

Answer Key – Patient Tracking and Clinical Record Items

Therapy Only Case

1) What is the patient's "M0030: Start of Care Date"?

The patient's start of care date, in this example, is 05/21- the date the physical therapist provided the patient's first reimbursable visit and thereby established the SOC.

2) What is the "M0090: Date Assessment Completed"?

The M0090 is 05/20, the date the nurse completed the SOC assessment.

3) Is there a problem with these dates (the M0030 and the M0090 dates)?

Yes. The assessment completed date may not be before the patient's start of care date.

a) What if the RN started the OASIS assessment on 05/20, but did not complete it until 05/21?

This would still not be correct, as no part of the comprehensive assessment may be started or completed until the patient's start of care has been established.

b) What if the patient also receives CNA services and the CNA's first visit was completed on 05/20?

The CNA visit is reimbursable/billable. Therefore, a visit by the CNA would establish the patient's start of care date and the RN could then complete the patient's comprehensive assessment on 05/20.

c) What if the RN opened the patient on the morning of 05/21, and the PT completed his/her evaluation during the afternoon of 05/21?

As long as the physical therapist saw the patient and established the start of care on the same date the RN completed the comprehensive assessment, it would be acceptable for the RN to go in to the home earlier than the physical therapist. Both visits must occur on the same calendar day.

4) Can agency office staff make the first visit to the patient's home to complete admission forms, rights forms, etc?

No. The first visit to a patient's home must be completed by a qualified clinician – a registered nurse if orders for nursing exist at the SOC. If no nursing orders exist, the first visit to a patient's home may be completed by a PT, ST, or OT if occupational therapy services establish program eligibility.

5) Can an LPN complete the initial patient assessment?

No. LPNs are not qualified to complete an initial patient assessment.

a) Can an LPN complete the OASIS assessment?

No. According to the Conditions of Participation, LPNs may not complete the OASIS assessment.

Mr. Jones

1) Should Mr. Jones's Medicare number be reported at M0063?

Yes. A patient with Medicare benefits should always have their Medicare number reported at M0063, even if Medicare will not be billed for this payment episode.

2) Should '1- Medicare (traditional fee-for-service)' be marked at "M0150: Current Payment Sources for Home Care"?

No. Mr. Jones is not homebound, and therefore does not meet the eligibility requirements for Medicare. Medicare should not be marked as a potential payer.

3) What OASIS assessment(s) should the nurse complete during his/her visit?

The nurse should complete a discharge assessment during the Wednesday visit, and discharge Mr. Jones from his Medicaid quality episode.

a) What assessment(s), if any, should be completed during the next skilled nursing visit?

During the next nursing visit, the nurse should complete a SOC assessment and open Mr. Jones to a Medicare quality episode. Keep in mind, the nurse found out about Mr. Jones's fall on Wednesday. The agency has 48 hours from knowledge of the change in payer source to open Mr. Jones to the new payer (in this case, Medicare).

4) Does this violate the one clinician rule?

No. Collaboration with the therapist regarding the anticipated number of therapy visits does not violate the one clinician rule.

5) What would the M0090 be in this instance?

The M0090 date would be the date the nurse and the therapist discussed the anticipated number of therapy visits, assuming all other OASIS items are complete.

6) What should the agency do?

The agency should complete the assessment as soon as possible, and document the reason for the delay in the patient's medical record.

7) What is the date of referral (M0102)?

The date of referral is Day 4 of Mr. Jones's hospitalization – the date the most recent information regarding his condition was sent to your agency.

8) For "M0110: Episode Timing", will this new care episode be '1 – Early' or '2 – Later'?

This episode will be a later episode. Mr. Jones was at the agency for two certification periods (payment episodes), and fewer than 60 days have passed since his home health discharge date. Thus, this is Mr. Jones's third adjacent payment episode and as such should be designated as 'later'.

9) Who is responsible for completing Mr. Jones's discharge OASIS?

The physical therapist, as the last qualified clinician in the home, is responsible for completion of the discharge OASIS.

Mrs. Blake

1) Who can complete the initial assessment visit?

