OASIS-E Clinical Training

Diane Henry, RN
State OASIS Education Coordinator

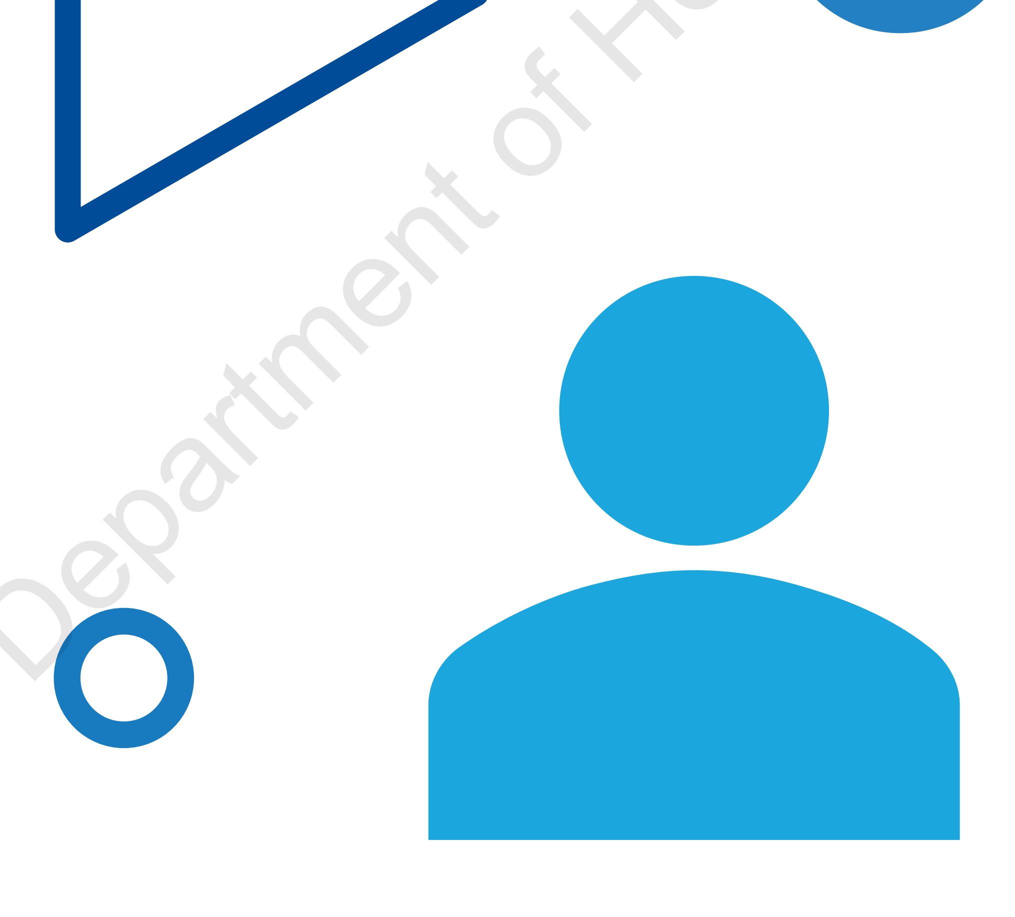
OKLAHOMA
State Department of Health

Oklahoma State Department of Health

QIES Team

- Diane Henry, RN Administrative Program Manager/State OASIS Education Coordinator

- Greg Freeman—CMSNet Systems Manager/State Automation Coordinator



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Oklahoma QIES Help Desk

- We are responsible for:
  - Educating surveyors and providers on OASIS requirements.
  - Providing consultative assistance regarding the OASIS process.
  - Coordinating database functions.
  - Assisting and interpreting validation reports.
  - Instructing on the correction process.

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Administrators

- If you are in attendance all day you may receive self-study hours to use for renewal of your administrator license.
- Provide a copy of your Certificate of Attendance with your renewal application.

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Housekeeping Items

- **No Smoking**
- **Sign-up for GovDelivery notifications at:**
  - Oklahoma.gov/health/qies **and click "Get Updates" at the top of the page.**

    Or
  - **Email:**

    OASIShelp@health.ok.gov

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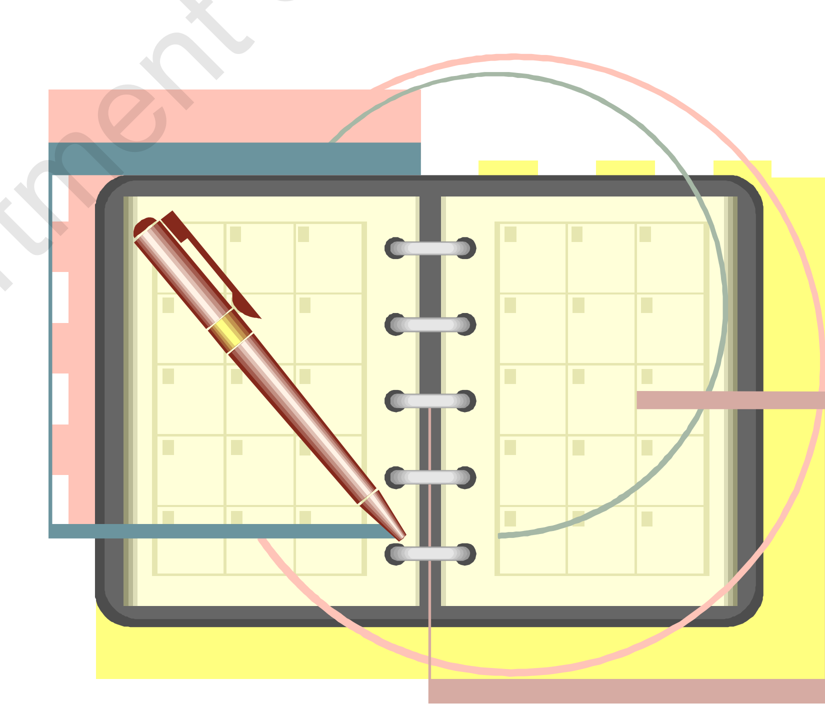
The Overview for Today

- Review Updates
- Top 5 OASIS Error Messages
- Overview & OASIS Conventions
- Review OASIS-E Clinical Guidance and review recent changes to the manual.
- Submit questions on index card, or email us at: OASIShelp@health.ok.gov, or call: **405.426.8160**



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Revisions to the State Operations Manual (SOM) Appendix B

- On April 12, CMS posted revisions to the SOM-Appendix B
- Surveyors will pull *"The HHA Error Summary by Agency Report*"
- Focus on -3330 "Record Submitted Late: The submission date is more than 30 days after M0090 (Date Assessment Completed) on this new record."
- If a HHA shows a pattern of multiple assessments with error -3330, surveyors are to investigate compliance with G372, Encoding and transmitting OASIS data (§484.45(a)).

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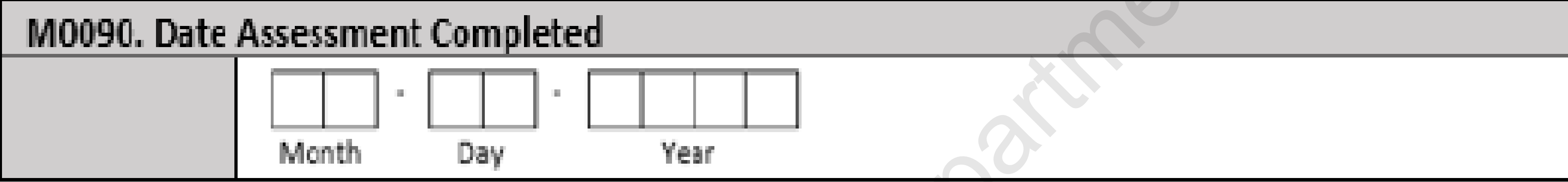
M0090 Date Assessment Completed


M0090. Date Assessment Completed

__ __ - __ __ - __ __ __ __
Month Day Year

- The last date information was collected by the assessing clinician and documentation of the specific responses was completed.

Important!

The OASIS assessment must be transmitted within 30 days of the M0090 date and prior to submission of the final claim, or you risk the claim being denied for payment.

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Home Health Review Choice Demonstration Certifying Provider Change

On Tuesday, May 14, Palmetto GBA notified home health agencies that effective May 20, agencies must submit a hand-off from any original certifying physician or nonphysician practitioner (NPP) to a subsequent physician or NPP.

Example: "Dr. A" signed the initial certification and "Dr. B" signed the recertification, there should be documentation signed by "Dr. A" that the patient was handed off to "Dr. B."

Documentation is required for each handoff if multiple handoffs occur between practitioners.

No designated format or specified form. Documentation can include, but is not limited to, progress notes, orders to change primary physician or NPP, or anything that shows the change(s) in certifying provider.

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Top 5 OASIS Error Messages

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OASIS Error Messages (Quarter 1, 88,343 total assessments)

1) Record Submitted Late
(Warning) (6,546 in Quarter 1)

The submission date is more than 30 days after M0090.

2) Patient Information Mismatch
(Warning) (2,788)

Submitted value(s) for the item(s) do not match the values in the database. Verify the new information is correct.

3) Inconsistent Record Sequence: (Warning) (2,159)

Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one.

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OASIS Error Messages (cont)

Duplicate Assessment (Fatal) (996)

The submitted record is a duplicate of a previously accepted record.

Record Timing Invalid (Warning) (553)

CMS timing guidelines require recertification follow-up records (M0100=4) at least every 60 days, but no earlier than day 56 of the follow-up cycle

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OASIS-E: General Overview

Diane Henry, RN

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OASIS-E Manual: Organizational Structure

- **Chapter 1**
  - Introduction to the OASIS Manual, including the manual's purpose, structure, and content, and description of the OASIS requirements and conventions.
  - The manual summarizes the statutory authority for OASIS data collection and provides background on the development of OASIS and its version history.
- **Chapter 2**
  - The importance of data accuracy, and how Home Health Agencies may audit OASIS data to minimize errors.
  - This chapter briefly describes OASIS data correction and implications for reporting.
- **Chapter 3**
  - Item-specific guidance, subdivided into sections.

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Physician's Order and Allowed Practitioners

- References to physicians have been amended in the HH Final Rule to include allowed practitioners.
  - Section 3708 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act amended section 1861(aa)(5) of the Act, allowing Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs) to certify eligibility and provide orders for home health services, where not prohibited by State law.

Refer to Oklahoma SB 388, which was made retroactive to March, 2020.

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OASIS Assessment

- Submission of OASIS is required to participate in the Medicare program.
- The assessment must accurately reflect that patient's status at the time of the assessment.
- OASIS data are collected for skilled Medicare and Medicaid patients, 18 years and older.
  - Exceptions: patients receiving services for pre- or postnatal conditions, only receiving personal care, homemaker or chore services.

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Who Completes OASIS?

- Registered Nurse
- Physical Therapist
- Speech-Language Pathologist
- Occupational Therapist
- LPNs, PTAs, OTAs, may not complete any OASIS assessment.

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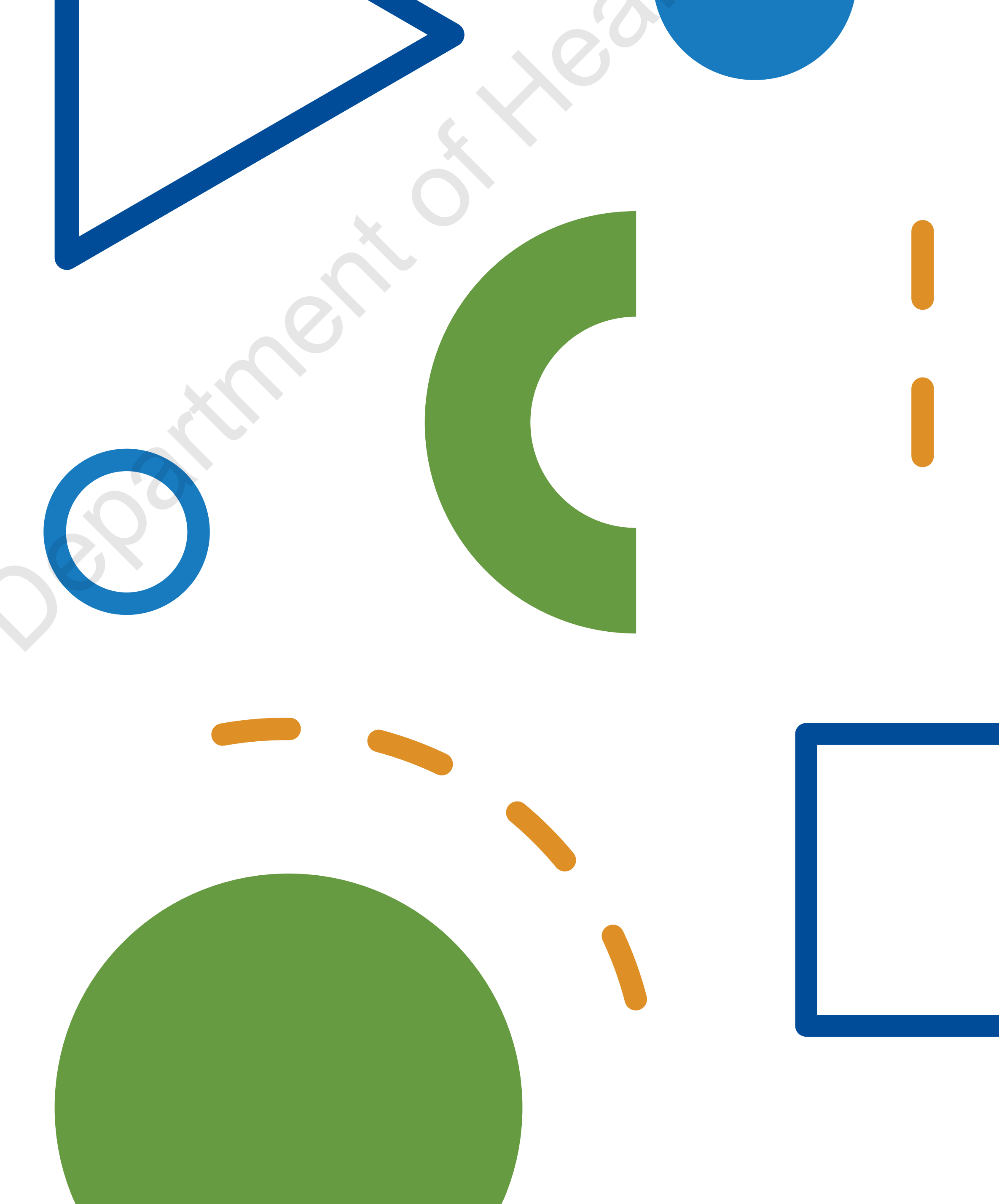
Establishing Home Health Benefit Eligibility

- Services which establish eligibility for the Medicare home health benefit include:
  - Skilled nursing
  - PT and
  - SLP



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Occupational Therapy and OASIS Completion

Added to the OASIS-E Manual in November 2023—**NOT new guidance**.

An OT may conduct and complete the initial assessment and SOC comprehensive assessment when the need for occupational therapy establishes program eligibility. While occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care, occupational therapy may establish eligibility under other programs, such as Medicaid.

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Completion of OASIS

If nursing services are initially ordered at SOC, a RN is responsible for completing the SOC assessment.

For Medicare therapy-only cases, PT, SLP, or OT may conduct the SOC assessment. (OT may complete SOC OASIS as long as PT or SLP services are also ordered to establish eligibility for the Medicare home health benefit).

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OASIS Assessment Timeframe

Time Point	Reason for Assessment (RFA, M0100)	Assessment Timeframe
Start of care (SOC)	1. Start of care – further visits planned	Within 5 calendar days after the SOC date (SOC = Day 0) **Refer to agency policy**
Resumption of care (ROC)	3. Resumption of care (after inpatient stay)	Within 2 calendar days of the facility discharge date or knowledge of patient's return home
Follow-up (FU)	4. Recertification (follow-up) assessment	The last 5 days of every 60 days i.e., days 56-60 of the current 60-day period
	5. Other follow-up	Within 2 calendar days of significant change of patient's condition
Transfer to an Inpatient Facility (TRN)	Transferred to an inpatient facility – patient not discharged from agency	Within 2 calendar days of disch/trans/death date or knowledge of a qualifying transfer to inpatient facility
	Transferred to an inpatient facility – patient discharged from agency	Within 2 calendar days of disch/trans/death date or knowledge of a qualifying transfer to inpatient facility
Discharge from Agency – not to an inpatient facility (DC)	Death at home (DAH)	Within 2 calendar days of disch/trans/death date
	Discharge from agency (DC)	Within 2 calendar days of disch/trans/death date.

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What Determines the SOC Date?

- **SOC date equals the date of the <u>first</u> billable service**
- **What is a billable service?**
  - Skilled Nursing Services
  - Skilled Therapy Services (all therapy)
  - Social Services
  - Home Health Aide
- <u>PT only case and RN conducts the assessment:</u>
  - RN may not begin or complete the SOC assessment <u>before</u> the SOC date!

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Reimbursable vs Qualifying Service

Qualifying Service:

Discipline "qualified" per CMS to complete the comprehensive assessment and establish eligibility.

For Medicare: RN, PT, SLP

OT if other therapy services are ordered

Reimbursable Services:

Skilled Nursing Services

- Observation & Assessment
- Teaching & Training
- Technical Service (injections, wound care)
- Management & Evaluation
- Psychiatric Nursing

Therapies: PT, SLP, OT

MSW and CHHA

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Content Review 1:

- If a patient is admitted to the hospital on day 58 and the agency has not completed the Recert, when the patient returns home what assessments would the agency be required to complete?

a) SOC
b) ROC
c) Recert
d) Both B and C

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Answer 1: Transfer Prior to Recert

When the patient returns home, if they have not been discharged from the home care agency, and the timeframe to complete the (ROC) overlaps with the timeframe to complete the Recertification then the ROC is all that is required to be completed. This satisfies both the ROC and the Recert requirements.

If the patient's facility stay extends beyond the end of the current certification period when the patient returns home complete a SOC OASIS if the M0090 date is on or after day 61. The agency would also need to perform an *internal discharge* from the previous episode **(no OASIS DC required).**

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Content Review 2: Transfer and Death at Home

- A patient was transported to the hospital and was placed in observation where they expired. Which assessment should be completed?
  - RFA 6—Transferred to an inpatient facility—patient not discharged from agency
- **OR**
  - The RFA 7 - Transferred to an inpatient facility - patient discharged from agency
- **OR**
  - RFA 8 – Death at home

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Answer 2: Transfer and Death at Home

- **Depending on awareness of transport**

- Complete RFA 6—Transferred to Inpatient facility—patient not discharged from agency **AND** RFA 8—Death at Home

- **Rationale:** If the clinician is aware of the transport to the hospital, the clinician would complete a *RFA 6: Transfer-Patient Not Discharged.* The agency should complete a *Death at Home* when a patient dies anywhere other than for a qualifying inpatient stay. A qualifying inpatient stay is defined as a patient being admitted to an inpatient facility for 24 hours or more for reasons other than diagnostic testing.

