Clinical Examples – Patient Tracking and Clinical Record Items

Therapy Only Case

Your agency has a policy that states a registered nurse must open and do the SOC OASIS for all therapy-only cases. The RN opens a new therapy-only patient on 05/20, and completes the patient's OASIS assessment. The PT completes a physical therapy evaluation on 05/21.

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

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

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

> a) What if the RN started the OASIS assessment on 05/20, but did not complete it until 05/21?
>
> b) What if the patient also receives CNA services and the CNA's first visit was completed 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?

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

5) Can an LPN complete the initial patient assessment?

a) Can an LPN complete the OASIS assessment?

Mr. Jones

Mr. Jones is a Medicare/Medicaid dual-eligible patient who suffers from chronic lower back pain. Mr. Jones is receiving skilled nursing services related to pain management, and CNA services for assistance with ADLs. However, Mr. Jones is not homebound and thus is not eligible to receive the home health Medicare benefit.

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

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

On Tuesday evening, Mr. Jones experienced a fall, and went to the emergency room. At the hospital, it was determined that he injured his back and will need to wear a back brace for several weeks. Mr. Jones was not admitted to the hospital, but was released from the emergency room with new orders for physical therapy and pain medications.

A nurse from your agency makes a routine visit to Mr. Jones on Wednesday morning and learns of his fall and new orders. The nurse determines that Mr. Jones is now homebound, and his payer source will need to be changed from Medicaid to Medicare.

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

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

The registered nurse waits until after the physical therapist has completed his/her evaluation of Mr. Jones, and then consults with the PT regarding the number of therapy visits Mr. Jones will need (M2200).

4) Does this violate the one clinician rule?

5) What would the M0090 be in this instance?

It is time to recertify Mr. Jones and update his comprehensive assessment. However, he will have family in town during his 5-day window, and asks the nurse to wait until the next week to perform the assessment.

6) What should the agency do?

Mr. Jones is discharged from the agency on day 32 of his second certification period with goals met. However, 50 days later, his lower back pain becomes uncontrollable and he is admitted to the hospital. A referral is received from the hospital discharge planner on day 3 of Mr. Jones's hospitalization. On day 4 of Mr. Jones's hospitalization he is released and the hospital faxes an updated medication list and a copy of his discharge orders to your agency.

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

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

Mr. Jones receives 4 more weeks of home health services from your agency. On his date of discharge, the nurse completes a visit during the morning, and the physical therapist completes a visit during the afternoon.

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

Mrs. Blake

Mrs. Blake is coming to your agency status post hip fracture resulting from a fall. She has no chronic conditions other than well-managed hypertension, and was completely independent in her home prior to her fall. Mrs. Blake's hospital discharge paperwork includes orders for both skilled nursing and physical therapy.

1) Who can complete the initial assessment visit?

a) Who can complete the SOC OASIS?

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?

The agency concludes that, based on review of Mrs. Blake's hospital record and other medical information, the patient does not require skilled nursing services. The PT completes Mrs. Blake's OASIS assessment on 11/14, and the RN completes Mrs. Blake's medication review on 11/15 and contacts the PT regarding the results of the review on 11/16.

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

Mr. Abrams

Mr. Abrams is a Medicare patient who is being discharged from the hospital with a new colostomy. He is being referred to your agency for skilled nursing services including education and management of his colostomy and related devices until he and his wife feel comfortable managing them on their own.

Mr. Abrams is being discharged from the hospital on a Friday. However, he would like a few days at home to rest and visit with family before starting home care.

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

At Mr. Abrams's SOC visit, the RN determines that the patient and his wife are proficient in managing his colostomy independently and no home care services are needed.

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

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

Jake Miller

Jake Miller is a 9 year old Medicaid patient who receives CNA services from his mom. The nurse visits the patient and his mom once every 60 days to complete a CNA supervisory visit and to recertify Jake for a new 60 day episode.

In reviewing the CNA visit notes that Jake's mom has turned in to the agency's office, it is noticed that 4 visit notes from the 3rd week of Jake's certification period are missing. When Jake's mom is contacted, she explains that Jake was briefly hospitalized during those four days but is home and back to his usual self now.

1) Does the agency need to do anything?

