Outcome and Assessment Information Set
OASIS-E2 Manual

Effective April 1, 2026

Centers for Medicare and Medicaid Services

TABLE of CONTENTS

CHAPTER 1: OASIS GUIDANCE MANUAL INTRODUCTION

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements home health agencies (HHAs) integrate into their comprehensive assessment, to collect and report quality data to the Centers for Medicare & Medicaid Services (CMS).

1.1 Purpose of the Manual

This manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS data. It includes both general data collection conventions and item-specific guidance, as well as links to resources for agencies.

1.2 Organization of the Manual

This manual includes the following content:

- Chapter 1 – Introduction to the OASIS Manual, including the manual purpose, structure and content, and description of the OASIS requirements and conventions. The manual summarizes the statutory authority for OASIS data collection, and describes the background on the development of OASIS, and its version history.
- Chapter 2 – The importance of Data Accuracy, and how HHAs 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.
- Appendix A Glossary and Common Acronyms
- Appendix B OASIS Items, Time Points and Uses
- Appendix C OASIS Instruments (All Items, and all Time Points versions), available as a separate zip file on the OASIS Data Sets webpage
- Appendix D Description of Changes to the instrument and guidance from the current to the new OASIS version
- Appendix E References and Resources
- Appendix F OASIS and Quality Improvement

1.3 Background

In the early 1990s the Health Care Financing Administration (renamed to the Centers for Medicare & Medicaid Service [CMS] in 2001) and the Robert Wood Johnson Foundation funded research at the University of Colorado (Denver) Health Sciences Center to develop, test and refine a system of outcome quality measures that Medicare and home health agencies (HHAs) could use to continuously improve the effectiveness of home health care. [See Shaughnessy PW, Crisler KS, Schlenker RI, Arnold AG, Kramer AM, Powell MC and Hittle DR. (Fall 1994]. Measuring and assuring the quality of home health care. *Health Care Financing Review, 16*(1):35-67). Through multiple phases of testing and revision researchers developed and refined a core group of data elements to uniformly measure and risk adjust outcomes quality measures. The data set, called the Outcomes and Assessment Information Set (OASIS), measured quality across all HHAs, to produce outcome measures and reports and serve as the basis of outcomes-based quality improvement (OBQI). Selected OASIS items were later identified for use in payment determination in the Prospective Payment System (PPS).

OASIS and its associated guidance Manual are periodically revised based on CMS's addition or removal of quality measures from the Home Health Quality Reporting Program (HHQRP) or for other program requirements. Table 1 lists the version history of OASIS.

Table 1.1: OASIS Version History

OASIS version	Effective date
OASIS	1999
OASIS-B	2002
OASIS-B1	2008
OASIS-C	2010
OASIS-C1 ICD9	2015
OASIS-C1-ICD10	2016
OASIS-C2	2017
OASIS-D	2019
OASIS-D1	2020
OASIS-E	2023
OASIS-E1	2025
OASIS-E2	2026

1.4 Changes from OASIS-E1 to OASIS-E2

The changes in OASIS for version E2, effective April 1, 2026, include the removal of the A1250 Transportation item, which is replaced by the modified A1255 Transportation item (1 data element [DE]) to align with a similar item used in other CMS programs. The item O0350 Patient's COVID-19 vaccination is up to date (1 DE) is removed to align with removal of the associated quality measure. Subregulatory changes include adding the B1000 Hearing, B0200 Vision, and A1110 Language items to the resumption of care (ROC) timepoint. The item A0810 Sex replaces the M0069 Gender item (no change in DE). OASIS Q&As are added to the Manual and a new section on completing OASIS for patients with all payers is added to Chapter 1.

1.4.1 What's new with the OASIS instrument for version E2?

- One item, O0350, has been removed.
- One item, A1250, has been replaced with a modified version, A1255.
- Three items have been added to the ROC timepoint (B1000, B0200, A1110)
- One item, M0069, has been replaced with a modified version A0810.

Refer to Appendix D for a more detailed description of instrument and guidance changes.

1.5 OASIS Requirements

This section provides a basic overview of collecting OASIS data. Refer to Chapter 3 of this manual for more detail on strategies for completing the OASIS as part of a comprehensive assessment.

1.5.1 Home Health Agencies that are Required to Complete OASIS

The comprehensive assessment and OASIS data collection requirements apply to home health agencies (HHAs) that must meet the Medicare home health (HH) Conditions of Participation (CoPs), that is **Medicare-certified HHAs and Medicaid home health providers** (including HHAs operating under a Medicaid waiver) in states *where that state's laws require those agencies to meet the Medicare HH CoPs.*

Example: Medicaid home health provider

A Medicaid-certified pediatric home care agency, which is not Medicare certified, is only required to collect and submit OASIS data if:

- The home care agency's state requires Medicaid home care agencies to meet the Medicare HH CoPs, **AND**
- The patient is not excluded from OASIS data collection, that is, a patient under the age of 18, a patient receiving maternity services, a patient receiving only personal care, housekeeping services or chore services.

1.5.2 All-Payer OASIS Data Collection and Submission

In the Calendar Year (CY) 2023 HH Prospective Payment System (PPS) final rule, CMS finalized:

- The end of the temporary suspension of OASIS data collection on non-Medicare/non-Medicaid HHA patients.
- The requirement for HHAs to submit all-payer OASIS data for the purposes of the HH Quality Reporting Program (QRP), beginning with the CY 2027 Program Year (87 FR 66862 through 66865).

Effective July 1, 2025:

OASIS data collection and submission are *required* for patients (1) with any pay source, (2) who are receiving skilled services, (3) who are not exempt from OASIS data collection, AND (4) who begin receiving home health care services with an OASIS SOC M0090 date on or after July 1, 2025.

1. **Any pay source**
   - Examples include but are not limited to charity-based pay, no payer, and self-pay.
   - **Exception:** All outpatient therapy services – PT, OT, SLP – provided by an HHA and billed under the Medicare Part B benefit that do not have a home health plan of care in effect do not require completion of the OASIS.

2. **Receiving skilled services** HHAs should follow the **Medicare home health benefit definition of "skilled services"** regardless of payer. Skilled services covered by the Medicare home health benefit are discussed in Chapter 7 of the Medicare Benefit Policy Manual. This publication can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.
   - If none of the services provided meet the definition of "skilled" as defined in Chapter 7 of the Medicare Benefit Policy Manual, then OASIS is not required. If any of the services provided meet the definition of "skilled" per Chapter 7 of the Medicare Benefit Policy Manual, then OASIS is required, assuming the patient

does not meet any of the OASIS exemptions.

- Please note, except as they relate to identifying if "skilled care" is being provided, other coverage criteria for the Medicare Home Health Benefit (e.g., homebound status, need for intermittent nursing, continuing Occupational Therapy), are not considered when identifying if OASIS is required.

3. **Not exempt from OASIS data collection** Patients under the age of 18, patients receiving maternity services, and patients receiving only personal care, housekeeping and/or chore services continue to be excluded from OASIS data collection and submission requirements.

4. **Begin receiving home health care services with an OASIS SOC M0090 date on or after July 1, 2025.**

   The requirement includes the SOC OASIS and any subsequent OASIS time point assessments relevant to the patient's home health stay (that is, resumption of care, recertification, other follow-up, transfer, discharge and/or death at home).

1.5.2.1 Voluntary OASIS Assessments

- Non-Medicare/non-Medicaid patients admitted prior to January 1, 2025, and still on service July 1, 2025, and after:
  - HHAs may decide to complete OASIS on these patients, but **no OASIS SOC or subsequent OASIS should be submitted to iQIES.**
- Non-Medicare/non-Medicaid patients, who are not exempt from OASIS data collection, and who begin receiving home health care services with an OASIS SOC M0090 date of January 1, 2025, through June 30, 2025:
  - OASIS data collection at all time points is voluntary, including those assessments completed on or after July 1, 2025.

How will CMS identify Voluntary Assessments?

CMS will use SOC data from M0090 Date Assessment Completed, and from M0150 Current Payment Sources, to identify voluntary assessments in the all-payer phase-in and mandatory periods. Voluntary assessments can be identified as any assessment at any time point collected on a patient who has a M0090 date for their SOC on or between January 1, 2025 and June 30, 2025, AND, the SOC M0150 coding does not include response 1, 2, 3 or 4 (i.e., the patient's home health care is not expected to be billed to a Medicare or Medicaid payer). Note that collection and submission of voluntary assessments could include all subsequent time points for a non-Medicare/non-Medicaid patient with a SOC M0090 date in the phase-in period, including those assessments occurring on or after July 1, 2025.

It is not intended that voluntary OASIS data will be used for any of the following initiatives:

- APU, including the QAO metric.
- Quality measure calculation, including those measures utilized in the expanded HHVBP Model
- HHVBP performance reports

- iQIES quality reports (See Appendix F for more information about quality reports)
- Risk adjustment
- Publicly reported data

1.5.2.2 Loaned Employee Agreements

If a company other than the Medicare-certified HHA is providing a service using HHA staff under a loaned employee agreement OASIS is not required. Examples include, but are not limited to:

- An HHA is contracted to provide a nurse to manage PICC line dressing changes and/or draw labs for a pharmacy company.
- An Assisted Living Program, or PACE program provides care using HHA staff under a loaned employee agreement.

1.5.2.3 Changes in Payer Source

Different states, different payers and different agencies have varying responses to payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs can usually work their way through what they need to do if they answer this question. If the new payer source requires a new SOC) CMS recommends that the patient be discharged from the previous pay source and reassessed under the new pay source (i.e., a new SOC OASIS assessment). The agency does not have to re-admit the patient in the sense that it would normally admit a new patient with all the paperwork that entails.

When transitioning **from a situation requiring OASIS to a situation not requiring OASIS**, such as moving from skilled Medicare to personal care only, CMS encourages HHAs to complete a discharge OASIS assessment at the last visit under the Medicare or Medicaid pay source. While this is not a requirement, conducting a discharge OASIS assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's quality episode for the purposes of the agency's quality initiatives.

Medicare **does not** require a new SOC when a patient's payer changes **from Original Medicare (FFS) to a Medicare Advantage (MA)** plan (per the Medicare Claims processing Manual, Chapter 10, Section 10.2.23 – Changes in Beneficiary's Payment Source). If the patient is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

When there is a pay source change **from MA to Medicare FFS**, while **a new SOC OASIS is required** the original eligibility for the home health benefit is uninterrupted. If continued OT is the only active service at the time of the pay source change from MA to Medicare FFS, the OT can complete the SOC OASIS and continue to provide care as the only active discipline for the remainder of the home health stay.

When an active patient is receiving both nursing and rehabilitation therapy services and experiences a payer change mid-episode that requires a new SOC OASIS, CMS recommends but does not require that the RN complete the SOC comprehensive assessment including OASIS.

Questions related to payment must be discussed with the HHA's Medicare Administrative Coordinator (CMS MAC) or Medicare Advantage payer.

1.5.2.4 When a Pediatric Patient turns 18 years of age while receiving Skilled Home Health Care

Services

If a pediatric patient with a non-Medicare/non-Medicaid payer was receiving skilled home health care services, and turned 18 years of age **before July 1, 2025,** the effective date of the OASIS all-payer requirement, **no OASIS is required** for any time point throughout the patient's home health stay, even if the skilled home health care services continue past July 1, 2025.

Effective July 1, 2025, if a pediatric patient, with any payer, turns 18 years of age while receiving skilled home health care services, OASIS data collection and submission begins with the next OASIS time point. That is, when one of the following takes place:

- The patient returns home from a qualifying inpatient stay (Complete the Resumption of Care, M0100 reason for assessment (RFA) 3).
- The patient is transferred to an inpatient facility for 24 hours or longer for a reason other than diagnostic testing (Complete the Transfer to inpatient facility, M0100 RFA 6 if not discharged from the HHA, or M0100 RFA 7 if discharged from the HHA).
- The 60-day recertification is due – i.e., the last five days of the certification period. (Complete the Follow-up, M0100 RFA 4).
- There is a major decline or improvement in the patient's condition (Complete Other Follow-up, M0100 RFA 5).
- The patient dies at home (Complete Death at Home, M0100 RFA 8).
- The patient is discharged from the agency, not to an inpatient facility (Complete Discharge, M0100 RFA 9).

1.5.3 OASIS and the Comprehensive Assessment

OASIS data are collected as part of the comprehensive assessment required by the Medicare HH Conditions of Participation (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484). OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures. The comprehensive assessment forms the basis of the physician-ordered Plan of Care. Thus, there should be congruence between the overall comprehensive assessment and the Plan of Care.

1.5.4 OASIS Item Sequence and Integration with HHA Systems

Agencies may rearrange OASIS item sequence in a way that permits logical ordering within their own forms and electronic records, if the actual item content, and OASIS number remain the same, and the same skip logic is maintained. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items into their own assessment instrument using the exact language of the items from the current data set. The most current version of OASIS can be found on the CMS Home Health Quality Reporting Program OASIS Data Sets website: OASIS Data Sets | CMS

CMS does not require HHAs to integrate the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set, although doing so would facilitate data entry of the items into the data collection and reporting software. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the OASIS system. As long as the agency can format the required CMS data submission file for

transmission to the OASIS system, it doesn't matter in what order the data are collected.

Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. This software includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than that provided by CMS to report their data so as long as the data are ultimately transmitted to the OASIS system in the required CMS data submission format found on the CMS Website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications.

In the development and maintenance of the OASIS assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications). While the Data Specifications dictate the assessment instrument items, their applicable time point(s) in the assessment instrument, the exact language of the items, and each item's allowable response options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the items in the assessment instrument. For example, presenting the allowable response options in the format of radio buttons in the GUI software is acceptable, and is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring.

While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, such as if additional prompts were added to clarify the reason for Coding 0 for one or more BIMS interview items (C0200-C0400). The items must be presented in a way that makes it clear which items (assessment questions and response options) are part of the OASIS, and which are not.

For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the OASIS item numbers when integrating to alert clinicians that the OASIS items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items.

The OASIS hard copy information for the chart printed out by a point of care system must use the exact language of the items from the current data set. Due to the size and complexity of some of the items (e.g., M1021/1023/1311/2102/2401) the formatting may be modified to fit the computer screen as long as the data set language is not modified, and any format variances in no way impact the accuracy of the item scoring.

The copyright information on certain items is considered part of the OASIS item. The OASIS hard copy information for the chart printed out by a point of care system must use the exact language of the items from the current data set, including the copyright attribution.

In order to be compliant with the Medicare Condition of Participation, §484.55, the OASIS Assessment Items must be incorporated into the agency's comprehensive assessment forms using the language of the OASIS items. The data items may not be kept on a separate form and attached as a separate document to the comprehensive assessment.

The Condition of Participation (CoP) §484.55 states that the current version of the OASIS data items is to be incorporated into the HHA's own assessments. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record, CoP §484.110. Verifying the accuracy of the transmitted OASIS data, CoP §484.45, requires that the OASIS data be retained as part of the clinical documentation.

Agencies may have the comprehensive assessment including OASIS, if applicable, completed by one clinician. If collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and practices related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted standards of practice.

1.5.5 When is OASIS Completed? (Time Points)

OASIS data are collected at the time points listed in the table below, and within the required assessment timeframe. Not all OASIS items are completed at every assessment time point. All OASIS assessments, except transfer to inpatient facility and death at home, require the clinician to have an in-person encounter with the patient during a home visit. The transfer to an inpatient facility and death at home time points require collection of limited OASIS data (most of which may be obtained through a telephone call). OASIS data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment.

Table 1.2: OASIS Data Collection Time Points

Time Point	Reason for Assessment (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)
Resumption of Care (ROC)	3. Resumption of Care after inpatient stay	Within 2 calendar days of the facility discharge date, or knowledge of the 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)
Follow-up (FU)	5. Other Follow-up (significant change in condition)	Within 2 calendar days of significant change in patient's condition.
Transfer	6. Transfer to an inpatient facility – patient not discharged from agency	Within 2 calendar days of the discharge/transfer/death date, or knowledge of a qualifying transfer to an inpatient facility
Transfer	7. Transfer to an inpatient facility – patient discharged from agency	Within 2 calendar days of the discharge/transfer/death date, or knowledge of a qualifying transfer to an inpatient facility
Death at Home	8. Death at Home	Within 2 calendar days of the discharge/transfer/death date.
Discharge	9. Discharge – not to an inpatient facility	Within 2 calendar days of the discharge/transfer/death date.

1.5.6 Who Completes OASIS?

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment including OASIS data collection, if applicable, is the responsibility of a registered nurse (RN) or any of the therapies, including physical therapist (PT), speech language pathologist/speech therapist (SLP/ST), or occupational therapist (OT). A licensed practical nurse or licensed vocational nurse (LPN/LVN), physical therapist assistant (PTA), occupational therapy assistant (OTA), medical social worker (MSW), or home health aide may not be responsible for completing the comprehensive assessment and OASIS. Social workers, although considered a skilled professional as noted in the Condition of Participation (CoP) 484.75 are not a qualifying Medicare home health service, therefore do not complete the comprehensive assessment including OASIS. Social workers may support the assessing clinician through collaboration.

Per the HH Conditions of Participation (CoPs), a registered nurse (RN) must complete the initial assessment and comprehensive assessment including OASIS, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status, **except:**

- When SLP, PT, or OT is the only service ordered by the physician or allowed practitioner who is responsible for the home health plan of care, **the initial assessment visit** may be made by the appropriate rehabilitation skilled professional.
    - For Medicare patients, an OT may complete the initial assessment when OT is ordered with another qualifying rehabilitation therapy service (SLP or PT) that establishes program eligibility.
- When PT, SLP, or OT is the only service ordered by the physician or allowed practitioner, a PT, SLP, or OT may complete **the comprehensive assessment**, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. For example, in a case where PT is the only ordered service and assuming PT services establish program eligibility for the payer, PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be reimbursable visits, therefore would not establish the start of care date for the home care episode.
    - For Medicare patients, the OT may complete the comprehensive assessment when OT is ordered with another qualifying rehabilitation therapy service (SLP or PT) that establishes program eligibility.
    - For non-Medicare/non-Medicaid patients, if OT is the only service ordered, HHAs should follow the Medicare home health benefit definition of “skilled services” to determine if OASIS is required. If the OT services meet this definition of “skilled services” then OASIS is required. Please note that while the need for OT alone does not establish initial eligibility for the Medicare home health benefit it may establish eligibility for other payers.
    - Although not required, if a HHA chooses to complete a new SOC when a patient’s payer changes from Original Medicare to a MA plan, and continuing OT is the only active service remaining as

the only active discipline, the OT may complete the SOC OASIS and continue to provide care as the only active discipline, as the original eligibility for the home health benefit remains uninterrupted.

- When there is a pay source change from MA to Original Medicare while the patient is on service with the HHA, the original eligibility for the home health benefit is uninterrupted. If continued OT is the only active service at the time of the pay source change, then OT can complete the SOC OASIS and continue to provide care as the only active discipline for the remainder of the home health stay.

If an order for nursing existed at the time of the initial referral, the RN must complete the initial assessment visit. If it is determined during the initial assessment visit, that the patient either did not have a need for nursing services and/or the patient declined all nursing services, the Start of Care (SOC) will not be established by that visit. A comprehensive assessment performed on a date BEFORE the SOC date does not meet the Medicare HH CoPs. The RN can notify the physician that nursing will not be involved in the patient's care, and either continue on to complete the SOC comprehensive assessment including OASIS (if the PT will be establishing the SOC that day), return for a non-billable visit to complete the SOC comprehensive assessment including OASIS on or within 5 days after PT establishes the start of care, OR have the PT complete the SOC comprehensive assessment including OASIS.

Multidisciplinary cases may have multiple points of discipline-specific discharge, though there is only one HHA discharge, which must include completion of the comprehensive discharge assessment including OASIS. Other non-OASIS required documentation for admission, recertification and discharge are specified in the Condition of Participation: Comprehensive Assessment of Patients: https://www.ecfr.gov/current/title-42/part-484.

1.5.7 OASIS Privacy Notice

As required by the HH Conditions Of Participation (COP), an OASIS privacy notice must be provided to all patients for whom the OASIS data is collected. Effective January 1, 2025, all patients for whom the HHA collects OASIS, regardless of payer, should be provided Attachment A – Statement of Patient Privacy Rights, and the Privacy Act Statement – Health Care Records. These documents are available on the Home Health Agency (HHA) Center page at https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center. Both documents are available in English and Spanish.

1.5.8 Conventions for Completing OASIS

This section lists conventions, or general rules, to follow when completing OASIS. Item-specific guidance is provided in Chapter 3. It is not possible to address all situations and exceptions that may arise in clinical practice. Each patient scenario, clinical status, and social and environmental situation requires the clinician to consider available guidance and allows use of professional judgment and interdisciplinary collaboration for assessment.

The OASIS guidance is updated periodically through the CMS Quarterly OASIS Q&As, based on questions received by the Home Health Quality Help Desk. In the event you cannot resolve your understanding of the OASIS item guidance by reviewing the OASIS Guidance Manual and/or the Q&A documents, consider submitting your question to the **Home Health Quality Help Desk** (a link to the OASIS Q&As and the email address for the Home Health Quality Help Desk can be found in Appendix E. References and Resources).

CMS provides several key resources to support OASIS data accuracy. The OASIS Guidance Manual contains an item-by-item review with key instructions within Chapter 3 of the manual. Chapter 1 of the OASIS Guidance Manual contains the general and ADL/IADL specific conventions for completing OASIS items.

There are also OASIS Q&As available at https://qtso.cms.gov/tools/oasis/reference-manuals. Categories 1-4 are most relevant for OASIS data collection activities. At the same site, CMS posts quarterly Q&A updates with new and/or refined guidance related to OASIS items. The user may conduct a key word search in these .pdf documents to expedite the search for information.

Questions not otherwise answered in published CMS OASIS resources may be submitted to the CMS Home Health Quality Helpdesk at HomeHealthQualityQuestions@cms.hhs.gov

1.5.8.1 General OASIS Item Conventions

1. Understand the **time period under consideration (look back)** for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
2. Unless otherwise indicated, OASIS item coding is based on the patient's status on the 'day of the assessment.' Since home care visits can occur at any time of the day, and to standardize the timeframe for assessment data, the "day of the assessment" refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient's ability and status, regardless of the time of day of the visit.
3. For OASIS purposes, a **quality episode** must have a beginning (that is, an SOC or ROC assessment) and a conclusion (that is, a Transfer, Death at Home, or Discharge assessment) to be considered a complete quality episode.
4. If the **patient's ability or status varies** on the day of the assessment, report what is true greater than 50% of the time period under consideration, unless the item specifies differently.
5. Minimize the use of **NA and Unknown** responses.
6. Some items allow a **Dash response**. A dash (–) value indicates that no information is available. CMS expects dash use to be a rare occurrence.
7. Responses to items documenting a patient's **current status** should be based on observation and report of the patient's condition and ability at the time of the assessment without referring back to prior assessments or documentation of status from a prior care setting. Several process items require review of documentation of care that occurred at the time of or at any time since the most recent SOC or ROC OASIS assessment. These instructions are included in item guidance for the relevant OASIS items.
8. **Assessment strategies** to complete any and all OASIS items include observation, interview, collaboration with other agency staff and other relevant strategies, unless otherwise noted in guidance. For example, it is acceptable to review the hospital discharge summary for information on a patient's episodes of confusion, or to interview the caregiver regarding the patient's incontinence. However, when assessing physiological or functional health status, direct observation is the preferred strategy. For OASIS items that reflect clinical/patient assessment (e.g., height, weight, functional status, pressure ulcer/injury status), home health agencies should base OASIS responses on assessment by agency staff, and not directly on documentation from previous care settings.
9. An agency's **software may not "answer" or "generate" the OASIS response** for the assessing clinician**.**
10. In the case of an **unplanned discharge** (an end of home care where no in-home visit can be made) the last

qualified clinician who saw the patient may complete the discharge comprehensive assessment, including the OASIS, based on information from their last visit. The assessing clinician may collect information to complete the OASIS items on the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unplanned discharge. The 'last 5 days that the patient received visits" are defined as the date of the last in-home patient visit, plus the four preceding calendar days. In the case of an unplanned discharge, use the following guidance to complete the OASIS:

- Items where a dash is a valid response: When there is no information available because the assessment of the item was not completed prior to the unplanned discharge, a dash may be the only valid response. A dash indicates "no information available" and CMS expects dash use to be a rare occurrence.

- Patient Interview items where a dash is a valid response (BIMS & PHQ-2 to 9): When assessing C0200- C0500 - Brief Interview for Mental Status (BIMS) and/or D0150 - Patient Mood Interview (PHQ-2 to 9), a patient interview is required to complete these items. If a clinician is not able to complete the assessment of these items due to an unplanned discharge and there is no documentation that the interview was completed in the last 5 days that the patient received visits, then a "dash" is the only allowable response.

- Items where a **Dash is not** a valid response: If assessment of an item was not completed prior to the unplanned discharge and there is no information available from the last 5 days the patient received visits, code the item using any available documentation/information. For patient interview items, where the **Dash is not** a valid response, if the patient is unable to respond due to an unplanned discharge and it is allowable, code X or code 8 - Patient unable to respond, depending on the item. Review the guidance manual and Q&As for item-specific guidance.

11. When an OASIS item refers to **assistance**, this means assistance from another person. Assistance is not limited to physical contact and can include necessary verbal cues and/or supervision.
12. **Complete OASIS items** accurately and comprehensively and adhere to skip patterns.
13. Understand the **definitions** of words as used in the OASIS.
14. **Follow rules** included in the item-specific Guidance (Chapter 3 of this manual).
15. **Stay current** with evolving CMS OASIS guidance via updates to the guidance manual and posted Q&A documents.
16. The comprehensive assessment includes the OASIS items and is part of the patient's **legal home health agency clinical record.**
17. While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, they may collaborate to collect data for all OASIS items, if agency policy allows. **Collaboration** may consider information from others such as the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to the OASIS data collection. When collaboration is utilized, the M0090 - Date Assessment Completed, is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed. When used, collaboration must occur within the assessment timeframe and be consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.

18. The use of the term "**specifically**," means scoring of the item should be limited to only the circumstances listed. The use of "**for example**," means the clinician may consider other relevant circumstances or attributes when scoring the item.
19. 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. Accordingly, when coding OASIS items where the presence of a physician's order affects the item coding, orders from these **allowed practitioners** would satisfy the condition of having a physician's order.

1.5.8.2 Conventions Specific to OASIS M1800 ADL/IADL Items

1. Report the patient's physical and cognitive **ability to perform a task**. Do not report on the patient's preference or willingness to perform a specified task.
2. 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.
3. While the presence or absence of a **caregiver** may impact the way a patient carries out an activity, it **does not impact the assessing clinician's ability to assess the patient** to determine and report the level of assistance the patient requires to safely complete a task.
4. Understand **what tasks are included and excluded** in each item and select the OASIS response based only on included tasks.
5. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a **majority of the included tasks**, giving more weight to tasks that are more frequently performed.
6. Consider **medical restrictions** when determining ability. For example, if the physician/allowed practitioner has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, bathing, etc.

CHAPTER 2: DATA ACCURACY AND CORRECTION OF THE OASIS ASSESSMENTS

2.1 Data Accuracy

In any data-driven system, the quality of the output is only as good as the quality of the data input. OASIS data are used for multiple purposes, including production of quality reports for agencies, public reports on the Care Compare website, and to determine payment. Thus, it is imperative that the OASIS data that HHAs collect and submit be accurate and complete. Regulatory language specifying accuracy of OASIS data can be found in the Medicare Conditions of Participation Accuracy of Encoded OASIS Data found in Section 484.55 of the Conditions of Participation (See Appendix E). This language stipulates that the encoded OASIS data must accurately reflect the patient's status at the time the information is collected. The State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted to the CMS.

2.2 Data Auditing

It follows that minimizing data errors that could affect accuracy of clinical data or outcome analyses is a necessary condition. This is the responsibility of the agency since, ultimately, agency-level quality reports reflect the data agencies input into the system. Internal staff development and training should focus on data accuracy, not only at the start-up of OASIS data collection, but on a continuing basis. Once the qualified skilled professional (specifically, RN, PT, SLP/ST, or OT) completes the assessment, the HHA should develop internal systems for monitoring data accuracy to ensure that the OASIS data transmitted to CMS exactly reflects the data collected by the skilled professional. The qualifications of individuals doing a quality review of the comprehensive assessment, including OASIS items, and/or providing education and instruction related to OASIS data collection should be defined by agency policy.

Processes to promote data accuracy may include clinical record audits, data entry audits, reports produced from electronic health record systems or other activities. Routine agency OASIS data audits are recommended, with audit frequency determined by the agency. Some data audit activities might be conducted monthly, while others conducted at less frequent intervals, such as quarterly.

The following guidelines offer examples of approaches for monitoring the quality of OASIS data in an agency. Types of audits, their recommended frequency, and categories of staff members (to conduct data audit activities and summarize findings) are suggested. Use of these approaches is not mandated by CMS, nor do they ensure regulatory compliance. If problems are identified, it is also recommended that the agency develop and implement a plan to correct data quality problems. Table 1 displays the data quality audit approaches discussed and summarizes the purpose, frequency, and procedures for each.

Table 2.1: Data Quality Audits

Audit Type	Purpose	Frequency	Overview of Procedure	Performed By
Clinical Record Audit	To verify accuracy of OASIS patient status items compared to other related patient documentation	Monthly	Review at least five SOC records and five discharge records. Compare OASIS items to other documentation from the SOC or discharge visits and from other visits surrounding SOC or discharge.	QI Coordinator
Clinical Audit Visits	To verify accuracy of OASIS assessment data (that is, evaluate Assessment methodology and assessment skills of clinical staff)	Quarterly	For at least three or four patients on a team or within the agency, a supervisor or peer auditor attends the SOC visit. The auditor completes OASIS items while the assessing clinician conducts the assessment and completes SOC paperwork. OASIS item codes are compared for consistency between auditor and care provider. Consider similar auditing efforts for the additional time points after the SOC.	QI Coordinator, Clinical Supervisor, or Clinical Staff

2.2.1 Clinical Record Audits

Clinical record audits allow an agency to monitor the validity of OASIS data. This quality check assesses the congruence of OASIS data with other patient status information found in the clinical record.

To complete a clinical record audit, an abbreviated record review can be conducted for at least five new admissions and five patients discharged from the agency (but not due to an inpatient facility admission). Records should be randomly selected, in order to evaluate data quality for a cross-section of patients and care providers. In the event that the agency has fewer than five patients admitted to or discharged from the agency, review all records. It should be noted that many agencies may choose to audit a larger sample, and some may audit 100% of records.

2.2.2 Procedure for Clinical Record Audits

For new admissions, review the start of care (SOC) OASIS items and compare them to other admission documentation and two or three subsequent visit notes, if they occur within the first week after SOC. In addition, if care providers from two disciplines perform assessments on the patient within one week of SOC (for example, registered nurse conducts comprehensive assessment visit and completes OASIS items; the physical therapist visits two days later and evaluates the patient), the documentation would be compared. Reviewers would evaluate whether any discrepancies between the SOC OASIS assessment and the other documentation are sufficiently significant to indicate a data quality problem. For example, if the SOC OASIS items indicate that the patient is fully independent in ambulation, but other documentation indicates that the patient needs assistance when walking, a data quality problem may exist. Assess for any discrepancies between sociodemographic items (for example, payment source or birth date) in addition to discrepancies in clinical assessments (ICD-10-CM codes, all clinical assessment OASIS items).

The records for discharged patients could be reviewed in the same manner. All discharge OASIS patient status items would be compared to other discharge information as well as to the previous two or three visit notes (if

those visits occur within the same week of discharge). If there are unexpected/unexplainable differences in descriptions of the patient, a potential data quality problem may exist.

If differences are found that cannot be explained by other documentation in the clinical record, the care provider who completed the OASIS would be contacted to determine if the discrepancies were real (for example, the patient did change significantly between the SOC visit and a visit the next day) or if an error was made when recording OASIS data. If data quality problems exist, the problems can be corrected. If clinical documentation must be amended, this is done according to agency policy. Any corrections to OASIS data in the clinical record must also be reflected in the OASIS database maintained by the agency, and if data submission has already occurred, a correction must be transmitted to CMS.

2.2.3 Clinical Audit Visits

Clinical audit visits provide an opportunity to verify the quality of patient status data collected by assessing clinicians. We recommend that agencies conduct supervisory (or peer) audit visits to at least three to four patients each quarter. These audit visits should occur at the admission comprehensive assessment visit, as well as at other time points based on agency needs and goals. Within a one-year period, each clinical staff member of an average-sized agency or an agency's team can receive an audit visit. The supervisor or peer auditor should complete the OASIS items while observing the assessing clinician conducting the assessment visit. The assessing clinician and auditor should not discuss OASIS items between themselves during the visit. The QI coordinator (or designated person) then compares each code on the OASIS items completed by the assessing clinician to the OASIS codes completed by the auditor. Discrepancies should be noted. Any differences

between OASIS coding should be discussed jointly by the assessing clinician and auditor to determine the reasons for the differences and to ensure that assessing clinicians fully understand the OASIS items and related guidance. It is not necessary to select a random sample of patients for the audit visits, but the QI coordinator or QI team should ensure that a variety of patients and assessing clinicians are represented.

2.3 Summarizing Audit Activities

Agencies would summarize findings from all audit activities as they are completed. Because these audit activities will be an ongoing quality monitoring activity, it may be helpful to include summaries of findings in quarterly QI reports. If data quality problems are identified from the audit activities, investigations would be conducted into the cause(s) of the problems, and action plans developed and implemented to resolve the problems. Approaches to assure that accurate patient-level data are utilized to describe patient status and to compute outcome measures increase the likelihood that agency-level outcome reports accurately describe the effectiveness of patient care.

2.4 Data Correction and Reporting Implications

All HHA users are expected to submit required OASIS records to CMS via the internet Quality Improvement and Evaluation System (iQIES). An automated correction policy exists related to submission of modification and inactivation records when the current OASIS record in the iQIES database is erroneous. The following two processes have been established to correct records that have been accepted into iQIES:

- A **Modification** record should be used when a record has been accepted into iQIES, but the information in the record contains clinical errors or errors to non-key fields.
- An **Inactivation** record should be used when a record has been accepted into iQIES, but the corresponding event did not occur or information in ANY of the key fields is erroneous.

Users are not allowed to change data in key fields. If data in the key fields in the current record are inaccurate,

the current record must be inactivated, and a new replacement record should be submitted.

Effective January 1, 2020, HHAs have 24 months from the assessment target date to submit, modify, or inactivate OASIS records. For additional details including the list of key fields, please reference the QIES Technical Support Office for HH Providers (See Appendix E).

Additionally, online help is available in iQIES for those users who take advantage of the assessment data entry software within iQIES. To access this online support authorized users would log into iQIES, select the Help link from the bottom of the page, and select the Assessments tab.

Before data is publicly reported on Care Compare, HH providers have an opportunity to review and correct, as well as preview, their data. A Review and Correct Report is available for providers to access in the iQIES CMS reporting system. The Review and Correct Report will assist providers in identifying whether there are any issues with the data already collected and submitted before the applicable quarterly data submission deadlines. Correction of any errors identified by the agency must be submitted by the final submission deadlines, which can be found on the CMS HH QRP Data Submission Deadlines web page. Only updates/corrections to the underlying assessment data submitted before the data correction deadline will be reflected in the publicly reported data on Care Compare.

If a provider corrects assessment data after the data correction deadline, the corrected data will only be reflected in the QM agency- and patient-level reports. Corrections will not be reflected in the Provider Preview Reports or on the Care Compare website.

A quarterly Provider Preview Report issued by CMS displays the data that will be publicly reported. This report is available approximately 3 months prior to the data being displayed on Care Compare. It provides an opportunity to review agency-level assessment and claims-based QM data for measures that will be publicly reported on the Care Compare website for that reporting period.

This page intentionally left blank

CHAPTER 3: ITEM-BY-ITEM GUIDE TO THE OASIS ASSESSMENT INSTRUMENT

3.1 Overview

This chapter provides item-by-item coding instructions for HH assessing clinicians to complete each section of the OASIS instrument. The goal of this chapter is to provide HH staff with the rationale and guidance necessary to accurately complete each OASIS item.

3.2 OASIS Manual Sections

The sections in the OASIS Manual are listed in Table 3.1, below.

Table 3.1: OASIS Manual Sections

Section	Title	Section	Title
A	Administrative Information • Patient Tracking	H	Bowel and Bladder
B	Hearing, Speech, and Vision	I	Active Diagnoses
C	Cognitive Patterns	J	Health Conditions
D	Mood	K	Swallowing/Nutritional Status
E	Behavior	M	Skin Conditions
F	Preferences for Customary Routine Activities	N	Medications
G	Functional Status	O	Special Treatments, Procedures and Programs
GG	Functional Status: Functional Abilities	Q	Participation in Assessment and Goal Setting

3.3 Using This Chapter

This chapter includes item-specific guidance for each OASIS item. Each section begins with a brief introduction describing the items found in the section.

Throughout this chapter, the OASIS sections are presented using a standard format for ease of review by HH staff. Item-specific guidance includes additional headings to convey information, for example, Coding Instructions, Coding Tips and Examples where appropriate. The order for information is presented as follows:

- **Item Display.** Item-specific guidance begins with a screen shot, which displays the item from the OASIS instrument.
- **Intent.** States the reason(s) for including this item.
- **Time Point(s) Items Completed.** Lists when the information for the data element is to be collected during the patient's home health episode of care.
- **Item Rationale.** Explains the purpose, meaning or importance of the item; the reason why the item is needed.
- **Response Specific Instructions.** General instructions for how to complete the item, which apply to most,

if not all, situations; how users are intended to collect information to complete the item.

- **Coding Instructions.** Provides additional information to supplement the instructions found in the data element.
- **Coding Tips.** Any special situations, outliers, or uncommon scenarios; or any tips to clarify confusing or equivocal circumstances when coding each item.
- **Examples.** Illustrates examples of appropriate coding for several of the items.

SECTION A: ADMINISTRATIVE INFORMATION – PATIENT TRACKING

Introduction

This section includes items for patient tracking and general administrative information.
Patient tracking items only need to be revised if the patient information changes during the episode. For each item, the first bullet under Response-Specific Instructions includes data sources and resources that may be used to respond to the item.

M0018: National Provider Identifier (NPI)

M0018. National Provider Identifier (NPI) for the attending physician who has signed the plan of care	
	☐☐☐☐☐☐☐☐☐☐ ☐ UK — Unknown or Not Available

Item Intent

Identifies the physician/allowed practitioner who will sign the Plan of Care.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Agency medical records department could be consulted about this item.
- For more information see the link for NPI registry in Appendix E of this manual.
- The NPI is a ten-digit numeric identifier.

Coding Instructions

Dash is not a valid response for this item.

Coding Tips

- The assessing clinician should enter the NPI number of the physician/allowed practitioner expected to oversee and sign the Plan of Care, even if a different provider made the referral.

M0010: CMS Certification Number

M0010. CMS Certification Number
☐☐☐☐☐☐

Item Intent

Specifies the agency's Centers for Medicare & Medicaid Services (CMS) certification number (CCN/Medicare provider number).

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Agency administrative and billing staff could be consulted about this item.
- Enter the agency's CMS certification (Medicare provider) number.
- If the agency is not Medicare-certified, leave this item blank.
- This is NOT the Provider's NPI number.
- Preprinting this number on clinical documentation is allowed and recommended.

Coding Instructions

Dash is not a valid response for this item.

M0014: Branch State

M0014. Branch State	
	☐☐

Item Intent

Specifies the State where the agency branch office is located.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Agency administrative and billing staff could be consulted about this item.
- Enter the two-letter postal service abbreviation of the State in which the branch office is located.
- If a branch ID (not N or P) is entered in M0016, then M0014 cannot be blank.
- Preprinting this abbreviation on clinical documentation is allowed and recommended.

Coding Instructions

Dash is not a valid response for this item.

M0016: Branch ID Number

M0016. Branch ID Number	
	☐☐☐☐☐☐☐☐☐☐

Item Intent

Specifies the branch identification code, as assigned by CMS.

Time Points Item(s) Completed

Start of Care

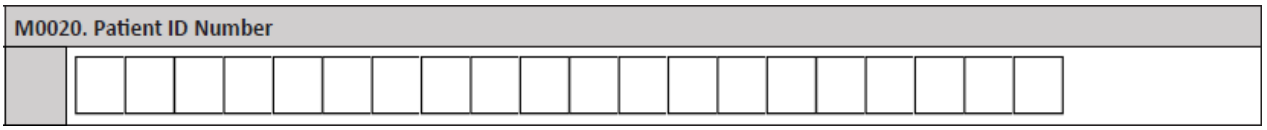
Response-Specific Instructions

- Agency administrative and billing staff could be consulted about this item.
- Enter the Federal branch identification number specified for this branch as assigned by CMS.
- The identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.
- Preprinting this number on clinical documentation is allowed and recommended.

Coding Instructions

- **Code N if** you are an HHA with no branches. The remaining 9 boxes should be blank.
- **Code P if** you are a parent HHA that has branches. The remaining 9 boxes should be blank.
- **Dash is not** a valid response for this item.

M0020: Patient ID Number



Item Intent

Identifies the agency-specific patient identifier.

Time Points Item(s) Completed

Start of Care

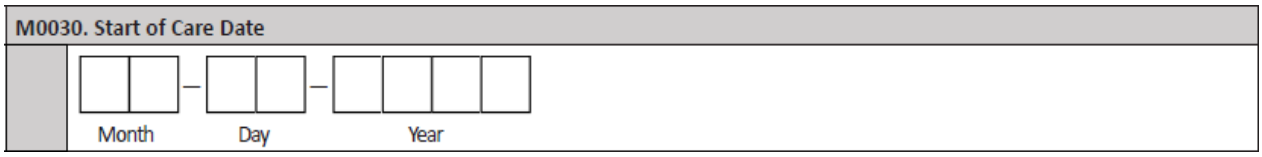
Response-Specific Instructions

- Agency medical records department could be consulted about this item.
- Enter the identification code the agency assigns to the patient and uses for record keeping purposes for this episode of care.
- If there are fewer digits than boxes provided, leave boxes at the end blank.
- The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (for example, from start of care to discharge).

Coding Instructions

Dash is not a valid response for this item.

M0030: Start of Care Date



Item Intent

Specifies the start of care date, which is the date that the first reimbursable service is delivered.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Agency administrative staff may be consulted on this item.
- In multidiscipline cases, coverage criteria, regulatory requirements (such as the Conditions of Participation), and agency policy establish which discipline's visit is considered the start of care. A reimbursable service must be delivered to be considered the start of care. All other coverage criteria must be met for this initial service to be billable and to establish the start of care.
- If the day or month is only one digit, that digit should be preceded by a "0" (for example, May 4, 2025, is 05/04/2025).
- Enter all four digits for the year.
- Accuracy of this date is essential; many other aspects of data collection are based on this date.
- When the agency's policy/practice is for an RN to perform the SOC assessment in a therapy-only case and the therapist's first visit is the start of care date (i.e., the first billable visit), the non-billable nursing assessment visit must be made the same day or within five days after the therapist's first visit.
- If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

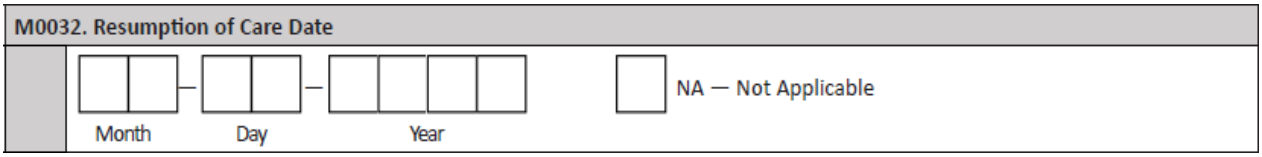
Coding Instructions

Dash is not a valid response for this item.

Coding Tips

- The Start of Care date is the date of the first reimbursable service and is maintained as the start of care date until the patient is discharged. It should correspond to the start of care date used for other documentation, including billing or physician orders.
- The Start of Care date does not change with a new certification period, or when a new service is added during the episode. There is only one Start of Care date for the episode.

M0032: Resumption of Care Date



Item Intent

Specifies the date of the first visit following an inpatient stay by a patient receiving service from the home health agency.

Time Points Item(s) Completed

Resumption of Care

Response-Specific Instructions

- Agency administrative staff may be consulted on this item.
- The resumption of care date must be updated on the Patient Tracking Sheet each time a patient returns to service following an inpatient facility stay.
- The most recent resumption of care date should be entered.
- If the day or month is only one digit, that digit is preceded by a "0" (for example May 4, 2025, = 05/04/2025).
- Enter all four digits of the year.

Coding Instructions

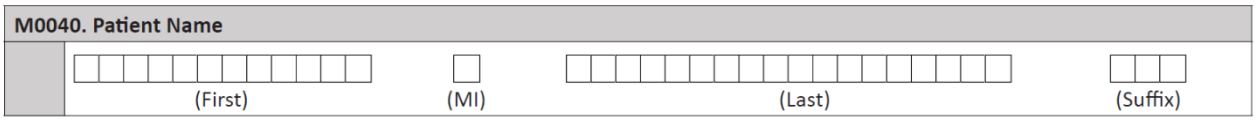
- **Code NA,** if a start of care assessment.
- **Dash is not** a valid response for this item.

Coding Tips

- When the physician specifies a date that home care services must resume (a physician- ordered Resumption of Care date), the agency is expected to conduct the ROC visit on that date. The agency has up to 2 calendar days from the physician-ordered ROC Date to complete the ROC assessment.
    - For example, if the patient is discharged from the hospital on September 1, and the physician orders home care to resume on September 4, the M0102 Physician-ordered Resumption of Care Date is 09-04-xxxx, and the M0032 Resumption of Care date is 09-04-xxxx, and the M0090 Date Assessment Completed can be on or between 09-04-xxxx and 09-06-xxxx.
- If a patient returns home from the hospital and requires immediate care, such as an injection, services may be provided before the ROC comprehensive assessment is completed. The ROC assessment, including OASIS, must be completed within 2 calendar days of the facility discharge date, the agency's knowledge of the patient's return home, or a physician-ordered ROC date. The ROC date (M0032) is defined as the date of the **first visit following an inpatient discharge**, regardless of which qualified clinician ultimately completes the ROC assessment. The ROC assessment must be completed by an RN, PT, OT, or SLP. In this example, an on-call nurse may conduct the initial visit and provide the necessary care prior to the completion of the ROC

assessment.

M0040: Patient Name



Item Intent

Specifies the full name of the patient: first name, middle initial, last name, and suffix (for example, Jr., III, etc.).

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- The data sources/resources for this item include the patient's Medicare card, private insurance card, HMO identification card, etc.
- Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important.
- If there is no suffix, leave blank. If the middle initial is not known, leave blank.
- The name entered should be exactly as it appears on the patient's Medicare or other insurance card.
- The name entered should be the patient's legal name, even if the patient consistently uses a nickname.
- The sequence of the names may be reordered (that is, last name, first name, etc.) in agency forms, if desired.

Coding Instructions

Dash is not a valid response for this item.

Coding Tips

- The OASIS item provides a maximum length of 12 characters for the first name, 1 character for the middle initial, and 18 characters for the last name.
- The length of the text submitted must not exceed the maximum length specified or it will result in a fatal Format Edit when submitted.
- In cases where a patient's name has more letters than the OASIS submission allows, enter the first 12 letters (for first name), the first letter (for middle initial), and the first 18 letters (for last name), and disregard any additional letters/characters.
- The name may contain an (') apostrophe.

M0050: Patient State of Residence

M0050. Patient State of Residence	
	☐☐

Item Intent

Specifies the State in which the patient is currently residing while receiving home care.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- The data sources/resources for this item include municipal, county, or State officials, in order to clarify the exact (State) location of the residence, if necessary.
- Enter the two-letter postal service abbreviation of the State in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence.

Coding Instructions

Dash is not a valid response for this item.

M0060: Patient ZIP Code

M0060. Patient ZIP Code	
	☐☐☐☐☐ – ☐☐☐☐

Item Intent

Specifies the ZIP code for the address at which the patient is currently residing while receiving home care.

Item Rationale

The patient's ZIP code is used for Care Compare to determine places where your agency provides service.

Time Points Item(s) Completed

Start of Care

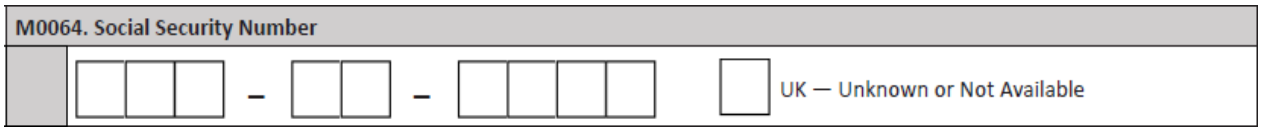
Response-Specific Instructions

- The data sources/resources for this item include the post office, to verify the ZIP code, if necessary.
- Enter the ZIP code for the address of the patient's CURRENT residence, even if this is not the patient's usual (or legal) residence.
- Be sure to use the ZIP code where the service is provided.
- Enter at least five digits (nine digits if known).

Coding Instructions

Dash is not a valid response for this item.

M0064: Social Security Number



Item Intent

Specifies the patient's Social Security number.

Time Points Item(s) Completed

Start of Care

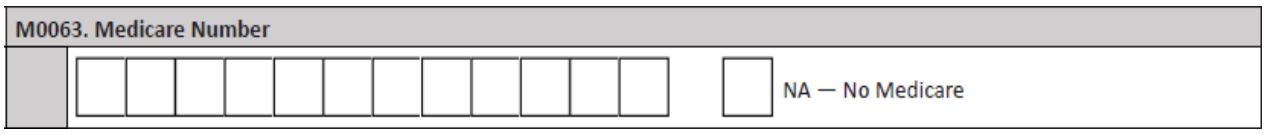
Response-Specific Instructions

- Review the Patient's Social Security card.
- Referral information may include the number, but it should be verified with the patient.
- Include all nine numbers. Mark "UK" if unknown or not available (for example, information cannot be obtained or patient refuses to provide information).

Coding Instructions

Dash is not a valid response for this item.

M0063: Medicare Number



Item Intent

This item identifies the patient's Medicare number, including any prefixes or suffixes.

Time Points Item(s) Completed

Start of Care

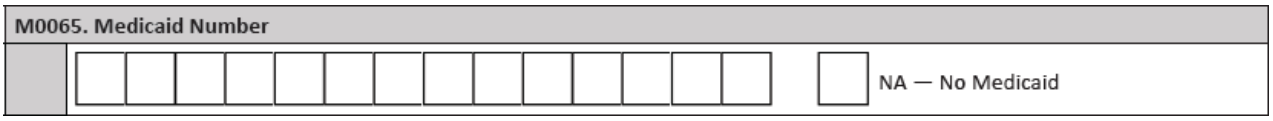
Response-Specific Instructions

- Review the patient's Medicare card. The referral information may include the number, but it should be verified with the patient.
- In an effort to fight identity theft for Medicare beneficiaries, CMS replaced the Social Security number (SSN)-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI).

- After December 31, 2019: Enter the MBI. Do not report the patient's SSN-based HICN.

- The patient's Medicare number, the Medicare Beneficiary Identifier (MBI) should be entered whether or not Medicare is the pay source for the episode.
  - Keep in mind that Medicare is often a secondary payer even when another payer is billed first. To bill Medicare as a secondary payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150 Current Payment Source for Home Care.
- If the patient does not have Medicare, mark "NA – No Medicare."
- If the patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number if available. If not available, mark "NA – No Medicare." 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.
- If there are fewer digits than boxes provided, leave boxes at the end blank.
- **Dash is not** a valid response for this item.

M0065: Medicaid Number



Item Intent

Specifies the patient's Medicaid number.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Review the patient's Medicaid card or other verifying information.
- Referral information may include the number, but it should be verified with the patient. Make sure that coverage is still in effect by checking the expiration date.
- Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency. Include all digits and letters. If patient does not have Medicaid coverage or Medicaid coverage is pending, mark "NA – No Medicaid."
- Regardless of payer source for the home care episode, indicate if the patient has Medicaid.

Coding Instructions

Dash is not a valid response for this item.

A0810: Sex

A0810. Sex	
Enter Code ☐	1. Male 2. Female

Item Intent

Specifies the sex of the patient.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Interview the patient and/or caregiver. Referral information (including hospital or physician office clinical data), or observation and physical assessment may be used.
- Based on the resources mentioned above, enter a response for patient's sex.

Coding Instructions

Dash is not a valid response for this item.

M0066: Birth Date

M0066. Birth Date	
	☐☐ – ☐☐ – ☐☐☐☐ Month Day Year

Item Intent

Specifies the birth date of the patient, including month, day, and four digits for the year.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Interview the patient and/or caregiver report, or review other legal documents (driver's license, state-issued ID card, etc.).
- If the day or month is only one digit, that digit should be preceded by a "0" (for example, May 4, 2025= 05/04/2025).
- Enter all four digits of the year.

Coding Instructions

Dash is not a valid response for this item.

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
☐	Y. Patient declines to respond

Item Intent

The intent of this item is to identify the patient's self-reported ethnicity data.

DEFINITION	**ETHNICITY: HISPANIC OR LATINO/A** • A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. The term "Spanish Origin" can be used in addition to Hispanic or Latino/a.

Item Rationale

- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple health care settings and is an important step in improving quality of care and health outcomes.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Ask the patient to select the category or categories that most closely correspond to the patient's ethnicity from the list in A1005, Ethnicity.
- Respondents should be offered the option of selecting one or more ethnic designations.
- If a patient is **unable to respond**, a proxy response may be used.
- Only use medical record documentation if the patient is unable to respond and a proxy is not able to provide a response to this item.
- If a patient declines to respond, do not code based on proxy response or medical record documentation.
- If the patient **can provide a response**:

- Check all that apply.
- Check the box(es) indicating the ethnic category or categories identified by the patient.

- Complete as close to the time of SOC as possible

Coding Instructions

- **Code X, Patient unable to respond**, if the patient is unable to respond.
  - If the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used.
  - If the response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including code X - Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, code X – Patient unable to respond, **only**.
- **Code Y, Patient declines to respond** if the patient declines to respond.
  - In the cases where the patient declines to respond, code Y – Patient declines to respond, **only**.
  - If the patient **declines to respond,** do not code based on proxy input or medical record documentation.
- **Dash is not** a valid response for this item.