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Content Review 3:

Which OASIS would you complete if the patient expires during outpatient surgery or in the care of the recovery room after outpatient surgery?

a) Transfer-DC
b) Transfer—Not DC
c) Death in Facility
d) Both B and C

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Answer 3: Death at Home

- *An RFA 8 - Death at Home* is completed when the patient dies at home or anywhere else. This includes a patient who expires during outpatient surgery or in the care of the recovery room after outpatient surgery.
- If the patient had been admitted for a qualifying inpatient stay, the Transfer—patient discharged would have been completed and no further OASIS assessments would be required. Only your internal agency discharge paperwork would be completed.

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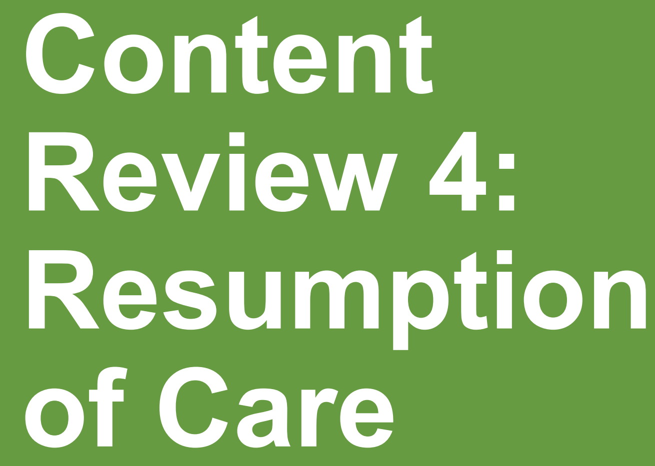

During a therapy-only episode, the patient had an accidental fall and was hospitalized. RFA 6- “Transferred to inpatient facility - patient not discharged from agency” was completed. Upon return from the hospital, the patient refused to have therapy continue and requested to be discharged from home health.

- What assessments should be completed?

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Answer 4: ROC & Discharge

- Did the agency make a visit when the patient returned home from the hospital?
  - If the patient refused further visits after returning home from the hospital the Transfer OASIS would be the last OASIS data collection required. You would not need to complete an OASIS Discharge, just your agency's internal agency discharge paperwork.

  - If the patient returned home from the hospital and you made one visit (the ROC visit) and *then* the patient refused further visits, you are not required to collect and submit the ROC OASIS data for one visit episodes (quality episodes). OASIS is not required when only one visit is made at the ROC. However, for billing purposes the OASIS WOULD be required.

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Content Review 5: Recert/ROC Prior to Last 5 Days of Cert Period

- Must both a recertification and a Resumption of Care (ROC) assessment be completed when a patient returns home and resumes home health services from an inpatient stay a day or two before the last 5 days of a certification period?

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Answer 5: Recert/ROC Prior to Last 5 Days

If the patient was discharged from the inpatient facility on day 53, the agency would be required to complete a ROC assessment no later than day 55, because the regulations require that the ROC assessment be done within 2 days of the discharge from the inpatient facility.

Additionally, a Recert would be required within days 56-60 to meet the Recertification requirements.

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Content Review 6: Recert/New Admit

Our patient's recertification was due August 12th. The nurse completed the recertification assessment on August 8th. Later that night, on August 8th, the patient fell, broke her leg and is now in the hospital on her recertification date. Do we submit the recertification assessment and continue with paperwork including the Transfer OASIS and new Plan of Care, or do we keep the Recertification paperwork and complete a Transfer OASIS, and pick back up after the discharge from the inpatient facility as a new referral?

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Answer 6: Recert/New Admit

A Recert (Follow-Up) must be conducted during the last 5 days of every certification period. In your scenario, the follow-up assessment was performed during the required timeframe, but then the patient's condition changed and required an inpatient facility stay during the recertification assessment timeframe. If your agency completed an RFA 7 - Transfer with Discharge, when the patient returns home, you would then complete a new Start of Care (SOC).

- You may also submit the Recertification assessment, although this is not necessary.

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Content Review 7: Recert/DC

A patient was recertified between days 56-60 and then in the new 60-day certification period, prior to any home health visits being made, the patient is admitted to the hospital for a qualifying inpatient stay. Should the agency complete the *RFA 6 - Transferred to an inpatient facility, patient not discharge from agency* and a *Resumption of Care* when the patient returns? Or should an *RFA 7 - Transferred to an inpatient facility, patient discharged from agency* be completed and a new Start of Care be completed?

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Answer 7: Recert/Discharge

If the Medicare PPS (PDGM) patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new 60-day certification period, the agency should complete a Transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency selects RFA 6 or RFA 7, depending on whether the agency anticipates the patient will be returning to service or not.

When an RFA 6 Transfer OASIS is submitted, the next expected submission would be a Resumption of Care (ROC) - RFA 3. If the patient did not resume services at your agency, then your internal agency discharge process would occur (with no OASIS collection).

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ROC Scenario

A patient is recertified on 04/22 for a new Cert period (episode of care). The patient is admitted to the hospital on 04/24 and discharged from the hospital on 04/26. The agency goes back out to see the patient on the 1st day of the new episode, 04/26. Would they complete a ROC or a SOC OASIS?

a) ROC
b) SOC

Rationale:

An agency should discharge a patient in all instances when an inpatient stay spans the end of a 60-day certification period. If the patient then returns to the agency, CMS requires that the agency complete a new Start of Care (SOC) assessment.

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APRIL 2024

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	Recert 22	23	Hosp 24	Day 60 25	DC from Hosp; 1st day of New Episode 26	27
28	29	30				

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OASIS-E: Conventions & Guidelines

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OASIS Convention #1: Time Period Under Consideration

- Report what is ***true on the day of the assessment***, unless a different time-period has been indicated.
- Understand the definitions:
  - The ***day of assessment*** is defined as the 24 hours immediately preceding the home visit and the time for the home visit.
  - ***Time period under consideration*** (***look-back period***)
    - For most items the look-back period is the Day of Assessment.
    - For other items it may be "in the last 14 days", or "at the time of or since the most recent SOC/ROC".

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Convention #3: When Ability or Status Varies

- When ability or status varies on the day of assessment, report what is true greater than 50% of the time, unless item specifies differently.

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Convention #5 Use of a Dash Response

- Some items allow a **dash response**. A dash (–) value indicates that no information is available.
- CMS expects dash use to be a rare occurrence.

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Convention # 8: Assistance

- When an OASIS item refers to assistance, this means assistance from another person. Assistance is not limited to physical contact only and may include necessary verbal cues and/or supervision.
- Convention specific to OASIS M1800 ADL/IADL Items:
  - The **level of ability** refers to the level of assistance (if any) that the patient requires to **safely** complete a specified task. Assistance includes verbal cues, reminders, supervision and/or stand-by or hands-on assistance.

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Section A: Administrative Information Patient Tracking

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M0030: Start of Care Date

- A reimbursable service must be delivered to be considered the start of care date. All other coverage criteria must be met for this initial service to be billable and to establish the start of care.
- In multidisciplinary cases, coverage criteria, regulatory requirements (such as the Conditions of Participation [COP]), and agency policy establish which discipline's visit is considered the start of care.
  - Example: It is feasible that Home Health Aide (HHA) visit could establish the start of care, but not necessarily best practice, and may not be agency policy.

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Content Review

If the RN is admitting and completing the Initial visit and SOC comprehensive assessment for a Medicare patient and there are orders for PT and home health aide (no nursing orders), can the home health aide establish the SOC by making a visit on the same day as the RN admits?

A. Yes, CHHA can establish SOC date

B. No, CHHA cannot establish the SOC date.

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Content Review #1:

If an agency sends an RN out on Sunday to provide a non-billable initial assessment visit for a PT only case and the PT establishes the Start of Care on Monday by providing a billable service, is the 60-day payment episode (485 “From” Date) Sunday or Monday?

A. Sunday

B. Monday

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Content Review #2

Who can perform the comprehensive assessment when PT is ordered at SOC and the RN will enter 7-10 days after SOC?

A. RN

B. PT

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M0063: Medicare Number

- Review the patient's Medicare card at SOC and Recert.
- Verify if payer source has changed, especially during the last quarter of the year.
- Do not enter the HMO identification number.
- Enter the Medicare number (if known) whether or not Medicare is the primary payment source for this episode of care.
- Dash is **not** a valid response for this item.

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A1005. Ethnicity

- If a patient is **unable to respond**, a proxy response may be used.
- If a patient **declines to respond**, **do not** code based on proxy response or medical record.
- **Do not dash**

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

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A1010. Race

- Ask the patient to select the category or categories that most closely correspond to the patient's race.
- Check all that applies.
- Do not rely on observation.
- Declines to respond **do not** code based on family/caregiver, or medical record.
- Do not dash.

A1010. Race
What is your race?

↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond
☐	Y. Patient declines to respond
☐	Z. None of the above

SOC

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Section A: Administrative Information

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A1110A: Preferred Language

A1110. Language

Enter Code	
☐	A. What is your preferred language?
	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
	B. Do you need or want an interpreter to communicate with a doctor or health care staff?
	0. No
	1. Yes
	9. Unable to determine

- Identifies if the patient needs an interpreter.
- American Sign Language (ASL), can be reported as the preferred language.
- A dash is an appropriate response for A1110A, but a dash <u>cannot be used</u> for A1110B.

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A1110: Reference for New Coding Tip

Question: A1110 - Language

Is it permissible to use a Spanish-speaking clinician as an interpreter?

Answer: A1110 - Language

Identifies the patient's self reported preferred language and need for an interpreter. This item does not report who the interpreter will be.

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A1250 Transportation

A1250. Transportation

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓	Check all that apply
☐	A. Yes, it has kept me from medical appointments or from getting my medications
☐	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	C. No
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

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A1250: Response Specific Instructions

- Ask the patient:

"In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"

"In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"

- Patient should be offered the option of selecting more than one "yes" designation, if applicable.
- If the patient is unable to respond, a proxy response may be used.

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A1250: Response Specific Instructions (cont.)

1. If the patient declines to respond, do not code based on proxy input or medical documentation.
2. Complete as close to the time of SOC/ROC as possible and within 2 days of discharge.
3. Check all that apply.

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A2120/A2121. Provision of Current Reconciled Medication List to Subsequent Provider at *Transfer & Discharge*

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code ☐	*0.* **No – Current reconciled medication list not provided to the subsequent provider** ➔ *Skip to J1800, Any Falls Since SOC/ROC* 1. **Yes – Current reconciled medication list provided to the subsequent provider** ➔ Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider 2. **NA** – The agency was not made aware of this transfer timely ➔ *Skip to J1800, Any Falls Since SOC/ROC*

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code ☐	*0.* **No – Current reconciled medication list not provided to the subsequent provider** ➔ *Skip to B1300, Health Literacy* 1. **Yes – Current reconciled medication list provided to the subsequent provider** ➔ Continue to A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

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A2120/A2121. Provision of Current Reconciled Medication List to Subsequent Provider at ***Transfer & Discharge***

Primary care providers, other outpatient providers, and residential treatment centers, are NOT considered to be a subsequent provider for purposes of coding these items.

Current Reconciled Medication list -refers to a list of the patient's current medications at the time of discharge that was reconciled by the agency prior to the patient's discharge.

Follow current standards of care and any applicable regulations and guidelines(e.g., Conditions of Participation) in determining what information should be included in a current reconciled medication list.

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Coding Tips A2120/A2121

- **At Transfer** - A subsequent provider is identified when the patient has transferred to any inpatient facility(M0100, RFA 6 or 7).
- **At Discharge** – A subsequent provider is identified when the patient has been discharged from your agency and remained in a non-inpatient setting receiving skilled services from another Medicare-certified home health agency (M2420 response 2) or hospice at home (M2420 response 3).

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A2122/A2124. Route of Current Reconciled Medication List Transmission to Subsequent Provider/Patient

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other M**	

A2124. Route of Current Reconciled Medication List Transmission to Patient
Indicate the route(s) of transmission of the current reconciled medication list to the patient, family, and/or caregiver.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

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Content Review: Reconciled Medication List

Question: A patient is not taking any prescribed or over the counter medications at the time of discharge. What should you do regarding providing a reconciled medication list?

- If the lack of any medications for a patient is clearly documented and communicated to the subsequent provider when the patient is discharged, code 1, Yes, that the medication list was transferred.
- If this information is not communicated to the subsequent provider, code 0, No.

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Practice Review

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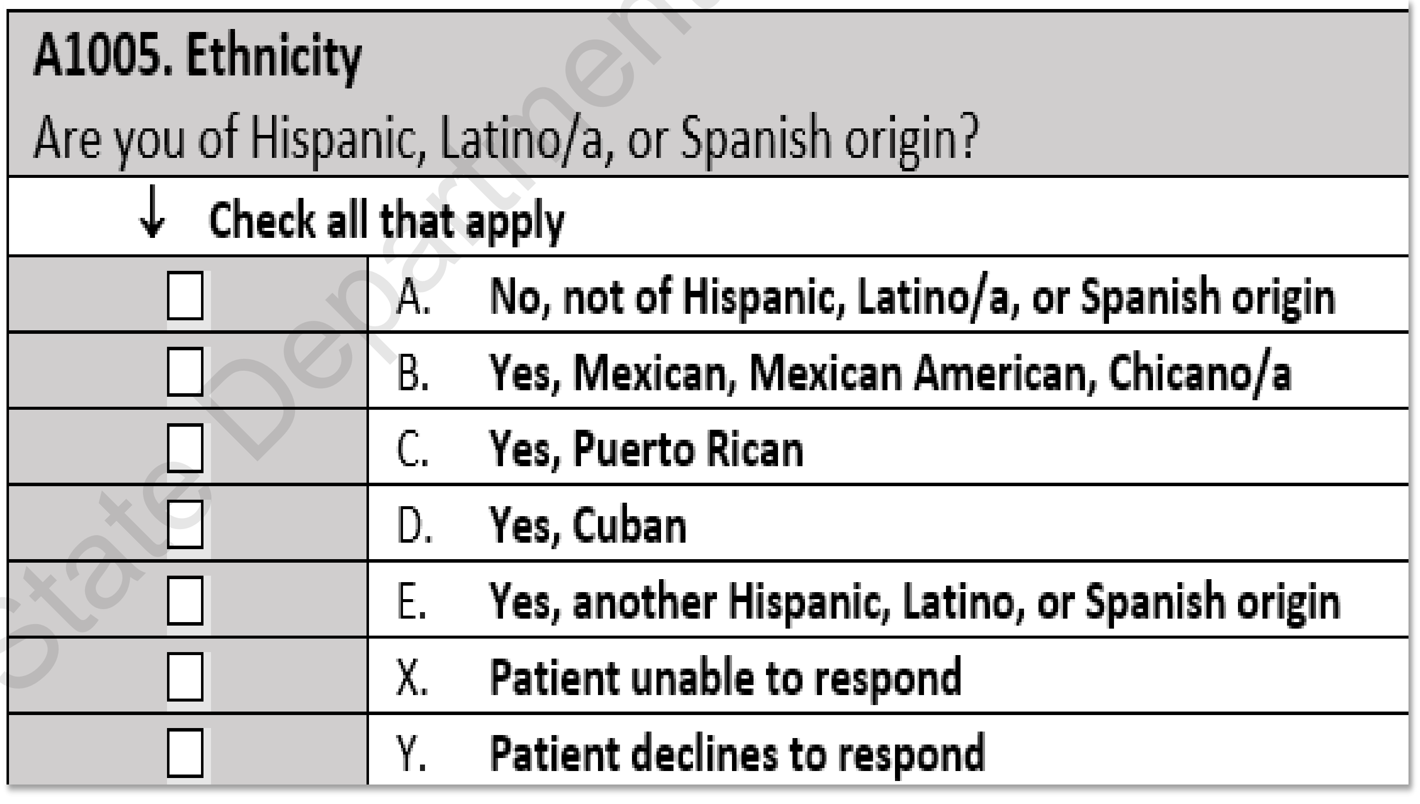
Question 2 A1005: Practice

At SOC, the patient was confused and unable to answer the question related to whether they are of Hispanic, Latino, or Spanish origin.

The patient's daughter stated that the patient was born in Brazil and has never considered themself of Hispanic, Latino, or Spanish origin.



A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

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Answer 2: How Would you Code A1005—Ethnicity?

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?		
↓ Check all that apply		
X	A.	No, not of Hispanic, Latino/a, or Spanish origin
☐	B.	Yes, Mexican, Mexican American, Chicano/a
☐	C.	Yes, Puerto Rican
☐	D.	Yes, Cuban
☐	E.	Yes, another Hispanic, Latino, or Spanish origin
X	X.	Patient unable to respond
☐	Y.	Patient declines to respond

Rationale: Guidance indicates to check all that apply; Code based on daughter's response, but also code X—Patient was not able to respond.

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Question 3: A1005: Ethnicity

During the SOC assessment, after several attempts, the patient declined to respond to the question of ethnic origin. The patient's spouse stated that they were Cuban.

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

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Answer 3: How would you code A1005. Ethnicity?

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?		
↓ **Check all that apply**		
☐	A.	**No, not of Hispanic, Latino/a, or Spanish origin**
☐	B.	**Yes, Mexican, Mexican American, Chicano/a**
☐	C.	**Yes, Puerto Rican**
☐	D.	**Yes, Cuban**
☐	E.	**Yes, another Hispanic, Latino, or Spanish origin**
☐	X.	**Patient unable to respond**
X	Y.	**Patient declines to respond**

Rationale: The patient declined to answer this question. Even though the spouse stated that the patient was Cuban, when the patient declines to respond, do not code based on a proxy input or medical record documentation.

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Section B: Hearing, Speech, and Vision

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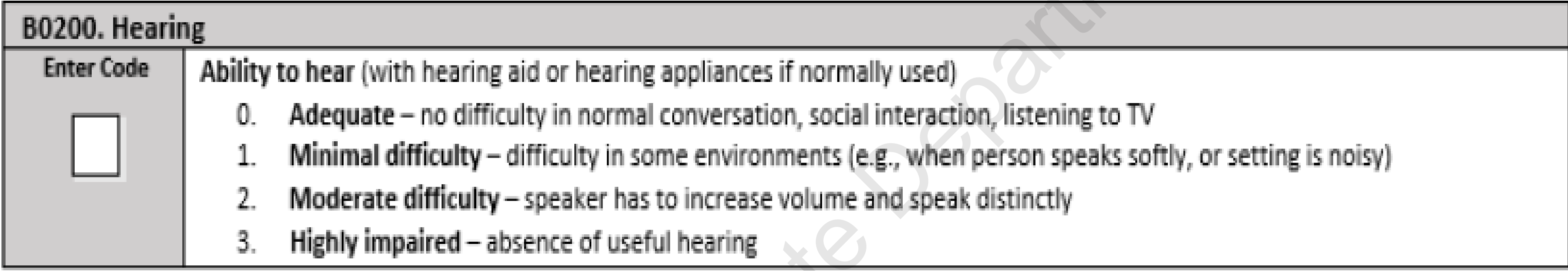
B0200 Hearing


B0200. Hearing

B0200. Hearing	
Enter Code	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly, or setting is noisy) 2. **Moderate difficulty** – speaker has to increase volume and speak distinctly 3. **Highly impaired** – absence of useful hearing

Hearing deficits can contribute to mood and behavior issues and can be mistaken for confusion or cognitive impairment.

