to respond.
- Response 1–Yes may NOT be selected if the patient refuses to hear the questions or states they are too personal.
- Response 1 –Yes may NOT be selected if the patient cannot understand the questions.

M1740

SOC

ROC

DC

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

- Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- Delusional, hallucinatory, or paranoid behavior
- None of the above behaviors demonstrated
M1740 Cognitive, behavioral, and psychiatric symptoms

- Behaviors can be observed by the clinician or reported by the patient, family, or others
- Consider problematic behaviors
  - Severe enough to make the patient unsafe OR cause considerable stress to caregivers OR require supervision or intervention
- Consider frequency of behaviors

M1740 Cognitive, behavioral, and psychiatric symptoms

- The time frame under consideration for M1740 is defined in the wording of the item - "at least once a week". The phrase "at least once a week" means that a behavior was demonstrated multiple times in the recent, relevant past and the frequency of the occurrence was at least one time a week prior to and including the day of assessment.
- The assessing clinician will determine "recent, relevant past" based on the patient/caregiver interview, referral information, assessment findings, diagnoses and recent history of medical treatment and its effectiveness.

M1740

- If a patient is alert and oriented, but decides not to use their cane because they think they don’t need it (they are unsafe without it) or they decide they aren’t going to take their diuretic because they are going to the doctor and don’t want to have any accident, would you select Response “2 – Impaired decision-making”?

M1740

- The intent of M1740, Cognitive, behavioral, and psychiatric symptoms, is to capture specific behaviors that are a result of significant neurological, cognitive, behavioral, developmental or psychiatric limitations or conditions. It is not the intent of M1740 to report noncompliance or risky choices made by cognitively intact patients who are free of the aforementioned conditions.
- The assessing clinician will have to determine if the patient has a disorder that is causing her noncompliance or is the patient making a choice not to comply completely with physician's orders, cognizant of the implications of that choice.
Doesn’t have to be a diagnosed disorder

• The behaviors identified for the purpose of responding to M1740 and M1745 could be determined to be associated with a significant neurological, behavioral or psychiatric disorder either by diagnosis and/or in the assessing clinician’s clinical judgment.

M1745 Frequency of Disruptive Behavior Symptoms

• Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur.

• Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver.
No M1011 or M1017

• Documentation of reason for hospitalization or inpatient stay
  • Impacts risk of re-hospitalization
  • Consideration of prior level of function for setting of discharge goals
• Consideration of diagnoses with recent treatment changes
  • Development of interventions/goals for Plan of Care
• Supports medical necessity and reason for skilled care

No M1018, M1034, M1036

• All used for risk adjustment in OASIS-C2
• Where will risk adjustment come from in OASIS-D?
• Consideration of prior problems with incontinence, intractable pain, cognitive issues, obesity, drug/alcohol dependence - all require assessment, impact Plan of Care interventions, risk factor(s) for hospitalization, affect potential achievement of goals

M1021 /M1023 Diagnoses

• Must comply with ICD-10-CM Conventions and Guidelines
• Primary diagnosis is the focus of home care services.
• When determining secondary diagnoses, consider coexisting conditions that are actively addressed in the Plan of Care as well as diagnoses that affect the patient’s responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.
  • Reminder regarding CoPs All KNOWN diagnoses
• The secondary diagnoses may or may not be related to a patient’s recent hospital stay, but must have the potential to impact the skilled services provided by the HHA.
M1021 /M1023 Diagnoses

• All diagnoses must be documented in the medical record or referral information by the provider (physician or designee). If not, must be verified with provider – document the confirmation.

• Diagnoses may change during the course of the home health stay due to a change in the patient’s health status or a change in the focus of home health care.

• At each required OASIS time point, the clinician must assess the patient’s clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.

Data Sources for Diagnoses

• Referral information
• Physician orders
• Comprehensive assessment
• Patient/caregiver interview
• Current medication list
• Physician

The order that secondary diagnoses are listed should be determined by the degree that they impact the patient’s health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is “controlled with difficulty,” this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is “poorly controlled.”

Which require physician verification?
M1028: Revised Item

If diabetes and PVD is documented, only one code is used and 1 and 2 are checked.