Examples

1. The patient had an acute CVA with mental status changes. During the SOC assessment the patient is unable to respond to questions regarding their ethnicity. The patient's spouse informs the nurse that they are Cuban.
   - **Coding:** A1005, Ethnicity would be coded as D - Yes, Cuban and X – Patient unable to respond.
   - **Rationale:** If a patient is unable to respond and the proxy provides the response, code both the proxy response and X - Patient unable to respond.
2. The patient is admitted following a THA and declines to respond to questions regarding their ethnicity.
   - **Coding:** A1005, Ethnicity would be coded as Y – Patient declines to respond.
   - **Rationale:** If a patient declines to respond to this item, then the only response option that should be coded is Y – Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1005, Ethnicity when a patient declines to respond.

A1010: Race

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

Item Intent

The intent of this item is to identify the patient's self-reported race data.

Item Rationale

- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple health care settings and is an important step in improving quality of care and health outcomes.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Time Points Item(s) Completed

Start of Care

DEFINITIONS	**AMERICAN INDIAN OR ALASKAN NATIVE** • A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **ASIAN** • A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam. **BLACK OR AFRICAN AMERICAN** • A person having origins in any of the black racial groups of Africa.

	Terms such as “Haitian” or “Negro” can be used in addition to “Black” or “African American.” **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER** • A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **ASIAN** • A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Response-Specific Instructions

- Ask the patient to select the category or categories that most closely correspond to the patient’s race from the list in A1010, Race.
- Respondents should be offered the option of selecting one or more race categories.
- If a patient is **unable to respond**, a proxy response may be used.
- Only use medical record documentation to code A1010, Race if the patient is unable to respond and a proxy is not able to respond to this item.
- If the patient declines to respond, do not code based on a proxy response or medical record documentation.
- If the patient **can provide a response**:
  - Check all that apply.
  - Check the box(es) for indicating the race category or categories identified by the patient.
- Complete as close to the time of SOC as possible.

Coding Instructions

- **Code X, Patient unable to respond**, if the patient is **unable to respond.**
  - In cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used.
  - If the response(s) is/are determined via proxy input and/or medical record documentation, check all boxes that apply, including Code X - Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, code X – Patient unable to respond, **only**.
- **Code Y, Patient declines to respond** if the patient **declines to respond.**
  - In the cases where the patient declines to respond, code Y – Patient declines to respond, **only**.
  - If the patient declines to respond, do not code based on proxy input or medical record documentation to complete this item.
- **Code Z, None of the above,** whether the patient reports or it is determined from proxy or medical record documentation that none of the listed races apply to the patient.
- **Dash is not** a valid response for this item.

Examples

1. The patient has severe dementia with agitation. During the SOC assessment the patient is unable to respond. The patient's child informs the nurse that the patient is Korean and African American.
   - **Coding:** A1010 would be coded as B - Black or African American, H – Korean, and X – Patient unable to respond.
   - **Rationale:** If a patient is unable to respond and the proxy provides the response, code both the proxy response and X – Patient unable to respond.
2. The patient declines to provide their race during the admission assessment stating, "I'd rather not answer."
   - **Coding:** A1010, Race would be coded as Y – Patient declines to respond.
   - **Rationale:** If a patient declines to respond to this item, then code only Y, Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1010, Race when a patient declines to respond.
3. The patient is admitted to the HHA following a recent CVA resulting in confusion and is unable to inform the assessing clinician which race applies to them. The proxy reports that none of the listed races apply to the patient.
   - **Coding:** A1010, Race would be coded as X, Patient unable to respond and Z, None of the above.
   - **Rationale:** If a patient is unable to respond, proxy input may be used to code A1010, Race. When a patient is unable to respond but proxy input can provide the necessary information, code both the information from the proxy input, in this case Z, None of the above, **and** X, Patient unable to respond.

M0150: Current Payment Sources for Home Care

M0150. Current Payment Sources for Home Care	
↓	Check all that apply
☐	0. None; no charge for current services
☐	1. Medicare (traditional fee-for-service)
☐	2. Medicare (HMO/managed care/Advantage plan)
☐	3. Medicaid (traditional fee-for-service)
☐	4. Medicaid (HMO/managed care)
☐	5. Worker's compensation
☐	6. Title programs (for example, Title III, V, or XX)
☐	7. Other government (for example, TriCare, VA)
☐	8. Private insurance
☐	9. Private HMO/managed care
☐	10. Self-pay
☐	11. Other (specify)
☐	UK. Unknown

Item Intent

This item identifies payers who will be billed by your home health agency for services provided during the home health episode.

Time Points Item(s) Completed

Start of Care

Response-Specific Instructions

- Review referral information and health insurance identification cards.
- Exclude "pending" payment sources.
- If the patient's care is being reimbursed by multiple payers (for example, Medicare and Medicaid; private insurance and self-pay; etc.), include all sources.
- If one or more payment sources are known but additional sources are uncertain, mark only those that are known.
- Do not consider any equipment, medications, or supplies being paid for by the patient in part or in full.

Coding Instructions

- **Code 2,** if the payment source is a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C.
- **Code 3,** if the patient is receiving services provided as part of a Medicaid waiver or home and community- based waiver (HCBS) program.
- **Code 6,** if the patient is receiving services through one of the following programs:
  - Title III – State Agency on Aging grants, which encourage State Agencies on Aging to develop and implement comprehensive and coordinated community-based systems of service for older individuals via Statewide planning and area planning. The objective of these services and centers is to maximize the informal support provided to older Americans to enable them to remain in their homes and communities. This program ensures that elders receive the services they need to remain independent by providing transportation services, in-home services, and caregiver support services.
  - Title V – State programs to maintain and strengthen their leadership in planning, promoting, coordinating, and evaluating health care for pregnant women, mothers, infants, and children, and children with special health care needs in providing health services for mothers and children who do not have access to adequate health care.
  - Title XX – Social service block grants available to states to provide homemaking, chore service, home management, or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.
- **Code 7**, if the patient is a member of a Tri-Care program.
- **Code 8, Private Health Insurance,** is traditional health insurance provided by private companies where individuals or employers purchase coverage.
- **Code 9, Private Managed Health Insurance,** is a type of private health insurance that contracts with a network of providers to deliver care at lower costs. Examples include HMO, PPO, EPO, POS plans that use a network of providers.
- **Code 10,** if the patient is self-pay for all or part of the care (for example, copayments).
- **Dash is not** a valid response for this item.

Coding Tips

- For definitions and descriptions of health insurance types, including commercial insurance, managed care plans (HMOs, PPOs), and other structures, please review the information available at: https://www.healthcare.gov/
- If a patient's care is being reimbursed under a combined Medicare and Medicaid managed care insurance plan, check both response 2 and response 4.

SECTION A: ADMINISTRATIVE INFORMATION

A1110: 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

Item Intent

The intent of this item is to identify the patient's self-reported preferred language and need for an interpreter.

Item Rationale

- Language barriers can lead to social isolation, depression, and patient safety issues.
- Language barriers can interfere with accurate assessment.

Time Points Item(s) Completed

Start of Care

Resumption of Care

Response Specific Instructions

- Ask for the patient's preferred language.
- Ask if the patient needs or wants an interpreter to communicate with a doctor or health care staff.
- If the patient themselves – or with the assistance of an interpreter – is unable to respond to A1110A, What is your preferred language? or A1110B, Do you need or want an Interpreter? a proxy response is permitted.
- Only use medical record documentation to code A1110A, What is your preferred language? Or A1110B, Do you need or want an Interpreter? if the patient is unable to respond and no proxy is able to provide a response.
- Complete as close to the time of SOC or ROC as possible.

Coding Instructions for A1110A Preferred Language

- Enter the preferred language the patient primarily speaks or understands.
- **Dash** is a valid response for this item.
  - If the patient or any available source cannot or does not identify preferred language, enter a dash.
  - ("- ") in the first box. A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Instructions for A1110B Need for Interpreter

- **Code 0, No:** if the patient indicates no want or need for an interpreter to communicate with a doctor or

health care staff.

- If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.
- If the patient is unable and a proxy response is not available, then medical record documentation may be used.

- **Code 1, Yes:** if the patient indicates the need or want of an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated.
  - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.
  - If the patient is unable and a proxy response is not available, then medical record documentation may be used.
- **Code 9, Unable to determine:** if no source can identify whether the patient needs or wants an interpreter.
- **Dash is not** a valid response for this item.

Coding Tips

- An organized system of signing, such as American Sign Language (ASL), can be reported as the preferred language if the patient needs or wants to communicate in this manner.
- A1110 does not report who the interpreter will be.

M0080: Discipline of Person Completing Assessment

M0080. Discipline of Person Completing Assessment	
Enter Code ☐	1. RN 2. PT 3. SLP/ST 4. OT

Item Intent

Specifies the discipline of the clinician completing the comprehensive assessment at the specified OASIS time point or the clinician reporting the transfer to an inpatient facility or death at home.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Transfer
- Discharge from agency
- Death at Home

Response-Specific Instructions

- Data sources/resources for this item are agency policies.
- Enter the response associated with the discipline of the individual completing the assessment (referred to as the assessing clinician).

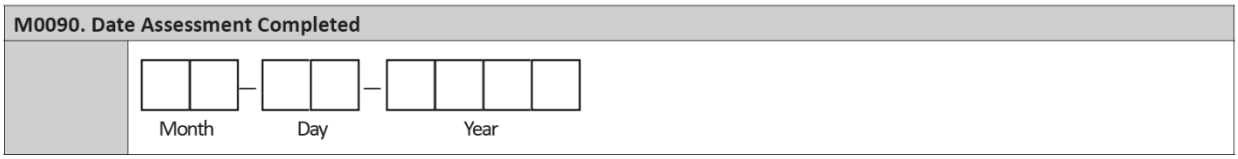
Coding Instructions

Dash is not a valid response for this item.

Coding Tips

- While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, they may collaborate to collect data for all OASIS items, if agency policy allows.
- According to the comprehensive assessment regulation, when both the RN and PT/SLP/OT are ordered on the initial referral, the RN must perform the SOC comprehensive assessment including OASIS. An RN, PT, SLP, or OT may perform subsequent assessments.
- LPNs, PTAs, COTAs, MSWs, and home health aides are not disciplines authorized to complete the comprehensive assessment or collect OASIS data.
- When both the RN and qualified therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

M0090: Date Assessment Completed



Item Intent

Specifies the actual date the assessment is completed.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Transfer
- Discharge from Agency
- Death at Home

Response-Specific Instructions

- If the day or month is only one digit, that digit should be preceded by a "0" (for example, May 4, 2025, is 05/04/2025).
- Enter all four digits of the year.

Coding Instructions

Dash is not a valid response for this item.

Coding Tips

- Date Assessment Completed cannot be before the SOC date.
- The M0090 - Date Assessment Completed is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.
  - Example: If the assessing clinician gathers additional information during the assessment timeframe that results in changing the coding of one or more OASIS items (for instance, identifies functional or cognitive information more representative of the patient's status than the code originally selected), the M0090 date would be changed to reflect the date the latest information was gathered by the assessing clinician and documentation of the specific information/responses was completed.
- The M0090 Date Assessment Completed may not coincide with the date of a home visit. For example, in a situation where the assessing clinician needs to follow-up with the patient's family or physician to complete an OASIS item that the patient is unable to answer, M0090 should reflect that date even if no visit is provided on that date.
- If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.
- When completing a Transfer or Death at Home, record the date the agency completed the data collection after learning of the event.

Comprehensive assessment, OASIS, and collaboration

- The comprehensive assessment is a legal document and when signed by the assessing clinician, the signature serves as an attestation that to the best of their knowledge, the document, including OASIS responses, reflects the patient status as assessed, documented and/or supported in the patient's clinical record.
- Some OASIS items, for example, patient name, date of birth, or Medicare Number, may be completed initially by clerical staff as part of the intake/referral process, but should be verified by the assessing clinician when completing the assessment.
- For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should have had direct in-person contact with the patient or have had some other means of gathering information to contribute to the OASIS data collection (health care monitoring devices, video streaming, review of photograph, phone call, etc.).
- When collaboration is utilized, the assessing clinician is responsible for considering available information from these other sources and selecting the appropriate OASIS item response(s), within the appropriate timeframe and consistent with data collection guidance.

M0100: Assessment Reason

M0100. This Assessment is Currently Being Completed for the Following Reason	
Enter Code ☐	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 5. Other follow-up Transfer to an Inpatient Facility 6. Transferred to an inpatient facility — patient not discharged from agency 7. Transferred to an inpatient facility — patient discharged from agency Discharge from Agency — Not to an Inpatient Facility 8. Death at home 9. Discharge from agency

Item Intent

Identifies the "time point" – reason why the assessment data are being collected and reported.

Item Rationale

Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been entered for this item.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Transfer
- Discharge from agency
- Death at Home

Response-Specific Instructions

- Consult with the agency case manager or other care team provider and/or the clinical record.
- Hospital or other health care provider information may identify transfer to inpatient facility or death at home.

Coding Instructions

Enter only one response.

- **Code 1, Start of care,**
  - For the start of care comprehensive assessment. A Plan of Care is being established, whether or not further visits will be provided after the start of care visit. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required.
- **Code 3, Resumption of care,** when the patient:
  - Resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests.

- Is discharged from an inpatient facility and care is resumed within the last 5 days of the 60-day certification period (that is, a recertification assessment is due). A ROC assessment, rather than a recertification assessment, is completed.

- **Code 4, Recertification,** if the follow-up assessment is conducted during the last five days of the 60-day certification period and is completed to continue the patient's services for an additional 60-day certification period.
- **Code 5, Other follow-up,** if the assessment is conducted due to a significant change in condition that causes a major decline or improvement in patient's health status occurring at a time other than during the last five days of the 60-day certification period. This assessment is done to re-evaluate the patient's condition, allowing revision to the patient's care plan as appropriate.
- **Code 6, Transferred to an Inpatient Facility- patient not discharged from agency,** if the patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests), with the expectation that home health care will be resumed following inpatient discharge. The patient is not discharged from the agency.
  - A telephone call may provide the information necessary to complete the required data items.
  - Short stay observation periods in a hospital (including time spent in the ER), regardless of duration, do not meet the definition for transfer to an inpatient facility.
- **Code 7, Transferred to an Inpatient Facility- patient discharged from agency,** if the patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests), and the agency does NOT anticipate the patient will be returning to care. The patient is discharged from the agency.
  - A telephone call may provide the information necessary to complete the required data items.
  - No additional OASIS discharge data are required.
  - Short stay observation periods in a hospital (including time spent in the ER), regardless of duration, do not meet the definition for transfer to an inpatient facility.
- **Code 8, Death at home, when the patient dies:**
  - At home, while receiving home health services.
  - Before being treated in the emergency department, or before being admitted to an inpatient facility.
  - In the emergency department.
  - Less than 24 hours after being admitted to an inpatient facility.
  - In outpatient surgery, or, in the care of the recovery room after outpatient surgery.
  - Do **not** use Code 8, Death at home, when the patient dies after being admitted for a qualifying inpatient facility stay.
  - A telephone call may provide the information necessary to complete the required data items.
- **Code 9, Discharge from agency**, when the patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home.
  - This response includes transfer and discharge to another home health agency or an in-home hospice.
  - When a patient is discharged after only one visit (a single visit quality episode), a Discharge OASIS should not be collected or submitted.
- **Dash is not** a valid response for this item.

Coding Tips

Coding tips for this item are grouped according to the reason for assessment (RFA).

Start of Care (SOC) RFA 1

- OASIS data collection and submission is not required when only one visit is made in a quality episode. This is a single visit quality episode (SOC/ROC to TRF/DC). When a patient is discharged after only one visit, a Discharge OASIS should NOT be collected or submitted. However, to bill Medicare PPS (PDGM) for a single visit quality episode, OASIS data must be collected and submitted. If OASIS is collected for a Medicare PPS patient's single visit quality episode M0100 RFA 1 - SOC is the appropriate response. Some payers may require OASIS data for a single visit quality episode. In such cases, the HHA will be expected to work with the payer to deliver any required OASIS data. When OASIS data is only required by the payer, submission to iQIES is not expected.

Resumption of Care (ROC)RFA 3

- When a patient is transferred to an inpatient facility and returns home during the last 5 days of the current 60-day certification period (days 56-60), the agency may complete only the Resumption of Care, allowing the assessment to serve both resumption and recertification functions.
- When a patient returns to the agency from an inpatient stay a day or two before the last 5 days of a certification period, and assuming no physician-ordered ROC date is provided, regulations require the agency to **complete a ROC assessment within 2 days of the inpatient facility discharge**.
  - A ROC and a recertification assessment are required if the 2 days following inpatient facility discharge occur **prior to** days 56 – 60 (the last 5 days of the 60-day certification period). For example, if the patient is discharged on day 53, and there is no physician-ordered ROC date, the agency would be required to complete a ROC assessment no later than day 55. The agency would then complete a recertification assessment within days 56-60.
  - Only a ROC is required if the 2 days following inpatient facility discharge occur within days 56 – 60. For example, if the patient is discharged on day 54 or day 55, and there is no physician-ordered ROC date, the agency may complete a ROC assessment on day 56 or day 57, and the ROC serves both resumption and recertification functions.

Recertification (Follow-Up) RFA 4

- The Home Health Conditions of Participation (CoPs) require the agency to perform a comprehensive assessment for the patient no less frequently than last 5 days of every 60 days, beginning with the start of care date. The time period for Code 4, Recertification, has been further clarified in OASIS Q&As to mean the last 5 days of every 60 days, which is days 56-60 of the current 60-day certification period. All patients who remain on service into a subsequent certification period require a follow-up comprehensive assessment (including OASIS) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged.
- A clinician may start the comprehensive assessment on day 56 and complete the assessment on or before day 60.

- Unless the patient has been discharged, the due dates for Follow-Up assessments are calculated from the original Start of Care date rather than from the Resumption of Care date.
- If a clinician visit is not made within the last 5 days of the 60-day certification period (i.e., a "missed" recertification visit), under Medicare PPS (PDGM), a visit can be made for only the purpose of performing a comprehensive assessment including OASIS, but it will not be considered a billable visit unless skilled services are performed.
    - For example, a patient refuses a visit within the last 5 days of the 60-day certification period. Although most patients are willing to receive visits if the schedule and required time points have been explained to them, if the agency is unable to schedule a visit within the 5-day time frame, the follow-up assessment should be completed as soon after this period as possible.

- If an agency misses the recertification assessment time frame (days 56-60 of the current 60-day certification period), the agency should not discharge and readmit the patient (i.e., complete a new SOC). Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date the assessment is completed, with documentation in the clinical record of the circumstances surrounding the late completion. When submitting the assessment, a warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. This situation should be avoided, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS (PDGM) patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

Other Follow Up RFA 5

- The HH CoPs require a comprehensive assessment including OASIS when there is a significant change in the patient's condition. The Other Follow-up, RFA 5, may be used when a patient experiences a significant change in condition that was not anticipated in the patient's plan of care and would warrant an update to the plan of care. CMS does not provide written requirements about what constitutes a significant decline or improvement. Each agency must determine its own policies regarding examples of major decline or improvement in health status and ensure that the clinical staff is adhering to these policies. If the agency determines, based on its own policies, that an assessment is necessary, RFA 5 would be selected.
    - The agency would not necessarily be required to discharge a patient who experienced a significant, or major, improvement in health status. If the patient has continuing home care needs and meets eligibility requirements, home care may continue.
- The requirement to complete an RFA 5 for a patient experiencing a major decline or improvement in health status should not be confused with the Significant Change in Condition (SCIC) payment adjustment which was introduced in the initial Home Health Prospective Pay System (PPS) model, and which no longer exists.

- Under PDGM, if the M0090 - Date Assessment Completed for the RFA 5 is before the start of a subsequent, contiguous 30-day period and results in a change in the functional impairment level, the second 30-day claim would be grouped into its appropriate case-mix group. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes

the case-mix group.

- When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete an RFA 5 - Other follow-up assessment to ensure that diagnosis coding on the claim matches to the OASIS assessment. The CoP §484.55(d) does require an RFA 5 when there has been a major improvement or decline in a patient's condition that was not envisioned in the original Plan of Care. CMS expects agencies to have and follow agency policies that determine the criteria for when the Other Follow-up assessment is to be completed.

Transferred to an Inpatient Facility- patient not discharged from agency RFA 6

- When a patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay or if the patient's return to service is unsure, the reason for assessment (RFA) 6 should be completed.
- The patient should be discharged at the end of the current 60-day certification period if the patient has not returned to the HHA.
- If you complete and transmit the RFA 6, Transfer to an inpatient facility - patient not discharged from agency, and the patient does not return to the care of the agency during the current 60-day certification period, no further OASIS is required. The quality episode ended with the Transfer (RFA 6) that was completed. You do not need to cancel the RFA 6 and resubmit the RFA 7, just complete your agency's internal discharge paperwork.
- If a Medicare patient returns to the HHA after an inpatient stay that spans the end of the 60-day certification period, Medicare requires a new start of care assessment.

Transferred to an Inpatient Facility- patient discharged from agency RFA 7

- There are several reasons why the RFA 7 may be used, including these examples:
  - The patient needs a higher level of care and is no longer appropriate for home health care.
  - The patient's family plans on moving the patient out of the service area.
  - The patient is no longer appropriate for the home health benefit.

- If the patient requires post-acute care in a SNF, IRF, LTCH or IPF during the 30-day period of home health care, CMS expects and recommends (but does not require) the HHA to discharge the patient by completing the RFA 7 and then to readmit the patient with a new Start of Care upon return to home care. If the HHA agency decides to complete an RFA 6 (Transferred to an inpatient facility - patient not discharged from agency), the home health agency will need to complete an RFA 3 (ROC) upon return to home care as long the ROC assessment is completed prior to the end of the current certification period.

M0906: Discharge/Transfer/Death Date

M0906. Discharge/Transfer/Death Date Enter the date of the discharge, transfer, or death (at home) of the patient.	
	☐☐ – ☐☐ – ☐☐☐☐ Month Day Year

Item Intent

Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.

Time Points Item(s) Completed

- Transfer
- Discharge from agency
- Death at Home

Response-Specific Instructions

- The data sources/resources for responding to this item include agency policy or physician/allowed practitioner order. Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.
- The date of discharge is determined by agency policy or physician/allowed practitioner order.
- The transfer date is the actual date the patient was admitted to an inpatient facility.
- The death date is the actual date of the patient's death at home.
  - Including when a patient dies in the following situations:
    - death while being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).
    - death occurs less than 24 hours after being admitted to an inpatient facility,
    - death in the emergency department,
    - death occurring during outpatient surgery or in the care of the recovery room after outpatient surgery.
  - Exclude death that occurs after the patient has been admitted to an inpatient facility for a qualifying inpatient stay as this situation would result in Transfer OASIS collection and would report the date of transfer.
- If the day or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2019, is 05/04/2019). Enter all four digits for the year.

Coding Instructions

Dash is not a valid response for this item.

M0102: Date of Physician-ordered Start of Care (Resumption of Care)

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.

☐☐ – ☐☐ – ☐☐☐☐ → *Skip to A1255, Transportation, if date entered*

Month Day Year

☐ NA — No specific SOC/ROC date ordered by physician

Item Intent

The date specified by a physician/allowed practitioner order to start home care services (that is, provide the first covered service), or resume home care services (that is provide the first visit following a qualifying inpatient stay) regardless of the type of services ordered (for example, therapy only).

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Review the physician/allowed practitioner orders to initiate home care or resume home care following inpatient facility stay.
- Enter the date specified on the most recent physician/allowed practitioner order for the start or resumption of home care services. If the day or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2025, is 05/04/2025). Enter all four digits of the year.
- If the originally ordered Start of Care (SOC)/Resumption of Care (ROC) is delayed due to the patient's condition or physician/allowed practitioner request (for example, extended hospitalization), then the date specified on the revised order to start/resume home care services would be considered the date of physician-ordered SOC/ROC.
  - For example, a patient discharged home on May 15, for whom the physician/allowed practitioner orders home care to begin May 20 for a specified order (for example, PT or administration of a subcutaneous drug), would have a physician-ordered SOC date of May 20.
- A revised physician's ordered SOC/ROC date must be received on or before the date of the previous physician's ordered SOC/ROC.
- If the order to extend the physician's ordered SOC/ROC date is received after the previous physician's ordered SOC/ROC date has passed, report NA for M0102 and report the original referral date in M0104.
- In order to be considered a physician-ordered SOC/ROC date, the physician/allowed practitioner must give a specific date to initiate or resume care, not a range of dates.
  - If a single date to initiate or resume services is not provided, the initial contact (via the initial assessment visit or ROC visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.

- When coding OASIS items where the presence of a physician's order affects the item coding, orders from an allowed practitioner including physician assistant, nurse practitioner, or other advanced practice nurse would satisfy the condition of having a physician's order.

Coding Instructions

- **Code N/A**,
- if the initial orders did not specify a SOC or ROC date, or,
- if the order to extend the physician's ordered SOC/ROC date is received after the date of the previous order has passed.

M0104: Date of Referral

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

Item Intent

Specifies the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- The data sources/resources for responding to this item include the agency referral form; agency records specifying the date the referral was received by the agency; and/or hospital, nursing home, or other referring facility discharge information.
- A valid referral is considered received when the agency has received adequate information about a patient (such as name, address/contact info, and diagnosis and/or general home care needs) to initiate patient assessment and confirmed that the referring physician/allowed practitioner or another physician/allowed practitioner, will provide the plan of care and ongoing orders.
  - In cases where home care is requested by a hospitalist who will not be providing an ongoing plan of care for the patient, the agency must contact an alternative or attending physician/allowed practitioner. The agency will note the date the alternate or attending physician/allowed practitioner agreed to follow the patient as the referral date (M0104) unless referral details are later updated or revised.
- Enter the date of the most recent/latest referral.
- If Start of Care or Resumption of Care is delayed due to the patient's condition or physician/allowed practitioner request (for example, extended hospitalization), the date the agency received the **updated/revised** referral for home care services would be considered the date of referral.

- This does not include calls or documentation from others, such as assisted living facility staff or family, who contact the agency to prepare the agency for possible admission.

- If the day or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2025, is 05/04/2025). Enter all four digits of the year.

Coding Instructions

Dash is not a valid response for this item.

Coding Tips

The date authorization was received from the patient's payer is NOT the date of the referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).

A1255: Transportation

A1255. Transportation *(NACHC©)*	
Enter Code ☐	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? 0. Yes 1. No 7. Patient declines to respond 8. Patient unable to respond

Adapted from: NACHC© 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without written consent from NACHC.

Item Intent

Identifies if a lack of transportation has kept the patient from medical appointments, meetings, work or from getting things needed for daily living.

Item Rationale

- Access to transportation for ongoing health care and medication access needs is essential to effective care management.
- Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.
- Information regarding transportation barriers will help facilitate better care coordination and discharge planning.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Ask the patient, "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?"
- Ask the patient to select the response that most closely corresponds to the patient's transportation status from the list in A1255.

- If the patient declines to respond, code 7, Patient declines to respond, and do not code based on other resources (proxy or medical records).
- If the patient is unable to respond, a proxy response may be used.
- Only use medical record documentation to code A1255, Transportation if the patient is unable to respond and no proxy provides a response for this item.

Coding Instructions

- **Code 0, Yes:** if the patient indicates that in the past 12 months, a lack of reliable transportation kept them from medical appointments, meetings, work or from getting things needed for daily living.
- **Code 1, No:** if the patient indicates that in the past 12 months, a lack of reliable transportation has not kept them from medical appointments, meetings, work or from getting things needed for daily living.
- **Code 7, Patient declines to respond:** if the patient declines to respond.
  - When the patient declines to respond, do not code based on other resources (proxy or medical records).
- **Code 8, Patient unable to respond:** if the patient is unable to respond and no other resources (proxy or medical records) provided the necessary information.
- **Dash** is a valid response for this item.
  - A dash indicates "no information.," CMS expects dash use to be a rare occurrence.

Coding Tips

- If the patient is unable to respond and the response is determined via proxy or medical records, select the response that applies.
- When a patient responds in their preferred language with the use of an interpreter, this is considered a patient response. Do not code X - Patient unable to respond. Patients may respond to questions in English, or in their preferred language with the assistance of an interpreter.

Examples

1. A patient is admitted with Multiple Sclerosis. They are confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with information about transportation is available, but their medical record indicates that in the past 12 months, their spouse used their car to transport the patient wherever they needed to go.
   - **Coding:** A1255, Transportation would be coded as 1, No.
   - **Rationale:** Neither the patient nor their proxy was able to provide a response, but the medical record documentation provided the necessary information regarding transportation.
2. The patient indicates that in the last 12 months, they have not had reliable transportation, which has occasionally kept them from attending medical appointments.
   - **Coding:** A1255, Transportation would be coded as 0, Yes.
   - **Rationale:** The patient reported they have not had access to reliable transportation in the last 12 months, which has kept them from medical appointments, meetings, work or from getting things needed for daily living.

M1000: Inpatient Facilities

M1000. From which of the following Inpatient Facilities was the patient discharged within the past 14 days?	
↓	Check 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** → *Skip to B0200, Hearing at SOC,ROC*

Item Intent

Identifies whether the patient has been discharged from one or more inpatient facilities within the 14 days immediately preceding the Start of Care/Resumption of Care date.

Item Rationale

The purpose of this item is to establish the patient's recent health care history before formulating the Plan of Care.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Interview the patient and/or caregiver and review referral information. Home health providers may access Medicare's Common Working File (CWF) (for Medicare patients) to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.
- Mark all that apply. For example, a patient may have been discharged from both a hospital and a rehabilitation facility within the past 14 days.
- The "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date. This means that for the purpose 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 inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported.
- An inpatient facility discharge that occurs on Day 0 should be included.
- Facility type is determined by the facility's state license.

Coding Instructions

- **Code 1, Long-term nursing facility,** if the patient was discharged from a long-term nursing facility or a Medicare-certified skilled nursing facility but did not receive care under the Medicare Part A benefit in the

14 days prior to home health care.

- **Code 2, Skilled nursing facility,** includes (a) a Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit, or (b) a transitional care unit (TCU) within a Medicare-certified nursing facility. Code 2, Skilled nursing facility if the answer to **all three** questions below is **"Yes."**
  - Was the patient discharged from a Medicare-certified skilled nursing facility?
  - While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit?
  - Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to the home health care Start of Care date?
- **Code 3,** Short-stay acute hospital applies to most hospitalizations.
- **Code 4,** Long-term care hospital applies to a hospital that has an average inpatient length of stay of greater than 25 days.
- **Code 5, Inpatient rehabilitation hospital, or unit (IRF)** means a freestanding rehab hospital or a rehabilitation bed in a distinct rehabilitation unit of a general acute care hospital.
- **Code 7, Other**, if the patient was discharged from other than the listed inpatient facilities.
- **Dash is not** a valid response for this item.

Coding Tips

- If patient has been discharged from a **swing-bed hospital**, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 3), a skilled nursing bed under Medicare Part A (Response 2), or a nursing bed at a lower level of care (Response 1). The referring hospital can answer this question regarding the bed status.
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) are considered "Other" (Response 7) for the purpose of this item.

M1005: Inpatient Discharge Date

M1005. Inpatient Discharge Date (most recent)

			–			–					UK — Unknown or Not Available
	Month			Day			Year			

Item Intent

Identifies the date of the most recent discharge from an inpatient facility that occurred within the 14 days immediately preceding the Start/Resumption of Care date.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Interview the patient and/or caregiver and review referral information. Home health providers may access Medicare's Common Working File (CWF) to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.
- The "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date. This means that for the purpose 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 inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported.
- An inpatient facility discharge that occurs on Day 0 should be included.
- Use **the most recent** date of discharge from any inpatient facility, even though the patient may have been discharged from more than one facility in the 14 days immediately preceding the Start/Resumption of Care date.
- If the day or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2025, is 05/04/2025). Enter all four digits of the year.

Coding Instructions

Dash is not a valid response for this item.

M2301: Emergent Care

M2301. Emergent Care At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code ☐	0. No → *Skip to M2410, Inpatient Facility* 1. **Yes, used hospital emergency department WITHOUT hospital admission** 2. **Yes, used hospital emergency department WITH hospital admission** UK **Unknown** → *Skip to M2410, Inpatient Facility*

Item Intent

Identifies whether the patient was seen in a hospital emergency department at or since the most recent SOC/ROC assessment, with or without a ***hospital admission***.

DEFINITION	**HOSPITAL ADMISSION** • Defined as admission to a hospital for an inpatient stay of 24 hours or longer for reasons other than diagnostic testing. • This is also called a qualifying admission and requires completion of an OASIS transfer assessment (Reason for assessment [RFA] 6 or 7).

Time Points Item(s) Completed

- Transfer
- Discharge from agency

- Interview the patient and/or caregiver. Review the clinical record and the hospital emergency department discharge information. Check with the physician and/or the hospital emergency department staff.
- This item is coded whether the patient independently decides to seek care at a hospital emergency department or was advised to go by the physician, the home health agency or other health care provider.
- This item excludes urgent care services not provided in a hospital emergency department, including care provided in a doctor's office, by an ambulance crew, or at an ***urgent care facility***.

DEFINITION	URGENT CARE FACILITY Freestanding walk-in clinic providing medical care outside of a traditional hospital- based or freestanding emergency department.

Coding Instructions

- **Code 0, No,** if the patient:
  - Was directly admitted to the hospital, without being evaluated or treated first in the hospital emergency department.
  - Was not seen in a hospital emergency department at any time during the episode, at or since the most recent SOC/ROC.
- **Code 1, Yes, used hospital emergency department WITHOUT hospital admission, if the patient:**
  - Went to a hospital emergency department, was "held" at the hospital for observation, then released.
    - The time period that a patient can be "held" without admission can vary. "Holds" can be longer than 23 hours.
    - Emergent care should be reported regardless of the length of the observation "hold."
- **Code 2, Yes, used hospital emergency department WITH hospital admission, if the patient:**
  - Was seen at a hospital emergency department and was then admitted to the hospital (See Definition – Hospital Admission).
- **Dash is not** a valid response for this item.

M2310: Reason for Emergent Care

M2310. Reason for Emergent Care For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?	
↓	Check all that apply
☐	1. Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
☐	10. Hypo/Hyperglycemia, diabetes out of control
☐	19. Other than above reasons
☐	UK Reason unknown

Item Intent

Identifies the reasons for which the patient sought and/or received care in a hospital emergency department.

Time Points Item(s) Completed

- Transfer
- Discharge from agency

Response-Specific Instructions

- Interview the patient/caregiver/family. Review the clinical record and hospital emergency department discharge information. Check with the physician and/or the hospital emergency department staff.
- This item **excludes** urgent care services not provided in a hospital emergency department, including care provided in a doctor's office, by an ambulance crew, or in an urgent care facility.
- If the patient has received emergent care in a hospital emergency department multiple times since the most recent SOC/ROC, include the reasons for all visits.
- If more than one reason contributed to the hospital emergency department visit(s), mark all appropriate responses.
    - For example, if a patient received care for a fall at home and was found to have medication side effects, use both Code 19, Other than above reasons (for the fall), and Code 1 (for the medication side effects).
- If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out.
    - For example, the patient was sent to a hospital emergency department for suspected DVT, but diagnostic testing and evaluation were negative for DVT – use Code 19 – Other than above reasons.

Coding Instructions

Dash is not a valid response to this item.

M2410: Inpatient Facility

M2410. To which Inpatient Facility has the patient been admitted?	
Enter Code ☐	1. Hospital 2. Rehabilitation facility 3. Nursing home 4. Hospice NA No inpatient facility admission [Omit "NA" option on TRN]

Item Intent

Identifies the type of inpatient facility to which the patient was admitted.

Time Points Item(s) Completed

- Transfer
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or family (for agency discharge); contact the family or caregiver by telephone if the patient was transferred, and/or contact the receiving facility.

- If the patient was admitted to more than one facility, indicate the facility type to which the patient was admitted first (for example, the facility type that they were transferred to from their home).

Coding Instructions

- **Code NA, No inpatient facility admission**, when completing a Discharge from Agency – Not to an Inpatient Facility.
  - This response is available on the Discharge OASIS assessment. The NA response is not included on the Transfer OASIS assessment.
- **Code 1, Hospital,** when the patient is admitted to a short-stay acute hospital.
  - This response includes admission to inpatient drug rehabilitation whether it was a freestanding drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital.
- **Code 2, Rehabilitation facility**, when the patient is admitted to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital.
- **Code 3, Nursing home,** when the patient is admitted to a skilled nursing facility (SNF), an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a nursing facility (NF) is a nursing home admission.
- **Dash is not** a valid response for this item.

M2420: Discharge Disposition

M2420. Discharge Disposition Where is the patient after discharge from your agency? (Choose only one answer.)	
Enter Code ☐	1. **Patient remained in the community (without skilled services from a Medicare Certified HHA or non-institutional hospice)** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* 2. **Patient remained in the community (with skilled services from a Medicare Certified HHA)** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 3. **Patient transferred to a non-institutional hospice** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 4. **Unknown because patient moved to a geographic location not served by this agency** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* UK **Other unknown** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*

Item Intent

Identifies where the patient resides after discharge from the home health agency.

Time Points

Discharge from agency

Response-Specific Instructions

Interview the patient/family and/or caregiver. Check with the physician and with community resources.

Coding Instructions

- **Code 1, Patient remained in the community (without skilled services from a Medicare Certified HHA or non-institutional hospice),** if, after discharge from your agency, the patient remained in a non-inpatient setting, either with no assistive services, or with any assistive services

EXCEPT:

- Skilled services from another Medicare certified home health agency, or
- Hospice care from a non-institutional ("home") hospice provider.

- **Code 2, Patient remained in the community (with skilled services from a Medicare Certified HHA),** if, after discharge from your agency the patient remained in a non-inpatient setting, receiving skilled services from another Medicare certified home health agency, (with or without other assistive services), or when an agency completes a discharge and new SOC OASIS due to a pay source change for a patient.
- **Code 3, Patient transferred to a non-institutional hospice**, if, after discharge from your agency, the patient remained in a non-inpatient setting receiving hospice care from a non-institutional ("home") hospice provider.
- **Dash is not** a valid response for this item.

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and 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

Special Note: The guidance for items A2120 and A2121 is the same, except that one item is used for home health transfers and the other one for discharges. The guidance is combined here, with specific instructions for either transfer or discharge as needed.

Item Intent

The intent of these items is to identify if the home health agency provided a current reconciled medication list to the subsequent provider.

DEFINITION	**MEANS OF PROVIDING A CURRENT RECONCILED MEDICATION LIST** Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR], giving providers access to a portal).

Item Rationale

- The transfer of a current reconciled medication list at the time of discharge or transfer can improve care coordination, quality of care, help subsequent providers reconcile medications and may mitigate adverse outcomes related to medications. Communication of medication information at discharge/transfer is critical to ensure safe and effective transitions from one health care setting to another.

Time Points Item(s) Completed

- Transfer (A2120)
- Discharge from agency (A2121)

Response Specific Instructions

For Home Health at **Transfer**:

Complete A2120 *only if M0100 This Assessment is Currently being Completed for the Following Reason =* ***6. Transferred*** *to an inpatient facility, patient not discharged from agency,* ***or - 7. Transferred*** *to an inpatient facility, patient discharged from agency*

For Home Health at **Discharge**:

Complete A2121 *only if M0100 This Assessment is Currently being Completed for the Following Reason =* ***9. Discharge*** *from agency,* ***and*** *M2420 Discharge Disposition =* ***2. Patient remained in the community*** *(with skilled services from a Medicare-certified HHA),* ***or – 3. Patient transferred to a non-institutional hospice***

Coding Instructions

- **Code 0, No**, if at transfer or discharge to a subsequent provider, your agency did not provide the patient's current reconciled medication list to the subsequent provider.
- **Code 1, Yes**, if at transfer or discharge to a subsequent provider, your agency did provide the patient's current reconciled medication list to the subsequent provider.
- **A2120 only: Code 2, NA,** if at transfer to a subsequent provider, your agency was not made aware of the transfer timely and was, therefore, unable to provide the patient's current reconciled medication list to the subsequent provider.
- **Dash is not** a valid response for this item.

Coding Tips

- At the time of transfer/discharge – This is the period of time as close to the actual time of transfer or discharge as possible. This time may be based on agency, State, or Federal guidelines for data collection at discharge.
- 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 home hospice (M2420 response 3).

- While the patient may receive care from other providers after discharge from your agency, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be a subsequent provider for the purpose of coding this item.
- Current Reconciled Medication list -This 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.
- Your agency should be guided by 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.

Additional Considerations for Important Medication List Content

Defining the completeness of that medication list is left to the discretion of the providers and patients who are coordinating this care. An example of items that could be on a reconciled medication list can be but are not limited to a list of the current prescribed and over-the-counter medications, nutritional supplements, vitamins, and/or homeopathic and herbal products administered by any route at the time of discharge or transfer. A reconciled medication list could also include important information about: (1) the patient, including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and/or any special instructions. However, this information serves as guidance and as stated prior, the completeness of the medication list is left to the discretion of the providers and patient.

Documentation sources for reconciled medication list information include electronic and/or paper records. Some examples of such records are discharge summary records, a Medication Administration Record, an Intravenous Medication Administration Record, a home medication list, and physician orders.

Examples

1. The patient is being transferred from home health to an acute care hospital in the same healthcare system which uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR) (see definition of EHR/EMR in Appendix A). The patient's current reconciled medication list at the time of transfer from the agency is accessible to the subsequent acute care hospital staff admitting them and this is how the medication list is shared.
    - **Coding:** A2120 would be coded 1, Yes.
    - **Rationale:** Having access to the patient's medication list through the same EHR system is one way to transfer a medication list. This code of 1, Yes, is used for this passive means of transferring the medication list when the sending and receiving provider can access the same EHR system.
2. A patient is not taking any prescribed or over the counter medications at the time of discharge.
    - **Coding:** 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.
    - **Rationale:** Information confirming that the patient is not taking any medications at discharge is given
    - to the subsequent provider and meets the item intent of providing the patient's current reconciled medication list to the subsequent provider.
3. When the nurse visited a patient for their monthly Foley catheter change, the patient informed the nurse that they had been admitted to the hospital last week for a urinary tract infection.

- **Coding:** Code A2120, 2, NA - the agency was not made aware of this transfer timely.
- **Rationale:** When a home health agency is not made aware of a transfer to an inpatient setting timely, they are unable to provide the current reconciled medication list to the subsequent provider timely.

A2123: Provision of Current Reconciled Medication List to Patient at Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the patient, family, and/or caregiver?	
Enter Code ☐	0. No — Current reconciled medication list not provided to the patient, family, and/or caregiver → *Skip to B1300, Health Literacy* 1. Yes — Current reconciled medication list provided to the patient, family, and/or caregiver → Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient

Item Intent

The intent of this item is to identify if the home health agency provided a current reconciled medication list to the patient, family, and/or caregiver at discharge.

Item Rationale

- Communication of medication information to the patient at discharge is critical to ensuring safe and effective discharges. The item, collected at the time of discharge, can improve care coordination, quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.
- It is recommended that a reconciled medication list that is provided to the patient, family, or caregiver uses consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable.

Time Points Item(s) Completed

Discharge

Response-Specific Instructions

For Home Health at **Discharge**:

Complete A2123 *only if M0100 This Assessment is Currently being Completed for the Following Reason =* ***9. Discharge*** *from agency,* ***and*** *M2420 Discharge Disposition =* ***1. Patient remained in the community*** *(without skilled services from a Medicare-certified HHA or non-institutional hospice),* ***or – 4. Unknown because patient moved, or – UK. Other Unknown***

Coding Instructions

- **Code 0, No**, if at discharge to a home setting, your agency did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver.
- **Code 1, Yes,** if at discharge to a home setting, your agency did provide the patient's current reconciled medication list to the patient, family, and/or caregiver.
- **Dash is not** a valid response for this item.

Coding Tips

- **At the time of discharge** – This is the period of time as close to the actual time of discharge as possible. This time may be based on facility/agency, State, or Federal guidelines for data collection at discharge.
- **Patient/family/caregiver** – The recipient of the current reconciled medication list can be the patient and/or a family member and/or other caregiver to code 1, Yes, a current reconciled medication list was provided. It is not necessary to provide the current reconciled medication list to all these recipients in order to code 1, Yes.

Examples

1. A patient will not be taking any prescribed or over-the-counter medications at the time of discharge.
   - **Coding:** If it is clearly documented that the patient is taking no medications and this is then clearly communicated to the patient, family, and/or caregiver when the patient is discharged, A2123 would be coded 1, Yes, that the medication list was provided. If this information is not communicated to the patient, family and/or caregiver, code 0, No.
   - **Rationale:** Information confirming that the patient is not taking any medications at discharge is provided to the patient, family, and/or caregiver and meets the item intent of providing the patient's current reconciled medication list to patient, family, and/or caregiver.

A2122 and A2124: Route of Current Reconciled Medication List Transmission to Subsequent Provider and 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 Methods (e.g., texting, email, CDs)	☐
After completing A2122, Skip to B1300, Health Literacy at Discharge	

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)	☐

Special Note: The guidance for items A2122 and A2124 is the same, except that one item is used for the subsequent provider at transfer/discharge and the other one at discharge for the patient, family, and/or caregiver. The guidance addresses coding the route(s) of transmission to the subsequent provider at transfer (A2120) and at discharge (A2121) and to the patient (A2123). The guidance is combined here, with specific instructions for either transfer or discharge as needed.

Item Intent

The intent of these items is to identify all routes used in the transmission of the current reconciled medication list to the subsequent provider at transfer or discharge or to the patient, family, and/or caregiver.

Item Rationale

These items collect important data to monitor how medication lists are transmitted at transfer/discharge to the subsequent provider and at discharge to the patient, family, and caregiver.

Time Points Item(s) Completed

- Transfer (A2122)
- Discharge from agency (A2122 and A2124)

Response Specific Instructions

- Complete A2122 Route of Current Reconciled Medication List Transmission to **Subsequent Provider** only with A2120/A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Transfer/Discharge.
- Complete A2124 Route of Current Reconciled Medication List Transmission to **Patient** only with A2123 Provision of Current Reconciled Medication List to Patient at Discharge.

Coding Instructions

- **Code A2122A/A2124A, Electronic Health Record,** if your agency has an EHR and used it to transmit or provide access to the reconciled medication list to the subsequent provider, patient, family, and/or caregiver. This would include situations where both the discharging and receiving provider have direct access to a common EHR system. This could also include providing the patient with direct access to their EHR medication information through a patient portal. Checking this route does not require confirmation that the patient has accessed the medication list from the portal, or the subsequent provider has accessed the common EHR system for the medication list.

DEFINITIONS	EHR/EMR • An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a patient's medical history that is maintained by the provider over time. PORTAL • A portal is a secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection.

- **Code A2122B/A2124B, Health Information Exchange,** if your agency participates in a Health Information Exchange (HIE) and uses the HIE to electronically exchange the current reconciled medication list with the subsequent provider, patient, family, and/or caregiver.
- **Code A2122C/A2124C, Verbal,** if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider, patient, family, and/or caregiver.
- **Code A2122D/A2124D, Paper-Based,** if the current reconciled medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using a paper-based method such as a printout, fax, or eFax.
- **Code A2122E/A2124E, Other Methods,** if the current reconciled medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using another method, not listed above (e.g., texting, email, CDs).
- **Dash is not** a valid response for this item.

Examples

1. A patient receives a paper copy of their medication list, receives education about their medications by the home health nurse at discharge, and is notified that the home health patient portal is another means that the patient can obtain their discharge medication list.
   - **Coding:** Code Electronic Health Record (A), Verbal (C), and Paper-based (D) for A2124.
   - **Rationale:** The copy of the medication list is paper based (D). The information about the patient's medication list was also communicated verbally by the nurse at the time of discharge (C). The patient portal uses the agency's EHR to provide access to the medication list (A). It is not necessary to confirm that the patient is a registered user of and accessed the patient portal to code EHR (A) as a route.
2. A PAC provider participates in a regional HIE as does a local acute care hospital. When patients are transferred to this acute care hospital, the PAC provider's medication list is included in the medications section of a transfer summary document from their EHR which is electronically exchanged through the HIE. The acute care hospital is then able to obtain and integrate the medication information into their EHR.
   - **Coding:** Code Electronic Health Record (A) and Health Information Exchange (B) for A2122.
   - **Rationale:** The medication information is exchanged by the regional HIE through health IT standards. Sending the medication information in transfer summary allows the acute care hospital to integrate the medication information into their EHR. Code as EHR (A) since it was used to generate and exchange the information, and as HIE (B) since it is the means through which information exchange is possible with external providers.
3. A home health agency has developed an interface that allows documents from their EHR to be electronically faxed to the subsequent provider.
   - **Coding:** Code Check Paper-Based (D) for A2122.
   - **Rationale:** Faxing information is considered paper based as faxed documents are comparable to hard copy documents, and not computable.
4. A home health agency created a process to automatically send a patient summary document containing medications and other information using Direct Messaging (Direct Exchange) to the receiving acute care hospital's EHR when a patient is transferred to this hospital. The EHR vendors are members of a health

information service provider, or HISP, and comply with DirectTrust requirements. The hospital clinicians can readily access the latest medication and other medical information which is 'pushed' or sent to their EHR.

- **Coding:** Code Electronic Health Record (A) and Health Information Exchange (B) for A2122.
- **Rationale:** Direct Messaging is interoperable exchange through a HIE such as a HISP and EHR (A) was used to generate and initiate the exchange of the information.

SECTION B: HEARING, SPEECH, AND VISION

Introduction

The items in this section assess the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.

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

Item Intent

Identifies the patient's ability to hear (with assistive devices if they are used).

Item Rationale

- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.
- Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Ensure that the patient is using their normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some patients by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational.
- Interview the patient and ask about hearing function in different situations (e.g., hearing staff or family members, talking to visitors, using telephone, watching TV, participation in group discussion).
- Observe the patient during your verbal interactions and when interacting with others.
- Review the clinical record or other available documentation.
- Consult the patient's family/caregiver, and/or speech or hearing specialists.

Coding Instructions

Complete as close to the time of SOC as possible.

- **Code 0, Adequate,** No difficulty hearing in normal conversation, social interaction, or listening to TV. The patient hears all normal conversational speech and telephone or group conversations.

- **Code 1, Minimal difficulty,** Difficulty in some environments (e.g., when a person speaks softly, or the setting is noisy). The patient hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The patient's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.
- **Code 2, Moderate difficulty,** Speaker has to increase volume and speak distinctly. Although hearing-deficient, the patient compensates when the speaker adjusts tonal quality and speaks distinctly; or the patient can hear only when the speaker's face is clearly visible.
- **Code 3, Highly impaired,** Absence of useful hearing. The patient hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

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.

Examples

1. When asked about whether they can hear normal conversation without difficulty, the patient responds, "When I'm at home, I usually keep the TV on a low volume and hear it just fine. When I have visitors, I can hear people from across the room."
   - **Coding:** B0200, Hearing, would be coded as 0, Adequate
   - **Rationale:** Patient hears normal conversational speech.
2. "Sitting at the dinner table, I can hear people who are sitting closer to me (e.g., within 5 feet) but not from farther across the table (e.g., 8 feet) speaking at a normal volume."
   - **Coding:** B0200, Hearing, would be coded as 1, Minimal difficulty
   - **Rationale:** Patient has difficulty in some situations (when someone is sitting farther away) but can hear clearly when someone is sitting close.
3. "I have trouble following normal conversations, especially when a lot of different people are talking at the same time. I can usually make out what someone is saying if they talk a little louder and make sure they speak clearly, and I can see their face when they are talking to me."
   - **Coding:** B0200, Hearing, would be coded as 2, Moderate difficulty
   - **Rationale:** Patient has difficulty hearing people in conversation, but comprehension is improved when the speaker makes adjustments like speaking at high volume, speaking clearly, and sitting close by so that the speaker's face is visible.

4. "I cannot hear one person speaking, even at a high volume, if others are speaking at the same time. I tend to listen to the TV at a high volume even if I am alone and I still struggle to hear what is being said. People complain that they need to scream at me for me to hear anything."
    - **Coding:** B0200, Hearing, would be coded as 3, Highly impaired
    - **Rationale:** Patient cannot hear people in conversation even if the speaker is making maximum adjustments of speaking at high volume and sitting close.

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

Item Intent

Identifies the patient's ability to see objects nearby in their environment, in adequate light, and with glasses or other visual appliances.

DEFINITION	ADEQUATE LIGHTING Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.

Item Rationale

- A person's reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books, or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms.
- Moderate, high, or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Ask the patient, family, caregivers, and/or staff, if possible, about the patient's usual vision patterns (e.g., is the patient able to see newsprint, menus, greeting cards?).
- Ensure that the patient's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass).
- Ensure adequate lighting.

- Ask the patient to look at regular-size print in a book or newspaper. Then ask the patient to read aloud, starting with larger headlines and ending with the finest, smallest print. If the patient is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.
- When the patient is unable to read out loud (e.g., due to aphasia, illiteracy), you should test this by another means such as, but not limited to:
  - Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper)

Coding Instructions

Complete as close to the time of SOC as possible.

- **Code 0, Adequate**, if the patient sees fine detail, including regular print in newspapers/books.
- **Code 1, Impaired,** if the patient sees large print, but not regular print in newspapers/books.
- **Code 2, Moderately impaired,** if the patient has limited vision and is not able to see newspaper headlines but can identify objects nearby in their environment.
- **Code 3, Highly impaired,** if the patient's ability to identify objects nearby in their environment is in question, but the patient's eye movements appear to be following objects (especially people walking by).
- **Code 4, Severely impaired,** if the patient has no vision, sees only light, colors, or shapes, or does not appear to follow objects with eyes.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Some patients have never learned to read or are unable to read English. In such cases, ask the patient to read numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).
- If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if their eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the patient has any visual ability. For patients who appear to do this, **code 3, Highly impaired.**

Examples

1. When asked about whether they can see fine detail, including regular print in newspaper/books, patient responds, "When I wear my glasses, I can read the paper fine. If I forget to wear glasses, it is harder to see unless I hold the paper a little closer."
   - **Coding:** B1000, Vision, would be coded as 0, Adequate
   - **Rationale:** The patient can read regular print when wearing glasses.
2. The assessor asks the patient to read aloud from a newspaper, starting with larger headlines and then the smaller print. The patient is able to read the headlines but not the regular newspaper print.
   - **Coding:** B1000, Vision, would be coded as 1, Impaired
   - **Rationale:** The patient sees large print, but not regular print in newspapers/books.

