Part 5:
OASIS-C2 Accuracy

Presented by:
Sharon Molinari, RN, HCS-D, HCS-O

For:
HealthCare Synergy

Let's Review!

$$$ (M1311)

Replaces M1308

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
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 at FU/DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
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 at FU/DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

$$$ M1311 = 2 or more Stage 3 or 4

(M1311)…continued

D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1]	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
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 at FU/DC Go to M1311F1]	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

M1311: Guidance

- Counts all current Stage 2, Stage 3, Stage 4, and unstageable pressure ulcers at all time points.
- 2-line format for reporting current pressure ulcers:
  - **Line 1 (Completed at all time points):** Number of current pressure ulcers at a given stage.
    - A1 (Stage 2); B1 (Stage 3); C1 (Stage 4); D1 (Unstageable due to non-removable dressing; E1 (Unstageable due to eschar/slough); F1 (Unstageable due to suspected DTI)
    - *If no pressure ulcer at a given stage at FU and DC, skip Line 2.*
  - **Line 2 (Completed at Follow-up and Discharge only):** Number of these ulcers at a given stage that were present at most recent SOC/ROC.
    - A2 (Stage 2); B2 (Stage 3); C2 (Stage 4); D2 (Unstageable due to non-removable dressing; E2 (Unstageable due to eschar/slough); F2 (Unstageable w/suspected DTI)
    - *Interpretation: Was the current stage present* ***AT THE SAME STAGE*** *at the most recent SOC/ROC assessment?*

M1311: Present on Admission = Present at SOC/ROC

- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did ***not*** form during this home health quality episode.
- If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame (5 days at SOC, 2 days at ROC), *the* ***initial stage*** *of the pressure ulcer would be reported.*
  - Do ***not*** change the stage on the SOC/ROC assessment.

Let's take a look…

- A SOC assessment is done on Tuesday. The patient has a Stage 2 pressure ulcer on her coccyx.

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	1
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	

Not answered at SOC/ROC

- On Saturday, the nurse noted that the pressure ulcer had worsened to a Stage 3.

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	1
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	

Not answered at SOC/ROC

- *If a pressure ulcer worsens during the assessment time period, the initial stage at SOC is reported.*

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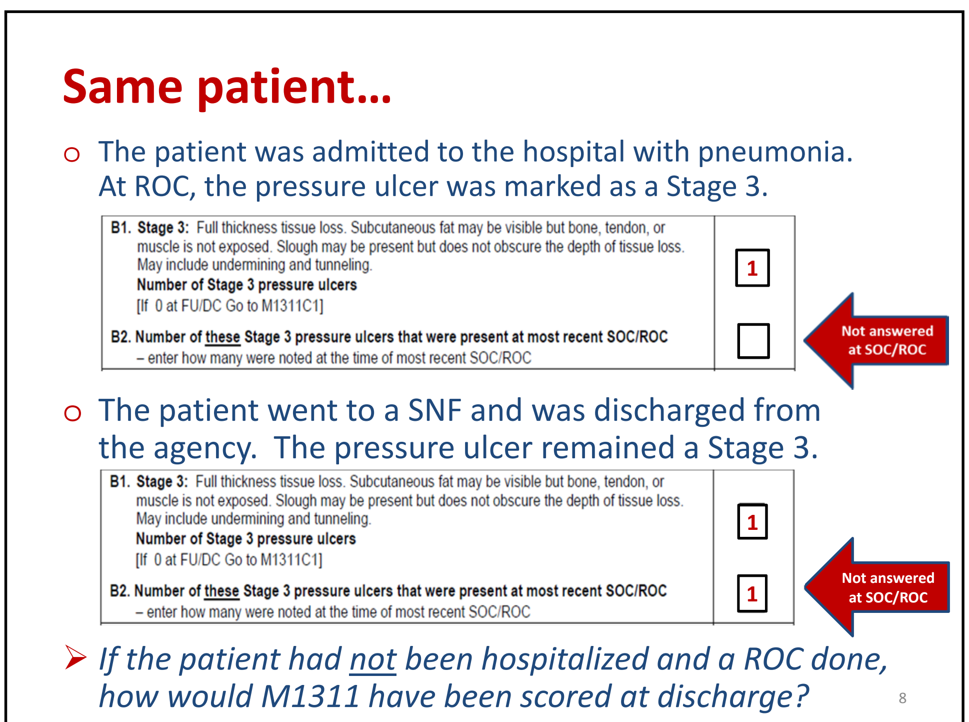

Unstageable Pressure Ulcer at SOC/ROC

- If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the **Discharge** assessment, its "Present on Admission" stage should be considered the stage at which it first becomes numerically stageable.
- If the ulcer subsequently increases in numerical stage, do ***not*** report the higher stage ulcer as being "present at SOC/ROC" when completing the Discharge assessment.

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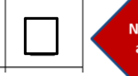
M1311: Scenario

- At SOC, patient had a pressure ulcer on his right hip that was covered with slough and eschar. Two days later, the physician debrided it and staged it as a 3. It progressed to a Stage 4 and a Stage 2 developed on his left hip, prior to being discharged to a nursing home.

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 at FU/DC Go to M1311F1]	1
E2. **Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	



- *The pressure ulcer was unstageable at SOC. This is not changed, if the status changes within the assessment time period (5 days at SOC).*

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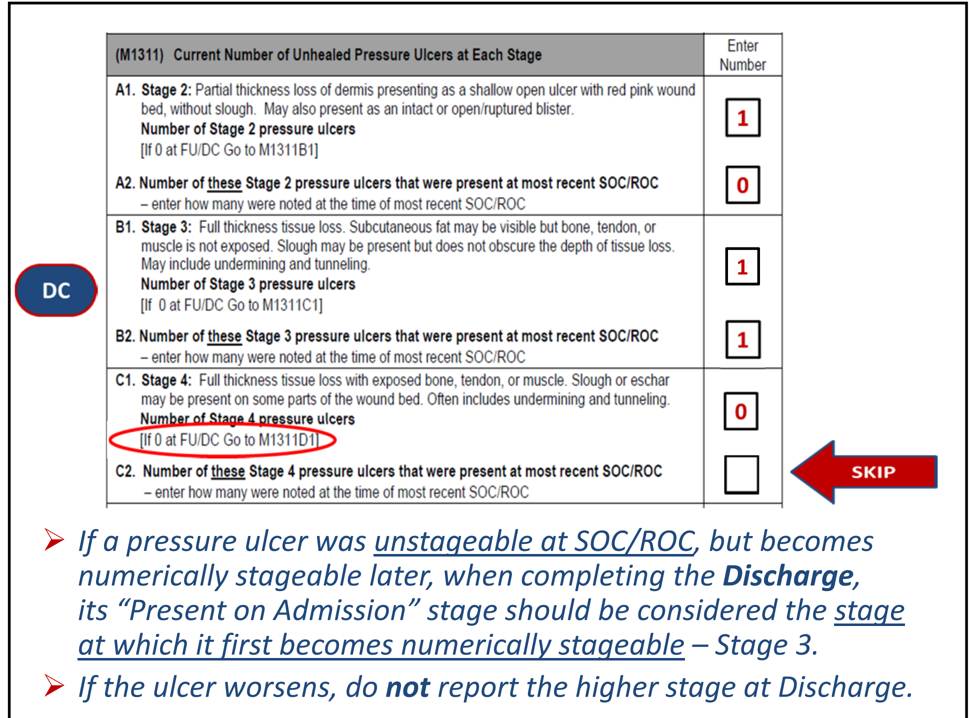

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	1
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	0
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 at FU/DC Go to M1311C1]	1
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	1
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 at FU/DC Go to M1311D1]	0
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	

- *If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the* ***Discharge****, its "Present on Admission" stage should be considered the stage at which it first becomes numerically stageable – Stage 3.*
- *If the ulcer worsens, do* ***not*** *report the higher stage at Discharge.*

(M1313)

Replaces M1309 → Impact Act

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable – Suspected deep tissue injury in evolution.	☐

- This item documents the number of pressure ulcers *present at Discharge* that were ***not*** present (are new) or have "worsened" (increased in numerical stage) *since the most recent SOC/ROC assessment*.

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M1313: Guidance

- Compare the current stage at Discharge to past stages to determine whether any pressure ulcer currently present is *new* or *at an increased numerical stage (worsened)* when compared to the most recent SOC/ROC.
- Count the number of current pressure ulcers that are *new* or *have increased in numerical stage* since the last SOC/ROC was completed.
- A pressure ulcer increased in numerical stage from SOC/ROC to Discharge, is considered worsened.
- For pressure ulcers that are currently Stage 2, 3, and 4, "worsening" refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is, therefore, staged at a higher number using a numerical scale of 1-4 at the time of discharge in comparison to the most recent SOC/ROC assessment.

M1313: Guidance (cont.)

- For pressure ulcers that are currently Stage 2, 3 or 4:
  - Mark a response for each row of this item: a, b, and c. If at Discharge there are currently NO ulcers at a given stage, enter "0" for that stage/row.
  - Report the number of current pressure ulcers at each stage that are *new or have worsened* since the most recent SOC/ROC assessment.
- If the pressure ulcer was *unstageable* for any reason at the most recent SOC/ROC, do ***not*** consider it new or worsened, *if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge*.
- If the pressure ulcer was *unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage*, is should be considered worsened at Discharge.

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M1313: Guidance (cont.)

- If a previously *stageable pressure ulcer becomes unstageable*, then was debrided sufficiently to be restaged by Discharge, compare its stage before and after it was deemed unstageable. If the pressure ulcer's stage has increased in numerical staging, report this as worsened.
- Pressure ulcers that are *Unstageable at Discharge due to a dressing/device*, such as a cast that cannot be removed to assess the skin underneath, ***cannot*** be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.
- A dash (–) value is a valid response for this item.

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M1311 and M1313: Scenario

- Patient had a Stage 2 pressure ulcer on her left hip at SOC. Two weeks later she had an exacerbation of her CHF and was hospitalized for 5 days.
- At the ROC assessment, the pressure ulcer on her left hip had deteriorated to a Stage 3, and she had a new Stage 1 pressure ulcer on her right hip.
- At discharge, the Stage 3 pressure ulcer on her left hip was 80% granulated, and the Stage 1 pressure ulcer on her right hip had evolved to a stage 2 pressure ulcer.

➢ ***Complete M1311 at SOC and ROC and M1313 at DC.***

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M1311: Completed

SOC

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	1
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
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 at FU/DC Go to M1311C1]	0
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	

ROC

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	0
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
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 at FU/DC Go to M1311C1]	1
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	

- Stage 1 pressure ulcers are excluded from M1311.
- Line 2 completed at FU and DC only.