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B0200: Coding Tips

- Patients who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods.
- The patient can be observed in their normal environment.
  - Do they respond (e.g., turn their head) when a noise is made at a normal level?
  - Does the patient seem to respond only to specific noise in a quiet environment?
- Assess whether the patient responds only to loud noise, or do they not respond at all.

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B1000: Vision

B1000. Vision	
Enter Code	**Ability to see in adequate light** (with glasses or other visual appliances)
	0. **Adequate** – sees fine detail, such as regular print in newspapers/books
	1. **Impaired** – sees large print, but not regular print in newspapers/books
	2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects
	3. **Highly impaired** – object identification in question, but eyes appear to follow objects
	4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

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B1300: Health Literacy

B1300. Health Literacy (from Creative Commons©)
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code	
	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Patient unable to respond 8. Patient declines to respond

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B1300: Rationale

- Similar to language barriers, low health literacy interferes with communication between provider and patient.
- Health literacy can also affect the ability for patients to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use.

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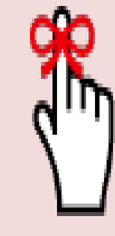
B1300: Coding Instructions



This item is intended to be a patient self-report item. No other source should be used to identify the response.

- Complete as close to the time of SOC/ROC as possible, and within 2 days of discharge.

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Section C: Cognitive Patterns

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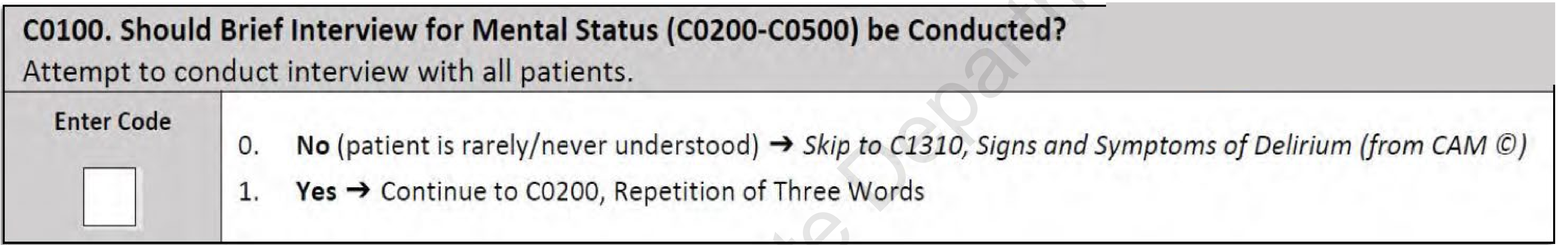
C0100 Should Brief Interview for Mental Status be Conducted?



C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt to conduct interview with all patients.	
Enter Code	0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM ©)* 1. **Yes** → Continue to C0200, Repetition of Three Words

***Attempt to conduct the interview on ALL patients.**

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C0200-C0500: Basic BIMS Instructions

- Interview any patient not screened out by item *C0100. Should Brief Interview for Mental Status be Conducted?*
- Conduct the interview in a private setting, if possible.
- Be sure the patient can hear you and see your face.
- Provide an introduction before starting the interview:

Suggested Language
"I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult."

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C0200-C0500: Basic BIMS Instructions Basic Instructions (cont.)

- If the patient expresses concern that you are testing their memory, reply: *"We ask these questions of everyone so we can make sure that our care will meet your needs."*
- Directly ask the patient each item in C0200 through C0400 in one sitting and in the order provided.
- If the patient chooses not to answer an item, accept their refusal and move on to the next question.

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C0200–C0500: Brief Interview for Mental Status (BIMS)

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The BIMS is composed of four sections:

- C0200. Repetition of Three Words.
- C0300. Temporal Orientation.
- C0400. Recall.
- C0500. BIMS Summary Score.

BIMS General Definitions

Nonsensical Response

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

Complete Interview

- The BIMS interview is considered complete if the patient attempted and provided relevant answers to at least four of the questions included in C0200–C0400C.
- Relevant answers do not have to be correct but do need to be related to the question.

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C0200: Repetition of Three Words: Item Rationale

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter Code ☐	Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed**. Now tell me the three words."* **Number of words repeated after first attempt** 0. **None** 1. **One** 2. **Two** 3. **Three** After the patient's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

- The inability to repeat three words on the first attempt may indicate:
  - A memory impairment.
  - A hearing impairment.
  - A language barrier.
  - Inattention that may be a sign of delirium or another health issue.

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C0200: Response-Specific Instructions

- **Say to the patient:**

"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed."

  - Assessing clinicians need to use the words exactly as provided.

- Immediately after presenting the three words, say to the patient:

"Now please tell me the three words."

If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.

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C0200: Response-Specific Instructions

- After the patient's first attempt to repeat the items:
  - If the patient correctly stated all three words, say:

> *"That's right. The words are sock, something to wear; blue, a color; and bed, a piece of furniture"* (stating the category cues).

  - Category cues serve as a hint that helps prompt patients' recall ability.
    - Putting words in context stimulates learning and fosters memory of the words that patients will be asked to recall in item C0400, even among patients able to repeat the words immediately.

Cue Card Pg 68

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C0200: Response-Specific Instructions (cont. 2)

- After the patient's first attempt to repeat the items:
  - If the patient recalled two or fewer words, code C0200 according to the **recall on the first attempt.**
- Next, say to the patient:

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

  - If the patient still does not recall all three words correctly, you may repeat the words and category cues one more time.
  - **Do not code the number of repeated words on the second or third attempt**.

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C0300: Temporal Orientation: Year, Month, Day

C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code ☐	Ask patient: *"Please tell me what year it is right now."* A. **Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
Enter Code ☐	Ask patient: *"What month are we in right now?"* B. **Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
Enter Code ☐	Ask patient: *"What day of the week is today?"* C. **Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**

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C0300: Response-Specific Instructions

In addition, use the Basic BIMS Interview Instructions, discussed earlier in this presentation and located in your guidance manual.

Ask the patient each of the 3 questions in item C0300 separately.

→

Allow the patient up to <u>30 seconds</u> for each answer and do not provide clues.

→

If the patient specifically asks for clues (e.g., *"Is this the day my daughter always visits?"*) respond by saying, *"I need to know if you can answer this question without my help."*

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C0300B. Able to Report Correct Month: Coding Instructions

- **Code 0, Missed by >1 month or no answer,** if the patient's answer is incorrect by more than 1 month or if the patient chooses not to answer the item, or if the answer is nonsensical.
- **Code 1, Missed by 6 days to 1 month,** if the patient's answer is accurate within 6 days to 1 month.
- **Code 2, Accurate within 5 days,** if the patient's answer is accurate within 5 days, counting the current date as Day 1.
- **Dash** is a valid response for this item.

Remember

Count the current day as Day 1 when determining whether the response was accurate within 5 days or missed by 6 days to 1 month.

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C0300B: Able to Report Correct Month

The date of interview is June 28, 2023. The clinician asks the question, “What month are we in right now?” Patient states that it is July.

How would you code C0300B?

a) Missed by > 1 month
b) Missed by 6 days to 1 month
c) Accurate within 5 days

Rationale: The resident correctly stated the month within 5 days, even though the correct month is June. June 28th (day 1) + 4 more days is July 2nd, so July is within 5 days of the interview.

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C0400: Recall

C0400. Recall	
Enter Code ☐	Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. **Able to recall "sock"** 0. No – could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code ☐	B. **Able to recall "blue"** 0. No – could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter Code ☐	C. **Able to recall "bed"** 0. No – could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required

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C0400: Response-Specific Instructions

- **Ask the patient the following:**

> *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*

- Allow up to **5 seconds** for spontaneous recall of each word.
- For any word that is not correctly recalled after 5 seconds, provide the category cue used in C0200. Repetition of Three Words.
  - Category cues should be used only after the patient is unable to recall one or more of the three words.
- Allow up to **5 seconds** after category cueing for each missed word to be recalled.

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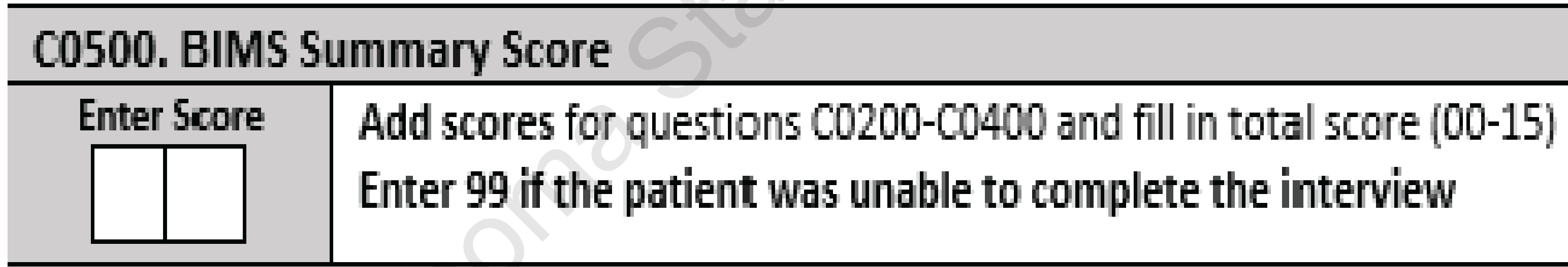
C0500: BIMS Summary Score and Rationale

The BIMS total score is highly correlated with Mini - Mental State Exam (MMSE) scores.

Scores from a carefully conducted BIMS assessment where patients can hear all questions and the patient is not delirious suggest the following distributions:

- 13–15: Cognitively intact.
- 8–12: Moderately impaired.
- 0–7: Severe impairment.



C0500. BIMS Summary Score	
Enter Score	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview

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C0500: Coding Instructions

- Enter the total score as a two-digit number on your assessment instrument. **The total possible BIMS score ranges from 00 to 15.**
  - Nonsensical responses, incorrect answers, and refusals are coded as zero **and the item(s) counts in the total score. A zero score does not mean the BIMS was incomplete.**
  - To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses **to four or more items**
  - To be considered a completed interview, the patient had to attempt and **provide relevant answers to at least four of the questions** included in C0200–C0400C.
- To be relevant, a response only has to be related to the question (logical); it **does not have to be correct.**

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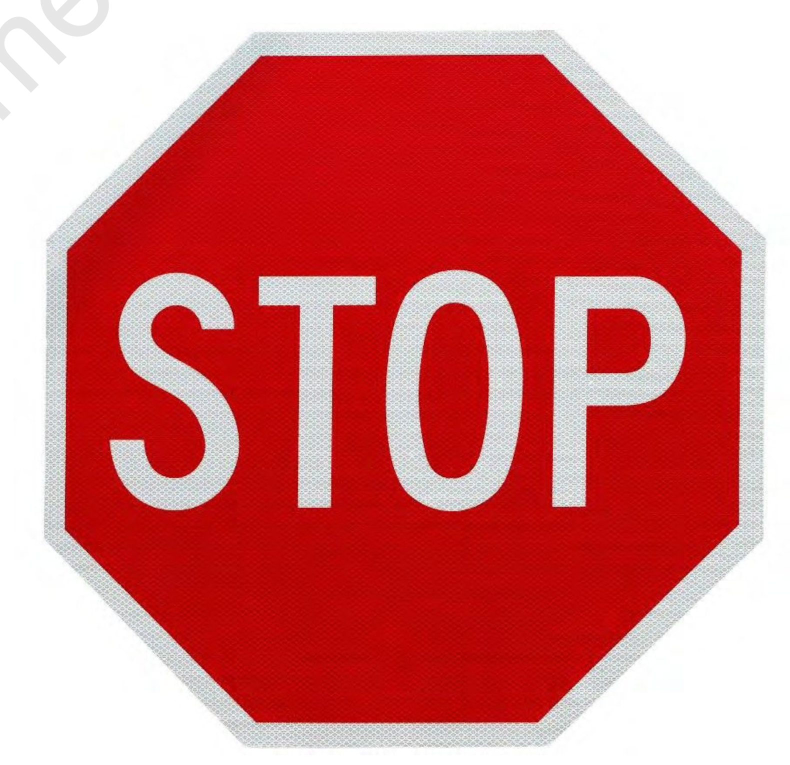
BIMS (C0200–C0500): Coding the Incomplete BIMS Interview

If the interview is stopped:

- Code "–" (dash) in C0400A, C0400B, and C0400C.
- Code "99" in C0500. BIMS Summary Score if unable to complete the interview.



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C0500: Coding Instructions (cont.)

Code 99. Unable to complete interview, if:

- The patient chooses not to participate in the BIMS.
- Four or more items were coded “0” because the patient chose not to answer or gave a nonsensical response.
- Any of the BIMS items is coded with a “–” (dash).

- **Note:** A zero score does not mean the BIMS was incomplete. To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.

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C1310: Signs and Symptoms of Delirium

CAM = Confusion Assessment Method

SOC/ROC

DISCHARGE FROM AGENCY

C1310. Signs and Symptoms of Delirium (from CAM©)	
Code after completing Brief Interview for Mental Status and reviewing medical record.	
A. Acute Onset of Mental Status Change	
Enter Code ☐	Is there evidence of an acute change in mental status from the patient's baseline? 0. No 1. Yes

Coding:	↓ Enter Codes in Boxes	
0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	☐	B. **Inattention** – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	☐	C. **Disorganized thinking** – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	☐	D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** – startled easily to any sound or touch ▪ **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** – very difficult to arouse and keep aroused for the interview ▪ **comatose** – could not be aroused

Intent: Identify any signs/symptoms of acute mental status changes as compared to the patient's baseline status **(Newly added): and if there are any sign/symptoms of delirium present at the time of the assessment.**

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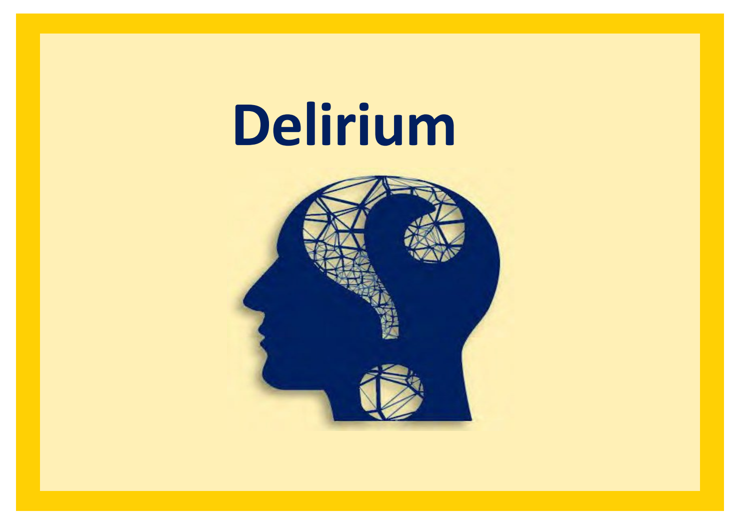
C1310: Definition of Delirium



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

Delirium is associated with:

- increased mortality,
- functional decline, withdrawal from activities,
- development or worsening of incontinence,
- behavior problems,
- rehospitalizations and increased length of home health stay.

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C1310: Signs/Symptoms of Delirium

- **C1310A-Acute Mental Status Change**
  - **Newly added Coding Tip:**
    - **At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period under consideration).**
- **C1310B-Inattention**
  - Patient may not be able to focus during the assessment and their gaze wanders.
  - Also can ask the patient to count backwards from 20.

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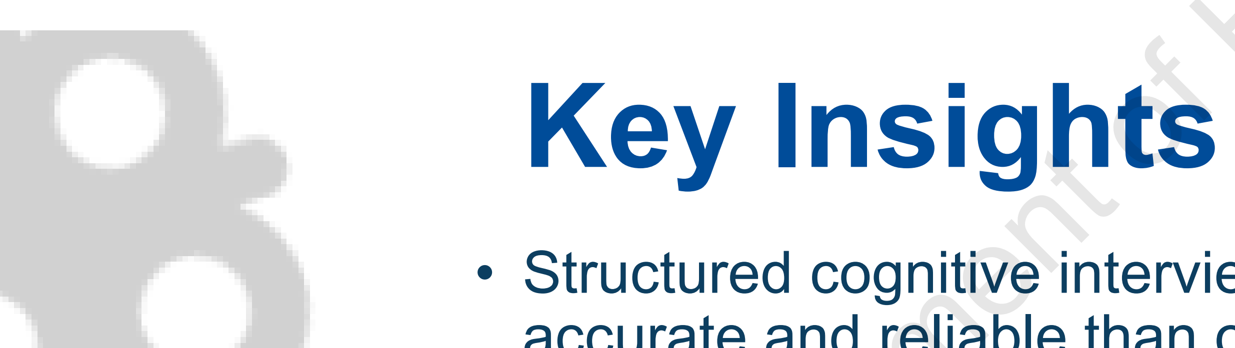

Key Insights

- Structured cognitive interviews are more accurate and reliable than observation alone for recognizing cognitive patterns.
- Structured interviews will efficiently provide insight into the patient's current condition that will enhance good care.
- Direct or performance - based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated early.

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Section D: Patient Mood Interview and Total Severity Score

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Section D

This section contains items related to the assessment and coding of mood distress.

Items include:

- D0150. Patient Mood Interview (PHQ-2 to 9).
- D0160. Total Severity Score.
- D0700. Social Isolation.