New response

M1030 Therapies

Identifies whether patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.

M1033

Payment item in proposed PDGM

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- History of falls (2 or more falls) (or any fall with an injury in the past 12 months)
- Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- Multiple hospitalizations (2 or more) in the past 6 months
- Multiple emergency department visits (2 or more) in the past 6 months
- Decline in mental, emotional, or behavioral status in the past 3 months
- Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- Currently taking 5 or more medications
- Currently reports exhaustion
- Other risk(s) not listed in 1 - 9
- None of the above

M1030 Therapies

- If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment (for example, the IV will be started at this visit or a specified subsequent visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.
  - Still may update within the time period
  - Counts as IV/infusion therapy (response 1):
    - intermittent medications or fluids via an IV line (including heparin or saline flushes).
    - ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump (Including implanted pumps), Eclipse bulb infusion device
    - hemodialysis or peritoneal dialysis in the home
M1030 Therapies

- Does not count as IV/infusion therapy:
  - IV catheter is present but not active (for example, site is observed only or dressing changes are provided)
  - orders for an IV infusion to be given when specific parameters are present (for example, weight gain), but those parameters are not met on the day of the assessment.
  - An irrigation or infusion of the bladder
  - Flushing of a biliary tube with normal saline (January 2016)
- Enteral Nutrition (Response 3) if any enteral nutrition is provided.
- Does not count as Enteral nutrition
  - Not currently used for nutrition,
  - Water, Pedialyte, medications or flush of a feeding tube
- Parenteral therapy (response 2)
  - Triple lumen with TPN/lipids infusing in one port and flushing other – Responses 1 and 2
  - Single lumen utilized for TPN with pre and post flush – Response 2 only

M1060 Height and Weight

- Policy & procedure to standardize how to obtain, use mathematical rounding
- Only enter height/weight directly measured by agency staff as part of the assessment
  - If patient weighed multiple times, use the first weight
- Do not enter weight that is self-reported or from documentation by another setting

What is the answer?

As part of the SOC comprehensive assessment, the registered nurse needs to obtain a height for Mr. B. who has had bilateral lower extremity amputations due to complications from diabetes. His legs are now uneven in length.

- Using a tape measure, the RN measures the patient’s current height while the patient is lying in bed. She obtains two measurements: 64.4 inches and 60.8 inches. Answer M1060a:
  - 64
  - 65
  - 61
  - Dash (the patient is unable to stand)

Jan. 2019 Q&A #2

The OASIS submission specifications indicate values entered for height and weight that fall outside of the provided parameters will cause a fatal error and prevent an OASIS assessment from being transmitted.

The parameters for M1060a Height are a minimum of 50 inches and a maximum value of 80 inches. The parameters for M1060b Weight are a minimum value of 65 pounds and a maximum value of 440 pounds.

In the unique situation that the patient’s height and/or weight falls outside of the parameters, a dash should be used to enable the OASIS assessment to be submitted.
M1200 Vision

• Corrective lenses: reading glasses (including "grocery store" reading glasses)
• NOT Corrective lenses: magnifying glass or adaptive reader
• Assessment strategies: In the health history interview, ask the patient about vision problems and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications
• Be sensitive to requests to read, as patient may not be able to read though vision is adequate.
• Hard cervical collar; orbital swelling; blind in one eye: assess impact on functional vision. 4b-A64.1.

Functional Vision

• “Newsprint” is an example of the size/type of print the patient needs to see to read medication or food labels, written instructions, etc.
• Instead of focusing on specific font sizes, use clinical judgment to select the response to M1200 that best represents the patient’s vision status, as it relates to managing in their home environment safely.
• Functional vision may involve assessing the patient’s ability to read a medication label, identify colored medication bottle caps, differentiate medications based on pill size, color or shape and/or the use of other visual cues to carry out the daily activity of medication identification.

