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

<b><u>Time Point</u></b>	<b><u>Items Used</u></b>
<b><u>Start of Care</u></b> ----- Start of care—further visits planned	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
<b><u>Resumption of Care</u></b> ----- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
<b><u>Follow-Up</u></b> ----- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1030, M1200, M1242, M1306, M1308, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
<b><u>Transfer to an Inpatient Facility</u></b> ----- Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	M0080-M0100, M1041-M1056, M1500, M1510, M2004, M2015, M2300-M2410, M2430, M0903, M0906
<b><u>Discharge from Agency — Not to an Inpatient Facility</u></b> Death at home ----- Discharge from agency-----	M0080-M0100, M0903, M0906 M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1500-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2102, M2300-M2420, M0903, M0906

### **CLINICAL RECORD ITEMS**

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

☐ 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:**

**Start/Resumption of Care**

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

**Follow-Up**

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

**Transfer to an Inpatient Facility**

- ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [*Go to M1041*]  
☐ 7 – Transferred to an inpatient facility—patient discharged from agency [*Go to M1041*]

**Discharge from Agency — Not to an Inpatient Facility**

- ☐ 8 – Death at home [*Go to M0903*]  
☐ 9 – Discharge from agency [*Go to M1041*]

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

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

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

	<u>Inpatient Facility Diagnosis</u>	<u>ICD-10-CM Code</u>
a.	_____	_____ . _____
b.	_____	_____ . _____
c.	_____	_____ . _____
d.	_____	_____ . _____
e.	_____	_____ . _____
f.	_____	_____ . _____

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

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

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

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

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

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

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

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

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

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

- Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
<b>(M1021) Primary Diagnosis</b>	<b>V, W, X, Y codes NOT allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>
a. _____	a. _____ . _____ □0 □1 □2 □3 □4	a. _____ (_____ . _____)	a. _____ (_____ . _____)
<b>(M1023) Other Diagnoses</b>	<b>All ICD-10-C M codes allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>	<b>V, W, X, Y, Z codes NOT allowed</b>
b. _____	b. _____ . _____ □0 □1 □2 □3 □4	b. _____ (_____ . _____)	b. _____ (_____ . _____)
c. _____	c. _____ . _____ □0 □1 □2 □3 □4	c. _____ (_____ . _____)	c. _____ (_____ . _____)
d. _____	d. _____ . _____ □0 □1 □2 □3 □4	d. _____ (_____ . _____)	d. _____ (_____ . _____)
e. _____	e. _____ . _____ □0 □1 □2 □3 □4	e. _____ (_____ . _____)	e. _____ (_____ . _____)
f. _____	f. _____ . _____ □0 □1 □2 □3 □4	f. _____ (_____ . _____)	f. _____ (_____ . _____)

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

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

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

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

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

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

**INTEGUMENTARY STATUS****(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

- ☐ 0 - No [*Go to M1322*]
- ☐ 1 - Yes

**(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:**  
(Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

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

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

- ☐ 0      ☐ 1      ☐ 2      ☐ 3      ☐ 4 or more

**(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable:** (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

- ☐ 1 - Stage I
- ☐ 2 - Stage II
- ☐ 3 - Stage III
- ☐ 4 - Stage IV
- ☐ NA - Patient has no pressure ulcers or no stageable pressure ulcers

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

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

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

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

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

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing

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

- ☐ 0 - No [*Go to M1400*]
- ☐ 1 - Yes, patient has at least one observable surgical wound
- ☐ 2 - Surgical wound known but not observable due to non-removable dressing/device [*Go to M1400*]

**(M1342) Status of Most Problematic Surgical Wound that is Observable**

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

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

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

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [*Go to M1620*]
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [*Go to M1620*]

**(M1620) Bowel Incontinence Frequency:**

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination

**(M1630) Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

- ☐ 0 - Patient does not have an ostomy for bowel elimination.
- ☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
- ☐ 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

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

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

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

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

**(M1830) Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

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

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

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

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

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



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

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

### **MEDICATIONS**

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

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

### **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.