

## Home Health Patient Tracking Sheet

(M0032) Resumption of Care Date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month			day			year			

☐ NA – Not Applicable

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

<u>Time Point</u>	<u>Items Used</u>
<b>Resumption of Care</b> ----- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170

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## CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment	
Enter Code <input type="checkbox"/>	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

/  /   
 month      day      year

(M0100) This Assessment is Currently Being Completed for the Following Reason:	
Enter Code <input type="checkbox"/>	<b>Start/Resumption of Care</b> 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) <b>Follow-Up</b> 4 Recertification (follow-up) reassessment [Go to M0110] 5 Other follow-up [Go to M0110] <b>Transfer to an Inpatient Facility</b> 6 Transferred to an inpatient facility – patient not discharged from agency [Go to M1041] 7 Transferred to an inpatient facility – patient discharged from agency [Go to M1041] <b>Discharge from Agency – Not to an Inpatient Facility</b> 8 Death at home [Go to M2005] 9 Discharge from agency [Go to M1041]

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

/  /  [Go to M0110, if date entered]  
 month      day      year

☐ NA - No specific SOC date ordered by physician

(M0104) **Date of Referral:** Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

/  /   
 month      day      year

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?	
Enter Code <input type="checkbox"/>	1 Early 2 Later UK Unknown NA Not Applicable: No Medicare case mix group to be defined by this assessment.

## **PATIENT HISTORY AND DIAGNOSES**

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

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF/TCU)
- ☐ 3 - Short-stay acute hospital (IPPS)
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) \_\_\_\_\_
- ☐ NA - Patient was not discharged from an inpatient facility [*Go to M1021*]

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

/   /     
month      day      year

- ☐ UK - Unknown

**(M1021/1023) Diagnoses and Symptom Control:** List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only – no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

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

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

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

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

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

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

(Form on next page)



**PATIENT HISTORY AND DIAGNOSES, continued**

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

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

**(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

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pounds

b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

**LIVING ARRANGEMENTS**

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

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

## SENSORY STATUS

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

## INTEGUMENTARY STATUS

<b>(M1306)</b> Does this patient have at least one <b>Unhealed Pressure Ulcer/Injury at Stage 2 or Higher</b> or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)	
Enter Code <input type="checkbox"/>	0 No [ <b>Go to M1322 at SOC/ROC/FU; Go to M1324 at DC</b> ] 1 Yes

<b>(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</b>	Enter Number
<b>A1. Stage 2:</b> 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. <b>Number of Stage 2 pressure ulcers</b>	<input type="checkbox"/>
<b>B1. Stage 3:</b> 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. <b>Number of Stage 3 pressure ulcers</b>	<input type="checkbox"/>
<b>C1. Stage 4:</b> 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. <b>Number of Stage 4 pressure ulcers</b>	<input type="checkbox"/>
<b>D1. Unstageable: Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device <b>Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b>	<input type="checkbox"/>
<b>E1. Unstageable: Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar <b>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b>	<input type="checkbox"/>
<b>F1. Unstageable: Deep tissue injury</b> <b>Number of unstageable pressure injuries presenting as deep tissue injury</b>	<input type="checkbox"/>

## INTEGUMENTARY STATUS, continued

<b>(M1322) Current Number of Stage 1 Pressure Injuries:</b> Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.	
Enter Code <input type="checkbox"/>	0 1 2 3 4 or more
<b>(M1324) Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:</b> (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 <input type="checkbox"/>	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
<b>(M1330) Does this patient have a Stasis Ulcer?</b>	
Enter Code <input type="checkbox"/>	0 No <b>[Go to M1340]</b> 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) <b>[Go to M1340]</b>
<b>(M1332) Current Number of Stasis Ulcer(s) that are Observable:</b>	
Enter Code <input type="checkbox"/>	1 One 2 Two 3 Three 4 Four or more
<b>(M1334) Status of Most Problematic Stasis Ulcer that is Observable:</b>	
Enter Code <input type="checkbox"/>	1 Fully granulating 2 Early/partial granulation 3 Not healing
<b>(M1340) Does this patient have a Surgical Wound?</b>	
Enter Code <input type="checkbox"/>	0 No <b>[Go to M1400]</b> 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device <b>[Go to M1400]</b>
<b>(M1342) Status of Most Problematic Surgical Wound that is Observable</b>	
Enter Code <input type="checkbox"/>	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