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M1313: Completed

DC

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.

	Enter Number
a. Stage 2	1
b. Stage 3	0
c. Stage 4	0
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	0
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	0
f. Unstageable – Suspected deep tissue injury in evolution.	0

- The Stage 1 pressure ulcer at ROC deteriorated to a Stage 2.
- The Stage 3 pressure ulcer at ROC remained a Stage 3 and is, therefore, ***not*** reported at Discharge.

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M1320: Scenario

- At SOC, the patient's Stage 3 pressure ulcer was assessed to be partially granulated. At discharge, the Stage 3 ulcer is "hypergranulated."
  - *What is the healing status of this pressure ulcer in M1320?*
  - **Response 3** - Not healing
  - **Hypergranulation** is the growth of granulation tissue above the area of surrounding tissue (skin plane) in all or part of the wound bed. Hypergranulation results in delayed healing of a wound due to obstructed epithelialization.
  - *Should it be reported in M1311/M1313 as worsened?*
  - **No** - Worsening in M1311/M1313 refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number.

What is the correct M1320 response?

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code	Code	Response
☐	0	Newly epithelialized
	1	Fully granulating
	2	Early/partial granulation
	3	Not healing
	NA	No observable pressure ulcer

- A Stage II pressure ulcer: ___________
- A deep tissue injury: ___________
- A pressure ulcer with 20% eschar: ___________
- A closed Stage III pressure ulcer: ___________

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M1320: Answers

- A non-epithelialized Stage II pressure ulcer: ***3 - Not healing***
- A deep tissue injury: ***3 - Not healing***
- A pressure ulcer with 20% eschar: ***2 - Early/partial granulation***
- A closed Stage III pressure ulcer: ***None - no longer a pressure ulcer***

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Pressure Ulcer Scenario

- On admission to your agency, patient had a Stage 2 pressure ulcer on his (L) hip. After 7 weeks of care, the SN notes that the Stage 2 ulcer has epithelialized. At discharge, the sacral area is noted to be reddened and non-blanchable, with no break in skin, and there are no other skin lesions.

➤ *How should the following OASIS items be answered?*

- ✓ M1306 – Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?
- ✓ M1320 – Status of Most Problematic Pressure Ulcer
- ✓ M1322 – Current Number of Stage 1 Pressure Ulcers
- ✓ M1324 – Stage of Most Problematic Unhealed Pressure Ulcer

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Answers

- On admission to your agency, patient had a Stage 2 pressure ulcer on his (L) hip. After 7 weeks of care, the SN notes that the Stage 2 ulcer has epithelialized. At discharge, the sacral area is noted to be reddened and non-blanchable, with no break in skin, and there are no other lesions.
- *How should the following OASIS items be answered at discharge*?
  - M1306 – Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?
    - ✓ ***Response 0 -*** *No [Go to M1322]*
  - M1320 – Status of Most Problematic Pressure Ulcer
    - ✓ ***M1320 is blank*** - M1306 Response 0 (No) instructs to skip this item; Even if Response 1 (Yes), Stage 1 ulcers ***not*** included in M1320
  - M1322 – Current Number of Stage 1 Pressure Ulcers
    - ✓ ***Response 1*** *- Stage 1*
  - M1324 – Stage of Most Problematic Unhealed Pressure Ulcer
    - ✓ ***Response 1*** *- Stage 1*

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Pressure Ulcer Scenario

- On admission to your agency, patient had a Stage 2 pressure ulcer on his (L) hip. After 7 weeks of care, the SN notes that the Stage 2 ulcer has epithelialized. At discharge, the sacral area is noted to be reddened and non-blanchable, with no break in skin, and there are no other skin lesions.
- *How should the following OASIS items be answered?*
  - ✓ M1306 – Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?
  - ✓ M1320 – Status of Most Problematic Pressure Ulcer
  - ✓ M1322 – Current Number of Stage 1 Pressure Ulcers
  - ✓ M1324 – Stage of Most Problematic Unhealed Pressure Ulcer

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Answers

- On admission to your agency, patient had a Stage 2 pressure ulcer on his (L) hip. After 7 weeks of care, the SN notes that the Stage 2 ulcer has epithelialized. At discharge, the sacral area is noted to be reddened and non-blanchable, with no break in skin, and there are no other lesions.
- *How should the following OASIS items be answered at discharge*?
  - M1306 – Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?
    - ✓ ***Response 0 -*** *No [Go to M1322]*
  - M1320 – Status of Most Problematic Pressure Ulcer
    - ✓ ***M1320 is blank*** - M1306 Response 0 (No) instructs to skip this item; Even if Response 1 (Yes), Stage 1 ulcers ***not*** included in M1320
  - M1322 – Current Number of Stage 1 Pressure Ulcers
    - ✓ ***Response 1*** *- Stage 1*
  - M1324 – Stage of Most Problematic Unhealed Pressure Ulcer
    - ✓ ***Response 1*** *- Stage 1*

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Quiz: M1330 – M1334

- For M1330, a scabbed stasis ulcer is _______________.
- For M1332, if there are both arterial ulcers and stasis ulcers present, include only the ______________.
- For M1334, an infected stasis ulcer is ______________.
- Diabetic lower extremity ulcers are a type of stasis ulcer. True or False? _________

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Answers: M1330 – M1334

- For M1330, a scabbed stasis ulcer is **observable.**
- For M1332, if there are both arterial ulcers and stasis ulcers present, count only the **stasis ulcers.**
- For M1334, an infected stasis ulcer is: **3 - Not healing**
- Diabetic lower extremity ulcers are a type of stasis ulcer. True or False? **FALSE**

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Scenario #1

- Patient's surgical incision is mostly approximated, but it is open slightly in 2 areas with some serous drainage. Minimal avascular tissue is present and open wound bed areas are smooth and red.

➢ Is the wound healing by primary or secondary intention?

➢ How would you answer M1342 (Status of most problematic (observable) surgical wound)?

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

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Answers

- Patient's surgical incision is mostly approximated but it is open slightly in 2 areas with some serous drainage. Minimal avascular tissue is present and open wound bed areas are smooth and red.

- Is the wound healing by primary or secondary intention?
  - ✓ ***Secondary Intention***
- How would you answer M1342?
  - ✓ ***Response 3*** *(Not healing) – smooth and red tissue is **not** granulation tissue*

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Scenario #2

- Patient is being discharged from home health because he's no longer homebound. His abdominal incision was documented as re-epithelialized 2 weeks ago, and his physician removed the retention sutures 3 days ago. Four of the 16 former retention suture sites have become reddened, and two of them have purulent drainage. Several sites have scabs adhering to the underlying tissue. He is now on an antibiotic.

- How would you score M1342 (Healing status of most problematic (observable) surgical wound) on the Discharge OASIS?
  - 0 - Newly epithelialized
  - 1 - Fully granulating
  - 2 - Early/partial granulation
  - 3 - Not healing

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Answer

- Patient is being discharged from home health because he's no longer homebound. His abdominal incision was documented as re-epithelialized 2 weeks ago, and his physician removed the retention sutures 3 days ago. Four of the 16 former retention suture sites have become reddened, and two of them have purulent drainage. Several sites have scabs adhering to the underlying tissue. He is now on an antibiotic.

- How would you score M1342 (Healing status of most problematic (observable) surgical wound) on the Discharge OASIS?
  - ✓ ***Response 0*** *(Newly epithelialized) – Openings in the skin, adjacent to the incision line, caused by staples or sutures are* ***not*** *considered part of the surgical wound when determining the healing status.*

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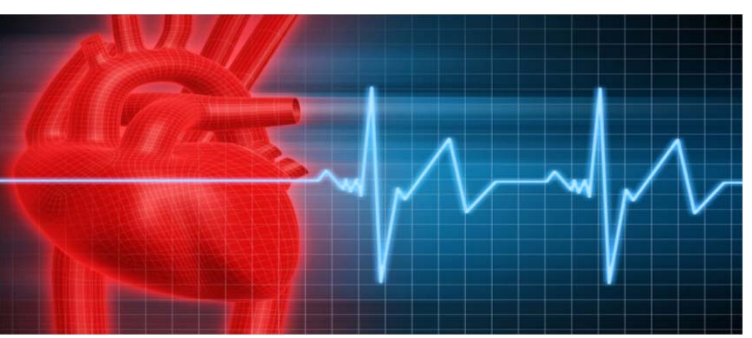
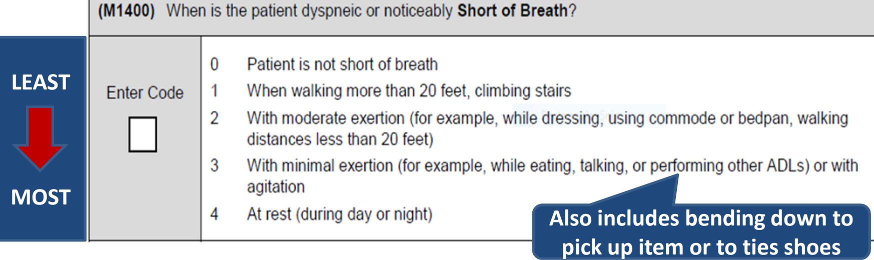


Respiratory and Cardiac Status M1400 – M1510

$$$ (M1400)



(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)

- Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath.

$$$ M1400 = 2, 3, or 4

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M1400: Guidance

- If the patient uses oxygen:
  - Continuously – assess with oxygen ON.
  - Intermittently – assess with oxygen OFF.

- Response is based on patient's <u>actual</u> use of oxygen in the home, ***not*** on the physician's oxygen order.
- For a chairfast <u>or</u> bedbound patient:
  - Evaluate the level of exertion required to produce SOB.
  - Assess for dyspnea while performing ADLs, transferring or wheeling self, changing positions, or at rest.

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M1400: Guidance (cont.)

- Select Response 1, if:
  - Physically demanding transfer activities produce dyspnea in the *chairfast* patient; or
  - Demanding bed-mobility activities produce dyspnea in the *bedbound* patient.
- Responses 2, 3, and 4 include assessment examples applicable to all patients.
- The responses represent increasing severity of shortness of breath. The most impaired choice is listed last.

Read response options from the bottom up!

