OASIS-C 1- Start of Care/3 - Resumption

Clinical Record Items

#	Question	Answer	To prevent emergent care…	Considerations
M0080	Discipline of Person Completing Assessment	☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT		
M0090	Date Assessment Completed			
M0100	This Assessment is Currently Being Completed for the Following Reason	☐ 1 – Start of care—further visits planned ☐ 3 – Resumption of care (after inpatient stay) ☐ 4 – Recertification (follow-up) reassessment [Go to M0110] ☐ 5 – Other follow-up [Go to M0110] ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M2300] ☐ 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M2300] ☐ 8 – Death at home [Go to M0906] ☐ 9 – Discharge from agency [Go to M1032]		
M0102	Date of Referral: Indicate the date the physician made the referral for this home health Start of Care (Resumption of Care		§484.55(a)(1) CMS requires that the on-site admission visit is made within 48 hours of the physician's referral.	
M0104	Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services* record the date specified.		To assess compliance with §484.55(a)(1) surveyors will compare the physician-ordered start of care with the date of referral.	

Clinical Record Items continued

#	Question	Answer	To prevent emergent care…	Considerations
M0110	Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an early episode or a later episode in the patient's current sequence of adjacent Medicare home health payment episodes?	☐ 1 - Early ☐ 2 - Later ☐ UK - Unknown ☐ NA - Not Applicable: No Medicare case mix group to be defined by this assessment.	The answer to this item affects the Medicare reimbursement calculation. An early episode is considered the first 2 certification periods of a patient's admission. Later episodes represent anything after the first 2 certification periods.	

Demographics and Patient History

#	Question	Answer	To prevent emergent care…	Considerations
M1000	From which of the following Inpatient Facilities was the patient discharged during the past 14 days (Mark all that apply.)	☐ 1 - Hospital ☐ 2 - Rehabilitation facility ☐ 3 - Skilled nursing facility ☐ 4 - Other nursing home ☐ 5 - Other (specify) ☐ NA - Patient was not discharged from an inpatient facility [Go to M1014]	A patient who as recently received skilled services in a facility is likely be more stable than a patient who has not recently received skilled services.	
M1005	Inpatient Discharge Date (most recent):			
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 for which the patient has recently received acute care treatment may be the reason the patient needs home health now. In case the record is audited by CMS, this diagnosis list should be obtained from the facility where the patient was admitted.	During referral phone call, obtain the ICD-9s from the source	
M1012	List each Inpatient Procedure and the associated ICD-9-CM procedure code	Procedures for which the patient has recently received acute care treatment may be the reason the patient needs home health now. In case the record is audited by CMS, the procedure list should be obtained from the facility where the patient was admitted.	During referral phone call, if possible obtain the CPTs from the source	

Demographic and Patient History continued

#	Question	Answer	To prevent emergent care…	Considerations
M1014	Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g.* medication* treatment* or service change due to new or additional diagnosis* etc.) in the last 14 days?	☐ 0 - No [Go to M1018 at SOC/ROC; Go to M1032at DC] ☐ 1 - Yes	A change in medications or treatments indicates the need for monitoring to make sure the changes are safe and effective. This is heads-up information for the admission nurse/therapist. Should be obtained during the referral phone call.	During referral phone call ask if the patient has new or changed medications, and if the physician has ordered new or changed procedures.
M1016	List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical* E-codes* or V-codes):		Refer to the codes documented for M1010 and M1012	
M1018	Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days* indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)	☐ 1 - Urinary incontinence ☐ 2 - Indwelling/suprapubic catheter ☐ 3 - Intractable pain ☐ 4 - Impaired decision-making ☐ 5 - Disruptive or socially inappropriate behavior ☐ 6 - Memory loss to the extent that supervision required ☐ 7 - None of the above ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days ☐ UK - Unknown	This list is a limited health history that, data has shown, are signficant risk factors for emergent care.	Obtain the information during the patient/family interview. Use these findings to focus on a related comprehensive assessment and careplan.
M1020/ 1022/ 1024	Diagnoses* Severity Index* and Payment Diagnoses	Refer to M1010 and M1016 for related codes. Try to obtain codes during referral phone call.		
M1030	Therapies the patient receives at home: (Mark all that apply.)	☐ 1 - Intravenous or infusion therapy (ex. 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	Document physician orders for this treatment, the ability of the patient/family/caregiver to properly manage this treatment, and if home care is needed to manage this treatment.	Assessment should include how well patient/family/caregiver manages nutritional therapy.