Clinical Examples – Patient History & Diagnoses and Living Arrangements

Mr. Remmer

Mr. Remmer was admitted to the hospital on 07/30 following a fall which resulted in a hip fracture. On 07/31, Mr. Remmer underwent hip replacement surgery. While in the hospital he was on telemetry monitoring for his atrial fibrillation, and on his third day in the hospital (08/01) the dosage for his antacid medication was increased. Mr. Remmer was discharged from the hospital on 08/04 and went to a skilled nursing facility for rehab. He was discharged from the SNF on 08/15. Today is 08/16 and you are opening Mr. Remmer to home care and services at your agency. Please answer the following M-items based on the information provided (ICD-9 codes not needed):

1) **(M1000)** From which of the following **Inpatient Facilities** was the patient discharged <u>during the past 14 days</u>? **(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]

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):

<u>Inpatient Facility Diagnosis</u> <u>ICD-9-CM Code</u>

a.______________________ ___ ___ ___. ___ ___
b.______________________ ___ ___ ___. ___ ___
c.______________________ ___ ___ ___. ___ ___
d.______________________ ___ ___ ___. ___ ___
e.______________________ ___ ___ ___. ___ ___
f.______________________ ___ ___ ___. ___ ___

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

Inpatient Procedure	Procedure Code
a.____________________	___ ___. ___ ___
b.____________________	___ ___. ___ ___
c.____________________	___ ___. ___ ___
d.____________________	___ ___. ___ ___

☐ NA - Not applicable

☐ UK - Unknown

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

Mrs. Sanders

Mrs. Sanders has metastatic breast cancer and was referred to your agency by her doctor following a round of chemotherapy. She has a double lumen PICC placed in her left arm for when she is receiving chemotherapy and for fluids as needed for dehydration. Her family can set up her fluids, but your agency will be maintaining her PICC and changing the dressings once weekly while she is in your care. Mrs. Sanders also receives nutrition through a G-tube on a regular basis. Her family is independent in maintaining and infusing through the G-tube.

On the day of your assessment, Mrs. Sanders has not needed any IV fluids. She has, however, had two cans of Ensure through her G-tube. After completing her comprehensive assessment and OASIS, you change her PICC dressing and flush the lines.

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

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

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?

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes [Go to M1050]
- ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

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?

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes [Go to M1050]
- ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

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?

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

☐ 0 - No
☐ 1 - Yes [Go to M1050]
☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

Living Arrangements

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

	Availability of Assistance				
Living Arrangement	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

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?

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?

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?

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?

Clinical Examples – Sensory and Integumentary Status Items

Mrs. Peter

Mrs. Peter was in a traumatic motorcycle accident and will be discharged from the hospital today. Mrs. Peter experienced a severe burn to her left leg in the accident. In the hospital, a skin graft from her right buttock was used to cover the burn area. Additionally, she has several scrapes and bruises which are nearly healed and will not need any further treatment from your agency. Following her hospital discharge, she continues to wear a neck brace which limits her range of motion and prevents her from being able to see items in her path; however, she has no problem reading her medication labels.

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 <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

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

- Burn site

- Skin graft donor site

- Scrapes, bruises

Mrs. Glenn

Mrs. Glenn is coming to your agency (in part) for treatment of a stage II pressure ulcer which has developed on her coccyx. At her SOC assessment, the wound is noted to be 3.0 cm in length by 2.7 cm in width and 0.5 cm in depth. The wound bed is pink and moist with minimal serous drainage and no odor. Surrounding skin is intact with no edema or redness. Please answer the following wound questions for 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	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
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.	___	___

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

At recert, Mrs. Glenn's pressure ulcer has healed. Please complete the following wound questions for Mrs. Glenn now.

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	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
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

Mr. Garcia

Mr. Garcia is a Spanish speaking patient who can communicate minimally in English. While he understands and responds to some of what you ask him, his daughter has been interpreting for him on the more difficult items. He experiences severe pain in his knees when going up and down stairs. As a result, he has been sleeping in a downstairs bedroom in his two-story home, and has only been using the bathroom on that level as well. During your assessment, he reports a pain level of '2' on a 0-10 scale. Mr. Garcia has two diabetic ulcers on his right foot.

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.

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.

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

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

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

Mr. Regan

Mr. Regan is coming to your agency from the hospital. He is being discharged to your agency with an abdominal incision which has been sutured closed. Additionally, he has a Medi-Port which has been in his chest for approximately 6 months now.