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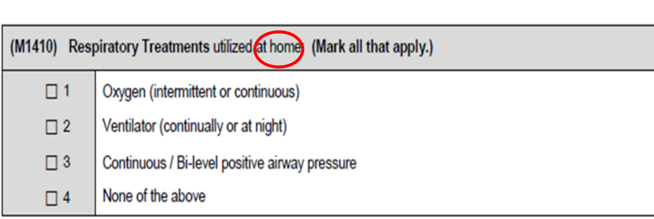
(M1410)



(M1410) Respiratory Treatments utilized at home: (Mark all that apply.)	
☐ 1	Oxygen (intermittent or continuous)
☐ 2	Ventilator (continually or at night)
☐ 3	Continuous / Bi-level positive airway pressure
☐ 4	None of the above

- Response 3 includes both CPAP and BiPAP
- **Excludes** any respiratory treatments ***not*** listed in the item (e.g., does ***not*** include nebulizers, inhalers)

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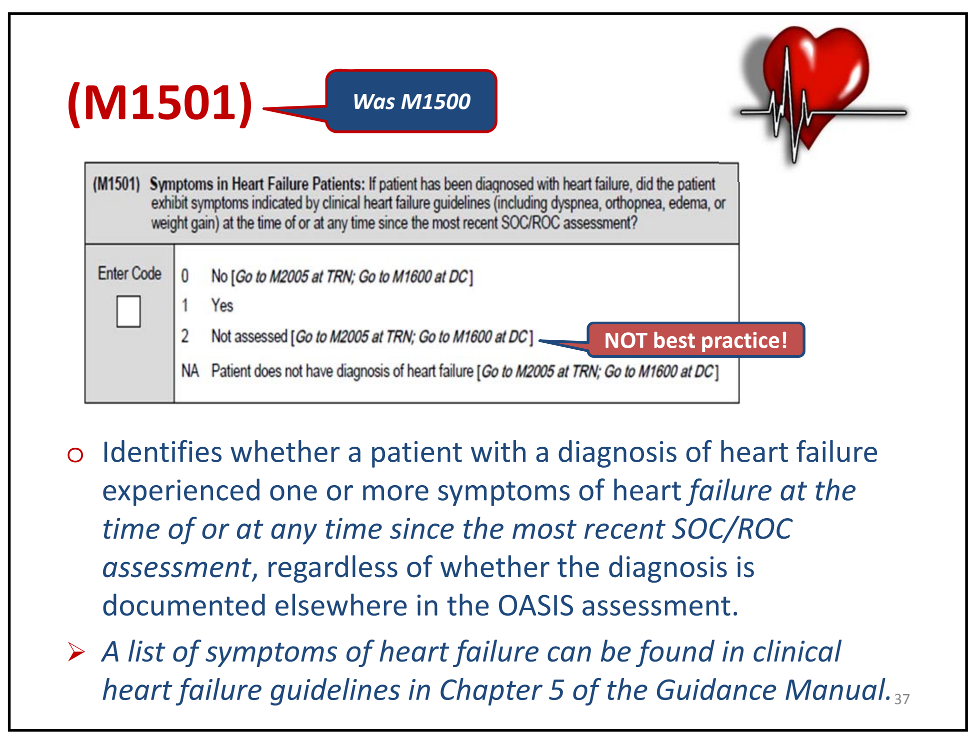

(M1501)
Was M1500
(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?
Enter Code
0 No [Go to M2005 at TRN; Go to M1600 at DC]
1 Yes
2 Not assessed [Go to M2005 at TRN; Go to M1600 at DC]
NOT best practice!
NA Patient does not have diagnosis of heart failure [Go to M2005 at TRN; Go to M1600 at DC]
Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart *failure at the time of or at any time since the most recent SOC/ROC assessment*, regardless of whether the diagnosis is documented elsewhere in the OASIS assessment.
A list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of the Guidance Manual.
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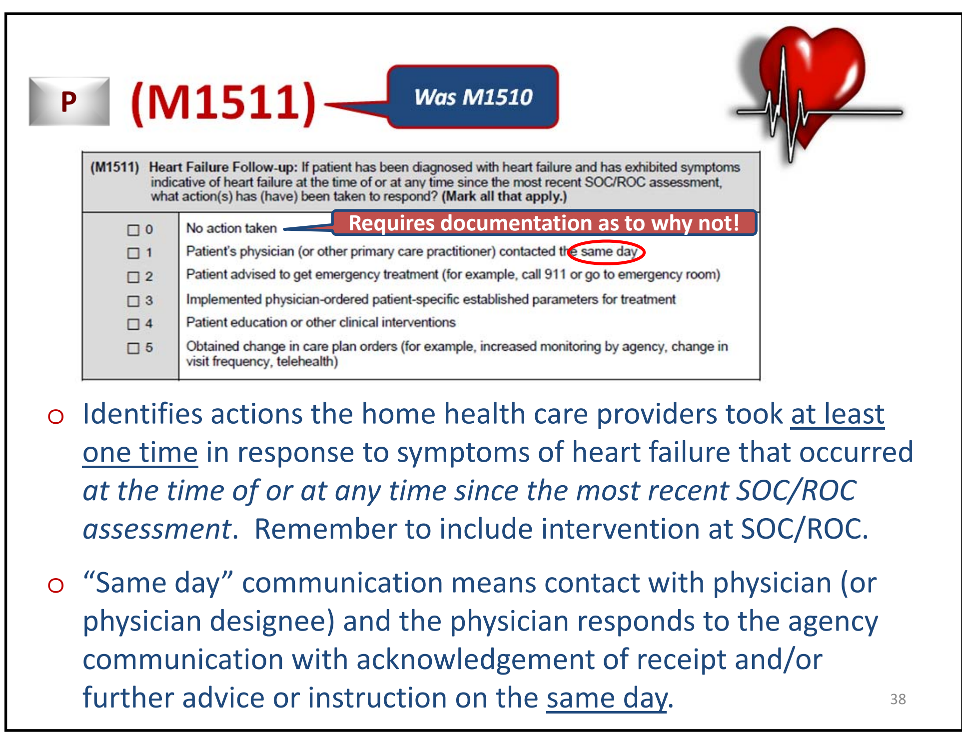


P
(M1511)
Was M1510
(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)
0 No action taken
Requires documentation as to why not!
1 Patient's physician (or other primary care practitioner) contacted the same day
2 Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
3 Implemented physician-ordered patient-specific established parameters for treatment
4 Patient education or other clinical interventions
5 Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)
Identifies actions the home health care providers took at least one time in response to symptoms of heart failure that occurred *at the time of or at any time since the most recent SOC/ROC assessment*. Remember to include intervention at SOC/ROC.
"Same day" communication means contact with physician (or physician designee) and the physician responds to the agency communication with acknowledgement of receipt and/or further advice or instruction on the same day.
38

M1511: Guidance

- **Response 1** (Physician communication) requires:
  - Same calendar day communication with the MD or primary care practitioner made by telephone, fax, voicemail or any other means to convey the patient's status; and
  - The MD responds to the agency communication with acknowledgement of receipt and/or further advice or instruction on the same day.
  - May also be marked with other responses indicating action resulting from physician contact.
  - Do ***not*** select, if patient/caregiver communicated directly with physician, and the agency did ***not*** verify accuracy of information with the physician on the same day.

39

M1511: Guidance (cont.)

- Select **Response 2**, when the patient exhibits symptoms of heart failure that require immediate attention in an emergency room and is advised to do so by agency staff.
  - It is ***not*** selected when a patient is educated to go to the ER or call 911 based on pre-established parameters.
- Select **Response 3** (Implement patient-specific treatment parameters) when:
  - The physician has provided order(s) that identifies specific parameters or guidelines for implementing treatment based on patient's condition.
  - The clinician reminds the patient to implement ***or*** is av

the patient is following MD established parameters for treatment.

40

M1511: Guidance (cont.)

- For **Response 4** - Patient education or other clinical interventions, simply providing a patient with printed materials regarding heart failure without assessment of their understanding of the content should ***not*** be considered patient education.
- Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms can be reported.

- *Examples of standard clinical guidelines can be found in Chapter 5 of the Guidance Manual.*

41

M1501: Scenario

- Patient is being discharged after 2 cert periods. During the first cert period she exhibited heart failure symptoms several times. Her MD was contacted each time and changes in her medication regimen were made and the nursing frequency increased for monitoring and teaching. Since her last recert, she hasn't exhibited any symptoms of heart failure, but the nurse reinforced prior education.

- What would be the correct response for M1501?

42

Answer: M1501 Scenario

- Patient is being discharged after 2 cert periods. During the first cert period she exhibited heart failure symptoms several times. Her MD was contacted each time and changes in her medication regimen were made and the nursing frequency increased for monitoring and teaching. Since her last recert, she has not exhibited any symptoms of heart failure, but the nurse reinforced prior education.

- What would be the correct response for M1501?
  - ✓ ***Response 1*** *- Yes (Patient exhibited symptoms since the most recent SOC/ROC assessment.)*

43

M1511: Scenario

- Which of the following is an example of physician-ordered patient-specific parameters for a patient who has CHF and has a weight gain of 4 lbs. in 2 days?
  a. The nurse reminds him to take Lasix as ordered – 20 mg. daily.
  b. The MD ordered an additional 40 mg. of Lasix to be taken if he has a weight gain of 3 lbs. in 2 days.
  c. The nurse instructed him on the symptoms of heart failure and gave him a handout on managing CHF.

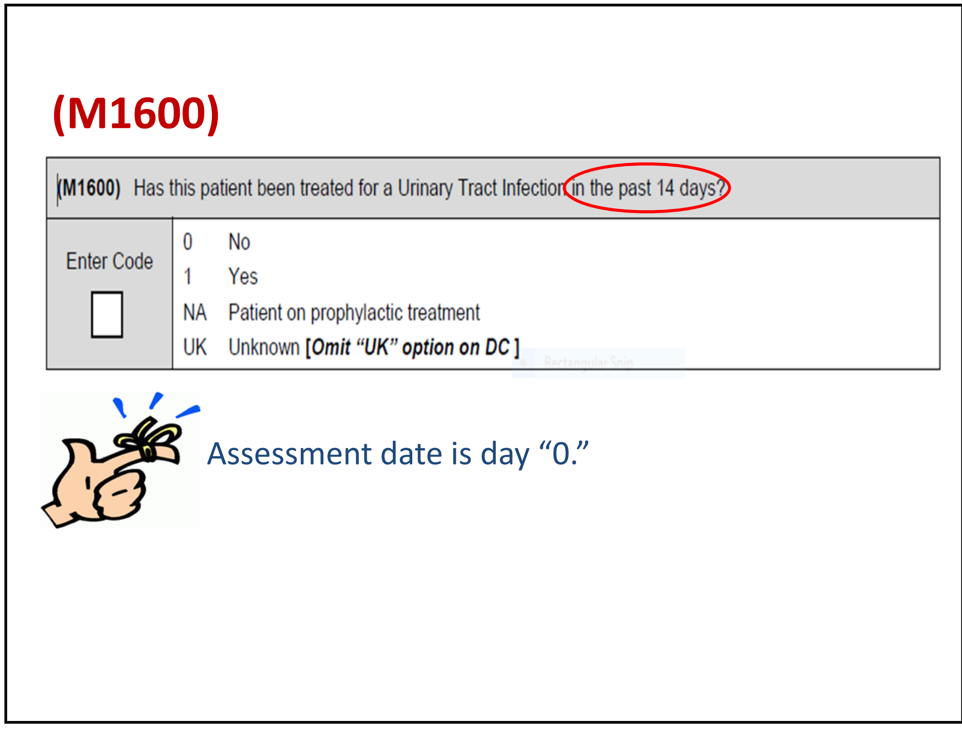
44

Answer: M1511 Scenario

- Which of the following is an example of physician-ordered patient-specific parameters for a patient who has CHF and has a weight gain of 4 lbs. in 2 days?
  a. The nurse reminds him to take Lasix as ordered – 20 mg. daily.
  b. The MD ordered an additional 40 mg. of Lasix to be taken if he has a weight gain of 3 lbs. in 2 days.
  c. The nurse instructed him on the symptoms of heart failure and gave him a handout on managing CHF.