A registered nurse must complete the initial assessment visit, as the patient has orders for nursing.

a) Who can complete the SOC OASIS?

A registered nurse must complete the SOC OASIS, as the patient has orders for nursing.

b) Does it make a difference if the order for registered nursing is to obtain a blood draw approximately 10 days after Mrs. Blake's hospital discharge date?

No.

2) What is the "M0090: Date Assessment Completed"?

The M0090 date is 11/16, the date the nurse contacted the physical therapist regarding the results of the drug regimen review.

Mr. Abrams

1) What should you do if he requests that your agency not make a visit to open him until Monday?

The agency should contact the patient's physician to ensure the patient will be safe in the home if no visit is made until Monday. If the physician approves this, the agency should note a physician ordered start of care date of Monday in the patient's clinical record, and complete the initial assessment visit on Monday.

2) Should the nurse collect OASIS data for Mr. Abrams?

If the agency wants to bill Medicare for the nursing visit, then OASIS data needs to be collected in order to generate an HHRG code.

3) If OASIS data is collected, should it be transmitted to the state system?

OASIS data from known one-visit episodes should not be submitted to the state system.

Jake Miller

1) Does the agency need to do anything?

Yes. The agency needs to update the patient's comprehensive assessment within 48 hours of knowledge that the patient has returned home from a qualifying inpatient facility stay.

Answer Key - Patient History & Diagnoses and Living Arrangements

Mr. Remmer

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

- 1 - Long-term nursing facility (NF)
- 2 - Skilled nursing facility (SNF / TCU)
- 3 - Short-stay acute hospital
- 4 - Long-term care hospital (LTCH)
- 5 - Inpatient rehabilitation hospital or unit (IRF)
- 6 - Psychiatric hospital or unit
- 7 - Other (specify)
- NA - Patient was not discharged from an inpatient facility [Go to M1016]

This question states to mark all responses that apply, and so the SNF and short-stay acute hospital would be marked. If Mr. Remmer completed his rehab in a designated and certified rehab unit at the SNF, then Response 5- 'Inpatient rehabilitation hospital or unit' would be marked instead of SNF.

2) (M1010) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

Diagnoses related to Mr. Remmer's hip fracture and reflux would be listed here. Atrial fibrillation would not be listed as that condition was only monitored, and not actively treated during Mr. Remmer's hospital stay.

3) (M1012) List each **Inpatient Procedure** and the associated ICD-9-CM procedure code relevant to the plan of care.

Mr. Remmer's hip replacement surgery would be listed here.

4) Can an agency billing specialist/coder assign the patient's ICD-9 codes?

Yes. However, the agency should have a policy regarding changes and corrections to the diagnoses, as the coder may not make these changes without first consulting the assessing clinician or other appropriate personnel.

Mrs. Sanders

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

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

PICC line flushes may be counted as IV therapy. However, if Mrs. Sanders was not receiving the flushes in her home and she did not require IV fluids for dehydration on the day of assessment then Response 1 would not be marked.

2) What assessment should be documented for Mrs. Sanders's G-tube, since her family is managing it?

Agencies should make sure that all 'abnormal' findings in a patient's assessment are well documented. G-tubes, PICC lines, implanted ports, tracheostomies, etc all need to be thoroughly assessed during the comprehensive assessment and those assessments need to be documented on the comprehensive assessment form.

Flu Vaccines

1) Your agency admitted a patient on 08/02. On 09/12, an agency nurse administered a flu shot to the patient for the upcoming flu season. The patient was discharged on the final day of his certification period (09/30). You are completing the patient's discharge OASIS. What should the response to "M1040: Influenza Vaccine" be?

Response 0 – 'No'. The patient's quality episode did not include any days between the dates of 10/01 and 03/31. Therefore, even though the flu vaccine was administered, the response at M1040 would be 'No'.

2) A patient was admitted to your agency on 11/03. On 11/05, an agency nurse administered a flu shot to the patient. On 12/20, the patient was transferred into the hospital, and resumed care 4 days later on 12/24. It is now 01/29, and the patient is being discharged from your agency. You are completing the discharge OASIS. How should M1040 be answered?