Demographic and Patient History continued

#	Question	Answer	To prevent emergent care…	Considerations
M1032	Frailty Indicators: Which of the following signs or symptoms characterize this patient as at risk for major decline or hospitalization (Mark all that apply.)	☐ 1 - Unstable vital signs ☐ 2 - Debilitating pain ☐ 3 - Recent decline in mental status ☐ 4 - Recent functional decline ☐ 5 - Multiple hospitalizations (>1) in the past 12 months ☐ 6 - History of falls (2 or more falls - or any fall with an injury - in the past year) ☐ 7 - Other ☐ 8 - None of the above	This answer to this question alone is a significant indicator of the patient's risk for hospitalization. This answer should be consistent with M1018.	Review your answer to M1018 to answer consistently.
M1034	Stability Prognosis: Which description best fits the patient's overall status (Check one)	☐ 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). ☐ 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). ☐ 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. ☐ 3 - The patient has serious progressive conditions that could lead to death within a year. ☐ UK - The patient's situation is unknown or unclear.	Like 1032, this answer to this question alone is a significant indicator of the patient's risk for hospitalization. This answer should be consistent with M1018 and M1032.	Review your answer to M1018 and M1032 to answer consistently.
M1036	Risk Factors characterizing this patient: (Mark all that apply.	☐ 1 - Smoking ☐ 2 - Obesity ☐ 3 - Alcohol dependency ☐ 4 - Drug dependency ☐ 5 - None of the above ☐ UK - Unknown	These are risk factors that exacerbate any existing health problem and significantly increase the risk for emergent care. The presence of any of these items require long term intervention. An MSW should be considered.	Obtain the information during the patient/family interview. Long term care and outreach should be included in the careplan for any of these items.

Demographic and Patient History continued

#	Question	Answer	To prevent emergent care…	Considerations
M1038	Guidelines for Physician Notification: Does the physician-ordered plan of care establish parameters (limits) for physician notification of changes in vital signs or other clinical findings	☐ 0 - No ☐ 1 - Yes	Labwork, symptom and vital sign parameters must be included in the plan of care in form locator 21.	Include parameters for labwork, symptom and vital signs in FL 21 on the CMS485.

Living Arrangements

#	Question		Around the clock	Regular Daytime	Regular Nigttime	Occ Short-term assistance	No Assistance Available
M1100	Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance (Check one box only).	a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
		b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
		c. Patient lives in congregate (e.g. assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

Sensory Status

#	Question	Answer	To prevent emergent care…	Considerations
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 non-responsive.	Modified teaching materials for vision limitations need to be available. Visual impairment increases safety and falls risk.	Document how vision impairment affects teaching and safety and include necessary interventions in the careplan.

Sensory Status continued

#	Question	Answer	To prevent emergent care…	Considerations
M1210	Ability to hear (with hearing aid or hearing appliance if normally used):	☐ 0 – Adequate: hears normal conversation without difficulty. ☐ 1 – Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. ☐ 2 – Severely Impaired: absence of useful hearing. ☐ UK – Unable to assess hearing.	Modified teaching materials for vision limitations need to be available. Hearing impairment increases safety risk.	Document how hearing impairment affects teaching and safety and include necessary interventions in the careplan.
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/Sometimes Understands: Comprehends only basic conversations or simple, direct phrases or requires cues to understand. ☐ 2 – Rarely/Never Understands ☐ UK – Unable to assess understanding.	Modified teaching materials for cognitive limitations need to be available. Cognitive impairment increases safety risk.	Document how cognitive limitation affects teaching and safety and include necessary interventions in the careplan.
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). ☐ 3 – Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener.. ☐ 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.	Modified teaching materials for speech limitations need to be available. Speech impairment increases safety risk.	Document how speech impairment affects teaching and safety and include necessary interventions in the careplan.