## RESPIRATORY STATUS

<b>(M1400)</b> When is the patient dyspneic or noticeably <b>Short of Breath</b> ?	
Enter Code <input type="checkbox"/>	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)

## ELIMINATION STATUS

<b>(M1600)</b> Has this patient been treated for a <b>Urinary Tract Infection</b> in the past 14 days?	
Enter Code <input type="checkbox"/>	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown [ <b>Omit "UK" option on DC</b> ]
<b>(M1610) Urinary Incontinence or Urinary Catheter Presence:</b>	
Enter Code <input type="checkbox"/>	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
<b>(M1620) Bowel Incontinence Frequency:</b>	
Enter Code <input type="checkbox"/>	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown [ <b>Omit "UK" option on FU, DC</b> ]
<b>(M1630) Ostomy for Bowel Elimination:</b> Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?	
Enter Code <input type="checkbox"/>	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.



## NEURO/EMOTIONAL/BEHAVIORAL STATUS

<b>(M1700) Cognitive Functioning:</b> Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.																			
Enter Code <input type="checkbox"/>	<p>0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</p> <p>1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.</p> <p>2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.</p> <p>3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.</p> <p>4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</p>																		
<b>(M1710) When Confused (Reported or Observed Within the Last 14 Days):</b>																			
Enter Code <input type="checkbox"/>	<p>0 Never</p> <p>1 In new or complex situations only</p> <p>2 On awakening or at night only</p> <p>3 During the day and evening, but not constantly</p> <p>4 Constantly</p> <p>NA Patient nonresponsive</p>																		
<b>(M1720) When Anxious (Reported or Observed Within the Last 14 Days):</b>																			
Enter Code <input type="checkbox"/>	<p>0 None of the time</p> <p>1 Less often than daily</p> <p>2 Daily, but not constantly</p> <p>3 All of the time</p> <p>NA Patient nonresponsive</p>																		
<b>(M1730) Depression Screening:</b> Has the patient been screened for depression, using a standardized, validated depression screening tool?																			
Enter Code <input type="checkbox"/>	<p>0 No</p> <p>1 Yes, patient was screened using the PHQ-2©* scale.</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th style="width: 40%;">PHQ-2©*</th> <th style="width: 12%;">Not at all 0-1 day</th> <th style="width: 12%;">Several days 2-6 days</th> <th style="width: 12%;">More than half of the days 7-11 days</th> <th style="width: 12%;">Nearly every day 12-14 days</th> <th style="width: 12%;">NA Unable to respond</th> </tr> </thead> <tbody> <tr> <td>a) Little interest or pleasure in doing things</td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> NA</td> </tr> <tr> <td>b) Feeling down, depressed, or hopeless?</td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> NA</td> </tr> </tbody> </table> </div> <p>2 Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.</p> <p>3 Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.</p> <p style="text-align: right;"><i>*Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.</i></p>	PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond	a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA	b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond														
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA														
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA														

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

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

<b>(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed):</b> Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.	
Enter Code <input type="checkbox"/>	0 Never 1 Less than once a month 2 Once a month 3 Several times each month 4 Several times a week 5 At least daily

### **ADL/IADLs**

<b>(M1800) Grooming:</b> Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).	
Enter Code <input type="checkbox"/>	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.
<b>(M1810) Current <b>Ability to Dress Upper Body</b> safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:</b>	
Enter Code <input type="checkbox"/>	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 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.
<b>(M1820) Current <b>Ability to Dress Lower Body</b> safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:</b>	
Enter Code <input type="checkbox"/>	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.