Response 0 – 'No' should be marked. The agency did not administer the patient's flu vaccine during this quality episode (the ROC on 12/24 through DC on 01/29). The agency's administration of the flu vaccine would have been captured when the agency completed the Transfer to Inpatient Facility OASIS on 12/20.

3) A patient started care with your agency on 03/20. The patient did not receive a flu vaccine, and was discharged 06/15. How should M1040 be answered?

Response 0 – 'No' should be marked. The patient received care between the dates of 10/01 through 03/31, and no vaccine was given by the agency.

Living Arrangements

1) A patient who normally lives alone currently has her daughter staying with her around the clock. The daughter leaves the patient's home very infrequently for grocery shopping and other errands. The patient's daughter also leaves for four hours every Saturday to volunteer at the local library. While the daughter is gone, the patient may always reach her on her cell phone. What numerical score would be assigned to this patient for M1100?

This patient would be given a numerical score of 03. The question states the patient normally lives alone, so a score from Row A: 'Patient lives alone' will be assigned. Since the patient's daughter has a planned, regular, absence from the patient's home (when she volunteers at the library) the agency may not mark that the patient has around the clock assistance. Instead, it would be noted that the patient has regular nighttime assistance as the question implies that the daughter is only absent from the home during the daytime hours. The ability of the patient to reach her daughter on the telephone has no bearing on the scoring of this item.

2) A patient lives at home with his spouse, who suffers from progressive dementia and is wheelchair bound. A CNA comes into the home three times daily during the day to

assist with personal care and activities of daily living. The CNA's visits are usually 2 hours in length. What numerical score would be assigned to this patient for M1100?

This patient would be assigned a score of 09. The patient lives with his spouse, so a score from Row B: 'Patient lives with other person in the home' will be assigned. The patient's spouse, based on the information provided, cannot provide the patient with any assistance. Therefore, her presence will not be considered when responding to this question. CNAs are in the home for approximately 6 hours each day; thus, the patient receives occasional/short-term assistance.

3) A patient lives with his son. His son is home every night, but works during the day. Every day while his son is at work, a neighbor comes over and stays with the patient. What numerical score would be assigned to this patient for M1100?

This patient would be assigned a score of 06. The patient lives with his son, so a score from Row B: 'Patient lives with other person in the home' will be assigned. The neighbor spends the day with the patient, and there is no indication given in the question that the patient spends any time alone in the home. Therefore, the patient has around the clock assistance available.

4) A patient and her spouse reside in an ALF. The patient's husband receives services from the ALF staff, but the patient does not. However, a call bell is in place to summon help 24 hours per day. What numerical score would be assigned to this patient for M1100?

This patient would be assigned a score of 11. The patient lives in an ALF, so a score from Row C: 'Patient lives in congregate situation' will be assigned. Since the call bell summons a person for assistance 24 hours per day, the patient has around the clock assistance.

Clinical Examples – Sensory and Integumentary Status Items

Mrs. Peter

- 1) **(M1200) Vision** (with corrective lenses if the patient usually wears them):
- 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
 - 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
 - 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

Mrs. Peter should be score at a '1 – Partially Impaired' or '2 – Severely Impaired'. The assessing clinician should, in this example, take into consideration Mrs. Peter's safety in moving about her home with the neck brace limiting her field of vision.

2) How should you categorize the following wounds on Mrs. Peter's assessment?

- Burn site – **Other wound or skin lesion**

- Skin graft donor site – **Surgical wound**

- Scrapes, bruises – **As they do not require any further home health interventions, Mrs. Peter's scrapes and bruises should not be noted on the OASIS assessment. However, an assessment of these wounds should be documented on the patient's comprehensive assessment.**

Mrs. Glenn

1) (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:
(Enter "0" if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	_1_	___
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	_0_	___
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	_0_	___
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	_0_	___
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	_0_	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	_0_	___

2) (M1320) Status of Most Problematic (Observable) Pressure Ulcer:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

Stage II pressure ulcers should always be documented as 'Not healing' until they have healed - at which point they would no longer be documented on in the OASIS assessment.