Sensory Status continued

#	Question	Answer	To prevent emergent care…	Considerations
M1240	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	A baseline pain assessment is necessary to make timely adjustments to pain treatment as needed.	If the patient has pain, document a complete pain assessment including current treatment and effectiveness.
M1242	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	A baseline pain assessment is necessary to make timely adjustments to pain treatment as needed.	If there are current and/or past pain issues, document a complete pain assessment including current or past treatment and effectiveness.
M1244	Planned Pain Intervention: Does the current physician-ordered plan of care include intervention(s) to monitor and mitigate pain	☐ 0 - No ☐ 1 - Yes	If the patient has pain, an effective pain control treatment must be established.	If there are current and/or past pain issues, document the physician-ordered pain treatment plan.

Integumentary Status

#	Question	Answer	To prevent emergent care…	Considerations
M1300	Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers	☐ 0 - No assessment conducted [Go to M1308] ☐ 1 - Yes, using a standardized tool (e.g., Braden, Norton, other) ☐ 2 - Yes, based on an evaluation of clinical factors (e.g., mobility, incontinence, nutrition, etc.)	A baseline risk assessment for pressure ulcer is necessary to implement preventive measures.	Perform a risk assessment for pressure ulcers.
M1302	Does this patient have a Risk of Developing Pressure Ulcers	☐ 0 - No [Go to M1308] ☐ 1 - Yes	If yes, a prevention must be included in the careplan.	
M1304	Planned Pressure Ulcer Prevention: Does the current physician-ordered plan of care include intervention(s) to prevent pressure ulcers	☐ 0 - No ☐ 1 - Yes	If the patient has risk for developing pressure ulcers, an effective prevention plan must be established.	If the patient has risk factors, a complete prevention plan must be documented in FL 21.

Integumentary Status continued

#	Question	Answer	To prevent emergent care…	Considerations
M1308	Does this patient have at least one unhealed (non-epithelialized) Pressure Ulcer at Stage II or higher or designated as not stageable?	☐ 0 - No [Go to M1322 at SOC/ROC/DC; Go to M1324 at FU] ☐ 1 - Yes		
M1310	Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: (Enter 0 if none; enter 4 if 4 or more; enter UK for rows d.1 – d.3 if Unknown)	If the patient has unhealed pressure ulcers, a comprehensive baseline assessment (including measurements) for each pressure ulcer is necessary to track effectiveness of treatment.	Perform a comprehensive baseline assessment (including measurements) for each pressure ulcer.	
M1312	Pressure Ulcer Length: Longest length in any direction | ___ | ___ | . | ___ | (cm)		Answer according to findings on 1310.	
M1314	Pressure Ulcer Width: Width of the same pressure ulcer* greatest width measured at right angles to length | ___ | ___ | . | ___ | (cm)		Answer according to findings on 1310.	
M1320	Status of Most Problematic (Observable) Pressure Ulcer:	☐ 0 - Re-epithelialized or healed ☐ 1 - Fully granulating ☐ 2 - Early/partial granulation ☐ 3 - Not healing ☐ NA - No observable pressure ulcer	Answer according to findings on 1310.	
M1322	Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful* firm* soft* warmer or cooler as compared to adjacent tissue.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more	Answer according to findings on 1310.	
M1324	Stage of Most Problematic (Observable) Pressure Ulcer:	☐ 1 - Stage I [Go to M1330 at SOC/ROC/FU] ☐ 2 - Stage II ☐ 3 - Stage III ☐ 4 - Stage IV ☐ NA - No observable pressure ulcer [Go to M1330 at SOC/ROC/FU]	Answer according to findings on 1310.	