## ADL/IADLs, continued

<b>(M1830) Bathing:</b> Current ability to wash entire body safely. <b>Excludes grooming (washing face, washing hands, and shampooing hair).</b>	
Enter Code <input type="checkbox"/>	<p>0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.</p> <p>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.</p> <p>2 Able to bathe in shower or tub with the intermittent assistance of another person:  (a) for intermittent supervision or encouragement or reminders, <u>OR</u>  (b) to get in and out of the shower or tub, <u>OR</u>  (c) for washing difficult to reach areas.</p> <p>3 Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.</p> <p>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.</p> <p>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.</p> <p>6 Unable to participate effectively in bathing and is bathed totally by another person.</p>
<b>(M1840) Toilet Transferring:</b> Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.	
Enter Code <input type="checkbox"/>	<p>0 Able to get to and from the toilet and transfer independently with or without a device.</p> <p>1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.</p> <p>2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).</p> <p>3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.</p> <p>4 Is totally dependent in toileting.</p>
<b>(M1845) Toileting Hygiene:</b> Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.	
Enter Code <input type="checkbox"/>	<p>0 Able to manage toileting hygiene and clothing management without assistance.</p> <p>1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.</p> <p>2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.</p> <p>3 Patient depends entirely upon another person to maintain toileting hygiene.</p>
<b>(M1850) Transferring:</b> Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
Enter Code <input type="checkbox"/>	<p>0 Able to independently transfer.</p> <p>1 Able to transfer with minimal human assistance or with use of an assistive device.</p> <p>2 Able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.</p> <p>4 Bedfast, unable to transfer but is able to turn and position self in bed.</p> <p>5 Bedfast, unable to transfer and is unable to turn and position self.</p>

## ADL/IADLs, continued

<b>(M1860)</b>		<b>Ambulation/Locomotion:</b> Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code <input type="checkbox"/>	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3	Able to walk only with the supervision or assistance of another person at all times.
	4	Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
	5	Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
	6	Bedfast, unable to ambulate or be up in a chair.
<b>(M1870)</b>		<b>Feeding or Eating:</b> Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u> , <u>chewing</u> , and <u>swallowing</u> , <u>not preparing</u> the food to be eaten.
Enter Code <input type="checkbox"/>	0	Able to independently feed self.
	1	Able to feed self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet.
	2	<u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
	3	Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4	<u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5	Unable to take in nutrients orally or by tube feeding.
<b>(M1910)</b>		Has this patient had a multi-factor <b>Falls Risk Assessment</b> using a standardized, validated assessment tool?
Enter Code <input type="checkbox"/>	0	No.
	1	Yes, and it does not indicate a risk for falls.
	2	Yes, and it does indicate a risk for falls.

## MEDICATIONS

<b>(M2001)</b>	<b>Drug Regimen Review:</b> Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code <input type="checkbox"/>	0	No – No issues found during review [ <b>Go to M2010</b> ]
	1	Yes – Issues found during review
	9	NA – Patient is not taking any medications [ <b>Go to M2102</b> ]
<b>(M2003)</b>	<b>Medication Follow-up:</b> 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 <input type="checkbox"/>	0	No
	1	Yes
<b>(M2010)</b>	<b>Patient/Caregiver High-Risk Drug Education:</b> Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?	
Enter Code <input type="checkbox"/>	0	No
	1	Yes
	NA	Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
<b>(M2020)</b>	<b>Management of Oral Medications:</b> <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <b><u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</b>	
Enter Code <input type="checkbox"/>	0	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1	Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.
	2	Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	3	<u>Unable</u> to take medication unless administered by another person.
	NA	No oral medications prescribed.
<b>(M2030)</b>	<b>Management of Injectable Medications:</b> <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. <b><u>Excludes</u> IV medications.</b>	
Enter Code <input type="checkbox"/>	0	Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
	1	Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart.
	2	Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
	3	<u>Unable</u> to take injectable medication unless administered by another person.
	NA	No injectable medications prescribed.

## **CARE MANAGEMENT**

<b>(M2102)</b>	<b>Types and Sources of Assistance:</b> Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code <input type="checkbox"/>	f. <b>Supervision and safety</b> (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

## **THERAPY NEED AND PLAN OF CARE**

**(M2200) Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

<b>Section GG</b>	<b>Functional Abilities and Goals</b>
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**GG0100. Prior Functioning: Everyday Activities:** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

<b>Coding:</b> <b>3. Independent</b> – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. <b>2. Needed Some Help</b> – Patient needed partial assistance from another person to complete activities. <b>1. Dependent</b> – A helper completed the activities for the patient. <b>8. Unknown</b> <b>9. Not Applicable</b>	↓ <b>Enter Codes in Boxes</b>	
	<input type="checkbox"/>	<b>A. Self Care:</b> Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	<input type="checkbox"/>	<b>B. Indoor Mobility (Ambulation):</b> 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.
	<input type="checkbox"/>	<b>C. Stairs:</b> 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.
	<input type="checkbox"/>	<b>D. Functional Cognition:</b> Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ <b>Check all that apply</b>	
<input type="checkbox"/>	<b>A. Manual wheelchair</b>
<input type="checkbox"/>	<b>B. Motorized wheelchair and/or scooter</b>
<input type="checkbox"/>	<b>C. Mechanical lift</b>
<input type="checkbox"/>	<b>D. Walker</b>
<input type="checkbox"/>	<b>E. Orthotics/Prosthetics</b>
<input type="checkbox"/>	<b>Z. None of the above</b>