3. "I cannot read the newspaper headlines, even with glasses." When the assessor presents the patient with newspaper text, while wearing glasses, the patient is not able to correctly read the headlines. The patient can identify objects in their environment.
   - **Coding:** B1000, Vision, would be coded as 2, Moderately impaired
   - **Rationale:** Patient cannot read newspaper headlines.
4. "I can't see much of anything at this point. I can see blurry shapes and I can tell what things are, but I can't read books anymore – even the ones with giant print. I do okay recognizing my caregivers by their voices, but I couldn't tell you what they look like. Everyone's just a blob of color, even with my glasses on." The patient's eyes appear to follow the assessor when they move about the room. When the assessor presents the patient with newspaper text, while wearing glasses, the patient is able to appropriately reach for and successfully hold the paper but is not able to correctly read the headlines.
   - **Coding:** B1000, Vision, would be coded as 3, Highly impaired
   - **Rationale:** Patient is able to follow objects and track movement in the environment (e.g., people moving throughout the room), but is unable to see people or objects in detail.

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 declines to respond 8. Patient unable to respond

Item Intent

The intent of this item is to identify the patient's self-reported health literacy.

DEFINITION	**HEALTH LITERACY** Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Item 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, and the receipt of fewer preventive services, higher medical costs, and rates of emergency department use.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- This item is intended to be a patient self-report item. No other source should be used to identify the response.
- Ask the patient, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

Coding Instructions

- **Code 0, Never,** if the patient indicates never needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 1, Rarely,** if the patient indicates rarely needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 2, Sometimes,** if the patient indicates sometimes needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 3, Often,** if the patient indicates often needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 4, Always,** if the patient indicates always needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 7, Patient declines to respond,** if the patient declines to respond.
- **Code 8, Patient unable to respond,** if the patient is unable to respond.
- **Dash is not** a valid response for this item.

Example

1. When asked how often they need help when reading the instructions provided by their doctor, the patient reports that they never need help. The patient's son is present and shares that a family member must always accompany the patient to doctors' visits and that the patient often needs someone to explain the written materials to them multiple times before they understand, providing examples of needing to frequently explain to the patient why they are on a special diet and why and how to take some of their medications.
    - **Coding:** B1300, Health Literacy is coded as Code 0, Never.
    - **Rationale:** The patient indicated they never need help reading instructions from their doctor or pharmacist. B1300, health literacy is intended to be a patient self-report item and no other sources, including proxy/caregivers, should be used to identify the response to this item.

SECTION C: COGNITIVE PATTERNS

Introduction

This section contains guidance for nine items that assess cognitive function including the Brief Interview for Mental Status (BIMS) and Signs and Symptoms of Delirium from CAM©.

There is general guidance for C0200 – C0500, including basic BIMS interview instruction and cue cards for administering the BIMS in written format, as well as specific guidance on the individual items.

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

Item Intent

The intent of this item is to identify if the Brief Interview for Mental Status (BIMS), a structured cognitive interview, should occur.

Item Rationale

- Most patients are able to attempt the Brief Interview for Mental Status (BIMS). The BIMS is a structured cognitive interview.
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
  - Without an attempted structured cognitive interview, a patient might be mislabeled based on their appearance or assumed diagnosis.
  - Structured interviews will efficiently provide insight into the patient's current condition that will enhance good care.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interact with the patient using their preferred language. Be sure the patient can hear you and/or has access to their preferred method for communication. If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
- Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood skip items C0200-C0500.

Coding Instructions

If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- **Code 0, No,** if the interview should not be conducted because the patient is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip items C0200-C0500.
- **Code 1, Yes,** if the interview should be conducted because the patient is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

Attempt to conduct the interview with ALL patients.

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

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.

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**

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**

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

Item Intent

The intent of this item is to determine the patient's attention, orientation, and ability to register and recall information.

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 need to be related to the question.

Item Rationale

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Cognitively intact patients may appear to be cognitively impaired because of a language barrier, hearing impairment, or lack of social interaction.
- Some patients may appear to be more cognitively intact than they actually are.
- If cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

- Discharge from Agency

Basic Interview Instructions for BIMS (C0200-C0500)

- 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.
  - Patients with a hearing impairment should be tested using their usual communication devices/techniques, as applicable.
  - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
  - Minimize background noise.
- Sit so that the patient can see your face. Minimize glare by directing light sources away from the patient's face.
- Give 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."
- If the patient expresses concern that you are testing their memory, they may be more comfortable if you 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 at one sitting and in the order provided.
- If the patient chooses not to answer a particular item, accept their refusal, and move on to the next question. For C0200 through C0400, code refusals as incorrect/no answer or could not recall.

Instructions for BIMS When Administered in Writing

- 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.
  - Patients with visual impairment should be tested using their usual visual aids.
  - Minimize glare by directing light sources away from the patient's face and from written materials.
- Provide a written introduction before starting the interview. Suggested language: "I would like to ask you some questions, which I will show you in a moment. 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. We ask these questions of everyone so we can make sure that our care will meet your needs."
- Directly provide the written questions for each item in C0200 through C0400 at one sitting and in the order provided.
  - For each BIMS question, show the patient a sheet of paper or card with the instructions for that question from the form clearly written in a large enough font to be easily seen.
  - The patient may respond to any of the BIMS questions in writing.

- Show separate sheets or cards for each question or statement.
- For C0200 items, instructions should be written as:
  - I have written 3 words for you to remember. Please read them. Then I will remove the card and ask you repeat or write down the words as you remember them.
  - Category cues should be provided to the patient in writing after the patient's first attempt to answer. Written category cues should state: "sock, something to wear; blue, a color; bed, a piece of furniture."
- For C0300 items, instructions should be written as:
  - C0300A: "Please tell me what year it is right now."
  - C0300B: "What month are we in right now?"
  - C0300C: "What day of the week is today?"
- For C0400 items, instructions should be written as:
  - "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
  - If the patient is unable to remember a word, provide Category cues again, but without using the actual word. Therefore, Category cues for:
    - C0400A should be written as "something to wear,"
    - C0400B should be written as "a color," and
    - C0400C should be written as "a piece of furniture."

- If the patient chooses not to answer a particular item, accept their refusal, and move on to the next question. For C0200 through C0400C, code refusals as incorrect/no answer or could not recall.
- Rules for stopping the interview are the same as for administering the BIMS verbally, see Coding Tips.
- The agency may develop their own signs for this process. If the agency develops their own, they must use the exact language as that used in the item set.

Coding Instructions

See coding instructions for individual items. If SOC/ROC assessment, collect as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Nonsensical responses, incorrect answers, and questions the patient chooses not to answer should be coded as zero.
  - The assessing clinician should track the reason for coding answers as zero because this information will be used later for the coding of the summary score in C0500.
- Rules for stopping the BIMS interview before it is complete:
  - Stop the interview after completing (C0300C) "Day of the Week" if:
    - All responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR
    - there has been no verbal or written response to any of the questions up to this point, OR

  - there has been no verbal or written response to some questions up to this point and for all others, the patient has given a nonsensical response.
- If the interview is stopped, do the following:
  - Code "-" (dash) in C0400A, C0400B, and C0400C.
  - Code 99 in the summary score in C0500.

- If all responses to C0200, C0300A, C0300B, and C0300C are 0 because answers are incorrect, continue interview.

Examples of Incorrect Answers, Refusals, and Nonsensical Responses

Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternate response code), nonsensical responses, and questions the patient chooses not to answer (or "refusals"). Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the assessing clinician may find it valuable to track the reason for the zero response to aid in accurately calculating the summary score.

1. Assessing clinician asks patient to state the year. The patient replies that it is 1935. This answer is incorrect but related to the question.
   - **Coding:** This answer is coded 0, incorrect but would NOT be considered a nonsensical response.
   - **Rationale:** The answer is wrong, but it is logical and relates to the question.
2. Assessing clinician asks patient to state the year. The patient says, "Oh what difference does the year make when you're as old as I am?" The clinician asks the patient to try to name the year, and the patient shrugs.
   - **Coding:** This answer is coded 0, incorrect but would NOT be considered a nonsensical response.
   - **Rationale:** The answer is wrong because refusal is considered a wrong answer, but the patient's comment is logical and clearly relates to the question.
3. Assessing clinician asks the patient to name the day of the week. The patient answers, "blue, that's my favorite color." The clinician asks the patient the question again to confirm the patient is not hearing the question incorrectly, and the patient answers with the same response.
   - **Coding:** The answer is coded 0, incorrect; the response is illogical and nonsensical.
   - **Rationale:** The answer is wrong, and the patient's comment clearly does not relate to the question; it is nonsensical.

Cue Cards for BIMS

Written Introduction Card – BIMS – Items C0200-C0400

I would like to ask you some questions, which I will show you in a moment.

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.

We ask these questions so that we can make sure that our care will meet your needs.

Written Instruction Cards – Item C0200 – Repetition of Three Words

I have written 3 words for you to remember.

Please read them.

Then, I will remove the card and ask you to repeat or write down the words as you remember them.

Word Card - Item C0200

SOCK

BLUE

BED

Category Cue Card – Item C0200

SOCK, something to wear

BLUE, a color

BED, a piece of furniture

Written Instruction Cards – Item C0300

Temporal Orientation Statement Card – C0300A – Year

Please tell me what year it is right now.

Question Card – C0300B – Month

What month are we in right now?

Question Card – Item C0300C – Day

What day of the week is today?

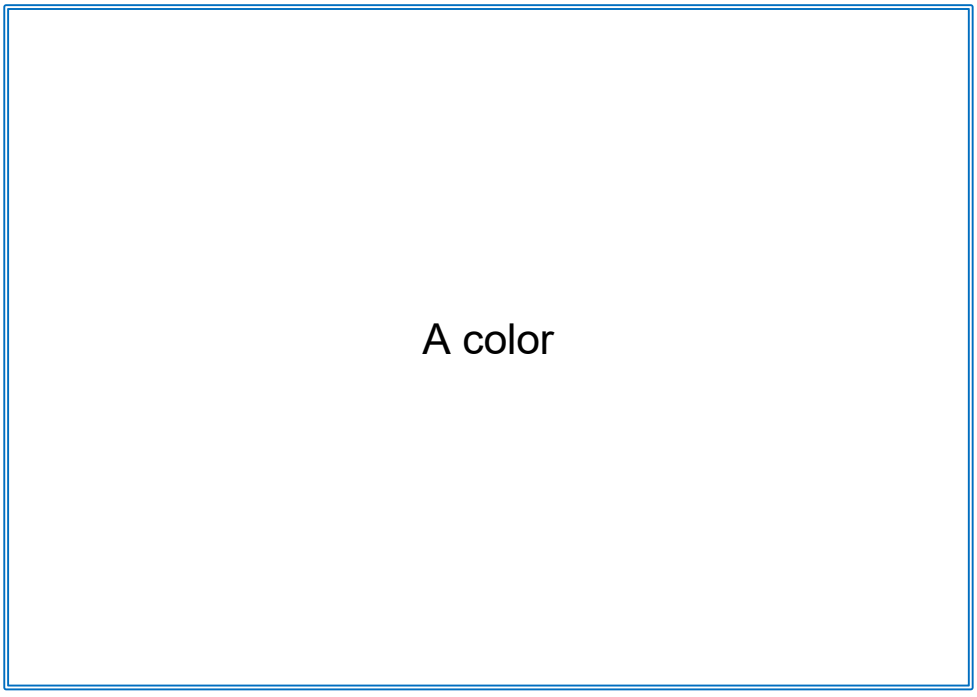
Written Instruction Card – Item C0400 – Recall

Let's go back to an earlier question.

What were those three words that I asked you to repeat?

Category Cue Card – Item C0400A – Sock

Category Cue Card – Item C0400B – Blue



Category Cue Card – Item C0400C – Bed

A piece of furniture

C0200: Repetition of Three Words

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.

Item Rationale

The inability to repeat three words on first attempt may indicate:

- a memory impairment,
- a hearing impairment,
- a language barrier, or
- inattention that may be a sign of delirium or another health issue.

DEFINITION	**CATEGORY CUE** Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the patient. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

Basic interview instructions for BIMS (C0200-0500) are shown in the C0200-C0500 Guidance. In addition, for C0200: Repetition of Three Words:

- 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 and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.
- Immediately after presenting the three words, say to the patient: "Now please tell me the three words."
- 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" [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.
  - If the patient recalled two or fewer words, code C0200, Repetition of Three words according to the patient's recall on this 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.
  - If the patient does not repeat all three words after three attempts, reassess ability to hear. If the patient can hear, move on to the next question. If they are unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding.

Coding Instructions

Record the maximum number of words that the patient correctly repeated on the **first** attempt. This will be any number between 0 and 3.

- **Code 0, None,** if the patient did not repeat any of the 3 words on the first attempt.
- **Code 1, One,** if the patient repeated only 1 of the 3 words on the first attempt.
- **Code 2, Two,** if the patient repeated only 2 of the 3 words on the first attempt.
- **Code 3, Three,** if the patient repeated all 3 words on the first attempt.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
- Do not score the number of repeated words on the second or third attempt. These attempts help with learning the item, but only the number correct on the first attempt goes into the total score. Do not record the number of attempts that the patient needed to complete.

Examples

1. The assessing clinician says, "The words are sock, blue, and bed. Now please tell me the three words." The patient replies, "Bed, sock, and blue." The clinician repeats the three words with category cues, by saying, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture."
   - **Coding:** C0200 Repetition of Three Words would be coded 3, Three words correct.
   - **Rationale:** The patient repeated all three items on the first attempt. The order of repetition does not affect the score. Per the Response Specific Instructions, the assessing clinician repeats the words with the category cues after the patient correctly states all three words.
2. The assessing clinician says, "The words are sock, blue, and bed. Now please tell me the three words." The patient replies, "Sock, bed, black." The clinician repeats the three words plus the category cues, saying, "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." The patient says, "Oh yes, that's right, sock, blue, bed."
   - **Coding:** C0200 Repetition of Three Words would be coded 2; Two of three words correct.
   - **Rationale:** The patient repeated two of the three items on the first attempt. Patients are scored based on the first attempt.
3. The assessing clinician says, "The words are sock, blue, and bed. Now please tell me the three words." The patient says, "Blue socks belong in the dresser." The clinician codes according to the patient's response. Then the clinician repeats the three words plus the category cues, saying, "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." The patient says, "Oh yes, that's right, sock, blue, bed."
   - **Coding:** C0200 Repetition of Three Words would be coded 2; Two of the three words correct.
   - **Rationale:** The patient repeated two of the three items—blue and sock on the first attempt. The patient put the words into a sentence, resulting in the patient repeating two of the three words.
4. The assessing clinician says, "The words are sock, blue, and bed. Now please tell me the three words." The patient replies, "What were those three words?" The patient's response is coded and then the clinician repeats the three words plus the category cues.
   - **Coding:** C0200 Repetition of Three Words would be coded 0, None of the words correct.
   - **Rationale:** The patient did not repeat any of the three words on the first attempt.

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 the 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 the 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 the correct day of the week 0. Incorrect or no answer 1. Correct

Item Rationale

- A lack of temporal orientation may lead to decreased communication or participation in activities.
- Not being oriented may be frustrating or frightening.

DEFINITION	TEMPORAL ORIENTATION In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

Basic interview instructions for BIMS (C0200-0500) are shown in the C0200-C0500 Guidance. In addition, for C0300 (A, B, and C): Temporal Orientation:

- Ask the patient each of the 3 questions in Item C0300 separately.
- Allow the patient up to 30 seconds 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 any help from me."

Coding Instructions for C0300A, Able to Report Correct Year

- **Code 0, Missed by >5 years or no answer if** the patient's answer is incorrect and is greater than 5 years from the current year or the patient chooses not to answer the item.
- **Code 1, Missed by 2-5 years,** if the patient's answer is incorrect and is within 2 to 5 years from the current year.

- **Code 2, Missed by 1 year,** if the patient's answer is incorrect and is within one year from the current year.
- **Code 3, Correct,** if the patient states the correct year.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Examples

1. The date of the interview is May 5, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is 2020.
   - **Coding:** C0300A would be coded 3, Correct.
   - **Rationale:** 2020 is the current year at the time of this assessment.
2. The date of the interview is June 16, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is 2017.
   - **Coding:** C0300A would be coded 1, Missed by 2-5 years.
   - **Rationale:** 2017 is within 2 to 5 years of 2020.
3. The date of the interview is January 10, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is 1920.
   - **Coding:** C0300A would be coded 0, Missed by more than 5 years.
   - **Rationale:** Even though the '20 part of the year would be correct, 1920 is more than 5 years from 2020.
4. The date of the interview is April 1, 2020. The patient, responding to the statement, "Please tell me what year it is right now," states that it is "'20." The assessing clinician asks, "Can you tell me the full year?" The patient still responds "'20," and the assessing clinician asks again, "Can you tell me the full year, for example, nineteen-eighty-two." The patient states, "2020."
   - **Coding:** C0300A would be coded 3, Correct.
   - **Rationale:** Even though '20 is partially correct, the only correct answer is the exact year. The patient must state "2020," not "20" or "1820" or "1920."

Coding Instructions for C0300B, Able to Report Correct Month

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.

- **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.
- **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, count current date as day 1.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Examples

1. The date of the interview is June 25, 2020. The patient, responding to the question, "What month are we in right now?" states that it is June.
   - **Coding:** C0300B would be coded 2, Accurate within 5 days.
   - **Rationale:** The patient correctly stated the month.
2. The date of the interview is June 28, 2020. The patient, responding to the question, "What month are we in right now?" states that it is July.
   - **Coding:** C0300B would be coded 2, Accurate within 5 days.
   - **Rationale:** The patient 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.
3. The date of the interview is June 25, 2020. The patient, responding to the question, "What month are we in right now?" states that it is July.
   - **Coding:** C0300B would be coded 1, Missed by 6 days to 1 month.
   - **Rationale:** The patient missed the correct month by six days. June 25th (day 1) + 5 more days = June 30th. Therefore, the patient's answer is incorrect within 6 days to 1 month.
4. The date of the interview is June 30, 2020. The patient, responding to the question, "What month are we in right now?" states that it is August.
   - **Coding:** C0300B would be coded 0, Missed by more than 1 month.
   - **Rationale:** The patient missed the month by more than 1 month.
5. The date of the interview is June 2, 2020. The patient, responding to the question, "What month are we in right now?" states that it is May.
   - **Coding:** C0300B would be coded 2, Accurate within 5 days.
   - **Rationale:** June 2 minus 5 days = May 29th. The patient correctly stated the month within 5 days even though the current month is June.

Coding Instructions for C0300C, Able to Report Correct Day of the Week

- **Code 0, Incorrect, or no answer,** if the answer is incorrect or the patient chooses not to answer the item.
- **Code 1, Correct,** if the answer is correct.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Examples

1. The day of the interview is Monday, June 27, 2020. The assessing clinician asks: "What day of the week is it today?" The patient responds, "It's Monday."
   - **Coding:** C0300C would be coded 1, Correct.
   - **Rationale:** The patient correctly stated the day of the week.

2. The day of the interview is Monday, June 27, 2020. The patient, responding to the question, "What day of the week is it today?" states, "Tuesday."
   - **Coding:** C0300C would be coded 0, Incorrect or no answer.
   - **Rationale:** The patient incorrectly stated the day of the week.
3. The day of the interview is Monday, June 27, 2020. The patient, responding to the question, "What day of the week is it today?" states, "Today is a good day."
   - **Coding:** C0300C would be coded 0, Incorrect or no answer.
   - **Rationale:** The patient did not answer the question correctly.

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

Item Rationale

- Many persons with cognitive impairment can be helped to recall if provided cues.
- Providing memory cues can help maximize patient cognitive function and decrease frustration for those patients who respond.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

Basic interview instructions for BIMS (C0200-C0500) are shown on the C0200-C0500 Guidance. In addition, for C0400 (A, B, and C): Recall:

- 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 (refer to C0200 guidance pages for the definition of category cue). 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.

Coding Instructions

For each of the three words the patient is asked to remember:

- **Code 0, No—could not recall,** if the patient cannot recall the word even after being given the category cue or if the patient responds with a nonsensical answer or chooses not to answer the item.
- **Code 1, Yes, after cueing,** if the patient requires the category cue to remember the word.
- **Code 2, Yes, no cue required,** if the patient correctly remembers the word spontaneously without cueing.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- If on the first try (without cueing), the patient names multiple items in a category, one of which is correct, they should be coded as correct for that item.
- If, however, the assessing clinician gives the patient the cue and the patient then names multiple items in that category, the item is coded as could not recall, even if the correct item was in the list.

Examples

1. The patient is asked to recall the three words that were initially presented. The patient chooses not to answer the question and states, "I'm tired, and I don't want to do this anymore."
   - **Coding:** C0400A-C0400C would be coded 0, No—could not recall, could not recall for each of the three words.
   - **Rationale:** Choosing not to answer a question often indicates an inability to answer the question, so refusals are coded 0, No—could not recall. This is the most accurate way to score cognitive function, even though, on occasion, patients might choose not to answer for other reasons.
2. The patient is asked to recall the three words. The patient replies, "Socks, shoes, and bed." The examiner then cues, "One word was a color." The patient says, "Oh, the shoes were blue."
   - **Coding:** C0400A, sock, would be coded 2, Yes, no cue required.
   - **Rationale:** The patient's initial response to the question included "sock." They are given credit for this response, even though the patient also listed another item in that category (shoes), because they were answering the initial question, without cueing.
   - **Coding:** C0400B, blue, would be coded 1, Yes, after cueing.
   - **Rationale:** The patient did not recall spontaneously but did recall after the category cue was given. Responses that include the word in a sentence are acceptable.
   - **Coding:** C0400C, bed, would be coded 2, Yes, no cue required.
   - **Rationale:** The patient independently recalled the item on the first attempt.

3. The patient is asked to recall the three words. The patient answers, "I don't remember." The assessor then says, "One word was something to wear." The patient says, "Clothes." The assessor then says, "OK, one word was a color." The patient says, "Blue." The assessor then says, "OK, the last word was a piece of furniture." The patient says, "Couch."
    - **Coding:** C0400A, sock, would be coded 0, No—could not recall.
    - **Rationale:** The patient did not recall the item, even with a cue.
    - **Coding:** C0400B, blue, would be coded 1, Yes, after cueing.
    - **Rationale:** The patient recalled after being given the cue.
    - **Coding:** C0400C, bed, would be coded 0, No—could not recall.
    - **Rationale:** The patient did not recall the item, even with a cue.

C0500: BIMS Summary Score

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

Item Rationale

The total score:

- Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Provides staff with a more reliable estimate of patient function and allows staff interactions with patients that are based on more accurate impressions about patient ability.

The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) 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

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- After completing C0200-C0400:
    - Add up the values for all questions from C0200 through C0400.

Coding Instructions

- Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.
  - If the patient chooses not to answer a specific question(s), that question is coded as incorrect, and the item(s) counts in the total score. If, however, the patient chooses not to answer four or more items, then the interview is coded as incomplete.
  - 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 must be related to the question (logical); it does not have to be correct. See general coding tips that follow for patients who choose not to participate at all.
  - If all BIMS items (C0200-C0400) are coded with a dash ("–"), code C0500 Summary Score with a dash ("–").
  - **Code 99, unable to complete interview,** if (a) the patient chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or (c) if any but not all of the BIMS items are 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.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Occasionally, a patient can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter code 99 for C0500, BIMS Summary Score.

Examples

1. The patient's scores on items C0200-C0400 were as follows:

C0200 (repetition)	3
C0300A (year)	2
C0300B (month)	2
C0300C (day)	1
C0400A (recall "sock")	2
C0400B (recall "blue")	2
C0400C (recall "bed")	0

Coding: C0500- BIMS summary score would be coded 12 (Sum of C0200-C0400C).

2. The patient's scores on items C0200-C0400C were as follows:

C0200 (repetition)	2
C0300A (year)	2
C0300B (month)	2
C0300C (day)	1
C0400A (recall "sock")	0
C0400B (recall "blue")	0
C0400C (recall "bed")	0

Coding: C0500- BIMS summary score would be coded as 07 (Sum of C0200-C0400C).

4. STOP the interview if each of items C0200-C0300C are coded as 0, because a patient chose not to participate in the BIMS and/or has provided nonsensical answers and/or does not provide verbal or written responses, then stop the interview after C0300C.

Example: The patient's score on items C0200-C0400C were as follows:

C0200 (repetition)	0
C0300A (year)	0
C0300B (month)	0
C0300C (day)	0 (Interview is stopped after C0300C)
C0400A (recall "sock")	(-)
C0400B (recall "blue")	(-)
C0400C (recall "bed")	(-)

Coding: C0200-C0300C, are coded 0 and dashes entered for C0400A-C. C0500 – BIMS Summary Score, enter code 99, unable to complete interview.

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. If one or more of the zeros in C0200 – C0300 are due to incorrect answers, the interview should continue.

C1310: Signs and Symptoms of Delirium

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 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	↓ **Enter codes in boxes**	
	☐	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

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Item Intent

The intent of this item is to identify any signs or symptoms of acute mental status changes as compared to the patient's baseline status and if there are any signs or symptoms of delirium present at the time of assessment.

Item Rationale

Delirium is associated with:

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

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

- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.
- Examples of acute mental status changes include:
  - A patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
  - A patient who is normally quiet and content suddenly becomes restless or noisy.
  - A patient who is usually able to find their way around their living environment begins to get lost.

DEFINITIONS	**INATTENTION** • Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention). **FLUCTUATION** • The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the assessment period. Fluctuating behavior may be noted by the assessing clinician, reported by staff or family, or documented in the medical record.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- Observe patient behavior during the assessment for the signs and symptoms of delirium.
- Review medical record documentation and consult with other staff, family members/caregivers, and others in a position to determine the patient's baseline status compared to status on the day of assessment.
- Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.

Scoring Guide

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C, or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

Coding Instructions for C1310A, Acute Mental Status Change

- **Code 0, No,** if there is no evidence of acute mental status change from the patient's baseline.
- **Code 1, Yes,** if patient has an alteration in mental status observed or reported or identified that represents an acute change from baseline.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips for C1310A, Acute Mental Status Change

At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period under consideration).

Examples

1. Patient was admitted to home health. The family reports that the patient was alert and oriented prior to the day

of assessment. During the BIMS interview and assessment, the patient is lethargic and incoherent.

- **Coding:** C1310A would be coded 1, Yes.
- **Rationale:** There is an acute change of the patient's mental status from alert and oriented (family report prior to admission) to lethargic and incoherent during the start of care assessment.

2. Caregiver reports that a patient with poor short-term memory and disorientation to time has suddenly become agitated, calling out to their dead spouse, tearing off their clothes, and being completely disoriented to time, person, and place.
   - **Coding**: C1310A would be coded 1, Yes.
   - **Rationale:** The new behaviors represent an acute change in mental status.

Response-Specific Instructions for C1310B, Inattention

- Assess attention separately from level of consciousness.
- An additional step to identify difficulty with attention is to ask the patient to count backwards from 20.

Coding Instructions for C1310B, Inattention

- **Code 0, Behavior not present,** if the patient remains focused during the assessment and all other sources agree that the patient was attentive during other activities.
- **Code 1, Behavior continuously present, does not fluctuate,** if the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary. All sources must agree that inattention was consistently present to select this code.
- **Code 2, Behavior present, fluctuates,** if inattention is noted during the assessment or any source reports that the patient had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied or if information sources disagree in assessing level of attention.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Examples

1. A patient tries to answer all questions during the BIMS. Although they answer several items incorrectly and respond "I don't know" to others, the patient pays attention to the assessing clinician. The family indicates that this is the patient's consistent behavior.
   - **Coding:** C1310B would be coded 0, Behavior not present**.**
   - **Rationale:** The patient remained focused throughout the assessment, and this was constant during the day of assessment.
2. Questions during the BIMS must be frequently repeated because the patient's attention wanders. This behavior occurs throughout the assessment. The family agrees that this behavior is consistently present. The patient has a diagnosis of dementia.
   - **Coding:** C1310B would be coded 1, Behavior continuously present, does not fluctuate.
   - **Rationale:** The patient's attention consistently wandered throughout the assessment. The patient's dementia diagnosis does not affect the coding.

3. During the BIMS interview, the patient was not able to focus on all questions asked and their gaze wandered. However, the family confirmed that the patient was attentive prior to the nurse arriving for the home health visit.
   - **Coding:** C1310B would be coded 2, Behavior present, fluctuates.
   - **Rationale:** Evidence of inattention was found during the assessment, but the family indicated the patient had been attentive earlier in the day. This disagreement shows possible fluctuation in the behavior. If any information source reports the symptom as present, C1310B cannot be coded as 0, Behavior not present.
4. Patient is dazedly staring at the television for the first several questions. When you ask a question, the patient looks at you momentarily but does not answer. Midway through questioning, they pay more attention and try to answer.
   - **Coding:** C1310B would be coded 2, Behavior present, fluctuates.
   - **Rationale:** Patient's attention fluctuated during the assessment. If as few as one source notes fluctuation, then the behavior should be coded as 2, Behavior present, fluctuates.

Coding Instructions for C1310C, Disorganized Thinking

- **Code 0, Behavior not present,** if all sources agree that the patient's thinking was organized and coherent, even if answers were inaccurate or wrong.
- **Code 1, Behavior continuously present, does not fluctuate,** if, during the assessment and according to other sources, the patient's responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the patient unpredictably switched from subject to subject.
- **Code 2, Behavior present, fluctuates,** if, during the assessment or according to other data sources, the patient's responses fluctuated between disorganized/incoherent and organized/clear. Also, code as fluctuating if information sources disagree.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

DEFINITION	DISORGANIZED THINKING Evidenced by rambling, irrelevant, or incoherent speech.

Examples

1. The assessing clinician asks a patient, who is often confused, to give the date, and the patient's response is: "Let's go get the sailor suits!" The patient continues to provide irrelevant or nonsensical responses throughout the interview, and their family indicates this is constant.
   - **Coding:** C1310C would be coded 1, Behavior continuously present, does not fluctuate.
   - **Rationale:** All sources agree that the disorganized thinking is constant.
2. A patient responds that the year is 1837 when asked to give the date. Their family indicates that the patient is never oriented to time but has relevant conversations and does not ramble with incoherent speech. For example, the family reports that the patient often discusses their passion for baseball.
   - **Coding:** C1310C would be coded 0, Behavior not present.

- **Rationale:** The patient's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

3. The patient was able to tell the assessing clinician their name, the year and where they were. The patient was able to talk about the activity they just attended in the assisted living facility and the residents and staff that also attended. Then the patient suddenly asked the clinician, "Who are you? What are you doing in my daughter's home?"
   - **Coding:** C1310C would be coded 2, Behavior present, fluctuates.
   - **Rationale:** The patient's thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be coded as 2, Behavior present, fluctuates.

Coding Instructions for C1310D, Altered Level of Consciousness

- **Code 0, Behavior not present,** if all sources agree that the patient was alert and maintained wakefulness during conversation, interview(s), and activities.
- **Code 1, Behavior continuously present, does not fluctuate,** if, during the assessment and according to other sources, the patient was consistently lethargic, stuporous, vigilant, or comatose.
- **Code 2, Behavior present, fluctuates,** if, during the assessment or according to other sources, the patient's level of consciousness varied. For example, the patient was at times alert and responsive, while at other times the patient was lethargic, stuporous, or vigilant. Code as fluctuating if information sources disagree.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

DEFINITION	**ALTERED LEVEL OF CONSCIOUSNESS** • VIGILANT – startles easily to any sound or touch. • LETHARGIC – repeatedly dozes off when you are asking questions but responds to voice or touch. • STUPOR – very difficult to arouse and keep aroused for the interview. • COMATOSE – cannot be aroused despite shaking and shouting.

Examples

1. At discharge, a patient is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation and family reports consistently note that the patient was alert.
   - **Coding:** C1310D would be coded 0, Behavior not present.
   - **Rationale:** All evidence indicates that the patient is alert during conversation, assessment(s), and activities.
2. The patient is lying in bed. They arouse to soft touch but only converse for a short time before their eyes close, and they appear to be sleeping. Again, the patient arouses to voice or touch but only for short periods during the assessment. Information from the caregivers indicates that this has been the patient's condition.
   - **Coding:** C1310D would be coded 1, Behavior continuously present, does not fluctuate.

- **Rationale:** The patient's lethargy was consistent throughout the assessment, and there is consistent validation from the caregivers.

3. The patient is usually alert, oriented to time, place, and person per family report. Today, at the time of the BIMS interview, the patient is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.
   - **Coding:** C1310D would be coded 2, Behavior present, fluctuates.
   - **Rationale:** The level of consciousness fluctuated during the assessment. If as few as one source notes fluctuation, then the behavior should be coded 2, Behavior present, fluctuates.

M1700: Cognitive Functioning

M1700. Cognitive Functioning Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.	
Enter Code ☐	0. Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. 1. Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions. 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. 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Item Intent

Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview patient and/or caregiver and review referral information.
- Consider the signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.
- Consider the amount of supervision and care required due to cognitive deficits.
- Links to cognitive assessment resources can be found in Appendix E of this manual.
- **Dash is not** a valid response for this item.

Coding Tips

- Diagnoses such as dementia, delirium, developmental delay disorders, mental retardation, etc., will have

various degrees of cognitive dysfunction.

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

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

M1710. When Confused (Reported or Observed Within the Last 14 Days):	
Enter Code ☐	0. Never 1. In new or complex situations only 2. On awakening or at night only 3. During the day and evening, but not constantly 4. Constantly NA Patient nonresponsive

Item Intent

Identifies the time of day or situations when the patient experienced confusion, if at all.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver and review the referral information.
- Assess specifically for confusion in the past 14 days.
- Codes 2, 3, and 4 differ from each other based on the time when the confusion occurred and the length of time the confusion persists.
- Links to cognitive assessment resources can be found in Appendix E of this manual.

Coding Instructions

- **Code 0**, **Never**, if the patient had no confusion in the last 14 days.
- **Code 1, In new or complex situations only,** if the patient's confusion is isolated to a new or a complex situation.
- **Code 4, Constantly,** if the patient's confusion was present at all times during the entire 14 days.
- **Code, NA, Patient nonresponsive,** if the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source.
- **Dash is not** a valid response for this item.

Coding Tips

- The "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date. This

means that for the 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 confusion reported or observed on or after August 6 and prior to the HHA admission would be reported.

- "Nonresponsive" means that the patient is unable to respond, or the patient responds in a way that you cannot make a clinical judgment about the patient's level of orientation.
- If the patient is nonresponsive at the time of assessment, elicit from the caregiver or other sources whether the patient experienced any confusion during the past 14 days.

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

M1720. When Anxious (Reported or Observed Within the Last 14 Days):	
Enter Code ☐	0. None of the time 1. Less than often daily 2. Daily, but not constantly 3. All of the time NA Patient nonresponsive

Item Intent

Identifies the frequency with which the patient has felt anxious within the past 14 days.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver and review referral information.
- Links to cognitive assessment resources can be found in Appendix E of this manual.

Coding Instructions

- **Code 3, All of the time**, if the patient felt anxious at all times during the entire look back period of 14 days.
- **Code NA, Patient nonresponsive**, if the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source.
- **Dash is not** a valid response for this item.

Coding Tips

- Anxiety includes worry that interferes with learning and normal activities, feelings of being overwhelmed and having difficulty coping, or symptoms of anxiety disorders.
- The "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date. This means that for the 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

anxiety reported or observed on or after August 6 and prior to the HHA admission would be reported.

- "Nonresponsive" means that the patient is unable to respond, or the patient responds in a way that you cannot make a clinical judgment about the patient's level of anxiety.
- If the patient is nonresponsive at the time of assessment, elicit from the caregiver or other sources whether the patient experienced any anxiety during the past 14 days.

SECTION D: MOOD

Introduction

This section contains items that address mood distress. The presence of indicators does not automatically mean that the patient has a diagnosis of depression or other mood disorder.

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

D0150. Patient Mood Interview (PHQ-2 to 9)		
Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9, No response, leave D0150A2 and D0150B2 blank, end the PHQ-2 interview, and leave D0160, Total Severity Score blank. Otherwise, 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	☐	☐
If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.		
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 the 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	☐	☐

Item Intent

This item identifies the presence of signs and symptoms of mood distress, a serious condition that is underdiagnosed and undertreated in home health and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among home health patients because these signs and symptoms can be treatable.

Item Rationale

Depression can be associated with:

- psychological and physical distress,
- decreased participation in therapy and activities,

- decreased functional status, and
- poorer outcomes.
- Mood disorders are common in home health and are often underdiagnosed and undertreated.

DEFINITION	**PATIENT HEALTH QUESTIONAIRE (PHQ-2 to 9)** A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge assessment, complete as close to the time of discharge as possible.

- Conduct the interview in a private setting, if possible.
- Interact with the patient using their preferred language.
  - If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
- If an interpreter is used during patient interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the patient's responses.
- 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."
- Explain and/or show the interview response choices. A cue card with the response choices clearly written in large print might help the patient comprehend the response choices.
  - **Suggested language:** "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 day—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."
- 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?"
- For each of the questions:
  - Read the item as it is written.
  - Do not provide definitions because the meaning **must be** based on the patient's interpretation. For example, the patient defines for themself what "feeling down" means; the item should be scored based on the patient's interpretation.

- Each question **must be** asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- Enter code 9 in Column 1 and leave blank (or skip) Column 2 if the patient was unable or chose not to complete an interview item or responded nonsensically. A **nonsensical** response is one that is unrelated, incomprehensible, or incoherent or if the patient's response is not informative with respect to the item being rated (e.g., when asked the question about "poor appetite or overeating," the patient answers, "I always win at poker.").
- For a **yes** response, ask the patient to tell you how often they were bothered by the symptom over the last 2 weeks. Use the response choices in D0150 Column 2, **Symptom Frequency**. Start by asking the patient the number of days that they were bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 day—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).

- Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood: Code D0150A1 and D0150B1 as 9 (No response) and leave D0150A2 and D0150B2 blank, end the PHQ-2 interview and skip D0160.
- Determine whether to complete the PHQ-9 (i.e., 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, OR, **both** D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue.
    - 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 total sum of 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 and complete D0160, Total Severity Score.

Coding Instructions for Column 1: Symptom Presence

Record the patient's responses as they are stated, regardless of whether the patient or the assessor attributes the symptom to something other than mood.

- **Code 0, No:** if patient indicates symptoms listed are not present. Enter 0 in Column 2 as well.
- **Code 1, Yes:** if patient indicates 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 or responded nonsensically. Leave Column 2, Symptom Frequency, blank.
- **Dash** is a valid response for this item. Enter a Dash in Column 1 if the symptom presence was not assessed. Leave Column 2, Symptom Frequency, blank.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Instructions for Column 2: Symptom Frequency

- **Code 0, Never or 1 day,** if the patient indicates that during the past 2 weeks they have never been bothered by the symptom or have only been bothered by the symptom on 1 day.
- **Code 1, 2-6 days (several days),** if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days),** if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day),** if the patient indicates that during the past 2 weeks they have been bothered by the symptom for 12-14 days.
- **Dash** is a valid response for this item.
  - Dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Attempt to conduct the interview with ALL patients.
- If Column 1 equals 0, enter 0 in Column 2
- If Columns 1 equals 9 or dash, leave Column 2 blank.
- If one or more of the symptom presence items from D0150 is not assessed, code Column 1 with a dash and leave Column 2 blank.
- In the rare situation that the patient cannot provide a frequency, following a "Yes" response to a symptom in Column 1, enter a dash in column 2. CMS expects a dash response to be rare.
- For question D0150I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the patient or may feel that the question is too personal. Others may worry that it will give the patient inappropriate ideas. However,
    - Experienced interviewers have found that most patients who have 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.
- If the patient uses their own words to describe a symptom, this should be briefly explored. If you determine that the patient is reporting the intended symptom but using their own words, ask them to tell you how often they were bothered by that symptom.
  - Select only one frequency response per item.
    - If the patient has difficulty selecting between two frequency responses, code for the higher frequency.
    - Some items (e.g., item F) contain more than one phrase. If a patient gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Patients may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR

- by writing out their answers

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some patients may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
  - **Example:** Say, "That's interesting, now I need to know...;" "Let's get back to...;" "I understand, can you tell me about ..."
- Validate your understanding of what the patient is saying by asking for clarification.
  - **Example:** Say, "I think I hear you saying that...;" "Let's see if I understood you correctly.;" "You said.... Is that right?"
- If the patient has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
  - **Example:** Say, "Would you say [name symptom] bothered you more than half the days in the past 2 weeks?"
    - If the patient says "yes," show the cue card and ask whether it bothered them nearly every day (12-14 days) or on half or more of the days (7-11 days).
    - If the patient says "no," show the cue card and ask whether it bothered them several days (2-6 days) or never or 1 day (0-1 day).
- Noncommittal responses such as "not really" should be explored. Patients may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered them, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
  - "What do you mean?"
  - "Tell me what you have in mind."
  - "Tell me more about that."
  - "Please be more specific."
  - "Give me an example."
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
  - **Example:** Item D0150E, **Poor Appetite or Overeating**. The patient responds "the food is always cold, and it just doesn't taste like it does at home. The doctor won't let me have any salt."
    - Possible clinician response: "You're telling me the food isn't what you eat at home, and you can't add salt. How often would you say that you were bothered by poor appetite or overeating during the last 2 weeks?"
  - **Example:** Item D0150A, **Little Interest or Pleasure in Doing Things**. The patient, when asked how often they have been bothered by little interest or pleasure in doing things, responds, "There's nothing to do here, all you do is eat, bathe, and sleep. They don't do anything I like to do."

  - Possible clinician response: "You're saying there isn't much to do here, and I want to come back later to talk about some things you like to do. Thinking about how you've been feeling over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?"
- **Example:** Item D0150B, **Feeling Down, Depressed, or Hopeless**. The patient, when asked how often they have been bothered by feeling down, depressed, or hopeless, responds: "How would you feel if you were here?"
  - Possible clinician response: "You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?"

- If the patient has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a patient has moderate cognitive impairment but can respond to simple, direct questions.
  - **Example:** Item D0150E, Poor Appetite or Overeating.
    - You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
  - **Example:** Item D0150C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
    - You can break the item down as follows: "In the past 2 weeks, how often have you been bothered by having problems falling asleep?" (pause for response) "How often have you been bothered by having problems staying asleep?" (pause for response) "How often have you been bothered by feeling you are sleeping too much?"
  - **Example:** Item D0150H, 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.
    - You can simplify this item by asking: "In the past 2 weeks, how often have you been bothered by having problems with moving or speaking so slowly that other people could have noticed?" (pause for response) "How often have you been bothered by feeling so fidgety or restless that you move around a lot more than usual?"

Examples

1. **Assessing clinician**: "Over the past 2 weeks, have you been bothered by any of the following problems? Little interest or pleasure in doing things?"
   - **Patient**: "I'm not interested in doing much. I just don't feel like it. I used to enjoy visiting with friends, but I don't do that much anymore. I'm just not interested."
   - **Assessing clinician**: "In the past two weeks, how often would you say you have been bothered by this? Would you say never or 1 day, 2-6 days, 7-11 days, or 12-14 days?"
   - **Patient**: "7-11 days."
     - **Coding:** D0150A1 (Symptom presence) would be **coded 1, Yes** and D0150A2 (Symptom frequency) would be **coded 2, 7-11 days.**
     - **Rationale:** The patient indicates that they have lost interest in activities that they previously enjoyed. The patient indicates that the symptom has bothered them 7-11 days in the past two weeks.
2. **Assessing clinician**: "Over the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?"
   - **Patient**: "Television? I used to like watching the news. I can't concentrate on that anymore."

- **Assessing clinician**: "In the past two weeks, how often have you been bothered by having difficulty concentrating on things like television? Would you say never or 1 day, 2-6 days, 7-11 days, or 12-14 days?"
- **Patient**: "I'd say every day. It bothers me every day."
  - **Coding:** D0150G1 (Symptom presence) would be **coded 1, Yes** and D0150G2 (Symptom frequency) would be **coded 3, 12-14 days.**
  - **Rationale:** The patient states that they have trouble concentrating and that this bothers them every day.

D0160: Total Severity Score

D0160. Total Severity Score	
Enter Score ☐☐	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

Item Intent

This item identifies the severity score calculated from responses to the PHQ-2 to 9, item D0150.

Item Rationale

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the patient's physician, other clinicians, and mental health specialists for appropriate follow up.
- The **Total Severity Score** is a summary of the frequency scores on the PHQ-2 to 9 that indicates the extent of potential depression symptoms.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Do not add up the score while you are interviewing the patient. Instead, focus your full attention on the interview.
- Use the scoring guide to complete scoring: **Scoring Rules: Patient Mood Interview Total Severity Score D0160.**
- The maximum patient score is 27 (3 x 9).

Coding Instructions

- If only the PHQ-2 is completed because both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ interview and skip D0160, Total Severity Score.
- If only the PHQ-2 is completed because both D0150A2 and D0150B2 are coded 0 or 1, add the numeric

scores from these two frequency items and enter the value in D0160, Total Severity Score

- If the PHQ-9 was completed (D0150C-I were not skipped due to the responses in D0150A and B), and if the patient answered the frequency responses of at least 7 of the 9 items on the PHQ- 9; add the numeric scores from D0150A2-D0150I2 and enter in D0160 Total Severity Score.
- If symptom frequency is blank or dashed for 3 or more items, the interview is deemed **NOT** complete. D0160, **Total Severity Score** should be coded as "99"
- The **Total Severity Score** will be between **00** and **27** (or "**99**" if symptom frequency is blank for 3 or more items).
- **Dash is not** a valid response for this item.

Coding Tips

- Responses to PHQ-2 to 9 can indicate possible depression if the full PHQ-2 to 9 is completed (i.e., interview is not stopped after D0150B due to responses). Responses can be interpreted as follows:
  - Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period.
  - Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed, or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period.
  - In addition, 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:
    - 0-4: Minimal depression
    - 5-9: Mild depression
    - 10-14: Moderate depression
    - 15-19: Moderately severe depression
    - 20-27: Severe depression

Scoring Rules: Patient Mood Interview Total Severity Score D0160

If only the PHQ-2 is completed because both D0150A2 and D0150B2 are coded 0 or 1, add the numeric scores from these two frequency items and enter the value in D0160.

If items D0150C through D0150I were asked, calculate the Total Severity Score:

- Item D0160 is used to store the total severity score for the Patient Mood Interview. The score in item D0160 is based upon the sum of the values that are contained in the following nine items: D0150A2, D0150B2, D0150C2, D0150D2, D0150E2, D0150F2, D0150G2, D0150H2, and D0150I2. These are referred to as the "items in Column 2", below.
- The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are skipped or dashed. An item in Column 2 is skipped if the corresponding item in Column 1 was equal to 9 (no response) or a dash (symptom presence not assessed).
- If all the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values.
- If any of the items in Column 2 are blank (or skipped) or dashed, then omit their values when computing the sum.

- If the number of missing items in Column 2 is equal to one, then compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0160.
- If the number of missing items in Column 2 is equal to two, then compute the simple sum of the seven items in Column 2 that have non-missing values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0160.
- If the number of missing items in Column 2 is equal to three or more, then item D0160 must equal [99].

Examples

1. All Items in Column 2 Have Non-missing Values

The following example shows how to score the Patient interview when all the items in Column 2 have non-missing values:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	2
D0150D2	0
D0150E2	3
D0150F2	0
D0150G2	1
D0150H2	3
D0150I2	2
D0160	14

- **Rationale:** In this example, all the items in Column 2 have non-missing values (i.e., none of the values are blank, (or skipped) or dashed). Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.

2. One Missing Value in Column 2

The following example shows how to score the Patient interview when one of the items in Column 2 has a missing value:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	
D0150D2	0
D0150E2	3
D0150F2	0
D0150G2	1
D0150H2	3
D0150I2	1
D0160	12

- **Rationale:** In this example, one of the items in Column 2 (D0150C2) has a missing value (it is blank, or skipped) and the other 8 items have non-missing values. D0160 is computed as follows:

    1. Compute the sum of the 8 items with non-missing values. This sum is 11.
    2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375.
    3. Round the result to the nearest integer. In the example, 12.375 rounds to 12.
    4. Place the rounded result in D0160.

3. **Two Missing Values in Column 2**

   The following example shows how to score the Patient interview when two of the items in Column 2 have missing values:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	
D0150D2	0
D0150E2	3
D0150F2	0
D0150G2	1
D0150H2	1
D0150I2	
D0160	10

- **Rationale:** In this example, two of the items in Column 2 have missing values: both D0150C2 and D0150I2 are blank (or skipped). The other 7 items have non-missing values. D0160 is computed as follows:

    1. Compute the sum of the 7 items with non-missing values. This sum is 8.
    2. Multiply this sum by 1.286. In the example, 8 x 1.286 = 10.288.
    3. Round the result to the nearest integer. In the example, 10.288 rounds to 10.
    4. Place the rounded result in D0160.

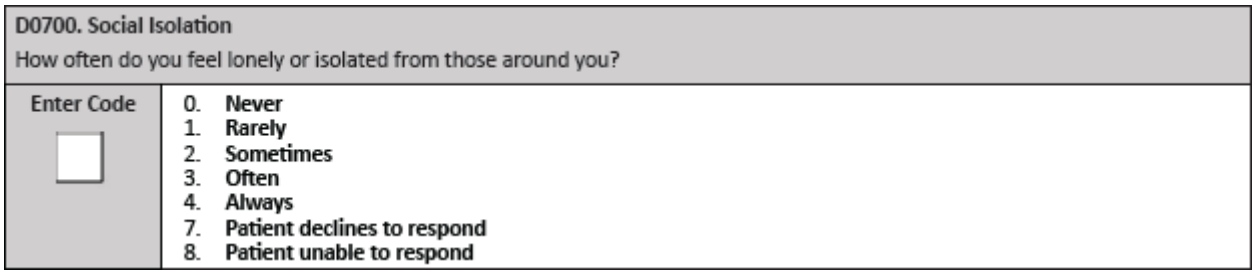
4. **Three or More Missing Values in Column 2**

The following example shows how to score the Patient interview when three or more of the items in Column 2 have missing values:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	
D0150D2	0
D0150E2	3
D0150F2	
D0150G2	
D0150H2	3
D0150I2	2
D0160	99

- **Rationale:** In this example, three of the items in Column 2 have missing values: D0150C2, D0150F2, and D0150G2 are blank (or skipped). Because three or more items have missing values, D0160 is equal to 99.

D0700: Social Isolation



Item Intent

The intent of this item is to identify the patient's actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

Item Rationale

- Social isolation tends to increase with age, is a risk factor for physical and mental illness, and a predictor of mortality.

DEFINITION	SOCIAL ISOLATION Social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

- Discharge from agency

Response-Specific 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 and DC as possible.
- Data sources/resources: Ask for the patient, "How often do you feel lonely or isolated from those around you?"

Coding Instructions

- **Code 0, Never,** if the patient indicates never feeling lonely or isolated from others.
- **Code 1, Rarely,** if the patient indicates rarely feeling lonely or isolated from others.
- **Code 2, Sometimes,** if the patient indicates sometimes feeling lonely or isolated from others.
- **Code 3, Often,** if the patient indicates often feeling lonely or isolated from others.
- **Code 4, Always,** if the patient indicates always feeling lonely or isolated from others.
- **Code 7, Patient declines to respond,** if the patient declines to respond.
- **Code 8, Patient unable to respond,** if the patient is unable to respond.
- **Dash is not** a valid response for this item.

SECTION E: BEHAVIOR

Introduction

The items in this section help to identify and describe the presence and frequency of behaviors associated with a variety of disorders.

M1740: Cognitive, behavioral, and psychiatric symptoms

M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):	
↓	Check 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**

Item Intent

Identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver, conduct a physical assessment, including observation of the patient. Review the clinical record, including but not limited to, referral information and physician history and physical. Links to cognitive assessment resources can be found in Appendix E of this manual.
- Behaviors reported could be identified by a formal diagnosis and/or determined by clinical judgment of the assessing clinician.
- Behaviors which are severe enough to make the patient unsafe to self or others cause considerable stress to the caregivers and/or require supervision or intervention should be included.

Coding Instructions

- **Code 7**, None of the above behaviors demonstrated, when none of the other responses are selected.
- **Dash is not** a valid response for this item.

M1745: Frequency of Disruptive Behavior Symptoms (Reported or Observed)

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

Item Intent

Identifies the frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver and conduct a physical assessment, including observation of the patient. Behaviors can be reported by the patient, caregiver, family, or others, and/or observed by the clinician.
- Review the clinical record, including but not limited to the referral information and the physician history and physical. Links to additional information sources can be found in Appendix E of this manual. Use professional judgment to determine if the behavior is disruptive or dangerous to the patient or others.
- Consider any and all disruptive/dangerous behaviors to respond to this item, not just the behaviors listed in M1740. Then consider how frequently these behaviors occur.
- Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders, identified by diagnosis and/or the assessing clinician's professional judgment.

Coding Instructions

- **Dash is not** a valid response for this item.

Coding Tips

- Examples of disruptive/dangerous behaviors include but are not limited to sleeplessness, "sun-downing," agitation, wandering, aggression, combativeness, and/or getting lost in familiar places.

SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE ACTIVITIES

Introduction

This section identifies the patient's living situation including types, sources, and amounts of assistance needed for routine activities.

M1100: Patient Living Situation

M1100. Patient Living Situation Which of the following best describes the patient's residential circumstance and availability of assistance?					
Living Arrangement	Availability of Assistance				
	Around the Clock	Regular Daytime	Regular Night-time	Occasional/ Short-Term Assistance	No Assistance Available
	↓ Check one box only ↓				
A. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
B. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
C. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

Item Intent

This item identifies, using the assessing clinician's professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s) other than home health agency staff to provide in-person assistance.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Interview the patient and/or caregiver, and review referral information. Information may also be available in an assisted living facility agreement or contract.
- First, determine living arrangement – whether the patient normally lives alone, in a home with others, or in a congregate setting.
- Second, determine availability of assistance – how frequently caregiver(s) other than home health staff are in the home and available to provide assistance if needed.
    - This item documents the time caregiver(s) are in the home and available without regard to the amount or types of assistance the patient requires, or whether the caregiver(s) are able to meet all or only some of the patient's needs.