Impaired Vision

• Miss Turtle has severe kyphosis and limited neck mobility and cannot adequately see objects in her path creating a safety issue on ambulation. She can read med labels and newsprint. Is she considered to have partially (1) or severely (2) impaired vision?
• When selecting the correct response for M1200 Vision, the clinician is assessing the patient’s functional vision, not conducting a formal vision acuity screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical deficits or impairments that limit the patient’s ability to use their existing vision in a functional way would be considered. If physical deficit/impairments (like limited neck range of motion) prevent a patient from seeing objects in his path, affecting safe function in his environment, **M1200 should be 2 – severely impaired vision**.
No M1240 Pain Assessment

- Screen for pain every visit
- Assess intensity, site, character, frequency, triggers
- Identify patient’s tolerable level of pain (goal)
- Identify measures used to relieve pain
- How effective is pain relief intervention? Be specific, compare to patient’s goal
- What side effects bother patient? How severe and does it keep patient from using the interventions for relief?
- Pain affect on physical and social functioning

M1242 Frequency of Pain Interfering with Movement

- Review of diagnoses
- Review of activities
  - Is there any interference with activity or movement?
  - What is the frequency of this interference with activity or movement?
- Evaluation of ADLs and IADLs
  - Avoidance or delay of ADLs and/or IADLs
  - Need for assistance, increased time to perform/rest
- Evaluation of other activities
  - Does pain affect eating, sleeping, hobbies, family interaction or socialization?

M1242: Assessment Techniques

- Ask if pain prevents or discourages them from doing anything. What activities are impacted? Does it take longer to do activities? Do they need help with activities due to pain?
- Observe non-verbal signs of pain/discomfort during assessment activities, facial expressions, VS, pallor, perspiration, irritability. Congruent with reported level of pain?
- Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk).
M1242 Assessment Techniques

• Check the medication list: the presence of medication for pain or joint disease is a cue to assess the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement.

• How does patient currently treat pain? Do they take analgesics? Do meds help relieve the pain so the patient can do more? What other treatment?

• Score before you teach pain management

M1242 Assessment Techniques

• The patient’s treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

• Assessing pain in a nonverbal patient involves observation of facial expression (for example, frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (for example, FACES).

Response 4—All of the Time

• “All of the time" means constantly throughout the day and night with little or no relief.

• Pain is also considered to be interfering if a patient stops performing an activity in order to avoid the pain. For the pain to be interfering "all the time" the frequency of the activity that was stopped in order to avoid pain must collectively represent all the hours of the day/night. Pain must wake them frequently at night.

• Use clinical judgment based on observation and patient interview to determine if pain is interfering all the time. July 2013

Example

• Your patient reports that her pain doesn’t bother her as long as she moves slowly and doesn’t sit in the same position for long. Once she takes her sleeping medication at night, she rests well.
Current Scores

- Improvement in Pain interfering with activity

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<th>Your agency</th>
<th>NE State Average</th>
<th>National Average</th>
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<td>77.1%</td>
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M1400 Shortness of Breath

May be observed during assessment or reported by the patient or family/caregiver

What is status on the day of assessment?

M1400 Assessment Techniques

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

M1400 Shortness of Breath

- Chairfast or bedbound patient:
  - Evaluate the level of exertion required to produce shortness of breath
  - The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest
    - Response 0
      - Patient has not been short of breath during the day of assessment
**M1400 Shortness of Breath**

- Chairfast or bedbound patient:
  - Response 1 (When walking more than 20 feet...)
    - Appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient).
  - Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.

**M1400 Shortness of breath**

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

**Example**

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

**M1400 Q&A to Note**

- **Q113.1. M1400.** What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.
  - **A113.1.** Since the patient’s supplemental oxygen use is not continuous, M1400 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be “4 – At rest (during day or night).” It would be important to include further clinical documentation to explain the patient’s specific condition.
More Examples

- Patient sleeps with 2 pillows or in recliner and currently not short of breath at rest and otherwise not SOB
- Environmental modifications: If patient restricts an activity to remain free of dyspnea, can be a “0”
  - Key: did the patient make the modification BEFORE the SOC visit?
- Go up stairs 2 steps at a time to avoid dyspnea can still be a 0

Current Scores

- Improvement in Shortness of Breath

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What questions do you have?

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- www.selmanholman.com
CoDR—Coding Done Right—home health and hospice outsource for coding, OASIS review, and coding audits
- www.Codingdoneright.com
CodeProU—comprehensive online ICD-10-CM and OASIS training for home health and hospice
- www.codeprou.com

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