3) (M1308) **Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:**
 (Enter “0” if none; excludes Stage I pressure ulcers)

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

4) (M1320) **Status of Most Problematic (Observable) Pressure Ulcer:**

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

As Mrs. Glenn's stage II pressure ulcer has healed, following the OASIS skip pattern would mean that M1308 and 1320 would not be answered.

Mr. Garcia

1) (M1220) **Understanding of Verbal Content** in patient's own language (with hearing aid or device if used):

- 0 - Understands: clear comprehension without cues or repetitions.
- 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- 3 - Rarely/Never Understands
- UK - Unable to assess understanding.

Mr. Garcia would most likely be scored at a 0 or 1. When using an interpreter, the assessing clinician may ask the interpreter how well the patient is able to understand what is being said and asked. The clinician may also observe how easily the patient appears to be responding to questions and statements in the patient's primary language.

2) (M1230) **Speech and Oral (Verbal) Expression of Language (in patient's own language):**

- 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- 5 - Patient nonresponsive or unable to speak.

Mr. Garcia would most likely be scored at a 0 or 1. When using an interpreter, the assessing clinician may ask the interpreter how well the patient is able to understand what is being said and asked. The clinician may also observe how easily the patient appears to be responding to questions and statements in the patient's primary language.

3) (M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- 0 - No standardized assessment conducted
- 1 - Yes, and it does not indicate severe pain
- 2 - Yes, and it indicates severe pain

Mr. Garcia rated his pain as a '2' on the 0-10 scale.

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

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

Mr. Garcia no longer goes up and down the stairs in his home as a result of his pain. Because the pain is preventing him from doing so, it is interfering with his activity on a daily basis, although not on a constant basis.

5) How should you categorize Mr. Garcia's diabetic ulcers?

Diabetic ulcers are categorized in the integumentary section as 'Other skin lesions or open wounds'.

Mr. Regan

1) How many wounds does Mr. Regan have?

Mr. Regan has 2 wounds – the abdominal incision and the implanted port site.

a) How would Mr. Regan's wound(s) be categorized?

Both of Mr. Regan's wounds would be categorized as surgical wounds.

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

0 - No [*Go to M1350*]

1 - Yes, patient has at least one (observable) surgical wound

2 -Surgical wound known but not observable due to non-removable dressing [*Go to M1350*]

Mr. Regan currently has one surgical wound.

3) (M1342) **Status of Most Problematic (Observable) Surgical Wound:**

0 - Newly epithelialized

1 - Fully granulating

2 - Early/partial granulation

3 - Not healing

Mr. Regan's surgical wound is newly epithelialized.

4) What is the location of Mr. Regan's surgical wound?

Mr. Regan's current surgical wound is his implanted port site. The abdominal incision has been healed for more than 30 days, and so is no longer documented on the OASIS as an active surgical wound. However, for as long as Mr. Regan has his implanted port, it will be documented upon during the OASIS.

Mrs. Anderson

1) (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:
(Enter "0" if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___	___
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___	___
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___	___
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	___	___
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	_0_	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___	___

Even though Mrs. Anderson's pressure ulcer was identified as a stage III in the hospital, the assessing clinician can now no longer visualize the wound bed well enough to make a determination regarding the depth of tissue loss. Thus, the wound is unstageable due to coverage of the wound bed by slough.

2) (M1320) Status of Most Problematic (Observable) Pressure Ulcer:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

Mrs. Anderson's wound is covered with approximately 65% slough. It should be categorized as 'Not healing'.

3) (M1324) **Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:**

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - No observable pressure ulcer or unhealed pressure ulcer

As the depth of tissue loss cannot currently be determined, Mrs. Anderson's pressure ulcer may not be staged.