45

Elimination Status M1600 – M1630



M1600: Guidance

- **Response 0 - No:**
  - Has ***not*** been treated for a UTI *within the past two weeks*
  - Had symptoms of a UTI <u>or</u> a positive culture
    - ✓ Physician did ***not*** prescribe treatment, OR
    - ✓ The treatment ended *more than 14 days ago*
- **Response 1 - Yes:**
  - Has been prescribed an antibiotic *within the past 14 days* specifically:
    - ✓ For *confirmed <u>or</u> suspected* UTI
    - ✓ Developed UTI while on prophylactic treatment
- **Response NA:**
  - On prophylactic treatment ONLY

48

(M1610)

(M1610) Urinary Incontinence or Urinary Catheter Presence:		
Enter Code	0	No incontinence or catheter (includes anuria or ostomy for urinary drainage) *[Go to M1620]*
	1	Patient is incontinent
	2	Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) *[Go to M1620]*

- "Incontinence" is defined as involuntary leakage of urine.
- Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling.
- The etiology (cause) of incontinence is not addressed in this item.

49

M1610: Guidance

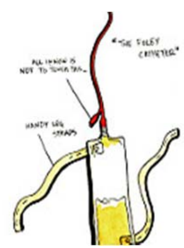
- A leaking urinary appliance or drainage device is ***not*** incontinence.

- A catheter solely used for irrigation of the bladder or instillation of an antibiotic is ***not*** reported in this item.
- If catheter is discontinued or both inserted ***and*** discontinued during the comprehensive assessment, Response 0 or 1 is appropriate, depending on whether or not the patient is continent.

50

M1610: Responses

- **Response 0** - No incontinence, if the patient has:
  - Anuria
  - A urinary ostomy (e.g., an ileal conduit)
  - A pouched urinary diversion (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma
- **Response 1** - Incontinent at any time
  - Includes patient on timed-voiding program
- **Response 2** - Requires urinary catheter (specifically: indwelling, external, suprapubic)
  - Intermittent or continuous use of catheter for any reason – e.g., retention, incontinence
  - Includes when patient is both incontinent and also requires a catheter



51

Responses (cont.)

Select **Response 2** - Requires urinary catheter, if:

- A catheter is inserted and left in place during the comprehensive assessment, but ***not*** inserted and removed.
- A catheter or tube used to drain urine, even if intermittent, unless it is capped, with no plan to drain urine.
- A penis pouch is used – considered to be a device "like" an external catheter:
  - For example, a patient with a retracted penis who cannot effectively wear an external catheter.

52

Scenario: M1600 and M1610

- Patient is admitted to home health following hospitalization for pneumonia. He complained of burning with urination, urinary frequency, and said his urine has a strong odor. The assessing clinician contacted the physician, who ordered a catheterization for a urine culture and an antibiotic for a possible UTI. He denied having any incontinence.

- How would you score M1600 (Has this patient been treated for a Urinary Tract Infection in the past 14 days?) and M1610 (Urinary Incontinence or Urinary Catheter Presence)?

53

Answers: M1600 and M1610

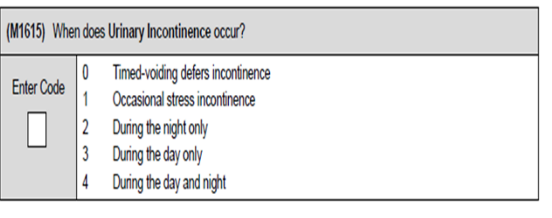
- Patient admitted to home health following hospitalization for pneumonia. He complained of burning with urination, urinary frequency, and said his urine has a strong odor. The assessing clinician contacted the physician, who ordered a catheterization for a urine culture and an antibiotic for a possible UTI. He denied having any incontinence.

- ***M1600 = Response 1*** *- Yes*
  The patient was prescribed an antibiotic within the past 14 days specifically for a suspected UTI. The day of assessment counts, since the antibiotic was ordered as a result of the assessment.

- ***M1610 = Response 0*** *- No incontinence or catheter*
  A catheter was inserted to obtain a urine culture and was then discontinued during the comprehensive assessment, and the patient denied being incontinent.

54

(M1615)



(M1615) When does Urinary Incontinence occur?		
Enter Code	0	Timed-voiding defers incontinence
	1	Occasional stress incontinence
	2	During the night only
	3	During the day only
	4	During the day and night

- "Timed-voiding defers incontinence" means ***100% effective***.
  - A compensatory strategy – does ***not*** cure incontinence
- Stress incontinence – if occurs under any situation(s), such as patient unable to prevent escape of relatively small amounts of urine when coughing sneezing, laughing, moving from sit to stand or other activities which increase abdominal pressure.
- Select Response 2, 3, or 4, if incontinence happens with regularity or in circumstances other than those described for stress incontinence.

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$$$ (M1620)

(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 FU, DC*]**

- 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.
- This item does not address treatment of incontinence or constipation (for example: a bowel program).
- The timeframe under consideration is *the day of assessment* and *the relevant past*.

$$$ M1620 = 2 to 5

M1620: Guidance

(CMS Q&A, Cat. 4, Q122.1, 04/15)

Question:

At the SOC assessment no bowel incontinence is reported for the past 7 days. At a repeat visit on day #4, the patient has experienced 3 episodes of bowel incontinence since the SOC. Can the clinician amend M1620 to reflect this additional assessment information?

Answer:

Yes. The SOC comprehensive assessment must be completed within 5 days after the SOC date (M0030). The assessing clinician may elect to re-assess bowel incontinence within the allowed timeframe and change her/his original response. The M0090 date should also be changed to reflect the date the assessment was completed/updated.

57

$$$ (M1630)

(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.

- Applies to any type of ostomy for bowel elimination (e.g., colostomy, ileostomy) – ONLY addresses *bowel ostomies*, ***not*** other types of ostomies (e.g., urinary ostomies).
- Mark Response 2, if a patient with an ostomy was hospitalized with diarrhea in the past 14 days.
- If an ostomy has been reversed, then the patient does ***not*** have an ostomy at the time of assessment, and the correct response would be "0."

$$$ M1630 = 1 or 2

58

Scenario: M1620 and M1630

- Patient was referred to home health from the hospital for continued treatment of an infected colostomy.

- How should the clinician score M1620 (Bowel Incontinence Frequency) and M1630 (Ostomy for Bowel Elimination)?

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Answers: M1620 and M1630

- Patient was referred to home health from the hospital for continued treatment of an infected colostomy.

- How should the clinician score M1620 and M1630?

- ***M1620 = Response NA -*** *Patient has ostomy for bowel elimination*

- ***M1630 = Response 2 -*** *The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.*

60

Neuro/Emotional/Behavioral Status M1700 – M1745

M1700-M1745: Guidance

- Assessment of the neuro/emotional/behavioral items includes:
  - Observation of patient during assessment process:
    - Posture and motor behavior
    - Manner of dress
    - Facial expressions
    - Grooming and personal hygiene
    - Affect and manner of speech
  - Obtain information from patient, family, caregivers, physician, past health history

  - Report any confusion <u>or</u> anxiety *within last 14 days*.

62

M1700-M1745: Guidance (cont.)

- "Non-responsive" means the patient is unable to respond or responds in a way that you're unable to make a clinical judgment. Attempt to obtain information from the caregiver or other source.

- Time span for assessment is specified in specific items.

Physician must confirm diagnoses associated with items!

63

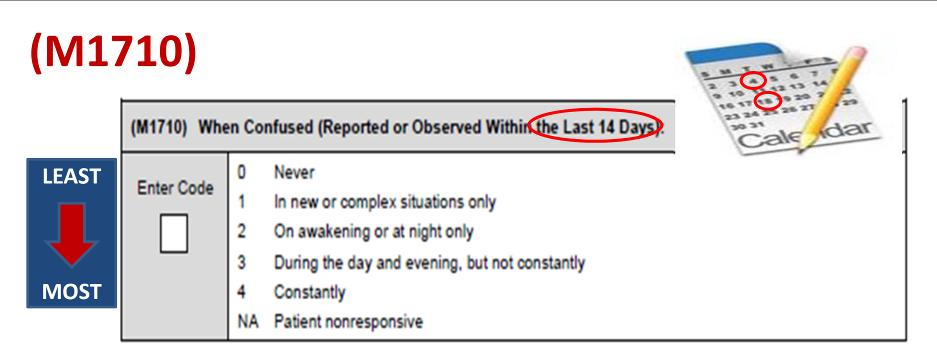
(M1700)

(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 (cuing, 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.

- Identifies the patient's current *(at the time of the assessment and in the preceding 24 hours)* level of cognitive functioning,
- Responses progress from no impairment to severely impaired.
- Consider the degree of impairment and amount of supervision required.

(M1710)



(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

- Identifies the time of day or situations when the patient experienced confusion, if at all, in the past 14 days.

➤ *This item may **not** relate directly to M1700.*

What is confusion?

- "Confusion" is defined in Mosby's Medical Dictionary as "a mental state characterized by disorientation regarding time, place, person, or situation. It causes bewilderment, perplexity, lack of orderly thought, and inability to choose or act decisively and perform the activities of daily living. It is usually symptomatic of an organic mental disorder, but it may accompany severe emotional stress and various psychological disorders."
- A "cognitive impairment," such as forgetfulness, learning disabilities, concentration difficulties, or decreased intelligence, may NOT result in confusion.

66

M1700 and/or M1710?