- Living arrangement
  - **Lives alone:** The patient lives in an independent (non-assisted) setting such as a home, an apartment, or a room in a boarding house. A patient is considered to be living alone when they have:
    - Only live-in, paid help.
    - A caregiver is temporarily staying in the home to provide assistance, but they normally live alone.
    - A lifeline or can obtain emergency help by phone but no other people are living with them.
  - **Lives with others:** The patient lives in an independent (non-assisted) setting with a spouse, family member or another significant other.
    - A patient who lives with others and is occasionally alone when caregiver(s) travel, is still considered to be living with others.
  - **Lives in congregate situation**: The patient lives in a setting where assistance, supervision and/or oversight are provided as part of the living arrangement, such as an assisted living facility, residential care home, or personal care home.
    - The patient may live alone, or with a spouse or significant other, in an apartment or room in an assisted living facility, for example, and still be considered living in a congregate situation.
- Availability of Assistance
  - **Around the clock:** Someone is in the home to provide assistance to the patient 24 hours a day.
  - **Regular daytime**: Someone is in the home to provide assistance during daytime hours every day with infrequent exceptions.
  - **Regular nighttime**: Someone is in the home to provide assistance during nighttime hours every night with infrequent exceptions.
  - **Occasional/short-term assistance**: Someone is in the home to provide assistance only for a few hours a day, **or** on an irregular basis, **or** only occasionally.
  - **No assistance available**: There is no one available to provide any in-person assistance.

Coding Instructions

- **Code** the response identifying the availability of assistance ***in the row that matches*** the patient's living arrangement. Only one response should be marked.
- **Dash is not** a valid response for this item.

Coding Tips

- If the patient has recently changed their living arrangement due to their condition, report the usual living arrangement prior to the illness, injury, or exacerbation for which the patient is receiving care, unless the new living arrangement is expected to be permanent.
- Use professional judgment to determine which hours constitute "regular daytime" and "regular nighttime" based on the patient's specific activities and routines. No hours are specifically designated as daytime or nighttime.
- Assistance refers to any type of in-person assistance provided in the home of the patient, including but not limited to ADLs and IADLs.

- Use professional judgment to determine if someone will be available to provide any assistance to the patient. If a person is living in the patient's home but is completely unable to or unwilling to provide any assistance to the patient, do not count them as a caregiver.
- Availability of assistance refers to the expected availability and willingness of caregiver(s) for this upcoming quality episode.
- If a person is in an assisted living or congregate setting with a call-bell that summons onsite, in-person help, this is considered in-person assistance. If its use is restricted to emergencies only, report the availability as occasional/short-term assistance unless other caregivers' availability meets a higher level.
- The caregiver(s) need not live in the home with the patient, but assistance via telephone is not included in this question.

Examples

1. Patient lives alone in their own apartment. Since the patient's discharge from the hospital, their two daughters alternate staying with them during the day and night so that one of them is always there, except for the times when one goes out to run an errand or pick up a child at day care.
   - **Coding:** 01
   - **Rationale:** Patient still considered to be living alone, since daughters are only staying there temporarily. The daughters provide round-the-clock care, even if one occasionally needs to be out of the house for brief periods.
2. Patient lives alone in their home but their son and daughter-in-law live across the street. They bring the patient dinner every night and are available around the clock by telephone.
   - **Coding:** 04
   - **Rationale:** Son and daughter-in-law are not there to provide in-person assistance consistently, day or evening, even if they live across the street and are available by phone.
3. Patient lives with their child who works during the day but is home every evening and sleep there every night. A paid aide comes 3 days a week to assist with ADLs. The patient's child has back problems that prevent them from lifting the patient, but they assist the patient with dressing every morning and take the patient to doctor's appointments.
   - **Coding:** 08
   - **Rationale:** Patient lives in a home with others who are available every night to offer in-person assistance. Even if the child can't meet all the patient's needs, they are available all night.
4. Patient lives with their spouse who has significant cognitive and functional impairments, is wheelchair bound, and is unable to provide the patient with any assistance. A member of the church comes by one evening a week and brings groceries.
   - **Coding:** 09
   - **Rationale:** Patient lives in a home with another person who is there 24 hours but is unavailable to provide assistance. A caregiver from church provides occasional assistance.
5. Patient lives alone in an apartment that is part of an ALF. The apartment does not have a call-bell but their contract with the ALF includes having a home health aide assist her with ADLs for 2 hours every morning. The patient's son also comes over occasionally to assist with bills, groceries, and errands.
   - **Coding:** 14

- **Rationale:** Patient is living in a congregate setting; one caregiver is available to assist for some part of every day on a regular basis, but not all day, another caregiver offers occasional assistance.

M2102: Types and Sources of Assistance

SOC/ROC	
M2102. Types and Sources of Assistance 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 ☐	f. **Supervision and safety** (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

Discharge	
M2102. Types and Sources of Assistance 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 ☐	a. **ADL assistance** (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding) 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
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled, or injectable) 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
Enter Code ☐	d. **Medical procedures/treatments** (for example, changing wound dressing, home exercise program) 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
Enter Code ☐	f. **Supervision and safety** (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

Item Intent

Identifies ability and willingness of the caregiver(s) (other than home health agency staff) to provide categories of assistance needed by the patient.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver, and review the clinical record, including but not limited to the previous health history.
- **At SOC/ROC**, report what is known on the day of assessment regarding ability and willingness of non-agency caregivers to provide supervision and safety due to a cognitive impairment for the upcoming episode of care.
- **At Discharge**, report what is known on the day of the discharge assessment regarding the ability and willingness of non-agency caregivers to provide assistance to the patient in the various categories of assistance at the time of the discharge.
- If a patient needs assistance with any aspect of a category of assistance (such as needs assistance with some ADLs but not others), consider the aspect that represents the most need.
- If more than one response represents the non-agency caregiver's ability to provide assistance, select the response that represents the caregiver's greatest barrier to meet the need. For example, the caregiver provides assistance but also needs training or support. In this example, report that the caregiver needs training/supportive services to provide assistance, because it represents the caregiver's greatest barrier to meeting the patient's need.
- For each row, enter one description of caregiver assistance.
    - **a. ADL assistance** includes basic self-care activities such as the examples listed.
    - **c. Medication administration** refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.
    - **d. Medical procedures/treatments** include procedures/treatments that the physician/allowed practitioner or physician-designee has ordered for the purpose of improving health status. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.
    - **f. Supervision and safety** includes needs related to the ability of the patient to remain safely in the home. This category of assistance needs should focus on supervision and safety necessary due to cognitive or mental health issues. The need for supervision and safety due to cognitive or mental health issues does not require a specific diagnosis. Such assistance may range from calls to remind the forgetful patient to take medications, to in-person visits to ensure that a patient with impaired decision making is safe, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, harm themselves or others or to monitor other safety risks related to cognitive/mental health concerns.
- For the purposes of coding d. Medical procedures/treatments, consider devices such as anti-embolism stockings, prosthetic devices, orthotic devices, or other supports that have a medical and/or therapeutic impact as medical procedures/treatments. Do not consider these items in a. ADL assistance.

Coding Instructions

- **Code 3**, **Non-agency Caregiver(s)** are not likely to provide assistance, if they are unwilling, reluctant, or unable to provide care.
- **Dash is not** a valid response for this item.

SECTION G: FUNCTIONAL STATUS

Introduction

The items in this section address the patient's ability to safely perform personal care activities. The items identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. 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.

M1800: Grooming

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.**

Item Intent

Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- Grooming includes several activities. The frequency with which selected activities are performed (such as washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more

- frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.
- In cases where a patient's ability is different for various grooming tasks, enter the response that best describes the patient's level of ability to perform the majority of grooming tasks.

Coding Instructions

- **Code 2, Someone must assist the patient**, if the patient can participate in grooming tasks but needs some assistance. The word "assistance" in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Dash is not** a valid response for this item.

M1810: Current Ability to Dress Upper Body

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.

Item Intent

Identifies the patient's ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing. Assess the ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- For the purposes of coding this item, prosthetics, orthotics, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must 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.

- In cases where a patient's ability is different for various upper body dressing tasks, enter the response that best describes the patient's level of ability to perform the majority of upper body dressing tasks.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

Coding Instructions

- **Code 2, Someone must help the patient** if the patient can participate in upper body dressing tasks but needs some assistance. The word "assistance" in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Code 3, Patient depends entirely upon another person to dress the upper body**, is selected only when the patient is dependent, relying entirely on another person to complete the majority of the upper body dressing tasks.
- **Dash is not** a valid response for this item.

M1820: Current Ability to Dress Lower 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.

Item Intent

Identifies the patient's ability to dress lower body, including the ability to obtain, put on, and remove lower body clothing. Assess the ability to put on whatever clothing is routinely worn.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.

- For the purposes of coding this item, prosthetics, orthotics, or other support devices applied to the lower body (for example, lower extremity prosthesis, ankle-foot orthosis [AFO], or anti-embolism stockings) should be considered as lower body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must 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.
- In cases where a patient's ability is different for various dressing lower body tasks, enter the response that best describes the patient's level of ability to perform the majority of dressing lower body tasks.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

Coding Instructions

- **Code 2, Someone must assist the patient** if the patient can participate in lower body dressing tasks but needs some assistance. The word "assistance" in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Code 3, Patient depends entirely upon another person to dress lower body**, is selected only when the patient is dependent, relying entirely on another person to complete the majority of lower body dressing tasks.
- **Dash is not** a valid response for this item**.**

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.

Item Intent

Identifies the patient's ability to bathe their entire body and the assistance that may be required to safely bathe,

including transferring in/out of the tub/shower.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- Specifically excludes washing face and hands, and shampooing hair.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must 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.
- The patient's status should not be coded based on a patient's ability to perform a task with equipment they have not been assessed using.

Coding Instructions

- **Code 4, 5 or 6,** depending on the patient's ability to participate in bathing activities:
  - If a patient is medically restricted from stair climbing, and the tub/shower requires climbing stairs.
  - If the patient does not have a tub or shower in the home.
  - If the tub/shower is nonfunctioning or not safe for patient use.
- **Dash is not** a valid response for this item.

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.
- For **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.

M1840: Toilet Transferring

M1840. Toilet Transferring Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	
Enter Code ☐	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.

Item Intent

Identifies the patient's ability to safely get to and from and transfer on and off the toilet or bedside commode.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- Excludes personal hygiene and management of clothing when toileting.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must 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.

Coding Instructions

- **Code 1**, if the patient:
  - Requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders.
  - if the patient needs assistance getting to/from the toilet or with toileting transfer or both.
  - if the patient can independently get to the toilet but requires assistance to get on and off the toilet.
- **Code 3**, if the patient who is unable to get to/from the toilet or bedside commode is able to place and remove a bedpan (and urinal if applicable) independently, whether or not a patient requires assistance to empty the bedpan/urinal.
- **Code 4**, if the patient, who is unable to get to/from the toilet, is not able to use the bedside commode or bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment.
- **Dash is not** a valid response for this item.

Coding Tips

- If the patient can get to and from the toilet during the day independently but uses the commode at night for convenience code 0.
- If a patient experiences incontinence on the way to the toilet, this should only be considered in coding this item if it affects their ABILITY to safely get to and from and transfer on and off the toilet or bedside commode.

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.**

Item Intent

Identifies the patient's ability to manage personal hygiene and clothing when toileting.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area.
- Toileting hygiene includes the patient's ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must 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.
- This item refers to the patient's ability to manage personal hygiene and clothing with or without assistive devices.

Coding Instructions

- **Code 0**, if the patient is independent in managing toileting hygiene and managing clothing.
- **Code 1**, if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.
- **Code 2,** if the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities The word "assistance" in this item refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- **Dash is not** a valid response for this item.

M1850: Transferring

M1850. Transferring Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
Enter Code ☐	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.

Item Intent

Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface.
- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are

imposed or lifted, or as the environment is modified. The clinician must 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.

- ***Able to bear weight*** refers to the patient's ability to support the majority of their body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support their entire weight through the other lower extremity and upper extremities).
- ***Bedfast*** refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.

Coding Instructions

- **Code 1**, if the patient:
  - Transfers either with minimal human assistance (but not a device), or with the use of a device (but no human assistance).
- **Code 2,** if the patient:
  - Requires both minimal human assistance AND an assistive device to transfer safely.
  - Can both bear weight and pivot but requires more than minimal human assistance.
- **Code 3,** if the patient is unable to bear weight or pivot and is not bedfast.
- **Dash is not** a valid response for this item.

Coding Tips

- "Minimal human assistance" applies when the helper is contributing less than 25% of the total effort required to complete the task.
- Assistance may include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.

M1860: Ambulation/Locomotion

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.	
Enter Code ☐	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.

Item Intent

Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method for coding this item.
- The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment, and may consider available input from other agency staff who have had direct patient contact.
- ***Variety of surfaces*** refers to typical surfaces that the patient would routinely encounter in their environment and may vary based on the individual residence.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), enter the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters.

Coding Instructions

- **Code 2 or 3**, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, regardless of the need for an assistive device. Code 2 if the assistance required is intermittent. Code 3 if the assistance required is continuous.
- **Code 2,** if the patient is:
  - Able to safely ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces.
  - Able to safely ambulate with a walker in the hallway or living room, even if there are some situations in the home where a cane provides adequate support as long as the patient does not require continuous human assistance.
- **Code 3,** if a patient does not have a walking device but is clearly not safe walking alone, unless the patient is chairfast.
- **Code 4 or 5**, if a patient:
  - Is unable to ambulate even with the use of assistive devices and/or continuous assistance.
  - Demonstrates or reports the ability to take one or two steps to complete a transfer but is otherwise unable to ambulate.
- **Dash is not** a valid response for this item.

SECTION GG: FUNCTIONAL ABILITIES

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 code 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 medication prior to the current illness, exacerbation, or injury.

Item Intent

This item identifies the patient's usual ability with everyday activities, prior to the current illness, exacerbation, or injury.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

Ask the patient and/or family/caregiver or review the clinical record for details describing the patient's prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent,** if the patient completed **ALL** the activities by themself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help,** if the patient needed partial assistance from another person to complete **ANY** of the activities.

- **Code 1, Dependent,** if the helper completed **ALL** the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.
- **Code 8,** Unknown**,** if the patient's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable,** if the activities were not applicable to the patient prior to the current illness, exacerbation, or injury.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- For GG0100 – Prior Functioning; Everyday Activities report the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is most recent, that initiated this episode of care.
- If no information about the patient's ability is available after attempts to interview the patient or their family and after reviewing the patient's clinical record, code as 8, Unknown.
- Completing the stair activity for GG0100C Stairs indicates that a patient went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift), and/or with or without some level of assistance. "By any safe means" may include a patient scooting up/down stairs on buttocks. Stairs include internal or external without a defined number.
- Going up and down a ramp is not considered going up and down stairs for coding GG0100C Stairs.

Examples

1. Prior to their recent illness, the patient ambulated with a walker around their home without assistance. They required the use of a stair lift to negotiate the stairs to the second floor, where their bedroom is located. They were safe using the stair lift without any assistance or supervision.
   - **Coding:** GG0100C, Stairs, would be coded 3, Independent.
   - **Rationale:** Using the stair lift, the patient's prior status was that they were able to go up and down the stairs safely and independently.

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

Item Intent

This item identifies the patient's use of devices and aids immediately prior to the most recent illness, exacerbation, or injury.

Time Points Item(s) Completed

Start of Care

Resumption of Care

Response-Specific Instructions

- Ask the patient and/or family/caregiver, or review the clinical record, for details describing the patient's use of prior devices and aids.
- Report the devices used by the patient prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is more recent, that initiated this episode of care.
- Check all devices that apply.
- For the response categories in GG0110 (e.g., Mechanical lift, Orthotics/Prosthetics), CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use. Clinical judgment may be used to determine whether other devices meet the definition provided.
- Devices may have been used indoors and/or outdoors.

Coding Instructions

- **GG0110C, Prior Devices: 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.
  - Clinical judgment may be used to determine whether other devices meet the mechanical lift definition provided.
- **GG0110D, Walker** refers to all types of walkers. Examples include but are not limited to pick-up walkers, hemi-walkers, rolling walkers, and platform walkers.
- **Code Z, None of the above,** if the patient did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Examples

1. The patient is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. They are unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. They used a motorized wheelchair to mobilize.
   - **Coding:** GG0110B, Motorized wheelchair and/or scooter would be checked.
   - **Rationale:** The patient used a motorized wheelchair prior to the current illness/injury.
2. The patient has bilateral lower extremity neuropathy secondary to diabetes. Prior to this current home health admission, they used a cane. Today, they are using a walker.
   - **Coding:** GG0110Z, None of the above, would be checked.
   - **Rationale:** A cane is not a device included in the list of devices in GG0110. Not all devices and aids are included in this item.

Introduction to GG0130 Self-Care and GG0170 Mobility

This section presents guidance that is applicable for both GG0130 Self-Care and GG0170 Mobility. Item-specific guidance follows this section, first for GG0130 Self-Care, then for GG0170 Mobility.

GG0130 Self-Care

SOC/ROC	
GG0130. Self-Care 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.	
Coding: **Safety and Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** – Patient completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)** 88. **Not attempted due to medical conditions or safety concerns**	
1. SOC/ROC Performance 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 not include 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.

Follow-up	
GG0130. Self-Care Code the patient's usual performance at Follow-up for each activity using the 6-point scale. If activity was not attempted at Follow-up, code the reason.	
Coding: **Safety and Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** – Patient completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)** 88. **Not attempted due to medical conditions or safety concerns**	
4. Follow-up Performance **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.

Discharge	
GG0130. Self-Care Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.	
Coding: **Safety and Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** – Patient completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)** 88. **Not attempted due to medical conditions or safety concerns**	
3. Discharge Performance **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 not include 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.

GG0170 Mobility

SOC/ROC
GG0170. Mobility 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.
Coding: **Safety and Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** – Patient completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)** 88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance 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 ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	G. **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.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88 → Skip to GG0170M, 1 step (curb)*
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	L. **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.

SOC/ROC GG0170. Mobility — Continued	
1. SOC/ROC Performance Enter Codes in Boxes ↓	
☐☐	M. **1 step (curb):** The ability to go up and down a curb or up and down one step. *If Follow-up performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.*
☐☐	N. **4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.*
☐☐	O. **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	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 GG170R, 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

Follow-up

GG0170. Mobility

Code the patient's usual performance at Follow-up for each activity using the 6-point scale. If activity was not attempted at Follow-up code the reason.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

4. Follow-up Performance **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 ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-up performance is coded 07, 09, 10 or 88 → Skip to GG0170M, 1 step (curb)*
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	L. **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.
☐☐	M. **1 step (curb):** The ability to go up and down a curb or up and down one step. *If Follow-up performance is coded 07, 09, 10 or 88 → Skip to GG0170Q, Does patient use wheelchair and/or scooter?*

Follow-up GG0170. Mobility — Continued	
4. Follow-up Performance **Enter Codes in Boxes ↓**	
☐☐	N. **4 steps:** The ability to go up and down four steps with or without a rail.
☐	Q. **Does patient use wheelchair and/or scooter?** 0. No → *Skip to M1033, Risk of Hospitalization* 1. Yes → Continue to GG170R, 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.

Discharge

GG0170. Mobility

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

Coding:

Safety and Quality of Performance – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

3. Discharge Performance **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.

Discharge GG0170. Mobility — Continued	
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	G. **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.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Discharge performance is coded 07, 09, 10 or 88 → Skip to GG0170M, 1 step (curb)*
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	L. **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.
☐☐	M. **1 step (curb):** The ability to go up and down a curb or up and down one step. *If Discharge performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.*
☐☐	N. **4 steps:** The ability to go up and down four steps with or without a rail. *If Discharge performance is coded 07, 09, 10 or 88 → Skip to GG0170P, Picking up object.*
☐☐	O. **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	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 GG170R, 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

Item Intent

These items identify the patient's ability to perform the listed self-care and mobility activities.

DEFINITIONS	
	TIME PERIOD UNDER CONSIDERATION (aka "look back period") • The time period under consideration is the look back period to use when coding each OASIS item. For most items, the look back period is the Day of Assessment. For other items, the look back period is different, such as "in the last 14 days," or "at the time of or since the most recent SOC/ROC." **DAY OF ASSESSMENT** • The 24 hours that immediately precedes the assessment and the time spent by the clinician conducting the assessment.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response Specific Instructions – General

- Licensed clinicians may assess the patient's self-care and mobility performance based on direct observation (preferred), patient/caregiver report, assessment of similar activities and/or collaboration with other agency staff who have had direct contact with the patient or some other means of gathering information.
- When possible, CMS invites a multidisciplinary approach to patient assessment.
- Patients should be allowed to perform activities as independently as possible if they are safe.
- Communicating the activity request (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required for the patient to safely complete the activity (e.g., "Push down on the grab bar," etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code.
- A clinician's presence for the purpose of completing the assessment should not automatically be considered as providing a "supervision" level of assistance when coding Section GG activities. For GG0130 and GG0170, the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely.
- If the patient only completes a portion of the activity (e.g., performs a partial bath or transfers into but not out of a vehicle) and does not complete the entire activity during the assessment timeframe, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the partial activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code.
- When a GG function activity is not completed entirely during one clinical observation (i.e., a patient transfers bed-to-chair in the morning, and transfers chair-to-bed at night), code based on the type and amount of assistance required to complete the ENTIRE activity.
- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity (for example, due to choking risk due to rate of eating, amount of food placed into mouth, risk of falling). Code based on the type and amount of assistance required to perform the activity safely.
- When using patient or caregiver reports, it is expected that the patient and caregivers are reporting on the patient's status within the time period under consideration (e.g., reporting on the patient's ability to complete an activity within the past 24 hours).
- For GG0130 and GG0170 the assessing clinician codes each activity based on the type and amount of assistance needed to complete the activity safely, not based on the availability of such assistance.
- Assessment of the GG self-care and mobility items is based on the patient's ability to complete the activity

with or without assistance and/or a device. This is true regardless of whether the activity is being/will be routinely performed (e.g., walking may be assessed for a patient who did/does/will use a wheelchair as their primary mode of mobility, stair activities may be assessed for a patient not routinely accessing stairs).

- Refer to agency, Federal, and State policies and procedures to determine which agency staff members may complete an assessment. Patient assessments are to be done in compliance with agency, Federal, and State requirements.
- A clinician's presence for the purpose of completing the assessment should not automatically be considered as providing a "supervision" level of assistance when coding Section GG activities. For GG0130 and GG0170, the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely.

Response Specific Instructions – Assistive Devices

- Activities may be completed with or without an assistive device. This includes the use of any new or previously utilized assistive device(s) or equipment. Use of a device or equipment may result in the patient needing less assistance from a helper.
- The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your agency staff.
- "Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.
- Introducing a new device should not automatically be considered as "providing a service." Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your agency staff.
- CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment (including a stair lift) that the patient can use to allow them to safely complete the activity as independently as possible.
- If the only help a patient needs to complete an activity is for a helper to retrieve an assistive device or adaptive equipment that is required for safe completion of the activity, such as a cane for walking, or a tub bench for bathing, before or after the activity, then enter code 05, Setup, or clean-up assistance.

Response-Specific Instructions for SOC/ROC Performance

DEFINITION	**ASSESSMENT TIMEFRAME** The maximum number of days within which the comprehensive assessment is completed. • Start of care (SOC) – on or within 5 calendar days after the SOC date. • Resumption of care (ROC) – within 2 calendar days of the facility discharge date, or knowledge of patient's return home, or the physician-ordered ROC date. • Follow-up (Recertification) – with the last 5 calendar days of every 60-day period. • Follow-up (Other) – within 2 calendar days of identification of the significant change in the patient's condition. • Discharge – within 2 calendar days of the discharge date.

- At SOC/ROC, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's SOC/ROC.
- At SOC/ROC, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by agency staff.
  - This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code and then coding based on the type and amount of assistance that was required prior to the benefit of services provided by your agency staff.

Response-Specific Instructions for Follow-up and Discharge Performance

DEFINITION	**USUAL PERFORMANCE** • If the patient's functional status varies during the look back period, record their usual ability to perform each activity. • For GG0130 and GG0170, a patient's usual performance is their ability greater than 50% of the time during the look back period.

- **Follow-up Performance:** Clinicians should code the patient's functional status based on a functional assessment that occurs within the Recertification or Other Follow-up assessment timeframe.
- **Discharge Performance:** Code the patient's discharge functional status based on a functional assessment that occurs at or close to the time of discharge.

Coding Instructions

When coding the patient's performance use the six-point scale or use one of the 4 "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not completed.

Performance Codes:

- **Code 06, Independent,** if the patient completes the activity by themself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance,** if the helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient

requires assistance cutting up food or opening container or requires set-up of hygiene item(s) or assistive device(s).

- **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. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or patient may require only contact guard or steadying assistance during the activity.
  - **Code 04, Supervision or touching assistance**, if a single helper is required to manage the oxygen tank and/or oxygen tubing and/or provide steadying assistance/contact guard, to allow the patient to complete an activity safely.
  - **Code 04, Supervision or touching assistance**, if a single helper only manages the oxygen tank or the IV pole and otherwise the patient needs no assistance to safely complete the activity.
  - **Code 04, Supervision or touching assistance**, if the patient requires only verbal cueing to complete the activity.
- **Code 03, Partial/moderate assistance,** if the helper does LESS THAN HALF the effort. The helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the patient requires minimal assistance from a helper to support partial weight-bearing during sit-to-stand.
- **Code 02, Substantial/maximal assistance,** if the helper does MORE THAN HALF the effort. The helper lifts or holds trunk or limbs and provides more than half the effort. For example, the patient is only able to wash their left arm and chest and requires a helper to complete all the remaining bath.
- **Code 01, Dependent,** if the helper does **ALL** of the effort. Patient does none of the effort to complete the activity. Or the assistance of **two or more helpers** is required for the patient to complete the activity.
  - **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 end up needing to provide hands on assistance.

Activity Not Attempted Codes:

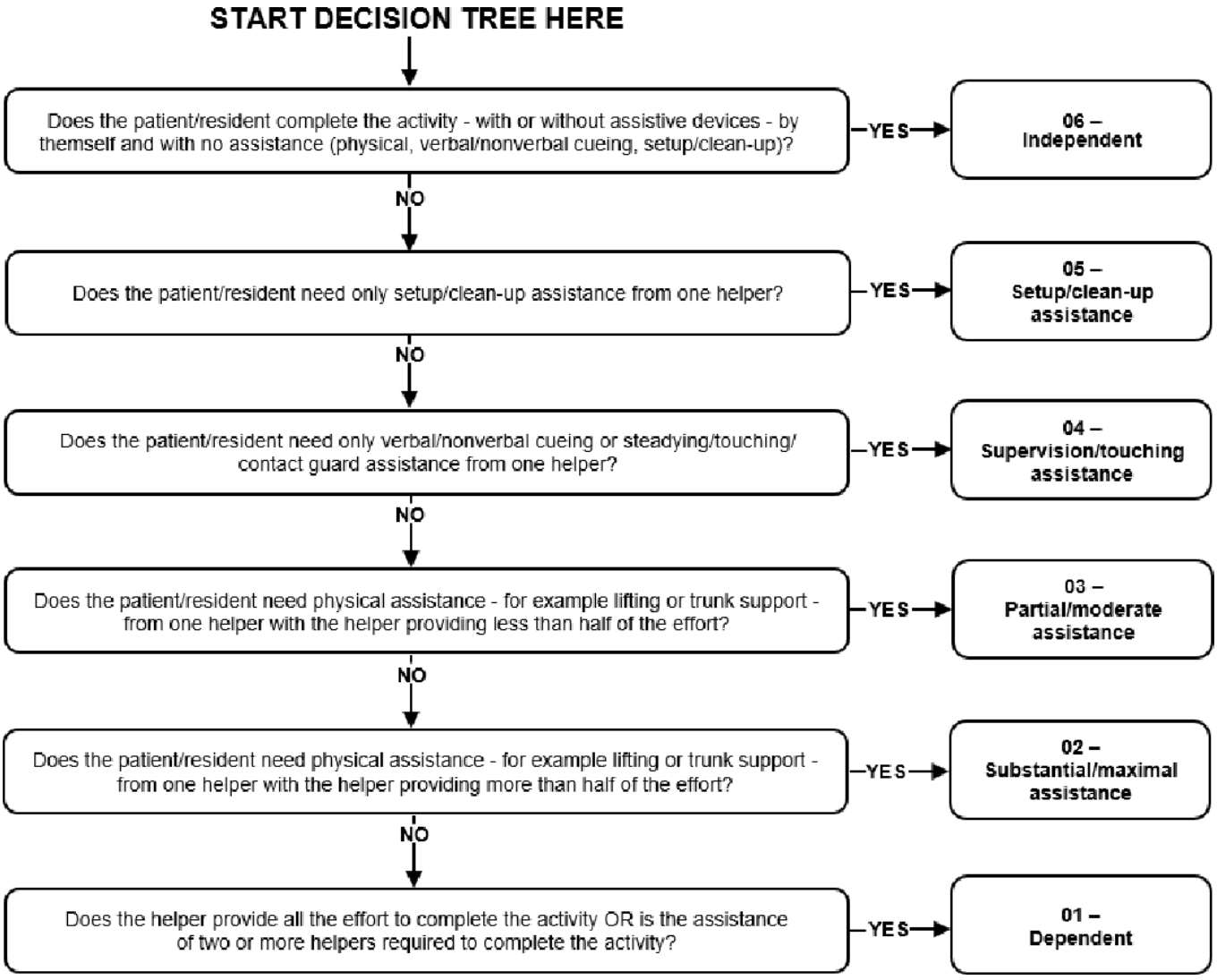
Use of an "activity not attempted" code should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

- **Code 07, Patient refused,** if the patient refused to complete the activity and no other Performance or "activity not attempted" code is applicable.
- **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 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 88, Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns, and the activity was completed prior to the current illness, exacerbation, or injury.
- **A Dash** is a valid response for this item.

- A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Decision Tree

This decision tree may be used to assist with coding the patient's self-care and mobility performance. If helper assistance is required because the patient's performance is unsafe or of poor quality, code according to the type and amount of assistance required. Use of an "activity not attempted" code should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.



GG0130: Description, Coding Tips, and Examples for GG0130 Self-Care Activities

The following are descriptions, coding tips and coding examples for each GG0130 Self-Care activity.

GG0130A Eating

GG0130A. 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.

Coding Tips

- 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 using their hands, then code GG0130A, Eating based upon the type and amount of assistance required. If the patient eats finger foods with their hands independently, for example, the patient would be coded as 06, Independent.
- If the patient eats and drinks by mouth and relies partially on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code eating based on the amount of assistance the patient requires to eat and drink by mouth.
- Assistance with tube feedings and parenteral nutrition is not considered when coding this activity.
- **Code 88, Not attempted due to medical condition or safety concerns** if the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) due to a new (recent onset) medical condition.
- **Code 09, Not applicable,** if the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, injury, or exacerbation.

Examples

1. The patient does not have any food consistency restrictions, but often needs to swallow two or three times so that the food clears their throat due to difficulty with pharyngeal peristalsis. They require verbal cues to use the compensatory strategy of extra swallows to clear the food.
   - **Coding:** GG0130A, Eating would be coded 04, Supervision or touching assistance.
   - **Rationale:** The patient swallows all types of food consistencies and requires verbal cueing (supervision) from the helper. Code based on assistance from the helper. The coding is not based on whether the patient had restrictions related to food consistency.
2. The patient is unable to eat or drink by mouth since they had a stroke 1 week ago. They receive nutrition and fluids through a G-tube, which is administered by a helper.
   - **Coding:** GG0130A, Eating would be coded 88, Not attempted due to medical condition or safety concerns.

- **Rationale:** The patient does not eat or drink by mouth at this time due to a recent-onset medical condition (their recent-onset stroke). This item includes eating and drinking by mouth only. If eating and drinking do not occur due to a recent-onset medical condition, then the activity is coded as 88, Not attempted due to medical condition or safety concerns. Assistance with G-tube feedings is not considered when coding this item.

3. The patient has no difficulty swallowing and is fed all meals by a helper, because the patient has severe arm weakness and is unable to assist.
   - **Coding:** GG0130A would be coded 01, Dependent.
   - **Rationale:** GG0130A Eating would be coded 01, Dependent, because the patient does not have a swallowing problem, and the helper does all of the effort related to bringing food/liquids to the mouth.

GG0130B Oral hygiene

GG0131B. 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.

Coding Tips

- 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.

Examples

1. During the SOC/ROC assessment, the patient states they prefer to participate in oral hygiene twice daily. On assessment, the clinician identifies that the patient's caregiver completes more than half of this activity. The patient has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments, including limited endurance, weak hand grasp, slow movements and tremors.
   - **Coding:** GG0130B Oral Hygiene SOC/ROC Performance would be coded 02, Substantial/maximal assistance.
   - **Rationale:** Performance assessment revealed the patient's caregiver completes more than half the Oral Hygiene activity, which would be coded Code 02, substantial/maximal assistance.

GG0130C Toileting hygiene

GG0130C. 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.

Coding Tips

- Toileting hygiene includes performing perineal hygiene and managing clothing (e.g., undergarments, incontinence briefs, pants) before and after voiding or having a bowel movement.
- Includes toileting hygiene and adjusting any clothing relevant to the individual patient.
- The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement at the time of the assessment.
- 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.
- Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. For some patients this may include assessing the type and amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence. If the patient completes a bowel toileting program in bed, code the item Toileting hygiene based on the patient's need for assistance for managing clothing and perineal cleansing.
- If the patient has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the type and amount of assistance needed by the patient when moving their bowels. This may necessarily include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.
- If a patient has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.
- If a patient manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.

Examples

1. The patient has a progressive neurological illness that affects their strength, coordination, and endurance. The patient prefers to use the bedside commode for as long as possible rather than using incontinence undergarments. The helper currently provides steadying assistance while the patient is standing so that the patient can pull down their underwear before sitting onto the bedside commode. After voiding, the patient wipes their perineal area, then requires the helper to support their trunk while the patient pulls up their underwear.
    - **Coding:** GG0130C, Toileting hygiene SOC/ROC Performance would be coded 03, Partial/moderate assistance.
    - **Rationale:** Assessment of SOC/ROC performance of toileting hygiene demonstrated that the helper provided less than half the effort for the patient's toileting hygiene.

GG0130E Shower/bathe self

GG0130E. 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.

Coding Tips

- 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 washing, rinsing, and drying the patient's back or hair.
- Shower/bathe self does not include 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). Bathing can be assessed with the patient sitting on a tub bench.
- If the patient can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks before or after the activity, code 05, Setup or clean-up assistance.
- If the only help a patient requires is assistance before or after the activity to cover wounds or devices for water-protection during bathing, code 05, Setup or clean-up assistance.
- If the patient cannot bathe their entire body, then code GG0130E Shower/bathe self-based on the type and amount of assistance needed to complete the activity.
- Use clinical judgment to determine if completing a partial bath or simulating the shower/bath allows the clinician to adequately assess the patient's ability to complete the activity of shower/bathe self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the shower/bathing activity.
- If the patient cannot bathe their entire body because of a medical condition (e.g., cast or a non-removable dressing), then code Shower/bathe self, based on the type and amount of assistance needed to complete the activity.

Examples

1. During SOC/ROC functional assessment, the patient states they prefer to bathe themself rather than depending on helpers or their spouse to perform this activity. The clinician assesses the patient's SOC/ROC performance for Shower/bathe self, and determines the helper performs more than half the effort.
   - **Coding:** GG0130E, Shower/bathe self, SOC Performance would be coded 02, Substantial/maximal assistance.
   - **Rationale:** At SOC/ROC assessment, the patient participates in the activity Shower/bathe self, but a helper performs more than half the activity.

GG0130F Upper Body Dressing, GG0130G Lower Body Dressing, and GG0130H Putting on/Taking off Footwear

This section presents Coding Tips that are applicable for GG0130F – Upper body dressing, GG0130G – Lower

body dressing, and GG0130H – Putting on/taking off footwear. Item-specific guidance and examples follow.

- Upper body and lower body dressing and footwear include dressing and undressing in clothing and footwear routinely worn by the patient.
    - The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the patient dresses and undresses themself and the only help the patient requires is for a helper to retrieve or put away the patient's clothing before or after the activity, then code 05, Setup or clean-up assistance.
- If a patient requires assistance with dressing including assistance with buttons, fasteners and/or fastening a bra, code based on the type and amount of assistance required to complete the entire dressing activity.
- When donning and doffing a supportive elastic bandage, compression stockings, or an orthosis or prosthesis, count the elastic bandage/compression stocking/orthosis/prosthesis as a piece of clothing when determining the amount of assistance the patient needs to complete the dressing activity.
- 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.
    - For example, if a patient dresses in the morning, puts on a prosthetic device later in the day, and then undresses in the evening, code based on the type and amount of assistance required to complete the entire dressing activity, even if portions occur in the morning, evening or throughout the day.

GG0130F Upper body dressing

GG0130F. Upper body dressing	The ability to dress and undress above the waist; including fasteners, if applicable.

Coding Tips

- Upper body dressing items to consider when coding GG0130F include but are not limited to bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, and pajama top.
- If a patient requires assistance with upper body dressing including assistance with buttons and/or fastening a bra, code based on the type and amount of assistance required to complete the entire upper body dressing activity.
- The following items are considered a piece of clothing as related to tasks associated with upper body dressing or undressing:
    - thoracic-lumbar-sacrum-orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand, or arm prosthetic/orthotic.

Examples

1. The patient has right-side upper extremity weakness as a result of a stroke and has received therapy to relearn how to dress their upper body. During the day, they require a helper to place clothing next to the bedside. The patient can then use compensatory strategies to put on their bra and top without any assistance. At night they remove their top and bra independently and put the clothes on the nightstand and the helper puts them away.
    - **Coding:** GG0130F would be coded 05, Setup or clean-up assistance.
    - **Rationale:** The patient dresses and undresses their upper body and requires a helper only to retrieve and put away their clothing; that is, setting up the clothing for patient use. The description refers to the patient as "independent" (when removing clothes), but they need setup assistance, so they are not independent with regard to the entire activity of upper body dressing.

GG0130G Lower body dressing

GG0130G. Lower body dressing	The ability to dress and undress below the waist, including fasteners; does not include footwear.

Coding Tips

- Lower body dressing items to consider when coding GG0130G include but are not limited to underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- The following items are considered a piece of clothing as related to tasks associated with lower body dressing or undressing:
    - knee brace, elastic bandage, stump sock/shrinker, above knee or below knee lower-limb prosthesis.

Examples

1. The patient has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. They have been issued a knee brace to be worn during the day. The patient threads their legs into their garments and pulls up and down their clothing to and from just below the hips. Only a little assistance from a helper is needed to pull up their garments over the hips. The patient requires the helper to fasten the knee brace because of grasp and fine motor weakness.
    - **Coding:** GG0130G would be coded 03, Partial/moderate assistance.
    - **Rationale:** A helper provides only a little assistance when the patient is putting on their lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace is considered when determining the type and amount of assistance required when coding lower body dressing.

GG0130H Putting on/taking off footwear

GG0130H. 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.

Coding Tips

- Footwear dressing items to consider when coding GG0130H include but are not limited to socks, shoes, boots, and running shoes.
- The following items are considered a piece of clothing as related to tasks associated with putting on/taking off footwear:
  - Footwear examples - ankle foot orthosis (AFO), elastic bandages, foot orthotic, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- If the patient wears just shoes or just socks (e.g., grip socks) that are safe for mobility, then GG0130H, Putting on/taking off footwear, may be coded.
- Note that while some types of clothing, wraps or supportive devices may cover both the lower leg/lower body and the foot, the patient's ability to put them on/take them off should not be considered for **both** GG0130G, Lower Body Dressing and GG0130H, Putting on/taking off footwear. To determine which activity the piece of clothing/wrap/orthotic/prosthetic should apply to, **consider items that cover all or part of the foot** (even if it extends up the leg, like a sock or ankle foot orthosis) **as footwear**.
- For patients with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  - If the patient performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury but the activity is not completed at SOC/ROC, code as 88, Not attempted due to medical condition or safety concerns.
  - If the patient did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the patient had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not completed at SOC/ROC, code as 09, Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
- For patients with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  - If the activity of putting on/taking off footwear occurs for the intact limb only, then code based upon the type and amount of assistance needed to complete the activity for one limb.
  - If the activity of putting on/taking off footwear occurs for both the intact limb and the prosthetic limb then code based upon the type and amount of assistance needed to complete the activity for both limbs.

Examples

1. The patient has been receiving physical and occupational therapy for right-side upper and lower body weakness following a stroke. They have made significant progress toward independence and are being discharged from home health today. The patient wears an ankle-foot orthosis that they put on their foot and ankle after they put on their socks but before they put on their shoes. They always place their AFO, socks, and shoes within easy reach of the bed. While sitting on the bed, they need to bend over to put on and take off the AFO, socks, and shoes, and they occasionally lose their sitting balance, requiring a helper to place their hands on them to maintain their balance while performing this task.
   - **Coding:** GG0130H would be coded 04, Supervision or touching assistance.

- **Rationale:** The patient puts on and takes off their AFO, socks, and shoes by themself; however, because of occasional loss of balance, they need a helper to provide touching assistance when they are bending over.

GG0170: Description, Coding Tips, and Examples for GG0170 Mobility Activities

The following are descriptions, coding tips and coding examples for each GG0170 Mobility activity.

GG0170A Roll Left and Right, GG0170B Sit to Lying, and GG0170C Lying to Sitting on Side of Bed

This section presents Coding Tips that are applicable for GG0170A - Roll left and right, GG0170B – Sit to lying, and GG0170C - Lying to sitting on side of bed. Item-specific guidance and examples follow.

- If the patient does not sleep in a bed, assess bed mobility activities using the preferred or necessary sleeping surface used by the patient.
- For GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed clinical judgment should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for that patient.
- **Code 88, Not attempted due to medical or safety concerns,** if at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation, or injury. For example, if a clinician determines that a patient's new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns.
- **Code 09, Not applicable**, if at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions and cannot perform the activity prior to the current illness, exacerbation, or injury.

GG0170A Roll left and right

GG0170A. 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.

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 clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated due to the patient's medical condition, code GG0170A, Roll left and right, using the appropriate "activity not attempted" code.
- 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.

Examples

1. At SOC, the physical therapist observes the patient turn onto their right side while their spouse prompts them to bend their left leg and roll to the right side. The spouse then prompts the patient to position their limbs to return to lying on their back and then to repeat a similar process for rolling onto their left side and then return to lying on their back. The patient completes the activity without physical assistance from a helper. The patient was moving about in bed without difficulty prior to hospitalization.
   - **Coding:** GG0170A, Roll left and right, SOC Performance would be coded 04, Supervision or touching assistance.
   - **Rationale:** At SOC, the spouse provides verbal cues to the patient as they roll from their back to their right side and returns to lying on their back. No physical assistance is provided.

GG0170B Sit to lying

GG0170B. Sit to lying	The ability to move from sitting on side of bed to lying flat on the bed.

Coding Tips

- The activity includes the ability to move from sitting on the side of bed to lying flat on the bed or on their preferred or necessary sleeping surface.
- If the patient does not sleep in a bed, assess the patient's ability to move from sitting on side of the patient's preferred or necessary sleeping surface to lying flat on the patient's preferred or necessary sleeping surface.
- If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated due to the patient's medical condition, code GG0170B, Sit to lying, using the appropriate "activity not attempted" code.

Examples

1. At SOC, the patient requires assistance from two helpers to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on their right side, obesity, and cognitive limitations. One of the helpers explains to the patient each step of the sitting to lying activity. The patient is then fully assisted by the 2 helpers to get from sitting to a lying position on the bed. The patient makes no attempt to assist when asked to perform the incremental steps of the activity.
   - **Coding:** GG0170B, Sit to lying would be coded 01, Dependent.
   - **Rationale:** The assistance of two helpers is needed to complete the activity of sitting to lying. If two or more helpers are required to assist the patient to complete an activity, code as 01, Dependent.
2. The patient suffered multiple vertebral fractures due to a fall off a ladder. At SOC, they require assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in their lower back. The therapist supports the patient's trunk and lifts both legs to assist them from sitting at the side of the bed to lying flat on the bed. The patient assists themself a small amount by bending both knees while transitioning into a lying position.
   - **Coding:** GG0170B, Sit to lying would be coded 02, Substantial/maximal assistance.
   - **Rationale:** The helper provided more than half the effort for the patient to complete the activity of sitting to lying.

GG0170C Lying to sitting on side of bed

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.

Coding Tips

- 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.
- It is not required that the patient's feet be flat on the floor to consider the activity as being completed. Note that the reference to the patient having their feet flat on the floor has been removed from GG0170C in the OASIS-E instrument.
- Back support refers to an object or person providing support for the patient's back.
- If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated due to the patient's medical condition, code GG0170A, Roll left and right, using the appropriate "activity not attempted" code.

Examples

1. The patient is recovering from spinal fusion. At Discharge, they roll to their right side and push themself up from the bed to get from a lying to a seated position. The family provides needed verbal cues as the patient safely uses their hands and arms to avoid twisting as they raise themself from the bed. The patient then maneuvers to the edge of the bed, to complete the activity without hands-on assistance.
    - **Coding:** GG0170C, Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.
    - **Rationale:** The helper provides verbal cues only as the patient moves from lying to sitting position on the side of the bed.

GG0170D Sit to stand

GG0170D. Sit to stand	The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.

Coding Tips

- The activity includes the patient coming to a standing position from any sitting surface.
- **Code 05, Setup or clean-up assistance,** if the only help a patient requires to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis.
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and even with assistance the patient is not able to complete the sit to stand activity, code GG0170D, Sit to stand with the appropriate "activity not attempted" code.

- 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.

Examples

1. The patient is being admitted to home health for pressure ulcer care. They have complete tetraplegia from an injury one year ago and have been unable to bear weight in standing since the injury. At SOC, even when fully supported, they are unable to stand and are transferred via Hoyer from their bed into a wheelchair with assistance.
   - **Coding:** GG0170D, Sit to stand, SOC Performance would be coded 09, Not applicable.
   - **Rationale:** The activity was not attempted at SOC, and the patient did not perform this activity prior to the current illness, exacerbation, or injury (the pressure ulcer) due to the diagnosis of complete tetraplegia.

GG0170E Chair/bed-to-chair transfer

GG0170E. Chair/bed-to-chair transfer	The ability to transfer to and from a bed to a chair (or wheelchair).

Coding Tips

- 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.
- When possible, the transfer should be assessed in an environmental situation where taking more than a few steps would not be necessary to complete the transfer.
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and the patient requires the assistance of two helpers code as 01, Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer.
- When a GG function activity is not completed entirely during one clinical observation (i.e., a patient transfers bed-to-chair in the morning, and transfers chair-to-bed at night), code based on the type and amount of assistance required to complete the ENTIRE activity. In addition to direct observation, coding can be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.
- The activities of GG0170B - Sit to lying and GG0170C - Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E – Chair/Bed to Chair Transfer.

Examples

1. The patient had a stroke and uses a wheelchair for mobility. When they get out of bed at SOC, their daughter moves the wheelchair into the correct position and locks the brakes so that the patient can transfer into the wheelchair safely. The patient transfers into the wheelchair by themself without the need for supervision or assistance during the transfer. The family reports that the patient does transfer safely from bed to wheelchair and back without the need for supervision, once the wheelchair is placed and locked.
   - **Coding:** GG0170E, Chair/bed-to-chair transfer, SOC Performance would be coded 05, Setup or cleanup assistance.

- **Rationale:** A helper must provide setup assistance only. Once set up is provided, the patient transfers to and from the wheelchair safely and does not need supervision or physical assistance during the transfer activity.

GG0170F Toilet transfer

GG0170F. Toilet transfer The ability to get on and off a toilet or commode.

Coding Tips

- Toilet transfer includes the patient's ability to get on and off a toilet (with or without a raised toilet seat), or bedside commode.
- Toileting hygiene, clothing management, getting to and from the toilet, and transferring on and off a bedpan are not considered part of the toilet transfer activity.
- The Toilet transfer activity can be assessed and coded regardless of the patient's need to use a toilet or commode to void or have a bowel movement in conjunction with the toilet transfer assessment.
- Communicating the activity request (i.e., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar," etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.
- **Code 05, Setup or clean-up assistance**, if the patient requires a helper to position/set-up the bedside commode before and/or after the patient's bed to commode transfers (place at an accessible angle/location next to the bed) and the patient does not require helper assistance during toilet transfers.
- **Code 05, Setup or clean-up assistance,** if the only help a patient needs to complete the toilet transfer activity is for a helper to retrieve and place the toilet seat riser and remove it after patient use.
- **Code 01, Dependent,** if the patient requires assistance from two or more helpers to get on and off the toilet or commode.

Examples

1. The assessing clinician notes that the home health aide visit note (documented on the afternoon visit on the SOC date) stated that the aide needed to steady the patient with a light contact when the patient lowers their underwear and also as they transfer onto the toilet. After voiding, the patient cleanses themself. They then stand up supporting their own weight as the aide steadies them with contact guard assistance. The patient pulls up their underwear as the aide steadies them to ensure they do not lose their balance.
   - **Coding:** GG0170F, Toilet transfer, SOC Performance would be coded 04, Supervision or touching assistance.
   - **Rationale:** The aide needs to provide only steadying assistance as the patient transfers on and off the toilet. Assistance with managing clothing and cleansing when toileting is coded under item GG0130C, Toileting hygiene, and is not considered when coding the toilet transfer item.
2. At SOC, the patient is on bedrest due to a new medical complication. They use a bedpan for bladder and bowel management.

- **Coding:** GG0170F, Toilet transfer, SOC Performance would be coded 88, Not attempted due to medical condition or safety concerns.
- **Rationale:** At SOC, the patient does not transfer onto or off a toilet due to being on bedrest because of a new medical condition but was able to perform this activity prior to the current medical condition.

GG0170G Car transfer

GG0170G. Car transfer	The ability to transfer in and out of a car of van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

Coding Tips

- The activity includes the patient's ability to transfer in and out of a car or van seat on the passenger side.
- Any vehicle model available may be used for the assessment of GG0170G, Car transfer.
- The car transfer could still be completed while accommodating medical restrictions such as long sitting.
- The car transfer does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seat belt.
- If the patient remains in a wheelchair and does not transfer in and out of a car or van seat, the activity is not considered completed 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.
- Clinicians may use clinical judgment to determine if observing a patient performing a portion of the car transfer activity (e.g., getting into the car) allows the clinician to adequately assess the patient's ability to complete the entire GG0170G, Car transfer activity (transferring in and out of a car). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the activity.
- Use of an "activity not attempted" code should occur only after determining that the car transfer activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

Example

1. The patient uses a wheelchair and ambulates for only short distances. At SOC, the patient requires the physical therapist to lift most of their weight to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when the patient takes several steps during the transfer turn. The patient lowers themself into the car seat with steadying assistance from the therapist. The patient moves their legs into the car as the therapist lifts the weight of their legs from the ground.
   - **Coding:** GG0170G, Car transfer, SOC Performance would be coded 02, Substantial/maximal assistance.
   - **Rationale:** The therapist completed more than half the effort to transfer the patient into the car by providing significant lifting assistance from the wheelchair, trunk support when taking steps toward the car seat, steadying when lowering into the car seat and lifting support when moving legs into the car.

2. The day after being admitted to home health, the patient is evaluated by an occupational therapist on transfers in and out of the passenger side of a car. When reviewing the therapist's evaluation, the assessing clinician reads that when performing car transfers, the patient required verbal reminders for safety and contact guarding assistance from the OT. Documentation showed that the therapist opened and closed the car door.
    - **Coding:** GG0170G, Car transfer, SOC Performance would be coded 04, Supervision or touching assistance.
    - **Rationale:** The therapist provides verbal cues and touching assistance only as the patient transfers in and out of the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

GG0170I Walk 10 feet, GG0170J Walk 50 feet, GG0170K Walk 150 feet, and GG0170L Walk 10 feet on uneven surfaces

This section presents Coding Tips that are applicable for GG0170I – Walk 10 feet, GG0170J – Walk 50 feet with two turns, GG0170K – Walk 150 feet, and GG0170L – Walking 10 feet on uneven surfaces. Item-specific guidance and examples follow.

- Assessment of the walking activities starts with the patient in a standing position.
- Code based on the type and amount of assistance required to complete the walking activity, with or without the use of assistive devices or adaptive equipment.
- Use of assistive device(s) and adaptive equipment (for instance a cane or leg brace) required to complete the walking activity should not automatically result in the reporting of a more dependent code.
- The walking activities cannot be completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a patient.
- 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.
- Report an appropriate "activity not attempted" code when the patient requires a sitting rest break, and/or cannot complete the walking activity with the assistance of one or more helpers.
- Clinicians can 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.
- Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity.
- If the patient who participates in walking requires the assistance of 2 helpers to complete the activity, code 01, Dependent.
- If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter code 05, Setup or clean-up assistance.

GG0170I Walk 10 feet

GG0170I. Walk 10 feet	Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.

Coding Tips

Starting from standing, the activity includes the patient's ability to walk 10 feet.

Examples

1. The patient had bilateral below the knee amputations 3 years ago, and prior to this home health admission for pressure ulcer care and initiation of prostheses use, they used a wheelchair and did not walk. At SOC, the patient does not use prosthetic devices and only uses a wheelchair for mobility.
   - **Coding:** GG0170I, Walk 10 feet SOC Performance would be coded 09, Not applicable.
   - **Rationale:** When assessing the patient for GG0170I, Walk 10 feet, consider the patient's status prior to the current illness, exacerbation, or injury. Use code 09, Not applicable, because the patient could not perform the activity of walking at SOC and did not perform the activity of walking prior to the most recent illness, exacerbation, or injury (the pressure ulcer).

GG0170J Walk 50 feet with two turns

GG0170J. Walk 50 feet with two turns	Once standing, the ability to walk 50 feet and make two turns.

Coding Tips

- Starting from standing, the activity includes the patient's ability to walk 50 feet, making two turns.
- The turns included in the item GG0170J (Walk 50 feet with two turns) are 90 degree turns. The turns may occur at any time during the 50-foot walk. The turns may be in the same direction (two 90-degree turns to the right or two 90 degrees turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).

Examples

1. At SOC, the patient is recovering from a recent stroke and now has difficulty walking. Even with assistance, they walk only 30 feet.
   - **Coding:** GG0170J, Walk 50 feet with two turns, SOC Performance would be coded 88, Not attempted due to medical condition or safety concerns.
   - **Rationale:** The patient is ambulatory but was not able to walk the entire distance because of their new medical condition (stroke). Since the patient is unable to complete the activity at SOC, but was completing the activity prior to the recent stroke, Code 88 is appropriate.