4) (M1308) **Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:**
(Enter "0" if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	_0_	_0_
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	_0_	_0_
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	_1_	_1_
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	_0_	_0_
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	_0_	_0_
d.3 Unstageable: Suspected deep tissue injury in evolution.	_0_	_0_

The purpose of Column 2 is to determine if any currently existing pressure ulcers (those in Column 1) were present during the patient's most recent SOC or ROC; or if those pressure ulcers in Column 1 developed while the patient was under the agency's care. Thus, any pressure ulcer in Column 1 which was present when the patient was admitted to the agency or when the patient resumed care would be noted in Column 2, even if the pressure ulcer is now a different stage than it was on admission or resumption. As the wound clinic determined Mrs.

Anderson had a stage IV pressure ulcer, the clinician should document the ulcer as such even though the wound has started to heal and bone is no longer visible.

5) (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:
 (Enter “0” if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	<u>_0_</u>	<u>_0_</u>
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	<u>_0_</u>	<u>_0_</u>
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	<u>_1_</u>	<u>_1_</u>
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	<u>_0_</u>	<u>_0_</u>
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	<u>_0_</u>	<u>_0_</u>
d.3 Unstageable: Suspected deep tissue injury in evolution.	<u>_0_</u>	<u>_0_</u>

Per WOCN guidelines, stage IV (and III) pressure ulcers never fully heal. Thus, once a patient is diagnosed as having a stage III or IV pressure ulcer, the agency should continue to document on the ulcer during the OASIS assessment once the wound has completely re-epithelialized.

6) **Directions for M1310, M1312, and M1314:** If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length “head-to-toe”

|_0_|_0_|.|_0_| (cm)

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length

|_0_|_0_|.|_0_| (cm)

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

|_0_|_0_|.|_0_| (cm)

Once a stage IV (or III) pressure ulcer has re-epithelialized, the wound dimensions should be reported as 0 cm in each direction.

7) **(M1320) Status of Most Problematic (Observable) Pressure Ulcer:**

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

Re-epithelialized stage III and IV pressure ulcers should be documented as '0 – Newly epithelialized'.

8) **(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:**

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - No observable pressure ulcer or unhealed pressure ulcer

Once a stage IV, always a stage IV.

Clinical Examples – Respiratory and Cardiac Status

Mr. Whitney

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

- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

Mr. Whitney does not use his oxygen continuously, so his dyspnea would be evaluated without the use of oxygen. Since Mr. Whitney experiences positional dyspnea when he lies down, he is dyspneic '4 – At rest'.

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

- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

As Mr. Whitney has changed his sleeping location, he is now only dyspneic while walking to the end of his driveway to get the mail - a distance which is presumably more than 20 feet.

3) **(M1500) 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 any point since the previous OASIS assessment?

0 - No [*Go to M2004 at TRN; Go to M1600 at DC*]

1 - Yes

2 - Not assessed [*Go to M2004 at TRN; Go to M1600 at DC*]

NA - Patient does not have diagnosis of heart failure [*Go to M2004 at TRN; Go to M1600 at DC*]

4) **(M1510) Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (**Mark all that apply.**)

0 - No action taken

1 - Patient's physician (or other primary care practitioner) contacted the same day

2 - Patient advised to get emergency treatment (e.g., 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 (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc)

As the patient called his physician himself, the clinician may not mark Response 1 – 'Patient's physician contacted the same day'. Response 1 may only be marked when a qualified clinician from the agency contacts the physician. However, the assessing clinician has knowledge that after contacting his physician, Mr. Whitney implemented patient specific parameters for treatment (by taking an extra dose of his diuretic). Response 3 may be marked in this case.

Clinical Examples – Elimination, Neuro/Emotional/Behavioral Status

Mrs. Cameron

1) (M1610) Urinary Incontinence or Urinary Catheter Presence:

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

Mrs. Cameron has stress incontinence. Therefore, she should be scored as incontinent on M1610.

2) (M1615) When does Urinary Incontinence occur?

- 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

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

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

Even though Mrs. Cameron is now on medication and has not experienced any anxiety for approximately 10 days now, the look-back period for this question is 14 days, and she should be scored based on the frequency of any symptoms of anxiety during those fourteen days.