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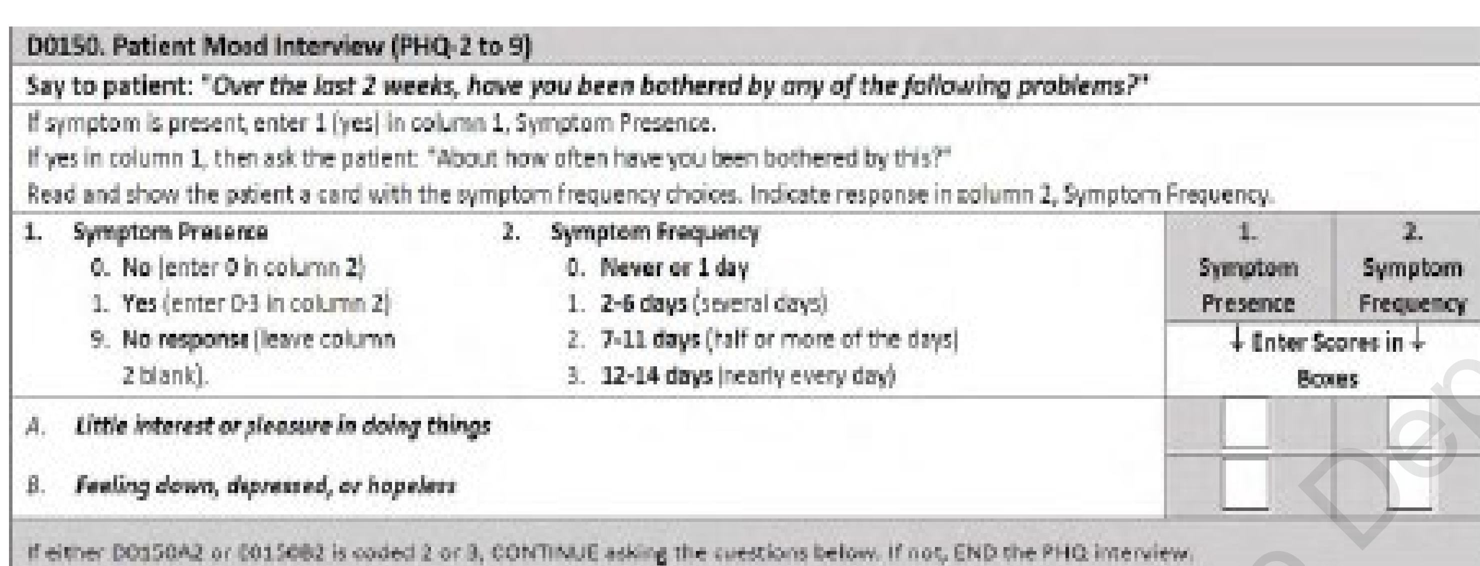
D0150: Patient Mood Interview (PHQ-2 to 9)



D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

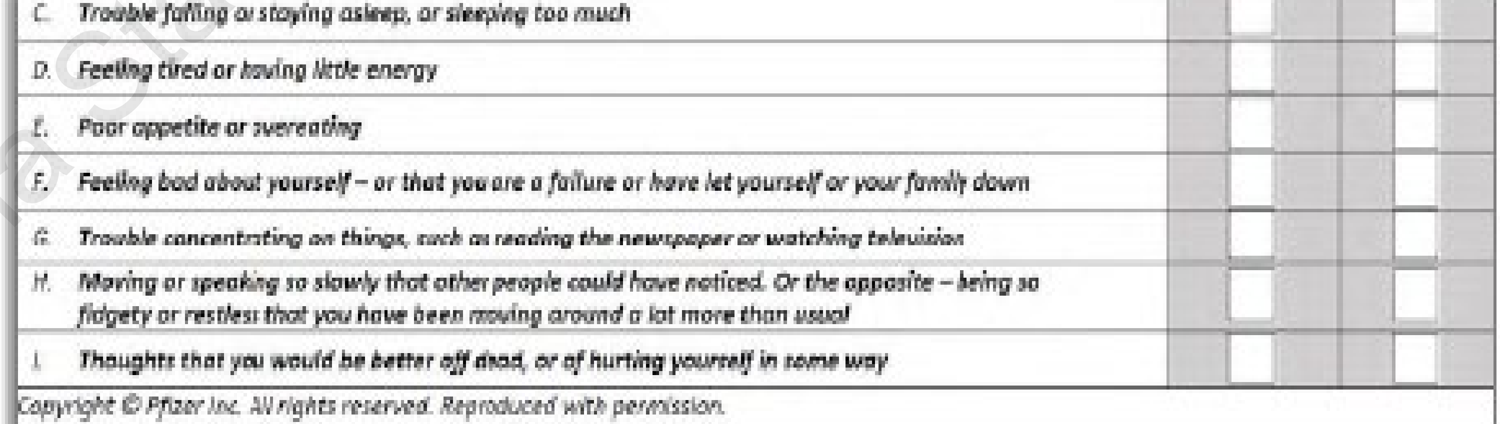
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**	2. **Symptom Frequency**	1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*			
B. *Feeling down, depressed, or hopeless*			

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

PHQ-2

PHQ-9
the remaining 7 questions



C.	*Trouble falling or staying asleep, or sleeping too much*		
D.	*Feeling tired or having little energy*		
E.	*Poor appetite or overeating*		
F.	*Feeling bad about yourself – or that you are a failure or have let yourself or your family down*		
G.	*Trouble concentrating on things, such as reading the newspaper or watching television*		
H.	*Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual*		
I.	*Thoughts that you would be better off dead, or of hurting yourself in some way*		

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D0150 Coding Guidance

- **Quarterly Q&A, April, 2023:**
  - Please clarify when the entire Patient Mood Interview should be completed for D0150 - Patient Mood Interview (PHQ-2 to 9). The instruction in the OASIS-E Guidance Manual appears to conflict with the language in the D0150 item.
- Answer: Related to the Patient Mood Interview, (Newly added to manual) **please disregard the statement in the OASIS item that states "If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview". This statement is outdated due to refinements in OASIS guidance.** Whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B). If both D0150A1 and D0150B1 are coded 9, OR, both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue. For all other scenarios proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160, Total Severity Score.

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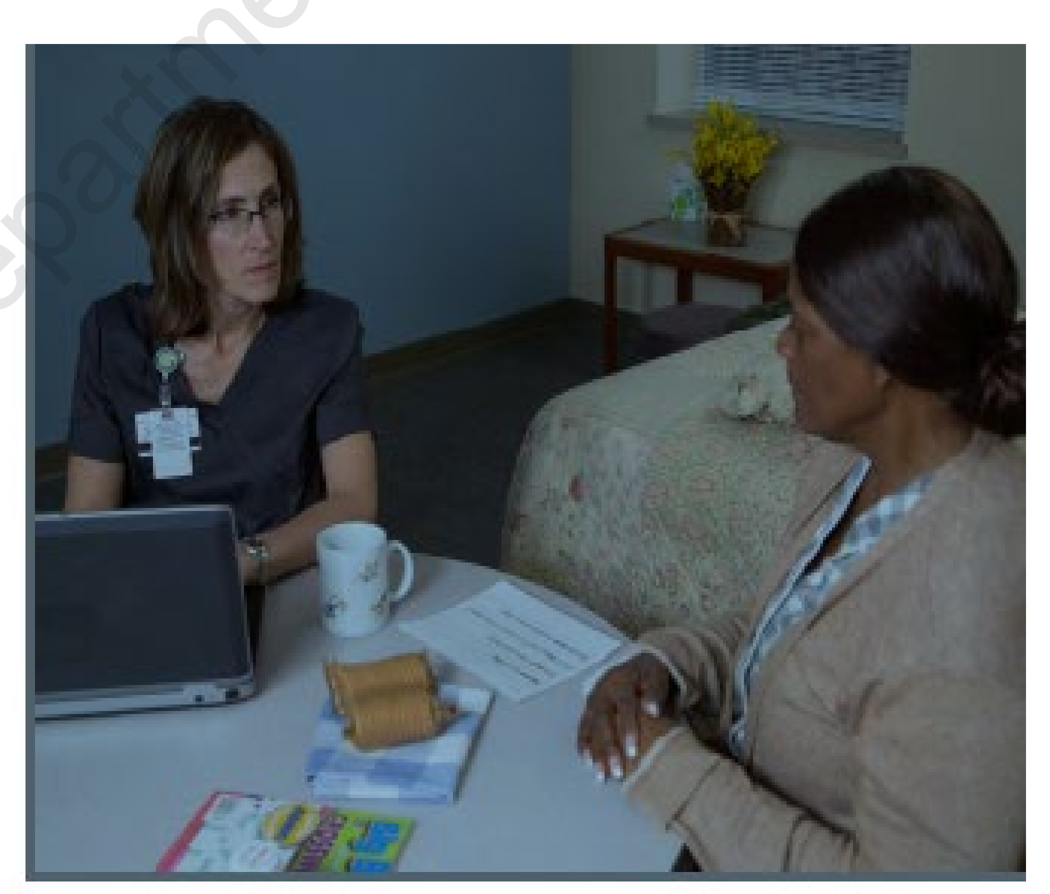
D0150: Response-Specific Instructions

Attempt to conduct the interview with ALL patients

- Explain the reason for the interview before beginning.

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



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D0150: Response-Specific Instructions

Ask the first two questions (D0150A and D0150B) of the Patient Mood Interview (PHQ-2 to 9).

"Over the last 2 weeks, have you been bothered by any of the following problems?"

Do not provide definitions; the meaning must be based on the patient's interpretation.

D0150. Patient Mood Interview (PHQ-2 to 9)		
Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.		
1. **Symptom Presence** 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank). 2. **Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
	↓ Enter Scores in ↓ Boxes	
A. *Little interest or pleasure in doing things*		
B. *Feeling down, depressed, or hopeless*		

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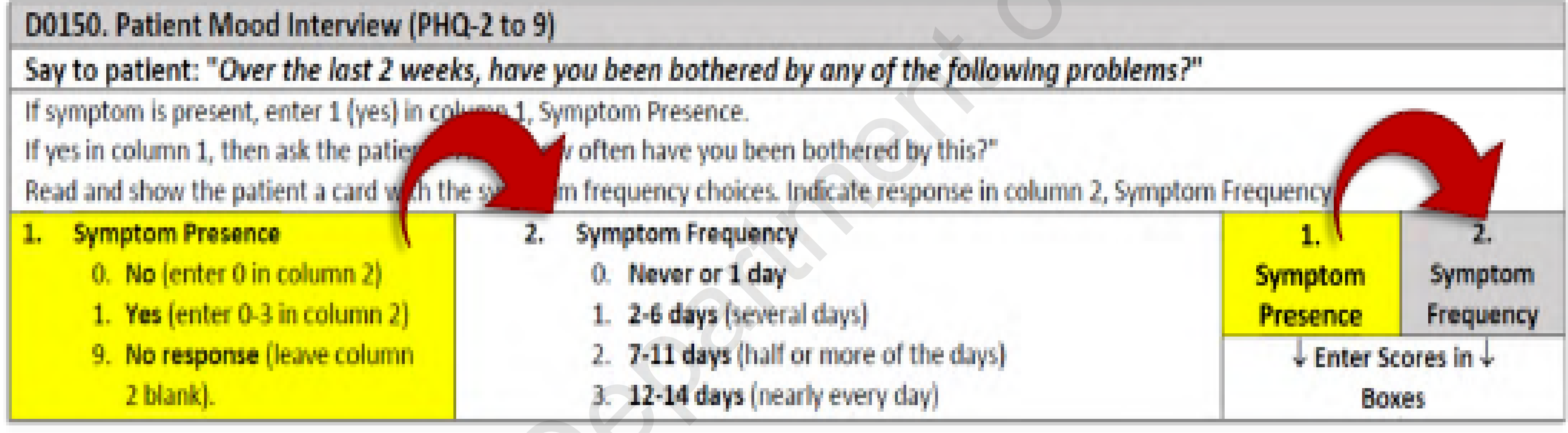
D0150: Symptom Presence & Frequency

- **Code 0, No,** if the patient indicates that the symptoms listed are not present.
  - Enter 0 in Column 2 as well.
- **Code 1, Yes,** if the patient indicates that the symptom listed is present.
  - Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, No response,** if the patient was unable or chose not to complete the interview, and/or responded nonsensically.
  - Leave Column 2, Symptom Frequency, blank.
- **Dash** is a valid response for Column 1 only.
  - Leave Column 2, Symptom Frequency, blank.



D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "How often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank).	0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	↓ Enter Scores in ↓ Boxes	

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D0150: Completing the Patient Interview

Determine whether to complete the PHQ-9 (ask the remaining seven questions: D0150C to D0150I).

- Whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B).

If **both** D0150A1 and D0150B1 are **coded 9**,

- Leave D0150A2 and D0150B2 **blank,**
- Then end the PHQ-2 and
- Skip D0160. Total Severity Score.

If **both** D0150A2 and D0150B2 are **coded 0 or 1,**

- Then end the PHQ-2 and
- Enter the sum from D0150A2 and D0150B2 in D0160. Total Severity Score.

– For all other scenarios:
  - Proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9.
  - Complete D0160. Total Severity Score.

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D0150: Completing the Interview Conducting the Interview

- For question D0150I. *Thoughts That You Would Be Better Off Dead, or of hurting yourself in some way:*
- Experienced interviewers have found that most patients who are having this feeling appreciate the opportunity to express it.
- Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the patient is already feeling.
- The best interviewing approach is to ask the question openly and without hesitation.

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D0160: Total Severity Score

- The score does not diagnose a mood disorder or depression but provides a standard score that the physician and other mental health specialists can utilize for follow-up.
- The **Total Severity Score** will be between **00** and **27** (or "**99**" if symptom frequency is blank for 3 or more items).
- If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. D0160, **Total Severity Score** should be coded as "99".
- Dash is **not** a valid response for this item.

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D0160:Total Severity Score Interpretation

- In addition, the PHQ-2 to 9 **Total Severity Score** can be used to track changes in severity over time.
- **Total Severity Score** can be interpreted as follows:

Score	Interpretation
0–4	Minimal depression.
5–9	Mild depression.
10–14	Moderate depression.
15–19	Moderately severe depression.
20–27	Severe depression.

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Section G
Functional Status

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Section G: Functional Status

Intent: Identify the patient's ability to safely perform personal care activities.

- Assess ABILITY not actual performance.
  - 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.

Note: Not all Section G items are included in the slides.

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

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

M1810. Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

Enter Code	
☐	0. Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1. Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2. Someone must help the patient put on upper body clothing. 3. Patient depends entirely upon another person to dress the upper body.

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

Enter Code	
☐	0. Able to obtain, put on, and remove clothing and shoes without assistance. 1. Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2. Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3. Patient depends entirely upon another person to dress lower body.

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Section G: Personal Care Activities

- **M1800—Grooming**; Consider the frequency of the items listed. If patient can perform frequently performed tasks (washing face and hands) versus less frequent tasks (cutting nails) then **code as having more ability in grooming**.

- **M1810—Ability to Dress Upper Body;** prosthetics, orthotics, or other support devices applied to the upper body (cervical collar, arm sling) are considered as upper boding dressing items/tasks.

- **M1820—Ability to Dress Lower Body;** same guidance as M1810.

- **M1810/M1820:** consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.

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M1830: Bathing

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

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M1830 Bathing Coding Tips

- **For Response 4**, the patient must be able to bathe outside the tub/shower safely and independently; including independently accessing water at the sink, or setting up a basin at the bedside, etc.
- **Response 5,** the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance.
- **Enter Response 6**, if the patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs or if patient has a functioning tub or shower.
- Dash is **not** a valid response.

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M1845 Toileting Hygiene

M1845. Toileting Hygiene Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.	
Enter Code ☐	0. **Able to manage toileting hygiene and clothing management without assistance.** 1. **Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.** 2. **Someone must help the patient to maintain toileting hygiene and/or adjust clothing.** 3. **Patient depends entirely upon another person to maintain toileting hygiene.**

- Identify what is included/excluded:
  - Pulling clothes up or down and adequately cleaning (wiping) the perineal area
  - Cleaning area around stoma, but not managing equipment
- Dash is **not** a valid response.

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Section GG: Self-Care and Functional Mobility Items

OKLAHOMA
State Department of Health

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GG0100: Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.		
Coding: 3. **Independent** – Patient completed all the activities by themself, with or without an assistive device, with no assistance from a helper. 2. **Needed Some Help** – Patient needed partial assistance from another person to complete any activities. 1. **Dependent** – A helper completed all the activities for the patient. 8. **Unknown** 9. **Not Applicable**	↓ Enter Codes in Boxes	
	☐	A. **Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.
	☐	B. **Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
	☐	C. **Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	☐	D. **Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take

GG0100 Prior Functioning

- **Stairs:** Going up and down, by any safe means.
- May include scooting up/down the stairs on buttocks.

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GG0110. Prior Device Use

GG0110. Prior Device Use

Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply	
☐	A. **Manual wheelchair**
☐	B. **Motorized wheelchair and/or scooter**
☐	C. **Mechanical lift**
☐	D. **Walker**
☐	E. **Orthotics/Prosthetics**
☐	Z. **None of the above**

Note, cane is not listed; Only consider those devices listed in GG0110.

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GG0110. Prior Device Use

- **Mechanical lift** includes any mechanical device or equipment a patient or caregiver requires for lifting or supporting the patient's bodyweight.
- Examples include, but are not limited to: Stair lift, Hoyer lift, bathtub lift, sit-to- stand lift, stand assist, electric recliner, and full-body style lifts, if required.

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GG0130 General Guidelines for Self-Care and GG0170 Mobility Items

Oklahoma State Department of Health

GG0130. Self-Care

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
		B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from mouth, and manage denture soaking and rinsing with use of equipment.
		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.
		E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
		G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does notinclude footwear.
		H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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GG0170. Mobility

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with no back support.
		D. **Sit to stand:** The abili side of the bed.
		E. **Chair/bed-to-chair tr**
		F. **Toilet transfer:** The a
		G. **Car transfer:** The abil include the ability to
		I. **Walk 10 feet:** Once st *If SOC/ROC performa*
		J. **Walk 50 feet with tw**
		K. **Walk 150 feet:** Once
		L. **Walking 10 feet on u** (indoor or outdoor), s
		M. **1 step (curb):** The abi *If SOC/ROC performa*
		N. **4 steps:** The ability to *If SOC/ROC performa*
		O. **12 steps:** The ability t

SOC/ROC GG0170. Mobility – Continued

1. SOC/ROC Performance	2. Discharge Goal		
		P. **Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.	
			Q. Does patient use wheelchair and/or scooter? 0. No → *Skip to M1600, Urinary Tract Infection* 1. Yes →Continue to GG0170R, Wheel 50 feet with two turns
		R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	
			RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
		S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.	
			SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

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GG0130/GG0170 Definitions

Time Period Under Consideration (look-back period)	Day of Assessment
• For most items, the look-back period is the Day of Asmt. For other items, it may be "in the last 14 days" or "at the time of or since the most recent SOC/ROC".	• The 24 hours that immediately precedes the assessment and the time spent by the clinician conducting the assessment.

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GG0130 and GG0170: SOC/ROC Performance

- At SOC/ROC, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity <u>prior to the benefit of services provided by agency staff.</u>
- <u>*Prior to the benefit of services*</u> means prior to provision of any care (e.g., instruction, therapy, etc.) by agency staff that would result in increase in independent coding.
- **Do NOT with-hold therapy or services.**

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GG0130 and GG0170: Instructions

- **Code 04, Supervision or touching assistance,** if the helper provides **verbal cues** and/or **touching/steadying** and/or **contact guard assistance** as patient completes activity.
- **Code 03, Partial/moderate assistance,** if the helper does **less than half** the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance,** if the helper does **more than half** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

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GG0130 and GG0170: Discharge Goal Coding

Choose a discharge goal for a minimum of **one** self-care **or** mobility activity.

- You may choose to complete more than one goal, or **all** discharge goals.

NOTE: Once a discharge goal is established, there is no need to update it.

- The discharge goal should be included in the Plan of Care.
- Dash fill any discharge goals not chosen.