GG0170K Walk 150 feet

GG0170K. Walk 150 feet	Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Coding Tips

- Starting from standing, the activity includes the patient's ability to walk 150 feet.
- When coding GG0170K, if the patient's environment does not accommodate a walk of 150 feet without turns, but the patient demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.

Examples

1. The patient has recent endurance limitations due to an exacerbation of heart failure and is only walking about 30 feet before they tire, lose strength, and must sit and rest. They report they were walking 150 feet or more with their cane prior to this exacerbation of their heart failure.
    - **Coding:** GG0170K, Walk 150 feet would be coded 88, Not attempted due to medical condition or safety concerns.
    - **Rationale:** The activity was not completed due to the patient's recent endurance limitations and current medical condition, and a helper cannot complete the walking activity for a patient. The patient was able to complete the activity prior to the recent exacerbation of their condition.

GG0170L Walking 10 feet on uneven surfaces

GG0170L. 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.

Coding Tips

- Starting from standing, the activity includes the patient's ability to walk 10 feet on uneven surfaces.
- 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 if a surface meets this intent.

Examples

1. The patient has severe joint degenerative disease and is recovering from sepsis. When walking on the uneven (gravel) driveway was attempted yesterday when they came home from the hospital, they were able to mostly walk by themself, but reports that their neighbor held their belt and helped support their weight during a few steps.
    - **Coding:** GG0170L, Walking 10 feet on uneven surfaces would be coded 03, Partial/moderate assistance.
    - **Rationale:** Per patient report, the patient required some weight-bearing support from a neighbor, as they walked 10 feet on uneven surfaces. The patient provided more than half the effort for walking 10 feet on uneven surfaces.

GG0170M 1 step (curb), GG0170N 4 steps, and GG0170O 12 steps

This section presents Coding Tips that are applicable for GG0170M – 1 step (curb), GG0170N – 4 steps, and GG0170O – 12 steps. Item-specific guidance and examples follow.

- The intent of GG0170M - 1 step (curb), GG0170N - 4 steps, and GG0170O - 12 steps is to assess the patient's ability to go up and down 1 step (curb), 4 steps, and 12 steps with or without a rail.
- Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance.
    - A ramp or elevator are not considered a step/curb and should not be used in place of a step or curb when assessing these activities.
- Getting to/from stairs is not included when coding the curb/step activities.
- Going up and down stairs by any safe means includes the patient walking up and down stairs on their feet or bumping/scooting up and down stairs on their buttocks.
- 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.
- A patient who is a wheelchair user may be assessed going up and down stairs (including 1 step/curb) in a wheelchair. Code based on the type and amount of assistance the patient required from the helper.
- If the patient goes up and down steps (1, 4, or 12) by any safe means (for example, walking on their feet, in a wheelchair, or bumping/scooting on their buttocks), with or without an assistive device, and with no set-up assistance, verbal or physical assistance, code 06, Independent.
- If the patient requires a helper to provide total assist, code 01, Dependent (for example, a patient requires total assist from a helper to move up and down a curb in their wheelchair).
- If at the time of the assessment the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for 2 weeks), but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.
- 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.
- A ramp or elevator is not considered a step/curb and should not be used in place of a step or curb when assessing these activities.

GG0170M 1 step (curb)

GG0170M. 1 step (curb) The ability to go up and down a curb or up and down one step.

Coding Tips

- Assess the patient going up and down 1 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 GG0170M 1 step (curb) based on the activity with which the patient requires the most assistance.

Examples

1. The patient had a stroke and needs to step up and down one step to enter and exit their home. At SOC, the patient's daughter is observed providing needed verbal cueing as the patient uses their quad cane to aid their balance in stepping up and back down one step. No physical assistance was required.
   - **Coding:** GG0170M, 1 step would be coded 04, Supervision or touching assistance.
   - **Rationale:** The patient needs only verbal cueing to complete the activity of stepping up and down one step.

GG0170N 4 steps

GG0170N. 4 steps	The ability to go up and down four steps with or without a rail.

Coding Tips

Assess the patient going up and down 4 steps.

Examples

1. At SOC, the patient has lower body weakness, and the physical therapist provides light touching assistance when they ascend 4 steps. While descending 4 steps, the physical therapist faces the patient and descends the stairs providing trunk support, with one hand on the patient's hip and the other holding the gait belt, as the patient holds the stair railing.
   - **Coding:** GG0170N, 4 steps would be coded 03, Partial/moderate assistance.
   - **Rationale:** The therapist provides touching assistance as the patient ascends 4 steps. The therapist provides trunk support when they descend the 4 steps, providing less than half the effort to complete the activity. The patient requires partial/moderate assistance to go up and down 4 steps.

GG0170O 12 steps

GG0170O. 12 steps	The ability to go up and down 12 steps with or without a rail.

Coding Tips

- Assess the patient going up and down 12 steps**.**
- 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.

Examples

1. At SOC, the patient is recovering from a stroke resulting in motor issues and poor endurance. The patient's

home has 12 stairs, with a railing, and they need to use these stairs to enter and exit their home. The patient's physical therapist uses a gait belt around the patient's trunk and provides less than half of the effort as they ascend and then descend 12 stairs.

- **Coding:** GG0170O, 12 steps would be coded 03, Partial/moderate assistance.
- **Rationale:** The helper provides less than half the required effort in providing the necessary support for the patient as they ascend and descend 12 stairs.

2. The patient is returning home after a hip replacement. They are restricted from stair climbing until they are seen for their follow-up MD appointment in one week. Just prior to their surgery, they climbed a flight of 12 stairs with stand-by assistance from a helper.
   - **Coding:** GG0170O, 12 steps would be coded 88, Not attempted due to medical condition or safety concerns.
   - **Rationale:** At the SOC, the patient is unable to complete the activity of going up and down 12 steps due to a temporary physician-ordered activity restriction. Prior to the recent surgery, the patient was able to complete that activity with assistance, so code 88 is appropriate.

GG0170P Picking up object

GG0170P. 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.

Coding Tips

- The activity includes the patient bending/stooping from a standing position to pick up a small object, such a spoon, from the floor.
- Assistive device(s) and adaptive equipment may be used, for example a cane to support standing balance and/or a reacher to pick up the object.
- Picking up an object must be assessed while the patient is in a 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.
- 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 a patient's degree of participation in picking up an object.

Examples

1. The patient has a neurologic condition that has resulted in coordination and balance problems. At SOC, the patient reports they and their spouse worked with the OT in the SNF on picking things up from the floor. The patient demonstrates how they stoop to pick up a pencil from the floor as their spouse provides the right amount of verbal cues for safety and stands by, ready to help in case the patient loses their balance.
   - **Coding:** GG0170P, Picking up object would be coded 04, Supervision or touching assistance.
   - **Rationale:** A helper is needed to provide verbal cues and stand-by assistance when the patient picks up an object due to their coordination and balance limitations.
2. The patient has recently undergone a hip replacement. At SOC, they walk with a walker without assistance. When they drop a hairbrush from their walker basket, they ask a helper to locate their long-handled reacher

and bring it to them. Using the reacher, the patient bends slightly, and safely picks up the hairbrush with the reacher, without need of additional assistance or verbal cues.

- **Coding:** GG0170P, Picking up object would be coded 05, Set-up or clean-up assistance.
- **Rationale:** The helper provides set-up assistance only by retrieving the reacher and then the patient is able use the device to pick up the hairbrush safely.

GG0170Q Wheelchair use, GG0170R Wheel 50 feet, GG0170RR Type of wheelchair, GG0170S Wheel 150 feet, and GG0170SS Type of wheelchair

This section presents guidance that is applicable for GG0170Q – Does patient use wheelchair and/or scooter? GG0170R – Wheel 50 feet with two turns, GG0170RR – Indicate the type of wheelchair or scooter used, GG0170S – Wheel 150 feet, and GG0170SS – Indicate the type of wheelchair or scooter used. Item-specific guidance and examples follow.

- The intent of the wheelchair mobility items is to assess the ability of patients who use a wheelchair and/or scooter under any condition.

GG0170Q Does patient use wheelchair and/or scooter?

GG0170Q. Does the patient use a wheelchair and/or scooter?

Coding Tips

- The intent of the wheelchair mobility items is to assess the ability of patients who use a wheelchair and/or scooter under any condition. This includes patients who are learning how to self-mobilize using a wheelchair or scooter, those who require assistance from a helper to mobilize using a wheelchair/scooter, and those who require a helper to push them in a wheelchair.
- **Only Code 0, No,** if at the time of the assessment the patient does not use a wheelchair or scooter under any condition, Skip all remaining wheelchair questions.
- **Code 1, yes,** if the patient uses a wheelchair and/or scooter.
- The responses for the gateway wheelchair item (GG0170Q1 and GG0170Q3) might not be the same on start/resumption of care and discharge assessments.
  - For example, at SOC a patient may never have used a wheelchair before and is currently not using one under any condition. GG0170Q at SOC is coded 0-No. During the episode, the patient does begin instruction in wheelchair use, and at Discharge the patient is able to mobilize the manual chair for short distances. GG0170Q at Discharge is coded 1-Yes.

Examples

1. Patient does not own a wheelchair but uses the assisted living facility's wheelchair in order to access activities and locations in the facility which are too far for the patient to walk.
   - **Coding:** GG0170Q - Does patient use wheelchair and/or scooter would be coded 1- Yes.
   - **Rationale:** Although it is in specific and possibly infrequent situations, the patient does use a wheelchair for mobility.

GG0170R, GG0170RR, GG0170S, GG0170SS

Coding Tips

- Clinicians can use clinical judgment to determine how the actual patient assessment of wheelchair mobility is conducted. If a clinician chooses to combine the assessment of multiple wheelchair activities use clinical judgment to determine the type and amount of assistance needed for each individual activity.
- A helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themselves the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.

GG0170R Wheel 50 feet with two turns, and GG0170RR Indicate the type of wheelchair or scooter used

GG0170R. Wheel 50 feet with two turns.	Once seated in a wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Coding Tips

- Assess the patient's ability to wheel 50 feet with two turns.
- The turns included in the item GG0170R (wheeling 50 feet with 2 turns) are 90-degree turns. The turns may occur at any time during the 50-foot distance. The turns may be in the same direction (two 90-degree turns to the right or two 90 -degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.
- If at the time of assessment, the patient uses both a manual and a motorized wheelchair or scooter to complete the Wheel 50 feet with two turns activity, code the activity based on the type of wheelchair/scooter with which the patient requires the most assistance.

Examples

1. At SOC, the patient is unable to bear any weight on their right leg due to a recent fracture. The nurse observes as the certified nursing assistant in the assisted living facility provides steadying assistance when transferring the patient from the bed into the manual wheelchair. Once in the wheelchair, the patient propels themselves safely about 60 feet down the hall using their left leg and both arms and safely makes two turns without any necessary physical assistance or supervision.
    - **Coding:** GG0170R, Wheel 50 feet with two turns would be coded 06, Independent. G0170RR, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
    - **Rationale:** Using a manual wheelchair, the patient wheels themself more than 50 feet safely without need for supervision or physical assistance. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns.
2. Once seated in the manual wheelchair, the patient wheels about 10 feet, including around one corner to the hallway. Due to shoulder pain, the patient asks a helper to push the wheelchair the additional 40 feet around another corner and into the bathroom.

- **Coding:** GG0170R, Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance. GG0170RR, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
- **Rationale:** Using a manual wheelchair, the patient assists in propelling themself in a wheelchair and also needs assistance from a helper, who provides more than half of the effort to complete distance and the activity.

GG0170S Wheel 150 feet, and GG0170SS Indicate the type of wheelchair or scooter used

GG0170S. Wheel 150 feet.	Once seated in a wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

Coding Tips

- If at the time of assessment, the patient uses both a manual and a motorized wheelchair or scooter to complete the Wheel 150 feet activity, code the activity based on the type of wheelchair/scooter with which the patient requires the most assistance.
- If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.

Examples

1. The patient uses a below-the-knee prosthetic limb. The patient has peripheral neuropathy and limited vision due to complications of diabetes. Via observation and patient report, the assessing clinician determines that the patient's usual performance is that a helper is needed to provide verbal cues for safety due to vision deficits, and the patient mobilizes their manual wheelchair a distance of 150 feet within their home.
   - **Coding:** GG0170S, Wheel 150 feet would be coded 04, Supervision or touching assistance. GG0170SS, Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   - **Rationale:** Using a manual wheelchair, the patient requires the helper to provide verbal cues for their safety as they propel themself in their wheelchair for 150 feet.

SECTION H: BLADDER AND BOWEL

Introduction

The items in this section assess bowel and bladder function to identify situations that could impact patient health status or their plan of care.

M1600: Has this patient been treated for a Urinary Tract Infection in the past 14 days?

M1600. Has this patient been treated for a Urinary Tract Infection in the past 14 days?	
Enter Code ☐	0. No 1. Yes NA Patient on prophylactic treatment UK Unknown [Omit "UK" option on DC]

Item Intent

Identifies treatment of urinary tract infection during the past 14 days.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver and review referral information.
- The "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date (or for Discharge, the M0090 Date Assessment Completed). This means that for the purpose 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.

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 if the treatment ended more than 14 days ago.
- **Code 1, Yes,** when:
  - The patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.
  - The patient is on prophylactic treatment and develops a UTI.
- **Code NA,** if the patient is on prophylactic treatment for the prevention of UTI.
- **Dash is not** a valid response for this item.

M1610: Urinary Incontinence or Urinary Catheter Presence

M1610. Urinary Incontinence or Urinary Catheter Presence	
Enter Code ☐	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)

Item Intent

Identifies presence of urinary incontinence or urinary catheterization of any type, including intermittent or indwelling.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Interview patient and/or caregiver and review referral information.
- The etiology (cause) of incontinence is not addressed in this item.

Coding Instructions

- **Code 0, No incontinence** or catheter, if the patient has:
  - Anuria
  - An ostomy for urinary drainage (for example: an ileal conduit)
  - A urinary diversion that is pouched (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma.
- **Code 1, Patient is incontinent**, if the patient is:
  - Incontinent at any time, including occasionally, "only when I sneeze," "sometimes I leak a little bit" etc.
  - Dependent on a timed-voiding program.

DEFINITION	TIMED VOIDING Timed voiding is scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Timed voiding is a compensatory strategy; it does not cure incontinence.

- **Code, 2, Patient requires a urinary catheter**, when the patient:
  - Uses a catheter or tube for drainage, even if catheterizations are intermittent
  - Requires the use of a catheter for urinary drainage for any reason (for example: retention, post-surgery, incontinence)
  - Has a catheter inserted during the comprehensive assessment
  - Is both incontinent, and requires a urinary catheter
- **Dash is not** a valid response for this item.

Coding Tips

- A leaking urinary drainage appliance is not incontinence.
- A catheter solely utilized for irrigation of the bladder or installation with an antibiotic is not reported in this item.
- If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Code 0 or 1 would be appropriate, depending on whether the patient is continent.

M1620: Bowel Incontinence Frequency

M1620. Bowel Incontinence Frequency	
Enter Code ☐	0. Very rarely or never has bowel incontinence 1. Less than once weekly 2. One to three times weekly 3. Four to six times weekly 4. On a daily basis 5. More often than once daily NA Patient has ostomy for bowel elimination UK Unknown [Omit "UK" option on DC]

Item Intent

Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

Interview patient and/or caregiver and review referral information.

Coding Instructions

Dash is not a valid response for this item.

Coding Tips

- "On a daily basis" means the patient experiences bowel incontinence once per day.
- This item does not address treatment of incontinence or constipation (for example, a bowel program).

M1630: 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?	
Enter Code ☐	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.

Item Intent

Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or caused a change in medical treatment plan.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Interview patient and/or caregiver and review referral information including current supply list.
- Applies to any type of ostomy for bowel elimination (for example: colostomy, ileostomy).
- This item only addresses bowel ostomies, not other types of ostomies (for example: urinary ostomies, tracheostomies).
- If the patient has an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or necessitated a change in the medical or treatment regimen within the last 14 days.
- The "last 14 days" is the two-week period immediately preceding the Start/Resumption of Care. This means that for the purpose 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 ostomy related to an inpatient stay or requiring medical, or treatment regimen change that occurred on or after August 6 would be considered.

Coding Instructions

Dash is not a valid response for this item.

Coding Tips

If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.

SECTION I: ACTIVE DIAGNOSES

Introduction

This section includes three items that identify active diagnoses and co-morbidities.

M1021/M1023: Primary Diagnosis/Other Diagnoses

M1021. Primary Diagnosis & M1023. Other Diagnoses	
Column 1	**Column 2**
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
M1021. Primary Diagnosis	
a. _____	V, W, X, Y codes NOT allowed a. ☐☐☐☐☐☐☐ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
M1023. Other Diagnoses	
b. _____	All ICD-10-CM codes allowed b. ☐☐☐☐☐☐☐ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
c. _____	c. ☐☐☐☐☐☐☐ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
d. _____	d. ☐☐☐☐☐☐☐ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e. _____	e. ☐☐☐☐☐☐☐ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
f. _____	f. ☐☐☐☐☐☐☐ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Item Intent

The intent of these items is to accurately report and enter ICD-10 CM codes for the patient's primary (M1021) and other (M1023) home health diagnoses and document the degree of symptom control for each diagnosis.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

DEFINITIONS	**PRIMARY DIAGNOSIS** • The chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care. **OTHER DIAGNOSES** • Comorbid conditions that exist at the time of the assessment that are actively addressed in the patient's Plan of Care – OR – that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. **ICD-10-CM** • A morbidity classification published by the United States for classifying diagnoses and reasons for care in all health care settings. The ICD-10-CM is based on the ICD-10, the International Classification of Disease published by the World Health Organization (WHO).

Response-Specific Instructions

Identifying Primary (M1021) and Other (M1023) Diagnoses

- The assessing clinician must determine the primary and other home health diagnoses based on the assessment findings, information in the medical record including but not limited to physician/allowed practitioner orders, medication list and referral information, and input from the physician/allowed practitioner.
- The assessing clinician is expected to complete the patient's comprehensive assessment and understand the patient's overall medical condition and care needs before assigning diagnoses.
- The assessing clinician may elicit input from other agency staff that have had direct in-person contact with the patient or have had some other means of gathering information to contribute to the OASIS data collection.
- The primary diagnosis (M1021) and other diagnoses (M1023) may or may not relate to the patient's most recent hospital stay but must meet the definitions of primary and other diagnoses presented in this guidance.
- Diagnoses may change during the course of the home health stay due to a change in the patient's health status or a change in the focus of home health care. At each required OASIS time point, the assessing clinician must assess the patient's clinical status and determine the primary and other diagnoses based on patient status and treatment plan at the time of the assessment.
- Only current diagnoses should be reported as primary and secondary diagnoses in M1021 and M1023. Diagnoses should be excluded if they are resolved or do not have the potential to impact the skilled services provided by the HHA. An example of a resolved condition is cholecystitis following a cholecystectomy.

Reporting ICD-10-CM codes for Primary (M1021) and Other (M1023) Diagnoses

- Adherence to the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). It is expected that each agency will ensure

that diagnoses and ICD-10-CM codes reported in OASIS meet these guidelines.

- CMS and the National Center for Health Statistics (NCHS) provide the "Official Guidelines for Coding and Reporting." "These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website."
- The assessing clinician can enter the ICD-10-CM codes. Alternatively, a coding specialist in the agency may enter the actual numeric ICD-10-CM codes in Column 2, as long as the assessing clinician has determined the primary and other diagnoses in Column 1.

Reporting the Symptom Control Rating in Column 2

- Assessing the degree of symptom control includes but is not limited to review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care providers.
  - Inquire about the degree to which each condition limits daily activities.
  - Assess the patient to determine if symptoms are controlled by current treatments.
  - Clarify which diagnoses/symptoms have been poorly controlled in the recent past.
  - 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 the sequencing may not coincide.
  - Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y, or Z code.

Coding Instructions

- **Column 1, Diagnoses:**
  - Enter the description of each diagnosis
  - List each diagnosis for which the patient is receiving home care
  - Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided
  - Complete Column 1 from top to bottom, leaving any blank entries at the bottom.
  - Order other diagnoses (M1023) according to the degree they impact the patient's health and need for home health care, rather than the degree of symptom control.
    - For example, if a patient is receiving home health care for Type 2 Diabetes that is "controlled with difficulty" this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is being treated, even if the fungal infection is "poorly controlled."
- **Column 2, ICD-10 CM codes:**
  - For each diagnosis in Column 1, enter its ICD-10-CM code at the highest level of specificity.
  - No surgical or procedure codes allowed in Column 2.
  - ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.
  - 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 (Other Diagnoses).
  - 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.

  - See the ICD-10-CM "Official Guidelines for Coding and Reporting" for complete instructions on code assignment and sequencing related to the use of Z codes, and use of multiple coding for a single condition (such as manifestation/etiology pairs).

- **Column 2, Symptom Control Rating:**
  - For each diagnosis in Column 1, rate the degree of symptom control 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 rehospitalizations.

M1028: Active Diagnoses – Comorbidities and Co-existing Conditions

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

Item Intent

This item identifies whether two specific diagnoses are present and active. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcers/injuries.

DEFINITION	**ACTIVE DIAGNOSES** Active diagnoses are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status, medical treatments, nurse monitoring, or risk of death at the time of the assessment.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

1. **Identify diagnoses:** The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis be present at the time of assessment.
   - Clinical record sources for these diagnoses include, but are not limited to transfer documents, physician/allowed practitioner: progress notes, recent history and physical, discharge summary, orders, and consults.
   - Do not include diseases or conditions that have been resolved or do not affect the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.

- Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the clinical record by the physician (or others as listed above) to ensure validity, follow-up, and coordination of care.
- Only diagnoses confirmed and documented by the physician (or others, as listed above) should be considered when coding this item.

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, determine whether the diagnosis is active.
   - If information regarding active diagnoses is learned after the end of the assessment timeframe, the OASIS item should not be revised to reflect this new information. The OASIS should reflect what was documented at the time of the assessment.
     - If, however, it comes to light after the OASIS assessment is submitted an error occurred, where a documented active diagnosis was initially present but not indicated on the OASIS, the Home Health Agency should correct the OASIS following the agency's correction policy and M0090 would not necessarily be changed.

Coding Instructions

- **Code 1, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) if** the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD).
- **Code 2, Diabetes Mellitus (DM),** if the patient has an active diagnosis of Diabetes Mellitus (DM).
- **Code 3, None of the Above,** if the patient does not have any of the active diagnoses listed above.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

The following tips may assist staff in determining whether a disease or condition should be coded as an active diagnosis.

- The physician (nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) may specifically indicate that a diagnosis is active.
- If there is documentation in the clinical record that a patient has diabetes mellitus, select Response 2, Diabetes Mellitus (DM). If there is only documentation in the clinical record of a complication such as nephropathy or neuropathy and there is no documentation that the patient has diabetes, it should not be assumed the complication is associated with diabetes, and Response 2, Diabetes Mellitus, should not be checked.
- If a diabetic patient has either PAD or PVD both Response 1 and Response 2 should be checked.
- The physician (nurse practitioner, physician assistant, clinical nurse specialist or other authorized licensed staff if allowable under state licensure laws) for example, documents at the time of assessment that the patient has inadequately controlled diabetes and requires adjustment of the medication regimen. This would be sufficient documentation of an active diagnosis and would require no additional confirmation because the physician documented the diagnosis and also confirmed that the medication regimen needed to be modified.

Examples

1. **Active Diagnosis of Diabetes Mellitus,** A patient is prescribed insulin for diabetes mellitus. They require regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician's progress note documents diabetes mellitus.
   - **Coding:** M1028, Active Diagnoses, would be coded 2, Diabetes Mellitus.
   - **Rationale:** This would be considered an active diagnosis because the physician progress note documents the diabetes mellitus diagnosis, and because there is ongoing medication management and glucose monitoring.
2. **None of the Above,** During the SOC/ROC assessment, a patient told Nurse J, RN that they have had diabetes for 20 years. Nurse J reviewed the transfer documents from the acute care facility and all clinical records on the patient but was unable find a documented diagnosis of Diabetes Mellitus by physician, nurse practitioner, physician assistant or authorized licensed staff member in their state. There is no documented diagnosis of PVD or PAD.
   - **Coding:** M1028, Active Diagnoses, would be coded 3, None of the Above.
   - **Rationale:** This would be considered a "none of the above" response because the nurse was unable to find the diagnosis of diabetes at the time of assessment, documented by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws). And there is no documented diagnosis of PVD or PAD.

SECTION J: HEALTH CONDITIONS

Introduction

This section includes seven items to assess risk for hospitalization, pain interfering with activities, falls, and shortness of breath.

M1033: Risk of 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 last 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

Item Intent

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

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up

Response-Specific Instructions

- Interview the patient/caregiver, conduct physical assessment, consult with the physician, and/or review the clinical record, including but not limited to health history, and referral information.
- History of falls (**Response 1**) includes witnessed and reported (unwitnessed) falls.

DEFINITION	**FALL** • Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. • A fall due to an overwhelming external force (e.g., a patient pushes another patient) is considered a fall. • An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themselves or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered an intercepted fall. • An exception is if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training. This is reported as both a fall and a major injury in J1800 Any Falls Since SOC/ROC and J1900 Number of Falls Since SOC/ROC.

- Multiple hospitalizations (**Response 3**) include only acute care hospitalizations, defined as the patient being admitted for 24 hours or longer to an inpatient acute bed for reasons other than diagnostic testing.
  - This response does not include admission to a freestanding inpatient rehabilitation hospital or a rehabilitation bed in a rehabilitation distinct unit of a general acute care hospital. This response does not include admission to an inpatient psychiatric hospital, or long-term care hospitals (LTCHs).
- Multiple hospitalizations (**Response 3**) define hospitalization as the patient being admitted for 24 hours or longer to an inpatient acute bed for reasons other than diagnostic testing.
- Multiple emergency department visits (**Response 4**) include only hospital emergency room departments (e.g., not urgent care centers or walk-in clinics).
- Decline in mental, emotional, or behavioral status (**Response 5**) refers to significant changes occurring within the past 3 months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization. A decline is considered a change 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.
- Medications (**Response 7**) include prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route and as noted on the reconciled medication profile. Medications may also include total parenteral nutrition (TPN) and oxygen.
- Other risk(s), (**Response 9**) may be selected if the assessing clinician finds characteristics other than those listed in Responses 1-8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).
- If None of the above (**Response 10**) is selected, no other responses should be selected.

Coding Instructions

Dash is not a valid response for this item.

J0510-J0530: Pain Interview

J0510. Pain Effect on Sleep	
Enter Code ☐	Ask patient: *"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"* 0. Does not apply — I have not had any pain or hurting in the past 5 days → *Skip to M1400, Short of Breath at SOC/ROC; Skip to J1800, Any Falls Since SOC/ROC at DC* 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer

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

J0530. Pain Interference with Day-to-Day Activities	
Enter Code ☐	Ask patient: "Over the past 5 days, *how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"* 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer

Item Intent

The intent of the items in this section is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.

DEFINITION	**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. It 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.

Item Rationale

The assessment of pain is not associated with any particular approach to pain management. Since the use of opioids is associated with serious complications, an array of successful non-pharmacologic and non-opioid approaches to pain management may be considered. There are a range of pain management strategies that can be utilized, including but not limited to non-narcotic analgesic drugs, transcutaneous electrical nerve stimulation (TENS) therapy, supportive devices, acupuncture, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electric stimulation, radiotherapy, and ultrasound.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

- Discharge from agency

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.
  - 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.
- The time period under consideration or "look back" for the pain interview items include the day of assessment in addition to looking back over the last 5 days. The day of assessment for these items is considered day 0.
- If the patient is unsure about whether the pain effect or interference occurred in the 5-day time interval, prompt the patient to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.
- Coding for J0510-J0530 - Pain Interview should be based on the first complete pain interview conducted within the assessment timeframe and should not be changed even if a patient's status might change within the assessment timeframe.

Coding Instructions

- **Code 8, Unable to answer**, if the patient is unable to answer the question, does not respond (refuses) or gives a nonsensical response.
- **Dash is not** a valid response for this item.

J0510: Pain Effect on Sleep

J0510. Pain Effect on Sleep	
Enter Code ☐	Ask patient: *"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"* 0. **Does not apply — I have not had any pain or hurting in the past 5 days →** *Skip to M1400, Short of Breath at SOC/ROC; Skip to J1800, Any Falls Since SOC/ROC at DC* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Read the question and response choices as written.

- No pre-determined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options.
- 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. For example, if the patient responded to the question, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" 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?" The clinician can then narrow down responses with additional follow-up questions about the frequency.

Coding Instructions

Code based on the first complete pain interview conducted within the assessment timeframe. Coding for this item should not be changed even if a patient's status might change within the assessment timeframe. If discharge assessment, complete as close to the time of discharge as possible.

- **Code 0, Does not apply**, if the patient responds that they did not have any pain or hurting in the past 5 days.
- **Code 1, Rarely or not at all,** if the patient responds that pain has been present and the pain rarely or not at all made it hard to sleep in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally made it hard to sleep in the past 5 days.
- **Code 3, Frequently,** if the patient responds that pain has frequently made it hard to sleep in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly made it hard to sleep in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond or gives a nonsensical response.
- **Dash is not** a valid response for this item.

Coding Tips

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between 2 options, then the assessing clinician should code for the option with the higher frequency.
- The key difference between **code 0, Does not apply** and **code 1, Rarely or not at all** is that for **code 0**, the patient reports no pain/hurting in the past 5 days, and **code 1**, the patient reports 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**.

Examples

1. **Assessing clinician:** "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

   Patient: "I've had a little back pain from being in the wheelchair all day, but it's felt so much better when I

go to bed. The pain hasn't kept me from sleeping at all."

- **Coding:** J0510 would be coded 1, Rarely or not at all.
- **Rationale:** The patient reports pain has been present, but no sleep problems related to pain.

2. **Assessing clinician:** "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

   Patient: "All the time. It's been hard for me to sleep all the time. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."

   - **Coding:** J0510 would be coded 4, Almost constantly.
   - **Rationale:** The patient reports pain-related sleep problems "all the time," so the most applicable response is "Almost constantly."

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

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Read the question and response choices as written.
- No pre-determined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options.
- Confirm that the patient has been offered rehabilitation therapies during the reference timeframe.

DEFINITION	**REHABILITATION THERAPY** Includes but is not limited to special healthcare services or programs that help a person regain and/or maintain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.

Coding Instructions

Code based on the first complete pain interview conducted within the assessment timeframe. Coding for this item should not be changed even if a patient's status might change within the assessment timeframe. If discharge assessment, complete as close to the time of discharge as possible.

- **Code 0, Does not apply**, if the patient responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule) in the past 5 days.
- **Code 1, Rarely or not at all,** if the patient responds that pain has rarely or not at all limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 3, Frequently**, if the patient responds that pain has frequently limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly limited participation in rehabilitation therapy sessions in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond or gives a nonsensical response.
- **Dash is not** a valid response for this item.

Coding Tips

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between 2 options, then the assessing clinician should code for the option with the higher frequency.
- 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, regardless of the rehab focus or goal(s).

Examples

1. **Assessing clinician**: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

   Patient: "Since the surgery a week ago, the pain has made it hard to even get out of bed. I try to push myself, but the pain frequently limits how much I can do with my therapist."

   - **Coding:** J0520 would be coded 3, Frequently
   - **Rationale:** The patient reports that pain frequently limits participation in therapies.

J0530: Pain Interference with Day-to-Day Activities

J0530. Pain Interference with Day-to-Day Activities	
Enter Code ☐	Ask patient: "Over the past 5 days, *how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?*" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Read the question and response choices as written.
- No pre-determined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options.

Coding Instructions

Code based on the first complete pain interview conducted within the assessment timeframe. Coding for this item should not be changed even if a patient's status might change within the assessment timeframe. If discharge assessment, complete as close to the time of discharge as possible.

- **Code 1, Rarely or not at all,** if the patient responds that pain has rarely or not at all limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 2, Occasionally,** if the patient responds that pain has occasionally limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 3, Frequently,** if the patient responds that pain has frequently limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 4, Almost constantly,** if the patient responds that pain has almost constantly limited day-to-day activities (excluding rehabilitation therapy sessions) in the past 5 days.
- **Code 8, Unable to answer,** if the patient is unable to answer the question, does not respond or gives a nonsensical response.
- **Dash is not** a valid response for this item.

Coding Tips

- This item should be coded based on the patient's interpretation of the provided response options for frequency. If the patient is unable to decide between 2 options, then the assessing clinician should code for the option with the higher frequency.

Examples

1. **Assessing clinician**: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

   Patient: "Although I have some pain in my back, I'm still able to read, eat my meals, and take walks like I usually do."

   - **Coding:** J0530 would be coded 1, Rarely or not at all.
   - **Rationale:** The patient reports that pain has not limited participation in day-to-day activities.

2. **Assessing clinician**: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

   Patient: "The pain has made it hard to do pretty much anything. Even getting out of bed to brush my teeth has been hard. I haven't been able to talk to my family because the pain is so bad. It's just constant. I'd say it constantly limits what I do."

   - **Coding:** J0530 would be coded 4, Almost constantly.
   - **Rationale:** The patient reports that pain has constantly limited participation in other activities.

J1800: Any Falls Since SOC/ROC

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

Item Intent

This item is intended to code any witnessed or unwitnessed falls since the most recent SOC/ROC.

Item Rationale

- Falls are a leading cause of morbidity and mortality.
- Fear of falling can limit an individual's activity and negatively impact quality of life.

DEFINITION	**FALL** • Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. • A fall due to an overwhelming external fore (e.g., a patient pushes another patient) is considered a fall. • An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themselves or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally

	challenged during balance training is not considered an intercepted fall. • An exception is if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance, during balance training. This would be reported as both a fall and a major injury in J1800 Any Falls Since SOC/ROC and J1900 Number of Falls Since SOC/ROC.

Time Points Item(s) Completed

- Transfer
- Death at home
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver, review the home health clinical record and any other relevant clinical documentation, such as incident reports or fall logs.
- Include all falls since the most recent SOC/ROC, regardless of where the fall occurred.

Coding Instructions

- **Code 0, No,** if the patient has not had any falls since the most recent SOC/ROC.
- **Code 1, Yes,** if the patient has fallen since the most recent SOC/ROC and continue to J1900. Number of Falls since SOC/ROC.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Report falls that occurred at any time during the quality episode, regardless of where the fall occurred. For example,
  - a fall that occurred at the doctor's office during the HH quality episode would be reported.
  - a fall that occurred during a qualifying inpatient facility transfer (e.g., hospital or SNF) would not be reported as it did not occur within a HH quality episode.

Examples

1. The discharging RN reviews the clinical record and interviews the patient and caregiver, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which the caregiver reported the patient slipped from their wheelchair to the floor the previous day.

- **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
- **Rationale:** This item addresses unwitnessed as well as witnessed falls.

2. An incident report describes an event in which a patient was walking down the hall and appeared to slip on a wet spot on the floor. The patient lost their balance and bumped into the wall but was able to grab onto the handrail and steady themself.
   - **Coding:** J1800 would be coded 1, Yes.
   - **Rationale:** An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person.
3. A patient is participating in balance training during a therapy session. The therapist is intentionally challenging the patient's balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides steadying/contact guard assistance to allow the patient to maintain standing.
   - **Coding:** J1800 would be coded 0, No.
   - **Rationale:** The patient's balance was intentionally being challenged, so a loss of balance is anticipated by the physical therapist. When the patient experiences an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training, unless there was a fall or "intercepted" fall that resulted in a major injury, it would not be coded as a fall in J1800.
4. 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.
   - **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.

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 code 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):** As described in the OASIS manual
	☐	C. **Major injury:** As described in the OASIS manual

Item Intent

This item is intended to code the number of falls a patient has had since the most recent SOC/ROC and fall-related injury.

Item Rationale

- Falls are a leading cause of morbidity and mortality.

- Fear of falling can limit an individual's activity and negatively impact quality of life.

EXAMPLES	**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 but is not limited to 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 but is not limited to traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries. .

Time Points Item(s) Completed

- Transfer
- Death at Home
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver and review the home health clinical record, incident reports, and any other relevant clinical documentation such as fall logs.
- Include all falls since the most recent SOC/ROC, regardless of where the fall occurred.

Coding Instructions

- Determine the number of falls that occurred since the most recent SOC/ROC and code the level of fall-related injury for each.
- Code each fall only once. If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

Coding Instructions for J1900A, No injury

- **Code 0, None,** if the patient has had no injurious fall since the most recent SOC/ROC.
- **Code 1, One,** if the patient had one non-injurious fall since the most recent SOC/ROC.
- **Code 2, Two or more,** if the patient had two or more non-injurious falls since the most recent SOC/ROC.

- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Instructions for J1900B, Injury (except major)

- **Code 0, None,** if the patient had no injurious fall (except major) since the most recent SOC/ROC.
- **Code 1, One,** if the patient had one injurious fall (except major) since the most recent SOC/ROC.
- **Code 2, Two or more,** if the patient had two or more injurious falls (except major) since the most recent SOC/ROC.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Instructions for J1900C, Major injury

- **Code 0, None,** if the patient had no major injurious fall since the most recent SOC/ROC.
- **Code 1, One,** if the patient had one major injurious fall since the most recent SOC/ROC.
- **Code 2, Two or more,** if the patient had two or more major injurious falls since the most recent SOC/ROC.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Report falls that occurred at any time during the quality episode, regardless of where the fall occurred. For example,
  - a fall that occurred at the doctor's office during the HH quality episode would be reported.
  - a fall that occurred during a qualifying inpatient facility transfer (e.g., hospital or SNF) would not be reported as it did not occur within a HH quality episode.
- Fractures confirmed to be pathological (versus traumatic) are not to be considered a major injury resulting from a fall.
- Agencies are encouraged to correct errors as accurate information regarding fall-related injuries becomes known. For example,
  - Injuries can present themselves later than the time of the fall.
  - The agency may not learn of the level of injury until after the OASIS assessment is completed (e.g., because the patient was transported to ER and admitted to an inpatient facility post-fall).
  - Errors should be corrected following the agency's correction policy. The M0090 date would not necessarily be changed.

Examples

1. A nursing note states that a patient slipped out of their wheelchair onto the floor during a transfer from the bed to the wheelchair. Before being assisted back into bed, an assessment was completed that indicated no injury.
   - **Coding:** J1900A, No injury, would be coded 1, One, if no other falls without injury occurred.
   - **Rationale:** Slipping onto the floor is a fall. No injury was noted.

2. A nurse's note describes a patient who climbed over their bedrail and fell to the floor. On examination, they had a cut over their left eye and some swelling on their arm. The patient was sent to the emergency room, where x-rays revealed no injury and neurological checks revealed no changes in mental status. The patient returned home within 24 hours.
   - **Coding:** J1900B, Injury (except major), would be coded 1, One.
   - **Rationale:** Lacerations and swelling without fracture are classified as injury (except major).
3. A patient fell, lacerated their head, and was sent to the emergency room, where a head computerized tomography (CT) scan revealed a subdural hematoma. The patient received treatment and returned home after 2 days.
   - **Coding:** J1900C, Major injury, would be coded 1, One.
   - **Rationale:** Subdural hematoma is a major injury, and it occurred as a result of the fall.
4. Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented in clinical notes. The first describes an event during which the patient tripped on the bathroom rug and almost fell but caught themself against the sink. The RN assessment identified no injury. The second describes an event during which the patient, while coming up the basement stairs with the laundry, fell against the stairs and sustained a bruise and laceration on their left knee.
   - **Coding:** J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC. J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC. J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.
   - **Rationale:** The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.
5. Review of the patient record, incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC. The fall is documented in an incident report, which describes an event during which the patient fell while walking from the bedroom to the bathroom and was transported to the emergency room via ambulance. Examination and testing revealed a skin tear on the patient's left hand, bruising on both knees, and a fractured left hip.
   - **Coding:** J1900A, No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC. J1900B, Injury (except major), would be coded 0, no injurious (except major) falls since the most recent SOC/ROC. J1900C, Major injury, would be coded 1, one fall with major injury since the most recent SOC/ROC.
   - **Rationale:** Documentation of only one fall since the most recent SOC/ROC was identified. The patient sustained multiple injuries in the fall. When multiple injuries are sustained in a single fall, code the injury of highest severity.
6. The therapist had a patient, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the patient's balance. Despite safety precautions, including contact guard assistance and safety mats, the patient fell while standing on one foot and landed on their left side. Due to pain and swelling in their left wrist the physician ordered a left wrist x-ray for the patient. The x-ray confirmed a distal radius fracture (non-displaced) of the left wrist.
   Coding: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**.

Rationale: Despite safety precautions in place the patient sustained a radius fracture, a major injury, during a therapeutic intervention with physical therapy where their balance was being intentionally challenged. This is being considered a fall as there was a major injury even though the fall and major injury occurred when the patient's balance was being intentionally challenged.

Differentiating Traumatic versus Pathological Fractures

7. A home health patient with osteoporosis falls, resulting in a right hip fracture. The Emergency Department physician confirms that the fracture is a result of the patient's bone disease and not a result of the fall.

   Coding: J1800 would be **coded 1, Yes** and J1900C would be **coded 0, None**.

   Rationale: The physician determined that the fracture was a pathological fracture and was a result of osteoporosis. Because it is not considered a traumatic fracture it would not be considered a major injury.

8. A home health patient with osteoporosis falls, resulting in a right hip fracture. The physician in the acute care hospital confirms that the fracture is a result of the patient's fall and not due to the patient's history of osteoporosis.

   Coding: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**.
   Rationale: Because the physician determined that the fracture was a result of the fall it would be considered a traumatic fracture and therefore would be considered a major injury.

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)

Item Intent

Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge

Response-Specific Instructions

- Conduct physical assessment, including observation. Interview the patient/caregiver and/or review the health history.
- If the patient uses oxygen continuously (at all times during the day of assessment, with only brief interruptions), code the response based on assessment of the patient's shortness of breath while using oxygen.

- If the patient uses oxygen intermittently, code the response based on the patient's shortness of breath ***without*** the use of oxygen.
    - Responses are based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.
- For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath.
- The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest.

Coding Instructions

- **Code 0, Patient is not short of breath,** if the patient has not been short of breath on the day of assessment.
- **Code 1, When walking more than 20 feet, climbing stairs,** and/or if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient).
- **Dash is not** a valid response for this item.

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Introduction

This section includes three items. Height and weight to calculate body mass, nutritional approaches, and assessment of the ability to eat, chew and swallow food.

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.)

Item Intent

These items support calculation of the patient's body mass index (BMI) using the patient's height and weight.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

Whenever possible, a current height and weight should be obtained by the agency as part of the SOC/ROC assessment.

- M1060A Height
  - Measure height in accordance with the agency's policies and procedures.
  - Measure and record the patient's height to the nearest whole inch.
  - Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
  - Only enter a height that has been directly measured by agency staff. Do not enter a height that is self-reported or derived from documentation from another provider setting.
- M1060B Weight
  - Weight should be measured in accordance with the agency's policies and procedures.
  - Measure and record the patient's weight in pounds.
  - Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.

- If agency staff weighs the patient multiple times during the assessment period, use the first weight.
- Only enter a weight that has been directly measured by agency staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.

Coding Instructions

- A **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
  - If a patient's height/weight cannot be measured during the assessment timeframe, and no agency-obtained height/weight from a documented visit conducted within the previous 30-day window is available.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- When reporting height for a patient with bilateral lower extremity amputation, measure and record the patient's current height (i.e., height after bilateral amputation).
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, the use of a dash (–) is appropriate.
- When there is an unsuccessful attempt to measure a patient's height or weight, at SOC/ROC, an agency-obtained height or weight from a documented home health visit conducted within the previous 30-day window may be used to complete this item.

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 above**	☐

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**	☐	☐

Item Intent

The intent of this item is to identify if any nutritional approaches listed are used by the patient.

Item Rationale

- Nutritional approaches such as mechanically altered food or those that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The patient's clinical condition may potentially benefit from the various nutritional approaches included here.

DEFINITIONS	**PARENTERAL/IV FEEDING** • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). **FEEDING TUBE** • The presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes. **MECHANICALLY ALTERED DIET** • A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. **THERAPEUTIC DIET** • 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 parenteral routes as part of treatment of disease or clinical condition to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet.[i]

[i] Academy of Nutrition and Dietetics. (2024). Definition of Terms List. https://www.cdrnet.org/vault/2459/web//20241104%20Revised%202025%20DoT%20List_Final%201-25.pdf

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions for SOC/ROC

Consult the patient, family, or caregiver and/or review the clinical record or other available documentation to determine if any of the listed nutritional approaches are part of the current care/treatment plan at the time of the SOC/ROC assessment, even if not used at the time of assessment.

Coding Instructions for SOC/ROC

- 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 not used at the time of assessment. If none apply, check K0520Z, None of the above.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Response Specific Instructions for Discharge

- Consult the patient, family, or caregiver and/or review the clinical record or other available documentation to determine if any of the listed nutritional approaches were:
  - Part of the current care/treatment plan in the last 7 days, even if not used in the last 7 days (Column 4).
  - Part of the current care/treatment plan at the time of the discharge, even if not used at the time of assessment (Column 5).

Coding Instructions for Discharge

- 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) and 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.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

General Coding Tip

If a patient will receive one of the listed nutritional approaches as a result of this SOC/ROC assessment (for example, IV hydration will be started at this visit or a specified subsequent visit; the physician is contacted for an enteral order, etc.), mark the applicable nutritional approach.

Coding Tips for K0520A, Parenteral/IV feeding

- Parenteral/IV feeding includes parenteral, or IV fluids provided for nutrition or hydration. Includes additional fluid intake specifically addressing a documented nutrition or hydration need. Excludes fluids provided solely to maintain access and patency.
  - The following items may be included:
    - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently.
    - Hypodermoclysis and subcutaneous ports in hydration therapy.
    - IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration.
  - 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 administered as a routine part of an operative or diagnostic procedure or recovery room stay.
    - IV fluids administered to flush the IV line.
    - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

Coding Tips for 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.

Coding Tips for K0520D, Therapeutic Diet

- Enteral feeding formulas:
  - Should not be coded as a mechanically altered diet.
  - Should only be coded as **K0520D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g., enteral formulas specific to diabetes.
- A nutritional supplement given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be ***part*** of a therapeutic diet. Therefore, supplements (whether taken with, in-between, or instead of meals) are only coded in K0520D, Therapeutic Diet when they are being taken as part of a therapeutic diet to manage problematic health conditions (e.g., supplement for protein-calorie malnutrition).
  - Food elimination diets related to food allergies (e.g., peanut allergy) can be coded as a therapeutic diet.
- A fluid restricted diet is considered a therapeutic diet for item K0520D if the fluid restriction is prescribed to manage a disease or clinical condition.
- Therapeutic diets are not defined by the content of what is provided or when it is served, but WHY is the diet required.

Examples for SOC/ROC: K0520A, Parenteral/IV feeding

1. A patient is admitted with orders for an antibiotic in 100 cc of normal saline via IV for symptoms of a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >105 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. The plan of care is updated to include a hydration intervention to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.
   - **Coding:** K0520A would be checked. The IV medication would be coded at IV Medications item (O0110H).
   - **Rationale:** The patient received 100 cc of IV fluid and there is supporting documentation that reflected an identified need for additional fluid intake for hydration.
2. A patient is admitted and receiving an antibiotic in 100 cc of normal saline via IV. They have a UTI, no fever, and documented adequate fluid intake. The patient is placed on an oral hydration plan to maintain adequate hydration.
   - **Coding**: K0520A would NOT be checked. The IV medication would be coded at IV Medications item (O0110H).
   - **Rationale:** The patient received IV fluids, but it is not reported in K0520A because documentation indicated that fluid intake was adequate. Oral hydration is not included in K0520.

Examples for Discharge

1. The patient will be discharged today. They were receiving rehabilitation services for a stroke. The patient has longstanding Celiac disease and therefore was placed on a gluten free diet. Because of their recent stroke, they also have documented dysphagia requiring a mechanical soft diet and honey-thick liquids to prevent aspiration and will be discharged on this same diet.
   - **Coding:** K0520C4 and K0520C5 as well as K0520D4 and K0520D5 would be checked.

- **Rationale:** The patient requires both a mechanically altered diet (i.e., mechanical soft diet and honey-thick liquids) and a therapeutic diet (i.e., gluten free) for Celiac disease and they were part of the current care/treatment plan in the last seven days as well as at the time of the discharge assessment.

2. Prior to their SOC/ROC with home health, the patient had been on a chopped diet due to facial trauma. They will be discharged today after rehabilitation services for multiple fractures after a car accident. The patient has been on a regular diet during their entire home health stay and has not required any parenteral or enteral nutrition.

   - **Coding:** K0520Z4 and K0520Z5 would be checked.
   - **Rationale:** The patient had a regular diet during their entire home health stay and did not require any nutritional modifications.

M1870: Feeding or Eating

M1870. Feeding or Eating Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code ☐	0. Able to independently feed self 1. Able to feed self independently but requires: a. meal set-up; OR b. intermittent assistance or supervision from another person; OR c. a liquid, pureed, or ground meat diet. 2. Unable to feed self and must be assisted or supervised throughout the meal/snack. 3. Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5. Unable to take in nutrients orally or by tube feeding.

Item Intent

Identifies the patient's ability to feed themself, including the process of eating, chewing, and swallowing food. The intent of the item is to identify the patient's ability, not necessarily actual performance. "Willingness" and "adherence" are not the focus of this item.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method to complete this item. Other sources of information include but are not limited to patient/caregiver interview, physical assessment, nutritional assessment, physician orders, plan of care, referral information, and review of past history. When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact.
- Code this item based on the assistance needed by the patient to feed themself once the food is placed in front of them. Assistance means human assistance by verbal cueing/reminders, supervision, and/or standby or hands-on assistance.
- 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.

- Do not consider preparation of food, or transport of food to the table when coding this item.
- "Meal set up," (Response 1, option a), refers to activities such as mashing a potato, cutting up
- meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. - all of which are special adaptations of the meal for the patient.

Coding Instructions

- **Code 5, Unable to take in nutrients orally or by tube feeding** if all nutrition is received intravenously (such as TPN) or for patients who are receiving only intravenous hydration.
- **Dash is not** a valid response for this item.

Coding Tips

- If a patient is being weaned from tube feeding, code 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, code 0, 1, or 2. This is true, even if the tube remains in place, unused for a period of time.

SECTION M: SKIN CONDITIONS

Introduction

This section includes items that assess the presence of pressure ulcers, stasis ulcers and surgical wounds.

M1306: Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

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**

Item Intent

Identifies the presence or absence of Unhealed Stage 2 or higher or Unstageable pressure ulcers/injuries only.

DEFINITION	**PRESSURE ULCER/INJURY** Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear and/or friction. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

Item Rationale

An existing pressure ulcer/injury identifies patients at risk for further complications or skin injury.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency

Response-Specific Instructions

- The presence of pressure ulcers/injuries and unstageable pressure ulcers/injuries should be determined by physical assessment and observation. Medical records, patient/caregiver report and physician input may be used for historical purposes only to identify the presence of an existing ulcer/injury or the stage of a previously healed pressure ulcer.
- Review the history of each pressure ulcer/injury in the clinical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, as long as it remains stageable, it should continue to be classified at the higher numerical stage until healed.
- 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.

DEFINITIONS	**NON-REMOVABLE DRESSING/DEVICE** • Examples of a non-removable dressing/device include a dressing that is not to be removed per physician's allowed/practitioner's order (such as those used in negative pressure wound therapy [NPWT], an orthopedic device, or a cast). **SLOUGH TISSUE** • Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. **ESCHAR TISSUE** • Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. **DEEP TISSUE INJURY** • A purple or maroon localized areas of discolored intact skin or blood- filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

Coding Instructions

- **Code 0, No,** if the only pressure ulcer/injury is one or more Stage 1 OR healed pressure ulcers/injuries (of any previous stage) AND the patient has no other pressure ulcers/injuries.
- **Code 1, Yes,** if the patient has an unhealed Stage 2, Stage 3, OR Stage 4 pressure ulcer OR if the patient has an unstageable pressure ulcer/injury.
- **Dash is not** a valid response for this item.

Coding Tips

- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer/injury.
- Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface, known as "re-epithelialization."

- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins). Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. For the purpose of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.

M1307: The Oldest Stage 2 Pressure Ulcer that is present at 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**

Item Intent

The intent of this item is to a) identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed), b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency, and c) identify patients who develop Stage 2 pressure ulcers while under the care of the agency.

Item Rationale

- Stage 2 pressure ulcers may worsen without proper interventions.
- These patients are at risk for further complications or skin injury.

DEFINITION	**STAGE 2 PRESSURE ULCER** Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured serum-filled blister.

Time Points Item(s) Completed

Discharge from agency

Response-Specific Instructions

- Staging of a pressure ulcer/injury should be determined by physical assessment and observation. Medical records, patient/caregiver report and physician input may be used for historical purposes only to identify the presence of an existing ulcer/injury or the stage of a previously healed pressure ulcer.
- Review the history of each pressure ulcer/injury in the clinical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, as long as it remains stageable, it should continue to be classified at the higher numerical stage until healed.
- 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. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented

as a Stage 4 pressure ulcer until it has healed or becomes unstageable.

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface called, "re-epithelialization."
- 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" (See M1311 for definition of Unstageable due to non-removable dressing/device).

Coding Instructions

- **Code 1, Was present at the most recent SOC/ROC assessment,** if the oldest Stage 2 pressure ulcer that is present at discharge was already present as a Stage 2 pressure ulcer at the first skin assessment completed at the most recent SOC/ROC.
- **Code 2, Developed since the most recent SOC/ROC assessment,** if the oldest Stage 2 pressure ulcer that is present at discharge was NOT a Stage 2 pressure ulcer at the first skin assessment completed at the most recent SOC/ROC.
    - If Code 2 is entered, specify the date the Stage 2 pressure ulcer was first identified. Use two digits to indicate the month (for example, May is 05), single-digit dates should begin with 0, and use four digits to indicate the year (for example, May 4, 2025, would be 05/04/2025).
- **Code 2, Developed since the most recent SOC/ROC assessment,** if no pressure ulcer existed at the SOC, then a Stage 1 pressure injury developed, which progressed to a Stage 2 by discharge. Specify the date that the pressure ulcer was first identified as a Stage 2 ulcer.
- **Code NA, No Stage 2 pressure ulcers are present at discharge,** if there are no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.
- **Dash is not** a valid response for this item.