4) (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 (e.g., 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

The answer to this question depends upon the clinician's assessment of the patient's level of risk in her familiar home environment (cognition, knowledge of surroundings, ability to safely navigate throughout her home). Response 2 – 'Impaired decision making' may be appropriate if the clinician deems the patient to be at high risk for falls or injury by walking through her house at night. However, if the clinician determines patient is safe while performing this activity, Response 7 – 'None of the above behaviors demonstrated' would be appropriate.

5) (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.

- 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

This item may be answered separately from M1740. Again, depending on the clinician's assessment of the risk to the patient's personal safety, Response 4 – 'Several times a week' or Response 0 – 'Never' could be appropriate.

6) (M1610) Urinary Incontinence or Urinary Catheter Presence:

0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage)

[*Go to M1620*]

1 - Patient is incontinent

2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [*Go to M1620*]

If agency clinician's have been monitoring Mrs. Cameron's symptoms of urinary incontinence and it is clear that she is no longer experiencing any episodes of incontinence, she may be scored a 0 at discharge.

Elimination Questions

1) If a patient on a timed voiding schedule experiences no episodes of incontinence, how would they be scored on the OASIS assessment?

Timed voiding is a compensatory mechanism and does not cure incontinence. The patient would be scored as incontinent (1).

a) If the patient on a timed voiding schedule experiences the occasional 'accident', what would be the correct response to M1615?

(M1615) When does Urinary Incontinence occur?

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

The correct response at M1615 would depend on when the patient experiences incontinence. As the patient continues to have ongoing episodes of incontinence despite the timed voiding schedule, Response 0 – 'Timed-voiding defers incontinence' would not be appropriate.

2) If a foley catheter is inserted during the patient's start of care visit, how would 'M1610: Urinary Incontinence or Urinary Catheter Presence' be scored?

If a foley catheter is inserted during the assessment visit, the patient would be scored a 2 – 'Patient requires a urinary catheter'.

a) If a foley catheter was removed during the patient's start of care visit, how would 'M1610: Urinary Incontinence or Urinary Catheter Presence' be scored?

If a foley catheter is removed during the assessment visit, the patient would be scored a 0 or 1, depending on whether or not the patient is incontinent.

3) How would a patient who receives a daily bowel program, with no other episodes of bowel incontinence, be scored on 'M1620: Bowel Incontinence Frequency'?

The patient would be scored a 0 – 'Very rarely or never has bowel incontinence'.

Clinical Examples – ADLs/IADLs and Medications

Activities of Daily Living Questions

1) Which M-Item captures the patient's ability to shampoo their hair?

None of the M-Items captures the patient's ability to shampoo their hair.

2) M1850 asks about the patient's ability to transfer from the bed to a chair. Should other types of transfers also be considered when responding to M1850 (such as car or floor transfers, as applicable to the patient)?

No, in order to standardize the data, only the bed to chair transfer should be considered when responding to M1850.

Mr. Meyer

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

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

Mr. Meyer's need to take extra time while dressing should not be considered when answering the dressing items.

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

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

When scoring M1810 and M1820, the number of clothing items the patient usually wears should be considered, as the focus of the questions is the patient's ability to complete the majority of dressing tasks. In Mr. Meyer's case, he is able to put on his undergarments, pants, socks, shoes, etc independently, and he only needs assistance with his TED hose. Thus, he is independent with the majority of his dressing tasks, and should be scored as such.

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

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

No indication is given that Mr. Meyer's wife is constantly supervising him throughout his bath - just that she is nearby while he is bathing. This would then be considered intermittent supervision, and Mr. Meyer would be scored at a 2.

4) **(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely.

Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

0 - Able to independently feed self.

1 - Able to feed self independently but requires:

(a) meal set-up; OR

(b) intermittent assistance or supervision from another person; OR

(c) a liquid, pureed or ground meat diet.

2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.

3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.

4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.

5 - Unable to take in nutrients orally or by tube feeding.

Mrs. Meyer does set-up Mr. Meyer's meals by placing his food onto a plate for him. However, the patient description states this is simply how meals are served in the Meyer household, rather than a special adaptation for Mr. Meyer.