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GG0130/GG0170 Coding Tips

Code 01, Dependent, if a patient requires the assistance of two helpers to complete an activity (one to provide support to the patient and a second to manage the necessary equipment to allow the activity to be completed).

Code 01, Dependent, if two helpers are required to complete an activity, even if the second helper was there for supervision/stand-by assist and did not provide hands on assistance.

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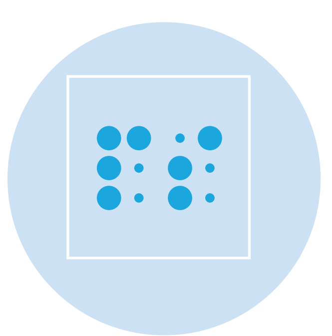
GG0130 and GG0170: Activity Not Attempted Codes



Code 07, Patient refused, if the patient refused to complete the activity and no other Performance or “activity not attempted” code is applicable.

Code 10, Not attempted due to environmental limitations, if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

Code 09, Not applicable, if the patient did not attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.

Code 88, Not attempted due to medical condition or safety concerns, if the activity was not completed due to medical condition or safety concerns, and the activity was completed prior to current illness, exacerbation, or injury.

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GG0130—Self Care Guidance

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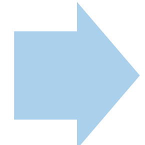
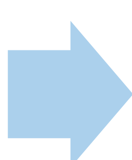
GG0130A. Eating: Coding Tips

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 placed before the patient.

If the patient requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding **and safe** swallowing.



If a patient swallows safely, exclude swallowing from consideration when coding GG0130A, Eating.



If the patient eats finger foods with their hands independently, code as 06, Independent.

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GG0130B. Oral Hygiene: Coding Tip

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

- If the patient does not perform oral hygiene during the home visit, determine the patient's ability based on the patient's performance of similar activities during the assessment, or on patient/caregiver report or collaboration with agency staff.
- For a patient who is edentulous, code oral hygiene based on the type and amount of assistance needed from a helper to clean the patient's gums, and care for dentures.

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GG0130C. Toilet Hygiene: Coding Tip

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.

Toileting hygiene includes performing perineal hygiene and managing clothing (e.g., undergarments, incontinence briefs, pants) before and after voiding or having a bowel movement.

– When the patient requires different levels of assistance to perform toileting hygiene after voiding vs. after a bowel movement, code based on the type and amount of assistance required to complete the **ENTIRE** activity.

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GG0130E. Shower/Bathe Self: Coding Tip

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

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area and feet, regardless of where the bathing takes place.
- Do not include the following:
  - Washing, rinsing, and drying the patient's back or hair.
  - Transferring in/out of a tub/shower, or onto or off of the tub bench.
- Assessment of GG0130E, Shower/bathe self can take place in any location, including a shower or bathtub, at a sink, or in bed (i.e., full-body sponge bath).

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GG0130F. Upper Body Dressing, GG0130G. Lower Body Dressing and GG0130H. Footwear

- When donning and doffing a supportive elastic bandage, compression stockings, or an orthosis or prosthesis, count these items as a piece of clothing when determining the amount of assistance the patient needs to complete the dressing activity.
- May also include: Thoracic-lumbar-sacrum-orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, and hand or arm prosthetic/orthotic.
- Coding of the dressing activities should consider all dressing items relative to the patient, regardless of the timing of when each item is put on/taken off.

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GG0170. Mobility Guidance

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GG0170A. Roll Left and Right: Coding Tips

- The activity includes the patient rolling to both the left and to the right while in a lying position on their preferred or necessary sleeping surface.
  - −If the patient does not sleep in a bed, assess the patient rolling to both the left and to the right while in a lying position, and returning to lying on the back on their preferred or necessary sleeping surface.

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GG0170B. Sit To Lying & GG0170C.Lying to Sitting:

Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

- The activity includes the ability to move from sitting on the side of the bed to lying flat on the bed, or on their preferred or necessary sleeping surface.

GG0170C

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

- The activity includes patient transitions from lying on their back to sitting on the side of the bed and sitting upright on the bed, or alternative sleeping surface, without back support. The patient does not have to have their feet flat on the floor.

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GG0170D. Sit To Stand: Coding Tips

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

- If a sit to stand lift is used and the patient requires the assistance of two helpers to get from a sitting to standing position, code as 01, Dependent.

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GG0170E. Chair/Bed-To-Chair Transfer: Coding Tips

Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

The activity reflects a transfer between (to and from) **any** two sitting surfaces. This could be a chair-to-chair transfer that does not include the bed.

Depending on the patient's abilities, the transfer may be a stand-pivot, squat-pivot, or a slide board transfer.

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GG0170G. Car Transfer: Coding Tips

Car Transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

The Car transfer does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seatbelt.

If the patient remains in a wheelchair and rolls into the van, the activity did not occur and the appropriate "activity not attempted" code would be used.

The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the Car transfer activity.

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General Coding Tips for Walking Items

- During a walking activity, a patient may take a brief **standing** rest break. If the patient **needs to sit** to rest during a GG walking activity, consider the patient **unable to complete** the walking activity.
- Clinicians may use clinical judgment to determine how the actual patient assessment of walking is conducted.
  - If a clinician chooses to combine the assessment of multiple walking activities, use clinical judgment to determine the type and amount of assistance needed for each individual activity.

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GG0170J. Walk 50 Feet With Two Turns

- The turns included in the item GG0170J. Walk 50 feet with two turns are:
  - 90-degree turns.
  - May occur at any time during the 50-foot walk.
  - May be in the same direction or
  - May be in different directions

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GG0170L. Walking 10 Feet On Uneven Surfaces

Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

- GG0170L. Walking 10 feet on uneven surfaces can be assessed inside or outside.
  - Examples of surfaces include:
    - Uneven or sloping surfaces.
    - Turf or gravel.
  - Use clinical judgment to determine whether a surface meets this intent.

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General Coding Tips: Step and Stair Items

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GG0170M, GG0170N, and GG0170O: Step and Stair General Guidelines

- Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs occurs sequentially, the patient may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps.
- When using a stair lift to ascend/descend stairs, code based on the type and amount of assistance the patient requires to ascend/descend the stairs, beginning once the patient is seated and ending when the patient is ready to transfer out of the seat.

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GG0170M. 1 Step (Curb): Coding Tips

1 step (curb): The ability to go up and down a curb and/or up and down one step.
If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.

- Assess the patient going up and down one step **or** up and down a curb.
- If both are assessed, and the patient's performance going up and down a curb is different than their performance going up and down one step (e.g., because the step has a railing), code based on the activity with which the patient requires the most assistance.

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GG0170O. 12 Steps: Coding Tips

12 steps: The ability to go up and down 12 steps with or without a rail.

- If a patient’s environment does not have 12 steps, clinical judgment may be used to determine if the combination of going up and down 4 stairs 3 times consecutively in a safe manner is an acceptable alternative to meet the intention of this activity.

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GG0170P. Picking Up Object: Coding Tips

Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

- Start assessment with patient in standing position.
- If the patient is not able to stand, the activity did not occur and the appropriate "activity not attempted" code would be used.
- May use adaptive equipment (reacher).
- If a **standing** patient is unable to pick up a small object from the floor, therefore requiring the helper to pick up the object, code 01, 02, or 03, depending on whether the helper is providing all the effort, more than half of the effort, or less than half of the effort.
  - Clinicians should use clinical judgment to apply guidance regarding patient's degree of participation in picking up an object.

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GG0170Q. Does Patient Use Wheelchair and/or Scooter?

Does patient use wheelchair and/or scooter?

0. No → skip to J1800 Any falls since SOC/ROC, whichever is more recent.

1. Yes → continue to GG0170R, Wheel 50 feet with two turns.

- This includes patients who:
  - Are learning how to self-mobilize using a wheelchair or scooter
  - Require assistance from a helper to mobilize using a wheelchair/ scooter and
  - Require a helper to push them in a wheelchair.

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Section H: Bladder and Bowel

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OKLAHOMA
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General Guidelines UTI/Urinary Incontinence

- M1600.Urinary Tract Infection (UTI) has a 14-day look-back period.
- For purposes of counting the 14-day period, the Start of Care date is day 0 and the day immediately prior to the Start of Care date is day 1.
  - For example, if the patient's SOC date is August 20, any treatment for a UTI occurring on or after August 6 would be considered.
- Completed at SOC, ROC, and Discharge

August 2024

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
28	29	30	31	1	2	3
4	5	6 Day 14	7	8	9	10
11	12	13	14	15	16	17
18	19 Day 1	20	21	22	23	24
25	26	27	28	29	30	31
1	2	Notes				

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M1600 UTI Coding Instructions

- **Code 0, No,** if patient has not been treated for a UTI within the past two weeks, including if the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago.
- **Code 1, Yes,** when:
  - The patient is on prophylactic treatment and develops a UTI.
  - The patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.
- **Code NA,** if the patient is on prophylactic treatment for the prevention of UTI.
- **Dash** is **not** a valid response for this item.

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M1610.Urinary Incontinence OR Urinary Catheter present.

- **Exclusions:** Do not code ileal conduit, urostomy, nephrostomy, etc. in this item; nor a catheter used for irrigation of the bladder or installation with an antibiotic.
- If the patient has a urinary catheter but it is leaking, this is not coded as incontinence.

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Section I:
Active Diagnoses

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M1021/M1023 Primary Diagnosis/Other Diagnosis

M1021. Primary Diagnosis

	V, W, X, Y codes NOT allowed
a. ______________________	a. [ ][ ][ ] [ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4

M1023. Other Diagnoses

	All ICD-10-CM codes allowed
b. ______________________	b. [ ][ ][ ] [ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4
c. ______________________	c. [ ][ ][ ] [ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4

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M1021/M1023 Primary Diagnosis and Other Diagnosis

- **M1021-Primary Diagnosis**
  - Enter the diagnosis that best identifies the reason for home health services. List diagnoses in order based on the seriousness of each condition. Reassess at each required OASIS.
- **Column 2, ICD-10 CM codes**
  - Enter control rating based on S/S, medications, frequency of readjustments, limits daily activities, controlled or poorly controlled by current treatments.
- Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y, or Z code.

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M1028: Active Diagnoses

M1028. Active Diagnoses – Comorbidities and Co-existing Conditions	
↓ Check all that apply	
☐	1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	2. Diabetes Mellitus (DM)
☐	3. None of the above

Step 1: Identify if there is a physician (or Non-physician practitioner if allowed by state) documented diagnosis of those listed in M1028.

Step 2: Determine if the diagnosis is active. Direct relationship to the patient's status and current plan of care. Reflect what was documented at the time of the assessment.

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Section J.
Health Conditions

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M1033. Risk for Hospitalization

M1033 identifies patient characteristics that may indicate the patient is at risk for hospitalization.

M1033. Risk for Hospitalization
Which of the following signs or symptoms characterize this patient as at risk for hospitalization?

↓ Check all that apply	
☐	1. History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
☐	2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months
☐	3. Multiple hospitalizations (2 or more) in the past 6 months
☐	4. Multiple emergency department visits (2 or more) in the past 6 months
☐	5. Decline in mental, emotional, or behavioral status in the past 3 months
☐	6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
☐	7. Currently taking 5 or more medications
☐	8. Currently reports exhaustion
☐	9. Other risk(s) not listed in 1-8
☐	10. None of the above

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M1033. Risk of Hospitalization: Response-Specific Instructions

- **Response-specific instructions:**
  - **History of Falls**: witnessed and reported
  - **Multiple hospitalizations** (Response 3) 2 or more in past 6 months. Hospitalized for 24 hours or longer to an inpatient acute bed for reasons other than diagnostic testing.
  - **Decline** (Response 5), a decline is considered significant changes in the past 3 months in which the patient, family, caregiver, or physician has noted a decline, regardless of cause. A decline can be temporary or permanent. Physician consultation may or may not have occurred.

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Section J: Health Conditions – Pain Interview

- The **pain interview** includes the following:
  - J0510. Pain Effect on Sleep.
  - J0520. Pain Interference with Therapy Activities.
  - J0530. Pain Interference with Day-to-Day Activities.

- The pain interview items have a **5-day look-back period.** Be aware that day of assessment for these items is considered day 0. Day of assessment plus previous 5 days.

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J0510–J0530: Definition

Definition of pain:

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

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J0510–J0530: Response-Specific Instructions

- Give an introduction before starting the interview. Suggested language:

"I'd like to ask you some questions about pain. The reason I am asking these questions is to understand how pain affects your sleep and activities. This will help us to develop the best plan of care to help manage your pain."

- Directly ask the patient each item in J0510 through J0530 in the order provided.

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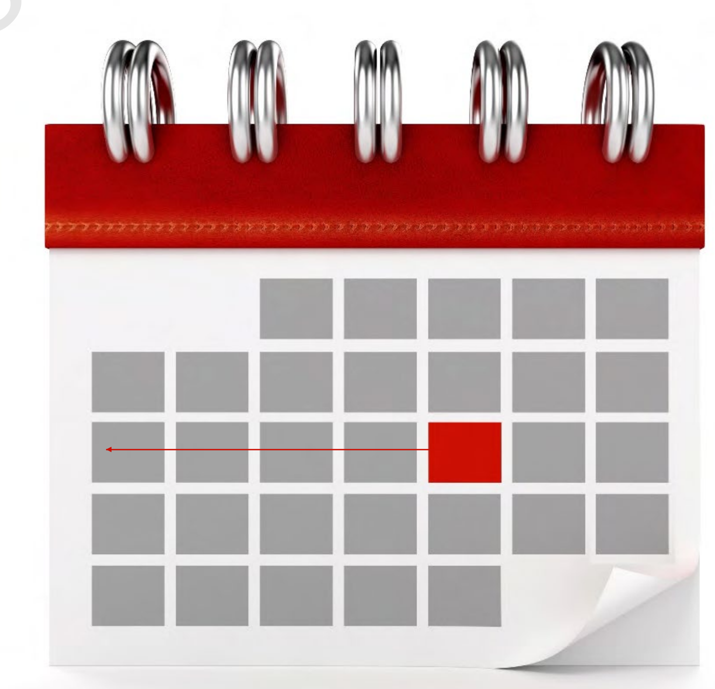
J0510–J0530: Response-Specific Instructions (cont.)

- Use other terms for pain or follow-up discussion if the patient seems unsure or hesitant.
  - Some patients avoid use of the term “pain” but may report that they “hurt.”
  - Patients may use other terms such as “aching” or “burning” to describe pain.

- Did the pain effect or interference occur in the 5-day look-back period?



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J0510: Response-Specific Instructions

- Read the question and response choices as written.
- No pre-determined definitions are offered to the patient.
- If the patient's response does not lead to a clear answer, repeat the patient's response and then try to narrow the focus of the response.

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J0510: Response-Specific Instructions – Example

The assessing clinician asks the patient, *“Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?”*

The patient responds by saying, “*I always have trouble sleeping.*”

Then the assessing clinician might reply, “*You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?”*

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J0510: Pain Effect on Sleep Coding Tips!

Code 0, Does not apply

The patient reports no pain/ hurting in the past 5 days.

Code 1, Rarely or not at all

The patient reports that pain/ hurting **HAS** been present in the past 5 days but has rarely or not at all impacted sleep.

If the patient reports they had pain in the past 5 days and the pain does not interfere with the patient's sleep (e.g., because the patient is using pain management strategies successfully), **code 1, Rarely or not at all**.

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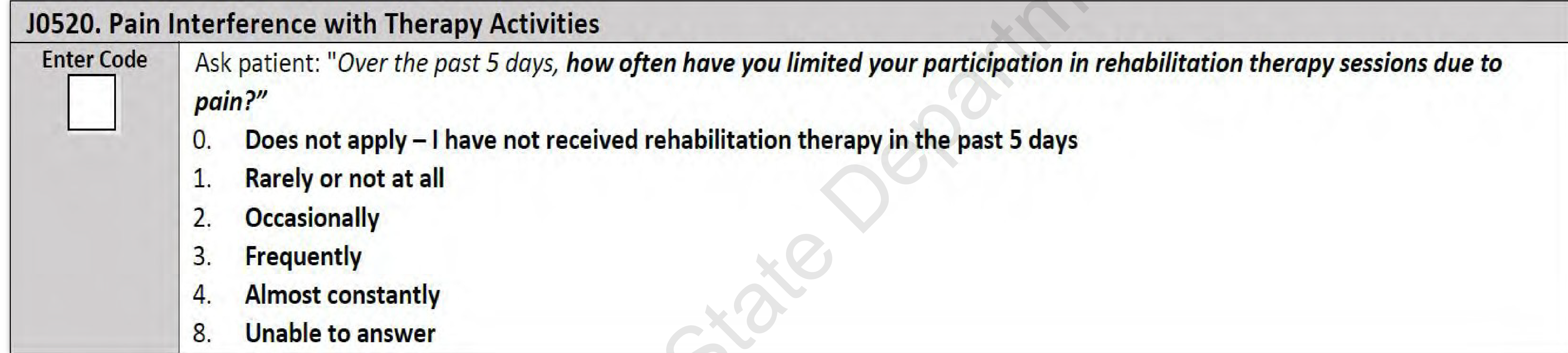
J0520. Pain Interference with Therapy Activities



J0520. Pain Interference with Therapy Activities	
Enter Code	Ask patient: "*Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***
	0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
	1. **Rarely or not at all**
	2. **Occasionally**
	3. **Frequently**
	4. **Almost constantly**
	8. **Unable to answer**

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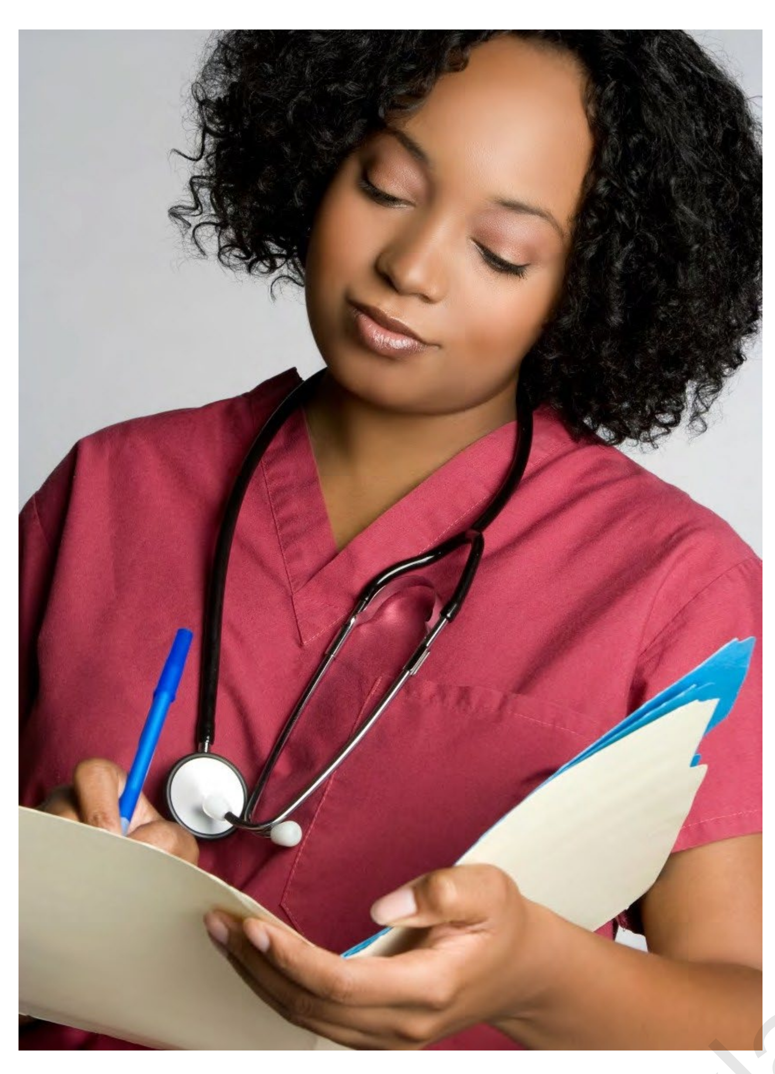
J0520: Pain Interference with Therapy Activities



- May include physical therapy, occupational therapy, speech therapy, or cardiac and pulmonary therapies.