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

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**

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 <u>these</u> 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 <u>these</u> 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 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 <u>these</u> 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 ☐	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 <u>these</u> 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 <u>these</u> 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 ☐	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 <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

Item Intent

This item identifies the number of pressure ulcers/injuries at each stage (Stage 2, 3, and 4) and designated as unstageable, that are observed on assessment.

DEFINITIONS	**STAGE 2 PRESSURE ULCER** • Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured serum-filled blister. **STAGE 3 PRESSURE ULCER** • Stage 3 pressure ulcers are characterized by 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 or tunneling. **STAGE 4 PRESSURE ULCER** • Stage 4 pressure ulcers are characterized by 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.

At discharge, this item also identifies if each pressure ulcer/injury present on the discharge assessment was observed at the same stage at the time of the most recent SOC/ROC.

Stage 1 pressure injuries and all healed pressure ulcers/injuries are not reported in this item.

Item Rationale

It is important to recognize and evaluate each patient's risk factors for developing skin ulcers, wounds, or lesions, and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer/injury prevention and skin treatment program. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- The presence of pressure ulcer/injuries and unstageable pressure ulcers/injuries should be determined by physical assessment and observation. Medical records, patient/caregiver report and physician input may be used for historical purposes only to identify the presence of an existing ulcer/injury or the stage of a previously healed pressure ulcer.
- Review the history of each pressure ulcer/injury in the clinical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, as long as it remains stageable, it

should continue to be classified at the higher numerical stage until healed.

- If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the highest numerical stage of the wound. The clinician should make every effort to contact previous providers (including the patient's physician) to determine the highest numerical stage of the pressure ulcer.
- 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. For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment timeframe, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311X1 at the SOC.
    - When the assessing clinician is unable to complete a full skin assessment at the first visit, the assessing clinician may collaborate with a second clinician who completes the first clinical skin assessment, within the assessment timeframe.
- Stage 2 Pressure Ulcers
    - Report in M1311A1 the number of Stage 2 pressure ulcers that are observed on the current day of assessment.
    - Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister demonstrates signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth, or coolness), these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 pressure ulcer.
    - Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.
- Stage 3 Pressure Ulcers
    - Report in M1311B1 the number of Stage 3 pressure ulcers that are observed on the current day of assessment.
    - 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 unstageable.
- Stage 4 Pressure Ulcers
    - Report in M1311C1 the number of Stage 4 pressure ulcers that are observed on the current day of assessment
    - If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
    - A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage
    - 4 pressure ulcer, unless currently unstageable.
- Unstageable Pressure Ulcers/Injuries: Non-removable dressing/device
    - Report in M1311D1 the number of pressure ulcers/injuries that on the current day of assessment are known but not stageable due to non-removable dressing/device.
    - Pressure ulcers/injuries that are known to be present but that are unstageable due to a non-removable dressing/device, such as a cast that cannot be removed to assess the skin underneath, should be reported in M1311D1, Unstageable.

- "Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device. Unstageable pressure ulcers/injuries covered with a non-removable dressing would not be considered healed.

DEFINITIONS	**NON-REMOVABLE DRESSING/DEVICE** • Examples of a non-removable dressing/device include a dressing that is not to be removed per physician's allowed/practitioner's order (such as those used in negative pressure wound therapy [NPWT], an orthopedic device, or a cast). **SLOUGH TISSUE** • Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. **ESCHAR TISSUE** • Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. **DEEP TISSUE INJURY** • A purple or maroon localized areas of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

- Unstageable Pressure Ulcers: Slough/Eschar
  - Report in M1311E1 the number of pressure ulcers that on the current day of assessment are unstageable due to coverage of wound bed by slough and/or eschar.
    - Pressure ulcers that have eschar or slough tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable.
    - If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.
    - Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only when enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
  - Unstageable pressure ulcers due to eschar or slough would not be considered healed.
- Unstageable: Deep Tissue Injury (DTI)
  - Report in M1311F1 the number of unstageable pressure injuries presenting as deep tissue injury.
    - Deep tissue injury may be difficult to detect in individuals with dark skin tones.
    - Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed.

- A pressure ulcer/injury presenting with characteristics of a DTI is reported as a DTI **unless full thickness tissue loss is present.** For example, a DTI presenting as purple localized discoloration with tenderness caused by pressure, but without full thickness tissue loss would be coded as a DTI, even though the wound is not completely intact.

Determining "Present at the most recent SOC/ROC" to answer M1311X2

- For each pressure ulcer/injury observed and reported in items M1311A1-F1 on Discharge, determine whether that pressure ulcer/injury was observed at the same stage at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- 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.
- 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.
- If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing/device, that pressure ulcer/injury should be considered new, and not be coded as "present at the most recent SOC/ROC" for M1311X2.
- If a pressure ulcer/injury that is stageable at SOC is unstageable due to a non-removable dressing/device at discharge, it would be 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. This is because even though the stage of the pressure ulcer/injury is unknown at discharge, there is no documentation or indication that it increased in numerical stage or worsened during the stay.
- A deep tissue injury with intact skin at SOC/ROC, that becomes stageable, is considered "present at the most recent SOC/ROC" at the stage at which it first becomes numerically stageable.
- If a DTI that was observed at SOC/ROC does not evolve to be numerically stageable but is subsequently classified as another type of unstageable pressure ulcer/injury, it would be considered and coded as "present at the most recent SOC/ROC" on the discharge assessment in that unstageable pressure ulcer/injury category (M1311X1=1 and M1311X2=1).

Coding Instructions

- At SOC/ROC, enter a response for the following rows of this item: A1, B1, C1, D1, E1, and F1.
  - Example: At SOC, in B1, enter the number of Stage 3 pressure ulcers that are observed at the first skin assessment completed during the SOC assessment timeframe. Enter 0 if no Stage 3 pressure ulcers are observed.
- **Dash is not** a valid response for this item at the SOC/ROC time points.
- At Discharge, enter a response for each row of this item: A1, A2, B1, B2, C1, C2, D1, D2, E1, E2, F1, and F2, unless directed to skip.

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

- **Dash** is a valid response for this item at the discharge time point.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- Any type of **flap** procedure performed to surgically replace a pressure ulcer is reported as a surgical wound, until healed. It should not be reported as a pressure ulcer/injury on M1311.
- A pressure ulcer treated with any type of **graft** is no longer reported as a pressure ulcer/injury, and until healed, should be reported as a surgical wound 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.

Examples - Identify "Present at the most recent SOC/ROC" to answer M1311 at Discharge

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 with intact skin 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. (In this example, there are no other pressure ulcers/injuries at the SOC assessment, during the episode or at discharge).
   - **Coding:** On the discharge assessment, M1311B1, Number of Stage 3 pressure ulcers, would be coded "1". M1311B2, Number of these 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". (Skip M1311F2).
   - **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 observed on the discharge skin assessment 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.
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 Stage 4 at 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". (Skip M1311F2).

- **Rationale:** The DTI with intact skin observed on the SOC skin assessment first became numerically stageable as 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."

3. Deep Tissue Injury (DTI) with intact skin at SOC, becomes numerically stageable, then is unstageable due to slough and/or eschar at discharge

   The RN assesses a patient's skin during the assessment timeframe for the SOC and identifies a DTI with intact skin on the patient's right heel. This DTI first becomes numerically stageable at the third home visit, as a Stage 3 pressure ulcer. At the discharge skin assessment, this pressure ulcer is unstageable due to slough and eschar.

   - **Coding:** On the discharge assessment, M1311E1, Number of unstageable pressure ulcers due to slough and/or eschar, would be coded "1". M1311E2, Number of these unstageable 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". (Skip M1311F2).
   - **Rationale:** The DTI with intact skin observed on the SOC skin assessment first became stageable as a Stage 3 pressure ulcer. This ulcer did not remain Stage 3, however. At the discharge skin assessment, the ulcer was unstageable due to slough and eschar. Any pressure ulcer/injury that is unstageable due to slough and/or eschar at discharge, but was previously numerically stageable, is considered new, and not coded as "present at the most recent SOC/ROC."

M1322: Current Number of Stage 1 Pressure Injuries

M1322. Current Number of Stage 1 Pressure Injuries 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 ☐	0. **Zero** 1. **One** 2. **Two** 3. **Three** 4. **Four or more**

Item Intent

Identifies the presence and number of Stage 1 pressure injuries.

DEFINITION	**STAGE 1 PRESSURE INJURY** An observable, pressure-related alteration of intact skin whose indicators, as compared with an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin. In darker skin tones, the injury may appear with persistent red, blue, or purple hues.

Item Rationale

- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.

- Development of a Stage 1 pressure injury is one of multiple factors that should lead providers to initiate pressure ulcer/injury prevention interventions.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Staging of a pressure ulcer/injury should be determined by physical assessment and observation. Medical records, patient/caregiver report and physician/allowed practitioner input may be used for historical purposes only to identify the presence of an existing ulcer/injury or the stage of a previously healed pressure ulcer.
- Review the history of each pressure ulcer/injury in the clinical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, as long as it remains stageable, it should continue to be classified at the higher numerical stage until healed.
- Recognize that although Stage 1 pressure injuries are closed (intact skin), they would not be considered healed.

Coding Instructions

- **Enter the number** of Stage 1 pressure injuries present at the first skin assessment completed at the SOC/ROC.
- **Dash is not** a valid response for this item.

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**

Item Intent

Identifies the stage of the most problematic unhealed stageable pressure ulcer/injury.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Staging of a pressure ulcer/injury should be determined by physical assessment and observation. Medical

records, patient/caregiver report and physician input may be used for historical purposes only to identify the presence of an existing ulcer/injury or the stage of a previously healed pressure ulcer.

- Review the history of each pressure ulcer/injury in the clinical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, as long as it remains stageable, it should continue to be classified at the higher numerical stage until healed.

Coding Instructions

- **Enter the response** that most accurately describes the stage of the most problematic unhealed stageable pressure ulcer/injury.
  - **Step 1:** Determine which pressure ulcer(s)/injury(injuries) are stageable or unstageable. Definitions of pressure ulcer/injury stages are in guidance for M1311, Current Number of Unhealed Pressure Ulcers/Injuries. A pressure ulcer/injury is considered unstageable if:
    - It is covered with a non-removable dressing/device, such as a cast, that cannot be removed.
    - The wound bed is obscured by some degree of necrotic tissue AND no bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible. Note that if a Stage 4 structure is visible, the pressure ulcer is reportable as a Stage 4 even if slough or eschar is present.
    - It presents as a deep tissue injury.
  - **Step 2:** Determine which stageable pressure ulcer/injury is the most problematic.
    - "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.
    - If the patient has only one stageable pressure ulcer, then that ulcer is the most problematic.
- Enter "NA" if the patient has NO pressure ulcers or only has pressure ulcers that are unstageable at the time of the assessment.
- Stage 1 pressure injuries, although closed (intact skin), would not be considered healed.
- **Dash is not** a valid response for this item.

Coding Tips

- Pressure ulcers/injuries that have healed are not considered for this item.
- 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. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Unless it becomes unstageable, clinical standards require that a Stage 4 pressure ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.
  - If a pressure ulcer is Stage 4 at SOC and is granulating at the next assessment, the ulcer remains a Stage 4 ulcer.

M1330: Does this patient have a Stasis Ulcer?

M1330. Does this patient have a Stasis Ulcer?	
Enter Code ☐	0. **No** → *Skip to M1340, Surgical Wound* 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) → *Skip to M1340, Surgical Wound*

Item Intent

Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Physical assessment and observation are the preferred approach to determine the presence of stasis ulcers. Patient/caregiver report, medical records including physician/allowed practitioner orders and input may be used.
- It is important to differentiate stasis ulcers from other types of skin lesions, and only report stasis ulcers in this item.
- Stasis ulcers DO NOT include arterial lesions or arterial ulcers.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.
- 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.

Coding Instructions

- **Code 1, Yes,** if patient has BOTH observable and unobservable stasis ulcers.
- **Code 2, Yes,** if the patient has *observable* stasis ulcers ONLY.
- **Code 3, Yes,** if the patient has unobservable stasis ulcers ONLY.
- **Dash is not** a valid response for this item.

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

M1332. Current Number of Stasis Ulcer(s) that are Observable	
Enter Code ☐	1. One 2. Two 3. Three 4. Four or more

Item Intent

Identifies the number of visible (observable) stasis ulcers.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Physical assessment and observation are the preferred approach to determine the presence of stasis ulcers. Patient/caregiver report, medical records including physician/allowed practitioner orders and input may be used.
- All stasis ulcers except those that are covered by a non-removable dressing/device, such as a cast or Unna boot, are considered observable.
- **Dash is not** a valid response for this item.

M1334: Status of Most Problematic Stasis 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

Item Intent

- Identifies the degree of healing present in the most problematic, observable stasis ulcer.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Physical assessment and observation are the preferred approach to determine the presence of stasis ulcers. Patient/caregiver report, medical records, including physician/allowed practitioner orders and input may be used.

- Determine which stasis ulcers are observable. Include all stasis ulcers that are not covered with a non-removable dressing/device, such as a cast or Unna boot.
- If the patient has only one observable stasis ulcer, that ulcer is the most problematic.
- "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)
- Once a stasis ulcer has completely epithelialized and is without signs/symptoms of infection, it is considered healed and should not be reported as a current stasis ulcer.

Coding Instructions

- **Code 1, Fully Granulating,** when the stasis ulcer wound bed has all the following characteristics:
  - is filled with granulation tissue to the level of the surrounding skin or new epithelium.
  - has no dead space.
  - has no avascular tissue.
  - has no signs or symptoms of infection.
  - has open wound edges.
- **Code 2, Early/Partial Granulation,** when the stasis ulcer wound bed has all the following characteristics:
  - ≥ 25% of the wound bed is covered with granulation tissue.
  - there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue).
  - may have dead space.
  - has no signs or symptoms of infection. has open wound edges.
- **Code 3, Not Healing,** when the stasis ulcer wound bed has any of the following characteristics:
  - ≥25% of the wound bed is avascular tissue.
  - signs/symptoms of infection are present.
  - the wound bed is clean but non-granulating.
  - the wound edges are closed/hyperkeratotic.
  - there is persistent failure to improve despite appropriate comprehensive wound management.
- **Dash is not** a valid response for this item.

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*

Item Intent

Identifies the presence of a wound resulting from a surgical procedure.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Physical assessment and observation are the preferred approach to determine the presence of surgical wounds. Patient/caregiver report, medical records, including physician/allowed practitioner orders and input may be used.
- The agency may use any skin assessment conducted during the assessment timeframe to code M1340.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item.
- Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.
- An incision line is considered a surgical wound. The staple or suture sites are not considered surgical wounds.

Coding Instructions

- **Code 1**, Yes, patient has at least one observable surgical wound, if the patient has at least one observable surgical wound
  - o If the patient has both an observable surgical wound, and a known but not observable surgical wound, Code 1, Yes.
- **Code 2, Surgical wound known but not observable** if the only surgical wound is not observable. A surgical wound is considered not observable when it is covered by a dressing/device, such as a cast, which is not to be removed per physician order.
- **Dash is not** a valid response for this item.

Coding Tips

- If a pressure ulcer is surgically closed with a flap or graft it is no longer reported as a pressure ulcer. It should be reported as a surgical wound until healed. If the flap or graft fails, it should continue to be considered a

surgical wound until healed.

- A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound. A bowel ostomy being allowed to close on its own is excluded as a surgical wound.
- All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds.
  - There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. Examples include cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc.
- Other examples of surgical wounds include, but are not limited to:
  - Orthopedic pin sites,
  - Central line sites (centrally inserted venous catheters),
  - Wounds with drains,
  - Medi-port sites and other implanted infusion devices, or
  - Venous access devices
- A PICC line (peripherally inserted venous catheter), either tunneled or non-tunneled, is NOT a surgical wound, when it is peripherally inserted.
- Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach do NOT create a surgical wound for the purpose of this item.

M1342: Status of Most Problematic Surgical Wound that is Observable

M1342. Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0. Newly epithelialized 1. Fully granulating 2. Early/partial granulation 3. Not healing

Item Intent

Identifies the degree of healing present in the most problematic, observable surgical wound.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Physical assessment and observation are the preferred approach to determine the presence of surgical wounds. Patient/caregiver report, medical records, including physician/allowed practitioner orders and input may be used.
- Determine which surgical wounds (as defined in M1340 guidance) are observable.

- Identify the most problematic observable surgical wound.
- If the patient has only one observable surgical wound, that wound is the most problematic.
- "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 a surgical wound that is infected or resistant to treatment
  - Size (may be the largest surgical wound)
  - Location (may be difficult to access for treatment)

Surgical Wound Assessment

- The clinician must first assess if the wound is healing entirely by primary intention (well-approximated with no dehiscence), or if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing). For surgical wounds healing by primary intention, observe if the incision line has re-epithelialized.
- 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"
  - A surgical incision is not automatically coded Response 3 – "Not healing" solely due to the presence of staples.
- For a surgical wound healing by primary intention, if there is not full re-epithelialization, such as in the case of a scab adhering to underlying tissue, the correct response is Response 3 – "Not healing"

DEFINITION	**EPITHELIALIZATION** Regeneration of the epidermis across a wound surface. • Epithelialization is characterized by "epidermal resurfacing" meaning the opening created during the surgery is covered by epithelial cells. • If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.

- Surgical wounds with incisional separation heal by secondary intention.
- Surgical incisions healing by secondary intention do granulate; therefore, in addition to meeting the definition for 0 – Newly epithelialized or 3 – Not healing, these secondary intention wounds may also fit the definitions for Response 1 – "Fully granulating" or Response 2 – "Early, partial granulation" if appropriate.
- If complete epidermal resurfacing of a surgical wound has occurred, the correct response is Response 0 - "Newly epithelialized" until approximately 30 days have passed without complication, at which time it is no longer a reportable surgical wound.

Coding Instructions

- **Code 0, Newly epithelialized,** when one or both of these are true:
  - the wound bed is completely covered with new epithelium; no exudate; no avascular tissue (eschar and/or slough); no signs or symptoms of infection.
  - the incision site of an implanted venous access device or infusion device is healed and without signs and symptoms of infection.

- **Code 1, Fully granulating,** when all the following are true:
  - the wound bed is filled with granulation tissue to the level of the surrounding skin and
  - has no dead space,
  - has no avascular tissue,
  - has no signs or symptoms of infection,
  - has open wound edges.
- **Code 2, Early/partial granulation**, when all the following are true:
  - ≥25% of the wound bed is covered with granulation tissue,
  - < 25% of the wound bed is covered with avascular tissue,
  - may have dead space,
  - wound bed has no signs or symptoms of infection,
  - wound has open edges.
- **Code 3, Not healing,** when any of the following are true:
  - The wound bed has ≥25% avascular tissue.
  - signs/symptoms of infection.
  - the wound bed is clean but non-granulating.
  - wound edges are closed/hyperkeratotic.
  - persistent failure to improve despite appropriate comprehensive wound management.
  - **Dash is not** a valid response for this item.

SECTION N: MEDICATIONS

Introduction

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 has been educated about the high-risk medications.
- a drug regimen review was conducted.
- the patient can manage oral and injectable medications.

N0415: High-Risk Drug Classes: Use and Indication

SOC/ROC and Discharge		
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**	☐	

Item Intent

This item identifies if the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Item Rationale

Patients who take medications in these high-risk drug classes are at risk for side effects that can adversely affect health, safety, and quality of life.

DEFINITION	**ADVERSE DRUG REACTION** Adverse drug reaction (ADR) is a form of an adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR. However, side effects are but one of five ADR categories, the others being: hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Data sources/resources include medical records received from facilities where the patient received health care, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
    - Discussions (including with the acute care hospital, other staff and clinicians, the patient, and the patient's family/significant other) may supplement and/or clarify the information gleaned from the patient's medical records.

DEFINITION	**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.

Coding Instructions

- Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1).
- If Column 1 is checked (patient is taking medication in the drug class), review patient documentation to determine if there is a documented patient-specific indication noted for all medications in the drug class (Column 2).
- Code medications according to the medication's therapeutic category and/or pharmacological classification, regardless of why the patient is taking it.
- Code a medication that is part of a patient's current reconciled drug regimen, even if it was not taken on the day of assessment.
- At discharge, N0415 identifies medications included in the patient's prescribed drug regimen at discharge, even if the medication was not taken on the day of assessment, and whether it is expected to be taken after discharge.

- 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.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- 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.
- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly only if they are part of the current reconciled drug regimen at the time of assessment.
- Include newly prescribed medications that are part of the current drug regimen, even if the medication is not yet in the home and/or the first dose has not been taken.
- A transdermal patch is designed to release medication over time (typically 3–5 days).
- Therefore, transdermal patches would be considered long-acting medications for the purpose of coding the OASIS and are included if it is part of the patient's current drug regimen.
- 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 N0415I, Antiplatelet, Column 1 – Is Taking would be checked, regardless of why the medication is being used.
- Herbal and alternative medicine products are considered dietary supplements by the Food and Drug Administration (FDA). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root) for N0415.
- CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification.
- 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.

Examples

1. The documentation for a patient reflects that (at SOC) they are taking edoxaban and glipizide. The documentation indicates the patient has type 2 diabetes and is taking the glipizide to control high blood sugar. There is no indication documented for the edoxaban.

- **Coding:** Medications in N0415 would be coded as follows: Column 1 (is taking) would be checked for E. Anticoagulant and J. Hypoglycemic. Column 2 (Indication noted) would be checked only for J. Hypoglycemic.
- **Rationale:** Column 2 would not be checked for E. Anticoagulant because there was no indication documented for the edoxaban.

2. At discharge, a patient's documentation indicates they are taking oxycodone for pain. Tramadol is also listed but there is no indication documented for the Tramadol.
   - **Coding:** Medications in N0415 would be coded as follows: Column 1 (is taking) would be checked for H. Opioid. Column 2 (Indication noted) would not be checked for H. Opioid.
   - **Rationale:** Column 1, H. Opioid is checked because the patient is taking oxycodone and tramadol, both medications within that class. However, all medications in the class need the indication to be documented to check Column 2.

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*

Item Intent

Identifies if a drug regimen review was conducted, and whether any potential or actual clinically significant medication issues were found.

DEFINITION	**DRUG REGIMEN REVIEW** The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

Item Rationale

- Potential and actual patient medication adverse consequences and errors are prevalent among post-acute care (PAC) settings and often occur during transitions in care.
- Medication errors can lead to medication-related adverse reactions (adverse consequences related to medications may result in serious harm or death), emergency department visits, and re-hospitalizations, and affect the patient's health, safety, and quality of life.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Complete a drug regimen review as close to the actual time of SOC/ROC as possible.
- The drug regimen review includes all medications, prescribed and over the counter (OTC) including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route (for example, oral, topical, sublingual and by infusion). The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.
- Potential or actual clinically significant medication issues may include, but are not limited to, the following:
  - 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 (such as generic name and brand name equivalent drugs are both prescribed)
  - omissions (such as missing drugs from a prescribed regimen)
  - dosage errors (either too high or too low)
  - nonadherence (purposeful or accidental)
- Any of the circumstances listed above must reach a level of clinical significance that in the clinician's professional judgment warrants notification of the physician/allowed practitioner (or physician-designee) for orders or recommendations 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.

Coding Instructions

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.

- **Code 0, No – No issues found during review,** if a complete drug regimen review was conducted upon SOC/ROC and based on the assessing clinician's professional judgement, no potential or actual clinically significant issues were identified.
  - Examples may include, but are not limited to:
    - Patient's inpatient facility discharge medication list matches medications patient has on hand.
    - Patient has a plan for taking medications safely at the right time.
    - Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
    - The diagnoses/conditions for which the patient is taking the medications appear adequately controlled.

- **Code 1, Yes – Issues found during review,** if a complete drug regimen review is conducted upon SOC/ROC and based on the assessing clinician's professional judgment, potential or actual clinically significant medication issues are identified.
  - Examples may include, but are not limited to:
    - Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
    - Assessment shows that diagnoses/symptoms for which the patient is taking medications are NOT adequately controlled.
    - Patient seems confused about when/how to take medications indicating a high risk for medication errors.
    - Patient has not obtained medications or indicates that they will not take prescribed medications because of financial, access, cultural, or other issues with medications.
    - Patient has signs/symptoms that could be adverse reactions from medications.
    - Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications.
    - Patient has a complex medication plan with medications prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high.
- **Code 9, NA- Patient is not taking any medications,** if a drug regimen review was conducted at the time of the patient's SOC/ROC and, per data sources/resources reviewed, there were no medications prescribed for the patient and the patient was not taking any medications, by any route, at the time of the assessment.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.
  - If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash (–) should be reported, indicating the drug regimen review was not completed.

Coding Tips

- The drug regimen review is part of the comprehensive patient assessment. The comprehensive patient assessment is the responsibility of and must ultimately be completed by one clinician, but collaboration is allowed. Agency policy and practice will determine this process and how it is documented.
  - For example, for this drug regimen review item, collaboration in which the assessing clinician evaluates patient status (for example, presence of potential ineffective drug therapy or patient nonadherence), and another clinician (in the office) assists with review of the medication list (for example, possible duplicate drug therapy or omissions) is allowed.
- If portions of the drug regimen review (for example, identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the assessing clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2001 may be entered.
  - The M0090 Date Assessment Completed, is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.

Examples

1. **No issues identified,** During the comprehensive assessment visit, the PT reviews all the patient's medications and identifies no problems except that the patient's newly prescribed pain medication is not in the home. The patient's child states they were only going to pick it up from the pharmacy if "the pain got bad enough." The PT reviews the physician's instructions for the new medication with the patient and their child; they both agree the medication should be on hand, and to follow physician's instructions for administration. Prior to the PT leaving the home, the child went to the drugstore and returned with the medication.
   - **Coding:** M2001 would be coded 0, No – No issues found during review.
   - **Rationale:** Because the issue, in the PT's professional judgment, did not require physician (or physician-designee) contact by midnight of the next calendar day, at the latest to resolve, it does not meet the criteria for a potential or actual clinically significant medication issue.
2. Drug regimen review (DRR) not complete; use of the dash

   During the SOC comprehensive assessment, the nurse completes all elements of the DRR except for checking for drug-drug interactions.
   - **Coding:** M2001, enter a dash, "–"
   - **Rationale:** When any element is not assessed, the DRR is considered incomplete.

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

Item Intent

Identifies if potential or actual clinically significant medication issues identified through the drug regimen review were communicated to the physician/allowed practitioner (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

Item Rationale

- Integral to the process of safe medication administration practice is timely communication with physician/ allowed practitioner (or physician-designee) when a potential or actual clinically significant medication issue has been identified.
- Completion of physician/allowed practitioner (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues by midnight of the next calendar day at the latest reduces patient harm.

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.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Review the clinical record, communication notes, plan of care and medication list.
- Determine whether the following criteria were met for all potential and actual clinically significant medication issues that were identified during the SOC/ROC drug regimen review:
  - Two-way communication between the agency and the physician/allowed practitioner (or physician-designee) was completed by midnight of the next calendar day; AND
  - All physician/allowed practitioner (or physician-designee) prescribed/recommended actions were completed to the extent possible by midnight of the next calendar day.
- For each potential or actual clinically significant medication issue identified during the SOC/ROC comprehensive assessment, identify if the physician/allowed practitioner (or physician-designee) was contacted, and prescribed/recommended actions were completed, to the extent possible, by midnight of the next calendar day (at the latest).
  - Examples of by midnight of the next calendar day:
    - A clinically significant medication issue is identified at 10:00 AM on February 12th and
    - physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on February 13th.
    - A clinically significant medication issue is identified at 10:00 PM on February 12th physician
    - (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on February 13th.

Coding Instructions

- **Code 0, No**, if all identified potential or actual clinically significant medication issues were not communicated to the physician/allowed practitioner (or physician designee), with prescribed/recommended actions completed to the extent possible by midnight of the next calendar day.
  - Examples:
    - The clinician did not communicate all identified clinically significant medication issues to the physician/allowed practitioner (or physician-designee) until after midnight of the next calendar day.
    - The clinician communicated all identified clinically significant medication issues to the physician/allowed practitioner (or physician-designee) by midnight of the next calendar day, but the clinician did not receive a response from the physician/allowed practitioner (or physician-designee) to communicate prescribed/ recommended actions until after midnight of the next calendar day.

  - The clinician did not complete all physician/allowed practitioner (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).

- **Code 1, Yes,** if the two-way communication AND completion of the prescribed/recommended actions to the extent possible occurred by midnight of the next calendar day after the potential (or actual) clinically significant medication issue was identified.
  - Examples:
    - Clinician communicated all identified clinically significant medication issues to the physician/allowed practitioner (or physician-designee), and all physician/allowed practitioner (or physician-designee) prescribed/recommended actions for all identified medication issues were completed by midnight of the next calendar day.
    - Clinician contacted the physician/allowed practitioner (or physician-designee) regarding all identified medication issues; and the physician/allowed practitioner (or physician-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.
  - **Dash** is a valid response for this item.
    - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Tips

- If the physician/allowed practitioner (or physician-designee) recommends an action that will take longer than the allowed time to complete, then **Code 1, Yes** should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.
  - Example of a physician/allowed practitioner (or physician-designee) recommended action that would take longer than midnight of the next calendar day to complete:
    - Physician/allowed practitioner (or physician-designee) writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of by **midnight of the next calendar day**:
    - A clinically significant medication issue was identified at 10:00am on Sept 12. The physician/allowed practitioner (or physician-designee)-prescribed/-recommended action is completed on or before 11:59pm on Sept 13.
    - A clinically significant medication issue was identified at 11:00pm on Sept 12. The physician/allowed practitioner (or physician-designee)-prescribed/-recommended action is completed on or before 11:59pm on Sept 13.

Examples

1. **Clinically significant medication issue identified, with follow-up,** During the SOC comprehensive assessment visit, the RN completes a drug regimen review and identifies that the patient is taking two antihypertensives; one which was newly prescribed during their recent hospital stay, and another that they were taking prior to hospitalization. During the home visit, the RN contacts the physician's office, and leaves a message with office staff providing notification of the potential duplicative drug therapy and a request for clarification. The next day, the RN returns to the home to complete the comprehensive assessment and again contacts the physician from the patient's home. The physician's office nurse reports to the agency and patient

that the physician would like the patient to continue with only the newly prescribed antihypertensive and discontinue the previous medication.

- **Coding:** M2001, Drug Regimen Review, would be coded 1, Yes, Issues found during review. M2003, Medication Follow-up, would be coded 1, Yes.
- **Rationale:** Because the issue identified was determined by the clinician to be clinically significant, requiring physician contact by midnight of the next calendar day, it meets the criteria for a potential clinically significant medication issue (M2001). As the clinically significant issue was communicated to the physician and the prescribed/recommended action was completed by midnight of the next calendar day, M2003 would be coded 1 – Yes.

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

Item Intent

Identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician/allowed practitioner (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

Item Rationale

Potential or actual clinically significant medication issues can occur throughout the patient's home health stay.

Time Points Item(s) Completed

- Transfer
- Death at Home
- Discharge from agency

Response-Specific Instructions

- To complete M2005, the assessing clinician (alone or in collaboration with other agency staff) reviews the patient's clinical record back to and including the most recent SOC/ROC, to determine if for each clinically significant medication issue identified, communication occurred and, to the extent possible, physician/allowed practitioner (or physician-designee) prescribed or recommended actions were completed by midnight of the next calendar day.
- Potential or actual clinically significant medication issues may include, but are not limited to, the following:
  - 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 (such as generic name and brand name equivalent drugs are both prescribed)
- omissions (such as missing drugs from a prescribed regimen)
- dosage errors (either too high or too low)
- nonadherence (purposeful or accidental)

Coding Instructions

- **Code 0, No,** if all clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were not communicated to the physician/allowed practitioner (or physician-designee) and/or all prescribed/recommended actions were not completed, to the extent possible, by midnight of the next calendar day.
  - Examples:
    - At the time of or at any time since the most recent SOC/ROC, the clinician(s) did not communicate all identified potential or actual clinically significant medication issues to the physician until after midnight of the next calendar day.
    - At the time of or at any time since the most recent SOC/ROC, the clinician(s) communicated to the physician/allowed practitioner (or physician-designee) all identified potential or actual clinically significant medication issues, but the physician/allowed practitioner (or physician-designee) did not respond until after midnight of the next calendar day.
    - At the time of or at any time since the most recent SOC/ROC, the clinician(s) did not complete all physician/allowed practitioner (or physician-designee) prescribed/recommended actions to the extent possible for all identified potential or actual clinically significant medication issues by midnight of the next calendar day.
- **Code 1, Yes,** if all clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician/allowed practitioner (or physician-designee) and all prescribed/recommended actions were completed, to the extent possible, by midnight of the next calendar day each time a potential (or actual) clinically significant issue was identified.
  - Examples:
    - At the most recent SOC/ROC and throughout the quality episode, the clinician(s) communicated all identified clinically significant medication issues to the physician/allowed practitioner (or physician-designee), and all physician/allowed practitioner (or physician-designee) prescribed/recommended actions for the identified issues were completed by midnight of the next calendar day.
    - At the most recent SOC/ROC and throughout the quality episode, the clinician(s) contacted the physician/allowed practitioner (or physician-designee) regarding all identified potential or actual clinically significant medication issues, and the physician/allowed practitioner (or physician-designee) communicated to the clinician(s) that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.
- **Code 9, NA,** if there were no potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC, or if the patient is not taking any medications at the time of or at any time since the most recent SOC/ROC.
- **Dash** is a valid response for this item.
  - A dash indicates “no information.” CMS expects dash use to be a rare occurrence.

Coding Tips

- If the physician/allowed practitioner (or physician-designee) prescribed/recommended action will take longer than midnight of the next calendar day to complete, then code 1, Yes, should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.
  - Example of a physician/allowed practitioner (or physician-designee) recommended action that would take longer than midnight of the next calendar day to complete:
    - The physician/allowed practitioner (or physician-designee) writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of by **midnight of the next calendar day:**
    - A clinically significant medication issue is identified at 10:00 AM on February 12th. Communication occurs and the physician/allowed practitioner (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on February 13th.
    - A clinically significant medication issue was identified at 10:00 PM on February 12th. Communication occurs and the physician/allowed practitioner (or physician-designee) prescribed/recommended action is completed on or before 11:59 PM on February 13th.

Examples

1. **No clinically significant medication issues identified throughout the episode,** During the Discharge assessment visit, the RN reviews the patient's medication list and confirms that no potential (or actual) clinically significant medication issues are present. In reviewing the clinical record, there is documentation that a drug regimen review was conducted at SOC, and no potential (or actual) clinically significant medication issues were identified. There is no other documentation to indicate that potential or actual clinically significant medication issues occurred during the episode of care.
   - **Coding:** M2005: ENTER Response 9 (NA) – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications.
   - **Rationale:** This item is reported as NA because there is documentation that the agency looked for potential clinically significant medication issues via completion of a drug regimen review and that no potential or actual clinically significant medication issues were identified at any time during the episode, from SOC through Discharge.
2. **Clinically significant medication issue identified, late follow-up,** During the SOC comprehensive assessment, the RN completes the drug regimen review and identifies a potential clinically significant medication issue. On that day of admission, the RN calls and leaves a message with the physician's office related to the medication issue. The physician does not return their call until after midnight of the next calendar day. No other medication issues arise during the episode, and the patient is discharged from home health.
   - **Coding:**
     - At SOC:
       - M2001: ENTER Response 1 – Yes – Issues found during review.
       - M2003: ENTER Response 0 – No.
     - At DC:
       - M2005: ENTER Response 0 – No.

- **Rationale:** Because an identified issue was determined by the clinician to be clinically significant, warranting physician contact by midnight of the next calendar day, it meets the criteria for a clinically significant medication issue (1 – Yes for M2001). However, the clinician-initiated communication with the physician, the required two-way communication, did not occur until after midnight of the next calendar day, resulting in 0 – No responses for M2003 and M2005.

M2010: Patient/Caregiver High-Risk Drug Education

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

Item Intent

Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Review the clinical record, communication notes, medication list, plan of care, documentation of other agency staff responsible for educating patient/caregivers on medications. High-risk medications should be identified based on one or more authoritative sources (e.g., the Institute for Safe Medication Practices, the American Geriatrics Society, and The Joint Commission) and would be identified from medications included on the patient's reconciled medication profile.
- High-risk medications are those identified by an authoritative source as having considerable potential for causing significant patient harm when they are used erroneously.
- If agency staff other than the clinician responsible for completing the SOC/ROC provided high-risk medication education to the patient/caregiver, this information may be communicated to the assessing clinician for consideration in completing the SOC/ROC OASIS assessment. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of and ultimately must be completed by one clinician.
- Links to resources for identifying high-risk medications can be found in Appendix E of this manual.

Coding Instructions

- **Code 0, No,** if the interventions are not completed as outlined in this item.
- **Code 1, Yes,** if high-risk medications are prescribed and education was provided.
- **Code NA,** if patient/caregiver is fully knowledgeable about special precautions associated with all high-risk medications in their medication profile, or if there are no high-risk drugs in their medication profile.
- **Dash is not** a valid response for this item.

M2020: Management of Oral Medications

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

Item Intent

This item is intended to identify the patient's ability to prepare and take all oral (p.o.) medications reliably and safely on the day of the assessment.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- Observation/demonstration is the preferred method, followed by patient/caregiver interview, and review of the referral information.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited manual dexterity),
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear),
  - sensory impairments (for example, impaired vision, pain),
  - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).
- Includes all prescribed and OTC (over the counter) p.o. medications that the patient is currently taking and are included on the Plan of Care.
- Excludes topical, injectable, and IV medications.
- Only medications whose route of administration is p.o. should be considered for this item. Medications are p.o. if they are placed in the mouth and swallowed, with absorption occurring through the gastrointestinal system. Medications administered by other routes, including sublingual, buccal, swish and expectorate, or administered per gastrostomy (or other) tube are not to be considered for this item.

- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times.
- If the patient's ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- If an oral medication is ordered PRN and the medication is needed by the patient on the day of assessment – and the patient needed a reminder to take this PRN medication on the day of assessment, **Code 2**, Able to take medication(s) at the correct times if given reminders by another person at the appropriate times. If the patient did not need any PRN oral medications on the day of assessment and therefore no reminders were necessary, assess the patient's ability based on all of the medications scheduled to be taken on the day of assessment.

Coding Instructions

- **Code 0, Able to independently,** if the patient is able to manage all oral medications without assistance. This includes if the patient sets up a their own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of using this device.
- **Code 1, Able to take medication(s) correctly,** if the patient is able to take their oral medication(s) but:
  - another person must prepare individual doses in advance (for example, place medications in a medi-planner or other device),
  - and/or another person in the home must modify the original medication container to enable patient access (for example, removing childproof lids, marking labels for the visually impaired or those who cannot read),
  - and/or someone in the home must develop a drug diary or chart which the patient relies on to take medications appropriately.
- **Code 2, Able to take medication(s) at correct times if given reminders,** if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (for example, setting up a "planner device") and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently set up and manage are not considered "assistance" or "reminders.").
- **Code 3, Unable to take medication unless administered by another person,** if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established that set up, diary, or reminders have already been or will be successful. The clinician would need to return to assess if the new interventions, such as reminders or a med planner, provided adequate support for the patient to take all medications safely.
- **Dash is not** a valid response for this item.

Coding Tips

- For a patient who resides in a facility, such as an assisted living facility (ALF), where the facility holds or locks up the patient's medications:
  - Report the patient's ability to take the correct oral medication(s) including proper dosage(s) reliably and safely at the correct times.

- Determine ability based on observation and assessment of the complexity of the patient's drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity, and general mobility.
- Assessment includes consideration of whether a patient:
  - can get to the location where the medications are routinely stored at the correct times,
  - can recognize the correct medication dose(s) and take their oral medications, recognizing that someone would need to make the medication available to the patient once they are at the location (e.g., nursing office or medication cart)
- Select response 0, 1, 2 or 3 depending on the level and timing of assistance required on the day of assessment to allow the patient to take the correct dose(s) of all oral medications reliably and safely at the correct times.

M2030: Management of Injectable Medications

M2030. Management of Injectable Medications Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the 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.

Item Intent

This item is intended to assess the patient's ability to take all injectable medications safely and reliably on the day of assessment.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care

Response-Specific Instructions

- Observation/demonstration is the preferred method, followed by patient/caregiver interview and review of the referral information.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited manual dexterity),
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear),
  - sensory impairments (for example, impaired vision, pain),

- environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorway.

- Excludes IV medications, infusions (for example, medications given via a pump), and medications given in the physician's office or other settings outside the home.
- Includes one-time injections administered in the home.
- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.
- If the patient's ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- PRN injectables, ordered and included on POC, are to be considered when determining the patient's ability to manage injectable medications. If the PRN medication was not needed during the assessment timeframe, use clinical judgment, and make an inference regarding the patient's ability by asking them to describe and demonstrate the steps for administration and needle disposal, considering the patient's cognitive and physical status as well as any other barriers.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Observe patient preparing injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

Coding Instructions

- **Code 0, Able to independently take the correct medication(s) and proper dosage(s) at the correct times if** the patient is able to manage all injectable medications without assistance. This includes if the patient sets up their own individual doses and is able to take the correct medication(s) in the correct dosage(s) at the correct time as a result of this.
- **Code 1, Able to take injectable medication(s) at the correct times** if, the patient is able to administer their injectable medication(s) but:
  - another person must prepare syringes/individual doses in advance,
  - and/or another person in the home must modify the original medication container in advance to enable patient access (for example marking labels for the visually impaired or those who cannot read),
  - and/or if another person must develop a drug diary or chart which the patient relies on to take medications appropriately.
- **Code 2, Able to take medication(s) at the correct time if given reminders by another person,** if reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- **Code 3, Unable to take injectable medication unless administered by another person, if:**

- The patient does not have the physical or cognitive ability on the day of assessment to take all injectable medications correctly (right medication, right dose, right time) as ordered, or
- Even with reminder the patient requires assistance administering their injectable medication(s), or
- The physician ordered the RN to administer an injection in the home.

- **Dash is not** a valid response for this item.

Coding Tips

- For a patient residing in a facility, such as an assisted living facility (ALF), where the facility holds or locks up the patient's medications.
  - Report the patient's ability to administer all injectable medication(s) and proper dosage(s) reliably and safely at the correct times.
  - Determine ability based on observation, an assessment of the complexity of the patient's drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity, and general mobility.
  - Assessment includes consideration of whether a patient:
    - Can get to the location where the medications are routinely stored at the correct times.
    - Can recognize the correct medications dose(s) and administer their injectable medications, recognizing that someone would need to make the medications available to the patient once they are at the location (e.g., nursing office or medication cart).
  - Select response 0, 1, 2, or 3 depending on the level and timing of assistance required on the day of assessment to allow the patient to take the correct dose(s) of all injectable medications reliably and safely at the correct times.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

O0110: Special Treatments, Procedures, and Programs

SOC/ROC	
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	☐

Discharge	
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on discharge.	c. At Discharge 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	☐

Item Intent

The intent of the item is to identify any special treatments, procedures, and programs that apply to the patient.

Item Rationale

The treatments, procedures, and programs listed can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

Time Points Item(s) Completed

- Start of Care
- Resumption of Care
- Discharge from agency

Response-Specific Instructions

- 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).
- 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.
- Include treatments, programs and procedures performed by others and those the patient performed themselves independently or after set-up by agency staff or family/caregivers.
- Check treatments, procedures and programs that are performed in the patient's home, or in other settings (e.g., dialysis performed in a dialysis center).
- Do not check services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications. Surgical procedures include routine pre- and post-operative
- procedures.
- For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment at the time of assessment.

Coding Instructions

- Check each type of treatment, procedure, or program that applies.
- **Code O0110A1, Chemotherapy,** if any type of chemotherapy medication administered as an antineoplastic for cancer treatment given by any route in this item.
  - **Code O0110A2, Chemotherapy, IV,** if chemotherapy administered intravenously.
  - **Code O0110A3, Chemotherapy, Oral,** if chemotherapy administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered enterally (e.g., feeding tube/PEG).
  - **Code O0110A10, Chemotherapy, Other,** if chemotherapy administered in a way other than intravenously, enterally, or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).
- **Code O0110B1, Radiation,** if radiation is administered intermittently or via radiation implant in this item.
- **Code O0110C1, Oxygen Therapy,** if continuous or intermittent oxygen is used via mask, cannula, etc., including in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP). Do not include hyperbaric oxygen for wound therapy in this item.
  - **Code O0110C2, Oxygen Therapy, Continuous,** if oxygen therapy is continuously delivered for ≥ 14 hours per day.

- **Code O0110C3, Oxygen Therapy, Intermittent,** if oxygen therapy is delivered intermittently (< 14 hours continuously).
- **Code O0110C4, Oxygen Therapy, High concentration,** if oxygen is delivered via a high-concentration delivery system at a concentration that exceeds FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flowrate of 4 liters per minute).
  - A high-concentration delivery system can include either high or low-flow systems (e.g., simple face masks, partial and non-rebreather masks, face tents, venturi masks, aerosol masks, high-flow cannula, or masks).
  - These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%.
  - Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO2 greater than 40%.

- **Code O0110D1, Suctioning,** only if tracheal and/or nasopharyngeal suctioning is performed. Do not include oral suctioning here. This item may also be checked if the patient performs their own tracheal and/or pharyngeal suctioning.
  - **Code O0110D2, Suctioning, Scheduled,** if suctioning is scheduled. Scheduled suctioning is performed when the patient is assessed to clinically benefit from regular interventions, such as every hour. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of agency-based clinical standards, protocols, and guidelines.
  - **Code O0110D3, Suctioning, As needed,** if suctioning is performed on an as needed basis, as opposed to regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted, or a sudden desaturation occurs from a mucus plug.
- **Code O0110E1, Tracheostomy care,** if cleansing of the tracheostomy and/or cannula is performed and/or if care to the tracheostomy/stoma is part of the current care/treatment plan, even after decannulation. This item may also be checked if the patient performs their own tracheostomy/stoma care or receives assistance.
  - This item also includes laryngectomy care.
- **Code O0110F1, Invasive Mechanical Ventilator (ventilator or respirator),** if any type of electrically or pneumatically powered closed-system mechanical ventilator support device is used that ensures adequate ventilation in the patient who is or who may become (such as during weaning attempts) unable to support their own respiration.
- **Code O0110G1, Non-Invasive Mechanical Ventilator,** 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. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration. 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
  - **Code O0110G2, BiPAP,** if the non-invasive mechanical ventilator support was BiPAP.
  - **Code O0110G3, CPAP,** if the non-invasive mechanical ventilator support was CPAP.
- **Code O0110H1, IV medications,** if any medication or biological is given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. This response includes IV fluids containing medications. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently, and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during

dialysis or chemotherapy.

- **Code O0110H2, Vasoactive medications,** if at least one of the IV medications was a vasoactive medication.
- **Code O0110H3, Antibiotics,** if at least one of the IV medications was an antibiotic.
- **Code O0110H4, Anticoagulation,** if at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.
- **Code O0110H10, Other,** if at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

- **Code O0110I1, Transfusions,** if any blood or any blood products (e.g., platelets, synthetic blood products), are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.
- **Code O0110J1, Dialysis,** if peritoneal or renal dialysis occurs in the home or at a facility. IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0520A (Parenteral/IV feeding), O0110H1 (IV medications), or O0110I1 (transfusions). This item is also checked if the patient performs their own dialysis.
  - **Code O0110J2, Hemodialysis,** if the dialysis was hemodialysis. In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.
  - **Code O0110J3, Peritoneal dialysis,** if the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) and serves as a filter to remove the waste products and excess fluid from the blood.
- **Code O0110O1, IV Access,** if a catheter is inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure. 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.
  - **Code O0110O2, Peripheral,** if IV access is peripheral access (catheter is placed in a peripheral vein) and remains peripheral.
  - **Code O0110O3, Midline,** if IV access is midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and do not reach all the way to a central vein such as the superior vena cava.
  - **Code O0110O4, Central (e.g., PICC, tunneled, port),** if IV access is centrally located (e.g., peripherally inserted central catheter [PICC], tunneled, port).
- **Code O0110Z1, None of the above,** if none of the above treatments, procedures, or programs apply.
- **Dash** is a valid response for this item.
  - A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Examples

1. The patient's referral information indicates that they were discharged from an acute care facility following an inpatient stay for bacterial pneumonia that required placement of a tracheostomy. At the start of care, the patient requires intermittent oxygen and assistance with trach care. Their tracheal suctioning needs are PRN. The patient has intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at a FiO2 of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.
   - **Coding:** Check boxes O0110C1 (Oxygen Therapy), O0110C3 (Intermittent), and O0110C4 (High concentration), O0100D1 (Suctioning) and O0110D3 (As Needed), O0110E1 (Tracheostomy Care), O0110H1 (IV Medications) and O0110H3 (Antibiotics), and O0110O1 (IV Access) and O0110O4 (Central).
   - **Rationale:** The patient is receiving intermittent oxygen, high-concentration oxygen delivery, as needed suctioning, tracheostomy care, and IV antibiotics via a PICC line at start of care**.**
2. A patient has advanced prostate cancer and is receiving radiation and oral chemotherapy medication to treat the prostate cancer. They are being admitted today, following an inpatient stay for an acute pulmonary embolism. Their discharge orders include enoxaparin subcutaneously for continued anticoagulation. The patient does not have orders for other IV medications but still has a port in place.
   - **Coding:** Check boxes O0110A1 (Chemotherapy), O0110A3 (Chemotherapy, Oral), O0110B1 (Radiation), and O0110O1 (IV Access) and O0110O4 (Central).
   - **Rationale:** O0110H4 (Anticoagulation) is not checked because enoxaparin is administered subcutaneously, not intravenously. Even though the patient's port is not being accessed currently, they still have one and therefore O0110O1 (IV Access) and O0110O4 (Central) should be checked. The patient is also receiving oral chemotherapy and radiation so O0110A1 (Chemotherapy), O0110A3 (oral), and O0110B1 (Radiation) should be selected.
3. A patient has multiple myeloma and was discharged from an acute hospitalization after a pathologic vertebral fracture with significant pain. On admission to home health, referral documentation and physician orders include palliative radiation, lenalidomide orally for chemotherapy, and notes that frequent transfusions are required not related to the chemotherapy. They have a port for pamidronate infusions due to hypercalcemia.
   - **Coding:** Check boxes O0110A1 (Chemotherapy), O0110A3 (Oral), and O0110B1 (Radiation), O0110I1 (Transfusions), O0110H1 (IV Medications) and O0110H10 (Other) and O0110O1 (IV Access) and O0110O4 (Central).
   - **Rationale:** The patient is receiving oral chemotherapy (lenalidomide), radiation, transfusions, an IV medication (pamidronate), which falls under "other" IV medications, and has a port. The transfusions are noted to not be related to chemotherapy, and as such should be coded separately.
4. During the home health start of care assessment, the assessing clinician learns that a patient has sleep apnea and requires a CPAP device to be worn when sleeping. The patient's spouse sets up the humidifier element of the CPAP and the patient puts on the CPAP mask prior to falling asleep.
   - **Coding:** Check boxes O0110G1 (Non-invasive Mechanical Ventilator) and O0110G3 (CPAP).
   - **Rationale:** The patient is able to breathe on their own and wears the CPAP mask when sleeping to manage the sleep apnea.

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

Item Intent

Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 and March 31).

Time Points Item(s) Completed

- Transfer
- Discharge from agency

Response-Specific Instructions

- Review the clinical record to identify the date of the most recent SOC or ROC.
- A care episode is one that includes both SOC/ROC and Transfer/Discharge. Therefore, when completing this item at Transfer or Discharge, only go back to the most recent SOC or ROC to determine if the patient was receiving home health agency services on or between October 1 through March 31.

Coding Instructions

- **Code 0, No,** if no part of the care episode (from SOC/ROC to Transfer/Discharge) occurred during the time period from October 1 and March 31.
- **Code 1, Yes,** if part of the care episode (from SOC/ROC to Transfer/Discharge) occurred during the time period from October 1 and March 31.
- **Dash is not** a valid response for this item.

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.

Item Intent

For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year's flu season, and if not, the reason why.

Time Points Item(s) Completed

- Transfer
- Discharge from agency

Response-Specific Instructions

- Interview the patient and/or caregiver, review the clinical record, and/or ask the physician or other health care provider.
- Refer to the Centers for Disease Control and Prevention (CDC) website for detailed guidelines on the influenza vaccine, including information about medical contraindications (Response 5), age and condition guidelines (Response 6), and information regarding vaccine availability and potential shortages (Response 7). A link to CDC Guidelines can be found in Appendix E of this manual. It is the agency's responsibility to make current guidelines available to clinicians.

Coding Instructions

- **Code 1, Yes,** if your agency provided the influenza vaccine to the patient ***during this episode*** of care (SOC/ROC to Transfer/Discharge).
- **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.
- **Code 3, Yes,** if the patient or caregiver reports, or there is documentation in the clinical record, that the patient received the influenza vaccine for the current flu season ***from another provider.*** The provider can be the patient's physician, a clinic, or health fair providing influenza vaccines, etc.
- **Code 4, No,** if the patient and/or healthcare proxy (for example, someone with power of attorney) was offered the vaccine and refused. Note: It is not required that your agency offer the vaccine. Enter Response 4 only if the patient was offered the vaccine and it was refused.
- **Code 5, No,** if the influenza vaccine is contraindicated for medical reasons.
- **Code 6, No**, if the patient does not meet age/condition guidelines for the influenza vaccine.
- **Code 7, No,** only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- **Code 8, No,** if the patient did not receive the vaccine due to a reason other than Responses 4-7, including situations where the assessing clinician is unable to determine whether the patient received the influenza vaccine.
- **Dash is not** a valid response for this item.

Coding Tips

Codes 1, 2 or 3 may be entered even if the influenza vaccine for this year's flu season was provided prior to October 1 (that is, influenza vaccine was made available early).

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Introduction

This section includes one item to identify interventions that were included in the physician-ordered plan of care and implemented.

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.

Item Intent

Identifies if specific interventions were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided at the time of or at any time since the most recent SOC/ROC assessment.

Time Points Item(s) Completed

- Transfer
- Discharge from agency

Response-Specific Instructions

- First, review the physician's orders and the Plan of Care to identify if specific interventions are included.
- Then, determine if the interventions were implemented by reviewing the clinical record, including but not limited to the clinical assessments, and communication notes.
- Consider interventions implemented any time during the quality episode (at the time of, or at any time since the most recent SOC/ROC assessment, to the time the Discharge or Transfer assessment is completed).