1) How many wounds does Mr. Regan have?

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

Mr. Regan's abdominal wound was completely re-epithelialized around day 20 of his certification period. His Medi-Port is still in place. It is now day 58, and you are completing his recertification assessment.

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*]**

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

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

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

Mrs. Anderson

Mrs. Anderson is coming to your agency for treatment of a pressure ulcer. Per her hospital discharge records, Mrs. Anderson has a stage III pressure ulcer over her right ischium. During your assessment, you note that the ulcer is now covered with approximately 65% yellow slough. The portion of the wound bed which is visible (approximately 35%) is beefy red and appears to be granulating.

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	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
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.	____	____

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

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

It is time for Mrs. Anderson's recertification assessment. At the wound clinic three weeks ago, her wound was debrided and determined to be a stage IV pressure ulcer. Currently, the wound has started to regranulate, and bone is no longer visible.

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	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
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.	___	___

Mrs. Anderson's ulcer has finally 'healed', and she is being discharged from your agency today.

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	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
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.	___	___

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"

| ___ | ___ | . | ___ | (cm)

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

| ___ | ___ | . | ___ | (cm)

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

| ___ | ___ | . | ___ | (cm)

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

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

Clinical Examples – Respiratory and Cardiac Status

Mr. Whitney

Mr. Whitney is a heart failure patient who has positional dyspnea when he is supine, and uses oxygen at night as a result. He also experiences some dyspnea when he walks outside his house to get the mail from the mailbox at the end of his driveway. He has a daily diuretic prescribed, and checks his weight daily. His nursing care plan includes skilled nursing visits twice weekly, reminders to take his diuretic during each nursing visit, and monitoring of Mr. Whitney's weight. The physician wants to be contacted if Mr. Whitney's weight increases by three pounds in two days or by five pounds over the course of a week.

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)

On day 25 of his certification period, Mr. Whitney noticed that he had gained four pounds between Tuesday and Thursday. His nurse was scheduled to visit that afternoon, but Mr. Whitney decided to go ahead and contact his physician before her visit. His physician told him to take an extra dose of his diuretic, which Mr. Whitney did, and call back if his weight was still increased the next day. Upon the nurse's arrival in the afternoon, Mr. Whitney was exhibiting no other symptoms of heart failure. No further interventions were needed.

Additionally, during his certification period, Mr. Whitney began sleeping in his recliner at night. This change eliminated his positional dyspnea, and he now no longer needs oxygen. However, he still experiences some shortness of breath when getting the mail. Mr. Whitney is being discharged from your agency today with goals met.

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)

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)

Clinical Examples – Elimination, Neuro/Emotional/Behavioral Status

Mrs. Cameron

Mrs. Cameron was admitted to the hospital about two weeks ago following a fall on some ice. Prior to and at the time of her hospital admission, Mrs. Cameron had been having frequent (daily) episodes of anxiety; she was placed on an anti-anxiety medication in the hospital and has not had any issues for the past 10 days. Mrs. Cameron reports that she has a lot of trouble sleeping, and will often (two or three nights per week) wake up during the night and walk around her house (she does not turn on the lights because she doesn't want to disturb her husband) until she feels tired again. Mrs. Cameron also states she has some stress incontinence, primarily when she coughs or when her grandson makes her laugh.

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*]**

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

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

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

Mrs. Cameron is being discharged today. She has been doing Kegel exercises and was placed on medication for her stress incontinence. Through regular follow-up by the nurse, it has been determined that she no longer experience incontinent episodes.

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*]**

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?

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

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?

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?

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'?

Clinical Examples – ADLs/IADLs and Medications

Activities of Daily Living Questions

1) Which M-Item 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)?

Mr. Meyer

Mr. Meyer is unable to fasten buttons. As a result, he now only wears shirts and pants which do not require buttoning. Recently, his physician ordered him to wear TED hose during the day. Mr. Meyer does require some assistance from his wife in order to apply the TED hose, but he is independent with all other dressing tasks, although he does take frequent rest breaks while he is dressing himself. Mr. Meyer tends to fatigue easily, and his wife usually stays in the bathroom or master bedroom while he is in the shower so that she can easily assist him if needed. If he had a shower chair, he would most likely not need this assistance.