- If a patient is **confused** on the day of the assessment, report it <u>both</u> in M1700 and M1710.
- If a patient is **NOT confused** on the day of assessment, but experienced confusion *during the prior 14 days*, report it <u>only</u> in M1710.
- If, on the day of the assessment, a patient has a cognitive impairment that does **NOT** result in confusion, report it <u>only</u> in M1700.
  - For example: forgetfulness, learning disabilities, concentration difficulties, decreased intelligence

67

M1710: Responses

- Responses 1 - 4 are selected if the patient has experienced confusion, and each response represents a worsening.
- Response 1 is selected when the patient's confusion is isolated to a new or a complex situation – e.g., when there is a new caregiver or when a new procedure is taught.
- Response 2, 3, and 4 are selected when confusion occurs <u>without</u> the stimulus of a new or complex situation, or when confusion persists after the new situation is routine.
- Responses 2, 3 & 4 differ from each other based on the time when the confusion occurred.

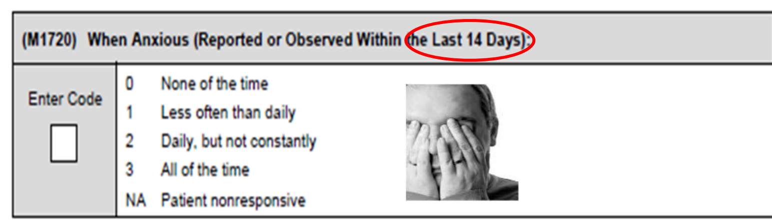
68

M1710 and M1720: Nonresponsive

- "Nonresponsive" means that the patient is unable to respond or responds in a way that you cannot make a clinical judgment about the patient's level of orientation.
- If the patient is nonresponsive at the time of assessment, report whether there was any confusion during the past 14 days, if this information can be elicited from the caregiver or other source.
- If the patient is nonresponsive at the time of assessment and the information cannot be elicited, enter "NA - Patient nonresponsive."
- Per CMS, a patient who simply refuses to answer questions should ***not*** automatically be considered "unresponsive." The clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview.

69

(M1720)



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

Enter Code		
	0	None of the time
	1	Less often than daily
	2	Daily, but not constantly
	3	All of the time
	NA	Patient nonresponsive

- Identifies the frequency with which the patient has felt anxious within the past 14 days.
- Anxiety includes:
  - Worry that interferes with learning and normal activities,
  - Feelings of being overwhelmed and having difficulty coping, or
  - Symptoms of anxiety disorders.
- Report any anxiety in last 14 days – even if only one time and then controlled with medication.

Scenario: M1700, M1710, and M1720

- Patient is admitted to home health following hospitalization for exacerbated COPD. He is alert and oriented, but his mind seems to wander, and he seems confused, at times. His son, who lives with him, said he needs reminders about certain things he hadn't before, since he came home yesterday. The patient denies feeling anxious, and he doesn't appear to be so. However, his hospital record shows he was treated for an episode of anxiety 6 days prior to SOC, but hasn't had any further problem since.

- What is the correct response for M1700, M1710 and M1720?

71

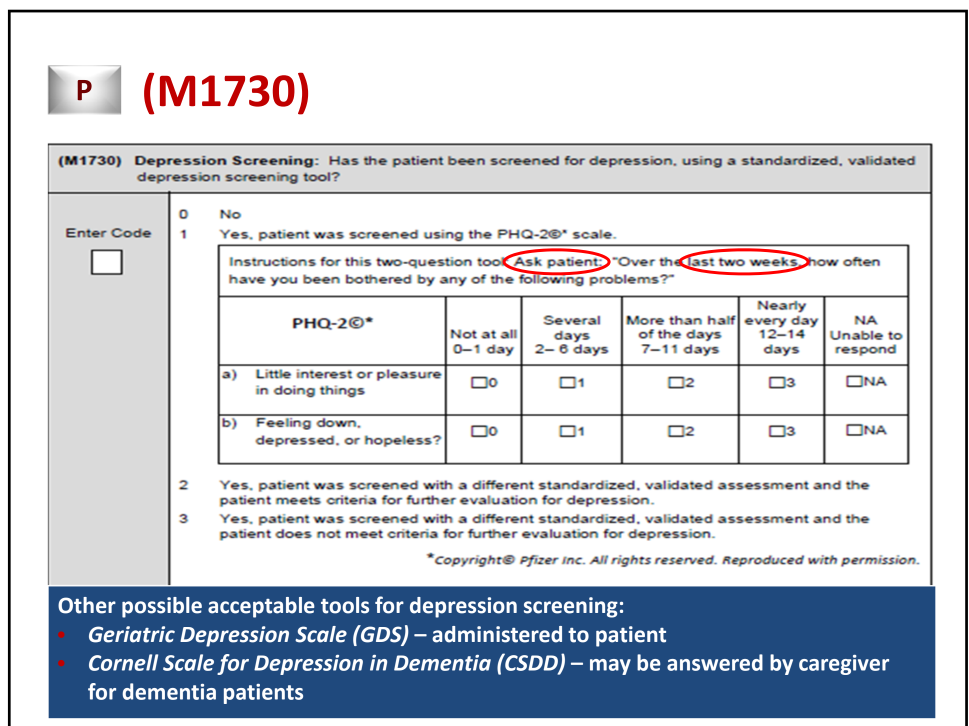
Scenario: M1700, M1710, and M1720

- Patient is admitted to home health following hospitalization for exacerbated COPD. He is alert and oriented, but his mind seems to wander, and he seems confused, at times. His son, who lives with him, said he needs reminders about certain things he hadn't before, since he came home yesterday. The patient denies feeling anxious, and he doesn't appear to be so. However, his hospital record shows he was treated for an episode of anxiety 6 days prior to SOC, but hasn't had any further problem since.

- What is the correct response for M1700, M1710, and M1720?
  - ✓ ***M1700 (Cognitive Functioning) = 1*** *- Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.*
  - ✓ ***M1710 (When Confused) = 1*** *- In new or complex situations only*
  - ✓ ***M1720 (When Anxious) = 1*** *- Less often than daily*

72

P (M1730)



(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

Enter Code

0 No
1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0–1 day	Several days 2–6 days	More than half of the days 7–11 days	Nearly every day 12–14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

2 Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.
3 Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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Other possible acceptable tools for depression screening:

- ***Geriatric Depression Scale (GDS)*** **– administered to patient**
- ***Cornell Scale for Depression in Dementia (CSDD)*** **– may be answered by caregiver for dementia patients**

Guidance for Depression Screening

- Identifies if the home health agency screened the patient for depression using a standardized depression screening tool, which MUST:
  - Include a standard response scale;
  - Be administered to patient who is cognitively intact and physically able;
  - Be appropriately administered, as indicated in the instructions; and
  - Be administered by the clinician completing the OASIS in the time frame specified by CMS.
- Questions MUST be answered by the patient!

- A score of 3 or greater warrants further depression screening.
  - Document screening results, report to physician, and include any ordered depression-related interventions in the POC.

74

Responses: M1730

- **Response 0 - No:**
  - The patient refuses to answer questions – e.g., states they are too personal.
  - The clinician chooses ***not*** to assess the patient – e.g., no appropriate depression screening tool or for any other reason.
- **Response 2 or 3 - Yes** (Does or does not meet criteria for further evaluation):
  - The clinician administered a different standardized, validated depression screening tool.
- **Response NA** (PHQ-2 finding):
  - The patient is cognitively intact and physically able to answer questions, but is unable to – e.g., can't quantify how many days they experienced the problems.

75

Scenario: M1730

- Patient is sitting in a chair during her assessment and does not readily respond to any questions, including the ones on the PHQ-2. She seems tired, but is cognitively alert and oriented. Her daughter, who is her caregiver, says that her mother has been depressed and seems to have just given up.

➢ How should the clinician answer M1730?

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Answer: M1730

- Patient is sitting in a chair during her assessment and does not readily respond to any questions, including the ones on the PHQ-2. She seems tired, but is cognitively alert and oriented. Her daughter, who is her caregiver, says that her mother has been depressed and seems to have just given up.

- How should the clinician answer M1730?
  - ✓ ***Response 0 - No***

    Patient did not respond to PHQ-2 questions, and the response cannot be based on what anyone else says.

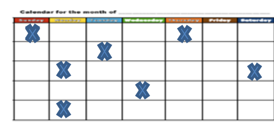
77

(M1740)

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

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

Time Frame for M1740



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

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M1740: Guidance

- Identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders.
  - May be determined either by diagnosis and/or in the assessing clinician's clinical judgment.
- Include behaviors which are severe enough to:
  - Make the patient unsafe to self or others;
  - Cause considerable stress to the caregivers; or
  - Require supervision or intervention.
- It is ***not*** the intent of M1740 to report non-adherence or risky choices made by cognitively intact patients.
- Behaviors may be observed by the clinician or reported by the patient, family, or others.

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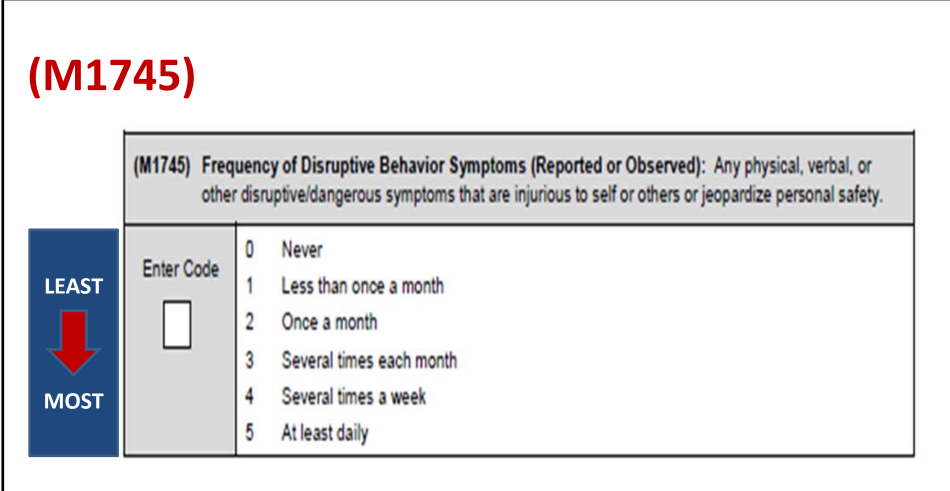
(M1745)


(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

- Identifies frequency of any behaviors that are disruptive or dangerous to the patient or caregiver(s).