## Section GG: Self-Care

GG0130. Self-Care		
<p><b>Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).</b></p>		
<p><b>Coding:</b></p> <p><b>Safety and Quality of Performance</b> – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. <b>Independent</b> – Patient completes the activity by him/herself with no assistance from a helper.</p> <p>05. <b>Setup or clean-up assistance</b> – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.</p> <p>04. <b>Supervision or touching assistance</b> – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. <b>Partial/moderate assistance</b> – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02. <b>Substantial/maximal assistance</b> – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. <b>Dependent</b> – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.</p> <p><b>If activity was not attempted, code reason:</b></p> <p>07. <b>Patient refused</b></p> <p>09. <b>Not applicable</b> – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.</p> <p>10. <b>Not attempted due to environmental limitations</b> (e.g., lack of equipment, weather constraints)</p> <p>88. <b>Not attempted due to medical conditions or safety concerns</b></p>		
1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	<b>A. Eating:</b> 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.
<input type="text"/>	<input type="text"/>	<b>B. Oral Hygiene:</b> The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
<input type="text"/>	<input type="text"/>	<b>C. Toileting Hygiene:</b> The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/>	<input type="text"/>	<b>E. Shower/bathe self:</b> 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
<input type="text"/>	<input type="text"/>	<b>F. Upper body dressing:</b> The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/>	<input type="text"/>	<b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	<input type="text"/>	<b>H. Putting on/taking off footwear:</b> The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.



## Section GG: Mobility

GG0170. Mobility		
<p><b>Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).</b></p>		
<p><b>Coding:</b></p> <p><b>Safety and Quality of Performance</b> – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. <b>Independent</b> – Patient completes the activity by him/herself with no assistance from a helper.</p> <p>05. <b>Setup or clean-up assistance</b> – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.</p> <p>04. <b>Supervision or touching assistance</b> – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. <b>Partial/moderate assistance</b> – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02. <b>Substantial/maximal assistance</b> – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. <b>Dependent</b> – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.</p> <p><b>If activity was not attempted, code reason:</b></p> <p>07. <b>Patient refused</b></p> <p>09. <b>Not applicable</b> – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.</p> <p>10. <b>Not attempted due to environmental limitations</b> (e.g., lack of equipment, weather constraints)</p> <p>88. <b>Not attempted due to medical conditions or safety concerns</b></p>		
1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. <b>Roll left and right:</b> The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="text"/>	<input type="text"/>	B. <b>Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. <b>Lying to sitting on side of bed:</b> The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/>	<input type="text"/>	D. <b>Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. <b>Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. <b>Toilet transfer:</b> The ability to get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	G. <b>Car Transfer:</b> 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.
<input type="text"/>	<input type="text"/>	I. <b>Walk 10 feet:</b> Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. <i>If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)</i>
<input type="text"/>	<input type="text"/>	J. <b>Walk 50 feet with two turns:</b> Once standing, the ability to walk 50 feet and make two turns.

<input type="text"/>	<input type="text"/>	<b>K. Walk 150 feet:</b> Once standing, the ability to walk at least 150 feet in a corridor or similar space.
<input type="text"/>	<input type="text"/>	<b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="text"/>	<input type="text"/>	<b>M. 1 step (curb):</b> The ability to go up and down a curb and/or up and down one step. <i>If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.</i>
<input type="text"/>	<input type="text"/>	<b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail. <i>If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.</i>
<input type="text"/>	<input type="text"/>	<b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	<input type="text"/>	<b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		<input type="checkbox"/> <b>Q. Does patient use wheelchair and/or scooter?</b> <b>0. No</b> → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. <b>1. Yes</b> → Continue to GG0170R, Wheel 50 feet with two turns.
<input type="text"/>	<input type="text"/>	<b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		<input type="checkbox"/> <b>RR1. Indicate the type of wheelchair or scooter used.</b> <b>1. Manual</b> <b>2. Motorized</b>
<input type="text"/>	<input type="text"/>	<b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		<input type="checkbox"/> <b>SS1. Indicate the type of wheelchair or scooter used.</b> <b>1. Manual</b> <b>2. Motorized</b>