At meal time, Mrs. Meyer prepares all of Mr. Meyer's meals, and places his food onto a plate before serving him. This has been their habit for years, and he requires no additional assistance. In order to take all of his medications, Mr. Meyer uses a medication chart that his daughter prepared for him. Each time his medications change, his daughter updates the chart.

1) **(M1810)** Current **Ability to Dress <u>Upper</u> 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.

2) **(M1820)** Current **Ability to Dress <u>Lower</u> 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.

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

☐ 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 throughout the bath.

☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

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.

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.

Ms. Hamm

Ms. Hamm is a self-proclaimed hoarder. Her home is filled with clothing, boxes of old household items, various knick knacks, and her ceramic plate collection. Stacks of papers and magazines cover the floors. There is a narrow walkway throughout her home which she uses to ambulate from room to room. Ms. Hamm is unsteady on her feet, and uses her furniture and walls to help stabilize herself. She uses her combined bathtub and shower for storage and chooses instead to bathe at the sink. She is independent in bathing at the sink, and states she had no difficulties using her shower with a shower chair prior to turning it into a storage place. She uses a long-handled sponge to clean her back and feet, but requires no other devices.

Ms. Hamm's bedroom is piled high with clothes on every surface. She tells you that when it became too difficult for her to open her dresser drawers she stopped using them and has just been leaving her clothes out so that they may be more easily accessed. Ms. Hamm's doctor recently prescribed a diabetic diet for her when he referred her to home care, but she states she is not sure what that really means. During her drug regimen review, Ms. Hamm admits that she has several prescriptions which she has not refilled. The medications ran out about 6 days ago, and Ms. Hamm tells you she doesn't think she needs them since she has been doing fine since they ran out.

1) **(M1810)** Current **Ability to Dress <u>Upper</u> 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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Clinical Examples – Case Management and Therapy Need

Mrs. Becker

Mrs. Becker has two daughters who provide her with assistance. Each morning, Mrs. Becker gets dressed, and when her daughter Laura comes over, she helps Mrs. Becker to put on her shoes. Laura also selects and sets out all of Mrs. Becker's morning medications for her to take with breakfast. In the evening, Mrs. Becker's daughter Kelly comes over to bring Mrs. Becker groceries and any other items she needs from the store. The daughters trade off taking Mrs. Becker to her doctor's office. Kelly took Mrs. Becker to the physician's office yesterday, where the physician ordered Mrs. Becker to take 4 units of Lantus subcutaneously each morning. Mrs. Becker received an insulin pen, but isn't sure she can remember how to work it. Her daughter Laura (who visits in the mornings) also does not know how to use the pen.

(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) not 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)	☐0	☐1	☐2	☐3	☐4	☐5
b. **IADL assistance** (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4	☐5
c. **Medication administration** (e.g., oral, inhaled or injectable)	☐0	☐1	☐2	☐3	☐4	☐5
d. **Medical procedures/ treatments** (e.g., changing wound dressing)	☐0	☐1	☐2	☐3	☐4	☐5
e. **Management of Equipment** (includes oxygen, IV/infusion equip-ment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐0	☐1	☐2	☐3	☐4	☐5
f. **Supervision and safety** (e.g., due to cognitive impairment)	☐0	☐1	☐2	☐3	☐4	☐5
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐0	☐1	☐2	☐3	☐4	☐5

Mr. Nelson

Mr. Nelson lives with his son who does all of his errands and housekeeping for him. Mr. Nelson has a wound V.A.C. and needs medication set up by an agency nurse. Mr. Nelson also needs some bathing assistance, but is not sure if his son will help him with that. Due to his son's busy work schedule, he is unable to take Mr. Nelson to and from his doctor's appointments, but he is in frequent communication with Mr. Nelson's physician by phone.

(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) not 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)	☐0	☐1	☐2	☐3	☐4	☐5
b. **IADL assistance** (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐0	☐1	☐2	☐3	☐4	☐5
c. **Medication administration** (e.g., oral, inhaled or injectable)	☐0	☐1	☐2	☐3	☐4	☐5
d. **Medical procedures/ treatments** (e.g., changing wound dressing)	☐0	☐1	☐2	☐3	☐4	☐5
e. **Management of Equipment** (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐0	☐1	☐2	☐3	☐4	☐5
f. **Supervision and safety** (e.g., due to cognitive impairment)	☐0	☐1	☐2	☐3	☐4	☐5
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐0	☐1	☐2	☐3	☐4	☐5