M1745: Guidance

- Consider if the patient has any problematic behaviors – ***not*** just those listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver, such as:
  - wandering, sleeplessness, sun-downing, agitation, aggression, combativeness, getting lost in familiar places, etc.
- Then, consider how frequently these behaviors occur.
- May be determined either by diagnosis and/or in the assessing clinician's clinical judgment.
- Behaviors can be observed by the clinician or reported by the patient, family, or others.

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Hoarding Disorder

- If hoarding disorder with associated behaviors result in concern for the patient and/or caregiver's safety, one or both of these M1740 responses may best describe it:
  - "2" - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions"
  - "5" - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions).

83

M1740 and M1745

- M1740 and M1745 are ***not*** directly linked to one another – may be behaviors reported in one and ***not*** the other.
  - For example, a patient may express excessive profanity or sexual references that cause considerable stress to the caregivers and be reported in M1740, but, in the clinician's judgment, the behavior does ***not*** jeopardize the safety and well-being of the patient or caregiver, therefore is ***not*** reported in M1745.
- Answer each question individually.
  - M1740 lists specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders and asks if they are demonstrated at least once a week.
  - M1745 is ***not*** reporting on a specific list of behaviors, but rather any behaviors that are disruptive or dangerous to the patient or caregivers.

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M1740 and M1745 (cont.)

- The environment in which the patient lives and the skills of the caregiver may impact the scoring of M1740 and M1745.
  - For example, patients with dementia may exhibit a number of behaviors listed in M1740, but may ***not*** be reported in this OASIS item if they live in a setting specifically designed to care for patients with dementia. The same would be true for M1745. Look to the descriptors for the behaviors that are reportable for both M1740 and M1745 to determine if the behavior would be reportable.

85

M1740 and M1745: Scenario

- Patient was admitted for SN for management of his CHF and PT for strengthening. He was instructed to use his walker for safety, due to his weakness. However, he refuses to do so…insists he walks fine without it. He doesn't seem to have any cognitive impairment. His wife says he's "as sharp as a tack, but is just stubborn."

- How should the clinician score M1740 and M1745?

86

Answers: M1740 and M1745

- Patient was admitted for SN for management of his CHF and PT for strengthening. He was instructed to use his walker for safety, due to his weakness. However, he refuses to do so…insists he walks fine without it. He doesn't seem to have any cognitive impairment. His wife says he's "as sharp as a tack, but is just stubborn."

- How should the clinician score M1740 and M1745?
  - ✓ ***M1740 = 7*** *- None of the above behaviors demonstrated*
  - ✓ ***M1745 = 0*** *- Never*

    Patient was cognitively intact and chose not to adhere to the instructions to use his walker.

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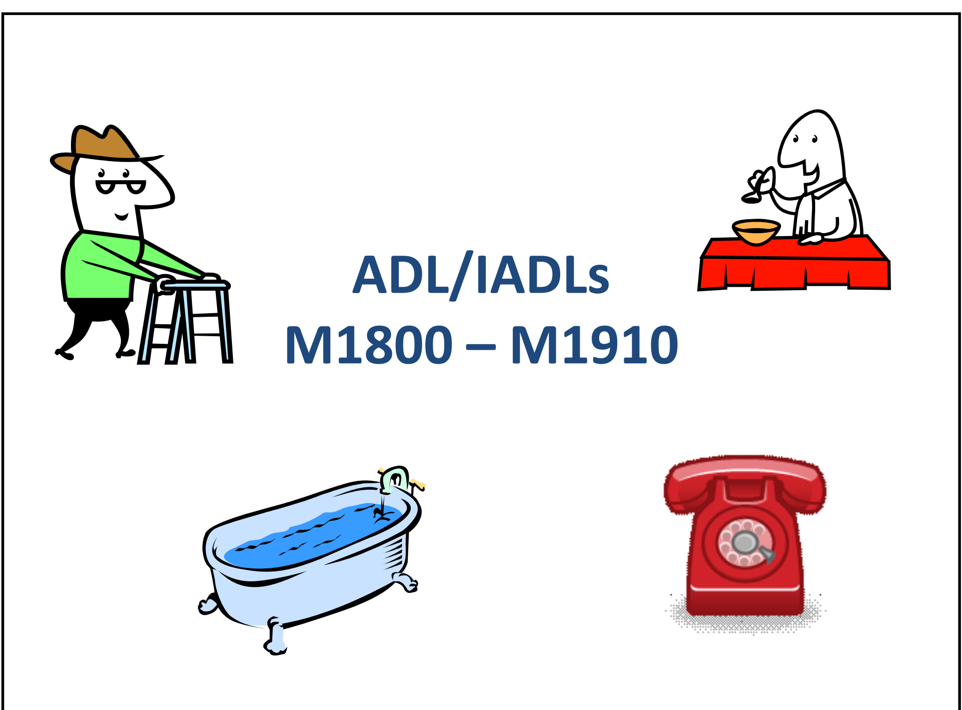

ADLs and IADLs

ADLs

- Defined as the tasks of everyday life
- Basic ADLs include:
  - eating
  - dressing
  - getting into or out of a bed or chair
  - taking a bath or shower
  - using the toilet

IADLs

- Instrumental activities of daily living related to independent living
- Include:
  - preparing meals
  - managing money
  - shopping
  - doing housework
  - using a telephone

89

ADL/IADL Item-Specific Conventions

- 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.
- The level of ability refers to the level of assistance (if any) that the patient requires to safely complete a specified task.

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 in order to determine and report the level of assistance that the patient requires to safely complete a task.

90

ADL/IADL Item-Specific Conventions

- Understand what tasks are included and excluded in each item and select the OASIS response based only on included tasks.
- 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.
- Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, bathing, etc.

91

Guidance for Functional Items

- Determine what the patient is able to do ***on day of assessment***. If ability varies over time, consider what patient is able to do more than 50% of time period under consideration (last 24 hours).
- Understand what tasks are included and excluded for each item.
  - Consider ability to complete the ***majority*** (50% or more) of the tasks in each item safely.
  - No specific portions of tasks are weighted more than others.

➢ ***Note:*** *Responses listed from independent to dependent.*
Read response options from the bottom up!

92

(M1800)

(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.

- Includes the patient's ability to access grooming utensils (e.g., grooming aids, mirror, sink).

$$$ (M1810)

(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.

- Identifies the patient's ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing. Assess 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.

$$$ M1810 or M1820 = 1, 2, or 3

$$$ (M1820)

(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.

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

$$$ M1810 or M1820 = 1, 2, or 3

M1810 and M1820: Guidance

- 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.
- There is no requirement to dress in a certain amount of time, as long as the patient can dress ***safely***.
- Consider what the patient routinely wears (usual status).
- If clothing modified, is there reasonable expectation that the patient could return to previous style of dressing? No time frame specified.

96

M1810 and M1820: Guidance (cont.)

- Elastic bandages (Ace wraps) worn for support and compression are considered a dressing item. Other wound dressings are ***not***. Wraps used solely to secure a wound dressing are ***not*** considered in either M1810 or M1820.
- Consider prosthetic, orthotic, or other support devices applied as dressing items.
  - Upper body – upper extremity prosthesis, cervical collar, or arm sling
  - Lower body – prosthesis, ankle-foot orthosis (AFO), or TED hose
- Devices the patient is ordered to wear (e.g., a brace) are considered dressing items, even if ***not*** routinely worn.
- The *majority rule* does ***not*** refer to the individual steps the patient must take to collect, put on or take off clothing.

97

How would you score M1820?

- Patient has compression stockings and needs assistance from another person with putting them on. He is able to put on all other lower body items as long as someone lays them out.

- What is the most appropriate response to M1820?

98

Answer: M1820

- Patient has compression stockings and needs assistance from another person with putting them on. He is able to put on all other lower body items as long as someone lays them out.

- What is the most appropriate response to M1820?
  - ***Response 1*** *- Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.*
  - *Remember,* ***the majority rules!*** *Per Q&A 132.2, "select the response that represents the patient's status in the "majority of tasks." Do* ***not*** *consider which items are more important than others*

99

$$$ (M1830)

(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 <u>shower or tub</u> 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, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas.
	3	Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	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.

$$$ M1830 = 2 or more

M1830: Guidance

- Identifies the patient's ability to bathe <u>entire body</u> and the assistance that may be required to **SAFELY** bathe, including transferring in and out of the tub ***or*** shower.
- If the patient is able to bathe in the tub or shower, options are 0, 1, 2, or 3.
  - **Response 0** – totally independent with bathing
  - **Response 1** – able to bathe with the use of devices
  - **Response 2** – requires:
    - Intermittent supervision, verbal cueing, or reminders, ***or***
    - Assistance to get in and out of tub, ***or***
    - Assistance only with difficult to reach areas

    Note: *Includes help with only one <u>or</u> all three areas as long as continuous presence of another person is not needed*

101

M1830: Guidance (cont.)

- **Response 3:**
  - Requires <u>continual</u> verbal cueing or reminders, ***or***
  - <u>Constant</u> supervision throughout bath due to physical or mental reasons
- **Response 4 or 5:**
  - Cannot bathe in tub or shower for physical, emotional or environmental reason (e.g., no tub/shower, unsafe, malfunctioning) depending on the patient's ability to assist
    - Response 4 applies ONLY if patient is *independent* <u>without</u> human assistance
- **Response 6:**
  - Totally dependent in bathing (unable to participate and bathed totally by another person)
  - Where bathed does ***not*** matter

- For a patient with medical restrictions, select response 4, 5, or 6 depending on ability.

102

M1830: Bathing Response Grid

Response	Environment	Assistance
0	In tub/shower	None
1	In tub/shower	Devices
2	In tub/shower	Intermittent assistance
3	In tub/shower	Presence of another person throughout
4	Sink/Chair/ Commode/BSC	Independent with or without devices. No human assistance.
5	Sink/Chair/ Commode/BSC	Presence of another person throughout
6	Unspecified	Totally dependent

103

How would you score M1830?

- Patient with considerable balance problems that result in him being very unsteady is able to bathe self in the shower once assisted into the shower.
- Patient with dementia who requires regular cueing to bathe himself is unable to use his shower because the plumbing is broken and bathes at the sink.

104

Answers: M1830

- Patient with considerable balance problems that result in him being very unsteady is able to bathe self in the shower once assisted into the shower.
  - ✓ ***Response 3*** *- Patient not safe in shower by himself*
- Patient with dementia who requires regular cueing to bathe himself is unable to use his shower because the plumbing is broken and bathes at the sink.
  - ✓ ***Response 5*** *- Unable to use tub/shower but able to participate in bathing at sink*

105

$$$ (M1840)

(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.