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

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Practice Review

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J0510: Practice Scenario

A patient is being discharged from home health services after recovering from a major automobile accident. The nurse is completing the discharge assessment.

At discharge, the nurse asks, *"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"*

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J0510: Practice Scenario (cont.)

The patient responds: *"Some nights I do not sleep at all because of the pain, especially when I have done too much during the day. On those nights, I pace a bit, sit up in the chair, and I might need to take an extra pain pill (as-needed medication) during the night before I can get back to sleep. Other nights, I just sleep through the night, no problem."*

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How would you respond to the patient's statement regarding pain effect on sleep?

A. Ask the patient's spouse to verify the patient's description of their pain.

B. Code 3, Frequently, since it sounds like the patient was awake a lot due to pain.

C. Repeat the patient's response and then try to narrow the focus of the response.

D. Code 8, Unable to answer, as the patient did not give a clear answer.

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J0510: Practice Scenario 2 – Rationale

- **Answer:** The answer is C, **Repeat the patient’s response and then try to narrow the focus of the response.**
- **Rationale:** Since the patient’s initial response did not lead to a clear answer, the assessing clinician should repeat the patient’s response and then try to narrow the focus of the response by asking additional follow-up questions about the frequency.

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J1800. Any Falls Since SOC/ROC

- Item rationale for falls added.
  - Falls are a leading cause of morbidity and mortality.
  - Fear of falling can limit an individual's activity and negatively impact quality of life.
  - This element is completed at Transfer, Death at Home, Discharge from Agency.

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code [ ]	Has the patient **had any falls since SOC/ROC,** whichever is more recent? 0. **No** → *Skip to M1400, Short of Breath at DC; Skip to M2005, Medication Intervention at TRN and DAH* 1. **Yes** →Continue to J1900, Number of Falls Since SOC/ROC

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J1800. Any Falls Since SOC/ROC (cont.)

Coding Tips

- Report falls that occur at any time during the quality episode, regardless of where the fall occurred.

  For example,

  - Falls that occur at the doctor's office during the home health quality episode **would** be reported.
  - A fall that occurred during a qualifying inpatient facility transfer (e.g., hospital or skilled nursing facility) **would not** be reported, as it did not occur within a HH quality episode.

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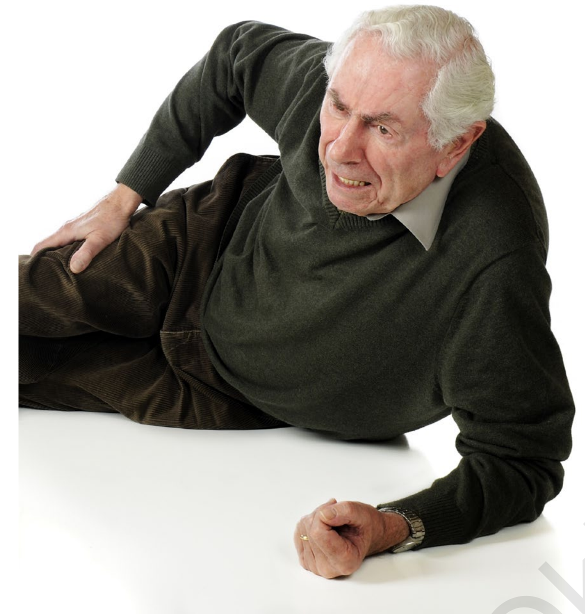
J1900: Number of Falls Since SOC/ROC

J1900. Number of Falls Since SOC/ROC, whichever is more recent		
Coding: 0. None 1. One 2. Two or more	↓Enter Codes in Boxes	
	☐	A. **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	B. **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	C. **Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Completed at Transfer, Death at Home, Discharge from Agency



DEFINITION

INJURY RELATED TO A FALL

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

NO INJURY

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

INJURY (EXCEPT MAJOR)

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

MAJOR INJURY

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

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J1900 Falls with Injury

- Correct errors as accurate information regarding fall-related injuries becomes known.
- For example:
  - Injuries can present themselves later than the time of the fall.
  - Errors should be corrected following the agency's correction policy. The M0090 date would not necessarily be changed.

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J1800: Any Falls Since SOC/ROC

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

How would you code J1800?

Coding: J1800 would be coded 1, Yes.

Rationale: The patient unexpectedly stumbled, which was not anticipated by the therapist, and the therapist intervened to prevent a fall. An intercepted fall is considered a fall if it is not an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training.

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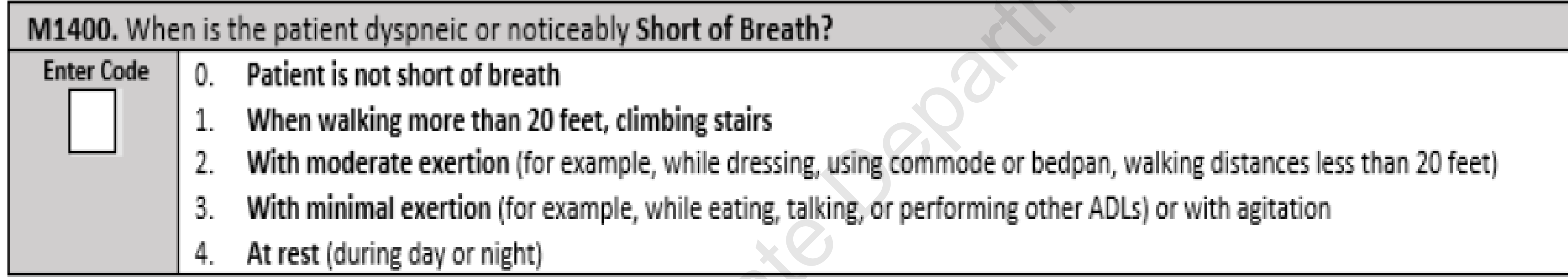
M1400: When Is the Patient Dyspneic or Noticeably Short of Breath?



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

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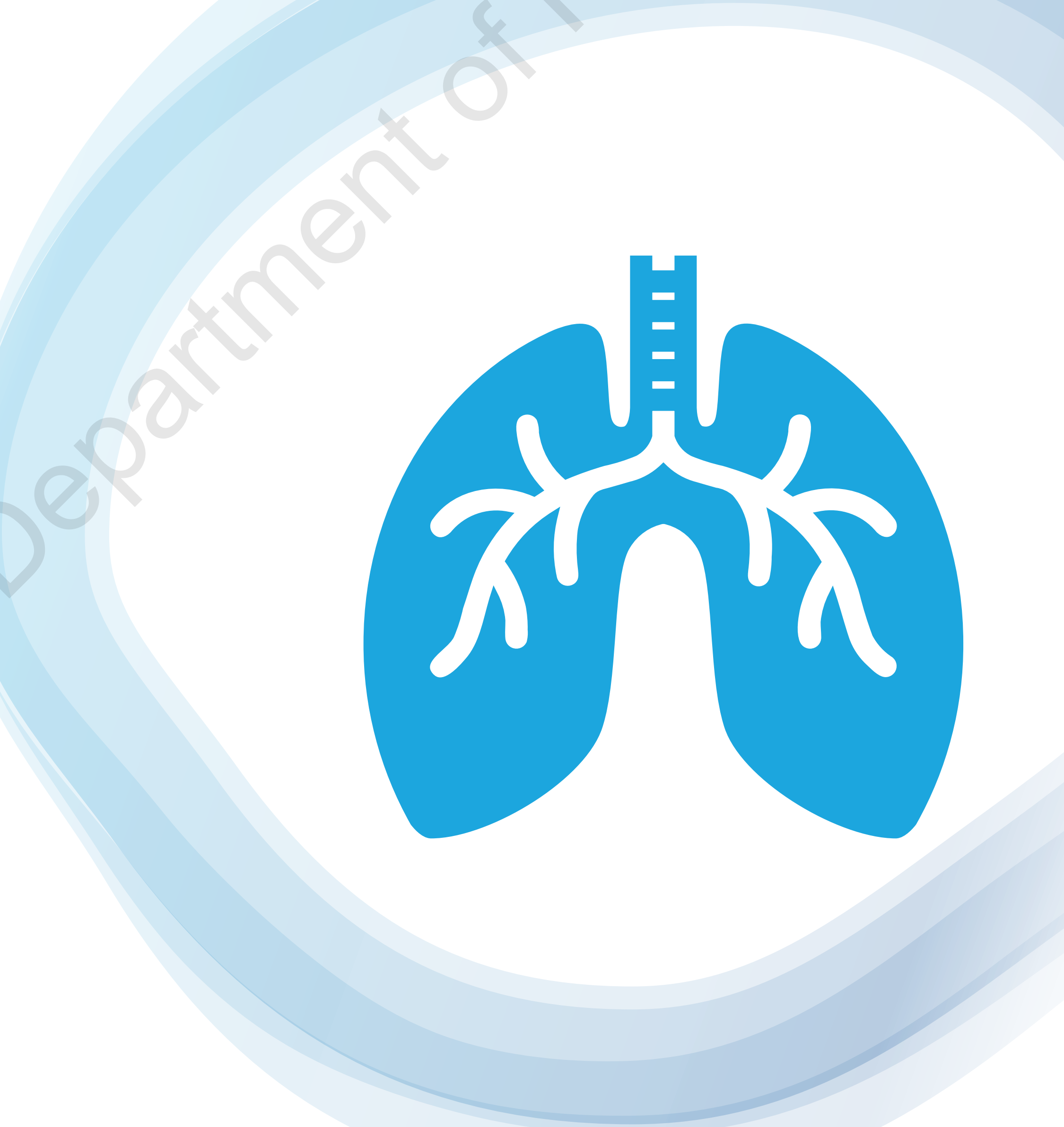
M1400: When Is the Patient Dyspneic or Noticeably Short of Breath?

- **Continuous oxygen use:** (with only brief interruptions), code the response based on the patient's shortness of breath while using oxygen.
- **Intermittent oxygen use**: code based on the patient's shortness of breath ***without*** the use of oxygen. Based on actual use, not the physician's order.
- For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath.



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Section K: Swallowing and Nutritional Status

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Section K: Swallowing/Nutritional Status

- This section includes three items:
  - Height and Weight
  - Nutritional approaches
  - Assessment of patient's ability to eat, chew and swallow food

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M1060 Height and Weight

M1060. Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up.	
inches	A. **Height** (in inches). Record most recent height measure since the most recent SOC/ROC
pounds	B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

General Coding tips:

- Only enter height and weight measurements that have been directly measured by agency staff.
- Do not enter height or weight that is self-reported or from documentation from another provider setting.
- If weighed multiple times in the assessment period, only use the first weight at SOC/ROC.

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M1060 Height and Weight

Coding Tips:

- Bilateral lower extremity amputation, report height *after* bilateral amputation.
- If unsuccessful attempts to measure height/weight at ROC, a *documented agency obtained height/weight* within the previous 30-day may be used.

- **Dash** is a valid response to this item if:
  - The patient falls outside the following height and/or weight parameters
    - ➢Height parameters <50 inches or >80 inches
    - ➢Weight parameters <65 lbs. or > 440lbs

  OR

  - If height/weight cannot be measured and no agency documented height/weight in last 30 days.

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K0520 Nutritional Approaches

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

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

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K0520 Nutritional Approaches

Newly added coding tip SOC/ROC (Jan.2024):

- **Check all of the nutritional approaches that are part of the current care/treatment plan at the time of the SOC/ROC assessment, even if <u>not</u> used at the time of assessment. If none apply, check K0520Z, None of the above.**

Revised coding tip at Discharge (two look-back periods):

Check all nutritional approaches that were part of the current care/treatment plan **in the last 7 days, even if not used in the last 7 days (Column 4) <u>and</u> at the time of the discharge assessment, even if not used at the time of discharge, and whether or not it is expected to be used after discharge** (Column 5). If none apply, check K0520Z, None of the above.

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K0520A. Parenteral/IV Feeding: Coding Tips

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

- IV medications. *(Code these when appropriate in O0110H. IV Medications.)*
- IV fluids used to reconstitute and/or dilute medications for IV administration.
- IV fluids for an operative or diagnostic procedure or recovery room stay.
- IV fluids administered to flush the IV line.
- Parenteral/IV fluids in conjunction with chemotherapy or dialysis.

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K0520B-Feeding Tube

- If a feeding tube is in place but there are no scheduled or prn orders to provide nutrition and/or hydration via the feeding tube on the current care/treatment plan, do not code K0520B Feeding Tube.

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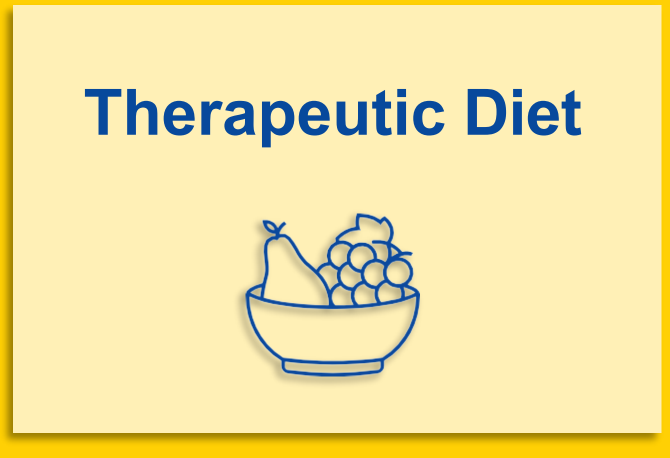
K0520: Definitions



- A therapeutic diet is a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral, and/or parenteral routes as part of treatment of disease or clinical conditions to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet. (Academy of Nutrition and Dietetics, 2019).
- A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

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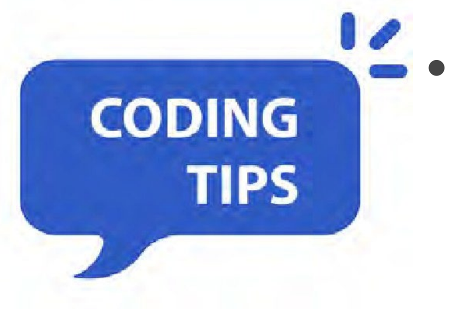
K0520D. Therapeutic Diet – Coding Tips



- Code enteral feeding formulas as a therapeutic diet **only** when used to manage problematic health conditions (e.g., enteral formulas specific to diabetes).
- Do **not** code enteral feeding formulas as a mechanically altered diet.
- Nutritional supplements (e.g., Ensure) are only coded as therapeutic diet when taken to manage a health condition (protein-calorie malnutrition).
- Food elimination diets related to food allergies may be coded.

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K0520: Practice Scenario

- The patient was discharged home following a stroke that resulted in the placement of a feeding tube. Since SOC, they have been receiving tube feedings daily in addition to speech therapy to improve swallowing and progress to oral intake.
- The patient also has a Peripherally Inserted Central Catheter (PICC) line in place with orders for it to be flushed, along with some intravenous (IV) medications. There is no documentation indicating the need for additional fluid intake to support nutrition/hydration.

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How would you code K0520 column 1 for this patient on the SOC assessment?

A. Check both K0520A. Parenteral/IV feeding and K0520B. Feeding tube.

B. Check K0520A. Parenteral/IV feeding, K0520B. Feeding tube, and K0520C. Mechanically altered diet.

C. Check K0520B. Feeding tube.

D. Check K0520Z. None of the above.

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K0520: Practice Scenario Rationale – SOC

- **Coding on SOC: Check C-K0520B. Feeding tube.**
- **Rationale:** At the time of the SOC assessment, the feeding tube was present, and the patient was receiving tube feedings.
  - The patient does have a PICC line for some IV medications. In the absence of documentation supporting the need for additional fluid intake specifically addressing a nutrition or hydration need, the presence of a PICC for medications would not support checking K0520A. Parenteral/IV feeding.

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Section M
Skin Conditions

Oklahoma State Department of Health

Section M: Intent

The items in this section assess the presence of pressure ulcers, stasis ulcers, and surgical wounds.

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National Pressure Injury Advisory Panel (NPIAP) Guidelines

Home health agencies may adopt the National Pressure Injury Advisory Panel (NPIAP) guidelines in their clinical practice and documentation. However, since CMS has ***adapted*** the NPIAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPIAP. When discrepancies exist between the NPIAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.

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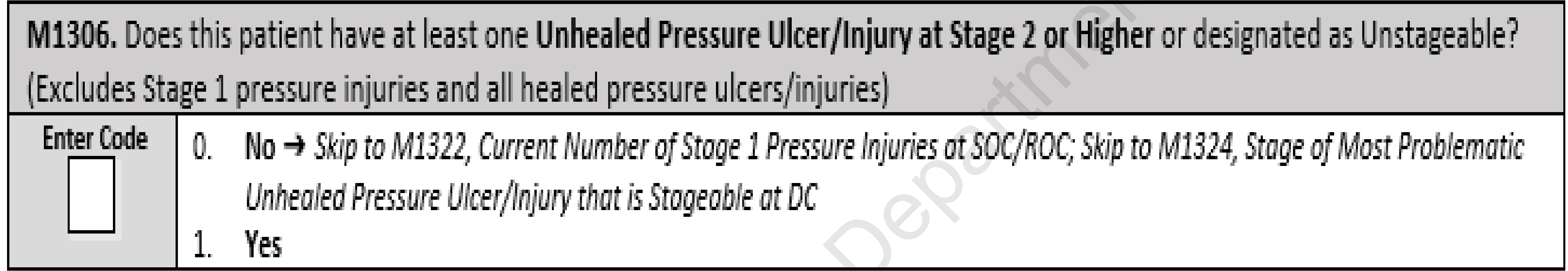
M1306 Unhealed Pressure Ulcer/Injury



M1306. Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)	
Enter Code ☐	0. No → *Skip to M1322, Current Number of Stage 1 Pressure Injuries at SOC/ROC; Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable at DC* 1. Yes

- The presence of pressure ulcers/injuries and unstageable pressure ulcers/injuries should be determined by physical assessment and observation.