DEFINITION	**STANDARDIZED VALIDATED ASSESSMENT/SCREENING TOOL** A tool that has: • Been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community dwelling elderly, noninstitutionalized adults with disabilities, etc.), and, • A standard response scale (for example, a scale where patients rate pain from 0-10). The standardized, validated tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond.

- The problem-specific interventions referenced in this item may or may not directly correlate with stated requirements in the Conditions of Participation.
- Interventions provided by home health agency staff, including the assessing clinician, 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. The M0090 - Date Assessment Completed should report the date the last information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.
- For row d, BOTH interventions (monitor and mitigate pain) must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected.

Coding Instructions

Enter one Code (Yes, No or Not Applicable) for each row: b, c, d, e, and f.

- **Code Yes,** if the physician-ordered Plan of Care includes the specified best practice interventions listed in each row, **AND** there is evidence of implementation in the clinical record, by the time the Discharge or Transfer assessment was completed.
    - Code "Yes" to M2401 b - e, if the specified clinical interventions were included in the physician ordered Plan of Care and implemented at the time of or at any time since the most recent SOC/ROC assessment whether or not a formal assessment was performed.
- **Code No,** if the interventions are not on the Plan of Care **OR** if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless "NA" applies.
- **Code NA,** according to the instructions in the last column of the item, for each row.

- **Dash is not** a valid response for this item.

Coding Tips

- Falls prevention interventions (Row b) may include, but are not limited to environmental modifications, strengthening exercises, and consultation with the physician regarding medication concerns.
- Interventions for depression (Row c) may include but are not limited to new medications, adjustments to already-prescribed medications, psychotherapy, or referrals to agency resources (for example, social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc.
- Interventions to monitor and mitigate pain (Row d) may include but are not limited to medication, massage, visualization, and biofeedback.
- Interventions to prevent pressure ulcers (Row e) may include but are not limited to teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc.
- Pressure ulcer treatments based on principles of moist wound healing (Row f) may include but are not limited to moisture retentive dressings.

APPENDIX A: GLOSSARY AND COMMON ACRONYMS

GLOSSARY

Term	Abbreviation	Definition
Activities of Daily Living	**ADLs**	Activities of daily living are those needed for self-care and include activities such as bathing, dressing, grooming, oral care, mobility (e.g., ambulation), toileting, eating, transferring, and communicating.
Active Diagnoses		Active diagnoses are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
Adequate Lighting		Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.
Assessment Timeframe		The maximum number of days allowed to complete the comprehensive assessment including OASIS (if applicable).
Assessing Clinician		The single person assuming responsibility for accurately completing and signing a comprehensive assessment.
Body Mass Index	**BMI**	Number calculated from a person's weight and height. BMI is a reliable indicator of body fat. BMI is used as a screening tool to identify possible weight problems for adults.
Brief Interview for Mental Status	**BIMS**	The BIMS is a structured cognitive interview.
Category Cue		Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the patient. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."
Code of Federal Regulations	**CFR**	A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government.
Collaboration		Data collection strategy allowing the assessing clinician to consider information from the patient, caregivers, and other healthcare personnel, including the physician, pharmacist and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to OASIS data collection.

Term	Abbreviation	Definition
Comprehensive Assessment		Assessment, review, and documentation of the patient's medical, rehabilitative, functional, cognitive, psychosocial and discharge planning status and needs. Includes a drug regimen review. Required for all patients in the Medicare certified Home Health Agency. Must include OASIS items for required patients.
Confusion Assessment Method	**CAM**	An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments. *Adapted from:* *Inouye, S.K., Van Dyck, C.H., Alessi, C.A., et al.: Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann. Intern. Med. 113(12):941- 948, 1990.*
Contact with Physician/allowed practitioner (or Physician- Designee)		Communication to the physician/allowed practitioner (or physician-designee) to convey an identified potential or actual clinically significant medication issue, AND a response from the physician/allowed practitioner (or physician-designee) to acknowledge receipt and/or convey prescribed/ recommended actions in response to the medication issue. Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician/allowed practitioner (or physician-designee), or indirectly through physician's office staff on behalf of the physician/allowed practitioner (or physician-designee), in accordance with the legal scope of practice.
Day of Assessment		The 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
Deep Tissue Injury	**DTI**	A purple or maroon localized area of discolored intact skin or blood- filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue

Term	Abbreviation	Definition
Delirium		A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.
Delusion		A fixed, false belief not shared by others that the patient holds even in the face of evidence to the contrary.
Discharge	**DC**	The assessment time point completed within 2 calendar days of the discharge date.
Disorganized Thinking		Having thoughts that are fragmented or not logically connected.
Dose		Total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24- hour period may be referred to as the "daily dose."
Drug Regimen Review	**DRR**	The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
Electronic Health Record/Electronic Medical Record	**EHR/EMR**	An electronic version of a patient's medical history that is maintained by the provider over time.
Epithelialization		Regeneration of the epidermis across a wound surface.
Eschar Tissue		Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

Term	Abbreviation	Definition
Fall		Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. A fall due to an overwhelming external force (e.g. a patient pushes another patient) would be considered a fall. An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered an intercepted fall. An exception would be, if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would be reported as both a fall and a major injury in M1033 - Risk for Hospitalization, J1800 - Any Falls Since SOC/ROC and J1900 - Number of Falls since SOC/ROC.
Feeding Tube		The presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.
Fluctuation		The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the assessment period. Fluctuating behavior may be noted by the assessing clinician, reported by staff or family, or documented in the medical record.
Follow-up (Recertification)		The assessment time point completed within the last 5 calendar days of every 60-day period
Follow-up (Other)		The assessment time point completed within 2 calendar days of identification of a significant change in patient's condition
Hallucination		A perception in a conscious and awake state, of something in the absence of external stimuli. May be auditory or visual or involve smells, tastes, or touch.

Health Information Exchange	**HIE**	An organization used by provider agencies to electronically exchange patients' health information, including medical records, current reconciled medication lists, etc.

Term	Abbreviation	Definition
Health Insurance Portability and Accountability Act of 1996	**HIPAA**	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.
Health Literacy		Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Hospice Services		A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.
Inattention		Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).
Initial Assessment		The visit used to determine the immediate care and support needs of the patient; and, for Medicare patients to determine eligibility for the Medicare Home Health benefit including homebound status.
Injury (Except Major)		Includes but is not limited to skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.
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.
International Classification of Diseases – 10 – Clinical Modification	**ICD-10-CM**	A morbidity classification published by the United States for classifying diagnoses and reasons for care in all health care settings. The ICD-10-CM is based on the ICD-10, the International Classification of Disease published by the World Health Organization (WHO).
Internet Quality Improvement and Evaluation System	**iQIES**	An internet-based system for state survey agency functions. This system replaces QIES, CASPER and ASPEN legacy systems. The system is used by providers and vendors to submit OASIS data.

Term	Abbreviation	Definition
Level of Consciousness		**Alert:** startles easily to any sound or touch. **Drowsy/Lethargic**: repeatedly dozes off when you are asking questions but responds to voice or touch. **Stuporous**: very difficult to arouse and keep aroused for the interview. **Comatose**: cannot be aroused despite shaking and shouting.
Major Injury		Includes but is not limited to traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries..
Means of Providing a Current Reconciled Medication List		Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record (EHR), giving providers
Mechanically Altered Diet		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.
Medicaid		A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.
Medicare		A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities. Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices. Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.
Medicare Beneficiary Identifier	**MBI**	CMS replacement for the Social Security number (SSN)-based Health Insurance Claim Number (HICN) for Medicare beneficiaries.

Term	Abbreviation	Definition
Medication Follow-Up		The process of contacting a physician/allowed practitioner (or physician-designee) to communicate the identified medication issue and, to the extent possible, completing all physician/allowed practitioner (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest.
National Provider Identifier	**NPI**	A unique federal number that identifies providers of health care services.
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.
Non-Removable Dressing/Device		Examples of a non-removable dressing/device include a dressing that is not to be removed per physician's order (such as those used in negative pressure wound therapy [NPWT], an orthopedic device, or a cast).
Nonsensical Response		Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated
Other Diagnoses		Comorbid conditions that exist at the time of the assessment that are actively addressed in the patient's Plan of Care – OR - that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.
Parenteral/IV Feeding		Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).
Patient Driven Groupings Model	**PDGM**	A payment model for the home health prospective payment system that became effective January 1, 2020. The model relies heavily on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories and eliminates the use of therapy service thresholds.
Patient Health Questionnaire (2- Item through 9-Item)	**PHQ-2 to 9©**	A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. *Copyright © Pfizer Inc. All rights reserved. Reproduced with permission.*

Term	Abbreviation	Definition
Portal		A portal is a secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection.
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.
Pressure Ulcer/Injury		Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear and/or friction. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.
Primary Diagnosis		The chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care.
Prospective Payment System	**PPS**	A payment system, developed for Medicare home health agencies, which pays agencies an all-inclusive rate for all services. Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.
Qualified Clinician		Clinicians allowed to complete comprehensive assessments and collect OASIS data. For the purposes of OASIS data collection, CMS defines a qualified clinician as a Registered Nurse, Physical Therapist, Occupational Therapist, and Speech-Language Pathologist.
Resumption of Care	**ROC**	The assessment time point completed within 2 calendar days of the facility discharge date, or knowledge of patient's return home, or the physician-ordered ROC date.
Start of Care	**SOC**	The assessment time point completed on or within 5 calendar days after the SOC date.

Term	Abbreviation	Definition
Slough Tissue		Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
Social Isolation		Social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.
Social Security Number	**SSN**	A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.
Stage 1 Pressure Injury		An observable, pressure-related alteration of intact skin whose indicators, as compared with an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin. In darker skin tones, the injury may appear with persistent red, blue, or purple hues.
Stage 2 Pressure Ulcer		Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured serum-filled blister.
Stage 3 Pressure Ulcer		Stage 3 pressure ulcers are characterized by 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 or tunneling.
Stage 4 Pressure Ulcer		Stage 4 pressure ulcers are characterized by 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.
Temporal Orientation		In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.

Term	Abbreviation	Definition
Therapeutic Diet		A therapeutic diet is a diet intervention prescribed by a physician or other authorized allowed practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of treatment of disease or clinical condition to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet.
Time Period Under Consideration (Look Back Period)		The time period under consideration is the look back period to use when coding each OASIS item. For most items, the look back period is the Day of Assessment. For other items, the look-back period is different, such as "in the last 14 days" or "at the time of or since the most recent SOC/ROC."
Timed Voiding		Timed voiding is scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Timed voiding is a compensatory strategy; it does not cure incontinence.
Total Severity Score		A summary of the Patient Health Questionnaire frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder but provides a standard of communication between clinicians and mental health specialists.
Z Codes		ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00–Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
AFO	Ankle Foot Orthosis
BIMS	Brief Interview for Mental Status
BMI	Body mass index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAM	Confusion Assessment Method
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMI	Case Mix Index
CMS	Centers for Medicare and Medicaid Services
CPAP	Continuous Positive Airway Pressure
CWF	Common Working File
CY	Calendar Year
DAH	Death at home
DME	Durable Medical Equipment
DRR	Drug Regimen Review
DTI	Deep Tissue Injury
EHR/EMR	Electronic Health Record/Electronic Medical Record
FR	Final Rule
FU	Follow-Up
FY	Fiscal Year
HCBS	Home and Community-Based Services
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIQH	Health Insurance Query for Home Health
IADLs	Instrumental Activities of Daily Living
ICD	International Classification of Diseases
ICD-10-CM	International Classification of Diseases 10, Clinical Modification
IFC	Interim Final Rule with Comment
IOM	Internet-Only Manual
iQIES	Internet Quality Improvement and Evaluation System
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument
LCDS	Long term Care Hospital CARE Data Set
LPN/LVN	Licensed Practical Nurse/Licensed Vocational Nurse
LTCH	Long-Term Care Hospital
LUPA	Low Utilization Payment Adjustment
MAC	Medicare Administrative Contractor

Acronym	Definition
MBI	Medicare Beneficiary Identifier
MDS	Minimum Data Set
MSW	Medical Social Worker
NPI	National Provider Identifier
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
OBQI	Outcome-Based Quality Improvement
OMB	Office of Management and Budget
OT	Occupational Therapist
OTC	Over the Counter
PAC	Post-Acute Care
PDGM	Patient Driven Groupings Model
PHQ©	Patient Health Questionnaire
POC	Plan of Care
POS	Point of Service
PPS	Prospective Payment System
PT	Physical Therapist
Pub.100-1	Medicare General Information, Eligibility, and Entitlement IOM
Pub.100-12	State Medicaid IOM
Pub.100-2	Medicare Benefit IOM
Pub.100-4	Medicare Claims Processing IOM
Pub.100-7	Medicare State Operation IOM
Pub.100-8	Medicare Program Integrity IOM
QM	Quality Measure
RN	Registered Nurse
ROC	Resumption of Care
SLP	Speech-Language Pathologist
SNF	Skilled Nursing Facility
SOC	Start of Care
SOM	State Operations Manual
SSN	Social Security Number
TPN	Total Parenteral Nutrition
UTI	Urinary Tract Infection

APPENDIX B: OASIS-E2 ITEMS, TIME POINTS, AND USES

Key for the Item Uses column:

A = Administrative

Q = Quality

PRA = Potential Quality Measure Risk Adjustment

$PDGM = Payment (PDGM)

$VBP = Payment (HHVBP)

Key for the Time Points columns:

SOC = Start of Care

ROC = Resumption of Care

FU = Follow-Up

TRN = Transfer

DC = Discharge

DAH = Death at Home

Section	Item	Description	SOC	ROC	FU	TRN	DC	DAH	Item Uses
SECTION A PATIENT TRACKING	M0018	National Provider Identifier (NPI)	X						A
	M0010	CMS Certification Number	X						A
	M0014	Branch State	X						A
	M0016	Branch ID Number	X						A
	M0020	Patient ID Number	X						A
	M0030	Start of Care Date	X						A, Q,
	M0032	Resumption of Care Date		X					A, Q,
	M0040	Patient Name	X						A
	M0050	Patient State of Residence	X						A
	M0060	Patient ZIP Code	X						A
	M0064	Social Security Number	X						A
	M0063	Medicare Number	X						A
	M0065	Medicaid Number	X						A
	M0810	Sex	X						A, PRA
	M0066	Birth Date	X						A, PRA
	A1005	Ethnicity	X						A
	A1010	Race	X						A
	M0150	Current Payment Source for Home Care	X						A, PRA

Section	Item	Description	SOC	ROC	FU	TRN	DC	DAH	Item Uses
SECTION A ADMINISTRATIVE INFORMATION	A1110	Language	X	X					A
	M0080	Discipline of Person Completing Assessment	X	X	X	X	X	X	A
	M0090	Date Assessment Completed	X	X	X	X	X	X	A, Q
	M0100	This Assessment is Currently Being Completed for the Following Reason	X	X	X	X	X	X	A, Q, PRA, $VBP
	M0906	Discharge/Transfer/Death Date				X	X	X	A, Q
	M0102	Date of Physician-Ordered Start of Care (Resumption of Care)	X	X					A, Q
	M0104	Date of Referral	X	X					A, Q
	A1255	Transportation	X	X					A, PRA
	M1000	Inpatient Facilities	X	X					A, Q, PRA
	M1005	Inpatient Discharge Date	X	X					A, Q
	M2301	Emergent Care				X	X		A, Q
	M2310	Reason for Emergent Care				X	X		A, Q
	M2410	To which Inpatient Facility has the patient been admitted?				X	X		A, Q
	M2420	Discharge Disposition					X		A, Q, $VBP
	A2120	Provision of Current Reconciled Medication List to Subsequent Provider at Transfer				X			A, Q
	A2121	Provision of Current Reconciled Medication List to Subsequent Provider at Discharge					X		A, Q
	A2122	Route of Current Reconciled Medication List Transmission to Subsequent Provider				X	X		A, Q
	A2123	Provision of Current Reconciled Medication List to Patient at Discharge					X		A, Q
	A2124	Route of Current Reconciled Medication List Transmission to Patient					X		A, Q
SECTION B HEARING, SPEECH, and VISION	B0200	Hearing	X	X					PRA
	B1000	Vision	X	X					PRA
	B1300	Health Literacy	X	X			X		PRA

Section	Item	Description	SOC	ROC	FU	TRN	DC	DAH	Item Uses
SECTION C COGNITIVE PATTERNS	C0100	Should Brief Interview for Mental Status (C0200-C0500) be Conducted?	X	X			X		PRA
	C0200	Repetition of Three Words	X	X			X		PRA
	C0300	Temporal Orientation	X	X			X		PRA
	C0400	Recall	X	X			X		PRA
	C0500	BIMS Summary Score	X	X			X		PRA
	C1310	Signs and Symptoms of Delirium (from CAM©)	X	X			X		PRA
	M1700	Cognitive Functioning	X	X			X		Q, PRA, $VBP
	M1710	When Confused	X	X			X		Q, PRA, $VBP
	M1720	When Anxious	X	X			X		Q, PRA, $VBP
SECTION D MOOD	D0150	Patient Mood Interview (PHQ-2 to 9)	X	X			X		PRA
	D0160	Total Severity Score	X	X			X		PRA
	D0700	Social Isolation	X	X			X		PRA
SECTION E BEHAVIOR	M1740	Cognitive, Behavioral, and Psychiatric Symptoms	X	X			X		Q, PRA
	M1745	Frequency of Disruptive Behavior Symptoms	X	X			X		PRA
SECTION F PREFERENCES for CUSTOMARY	M1100	Patient Living Situation	X	X					PRA
	M2102	Types and Sources of Assistance	X	X			X		Q, PRA
SECTION G FUNCTIONAL STATUS	M1800	Grooming	X	X	X		X		Q, $PDGM, PRA
	M1810	Current Ability to Dress Upper Body	X	X	X		X		Q, $PDGM, PRA
	M1820	Current Ability to Dress Lower Body	X	X	X		X		Q, $PDGM, PRA
	M1830	Bathing	X	X	X		X		Q, $PDGM, PRA
	M1840	Toilet Transferring	X	X	X		X		Q, $PDGM, $VBP, PRA
	M1845	Toileting Hygiene	X	X			X		Q, PRA
	M1850	Transferring	X	X	X		X		Q, $PDGM, PRA
	M1860	Ambulation/Locomotion	X	X	X		X		Q, $PDGM, PRA

Section	Item	Description	SOC	ROC	FU	TRN	DC	DAH	Item Uses
SECTION GG FUNCTIONAL ABILITIES AND GOALS	GG0100	Prior Functioning: Everyday Activities	X	X					PRA
	GG0110	Prior Device Use	X	X					PRA
	GG0130	Self-Care							
		GG0130A. Eating	X	X	X		X		Q, $VBP, PRA
		GG0130B. Oral hygiene	X	X	X		X		Q, $VBP, PRA
		GG0130C. Toileting hygiene	X	X	X		X		Q, $VBP, PRA
		GG0130E. Shower/bathe self	X	X			X		PRA
		GG0130F. Upper body dressing	X	X			X		PRA
		GG0130G. Lower body dressing	X	X			X		PRA
		GG0130H. Putting on/taking off footwear	X	X			X		PRA
	GG0170	Mobility							
		GG0170A. Roll left and right	X	X	X		X		Q, $VBP, PRA
		GG0170B. Sit to lying	X	X	X		X		PRA
		GG0170C. Lying to sitting on side of bed	X	X	X		X		Q, $VBP, PRA
		GG0170D. Sit to stand	X	X	X		X		Q, $VBP, PRA
		GG0170E. Chair/bed-to-chair transfer	X	X	X		X		Q, $VBP, PRA
		GG0170F. Toilet transfer	X	X	X		X		Q, $VBP, PRA
		GG0170G. Car transfer	X	X			X		PRA
		GG0170I. Walk 10 feet	X	X	X		X		Q, $VBP, PRA
		GG 0170J. Walk 50 feet with two turns	X	X	X		X		Q, $VBP, PRA
		GG0170K. Walk 150 feet	X	X			X		, PRA
		GG0170L. Walking 10 feet on uneven surfaces	X	X	X		X		PRA
		GG0170M. 1 step (curb)	X	X	X		X		PRA
		GG0170N. 4 steps	X	X	X		X		PRA
		GG0170O. 12 steps	X	X			X		PRA
		GG0170P. Picking up object	X	X			X		PRA
		GG0170Q. Use wheelchair/scooter	X	X	X		X		Q, PRA
		GG0170R. Wheel 50 feet with two turns	X	X	X		X		Q, $VBP, PRA
		GG0170RR. Indicate the type of wheelchair or scooter used	X	X			X		PRA
		GG0170S. Wheel 150 feet	X	X			X		Q, $VBP, PRA

Section	Item	Description	SOC	ROC	FU	TRN	DC	DAH	Item Uses
		GG0170SS. Indicate the Type of wheelchair or scooter used	X	X			X		Q, PRA
SECTION H BOWEL and BLADDER	M1600	Has this patient been treated for a Urinary Tract Infection in the past 14 days?	X	X			X		Q
	M1610	Urinary Incontinence or Urinary Catheter Presence	X	X					PRA
	M1620	Bowel Incontinence Frequency	X	X			X		Q, PRA
	M1630	Ostomy for Bowel Elimination	X	X					PRA
SECTION I ACTIVE DIAGNOSES	M1021	Primary Diagnosis	X	X					Q, $VBP, PRA
	M1023	Other Diagnoses	X	X					PRA
	M1028	Active Diagnoses – Comorbidities and Co-existing	X	X					PRA
SECTION J HEALTH CONDITIONS	M1033	Risk for Hospitalization	X	X	X				$PDGM, PRA
	J0510	Pain Effect on Sleep	X	X			X		PRA
	J0520	Pain Interference with Therapy Activities	X	X			X		PRA
	J0530	Pain Interference with Day-to-Day Activities	X	X			X		PRA
	J1800	Any Falls Since SOC/ROC				X	X	X	Q
	J1900	Number of Falls				X	X	X	Q
	M1400	When is patient dyspneic or short of breath?	X	X			X		Q, PRA, $VBP
SECTION K SWALLOWING/ NUTRITIONAL STATUS	M1060	Height and Weight	X	X					PRA
	K0520	Nutritional Approaches	X	X			X		PRA
	M1870	Feeding or Eating	X	X			X		Q, PRA
SECTION M SKIN CONDITIONS	M1306	Unhealed Pressure Ulcer/Injury at Stage 2 or Higher	X	X	X		X		Q, PRA
	M1307	Oldest Stage 2 Pressure Ulcer					X		Q
	M1311	Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	X	X			X		Q, PRA
	M1322	Current Number of Stage 1 Pressure Injuries	X	X					PRA
	M1324	Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable	X	X			X		Q
	M1330	Does this patient have a Stasis Ulcer?	X	X			X		PRA
	M1332	Current Number of Stasis Ulcers Observable	X	X					PRA
	M1334	Status of Most Problematic Stasis Ulcer Observable	X	X			X		Q, PRA
	M1340	Does this patient have a Surgical Wound	X	X			X		PRA
	M1342	Status of Most Problematic Surgical Wound Observable	X	X			X		Q, PRA

Section	Item	Description	SOC	ROC	FU	TRN	DC	DAH	Item Uses
SECTION N MEDICATIONS	N0415	High Risk Drug Classes: Use and Indication	X	X			X		PRA
	M2001	Drug Regimen Review	X	X					Q
	M2003	Medication Follow-up	X	X					Q
	M2005	Medication Intervention				X	X	X	Q
	M2010	Patient/Caregiver High-Risk Drug Education	X	X					PRA
	M2020	Management of Oral Medications	X	X			X		Q, PRA, $VBP
	M2030	Management of Injectable Medications	X	X					PRA
SECTION O SPECIAL TREATMENTS, PROCEDURES, and PROGRAMS	O0110	Special Treatments, Procedures, and Programs	X	X			X		PRA
	M1041	Influenza Vaccine Data Collection Period				X	X		Q
	M1046	Influenza Vaccine Received				X	X		Q
SECTION Q PARTICIPATION in ASSESSMENT and GOAL SETTING	M2401	Intervention Synopsis				X	X		PRA

APPENDIX C: OASIS-E2 INSTRUMENTS

The final OASIS-E2 All Items and time point versions of the instrument are available in the Downloads section of the CMS **OASIS Data Sets webpage** at https://www.cms.gov/medicare/quality/home-health/oasis-data-sets

APPENDIX D: DESCRIPTION OF CHANGES FROM OASIS-E1 TO OASIS-E2

OASIS-E2 is a minor revision to the OASIS instrument reflecting proposals finalized in the Calendar Year (CY) 2026 Home Health (HH) Final Rule to remove item O0350 Patient's COVID Vaccination is Up to Date, modify A1250 Transportation to A1255 Transportation, and modify M0069 Gender to A0810 Sex. Also, for OASIS-E2 A110 Language, B1000 Hearing and B2000 Vision, have been added to the ROC time point. Table D1 lists the items added, removed or revised for OASIS-E2. Table D2, that follows, details the changes in guidance from OASIS-E1 to OASIS-E2.

Table D1: Items Added, Removed and Revised for OASIS-E2

Section	Item #	Added/Removed/Revised	Item Description
Section O	O0350	Removed	COVID-19 Vaccination Up to Date
Section A	A1255	Revised from A1250	Transportation
Section A	A0810	Revised from M0069 Gender	Sex
Section A	A1110	Added to ROC timepoint	Language
Section B	B1000	Added to ROC timepoint	Hearing
Section B	B2000	Added to ROC timepoint	Vision

Table D2: Changes to Guidance for OASIS-E2 Manual

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
1	All sections and appendices	N/A	Where applicable, the manual is edited for the following: formatting, grammar, stylistic edits, to improve clarity, updated dates, updated references, updated resources, reorganized information, and updated version title from E1 to E2.	--
2	All sections and appendices	OASIS-E1 Guidance Manual Updated 1/1/2025 Centers for Medicare & Medicaid Services	OASIS-E2 Manual Effective 4/1/2026 Centers for Medicare & Medicaid Services	Updated footer with new version and effective date.
	Chapter 1	1.4 Changes from OASIS-E to OASIS-E1	1.4 Changes from OASIS-E1 to OASIS-E2	Revised to describe changes for version OASIS-E2

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
	Section 1.4	The main reason for revising OASIS for version E1, effective January 1, 2025, is to add one new item, O0350 Patient's COVID vaccination is up to date, associated with the COVID Vaccine quality measure (QM) finalized in the Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Final Rule (CMS-1780-F). CMS is removing two items, M0110 Episode Timing and M2200 Therapy Need that are no longer used in the HH Quality Reporting Program (QRP) or for other CMS purposes. The GG0130 Self Care and GG0170 Mobility items are revised to remove the Discharge Goals, due to the removal of the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (Application of Functional Assessment/Care Plan), also finalized in the CY2024 HH final rule. One item, D0150 Patient Health Questionnaire, is revised to clarify the instructions.	The changes in OASIS for version E2, effective April 1, 2026, include the removal of the A1250 Transportation item, which is replaced by the modified A1255 Transportation item (1 data element [DE]) to align with a similar item used in other CMS programs. The item O0350 Patient's COVID-19 vaccination is up to date (1 DE) is removed to align with removal of the associated quality measure. Subregulatory changes include adding the B1000 Hearing, B0200 Vision, and A1110 Language items to the resumption of care (ROC) timepoint. The item A0810 Sex replaces the M0069 Gender item (no change in DE). OASIS Q&As are added to the Manual and a new section on completing OASIS for patients with all payers is added to Chapter 1.	
	Chapter 1 Section 1.4.1	1.4.1 What's new with the OASIS instrument for version E1? • One new item has been added (O0350) • Two items are removed (M0110, M2200) • Three items are revised (GG0130, GG0170, D0150)	1.4.1 What's new with the OASIS instrument for version E2? • One item, O0350, has been removed. • One item, A1250, has been replaced with a modified version, A1255. • Three items have been added to the ROC	Revised to describe changes for version OASIS-E2

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		• Updated skip pattern (M0102)	timepoint (M0110, M2200B1000, B0200, A1110) • One item, M0069, has been replaced with a modified version A0810.	
	Chapter 1 Section 1.5	1.5.1 Who does OASIS data collection apply to?	1.5.1 Home Health Agencies that are required to complete OASIS	Section title revised to reflect that content is related to types of home health agencies (Content in this section has not changed).
	Chapter 1 Section 1.5.2	1.5.1.1 How to Transition to All-Payer OASIS Data Collection and Submission	1.5.2 All-Payer OASIS Data Collection and Submission	Revised section header to reflect that transition period is ended
	Chapter 1 Section 1.5.2	Prior to January 1, 2025, OASIS data collection and submission are required for: All skilled Medicare and/or Medicaid patients with some exceptions. Patients under the age of 18, patients receiving maternity services, and patients receiving only personal care, housekeeping services, or chore services are excluded from the requirement for OASIS data collection and submission. NOTE: Some payers may require OASIS data for patients who are otherwise excluded from the requirement for OASIS data collection and submission. OASIS data for these patients should not be submitted to iQIES.	N/A	Paragraph deleted; the transition period is over.
	Chapter 1 Section 1.5.2	Effective January 1, 2025, through June 30, 2025:	N/A	Paragraph deleted; the transition period is over.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		Continue OASIS data collection and submission for all skilled Medicare and/or Medicaid patients OASIS data collection and submission are *voluntary* for: Non-Medicare/non-Medicaid patients who are not exempt from OASIS data collection, and who begin receiving home health care services with an OASIS start of care (SOC) M0090 date from January 1, 2025 through June 30, 2025. When OASIS data collection and submission is started for a non-Medicare/non-Medicaid patient with the SOC OASIS assessment HHAs may, but are not required, to complete all subsequent OASIS time point assessments related to the patient's home health stay (that is, resumption of care, recertification, other follow-up, transfer, discharge, and death at home). This includes assessments completed on or after July 1, 2025.		
	Chapter 1 Section 1.5.2	Effective July 1, 2025: OASIS data collection and submission are *required* for patients with any pay source who are not exempt from OASIS data collection, and who begin receiving home health care services with an OASIS SOC M0090 data on or after July 1, 2025. The requirement includes the SOC OASIS and any subsequent OASIS time point assessments relevant to the patient's home health stay (that is, resumption of care, recertification, other follow-up, transfer, discharge, and death at home). Patients under the age of 18, patients receiving	Effective July 1, 2025: OASIS data collection and submission are *required* for patients (1) with any pay source, (2) who are receiving skilled services, (3) who are not exempt from OASIS data collection, AND (4) who begin receiving home health care services with an OASIS SOC M0090 date on or after July 1, 2025. 1. Any pay source • Examples include but are not limited to charity-based pay, no payer, and self-pay • **Exception:** All outpatient therapy services – PT, OT, SLP – provided by	Section revised and expanded with additional clarification of all-payer OASIS requirements.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		maternity services, and patients receiving only personal care, housekeeping and/or chore services continue to be excluded from OASIS data collection and submission requirements.	an HHA and billed under the Medicare Part B benefit that do not have a home health plan of care in effect do not require completion of the OASIS. 2. Receiving skilled services. HHAs should follow the Medicare home health benefit definition of "skilled services" regardless of payer. Skilled services covered by the Medicare home health benefit are discussed in Chapter 7 of the Medicare Benefit Policy Manual. This publication can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673 If none of the services provided meet the definition of "skilled" as defined in Chapter 7 of the Medicare Benefit Policy Manual, then OASIS is not required. If any of the services provided meet the definition of "skilled" per Chapter 7 of the Medicare Benefit Policy Manual, then OASIS is required, assuming the patient does not meet any of the OASIS exemptions. o Please note, except as they relate to identifying if "skilled care" is being provided, other coverage criteria for the Medicare Home Health Benefit (e.g., homebound status, need for intermittent nursing, continuing Occupational Therapy), are not considered when identifying if OASIS is required.	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			3. Not exempt from OASIS data collection Patients under the age of 18, patients receiving maternity services, and patients receiving only personal care, housekeeping and/or chore services continue to be excluded from OASIS data collection and submission requirements. 4. Begin receiving home health care services with an OASIS SOC M0090 date on or after July 1, 2025. The requirement includes the SOC OASIS and any subsequent OASIS time point assessments relevant to the patient's home health stay (that is, resumption of care, recertification, other follow-up, transfer, discharge and/or death at home).	
	Chapter 1 Section 1.5.2.1	N/A	1.5.2.1 Voluntary OASIS Assessments • Non-Medicare/non-Medicaid patients admitted prior to January 1, 2025, and still on service July 1, 2025, and after: ○ HHAs may decide to complete OASIS on these patients, but no OASIS SOC or subsequent OASIS should be submitted to iQIES. • Non-Medicare/non-Medicaid patients, who are not exempt from OASIS data collection, and who begin receiving home health care services with an OASIS SOC M0090 date of January 1, 2025, through June 30, 2025:	New section for OASIS-E2 with expanded information about OASIS all-payer requirements.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			OASIS data collection at all time points is voluntary, including those assessments completed on or after July 1, 2025. How will CMS identify Voluntary Assessments? CMS will use SOC data from M0090 Date Assessment Completed, and from M0150 Current Payment Sources, to identify voluntary assessments in the all-payer phase-in and mandatory periods. Voluntary assessments can be identified as any assessment at any time point collected on a patient who has a M0090 date for their SOC on or between January 1, 2025 and June 30, 2025, AND, the SOC M0150 coding does not include response 1, 2, 3 or 4 (i.e., the patient's home health care is not expected to be billed to a Medicare or Medicaid payer). Note that collection and submission of voluntary assessments could include all subsequent time points for a non-Medicare/non-Medicaid patient with a SOC M0090 date in the phase-in period, including those assessments occurring on or after July 1, 2025. It is not intended that voluntary OASIS data will be used for any of the following initiatives: • APU, including the QAO metric. • Quality measure calculation, including those measures utilized in the expanded HHVBP Model • HHVBP performance reports	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			• iQIES quality reports (See Appendix F for more information about quality reports) • Risk adjustment • Publicly reported data	
	Chapter 1 Section 1.5.2.2	N/A	1.5.2.2 Loaned Employee Agreements If a company other than the Medicare-certified HHA is providing a service using HHA staff under a loaned employee agreement OASIS is not required. Examples include, but are not limited to: • An HHA is contracted to provide a nurse to manage PICC line dressing changes and/or draw labs for a pharmacy company. • An Assisted Living Program, or PACE program provides care using HHA staff under a loaned employee agreement.	New section for OASIS-E2 with expanded information about OASIS all-payer requirements.
	Chapter 1 Section 1.5.3	N/A	1.5.2.3 Changes in Payer Source Different states, different payers and different agencies have varying responses to payer change situations, so we usually find it most effective to ask, “Does the new payer require a new SOC?” HHAs can usually work their way through what they need to do if they answer this question. If the new payer source requires a new SOC)	New section with expanded information about all-payer requirements

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			CMS recommends that the patient be discharged from the previous pay source and reassessed under the new pay source (i.e., a new SOC OASIS assessment). The agency does not have to re-admit the patient in the sense that it would normally admit a new patient with all the paperwork that entails. When transitioning **from a situation requiring OASIS to a situation not requiring OASIS**, such as moving from skilled Medicare to personal care only, CMS encourages HHAs to complete a discharge OASIS assessment at the last visit under the Medicare or Medicaid pay source. While this is not a requirement, conducting a discharge OASIS assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's quality episode for the purposes of the agency's quality initiatives. Medicare **does not** require a new SOC when a patient's payer changes **from Original Medicare (FFS) to a Medicare Advantage (MA)** plan (per the Medicare Claims processing Manual, Chapter 10, Section 10.2.23 – Changes in Beneficiary's Payment Source). If the patient is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			When there is a pay source change **from MA to Medicare FFS**, while **a new SOC OASIS is required** the original eligibility for the home health benefit is uninterrupted. If continued OT is the only active service at the time of the pay source change from MA to Medicare FFS, the OT can complete the SOC OASIS and continue to provide care as the only active discipline for the remainder of the home health stay. When an active patient is receiving both nursing and rehabilitation therapy services and experiences a payer change mid-episode that requires a new SOC OASIS, CMS recommends but does not require that the RN complete the SOC comprehensive assessment including OASIS. Questions related to payment must be discussed with the HHA's Medicare Administrative Coordinator (CMS MAC) or Medicare Advantage payer.	
	Chapter 1 Section 1.5.2.4	1.5.1.2 When a pediatric patient turns 18 years of age while receiving skilled home health care services For a pediatric patient who turns 18 years of age while receiving skilled home health care services, OASIS data collection and submission begins with the next OASIS time point. That is, when one of the following takes place	1.5.2.4 When a pediatric patient turns 18 years of age while receiving skilled home health care services If a pediatric patient with a non-Medicare/non-Medicaid payer was receiving skilled home health care services, and turned 18 years of age before July 1, 2025, the effective date of the OASIS all-payer requirement, no OASIS is required for any time point throughout the patient's home health stay, even if the skilled home health care services continue past July 1,	Revised section number, and revised content to clarify OASIS all-payer requirement.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			2025. Effective July 1, 2025, if a pediatric patient, with any payer, turns 18 years of age while receiving skilled home health care services, OASIS data collection and submission begins with the next OASIS time point. That is, when one of the following takes place	
	Chapter 1 Section 1.5.3	1.5.2 OASIS and the comprehensive assessment OASIS data are collected as part of the comprehensive assessment required by the Medicare HH Conditions of Participation (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484). OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures. Agencies may rearrange OASIS item sequence in a way that permits logical ordering within their own forms and electronic records, if the actual item content, and OASIS number and formatting remain the same, and maintaining the same skip logic. The comprehensive assessment forms the basis of the physician-ordered Plan of Care. Thus, there should be congruence between the overall comprehensive assessment and the Plan of Care. Agencies may have the comprehensive assessment including OASIS, if applicable, completed by one clinician. If collaboration with other health care personnel and/or agency	1.5.3 OASIS and the comprehensive assessment OASIS data are collected as part of the comprehensive assessment required by the Medicare HH Conditions of Participation (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484). OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures. ~~Agencies may rearrange OASIS item sequence in a way that permits logical ordering within their own forms and electronic records, if the actual item content, and OASIS number and formatting remain the same, and maintaining the same skip logic.~~ The comprehensive assessment forms the basis of the physician-ordered Plan of Care. Thus, there should be congruence between the overall comprehensive assessment and the Plan of Care. ~~Agencies may have the comprehensive assessment including OASIS, if applicable, completed by one clinician. If collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and practices related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted~~	New section number Selected content moved to new section that follows, 1.5.4 OASIS Item Sequence and Integration with HHA Systems

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		staff is utilized, the agency is responsible for establishing policies and practices related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted standards of practice.	~~standards of practice.~~	
	Chapter 1 Section 1.5.4	N/A	1.5.4 OASIS item Sequence and Integration with HHA Systems Agencies may rearrange OASIS item sequence in a way that permits logical ordering within their own forms and electronic records, if the actual item content, and OASIS number ~~and formatting~~ remain the same, and the same skip logic is maintained. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items into their own assessment instrument using the exact language of the items from the current data set. The most current version of OASIS can be found on the CMS Home Health Quality Reporting Program OASIS Data Sets website: OASIS Data Sets | CMS CMS does not require HHAs to integrate the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set, although doing so would facilitate data entry of the items into the data collection and reporting software. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the OASIS system. As long as the agency can format the required CMS data submission file for transmission to the OASIS system, it doesn't matter	New section for OASIS-E2 with expanded information from OASIS Q&As The reference to formatting is removed from the first paragraph, as formatting is addressed in subsequent paragraphs of this section.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			in what order the data are collected. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. This software includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than that provided by CMS to report their data so as long as the data are ultimately transmitted to the OASIS system in the required CMS data submission format found on the CMS Website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications. In the development and maintenance of the OASIS assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications). While the Data Specifications dictate the assessment instrument items, their applicable time point(s) in the	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			assessment instrument, the exact language of the items, and each item's allowable response options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the items in the assessment instrument. For example, presenting the allowable response options in the format of radio buttons in the GUI software is acceptable, and is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring. While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, such as if additional prompts were added to clarify the reason for Coding 0 for one or more BIMS interview items (C0200-C0400). The items must be presented in a way that makes it clear which items (assessment questions and response options) are part of the OASIS, and which are not. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the OASIS item numbers when integrating to alert clinicians that the OASIS items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Agencies may have the comprehensive assessment including OASIS, if applicable, completed by one clinician. If collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			practices related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted standards of practice.	
		1.5.3 When is OASIS Completed? (Time Points)	1.5.5 When is OASIS Completed (Time Points)	New section number
		1.5.4 Who Completes OASIS? (paragraph 1) As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment including OASIS data collection, if applicable, is the responsibility of a registered nurse (RN) or any of the therapies, including physical therapist (PT), speech language pathologist/speech therapist (SLP/ST), or occupational therapist (OT). A licensed practical nurse or licensed vocational nurse (LPN/LVN), physical therapist assistant (PTA), occupational therapy assistant (OTA), medical social worker (MSW), or home health aide may not be responsible for completing the comprehensive assessment and OASIS.	1.5.6 Who Completes OASIS? (paragraph 1) As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment including OASIS data collection, if applicable, is the responsibility of a registered nurse (RN) or any of the therapies, including physical therapist (PT), speech language pathologist/speech therapist (SLP/ST), or occupational therapist (OT). A licensed practical nurse or licensed vocational nurse (LPN/LVN), physical therapist assistant (PTA), occupational therapy assistant (OTA), medical social worker (MSW), or home health aide may not be responsible for completing the comprehensive assessment and OASIS. Social workers, although considered a skilled professional as noted in the Condition of Participation (CoP) 484.75 are not a qualifying Medicare home health service, therefore do not complete the comprehensive assessment including OASIS. Social workers may support	New section number Expanded content from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			the assessing clinician through collaboration.	
		1.5.4 Who Completes OASIS? (Bullet 2, and remainder of section) • When PT, SLP, or OT is the only service ordered by the physician or allowed practitioner, a PT, SLP, or OT may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. o For Medicare patients, the OT may complete the comprehensive assessment when OT is ordered with another qualifying rehabilitation therapy service (SLP or PT) that establishes program eligibility. Multidisciplinary cases may have multiple points of discipline-specific discharge, though there is only one HHA discharge, which must include completion of the comprehensive discharge assessment including OASIS. Other non-OASIS required documentation for admission, recertification and discharge are specified in the Condition of Participation: Comprehensive Assessment of Patients: https://www.ecfr.gov/current/title-42/part-484.	1.5.6 Who Completes OASIS? (Bullet 2, and remainder of section) When PT, SLP, or OT is the only service ordered by the physician or allowed practitioner, a PT, SLP, or OT may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. For example, in a case where PT is the only ordered service and assuming PT services establish program eligibility for the payer, PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be	Expanded content from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			reimbursable visits, therefore would not establish the start of care date for the home care episode. • For Medicare patients, the OT may complete the comprehensive assessment when OT is ordered with another qualifying rehabilitation therapy service (SLP or PT) that establishes program eligibility. • For non-Medicare/non-Medicaid patients, if OT is the only service ordered, HHAs should follow the Medicare home health benefit definition of "skilled services" to determine if OASIS is required. If the OT services meet this definition of "skilled services" then OASIS is required. Please note that while the need for OT alone does not establish initial eligibility for the Medicare home health benefit it may establish eligibility for other payers. • Although not required, if a HHA chooses to complete a new SOC when a patient's payer changes from Original Medicare to a MA plan, and continuing OT is the only active service remaining as the only active discipline, the OT may complete the SOC OASIS and continue to provide care as the only active discipline, as the original eligibility for the home health benefit remains uninterrupted. • When there is a pay source change from MA to Original Medicare while the patient is on service with the HHA,	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			the original eligibility for the home health benefit is uninterrupted. If continued OT is the only active service at the time of the pay source change, then OT can complete the SOC OASIS and continue to provide care as the only active discipline for the remainder of the home health stay. If an order for nursing existed at the time of the initial referral, the RN must complete the initial assessment visit. If it is determined during the initial assessment visit, that the patient either did not have a need for nursing services and/or the patient declined all nursing services, the Start of Care (SOC) will not be established by that visit. A comprehensive assessment performed on a date BEFORE the SOC date does not meet the Medicare HH CoPs. The RN can notify the physician that nursing will not be involved in the patient's care, and either continue on to complete the SOC comprehensive assessment including OASIS (if the PT will be establishing the SOC that day), return for a non-billable visit to complete the SOC comprehensive assessment including OASIS on or within 5 days after PT establishes the start of care, OR have the PT complete the SOC comprehensive assessment including OASIS. Multidisciplinary cases may have multiple points of discipline-specific discharge, though there is only one HHA discharge, which must include completion of the comprehensive discharge assessment including OASIS. Other non-OASIS required documentation for admission, recertification and discharge are specified in the Condition of Participation: Comprehensive	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			Assessment of Patients: https://www.ecfr.gov/current/title-42/part-484.	
		N/A	1.5.7 OASIS Privacy Notice As required by the HH Conditions Of Participation (COP), an OASIS privacy notice must be provided to all patients for whom the OASIS data is collected. Effective January 1, 2025, all patients for whom the HHA collects OASIS, regardless of payer, should be provided Attachment A – Statement of Patient Privacy Rights, and the Privacy Act Statement – Health Care Records. These documents are available on the Home Health Agency (HHA) Center page at https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center. Both documents are available in English and Spanish.	New section with updated information about the OASIS Privacy Notice.
		1.5.5 Conventions for Completing OASIS	1.5.8 Conventions for Completing OASIS CMS provides several key resources to support OASIS data accuracy. The OASIS Guidance Manual contains an item-by-item review with key instructions within Chapter 3 of the manual. Chapter 1 of the OASIS Guidance Manual contains the general and ADL/IADL specific conventions for completing OASIS items. There are also OASIS Q&As available at https://qtso.cms.gov/tools/oasis/reference-manuals. Categories 1-4 are most relevant for OASIS data collection activities. At the same site,	New section number Expanded content from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			CMS posts quarterly Q&A updates with new and/or refined guidance related to OASIS items. The user may conduct a key word search in these .pdf documents to expedite the search for information. Questions not otherwise answered in published CMS OASIS resources may be submitted to the CMS Home Health Quality Helpdesk at HomeHealthQualityQuestions@cms.hhs.gov	
		1.5.5.1 General OASIS item Conventions	1.5.8.1 General OASIS Item Conventions (convention #2) Unless otherwise indicated, OASIS item coding is based on the patient's status on the 'day of the assessment.' Since home care visits can occur at any time of the day, and to standardize the timeframe for assessment data, the "day of the assessment" refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient's ability and status, regardless of the time of day of the visit. vention #9) An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician. vention #10) In the case of an unplanned discharge (an end of home care where no in-home visit can be	New section number Expanded content from OASIS Q&As, with renumbering of existing conventions.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			made) the last qualified clinician who saw the patient may complete the discharge comprehensive assessment, including the OASIS, based on information from their last visit. The assessing clinician may collect information to complete the OASIS items on the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unplanned discharge. The 'last 5 days that the patient received visits" are defined as the date of the last in-home patient visit, plus the four preceding calendar days. In the case of an unplanned discharge, use the following guidance to complete the OASIS: • Items where a dash is a valid response: When there is no information available because the assessment of the item was not completed prior to the unplanned discharge, a dash may be the only valid response. A dash indicates "no information available" and CMS expects dash use to be a rare occurrence. • Patient Interview items where a dash is a valid response (BIMS & PHQ-2 to 9): When assessing C0200- C0500 - Brief Interview for Mental Status (BIMS) and/or D0150 - Patient Mood Interview (PHQ-2 to 9), a patient interview is required to complete these	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			items. If a clinician is not able to complete the assessment of these items due to an unplanned discharge and there is no documentation that the interview was completed in the last 5 days that the patient received visits, then a "dash" is the only allowable response. • Items where a Dash is not a valid response: If assessment of an item was not completed prior to the unplanned discharge and there is no information available from the last 5 days the patient received visits, code the item using any available documentation/information. For patient interview items, where the Dash is not a valid response, if the patient is unable to respond due to an unplanned discharge and it is allowable, code X or code 8 - Patient unable to respond, depending on the item. Review the guidance manual and Q&As for item-specific guidance.	
		Chapter 2, Section 2.2 Data Auditing (paragraph 1) N/A	Chapter 2, Section 2.2 Data Auditing (paragraph 1) The qualifications of individuals doing a quality review of the comprehensive assessment, including OASIS	Expanded content from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			items, and/or providing education and instruction related to OASIS data collection should be defined by agency policy.	
		Chapter 3 3.2 OASIS-E1 Manual Sections The sections in the OASIS-E1 Manual are listed in Table 3.1, below. *Table 3.1 OASIS-E1 Manual Sections*	Chapter 3 3.2 OASIS~~-E1~~ Manual sections The sections in the OASIS~~-E1~~ Manual are listed in Table 3.1, below. *Table 3.1 OASIS~~-E1~~ Manual Sections*	Removed reference to specific OASIS version number.
		3.3 Using This Chapter Item-specific guidance has been included for the new item introduced in OASIS-E1 and for those retained from OASIS-E. OASIS-E. Each section begins with a brief introduction describing the items found in the section. Throughout this chapter, the sections of OASIS-E1 are presented using a standard format for ease of review by HH staff. Item-specific guidance includes additional headings to convey information, for example, Coding Instructions, Coding Tips and Examples where appropriate. The order of information is presented as follows:	3.3 Using This Chapter This chapter includes item-specific guidance ~~has been included for the new item introduced in OASIS-E1 and for those retained from OASIS-E. OASIS-E.~~ for each OASIS item. Each section begins with a brief introduction describing the items found in the section. Throughout this chapter, the OASIS sections ~~of OASIS-E1~~ are presented using a standard format for ease of review by HH staff. Item-specific guidance includes additional headings to convey information, for example, Coding Instructions, Coding Tips and Examples where appropriate. The order of information is presented as follows:	Removed reference to specific OASIS version number.
	Chapter 3 Section A M1018	M1018 National Provider Identifier (NPI) N/A	M1018 National Provider Identifier Coding Tips • The assessing clinician should enter the NPI number of the physician/allowed practitioner expected to oversee and sign the Plan of Care, even if a different provider made the referral.	New Coding Tip added from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
	Chapter 3 Section A M0030	M0030 Start of Care Date N/A	M0030 Start of Care Date Coding Tips • The Start of Care date is the date of the first reimbursable service and is maintained as the start of care date until the patient is discharged. It should correspond to the start of care date used for other documentation, including billing or physician orders. • The Start of Care date does not change with a new certification period, or when a new service is added during the episode. There is only one Start of Care date for the episode.	New Coding Tips added from OASIS Q&As.
	Chapter 3 Section A M0032	M0032 Resumption of Care Date N/A	Coding Tips • When the physician specifies a date that home care services must resume (a physician- ordered Resumption of Care Date), the agency is expected to conduct the ROC visit on that date. The agency has up to 2 calendar days from the physician-ordered ROC Date to complete the ROC assessment. o For example, if the patient is discharged from the hospital on September 1, and the physician orders home care to resume on September 4, the M0102 Physician-ordered Resumption of Care Date is 09-04-xxxx, and the M0032 Resumption of Care data is 09-04-xxxx, and the M0090 Date Assessment Completed can be on or between 09-04-xxxx and 09-06-xxxx.	New Coding Tips from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			• If a patient returns home from the hospital and requires immediate care, such as an injection, services may be provided before the ROC comprehensive assessment is completed. The ROC assessment, including OASIS, must be completed within 2 calendar days of the facility discharge date, the agency's knowledge of the patient's return home, or a physician-ordered ROC date. The ROC date (M0032) is defined as the date of the first visit following an inpatient discharge, regardless of which qualified clinician ultimately completes the ROC assessment. The ROC assessment must be completed by an RN, PT, OT, or SLP. In this example, an on-call nurse may conduct the initial visit and provide the necessary care prior to the completion of the ROC assessment.	
	Chapter 1 Section A M0040	M0040 Patient Name N/A	M0040 Patient Name Coding Tips • The OASIS item provides a maximum length of 12 characters for the first name, 1 character for the middle initial, and 18 characters for the last name. • The length of the text submitted must not exceed the maximum length specified or it will result in a fatal Format Edit when submitted. • In cases where a patient's name has more letters than the OASIS submission allows, enter the first 12 letters (for first name), the first letter (for middle initial), and the first 18 letters (for last name), and disregard any additional letters/characters.	New Coding Tips from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			• The name may contain an (‘) apostrophe	
	Chapter 1 Section A M0063	M0063 Medicare Number N/A	M0063 Medicare Number Response-Specific Instructions The patient’s Medicare number, the Medicare Beneficiary Identifier (MBI) should be entered whether or not Medicare is the pay source for the episode. • Keep in mind that Medicare is often a secondary payer even when another payer is billed first. To bill Medicare as a secondary payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150 Current Payment Source for Home Care.	New Response-Specific Instruction from OASIS Q&As
	Chapter 1 Section A A0810	M0069 Gender Item Intent Specifies the gender of the patient. Response Specific Instructions • Interview the patient and/or caregiver. If the patient does not self-identify, referral information (including hospital or physician office clinical data), or observation and physical assessment may be used. • Based on the resources mentioned above, enter a response for patient’s gender.	A0810 Sex Item Intent Specifies the sex of the patient. Response-Specific Instructions • Interview the patient and/or caregiver. Referral information (including hospital or physician office clinical data), or observation and physical assessment may be used. • Based on the resources mentioned above, enter a response for patient’s sex.	New item number and name Revised gender to sex in item intent and response-specific instructions.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
	Chapter 3 Section A A1005	A1005 Ethnicity N/A	A1005 Ethnicity ETHNICITY: HISPANIC OR LATINO/A A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. The term "Spanish Origin" can be used in addition to Hispanic or Latino/a.	New definition box added.
	Chapter 3 Section A A1005	A1005 Ethnicity Item Rationale • (Bullet one) The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity. • (Bullet four) Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute care settings.	Item Rationale • N/A • Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple health care settings and is an important step in improving quality of care and health outcomes.	Bullet one in Item Rationale deleted. Fourth bullet revised for clarification.
	Chapter 3 Section A A1005	A1005 Ethnicity Response-Specific Instructions • Ask the patient to select the category or categories that most closely corresponds to the patient's ethnicity from the list in A1005, Ethnicity. ○ Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to	A1005 Ethnicity Response-Specific Instructions • Ask the patient to select the category or categories that most closely corresponds to the patient's ethnicity from the list in A1005, Ethnicity. ○ N/A	Sub-bullet one, of bullet one in Response-Specific Instructions deleted