5) **(M2020) Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications.**

(NOTE: This refers to ability, not compliance or willingness.)

0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

1 - Able to take medication(s) at the correct times if:

(a) individual dosages are prepared in advance by another person; OR

(b) another person develops a drug diary or chart.

2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

3 - Unable to take medication unless administered by another person.

NA - No oral medications prescribed.

Since Mr. Meyer's daughter prepared his medication chart, that is considered assistance from another person, and Mr. Meyer would be scored at a 1 in responding to M2020.

Ms. Hamm

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

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

Presumably, Ms. Hamm's choice to leave her clothes lying out on her dressers is a permanent decision. Thus, she would be scored a 0 at M1810.

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

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

The response to M1830 for Ms. Hamm depends upon the clinician's assessment of how safe she would be getting in and out of her shower. Ms. Hamm is choosing to bathe at the sink – the items filling her bathtub are not an environmental barrier, they are a patient choice - and so Ms. Hamm should be

scored based on her ability to safely bathe in the shower/tub. The patient description states Ms. Hamm is unsteady on her feet and that previously, when she still bathed in the shower, Ms. Hamm used a shower chair. If the clinician determined Ms. Hamm was safe getting in and out of the shower independently, she could be scored at a 1 – 'With the use of devices'. However, if the clinician determined she was unsafe getting in and out of the shower and needed assistance to be safe, she should be scored at a 2 – 'With the intermittent assistance of another person'.

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

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. 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 (e.g., 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.

Ms. Hamm is not safe ambulating through her home and the patient description does not indicate that she has any assistive devices in the home. Ms. Hamm should be scored at a 3 – 'Able to walk only with the supervision or assistance of another person at all times'.

4) (M1880) **Current Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

Ms. Hamm was recently prescribed a diabetic diet, but she is not certain what that diet entails. Thus, she is cognitively unable to prepare light meals on a regular basis, and should be scored at a 1. If agency staff teaches Ms. Hamm about the diabetic diet and she expresses understanding, she may be scored up to a 0 on her next OASIS assessment.

Compliance with a special diet should not be considered on this M-Item. However, patient knowledge about the diet should be considered, as knowledge impacts the patient's ability.

5) (M2000) **Drug Regimen Review:** Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 - Not assessed/reviewed [*Go to M2010*]
- 1 - No problems found during review [*Go to M2010*]
- 2 - Problems found during review
- NA - Patient is not taking any medications [*Go to M2040*]

Further Questions

1) If a patient who has previously been independent in bathing is now medically restricted from going upstairs and the only shower in their home is on the second floor, how should they be scored on M 1830?

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

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

The patient should be scored at a 4 or a 5, depending upon their ability to safely bathe at the sink.

2) If a patient can get to and from the toilet with assistance from another person, but uses a commode because there is no one in the home to assist them, how should they be scored on M1840?

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

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

The availability of a caregiver does not affect the patient's physical ability to complete a task (it affects the patient's performance). This patient should be scored based upon their physical ability, and their ability is that they can get to and from the toilet with assistance from another person.

3) If a patient uses a wheelchair 75% of the time, but ambulates safely with a cane the other 25% of the time, how should they be scored on 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.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 -With the use of a one-handed device (e.g. 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 (e.g., 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.

If the patient can walk at all, they should be scored based on their ability to ambulate. Even though this patient only ambulates 25% of the time, they should be scored a '1 – With the use of a one-handed device'.

4) A patient lives with his children and grandchildren. In order to keep his grandchildren safe, the patient's medications are kept on a high shelf in the kitchen where he cannot access them. Each day, when it is time to take his medications, his daughter gets them down from the shelf and hands them to him. He is otherwise independent in administering his medications.

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications.**

(NOTE: This refers to ability, not compliance or willingness.)

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

The patient's medications are kept out of reach as an adaptation to keep the patient's grandchildren safe. Presumably, the medications would be somewhere the patient could reach them if there were no grandchildren in the home. The patient should be scored as independent with management of oral medications.