- Do not consider Stage 1 pressure injuries or healed pressure ulcers for M1306.

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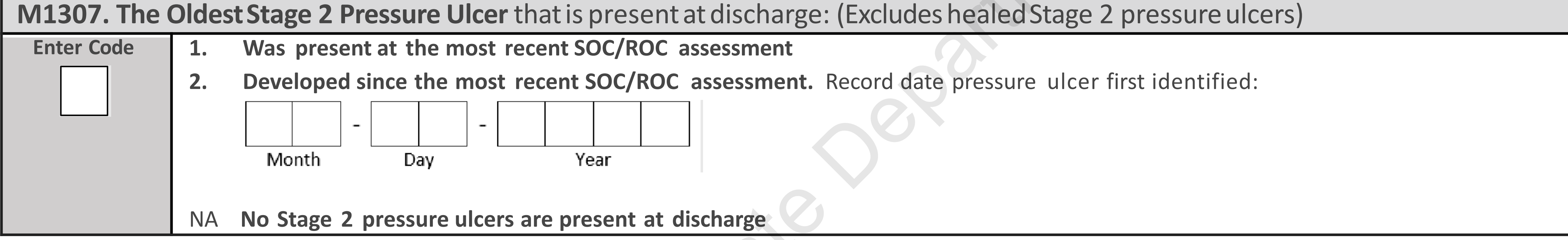
M1307: The Oldest Stage 2 Pressure Ulcer That Is Present at Discharge

Discharge


M1307. **The Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 pressure ulcers)

Enter Code

1. **Was present at the most recent SOC/ROC assessment**
2. **Developed since the most recent SOC/ROC assessment.** Record date pressure ulcer first identified:

Month - Day - Year

NA **No Stage 2 pressure ulcers are present at discharge**

An ulcer that is suspected of being a Stage 2, but is Unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the "oldest Stage 2 pressure ulcer".

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M1307: Response Specific Instructions

- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
  - The tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Tensile strength will not be as strong and will be subject to quicker breakdown again.
  - Clinical standards require that the ulcer continues to be documented at the highest stage (e.g. Stage 3 or Stage 4) until it has healed or becomes unstageable.

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M1311—Current Number of Unhealed Pressure Ulcers at Each Stage

SOC/ROC

SOC/ROC	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	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**
Enter Number ☐	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**
Enter Number ☐	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**
Enter Number ☐	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**
Enter Number ☐	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**
Enter Number ☐	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury**

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage – Discharge

Discharge

Discharge

M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number [ ]	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** – If 0 ➔*Skip to M1311B1, Stage 3*
Enter Number [ ]	A2. **Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number [ ]	B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers –** If 0 ➔*Skip to M1311C1, Stage 4*
Enter Number [ ]	B2. **Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number [ ]	C1. **Stage 4:** Full thickness tissue loss with exposed bon the wound bed. Often includes undermining and tu **Number of Stage 4 pressure ulcers –** If 0 ➔*Skip to M*
Enter Number [ ]	C2. **Number of these Stage 4 pressure ulcers that were** – enter how many were noted at the time of most r

Enter Number [ ]	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** – If 0 ➔*Skip to M1311E1, Unstageable: Slough and/or eschar*
Enter Number [ ]	D2. **Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number [ ]	E1. **Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** – If 0 ➔*Skip to M1311F1, Unstageable: Deep tissue injury*
Enter Number [ ]	E2. **Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number [ ]	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury** – If 0 ➔*Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable*
Enter Number [ ]	F2. **Number of these unstageable pressure injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

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M1311: Response Specific Instructions

- The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible.
- May collaborate with a second clinician who completes the first skin assessment within the assessment timeframe.

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M1311 Response Specific Instructions

M1311A1. Stage 2

- Identify the number of Stage 2 pressure ulcers present at time of assessment.
- Deep tissue injury (DTI) versus Stage 2 pressure ulcer.
  - DTI=Surrounding area has signs of tissue damage (color change, tenderness, bogginess or firmness, warmth or coolness)
- Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.

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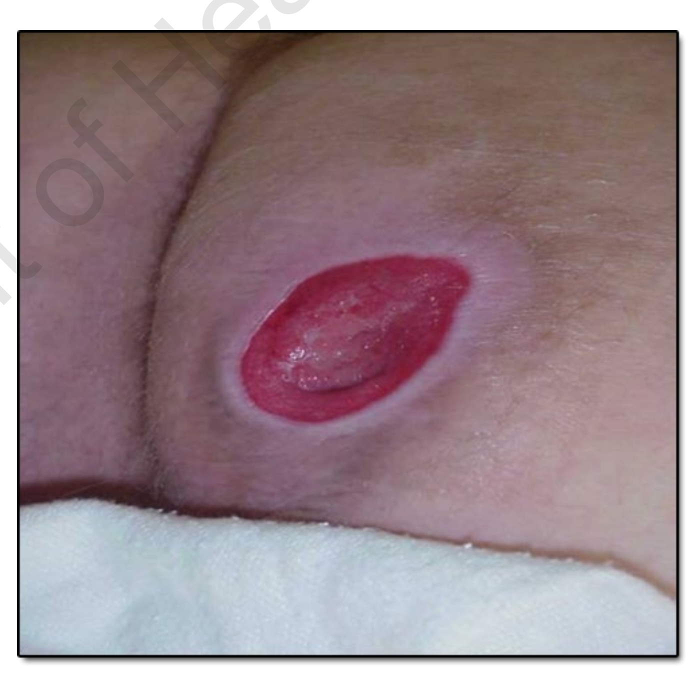
Stage 3 Pressure Ulcer

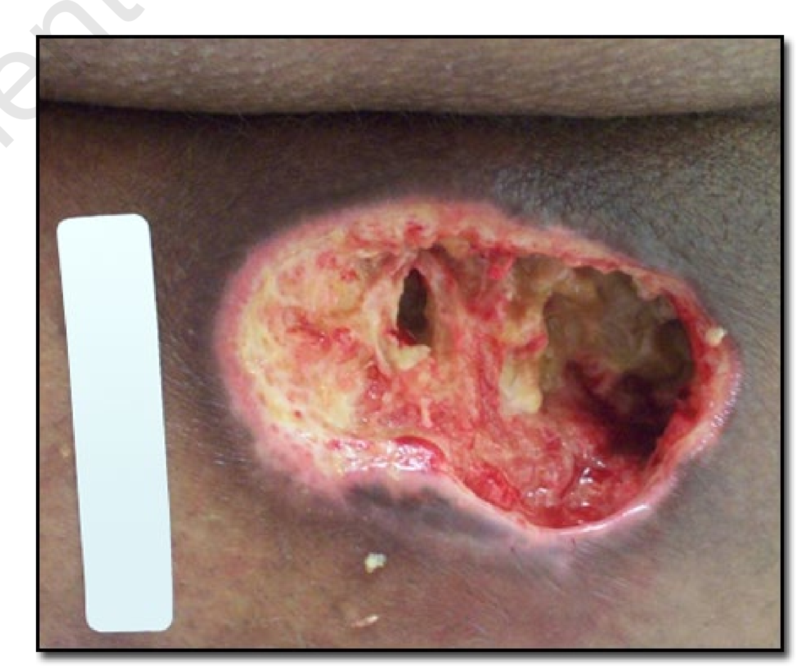


- Full thickness tissue loss
- Subcutaneous fat may be visible but bone, tendon or muscle are not exposed
- Depth varies depending on anatomical location
- A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer, unless currently presenting at a higher stage or is unstageable.

Oklahoma State Department of Health

Stage 4 Pressure Ulcer

- Full thickness tissue loss with bone, tendon, muscle, or joint capsule visible.
- Often includes undermining and tunneling.
- A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer, unless currently unstageable.



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M1311 D1: Unstageable Ulcers/Injury: Non-Removable Dressing/Device

- Pressure ulcers/injuries that are known to be present but are Unstageable due to a non-removable dressing/device are reported in in M1311D1.
- Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device.
- Non-removable dressing/device: Includes dressing or device not to be removed per physician's order.

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M1311: Determining "Present at the Most Recent SOC/ROC"

- If the patient has a pressure ulcer that was documented at SOC/ROC and at discharge is documented at the same stage, it would be considered as **"present at the most recent SOC/ROC**," **even if** during the episode the original pressure ulcer **healed and reopened.**
- If the pressure ulcer/injury was Unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present at the most recent SOC/ROC" stage should be considered the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at the most recent SOC/ROC" when completing the Discharge assessment.

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Present at the most recent SOC/ROC (cont)

- Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is ***unstageable due to slough and/or eschar*** at discharge, should be considered new, and not coded as "present at the most recent SOC/ROC" for M1311E2.

- A pressure ulcer that is stageable at SOC becomes unstageable due to a non-removable dressing/device at discharge, considered "present at the most recent SOC/ROC" if it had not 1) increased in numerical stage, or 2) become unstageable due to slough/eschar when the non-removable dressing/device was applied.

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Coding Tips

- A pressure ulcer treated with a **flap or graft** is no longer reported as a pressure ulcer/injury. Report as a surgical wound until healed on M1340.
- A pressure ulcer that has been **surgically debrided** remains a pressure ulcer and should *not* be reported as a surgical wound on M1340.

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Knowledge Check 1. Deep Tissue Injury (DTI) with intact skin at a SOC assessment becomes numerically stageable.

- The RN assesses a patient's skin at the SOC and identifies a DTI on the patient's left heel. This DTI remains unchanged until the RN skin assessment 10 days later, which reveals open skin presenting as a Stage 3 pressure ulcer. The pressure ulcer does not change for the remainder of the episode. At the discharge skin assessment, the ulcer remains a Stage 3. There are no other pressure ulcers/injuries at the SOC assessment, during the episode or at discharge.

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How would you code? Knowledge Check 1. Deep Tissue Injury (DTI) with intact skin at a SOC assessment becomes numerically stageable

Discharge	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** – If 0 ➔ *Skip to M1311C1, Stage 4*
Enter Number ☐	B2. **Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury** – If 0 ➔ *Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable*
Enter Number ☐	F2. **Number of these unstageable pressure injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

Oklahoma State Department of Health

Answer 1. Deep Tissue Injury (DTI) with intact skin at a SOC assessment becomes numerically stageable

Coding On the discharge assessment:

- M1311B1, Number of Stage 3 pressure ulcers, would be coded “1”.
- M1311B2, Number of <u>these</u> Stage 3 pressure ulcers that were present at the most recent SOC/ROC would be coded “1”.
- M1311F1, Number of unstageable pressure injuries presenting as DTI, would be coded “0”.
- M1311F2, Number of unstageable presenting as DTI, coded as “0”.

Rationale: At the discharge assessment, the patient had one Stage 3 pressure ulcer, and zero unstageable pressure injuries presenting as DTI. The Stage 3 pressure ulcer is reported “present at the most recent SOC/ROC” because that is the stage at which the DTI observed at the SOC assessment first became numerically stageable.

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Knowledge Check 2: Deep tissue injury (DTI) with intact skin at SOC, becomes numerically stageable and increases in numerical stage by discharge.

- The RN completes a skin assessment during the SOC visit for a patient and identifies a right hip DTI with intact skin. This DTI is first numerically stageable 10 days later as a Stage 3 pressure ulcer and increases in numerical stage five days after that, to a Stage 4 pressure ulcer. The pressure ulcer remains a Stage 4 at discharge.

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How Would you Code? Knowledge Check 2: Deep tissue injury (DTI) with intact skin at SOC, becomes numerically stageable and increases in numerical stage by discharge.

Discharge	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	C1. **Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** – If 0 ➔*Skip to M1311D1, Unstageable: Non-removable dressing/device*
Enter Number ☐	C2. **Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury** – If 0 ➔*Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable*
Enter Number ☐	F2. **Number of these unstageable pressure injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

Oklahoma State Department of Health

Answer 2. Deep tissue injury (DTI) with intact skin at SOC, becomes numerically stageable and increases in numerical stage by discharge.

Coding On the DC discharge assessment:

- M1311C1, Number of Stage 4 pressure ulcers, would be coded “1”.
- M1311C2, Number of these Stage 4 pressure ulcers that were present at the most recent SOC/ROC, would be coded “0”.
- M1311F1, Unstageable pressure injuries presenting as DTI, would be coded “0”.

Rationale: The DTI with intact skin observed on the SOC skin assessment first became numerically stageable as a Stage 3. Because the Stage 3 pressure ulcer increased in numerical stage to a Stage 4 by the discharge assessment, the Stage 4 pressure ulcer at discharge is considered new, and not coded as present at the most recent SOC/ROC.

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M1324 Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.	
Enter Code ☐	1. **Stage 1** 2. **Stage 2** 3. **Stage 3** 4. **Stage 4** NA **Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries**

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.

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M1330 Stasis Ulcer

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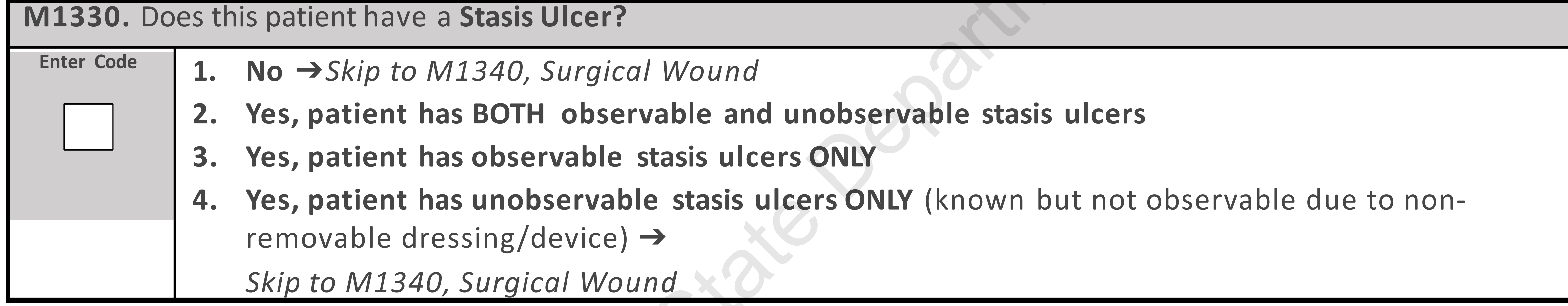
M1330: Does This Patient Have a Stasis Ulcer?



M1330. Does this patient have a **Stasis Ulcer?**	
Enter Code	1. **No** ➔ *Skip to M1340, Surgical Wound* 2. **Yes, patient has BOTH observable and unobservable stasis ulcers** 3. **Yes, patient has observable stasis ulcers ONLY** 4. **Yes, patient has unobservable stasis ulcers ONLY** (known but not observable due to non-removable dressing/device) ➔ *Skip to M1340, Surgical Wound*

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M1330 Stasis Ulcer

- Stasis Ulcer is also known as Venous Stasis Ulcer
- Usually occur around the ankle or lower leg (calf)
- Usually painful and red
- Lengthy healing time (3-4 months)
- **Compression therapy, exercise, and leg elevation at rest**. Long term treatment with double bandages (zinc paste bandages and elastic compression), changed once weekly.

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M1330: Response Specific Instructions

- Unobservable stasis ulcers are reported stasis ulcer(s) that cannot be observed because of a dressing or device, such as a cast or Unna boot, that cannot be removed.
- Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.
- Stasis ulcers DO NOT include arterial lesions or arterial ulcers.

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M1334 Status of Most Problematic Statis Ulcer that is Observable

M1334. Status of Most Problematic Stasis Ulcer that is Observable	
Enter Code ☐	1. Fully granulating 2. Early/partial granulation 3. Not healing

"Most problematic" is determined by the clinician's professional evaluation of the individual's overall wound status, and may be based on the following factors, but not limited to:

- Healing status, such as an ulcer that is infected or resistant to treatment
- Size (may be the largest ulcer)
- Location (may be difficult to access for treatment)

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M1340: Does This Patient Have a Surgical Wound?

M1340. Does this patient have a **Surgical Wound?**	
Enter Code ☐	0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication* 1. **Yes, patient has at least one observable surgical wound** 2. **Surgical wound known but not observable due to non-removable dressing/device** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*

- Ostomies are excluded from consideration under this item and should not be counted as surgical wounds. Exception: "take-down" procedure of a previous bowel ostomy.
- A PICC line (peripherally inserted venous catheter), either tunneled or non-tunneled, is NOT a surgical wound, when it is peripherally inserted.

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M1340: Response Specific Instructions

- For coding this item, the agency may use any skin assessment conducted during the assessment time frame.
- A surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described 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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M1342: Review of "Most Problematic" Surgical Wound

- "Most problematic" is determined by the clinician's professional evaluation of the individual's overall wound status and may be based on factors including, but not limited to:
  - Healing status, such as an ulcer that is infected or resistant to treatment.
  - Size (may be the largest ulcer).
  - Location (may be difficult to access for treatment).

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M1342: Surgical Wound Assessment

- Surgical wounds healing by primary intention (approximated incisions) do not granulate; therefore, the only appropriate responses are:
  - Response 0. – “Newly epithelialized” or
  - Response 3. – “Not healing.”

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Section N: Medication

Oklahoma State Department of Health

N0415: High Risk Drug Classes

N0415. High-Risk Drug Classes: Use and Indication		
1. **Is taking** Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. **Indication noted** If column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking Check all that apply ↓	2. Indication noted ↓
A. Antipsychotic	☐	☐
E. Anticoagulant	☐	☐
F. Antibiotic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

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N0415: Item Intent and Rationale

The intent of the items in this section is to record whether:

- the patient is taking any medications in high-risk drug classes, there is a **patient- specific** indication noted and the patient/caregiver have been educated about the high-risk medications.
- a drug regimen review was conducted
- the patient can manage oral and injectable medications

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DEFINITION: Indication

Added definition for Indication:

- The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the patient's condition and therapeutic goals.

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NN0415 Coding Tip

- **Coding Tip:**
  - CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication. Use available resources along with clinical judgment to determine if a scenario meets the criteria for a patient-specific indication.

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N0415: High-Risk Drug Classes – Data Sources

Medical Record

- Received from facilities where the patient received healthcare.

Recent Documents

- Most recent history and physical.
- Transfer documents.
- Discharge summaries.
- Medication lists/records.
- Clinical progress notes.

Discussions

- With acute care hospital.
- With other staff and clinicians.
- With patient and the patient's family or significant other.

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N0415: Coding Instructions

- **Code 1, Is Taking**:
  - A medication that is part of a patient's current **reconciled** drug regimen, even if it was not taken on the day of assessment.
  - Anticoagulants such as target-specific oral anticoagulants, which may or may not require laboratory monitoring.
  - Medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it.

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N0415: Coding Instructions (cont.)