Integumentary Status continued

#	Question	Answer	To prevent emergent care…	Considerations
M1326	Pressure Ulcer Intervention: Are moisture retentive dressings specified on the physician-ordered plan of care	☐ 0 - No ☐ 1 - Yes ☐ 2 - Order requested from physician ☐ 3 - Moisture retentive dressings not indicated	Data shows that moisture retentive dressings are highly effective for wound healing.	Answer according to physician orders.
M1330	Does this patient have a Stasis Ulcer	☐ 0 - No [Go to M1340] ☐ 1 - Yes, patient has one or more (observable) stasis ulcers ☐ 2 - Stasis ulcer known or likely but not observable due to non-removable dressing [Go to M1340]	In order to track effectiveness of treatment, the comprehensive assessment should have a comprehensive baseline integumentary assessment for all skin anomalies including wounds (with measurements) and their type.	Answer according to findings on 1310.
M1332	Current Number of (Observable) Stasis Ulcer(s):	☐ 1 - One ☐ 2 - Two ☐ 3 - Three ☐ 4 - Four or more	Answer according to findings on 1310.	
M1334	Status of Most Problematic (Observable) Stasis Ulcer:	☐ 0 - Re-epithelialized or healed ☐ 1 - Fully granulating ☐ 2 - Early/partial granulation ☐ 3 - Not healing	Answer according to findings on 1310.	
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 or likely but not observable due to non-removable dressing [Go to M1350]	Answer according to findings on 1310.	
M1342	Status of Most Problematic (Observable) Surgical Wound:	☐ 0 - Re-epithelialized or healed ☐ 1 - Fully granulating ☐ 2 - Early/partial granulation ☐ 3 - Not healing	Answer according to findings on 1310.	

Integumentary Status continued

#	Question	Answer	To prevent emergent care…	Considerations
M1350	Does this patient have a Skin Lesion or Open Wound* excluding bowel ostomy* other than those described above that is receiving assessment and/or intervention by the home health agency	☐ 0 - No ☐ 1 - Yes	Answer according to findings on 1310.	
M1360	Diabetic Foot Care Plan: Does the physician-ordered plan of care include for the presence of skin lesions on the lower extremities and patient education on proper foot care	☐ 0 - No ☐ 1 - Yes ☐ NA - Bilateral amputee OR Patient does not have diagnosis of diabetes	If a diabetic diagnosis is documented on M1020, 1022 and/or 1024, foot care should be included in the careplan.	Include foot care in the careplan if a diabetic diagnosis is documented on M1020, 1022 and/or 1024

Respiratory Status

#	Question	Answer	To prevent emergent care…	Considerations
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)	SOB needs to be controlled.	If SOB is present, tracking of the effectiveness of treatment should be included on every progress note. Notify physician if there's no improvement.
M1410	Respiratory Treatments utilized at home: (Mark all that apply.)	☐ 1 - Oxygen (intermittent or continuous) ☐ 2 - Ventilator (continually or at night) ☐ 3 - Continuous positive airway pressure ☐ 4 - None of the above	Safe and effective management of respiratory treatments at home is necessary to prevent emergent care.	Document who manages the treatment and how well respiratory treatments are managed.

Elimination Status

#	Question	Answer	To prevent emergent care…	Considerations
M1600	Has this patient been treated for a Urinary Tract Infection in the past 14 days	☐ 0 - No ☐ 1 - Yes ☐ NA - Patient on prophylactic treatment ☐ UK - Unknown	UTI is a significant re-hospitalization risk factor. If yes close monitoring of urine status needed.	If yes, include urinary monitoring in the careplan.
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]	Urinary issues are significant re-hospitalization risk factors. If present close monitoring of urine status is needed.	If urinary problems are present close monitoring of urine status should be included in the careplan. Notify physician if there's no improvement.
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		
M1620	Bowel Incontinence Frequency:	☐ 0 - Very rarely or never has bowel incontinence ☐ 1 - Less than once weekly ☐ 2 - One to three times weekly ☐ 3 - Four to six times weekly ☐ 4 - On a daily basis ☐ 5 - More often than once daily ☐ NA - Patient has ostomy for bowel elimination ☐ UK - Unknown	if present, treatment for bowel incontinence is needed.	Include treatment for bowel incontinence on the careplan. Notify physician if there's no improvement.

Elimination Status continued

#	Question	Answer	To prevent emergent care…	Considerations
M1630	Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay* or b) necessitated a change in medical or treatment regimen	☐ 0 - Patient does not have an ostomy for bowel elimination. ☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change. ☐ 2 - The ostomy was related to an inpatient stay/did necessitate change in medical tx	if ostomy is new, monitoring is needed to prevent complications of the recent surgery.	If the ostomy is new, include monitoring of the new surgery in the careplan.