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

$$$ M1840 = 2 or more

M1840: Guidance

- Excludes personal hygiene and management of clothing when toileting.
- Ability to use a bedpan/urinal independently (Response 3) does ***not*** include whether or not the patient needs assistance in emptying it.
- In absence of a toilet in the home, determine:
  - If patient is able to use a bedside commode (Response 2)
  - If unable to use a bedside commode, is he/she able to use a bedpan/urinal independently (Response 3)
  - If unable to use a bedside commode or bedpan/urinal or if such equipment is not present in the home to allow assessment (Response 4 - Dependent)

107

M1840: Toilet Transferring Response Grid

Response	Device Used	Assistance
0	Toilet	Independent with or without device
1	Toilet	When reminded, supervised, or assisted by another person
2	Bedside commode	Unable to get to/from toilet but able to use BSC with or without assistance
3	Urinal/Bedpan	Unable to get to/from toilet; Uses urinal/bedpan independently
4	Urinal/Bedpan	Totally dependent

108

How would you score M1840?

- Patient uses a commode at night for convenience but can walk to and from the toilet and transfer safely during the day.
- ➢ What is the most appropriate response for M1840?

- Patient lives alone and walks to the bathroom using her cane, but is assessed to be safe only with assistance.
- ➢ What response would you select for M1840?

109

Answers: M1840

- Patient uses a commode at night for convenience but can walk to and from the toilet and transfer safely during the day.
- ➢ What is the most appropriate response for M1840?
  - ✓ ***Response 0*** *- Able to get to and from the toilet and transfer independently with or without a device*

- Patient lives alone and walks to the bathroom using her cane, but is assessed to be safe only with assistance.
- ➢ What response would you select for M1840?
  - ✓ ***Response 1*** *- When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer*

110

(M1845)

(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.

- **Includes** patient's ability to access needed supplies and to maintain hygiene related to catheter and ostomy care.
- **Excludes** management of equipment related to urinary or bowel elimination.

Scenario: M1840/M1845

- Patient is post-op hip replacement and admitted to agency for rehab. At the time of admission, he is using a walker and his wife is walking with him to the toilet, assisting him on and off, and helping him adjust his clothing. The elevated commode seat, ordered by his surgeon, has not been delivered to the home yet.

➢ What are the most appropriate responses for M1840 and M1845?

112

Answers: M1840/M1845

- Patient is post-op hip replacement and admitted to agency for rehab. At the time of admission he is using a walker and his wife is walking with him to the toilet, assisting him on and off, and helping him adjust his clothing. The elevated commode seat, ordered by his surgeon, has not been delivered to the home yet.
- What are the most appropriate responses for M1840 and M1845?

M1840 = Response 1 *- When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.*

M1845 = Response 2 *- Someone must help patient to maintain perineal hygiene.*

113

$$$ (M1850)

(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.

- **"Bedfast"** means confined to bed due to medical restriction or unable to tolerate being out of bed.

$$$ M1850 = 2 or more

M1850: Responses

- **Response 1** – if the patient requires "minimal human assistance" – verbal cueing, environmental set-up, hands-on assistance from another person who contributes < 25% of the total effort required to perform the transfer or requires the use of an assistive device
- **Response 2** – if the patient requires BOTH minimal human assistance and an assistive device to transfer safely.
- **Response 3** – if the patient unable both to bear weight or pivot AND is ***not*** bedfast.
- **Response 4 or 5** (patient is bedfast) – depends on ability to turn AND position self in bed.

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M1850: Transferring Response Grid

Response	Status	Assistance
0	Independent	None needed
1	Not bedfast	Minimal assist – requires only verbal cueing, environmental set-up, or hands-on assistance from another person contributing < 25% of the total effort; either human assist or device
2	Not bedfast	Unable to transfer self but is able to BOTH bear weight and pivot
3	Not bedfast	Unable to transfer self and unable to bear weight or pivot
4	Bedfast	Able to turn and position self in bed
5	Bedfast	Unable to turn and position self in bed

116

Scenario: M1850

- Patient requires the assistance of his wife to come to a sitting position in bed. Once sitting on the bedside, he is able to use his walker to rise and transfer from his bed to his chair.

- How would you score M1850?

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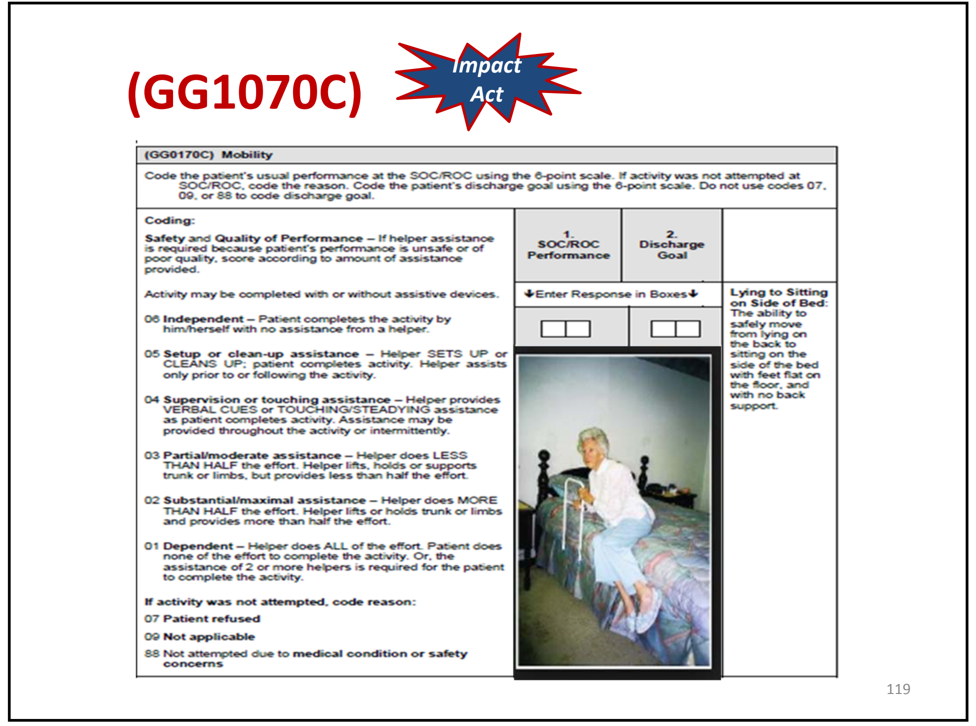
Answer: M1850

- Patient requires the assistance of his wife to come to a sitting position in bed. Once sitting on the bedside, he is able to use his walker to rise and transfer from his bed to his chair.

- How would you score M1850?
  - ✓ ***Response 2*** *- Able to bear weight and pivot during the transfer process but unable to transfer self.*
    - Per CMS, when a patient requires BOTH an assistive device AND minimal human assistance to transfer, Response 2 is appropriate.
    - ❖Minimal human assistance = any combination of verbal cueing, environmental set-up and/or hands on assist < 25% of total effort.

118



(GG1070C)

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

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.

Activity may be completed with or without assistive devices.

06 **Independent** – Patient completes the activity by him/herself 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 or TOUCHING/STEADYING 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**

88 Not attempted due to **medical condition or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓Enter Response in Boxes↓		**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	

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Why GG1070C?

- Like the diabetes and PVD/PAD diagnoses, as well as the inclusion of height and weight measurements, this item has been added to the OASIS as mobility limitations can adversely affect wound healing and increase the risk for the development of pressure ulcers.

GG0170C: Assessment Steps

- Assesses the ability to SAFELY move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- Assess the patient's self-care status based on **direct observation** and/or on ***report by the patient, caregiver, or family***. new
- Have patient perform independently, if SAFE to do so, or with caregiver assistance if, needed to be safe. Respond according to level of assistance needed.
- May use assistive device to be safe to complete task. Use of device should ***not*** impact score adversely.
- If performance varies, report patient's **usual** performance.

121

But what if…

- The patient uses a **recliner, sofa, or mattress** on the floor as their preferred or necessary sleeping surface?
  - ✓ *Consider that their "bed."*
- The patient's **feet do not touch the floor** because the patient's feet do not reach the floor, and the patient performs the activity of getting from lying to sitting independently and safely?
  - ✓ *Score the patient as 06, Independent.*
- If the assessing clinician feels the patient is not safe sitting at the bedside without their feet on the floor, and **requires assistance to lower the bed prior to the transfer, or to place a foot stool prior to the transfer**?
  - ✓ *Score the patient as 05, Set up or clean-up assistance.*

Scoring SOC/ROC Performance

- Report the patient's usual status at SOC/ROC using the 6-point scale (01-06).

  OR
- If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted.
- Use one of three "activity was not attempted" codes:
  - **07** - Patient refused
  - **09** - Not applicable, patient did not perform this activity prior to the current illness, exacerbation, or injury
  - **88** - Not attempted due to medical or safety concerns
- If no information is available or assessment is not possible for reasons other than above, enter a dash (–) for 1-SOC/ROC Performance.

123

GG0170C: Performance Levels

- **06 - Independent:** No human assistance needed.
- **05 - Setup or clean-up assistance:** Caregiver assists prior to or after activity, but not during activity.
- **04 - Supervision or touching assistance:** Caregiver must provide VERBAL CUES or TOUCHING/STEADYING assist as patient completes activity.
- **03 - Partial/moderate assistance:** Caregiver provides less than half of effort (lifts, holds, supports trunk or limbs).
- **02 - Substantial/maximal assistance:** Caregiver provides more than half of effort (lifts, holds, supports trunk or limbs)
- **01 - Dependent:** Caregiver must provide ALL effort or 2 or more caregivers are required to complete activity.

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Scoring Discharge Goal

- Report the Discharge Goal using the 6-point scale (01-06). Do ***not*** use 07, 09, or 88 to report the Discharge Goal.
- The assessing clinician, in conjunction with patient and family input, can establish the Discharge Goal.
- For example:
  - If the patient is expected to make progress, the Discharge Goal would be higher than the SOC/ROC response.
  - If the patient is not expected to make progress but would be expected to maintain the SOC functional level, the Discharge Goal would be the same as the SOC score.
  - If the patient is expected to decline rapidly but skilled therapy services may slow the decline of function, the Discharge Goal would be lower than the SOC score.

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GG0170C: Scenario #1

Your patient just had a lumbar laminectomy and is hesitant to move her legs on her own. During the SOC assessment, the RN provides great effort with helping the patient sit up from supine in moving both the trunk and the legs. The patient is unhappy with her current status, as she states she was able to do everything all by herself before the surgery.