- Do **not** code:
  - Antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E. Anticoagulant.
  - **Do not code flushes provided to keep an IV access port patent as N0415, Anticoagulant.**
- **Dash** is a valid response for this item.
  - Dash indicates “no information.” CMS expects dash use to be a rare occurrence.

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N0415 Coding Tip

- **Revised coding tip:**
  - Include any of these medications used by any route in any setting (e.g., at home, in a hospital emergency room, at physician office or clinic) while a patient of the home health agency **that are also a part of a patient's current reconciled drug regimen, even if it was not taken at the time of assessment.**

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N0415 Coding Tip

- **Revised coding tip:**
  - Combination medications should be coded in all categories/pharmacologic classes that constitute the combination, **regardless of why the medications are being used.**
    - **For example, Percodan is a combination medication (oxycodone and aspirin) classified as both an opioid and antiplatelet. Therefore, for both N0415H, Opioid and NN0415I, Antiplatelet, Column 1 –would be checked, regardless of why the medication is being used.**

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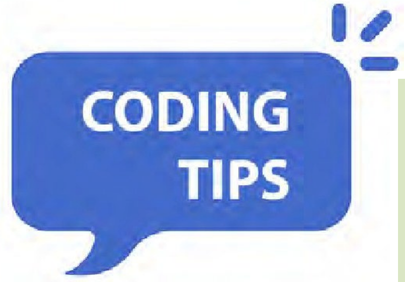
N0415: Coding Tips (cont.)



Long-Acting Medications

Count only if they are part of the current drug regimen at the time of the assessment.

Example: Transdermal patches designed to release medication over a period of time (typically 3 to 5 days) would be considered long-acting medications and are included as long as they are part of the patient's current drug regimen.

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What Do High-Risk Drug Classes NOT Include?

For N0415: Herbal and Alternative Medications by Any Route

These products are considered to be dietary supplements by the U.S. Food and Drug Administration and should not be counted as medications (e.g., melatonin, chamomile, valerian root).

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M2001 Drug Regimen Review

M2001. Drug Regimen Review Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0. No – No issues found during review → *Skip to M2010, Patient/Caregiver High-Risk Drug Education* 1. Yes – Issues found during review 9. NA – Patient is not taking any medications → *Skip to O0110, Special Treatments, Procedures, and Programs*

DEFINITION

POTENTIAL (OR ACTUAL) CLINICALLY SIGNIFICANT MEDICATION ISSUE

- A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/allowed practitioner (or physician-designee) communication and completion of prescribed/recommended actions 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 for the purpose of the drug regimen review items.

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Clinically Significant Medication Issues

May include, but are not limited to:

- Adverse reactions to medications (such as a rash)
- Ineffective drug therapy (such as analgesic that does not reduce pain)
- Side effects (such as potential bleeding from an anticoagulant)
- Drug interactions (such as serious drug-drug, drug-food and drug-disease interactions)
- Duplicate therapy
- Omissions
- Dosage errors
- Nonadherence

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Coding Tips

- Code 0, No—No issues found during review
- Code 1, Yes—Issues found during review
  - Patient's med list from the inpatient facility doesn't match what is in the home
  - Diagnosis/symptoms not well controlled
  - Patient confused regarding meds
  - Patient has not obtained medications prescribed
  - Exhibiting S/S of possible adverse reaction
- Dash is a valid response
  - If part of the drug regimen review were not completed, a dash should be reported.

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M2003 Medication Follow-Up

M2003. Medication Follow-up Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0. No 1. Yes

DEFINITION

MEDICATION FOLLOW-UP

- The process of contacting a physician/allowed practitioner (or physician-designee) to communicate the identified medication issue and addressing all physician/allowed practitioner (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest.

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M2003 Medication Follow-Up

- Two-way communication between the agency and the physician (or physician-designee) was completed by midnight of the next calendar day; **AND**
  - All physician (or physician-designee) prescribed/recommended actions were completed to the extent possible by midnight of the next calendar day.

Example:

- A clinically significant medication issue is identified at **10:00 AM** on December 12 and physician prescribed/recommended action is completed on or before 11:59 PM on December 13th.
- A clinically significant medication issue is identified at **10:00 PM** on December 12th physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on December 13th.

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M2003 Medication Follow-Up

- Code 0, No if:
- Clinician did not communicate all identified clinically significant medication issues to the physician (or physician-designee) until *after* midnight of the next calendar day.
- Physician, or designee, did not respond until after midnight of the next calendar day.
- Clinician did not complete all physician (or physician-designee) prescribed/recommended actions for **all** identified clinically significant medication issues until after midnight of the next calendar day (even if all but one medication issue was addressed before midnight of the next calendar day).

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M2003 Medication Follow-Up

- Code 1, Yes if:
- The two-way communication AND completion of prescribed/recommended actions occurred by midnight of the next calendar day.

Example:

- Clinician contacted the physician, or designee, regarding all identified medication issues; and the physician, or designee, communicated to the clinician that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.

- Physician, or designee, writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.

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M2005 Medication Intervention

M2005. Medication Intervention Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0. No 1. Yes 9. NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- Completed at Transfer, Death at Home, and Discharge from Agency.
- Review the medical record back to, and including, the most recent SOC/ROC to identify if all required criteria was met **EACH time** a potential clinically significant medication issue was identified.

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M2020: Management of Oral Medications and M2030 Injectable Medications

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

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

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

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

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M2020/M2030 Management of Oral/Injectable Medications

- **M2020 Oral meds**:
  - Ability to obtain the medication, read the label, open the container, select the pill/tablet, or mils of liquid, and orally ingest at correct time.
  - May vary from medication to medication, consider which medication the patient needs the most assistance with when coding.
- **M2030 Injectable meds:**
  - Ability to obtain the medication, read the label, draw up the correct dose using aseptic technique, inject in the appropriate site with proper technique, and dispose of the syringe properly.

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N0415: Practice Scenario

The patient was discharged to home from the hospital. During the home health SOC, the referral documentation was reviewed.

The records indicate that the patient is taking oxycodone for pain. Tramadol is also listed, but there is no indication documented for the tramadol.

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How would you code N0415. High-Risk Drug Classes: Use and Indication for the patient at discharge?

A. Check N0415H. Opioid in column 1 and 2.
B. No medications would be checked.
C. Check N0415H. Opioid in column 1 and leave column 2 blank.
D. Leave column 1 blank and Check N0415H. Opioid in column 2.

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N0415: Practice Scenario 2 – Rationale

- **Answer:** The answer is C. **Check N0415H. Opioid in column 1 and leave column 2 blank.**
- **Rationale:** Column 1, **N0415H. Opioid** is checked because the patient is taking oxycodone and tramadol, both medications within that class. However, there needs to be a documented indication for both medications in the class for column 2 to be checked.

Oklahoma State Department of Health

Section O. Special Treatments, Procedures, and Programs Workshop

Oklahoma State Department of Health

OKLAHOMA
State Department of Health

O0110. Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	a. On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐

Other
H1. IV Medications
H2. Vasoactive medications
H3. Antibiotics
H4. Anticoagulation
H10. Other
I1. Transfusions
J1. Dialysis
J2. Hemodialysis
J3. Peritoneal dialysis
O1. IV Access
O2. Peripheral
O3. Mid-line
O4. Central (e.g., PICC, tunneled, port)
None of the Above
Z1. None of the Above

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O0110: Data Sources

Review

- Patient's clinical record.

Consult

- Patient, family, caregiver(s), and/or staff.

Determine

- Whether or not any of the treatments, procedures, or programs apply.
  - During the time period under consideration for the Start of Care/Resumption of Care (SOC/ROC) assessment.
  - During the time period under consideration for the DC assessment.

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O0110: Revised Response Specific Instruction

Revised guidance:

- Bullet 1: Review the patient's clinical record and consult with the patient, family, caregiver(s) and/or staff to determine whether or not any of the treatments, procedures, or programs **are part of the current care/treatment plan at the time of the assessment for SOC/ROC (or discharge).**

- Bullet 2: Check all treatments, programs and procedures that are part of the patient's current care/treatment plan **at the time of the SOC/ROC (or discharge) assessment**, even if not used **at the time of assessment**, and whether or not it is expected to occur after discharge.

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O0110: Response-Specific Instructions

- **Check** all treatments, programs, and procedures that apply and are:
  - Performed by others, the patient independently, or after setup by agency staff or family/caregivers.
  - Performed in the patient's home or in another setting, such as a dialysis center.
- **Check** if the patient is undergoing any of the following treatments at the time of assessment.
  - **A1. Chemotherapy, B1. Radiation**, and **J1. Dialysis.**

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O0110: Response-Specific Instructions (cont. 1)

- Do **not** check:
  - Services provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications.
  - Surgical procedures include routine pre- and post-operative procedures.

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O0110B1. Radiation – Coding Instructions

- **Code O0110B1. Radiation**
  - Check if radiation is administered intermittently or via radiation implant in this item.

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O0110C1. Oxygen Therapy – Coding Instructions

- **O0110C1. Oxygen Therapy**
  - Check if continuous or intermittent oxygen is used via mask, cannula etc., including in BiPAP/CPAP.
- **O0110C2. Continuous**
  - Check if oxygen therapy was continuously delivered for greater than/equal to 14 hours per day.

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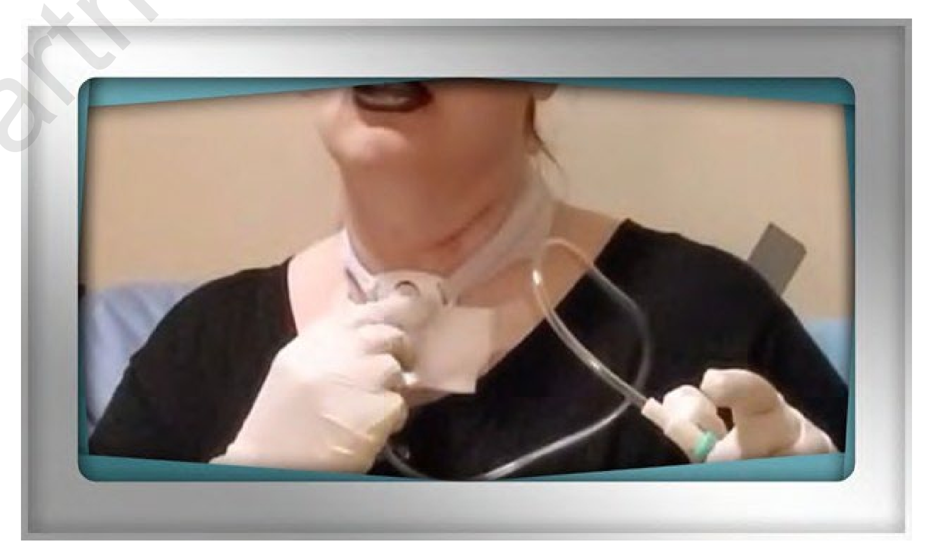
O0110D1. Suctioning – Coding Instructions

- **O0110D1. Suctioning**
  - Code only tracheal and/or nasopharyngeal suctioning in this item.
  - If the patient performs their own suctioning, this item may also be checked.
- **Do not include oral suctioning here.**



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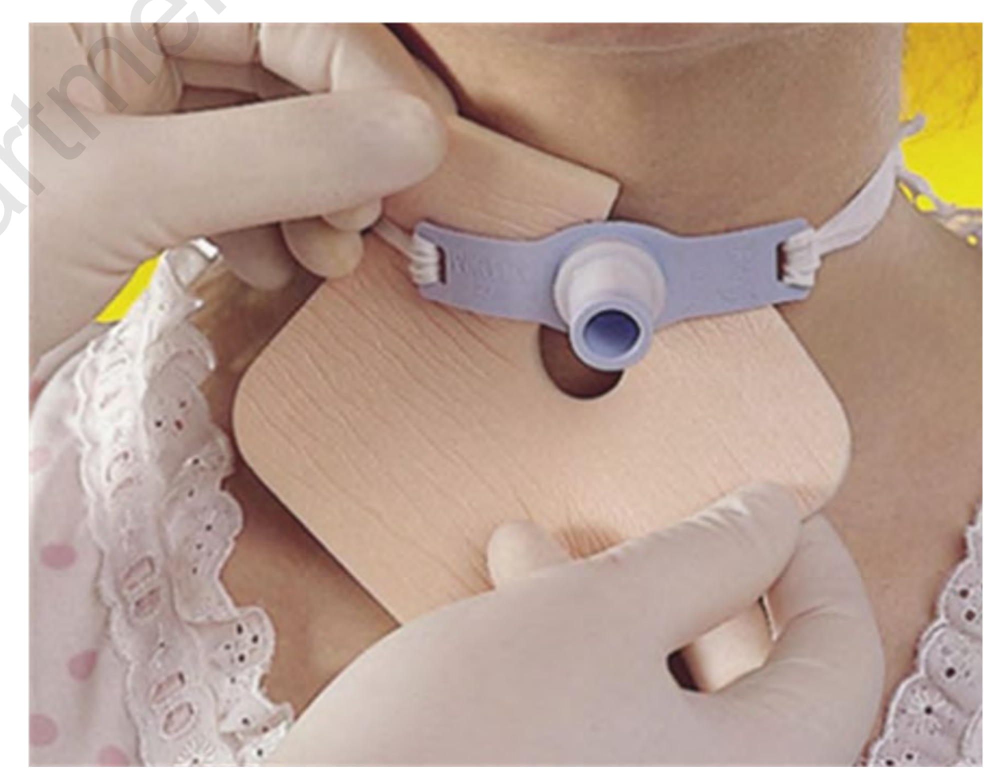
O0110E1. Tracheostomy Care – Coding Instructions

- **O0110E1. Tracheostomy care**
  - Check if cleansing of the tracheostomy and/or cannula is performed.
  - This item may also be checked if the patient performs their own tracheostomy care or receives assistance.



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O0110G1. Non-invasive Mechanical Ventilator – Coding Instructions

- **O0110G1. Non-Invasive Mechanical Ventilator**
  - The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration.
  - Check if any type of respiratory support device is used that prevents airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.
  - This item may be checked if the patient places or removes their own BiPAP/CPAP mask/device or if the family/caregiver applies it for the patient.
  - Check **G2. BiPAP** or **G3. CPAP** as appropriate.

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O0110H1. IV Medications – Coding Instructions

- **O0110H1. IV Medications**
  - Check if:
    - Any medication or biological is given by IV push, epidural pump, or drip through a central or peripheral port in this item. **This response includes IV fluids containing medications.**
    - Epidural, intrathecal, and baclofen pumps are used as they are similar to IV medications, involve the continuous administration of a substance, and must be monitored frequently.
- Do **not** include:
  - Flushes to keep an IV access port patent or IV fluids *without* medication.
  - Subcutaneous pumps or IV medications administered during dialysis or chemotherapy.
  - Dextrose 50% and/or Lactated Ringers given IV are not considered medications.

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O0110O1, IV Access

- **Newly added coding instructions:**
  - If there is not a current IV access in place at the time of assessment, do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.

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Influenza Vaccine Data Collection Period

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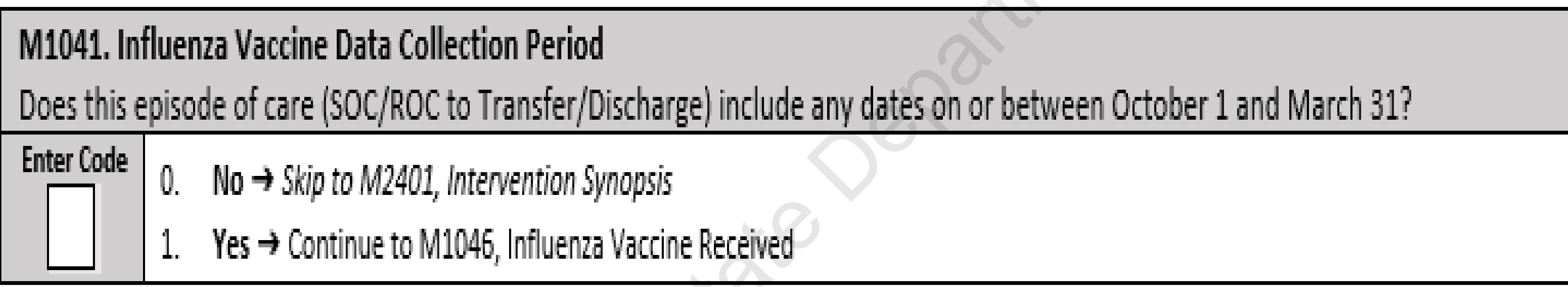
M1041 Influenza Vaccine Data Collection Period



M1041. Influenza Vaccine Data Collection Period	
Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?	
Enter Code	0. No → *Skip to M2401, Intervention Synopsis* 1. Yes → Continue to M1046, Influenza Vaccine Received

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M1046 Influenza Vaccine Received

M1046. Influenza Vaccine Received Did the patient receive the influenza vaccine for this year's flu season?	
Enter Code ☐	1. Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge) 2. Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge) 3. Yes; received from another health care provider (for example, physician, pharmacist) 4. No; patient offered and declined 5. No; patient assessed and determined to have medical contraindication(s) 6. No; not indicated – patient does not meet age/condition guidelines for influenza vaccine 7. No; inability to obtain vaccine due to declared shortage 8. No; patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

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M1046 Influenza Vaccine Received

- **Code 2, Yes**, if your agency provided the influenza vaccine to the patient for this year's flu season ***prior to this episode***, in a prior episode or at a flu clinic run by your agency (a roster billing situation).
  - For example, if the SOC/ROC for this episode was in winter, but your agency provided the vaccine in the fall (during a prior episode) when the vaccine became available.

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Section Q: Participation in Assessment and Goal Setting

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M2401: Intervention Synopsis

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

Plan/Intervention	No	Yes	Not Applicable	
	↓Check only one box in each row↓			
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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M2401 Intervention Synopsis

Response Specific Instructions:

Completed at Transfer and Discharge

- Interventions provided by home health agency staff may be reported in this item.
  - For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the Plan of Care prior to the end of the quality episode, the RN may Code “Yes” for row b: Falls prevention interventions.

- BOTH of the interventions (monitor and mitigate pain) must be on the physician-ordered Plan of Care AND implemented for “Yes” to be selected.

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OASIS References and Resources

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OASIS Resources

- **State Department of Health: OASIShelp@health.ok.gov**
  - **Guidance on OASIS coding, submission and modification of records, iQIES assistance**

- **Home Health Quality Help Desk -** homehealthqualityquestions@cms.hhs.gov
  - **Home Health Quality Measures—including Care Compare, public reporting and Pay for Reporting**

- **Home Health Quality Reporting Program (HHQRP)** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits

- **Home Health Quality Reporting Training** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training

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Thank You for Your Attendance and Participation!

- Certificates will be emailed to you.

- Submit questions to: OASIShelp@health.ok.gov

  Or Phone: (405) 426.8160

Note: The information provided during this training is accurate and up-to-date as of the date of the training. Any revisions and/or updated Quarterly Q&As that CMS provides after this training date will supersede the guidance provided during this training.

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