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		make sure that all of our patients get the best care possible, regardless of their ethnic background." • If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation. • If a patient declines to respond, do not code based on proxy response or medical record documentation. • If the patient can provide a response: o Check all that apply. o Check the box(es) indicating the ethnic category or categories identified by the patient. o Complete as close to the time of SOC as possible		
	Chapter 3 Section A A1005	A1005 Ethnicity Response-Specific Instructions • (Bullet four) If neither the patient not a proxy is able to provide a response to this item, use medical record documentation.	A1005 Ethnicity Response-Specific Instructions • (Bullet four) Only use medical record documentation if the patient is unable to respond and a proxy is not able to provide a response to this item	Bullet four in Response-Specific Instructions revised for clarification.
	Chapter 3 Section A A1010	A1010 Race N/A	A1010 Race AMERICAN INDIAN OR ALASKAN NATIVE • A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. ASIAN	New definition box added.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			• A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam. BLACK OR AFRICAN AMERICAN • A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American." NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER • A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. ASIAN • A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.	
	Chapter 3 Section A A1010	A1010 Race Item Rationale • (Bullet one) The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including race. • (Bullet four) Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute care	A1010 Race Item Rationale • (Bullet one) N/A • (Bullet four) Standardizing self-reported data collection for race allows for the equal comparison of data across multiple health care settings and is an important step in improving quality of care and health outcomes.	Bullet one in Item Rationale deleted. Bullet four in Item Rationale revised for clarification.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		settings.		
	Chapter 3 Section A A1010	A1010 Race Response-Specific Instructions • (Bullet one) Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race. ○ Individuals may be more comfortable if this and the preceding question are introduced by saying "We want to make sure that all our patients get the best care possible, regardless of their racial background." • (Bullet four) If neither the patient nor a proxy is able to respond to this item use medical record documentation.	A1010 Race Response-Specific Instructions • (Bullet one) Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race. ○ N/A • (Bullet four) Only use medical record documentation to code A1010, Race if the patient is unable to respond and a proxy is not able to respond to this item.	Sub-bullet one in bullet one of Response-Specific Instructions deleted. Bullet four revised for clarification.
	Chapter 3 Section A M0150	M0150 Current Payment Sources for Home Care N/A	M0050 Current Payment Sources for Home Care Coding Instructions ○ Code 8, Private Health Insurance, is traditional health insurance provided by private companies where individuals or employers purchase coverage. ○ Code 9, Private Managed Health Insurance, is a type of private health insurance that contracts with a network of providers to deliver care at lower costs. Examples include HMO, PPO, EPO,	New Coding Instructions added from OASIS Q&As

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			POS plans that use a network of providers.	
	Chapter 3 Section A M0150	M0150 Current Payment Sources for Home Care N/A	M0150 Current Payment Sources for Home Care Coding Tips • For definitions and descriptions of health insurance types, including commercial insurance, managed care plans (HMOs, PPOs), and other structures, please review the information available at: https://www.healthcare.gov/ • If a patient's care is being reimbursed under a combined Medicare and Medicaid managed care insurance plan, check both response 2 and response 4	New Coding Tips added from OASIS Q&As
	Chapter 3 Section A A1110	A1110 Language Response-Specific Instructions • (Bullet four) If neither the patient nor a proxy is able to provide a response to A1110A or A1110B, medical record documentation may be used. • (Bullet five) Complete as close to the time of SOC as possible	A1110 Language Response-Specific Instructions ○ (Bullet four) Only use medical record documentation to code A1110A, What is your preferred language? Or A1110B, Do you need or want an Interpreter? if the patient is unable to respond and no proxy is able to provide a response. ○ (Bullet five) Complete as close to the time of SOC or ROC as possible.	Bullet four in Response-Specific Instructions revised for clarification. Bullet five revised to add Resumption of Care (ROC)
	Chapter 3 Section A M0090	M0090 Date Assessment Completed Coding Tips	M0090 Date Assessment Completed Coding Tips	New Coding Tip added from OASIS Q&As.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		N/A	• The M0090 Date Assessment Completed may not coincide with the date of a home visit. For example, in a situation where the assessing clinician needs to follow-up with the patient's family or physician to complete an OASIS item that the patient is unable to answer, M0090 should reflect that date even if no visit is provided on that date.	
	Chapter 3 Section A M0100	M0100 Assessment Reason Coding Instructions, Code 7 ○ Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.	M0100 Assessment Reason Coding Instructions, Code 7 • Short stay observation periods in a hospital (including time spent in the ER), regardless of duration, do not meet the definition for transfer to an inpatient facility.	Revised Coding Instruction to include information from OASIS Q&As.
	Chapter 3 Section A M0100	M0100 Assessment Reason Coding Tips N/A	M0100 Assessment Reason Coding Tips *Start of Care (SOC) RFA 1* ○ OASIS data collection and submission is not required when only one visit is made in a quality episode. This is a single visit quality episode (SOC/ROC to TRF/DC). When a patient is discharged after only one visit, a Discharge OASIS should NOT be collected or submitted. However, to bill Medicare PPS (PDGM) for a single visit quality episode, OASIS data must be collected and submitted. If OASIS is collected for a Medicare PPS patient's single visit quality episode M0100 RFA 1 - SOC is the appropriate response. Some payers may require OASIS data for a single visit quality	New Coding Tips added from OASIS Q&As.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			episode. In such cases, the HHA will be expected to work with the payer to deliver any required OASIS data. When OASIS data is only required by the payer, submission to iQIES is not expected. *Resumption of Care (ROC)RFA 3* ○ When a patient is transferred to an inpatient facility and returns home during the last 5 days of the current 60-day certification period (days 56-60), the agency may complete only the Resumption of Care, allowing the assessment to serve both resumption and recertification functions ○ When a patient returns to the agency from an inpatient stay a day or two before the last 5 days of a certification period, and assuming no physician-ordered ROC date is provided, regulations require the agency to complete a ROC assessment within 2 days of the inpatient facility discharge. – A ROC and a recertification assessment are required if the 2 days following inpatient facility discharge occur prior to days 56 – 60 (the last 5 days of the 60-day certification period). For example, if the patient is discharged on day 53, and there is no physician-ordered ROC date, the agency would be required to complete a ROC assessment no later than day 55. The agency would then complete a recertification assessment within days 56-60. • Only a ROC is required if the 2 days following inpatient facility discharge occur within days 56 – 60. For example, if the patient is discharged on day 54 or day 55, and there is no physician-	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			ordered ROC date, the agency may complete a ROC assessment on day 56 or day 57, and the ROC serves both resumption and recertification functions. *Recertification (Follow-Up) RFA 4* ○ The Home Health Conditions of Participation (CoPs) require the agency to perform a comprehensive assessment for the patient no less frequently than than last 5 days of every 60 days, beginning with the start of care date. The time period for Code 4, Recertification, has been further clarified in OASIS Q&As to mean the last 5 days of every 60 days, that is days 56-60 of the current 60-day certification period. All patients who remain on service into a subsequent certification period require a follow-up comprehensive assessment (including OASIS) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged. ○ A clinician may start the comprehensive assessment on day 56, and complete the assessment on or before day 60. ○ Unless the patient has been discharged, the due dates for Follow-Up assessments are calculated from the original Start of Care date rather than from the Resumption of Care date. ○ If a clinician visit is not made within the last 5 days of the 60-day certification period (i.e., a "missed" recertification visit), under Medicare PPS (PDGM), a visit can be made for only the purpose of performing a comprehensive assessment including OASIS, but it will not be	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			considered a billable visit unless skilled services are performed. ○ For example, a patient refuses a visit within the last 5 days of the 60-day certification period. Although most patients are willing to receive visits if the schedule and required time points have been explained to them, if the agency is unable to schedule a visit within the 5 day time frame, the follow-up assessment should be completed as soon after this period as possible. ○ If an agency misses the recertification assessment time frame (days 56-60 of the current 60-day certification period), the agency should not discharge and readmit the patient (i.e., complete a new SOC). Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date the assessment is completed, with documentation in the clinical record of the circumstances surrounding the late completion. When submitting the assessment, a warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. This situation should be avoided, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			the Medicare PPS (PDGM) patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC). *Other Follow Up RFA 5* ○ The HH CoPs require a comprehensive assessment including OASIS when there is a significant change in the patient's condition. ○ The Other Follow-up, RFA 5, may be used when a patient experiences a significant change in condition that was not anticipated in the patient's plan of care and would warrant an update to the plan of care. CMS does not provide written requirements about what constitutes a significant decline or improvement. Each agency must determine its own policies regarding examples of major decline or improvement in health status and ensure that the clinical staff is adhering to these policies. If the agency determines, based on its own policies, that an assessment is necessary RFA 5 would be selected. – The agency would not necessarily be required to discharge a patient who experienced a significant, or major, improvement in health status. If the patient has continuing home care needs and meets eligibility requirements, home care may continue. ○ The requirement to complete an RFA 5 for a patient experiencing a major decline or improvement in health status should not be confused with the Significant Change in Condition (SCIC) payment adjustment	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			which was introduced in the initial Home Health Prospective Pay System (PPS) model, and which no longer exists. ○ Under PDGM, if the M0090 - Date Assessment Completed for the RFA 5 is before the start of a subsequent, contiguous 30-day period and results in a change in the functional impairment level, the second 30-day claim would be grouped into its appropriate case-mix group. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group. ○ When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete an RFA 5 - Other follow-up assessment to ensure that diagnosis coding on the claim matches to the OASIS assessment. The CoP §484.55(d) does require an RFA 5 when there has been a major improvement or decline in a patient's condition that was not envisioned in the original Plan of Care. CMS expects agencies to have and follow agency policies that determine the criteria for when the Other Follow-up assessment is to be completed. *Transferred to an Inpatient Facility- patient not discharged from agency RFA 6* • When a patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay or if the patient's return to service is unsure, the reason for assessment (RFA) 6 should be completed.	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			• The patient should be discharged at the end of the current 60-day certification period if the patient has not returned to the HHA. • If you complete and transmit the RFA 6, Transfer to an inpatient facility - patient not discharged from agency, and the patient does not return to the care of the agency during the current 60-day certification period, no further OASIS is required. The quality episode ended with the Transfer (RFA 6) that was completed. You do not need to cancel the RFA 6 and resubmit the RFA 7, just complete your agency's internal discharge paperwork. • If a Medicare patient returns to the HHA after an inpatient stay that spans the end of the 60-day certification period, Medicare requires a new start of care assessment. *Transferred to an Inpatient Facility- patient discharged from agency RFA 7* • There are several reasons why the RFA 7 may be used, including these examples: ○ The patient needs a higher level of care and is no longer appropriate for home health care. ○ The patient's family plans on moving the patient out of the service area. ○ The patient is no longer appropriate for the home health benefit. • If the patient requires post-acute care in a SNF, IRF, LTCH or IPF during the 30-day period of home health care, CMS expects and recommends (but does not require) the HHA to discharge the	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			patient by completing the RFA 7 and then to readmit the patient with a new Start of Care upon return to home care. If the agency decides to complete an RFA 6 (Transferred to an inpatient facility - patient not discharged from agency), the home health agency will need to complete an RFA 3 (ROC) upon return to home care as long the ROC assessment is completed prior to the end of the current certification period.	
	Chapter 3 Section A A1255	A250 Transportation N/A Time Points Item(s) Completed • Start of Care • Resumption of Care • Discharge from agency	A1255 Transportation *Item Intent* Identifies if a lack of transportation has kept the patient from medical appointments, meetings, work or from getting things needed for daily living Item Rationale • Information regarding transportation barriers will help facilitate better care coordination and discharge planning. *Time Points Item(s) Completed* ○ Start of Care ○ Resumption of Care	Added new Item Intent, and a new Item Rationale bullet. Revised Time Points Item Completed to remove Discharge.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
	Chapter 3 Section A A1255	A1250 Transportation Response-Specific Instructions Ask the patient: ○ "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" ○ "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?" • 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. • If neither the patient nor a proxy is able to provide a response to this item, medical record documentation may be used. • If the patient declines to respond, do not code based on proxy input or medical record documentation. • Complete as close to the time of SOC/ROC as possible and within two days of discharge. Check all that apply.	A1255 Transportation Response-Specific Instructions ○ Ask the patient, "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?" ○ Ask the patient to select the response that most closely corresponds to the patient's transportation status from the list in A1255. ○ If the patient declines to respond, code 7, Patient declines to respond, and do not code based on other resources (proxy or medical records). ○ If the patient is unable to respond, a proxy response may be used. ○ Only use medical record documentation to code A1255, Transportation if the patient is unable to respond and no proxy provides a response for this item.	Revised Response-Specific Instructions for modified item.
	Chapter 3 Section A A1255	A1250 Transportation Coding Instructions • Code A, Yes, if the patient indicates that lack of transportation has kept the patient from medical appointments or	A1255 Transportation Coding Instructions • Code 0, Yes: if the patient indicates that in the past 12 months, a lack of reliable transportation kept them from medical appointments, meetings,	Revised Coding Instructions for the modified item.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		from getting medications. • Code C, No, if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the patient needs. • Code X, Patient unable to respond, if the patient is unable to respond. o In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. o If the response(s) is/are determined via proxy input and/or medical record documentation, check all boxes that apply, including code X - Patient unable to respond. o If the patient is unable to respond and no other resources (proxy or medical record documentation) provided the necessary information, code X – Patient unable to respond, only. • Code Y, Patient declines to respond, if the patient declines to respond. o In the cases where the patient	work or from getting things needed for daily living. • Code 1, No: if the patient indicates that in the past 12 months, a lack of reliable transportation has not kept them from medical appointments, meetings, work or from getting things needed for daily living. • Code 7, Patient declines to respond: if the patient declines to respond. o When the patient declines to respond, do not code based on other resources (proxy or medical records). • Code 8, Patient unable to respond: if the patient is unable to respond and no other resources (proxy or medical records) provided the necessary information. • Dash is a valid response for this item. o A dash indicates “no information.”, CMS expects dash use to be a rare occurrence.	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		declines to respond, code Y – Patient declines to respond, only. o If the patient declines to respond do not code based on proxy input or medical record documentation to complete this item. • Dash is not a valid response for this item		
	Chapter 3 Section A A1255	A1250 Transportation NA	A1255 Transportation Coding Tips • If the patient is unable to respond and the response is determined via proxy or medical records, select the response that applies. • When a patient responds in their preferred language with the use of an interpreter, this is considered a patient response. Do not code X - Patient unable to respond. Patients may respond to questions in English, or in their preferred language with the assistance of an interpreter.	New Coding Tips added for the modified item.
	Chapter 3 Section A A1255	A1250 Transportation Example The patient has Multiple Sclerosis. During the SOC assessment the patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with related information is available, but the patient's medical record	A1255 Transportation 3. A patient is admitted with Multiple Sclerosis. They are confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with information about transportation is available, but their medical record indicates that in the past 12 months, their spouse used their car to transport the patient wherever they need to go.	Example revised with updated guidance for modified item.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		indicates that their sibling uses their car to transport the patient wherever the patient needs to go. ○ Coding: A1250, Transportation would be coded as Code C – No and Code X – Patient unable to respond. Rationale: If neither the patient nor a proxy is able to provide a response, but the medical record documentation can provide the necessary information, code both the information in the medical record, and Code X, Patient unable to respond.	○ Coding: A1255, Transportation would be coded as 1, No. ○ Rationale: Neither the patient nor their proxy was able to provide a response, but the medical record documentation provided the necessary information regarding transportation.	
	Chapter 3 Section A A1255	A1250 Transportation N/A	A1255 Transportation 4. The patient indicates that in the last 12 months, they have not had reliable transportation, which has occasionally kept them from attending medical appointments. ○ Coding: A1255, Transportation would be coded as 0, Yes. ○ Rationale: The patient reported they have not had access to reliable transportation in the last 12 months, which has kept them from medical appointments, meetings, work or from getting things needed for daily living.	New example added for modified item.
	Chapter 3 Section A M1000	M1000 Inpatient Facilities Coding Instructions Code 1, Long-term nursing facility, if the patient was discharged from a Medicare-certified skilled nursing facility but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care.	M1000 Inpatient Facilities Code 1, Long-term nursing facility, if the patient was discharged from a long-term nursing facility or a Medicare-certified skilled nursing facility but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care	Revised with guidance from OASIS Q&As.

Appendix D **Description of Changes from OASIS-E1 to OASIS-E2**

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
	Chapter 3 Section A M2420	M2420 Discharge Disposition Coding Instructions Code 1, Patient remained in the community (without formal assistive services) Code 2, Patient remained in the community (with formal assistive services	M2420 Discharge Disposition Coding Instructions Code 1, Patient remained in the community (without skilled services from a Medicare-certified HHA or non-institutional hospice) Code 2, Patient remained in the community (with skilled services from a Medicare Certified HHA)	Revised Coding Instructions
	Chapter 3 Section B B0200	B0200 Time Points Item Collected Start of Care	B0200 Hearing Time Points Item Collected Start of Care Resumption of Care	Added to ROC time point
	Chapter 3 Section B B1000	B1000 Vision Time Points Item Collected Start of Care	B1000 Vision Time Points Item Collected Start of Care Resumption of Care	Added to ROC time point
	Chapter 3 Section B B1300	B1300 Health Literacy Coding Instructions Complete as close to the time of SOC/ROC as possible and within two days of discharge.	B1300 Health Literacy N/A	This coding instruction removed.
	Chapter 3 Section D D150	D0150 PHQ 2 to 9 *Coding Instructions for Column 2: Symptom Frequency* • *Dash is not a valid response for this item.*	D0150 PHQ 2 to 9 *Coding Instructions for Column 2: Symptom Frequency* o Dash is a valid response for this item. □ Dash indicates “no information.” CMS expects dash use to be a rare occurrence.	Revised Coding Instructions to permit a dash in Column 2, Symptom Frequency

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
	Chapter 3 Section D D150	D0150 PHQ 2 to 9 N/A	D0150 PHQ 2 to 9 Coding Tips: - Under 4th bullet added new bullet to read: In the rare situation that the patient cannot provide a frequency, following a Yes response to a symptom in Column 1, enter a dash in column 2. CMS expects a dash response to be rare.	New Coding Tip.
	Chapter 3 Section D D0160	D0160 Total Severity Score Coding Instructions • 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" • Scoring Rules: Patient Mood Interview Total Severity Score D0160 If only the PHQ-2 is completed because both D0150A2 and D0150B2 are coded 0 or 1, add the numeric scores from these two frequency items and enter the value in D0160. If items D0150C through D0150I were asked, calculate the Total Severity Score: • Item D0160 is used to store the total severity score for the Patient Mood Interview. The score in item D0160 is based upon the sum of the values that are contained in the following nine items: D0150A2, D0150B2, D0150C2, D0150D2, D0150E2, D0150F2,	D0160 Total Severity Score Coding Instructions • If symptom frequency is blank or dashed for 3 or more items, the interview is deemed NOT complete. D0160, Total Severity Score should be coded as "99" Scoring Rules: Patient Mood Interview Total Severity Score D0160 - Updated 2nd bullet to read: The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are skipped or dashed. An item in Column 2 is skipped if the corresponding item in Column 1 was equal to 9 (no response) or a dash (symptom presence not assessed). - Updated 4th bullet to read: If any of the items in Column 2 are blank (or skipped) or dashed, then omit their values when computing the sum. Examples Example #1 Rationale - Updated rationale to read: In this	Revised Coding instructions, and Scoring Rules, to account for possible dash use in D0150.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		D0150G2, D0150H2, and D0150I2. These are referred to as the "items in Column 2", below. • The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are skipped. An item in Column 2 is skipped if the corresponding item in Column 1 was equal to 9 (no response) or a dash (symptom presence not assessed). • If all the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values. • If any of the items in Column 2 are blank (or skipped), then omit their values when computing the sum. • If the number of missing items in Column 2 is equal to one, then compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0160. • If the number of missing items in Column 2 is equal to two, then compute the simple sum of the seven items in Column 2 that have non-missing values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0160. • If the number of missing items in Column	example, all the items in Column 2 have non-missing values (i.e., none of the values are blank (or skipped) or dashed. Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14. -	

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		2 is equal to three or more, then item D0160 must equal [99] Examples Example #1 Rationale: In this example, all the items in Column 2 have non-missing values (i.e., none of the values are blank, or skipped). Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.		
	Chapter 3 Section G M1840	M1840 Toilet Transferring N/A	M1840 Toilet Transferring Coding Tips • If a patient experiences incontinence on the way to the toilet, this should only be considered in coding this item if it affects their ABILITY to safely get to and from and transfer on and off the toilet or bedside commode.	New Coding Tip from OASIS Q&As.
	Chapter 3 Section GG GG0110	GG0110 Prior Device Use Response-Specific Instructions • For the response categories in GG0110 (e.g., Mechanical lift, Orthotics/Prosthetics), CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use.	GG0110 Prior Device Use Response-Specific Instructions • For the response categories in GG0110 (e.g., Mechanical lift, Orthotics/Prosthetics), CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use. Clinical judgment may be used to determine whether other devices meet the definition provided	Revised with guidance from OASIS Q&As.
	Chapter 3 Section GG GG0170	GG0170 Mobility Response-Specific instructions – General	GG0170 Mobility Response-Specific instructions – General A clinician's presence for the purpose of completing	Revised with guidance from OASIS Q&As.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		N/A	the assessment should not automatically be considered as providing a "supervision" level of assistance when coding Section GG activities. For GG0130 and GG0170, the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely	
	Chapter 3 Section GG GG0170	GG0170M 1 step (curb), GG0170N 4 steps, and GG0170O 12 steps • Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance.	GG0170M 1 step (curb), GG0170N 4 steps, and GG0170O 12 steps • The intent of GG0170M - 1 step (curb), GG0170N - 4 steps, and GG0170O - 12 steps is to assess the patient's ability to go up and down 1 step (curb), 4 steps, and 12 steps with or without a rail. • Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance. A ramp or elevator are not considered a step/curb and should not be used in place of a step or curb when assessing these activities.	New Coding Tips from OASIS Q&As
	Chapter 3 Section J J0510- J0530	J0510 Pain Effect on Sleep, J0520 Pain Interference with Therapy Activities, and J0530 Pain Interference with Day-to-Day Activities Coding Instructions *If SOC/ROC assessment, complete as close to the time of SOC/ROC as possible. If discharge*	J0510 Pain Effect on Sleep, J0520 Pain Interference with Therapy Activities, and J0530 Pain Interference with Day-to-Day Activities Coding Instructions *Code based on the first complete pain interview conducted within the assessment timeframe. Coding for this item should not be changed even if a patient's*	Coding Instructions revised for each item from OASIS Q&As.

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
		assessment, complete as close to the time of discharge as possible	*status might change within the assessment timeframe. If discharge assessment, complete as close to the time of discharge as possible.*	
	Chapter 3 Section K K0520	K0520D Therapeutic Diet Coding Tips N/A	K0520D Therapeutic Diet Coding Tips • A fluid restricted diet is considered a therapeutic diet for item K0520D if the fluid restriction is prescribed to manage a disease or clinical condition. • Therapeutic diets are not defined by the content of what is provided or when it is served, but WHY is the diet required	New Coding Tips from OASIS Q&As.
	Chapter 3 Section O O0110	O0110: Special Treatments, Procedures, and Programs Coding Instructions • Code O0110E1, Tracheostomy care, 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.	O0110: Special Treatments, Procedures, and Programs Coding Instructions • Code O0110E1, Tracheostomy care, if cleansing of the tracheostomy and/or cannula is performed and/or if care to the tracheostomy/stoma is part of the current care/treatment plan, even after decannulation. This item may also be checked if the patient performs their own tracheostomy/stoma care or receives assistance. ○ This item also includes laryngectomy care.	Revised Coding Instructions from OASIS Q&As
	Chapter 3 Section O	O0350. Paatient's COVID-19 Vaccination is Up to Date	N/A	Item removed from OASIS.
	Appendix B	N/A	O0350 is removed A1255 replaced A1250	Updated table with OASIS-E2 changes

Edit #	Chapter, Section, Item	OASIS-E1	OASIS-E2	Description of Change
			A0810 replaced M0069 A1110 Added to ROC time point B0200 Added to ROC time point B1000 Added to ROC time point	
	Appendix D	N/A	New content	New content to delineate changes from OASIS-E1 to OASIS-E2
	Appendix E	Vaccination Guidelines Centers for Disease Control & Prevention (CDC) COVID-19 vaccine guidelines Stay Up to Date with COVID-19 Vaccines | CDC	N/A	Resource deleted due to removal of item O0350
	Appendix F	OASIS & Quality Measure Reports N/A	OASIS & Quality Measure Reports ***Non-quality measures reports (including the HHA Activity Report, HHA Roster Report, HHA Discharge Report, OASIS Agency Final Validation Report, OASIS Submitter Final Validation Report, HHA Error Summary by Agency, and OASIS Error Detail Report) will include any relevant, voluntary OASIS all-payer data.*** ***CMS plans to update the following non-QRP iQIES reports to include all-payer OASIS data. This update is planned for late 2025 - early 2026 as mandatory all-payer data is available for these reports:*** • ***Agency Patient-Related Characteristics (Case Mix) Report*** • ***Agency Patient-Related Characteristics (Case Mix) Tally Report*** • ***Potentially Avoidable Events (PAE) Report*** • ***Potentially Avoidable Events Patient (PAE) Listing Report***	New guidance from OASIS Q&As.

APPENDIX E: REFERENCES AND RESOURCES

This appendix provides information on print and electronic resources available to support you in OASIS accuracy, quality of care, patient safety, and best practices.

Disclaimer

The links are valid at the time this document is being prepared but cannot be expected to remain unchanged indefinitely. CMS does not control the content of the websites that are not listed as CMS. The opinions expressed may or may not match those of CMS policy.

Home Health Quality Help Desk

Home Health Quality Help Desk – homehealthqualityquestions@cms.hhs.gov

Questions related to: Guidance on OASIS coding and documentation of the OASIS responses; Home Health Quality Measures including, but not limited to quality manuals, quality measures, measure calculation including Quality of Patient Care Stars, Care Compare), risk adjustment, public reporting, and Quality Assessment Only (QAO)/Pay for Reporting (P4R).

- **Excludes All Inquiries For** the expanded Home Health Value Based Purchasing (HHVBP) Model which may be directed to HHVBPquestions@cms.hhs.gov

CMS Websites

e-Rulemaking: Electronic Comments on CMS Regulations - instructions for viewing documents open for public comment, submitting public comments and reviewing public comments received on regulations https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html

e-CFR: Electronic Code of Federal Regulations - https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=689910789421528509d5af9867d06e0d&mc=true&n=pt42.5.484&r=PARTaty=HTML

Internet Quality Improvement and Evaluation System (iQIES) - Information and assistance with OASIS submission https://qtso.cms.gov/providers.

iQIES Help Desk - E-mail: iqies@cms.hhs.gov. Phone: 1-800-339-9313

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

OASIS Q&As (OASIS Quarterly Q&As, OASIS Static Q&As), CASPER HHA Reporting User's Manual, CMSnet Installation Guide & FAQs, jHAVEN User's Guide - https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals

Home Health Agency (HHA Center)

https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html

- Enrollment, Participation & Certification
- Policies/Regulations
- Billing/Payment
- Educational Resources
- CMS Manuals & Transmittals
- Demonstrations
- Initiatives (Quality Initiative, Home Health Research & Analysis Compare, etc.)
- How to Stay Informed

The Medicare Learning Network® - http://www.cms.hhs.gov/MLNGenInfo/

Medicare.gov - What Medicare Covers: Home health patient rights https://www.medicare.gov/what-medicare-covers/home-health-patient-rights

National Provider Identifier (NPI) Registry - https://npiregistry.cms.hhs.gov/

Guidelines and Best Practices

Vaccination Guidelines

Influenza Vaccine Guidelines: https://www.cdc.gov/flu/professionals/vaccination/vaccine_safety.htm

Wound Care

The National Pressure Injury Advisory Panel – NPIAP: Educational and Clinical Resources

https://npiap.com/page/resources

Healthcare Technology

National Quality Forum and Health Information Technology
http://www.qualityforum.org/HealthIT/

Office of the National Coordinator for Health Information Technology (ONC)

https://www.healthit.gov/

About ONC: https://www.healthit.gov/topic/about-onc

Healthcare Information and Management Systems Society (HIMSS) http://www.himss.org/

International Classification of Diseases (ICD)

Official Guidelines International Classification of Diseases (ICD) Official

ICD-10-CM https://www.cdc.gov/nchs/icd/icd-10-cm.htm

ICD-11-CM Release
ICD-11 (who.int)

Clinical Resources

Medications

Institute of Safe Medication Practices (ISMP) List of High-Alert Medications in Community/Ambulatory Healthcare

https://www.ismp.org/recommendations/high-alert-medications-community-ambulatory-list

MEDLINE Plus - http://www.nlm.nih.gov/medlineplus/druginformation.html

Caregivers

AARP Family Caregiving - Caregiving Tools

https://www.aarp.org/home-family/caregiving/caregiving-tools/

Next Step in Care - http://www.nextstepincare.org/

Mental Health Resources

Alzheimer's - http://www.alz.org

National Alzheimer's and Dementia Resource Center (NADRC) https://nadrc.acl.gov/

Brief Interview for Mental Status (BIMS) – Assessment Tool

Journal Article: *Nursing Home Assessment of Cognitive Impairment: Development and Testing of a Brief Instrument of Mental Status*

https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2008.01944.x

Confusion Assessment Method (CAM) Assessment

Inouye, S.K., Van Dyck, C.H., Alessi, C.A., et al.: Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann. Intern. Med. 113(12):941- 948, 1990. Clarifying confusion: the confusion assessment method. A new method for detection of delirium - PubMed (nih.gov)

Depression Recognition & Assessment in Older Home Care Patients

Journal Article: *Training Nursing Staff to Recognize Depression in Home Healthcare*. Full text link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3684961/

Risk Assessment Tools

Obesity – Body Mass Index (BMI)

National Heart, Lung, and Blood Institute

https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Behavioral Health

SAMHSA-HRSA National Center of Excellence for Integrated Health Solutions

National Center of Excellence for Integrated Health Solutions | SAMHSA

Pain

Wong-Baker FACES® http://wongbakerfaces.org

Brief Pain Inventory Brief Pain Inventory (BPI) | MD Anderson Cancer Center

Falls

MAHC 10 – Fall Risk Assessment Tool

https://www.homecaremissouri.org/projects/falls/documents/Oct2012FINALValidatedFallriskassessmen ttool.pdf

Professional Organizations

American Nurses Association (ANA) - http://www.nursingworld.org/

American Occupational Therapy Association (AOTA) - http://www.aota.org/

American Physical Therapy Association (APTA) - http://www.apta.org/

American Speech-Language-Hearing Association (ASHA) - https://www.asha.org/

Quality Resources

Agency for Healthcare Research and Quality (AHRQ) - https://www.ahrq.gov/ **AHRQ's Health Care Innovations Exchange Web site -** https://innovations.ahrq.gov/

AHRQ's Quality Measures Database - https://www.qualitymeasures.ahrq.gov/ **Institute for Healthcare Improvement -** http://www.ihi.org

National Academies: Health and Medicine Division -
http://www.nationalacademies.org/hmd/

Crossing the Quality Chasm

https://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the

Patient Safety and Care

Patient Safety and Quality: An Evidence-Based Handbook for Nurses
https://www.ncbi.nlm.nih.gov/books/NBK2631/

Transitional Care Model
https://www.nursing.upenn.edu/ncth/transitional-care-model/

Care Transitions Intervention
http://www.caretransitions.org

National Transitions of Care Coalition (NTOCC)

http://www.ntocc.org/

PSNET Patient Safety Network

https://psnet.ahrq.gov/

TeamSTEPPS

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html

VA National Center for Patient Safety

http://www.patientsafety.va.gov/

APPENDIX F: OASIS AND QUALITY IMPROVEMENT

Overview

The OASIS instrument was introduced nationally in 1999. Its initial purpose was to provide a standardized home health item set and standardized quality measures for use in quality improvement activities within individual home health agencies. The uses for OASIS data quickly expanded beyond quality measurement to also include determining reimbursement under Medicare Prospective Payment System (PPS). The uses for OASIS data have continued to evolve over the years with significant quality and payment implications tied to OASIS data. The current uses for OASIS include: 1) Home Health Agency Medicare-certification surveys, 2) the quality measures on the consumer-focused Care Compare website, 3) the quality measures used in the Home Health Quality of Patient Care Star Ratings, 4) the quality measures used in the Centers for Medicare & Medicaid Services (CMS) Home Health Value- Based Purchasing (HHVBP) Model, and 5) the Quality Assessment Only (QAO) Metric used in home health pay-for- reporting (P4R). The OASIS instrument also plays a pivotal role in post-acute care quality improvement related to the mandates of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).

History of OASIS and Outcome-Based Quality Improvement (OBQI)

In the early 2000s, CMS promoted a quality improvement process for home health called Outcome-Based Quality Improvement (OBQI). OBQI used OASIS-based quality measures as the foundation for home health quality improvement activities. CMS, through their contracts with state Quality Improvement Organizations (QIOs), provided training to home health agencies nationally on OBQI. Agency training and the use of OBQI to improve quality was a preparatory step for the home health public reporting of quality measures.

In 2002, CMS announced plans for public reporting of home health quality measures. In the fall of 2003, CMS launched the Home Health Compare website. This initiative encouraged consumers to use publicly available home health quality measures when selecting a home health agency. The launch of Home Health Compare was also a catalyst for agency quality improvement activities as well as the marketing and promotion of quality of care by individual agencies. The OASIS-based measures created the foundation for these early activities and advances in home health quality improvement. In 2021, CMS retired the Home Health Compare website and launched the Care Compare website (https://www.medicare.gov/care-compare). With Care Compare, CMS merged multiple setting-specific Compare sites into one consumer-friendly site that features information from providers across the continuum. At the time of the launch of Care Compare, CMS also launched another website related to publicly reported data: the Provider Data Catalog (PDC) (https://data.cms.gov/provider-data). While Care Compare is a consumer-focused tool, PDC is a resource geared toward providers, vendors, and researchers. The PDC website includes downloadable data from the Care Compare site as well as additional measure-specific information.

Understanding Quality & Quality Improvement

What is quality? The term “quality” in healthcare may have many different meanings. However, standard definitions are required to be able to measure quality and to then improve quality. The OASIS-based quality measures provide the home health industry with a framework for defining quality in terms of what matters to a patient and their caregivers. The home health quality measures have included many measures of activities of daily living (ADLs), patient status, and home health agency care processes. These include the measures of “Improvement in Ambulation- Locomotion,” “Stabilization in Grooming,” “Improvement in Bed Transferring,” etc. These measures are important to patients as they symbolize quality of life and independence in a home setting. Quality measures also benefit clinicians by promoting best practice interventions. Home health care

quality is reflected in measures of agency best practices such as "Drug Regimen Review Conducted with Follow-Up for Identified Issues."

Agencies can measure their overall progress in each quality measure to determine if they are improving in the measure, worsening in the measure, or remaining unchanged. Through the internet Quality Improvement and Evaluation System (iQIES) reports, agencies can compare, or benchmark, their current performance to their prior performance on each quality measure and compare their performance to a national reference rate.

Outcome And Process Measures

The initial OASIS-based quality measures were risk adjusted *outcome* measures. Shortly after the 2010 implementation of OASIS-C, agencies were introduced to the first standardized *process* measures which were derived from OASIS data.

Outcome Measures

An **outcome** is a health status change that occurs over time, where the change is intrinsic to the patient and change can be positive (improvement), negative (worsening) or neutral (no change). **Outcome of care measures** are one tool for examining changes in patient condition or functioning that may be impacted by home health care services. Thus, a change in the patient's environment, such as the provision of a walker or handrails in the patient's residence, is not considered an outcome according to this definition—such changes are services or processes of care.

The definition of an outcome does not include a presumed direction; therefore, any deviation (or non-deviation) in health status between the initial time point and the follow-up time point constitutes an outcome. For example, did the patient's ability to walk and move around improve by the time they finished working with the home health agency? A rate of 88% for that quality measure means that 88% of the time, the agency improved their patients' ability to walk and move around.

An **end-result outcome** is a change in patient health status, such as physiologic, functional, cognitive, emotional, or behavioral health, between two or more time points. Examples of end-result outcome quality measures are Improvement in Management of Oral Medications and Stabilization in Bathing. For example, did the patient's ability to manage their oral medications improve by the time they finished working with the home health agency? A rate of 80% for that quality measure means that 80% of the time, the patients' ability to manage their oral medications improved from the start to the end of their home care episode.

A **utilization outcome** is a type of quality measure that reflects use of health care services presumably resulting from a change in the patient's health status. Examples of utilization outcomes include quality measures that identify hospital admission, use of hospital emergency department services, and discharge to the community. Utilization measures were initially computed using only OASIS data; however, current, and potential future measures may be computed using Medicare FFS claims data. A complete list of quality measures and measure descriptions are available on the CMS Home Health Quality Reporting Program website.

Measure Exclusions For Outcome Measures

Some patients are excluded from the improvement or the stabilization computations. Any patient whose status at start (or resumption) of care is optimal for the health attribute under consideration is excluded from the improvement computation. Such a case is excluded because the patient could not possibly show improvement, since they are as "good" as they can possibly be for this attribute. All the patients included in the improvement computation had the potential to show improvement; the percentage (and the actual number of cases) listed at the end of the bar actually did improve.

Like exclusions from the improvement measures, some cases are excluded from the stabilization computation. Any patient whose status at start (or resumption) of care is at the most severely impaired level for the health attribute under consideration is excluded from the stabilization computation. This patient could not possibly show worsening, and therefore is excluded.

A quality measure may also have exclusions specific to that measure. Measure exclusions are noted on the Home Health Quality Measure Tables and in the Home Health Quality Measure User's Manual (found on the Home Health Quality Reporting Program website.)

Examples – Outcome Measures

Quality Measure Name	Consumer Language (on Care Compare)	Measure Description	Measure Focus (Numerator)	OASIS Items Used in Measure Calculation
Improvement in Ambulation-Locomotion	How often patients got better at walking or moving around.	Percentage of home health quality episodes during which the patient improved in ability to ambulate.	Number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in ambulation - locomotion at discharge than at start (or resumption) of care	Items Used to Compute Change: (M1860) Ambulation/Locomotion Items Used to Compute Exclusions: (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious (M0100) Reason for Assessment (M2420) Discharge Disposition
Stabilization in Grooming	NA – This measure is not publicly reported.	Percentage of home health quality episodes during which patients improved or stayed the same in ability to groom self.	Number of home health quality episodes where the value recorded on the discharge assessment indicates the same or less impairment in grooming themselves at discharge than at start (or resumption) of care.	Items Used to Compute Change: (M1800) Grooming. Items Used to Compute Exclusions: (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

Process Measures

Process quality measures evaluate the rate of home health agency use of specific evidence-based processes of care. The standardized home health quality process measures focus on high-risk, high-volume, problem-prone areas for home health care. These include measures pertaining to all or most home care patients, such as timeliness of home care admission/resumption of care and immunization rates.

Process items represent actions taken by home health care providers that are designed to favorably impact patient outcomes. An example of a process measure is the percentage of home health quality episodes during which

patients received the influenza immunization for the current flu season. An agency rate of 72% for that measure means that the agency's process of caring for patients included the recommended practice in 72% of the included quality episodes. The processes of care items in OASIS have been carefully developed to represent "evidence-based" practice.

Measure Exclusions For Process Measures

Most OASIS-based process measures have measure-specific exclusions. Exclusions are specific to each measure. For example, the process measure of "Influenza Immunization Received for Current Flu Season" excludes quality episodes in which no care was provided during October 1–March 31, or the patient died, or the patient does not meet age/condition guidelines for influenza vaccine. Quality episodes that are excluded are not counted favorably or unfavorably toward the measure calculation.

Example – Process Measures

Quality Measure Name	Consumer Language (on Home Health Compare)	Measure Description	Measure Focus (Numerator)	OASIS Items Used in Measure Calculation
Influenza Immunization Received for Current Flu Season	How often the home health team made sure that their patients have received a flu shot for the current flu season.	Percentage of home health quality episodes during which patients received influenza immunization for the current flu season.	Number of home health quality episodes during which the patient a) received vaccination from the HHA or b) had received vaccination from HHA during earlier episode of care, or c) was determined to have received vaccination from another provider	Items Used to Compute Care Processes: (M0030) Start of Care Date (M0032) Resumption of Care Date (M0906) Discharge/Transfer/ Death Date (M1046) Influenza Vaccine Received Items Used Compute Exclusions: (M1041) Influenza Vaccine Data Collection Period (M1046) Influenza Vaccine Received (M0906) Discharge/Transfer/ Death Date

Home Health Quality Improvement

As home health quality initiatives have evolved over the years, the OBQI process has also evolved. Today, agencies may decide to use other quality improvement methodologies in addition to or in place of OBQI. Examples include Six Sigma, Lean Methodology, and PDSA (Plan, Do, Study, Act).

Although agencies may choose not to use the original OBQI process, many of the steps within OBQI are relevant to home health quality improvement today. A cyclical and ongoing quality improvement process may include the following steps:

1. Review Quality Measure Reports
2. Select Quality Measures—for focused quality improvement activities
3. Investigate Care Processes (related to measures selected for quality improvement)
4. Develop a Plan of Action (a.k.a., Quality Improvement Plan)

5. Implement the Plan
6. Monitor the Plan
7. Revise/Update the Plan – as needed

Most current home health quality measures are based on OASIS data. In addition to the OASIS- based quality measures, there are home health quality measures derived from Medicare FFS claims data and Home Health CAHPS® (Consumer Assessment of Healthcare Providers and Systems) data. Some agencies may have access to additional quality measures through their health system or payer affiliations, through other programs (such as benchmarking vendors, state collaboratives, etc.), or quality reports generated from their electronic health records. Home health agencies are encouraged to use any of these information sources in systematic efforts to continuously monitor and improve the care provided to their patients. However, CMS cannot provide guidance on data, analysis, or reports from software or data benchmarking from other sources such as software vendors or data benchmarking companies.

Quality Episodes

Quality episodes are used in the calculation of the quality measures. Quality episodes are not the same as certification periods or Patient-Driven Groupings Model (PDGM) payment periods. A quality episode begins with either a Start of Care or Resumption of Care assessment and ends with a Transfer, Death at home, or Discharge assessment. A quality episode does not include Recertification (follow-up) or Other Follow-up assessments and may span payment periods.

A quality episode is measured from:

- Start of Care to the Transfer OR
- Start of Care to the Death at Home OR
- Start of Care to the Discharge
- Resumption of Care to the Transfer OR
- Resumption of Care to the Death at Home OR
- Resumption of Care to the Discharge

For example, let's look at a patient who was admitted on 1/1/25 and transferred to an inpatient facility on 1/15/23, then had a resumption of care on 1/20/25 and was discharged from the agency on 2/1/23. In this example, this patient had two quality episodes. The first quality episode began with the start of care on 1/1/23 and ended with the transfer to an inpatient facility on 1/15/25. The second quality episode began with the resumption of care on 1/20/23 and ended with the discharge on 2/1/25.

Calculating Quality Measures

Measuring quality first begins at the patient level. Outcome measures indicate the change in patient status from one point in time to another point in time. For the OASIS-based quality measures, we use the OASIS items for this calculation. To calculate quality measures, we also need to understand the measure definition for each individual measure. The Quality Measure Tables found on the CMS Home Health Quality Reporting Program website include information on the measure numerator, denominator, and measure exclusions for each home health quality measure (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits).

Example: Improvement In Dyspnea

Measure Definition: The "Improvement in Dyspnea" quality measure is the "Percentage of home health quality episodes during which the patient became less short of breath or dyspneic."

OASIS Item(s) Used in Quality Measure Calculation: The quality measure is calculated using the OASIS item: (M1400) When is the patient dyspneic?

(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)

Measure Exclusions: The first step in calculating quality measures is to determine the patients that are eligible for the measure. In this example, this quality measure excludes home health quality episodes for which the patient, at start/resumption of care, was not short of breath at any time, and also excludes quality episodes that end with inpatient facility transfer, death, or a discharge to a non-institutional/home hospice. Therefore, for this quality measure, all patients who at start of care or resumption of care are scored a "0 – Patient is not short of breath" on OASIS are excluded from this quality measure because the patient cannot improve. If the patient cannot improve, then Improvement in Dyspnea is not computed. Quality episodes that are excluded are not counted favorably or unfavorably toward the quality measure calculation.

Improvement: To improve in this quality measure, a patient must move from a higher numeric score on the OASIS response scale at start of care or resumption of care to a lower numeric score at discharge (e.g., M1400 start of care score of "3" and discharge score of "2" would be an improvement). The following table depicts how an individual patient's score at the beginning of a quality episode (start of care or resumption of care) and at the end of a quality episode (discharge for this quality measure) would be calculated for the Improvement in Dyspnea measure:

OASIS Responses & Quality Measure Calculation For Improvement In Dyspnea Measure

Start of Care OR Resumption of Care	Discharge	Calculation
0	0–4	Excluded
1	0	Improved
1	1–4	Did Not Improve
2	0–1	Improved
2	2–4	Did Not Improve
3	0–2	Improved
3	3–4	Did Not Improve
4	0–3	Improved
4	4	Did Not Improve

Agency "Improvement in Dyspnea" Observed Rate: In determining the agency rate for each outcome measure, we also need to understand the definitions for the quality measure numerator and denominator.

The numerator for this quality measure is the number of cases where improvement occurred. In the "Improvement in Dyspnea" measure, the numerator is number of home health quality episodes where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care.

The denominator is the entire population (i.e., patients who improved and who did not improve) for the quality measure. Therefore, the denominator is every patient in the reporting period that is not excluded from the measure. In the "Improvement in Dyspnea" quality measure, the denominator is the number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions. (Remember that for the "Improvement in Dyspnea" quality measure, home health quality episodes for which the patient, at start/resumption of care, was not short of breath at any time, are excluded from this quality measure as are quality episodes that end in transfer to an inpatient facility, death, or discharge to a non-institutional/home hospice.)

Sample Agency Calculation: If an agency had 100 patients during the reporting period that were discharged from the agency, and 10 of these patients scored "0" at start of care/resumption of care on M1400 (and therefore were excluded) and 70 of the remaining 90 patients improved in dyspnea (moved from a higher numeric score on M1400 to a lower numeric score), then 70/90 (or 0.777) which equals 77.77% scored favorably or improved in dyspnea.

For a high-level overview of how data elements are used within CMS assessment instruments to construct quality measures, refer to training resources at the Home Health Quality Reporting Training webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.

Measuring Stabilization

In our example, we noted that with improvement in OASIS-based quality measures, the patient's status moved from a higher numeric score (at start of care or resumption of care) on the OASIS response scale to a lower

numeric score (at discharge). A number of OASIS-based quality measures are calculated for "improvement" and/or "stabilization." For example, there is a measure for "Improvement in Bathing" and there is also a quality measure for "Stabilization in Bathing." How then is "stabilization" measured? For the OASIS-based quality measures, stabilization is calculated as all patients who did not worsen for the measure. Stabilization includes all patients who remain numerically the same on the OASIS response scale (i.e., "stabilized") from start of care or resumption of care to discharge AND all patients who improved (moved from a higher numeric score to a lower numeric score).

As the stabilization quality measures include all patients who have stabilized AND all patients who have improved, the measure rates for the stabilization quality measures are much higher than the corresponding improvement quality measure rates. For example, at the time of development of this manual, the "Improvement in Bathing" national reference rate was approximately 82%. However, the "Stabilization in Bathing" national reference rate was approximately 98% as the stabilization rate includes patients who numerically stay the same for OASIS M1830 AND patients who numerically improve in the OASIS M1830 score.

OASIS & Quality Measure Reports

CMS provides several quality measure reports. Home health agencies can obtain these reports from iQIES. Information on obtaining OASIS-based quality measure reports can be found on CMS's iQIES Technical Support Office (QTSO) website https://qtso.cms.gov/software/iqies/reference-manuals

Non-quality measures reports (including the HHA Activity Report, HHA Roster Report, HHA Discharge Report, OASIS Agency Final Validation Report, OASIS Submitter Final Validation Report, HHA Error Summary by Agency, and OASIS Error Detail Report) will include any relevant, voluntary OASIS all-payer data.

CMS plans to update the following non-QRP iQIES reports to include all-payer OASIS data. This update is planned for late 2025 - early 2026 as mandatory all-payer data is available for these reports:

- Agency Patient-Related Characteristics (Case Mix) Report
- Agency Patient-Related Characteristics (Case Mix) Tally Report
- Potentially Avoidable Events (PAE) Report
- Potentially Avoidable Events Patient (PAE) Listing Report

Quality Measure Reports: Title, Description and Uses

Report Title	Report Description	Report Uses
1. Agency Patient-Related Characteristics (Case Mix) Report	The average value of each OASIS patient-related characteristics (patient attributes or circumstances) measure for quality episodes that ended during a specified period for the agency, along with national observed values for the same period.	Agencies can use this report as a companion to their Outcome Report and their Process Measures Report.

2.Outcome Report	Lists End Results Outcome measures, Utilization Outcome measures, and Claims Based Outcome measures (Some risk adjusted). Significance levels are presented for each quality measure when the sample size corresponding to the quality measure is at least ten. If the agency had nine or fewer patients on whom the outcome measure could be computed validly, statistical significance is not provided.	Agencies can use this report to monitor their outcome measures. Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly.
3. Potentially Avoidable Event Report	Lists each of the Potentially Avoidable Event Measures and statistics for each quality measure.	Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly.
4. Potentially Avoidable Event: Patient Listing Report	Lists each of the Potentially Avoidable Event Measures and the patients who experienced those events for a select agency during a specified period.	Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly.

Report Title	Report Description	Report Uses
5.Process Measures Report	Provides the number and percentage of each OASIS process quality measure followed for quality. episodes that ended during a specified period for the agency, along with national observed values for the same period: Significance levels are presented for each quality measure when the sample size; Corresponding to the quality measure is at least. 10. If the agency had nine or fewer patients on whom the process quality measure could be computed validly, statistical significance is not provided.	Agencies can use this report to monitor their OASIS-based process quality measures. Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly for optimal monitoring of quality measures.
6. Agency Patient-Related Characteristics (Case Mix) Tally Report	Details the patient-related Characteristics of each quality episode that ended during a specified period for the agency.	Agencies can use this report to drill- down to the individual patient-level to identify cases that triggered for each of the indicators on the Agency- Patient -Related Characteristics (Case Mix) Report.
7.Outcome Tally Report	Details the quality episodes that ended during a specified period for a select agency and were used to calculate the Outcome Reports.	Agencies can use this report to drill- down to the individual patient-level to identify cases that triggered for each of the quality measures on the Outcome Report. Agencies may find this report useful in investigating unfavorable OASIS- based outcome measures.
8.Process Tally Report	Details the quality episodes that ended during a specified period for a select agency and were used to calculate the Process Measures Reports.	Agencies can use this report to drill- down to the individual patient-level to identify cases that triggered for each of the quality measures on the Process Measures Report. Agencies may find this report useful in investigating unfavorable OASIS- based process measures.
9. Care Compare Home Health Provider Preview Report	This report is a preview of the agency's Care Compare data.	This report is placed in the agency's iQIES folders no less than 3 months prior to the Care Compare update to allow the agency to preview their Care Compare data and contact CMS with any potential data issues.
10. Quality of Patient Care Star Ratings Provider Preview Report	This report is a preview of the agency's Quality of Patient Care Star Rating and includes a scorecard for each of the quality measures used to compute the Quality of Patient Care Star Rating.	This report is placed in the agency's iQIES folders no less than 3 months prior to the Care Compare quarterly refresh to allow the agency to preview their data. Agencies that have proof that there are errors in calculating your Quality of Patient Care Star Rating may request a review of their rating by submitting that proof to CMS.

Report Title	Report Description	Report Uses
11. Quality Assessment Only (QAO) Performance Report	CMS provides a quarterly Quality Assessments Only (QAO) Performance Report and a year- end Historical Quality Assessments Only (QAO) Performance Report. This report is based on OASIS assessments submitted by an HHA during the applicable reporting period as it relates to compliance with OASIS submission requirements for the Annual Payment Update (APU).	These reports are placed in the HHA's iQIES folder. Agencies can use these reports to monitor their compliance with Home Health pay-for-reporting requirements.
12. Home Health Review and Correct Report	These reports provide quarterly measure results, displaying four quarters of data. A new quarter is added on the first day of each calendar quarter. These reports are updated weekly to provide confidential agency-level and patient-level performance for the OASIS-based quality measures that are publicly reported on Care Compare. The purpose of these reports is to provide agencies with an opportunity to review and correct their quality measure data before it is publicly reported.	Agencies can use these reports in conjunction with the other iQIES quality measure reports to determine if they have any data submission errors that may affect agency-level performance for one or more of the quality measures.

Risk Adjustment Of Quality Measures

Change in health status over a time interval during which care is provided (e.g., a quality episode) can occur either because of the care provided or the natural progression of disease and disability. The challenge in outcome analysis is to attempt to somehow separate changes due to care from those due to natural progression. Statistical **risk adjustment** refers to a collection of analytic methods designed to separate the relationship of outcomes with care provided from the relationship of outcomes with natural progression of disease and disability, which is critical to accurate outcome analysis. One of the major purposes of OASIS is to provide data items needed for risk adjustment. In essence, the general intent of risk adjustment is to compensate or adjust for differences in case mix or risk factors (between agency and a comparison sample) that should be taken into consideration if outcomes are to be compared validly. *Risk adjustment compensates or controls for the potential influence of case mix variables (i.e., risk factors) that can affect outcomes.*

The OASIS-based quality measures are calculated using items from the OASIS assessments from Medicare FFS, Medicare Advantage, Medicaid, and Medicaid Managed care. For a set of these quality measures a logistic regression prediction model is created. Hundreds of risk factors are tested in the development of prediction models. Risk models are quality measure specific. A rigorous, multi-step process is followed that includes clinical review of the scientifically identified risk factors. Hence, the result of applying this prediction model for any episode of care is, in fact, the predicted value based on this logistic regression equation.

A subset of the OASIS-based outcome quality measures is risk adjusted. The OASIS-based process quality measures are not risk adjusted.

Additional information on home health risk adjustment methodology is available on the CMS Home Health Quality Reporting Program website and in the Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual found in the Quality Measures section of the Home Health Quality Reporting Program website.