Scoring Scenario #1

(GG0170C) Mobility

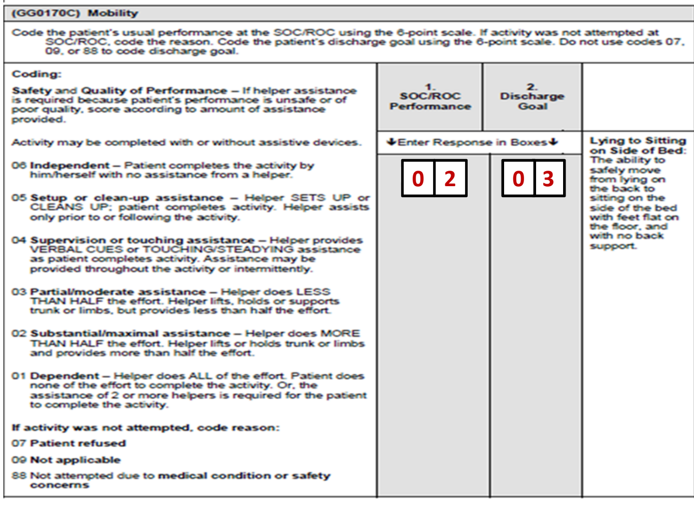
Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:	1. SOC/ROC Performance	2. Discharge Goal	
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. Activity may be completed with or without assistive devices. 06 **Independent** – Patient completes the activity by him/herself 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 or TOUCHING/STEADYING 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** 88 Not attempted due to **medical condition or safety concerns**	↓Enter Response in Boxes↓ 0 2	0 6	**Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

GG0170C: Scenario #2

At SOC, the patient's wife had to provide most of the effort in order for him to sit on the edge of the bed from a sitting position. He said he wishes he could get out of bed himself rather than depending on his wife to help. Based on the patient's prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that, by discharge, the patient would likely only require assistance getting his legs off the bed to complete the supine to sitting task.

Scoring Scenario #2



(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

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.

Activity may be completed with or without assistive devices.

06 **Independent** – Patient completes the activity by him/herself 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 or TOUCHING/STEADYING 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**

88 Not attempted due to **medical condition or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓Enter Response in Boxes↓		**Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
0 2	0 3	

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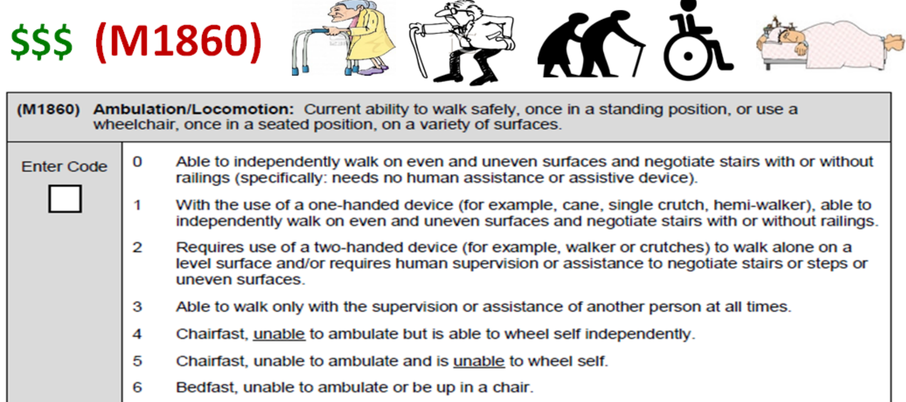
$$$ (M1860)



(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.

- 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.

Tip: *A patient who is clearly not safe walking alone should scored as Response 3 if he/she is not chairfast.*

$$$ M1860 = 1 or more

M1860: Usual Status (Majority Rule) Convention Does NOT Apply

- **Ambulatory Patient** – ***On the day of assessment*:**
  - **Response 0 and 1** – must be able to walk safely when independent of human assistance at all times
  - **Response 2** – needs assistance ambulating, but at times, or in certain circumstances, can ambulate safely without assistance
  - **Response 3** – needs human assistance at all times in order to safely ambulate
- **Non-ambulatory (not bedfast) Patient**
  - **Response 4** – Chairfast and unable to ambulate but is able to wheel self independently
    - No assistance needed at any time during the day of assessment
  - **Response 5** – Chairfast and unable to ambulate or wheel self
    - If patient needs any assistance at all on the day of assessment

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M1860: Ambulation Response Grid

Response	Environment	Assistance
0	Even/uneven surfaces & stairs	None
1	Even/uneven surfaces & stairs	One-handed device
2	Even/uneven surfaces & stairs	Two-handed device on level surface and/or human supervision or assistance on stairs or uneven surface
3	Unspecified	Human supervision or assistance at all times
4	Chairfast	Able to wheel self
5	Chairfast	Unable to wheel self
6	Bedfast	Totally dependent

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How would you score M1860?

- A patient who is assessed as safe walking with a walker, but refuses to use the walker and regularly walks with a single point cane.
- Patient with poor cognition can ambulate safely with a walker, but he forgets to use it or uses it improperly.

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Answers: M1860

- A patient who is assessed as safe walking with a walker, but refuses to use the walker and regularly walks with a single point cane.
  - ✓ ***Response 2*** *- Can only walk safely with a walker*
- Patient with poor cognition can ambulate safely with a walker, but he "forgets" to use it or uses it improperly.
  - ✓ ***Response 3*** *- Requires supervision/assistance at all times to ambulate safely*

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(M1900)

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code ☐	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent

- Slight wording change due to reformatting with boxes.
- "Majority rule" applies if patient's ability varies.
- Transfer includes: bed to chair, tub/shower, commode transfers.
- Ambulation refers to with or without a device.
- Patients who use a wheelchair are considered "dependent" in ambulation.

M1900: Guidance

- Definitions of functional terms:
  - **Independent** = No human assistance (verbal or physical) required to complete task.
  - **Needed Some Help** = Contributed some effort but needed some human assistance to accomplish task.
  - **Dependent** = Physically or cognitively unable to contribute effort to complete task. Helper must contribute ALL the effort.
- **Timeframe clarification:** For the patient undergoing hip replacement prior to admission to home health, consider the timeframe prior to the TJR surgery ***not*** the time prior to development of hip joint pain.

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(M1910)

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?	
Enter Code	0 No. 1 Yes, and it does not indicate a risk for falls. 2 Yes, and it does indicate a risk for falls.

- Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls.

M1910: Guidance

- Multi-factor falls risk assessment must include at least one standardized tool that has been validated as effective in identifying falls risk in a population with characteristics of the patient being assessed and which includes a standardized response scale.
- A single comprehensive tool that meets criteria (MAHC-10) or several tools may be used.
- If only one tool is *standardized **and** validated*, it must be the one used to determine risk.
- If both tools used are *standardized* and validated:
  - An at risk score on either = patient is at risk for falls

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M1910: Guidance *(cont.)*

- Use the scoring parameters specified in the tool to identify if a patient is at risk for falls.
- Select Response 1 if the standardized, validated response scale rates the patient as no-risk, low-risk, or minimal risk.
- Select Response 2 if the standardized, validated response scale rates the patient as anything above low/minimal-risk.
- If the tool does not provide various levels, but simply has a single threshold separating those "at risk" from those "not at risk," then the patient scoring "at risk" should be scored as Response 2.

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M1910: Guidance (cont.)

- Select Response 0 (No multi-factor falls risk assessment conducted) when:
  - No standardized, validated multi-factor test done
  - Standardized, validated multi-factor test ***not*** done within the CMS time frame
  - Standardized, validated multi-factor test ***not*** done by clinician responsible for completing OASIS assessment.
  - Patient not able to participate in task required to allow completion and scoring of standardized assessment(s) that agency chooses to utilize

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To Accurately Score M1910…

- Complete a standardized and validated multi-factor falls risk assessment (i.e., MACH). **OR**
- Complete a multi-factor falls risk assessment including at least one standardized tool (e.g., TUG, FR)

Fall Risk Assessment

M1910

- If not done using appropriate tool within the required time frame by assessing clinician, M1910 = "0."
- If done and (-) using standard response scale, M1910 = "1."
- If (+), M1910 = "2."

- Person who is + for Fall Risk **cannot** be safe and independent for ADLs/IADLs.
- Score M1800s with ***safety*** in mind.
  - For example: M1860 cannot be better than a "3," if patient is a + Falls Risk.

M1800s

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Timed Up and Go (TUG) Test

- Ask patient to sit in a standard armchair. The patient may use assistive devices that he/she normally uses.
- Have patient get up, walk 10 feet, turn around, walk back to the chair, and sit down again.
- Begin timing when the patient starts to get up.
- **Interpretation:**
  - **< 10 seconds** – free mobility
  - **< 14 seconds** – decreased risk for falls
  - **< 20 seconds** – patient is mostly independent
  - **20 – 29 seconds** – moderately impaired / variable mobility
  - **>30 seconds** – significantly impaired mobility

➢ ***Note:*** *≥ 14 seconds = patient at risk for falls*

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Applicability of the TUG Test

- ✓ M1200: Was the patient able to see where the tape is on the floor to turn around?
- ✓ M1210: Was patient able to hear directions?
- ✓ M1220: Was patient able to comprehend directions?
- ✓ M1242: Was there any pain associated with the activity?
- ✓ M1400: Was patient SOB within 20 feet?
- ✓ M1700: Did directions need to be repeated?
- ✓ M1850: Was the sit to stand to sit component safe?
- ✓ M1860: Was the gait component safe?
- ✓ M1910: Was the patient a falls risk?

Additional Resources

- Geriatric Depression Scale

https://consultgeri.org/try-this/general-assessment/issue-4.pdf

- Cornell Scale for Depression in Dementia

http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf

Join me!

For Part 6:

Care Management:
M2102 and M2110
Therapy Need and Plan of Care:
M2200 and M2250
Emergent Care:
M2301 and M2310
Transfer and Discharge:
M2401-M2430;
M0903 and M0906
Q&As

Thursday, December 15th
1:00 – 3:00 EST

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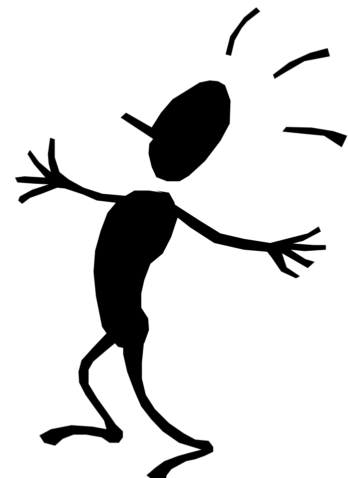
Thank you for attending!

Sharon Molinari, RN, HCS-D, HCS-O

Home Health Consultant and Educator

sharon.molinari@gmail.com



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