5) The nurse goes into the patient's home once weekly to set up an automated medication dispenser which flashes lights and 'speaks' to the patient to tell her when it is time to take her medications.

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications.**

(NOTE: This refers to ability, not compliance or willingness.)

0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

1 - Able to take medication(s) at the correct times if:

(a) individual dosages are prepared in advance by another person; OR

(b) another person develops a drug diary or chart.

2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

3 - Unable to take medication unless administered by another person.

NA - No oral medications prescribed.

The use of a machine which speaks to the patient when it is time to take her medications is not equivocal to a human reminding the patient to take her medications. The patient is scored a 1 because the nurse sets up the patient's medications for her.

6) A patient is ordered to receive Vitamin B-12 injections once monthly from the registered nurse. At the time of the patient's assessment, the B-12 injection does not yet need to be given for the month. How should M2030 be scored?

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

0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

1 - Able to take injectable medication(s) at the correct times if:

(a) individual syringes are prepared in advance by another person; OR

(b) another person develops a drug diary or chart.

2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

3 - Unable to take injectable medication unless administered by another person.

NA - No injectable medications prescribed.

If the order exists for the injection to be given, then the patient should be scored based upon their ability to administer that injection, regardless of if the injection is scheduled for the day of the assessment. In this case, since the nurse is ordered to administer the B-12 injection, the patient is scored at a '3 - Unable to take injectable medication unless administered by another person'.

7) A patient self-administers Lovenox injections daily. The syringes come pre-filled from the patient's pharmacy. How should M2030 be scored?

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

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

Since the syringes come pre-filled from the pharmacy, the patient's ability to fill the syringes becomes irrelevant to this question, and the focus is simply on the patient's ability to obtain the syringes from their storage place in the home and administer the medication.

If the syringes did not come pre-filled from the pharmacy and the patient needed to draw up the medication with each administration, then the patient's ability to complete that task would be relevant to the scoring of this item.

Clinical Examples – Case Management and Therapy Need

Mrs. Becker

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) <u>not</u> likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Medical procedures/ treatments (e.g., changing wound dressing)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Supervision and safety (e.g., due to cognitive impairment)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Row A – Mrs. Becker's daughter Laura currently assists her with some ADLs. Keep in mind the focus of this item is on the patient's greatest dependency, not on the ability to complete the majority of tasks.

Row B – Mrs. Becker's daughter Kelly assists with grocery shopping.

Row C – With some education and training by home health agency staff, it seems likely that Laura will help Mrs. Becker with the use of the insulin pen.

Rows D through F – The description gives no indication that Mrs. Becker needs any assistance with these items.

Row G – Mrs. Becker's daughters take her to her physician's appointments.

Mr. Nelson

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/supportive services to provide assistance	Caregiver(s) <u>not</u> likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input checked="" type="checkbox"/> 5
d. Medical procedures/treatments (e.g., changing wound dressing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input checked="" type="checkbox"/> 5
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Supervision and safety (e.g., due to cognitive impairment)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input checked="" type="checkbox"/> 5

Row A – It is not clear if Mr. Nelson's son will help him with bathing.

Row B – Mr. Nelson's son takes care of the housekeeping and grocery shopping for him.

Row C – Since the agency's nurse will set up Mr. Nelson's medications, the response is '5 – Caregiver needed but none available'.

Row D – Once again, the agency is responsible for changing Mr. Nelson's wound V.A.C., and so the response is 5.

Row E – The score for this row depends on the ability of Mr. Nelson and/or his son to be able to troubleshoot the wound V.A.C. If it is clear that they know how to resolve any beeping, and that they are aware of when to contact the agency, then they should be scored a 0 or 1 (depending on if Mr. Nelson is aware, or if it is his son who knows everything). If it seems as though the son would be able to troubleshoot with some additional training, a 2 would be the appropriate score.

Row F – The description gives no indication that Mr. Nelson needs assistance in this area.

Row G – Mr. Nelson's son is unable to take him to/from doctor's appointments, and so assistance is needed with no caregiver available.