Neuro/Emotional/Behavioral

#	Question	Answer	To prevent emergent care…	Considerations
M1700	Cognitive Functioning: (Patient's current level of alertness* orientation* comprehension* concentration* and immediate memory for simple commands.)	☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.	If cognitive issues are present, modified teaching materials are needed and safety issues need to be addressed.	If cognitive issues are present, provided appropriate teaching materials and address safety issues in the careplan.

Neuro/Emotional/Behavioral continued

#	Question	Answer	To prevent emergent care…	Considerations
M1710	When Confused (Reported or Observed):	☐ 0 - Never ☐ 1 - In new or complex situations only ☐ 2 - On awakening or at night only ☐ 3 - During the day and evening, but not constantly ☐ 4 - Constantly ☐ NA - Patient nonresponsive	If patient is confused, modified teaching materials are needed and safety issues need to be addressed.	If patient is confused, provided appropriate teaching materials and address safety issues in the careplan.
M1720	When Anxious (Reported or Observed):	☐ 0 - None of the time ☐ 1 - Less often than daily ☐ 2 - Daily, but not constantly ☐ 3 - All of the time ☐ NA - Patient nonresponsive	If patient is anxious, treatment for anxiety is needed.	If patient is anxious, include treatment for anxiety in the careplan. Notify physician if there's no improvement.
M1730	Depression Screening: Has the patient been screened for depression* using a standardized depression screening tool	☐ 0 - No ☐ 1 - Yes, and the patient exhibits no current symptoms of depression during the last 14 days. [Go to M1740] ☐ 2 - Yes, and the patient exhibits some symptoms of depression during the last 14 days.	Depression is a significant re-hospitalization risk factor. If depressed, comprehensive neuro/mental health depression assessment and treatment is needed	If patient is depressed, include treatment for depression in the careplan. Notify physician if there's no improvement.
M1732	Depressive Symptoms Reported or Observed in Patient in past 14 days: (Mark all that apply.)	☐ 0 - No symptoms observed or reported ☐ 1 - Depressed mood (e.g., feeling sad, tearful) ☐ 2 - Sense of failure or self reproach ☐ 3 - Hopelessness ☐ 4 - Recurrent thoughts of death ☐ 5 - Thoughts of suicide ☐ 6 - Other signs or symptoms		

Neuro/Emotional/Behavioral continued

#	Question	Answer	To prevent emergent care…	Considerations
M1734	Depression Intervention Plan: Does the current physician-ordered plan of care include intervention(s) for symptoms of depression* such as medication* or a monitoring plan for current treatment	☐ 0 - No ☐ 1 - Yes, medication(s), referral, and/or monitoring in physician-ordered plan of care ☐ NA - Patient does not have symptoms of depression, diagnosis of depression, or current treatment for depression.		
M1740	Behaviors 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		
M1745	Frequency of Behavior Problems (Reported or Observed) (e.g.* wandering episodes* self abuse* verbal disruption* physical aggression* etc.):	☐ 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		

Neuro/Emotional/Behavioral continued

#	Question	Answer	To prevent emergent care…	Considerations
M1750	Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse☐	☐ 0 - No ☐ 1 - Yes	if patient has positive findings on M1732, M1740 and M1745 psychiatric nursing is indicated.	if patient has positive findings on M1732, M1740, and M1745 be specific how these neuro/emotional/behavioral problems will be managed. Notify physician if there's no improvement.

ADLs/IADLs

#	Question	Answer	To prevent emergent care…	Considerations
M1800	Grooming: Current ability to tend safely to personal hygiene needs (i.e.* washing face and hands* hair care* shaving or make up* teeth or denture care* fingernail care).	☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities. ☐ 2 - Someone must assist the patient to groom self. ☐ 3 - Patient depends entirely upon someone else for grooming needs.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.

ADLs/IADLs continued

#	Question	Answer	To prevent emergent care…	Considerations
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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1830	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face and hands only).	☐ 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 bath 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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit. Notify physician if there's no improvement.

ADLs/IADLs continued

#	Question	Answer	To prevent emergent care…	Considerations
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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1845	Toileting Hygiene: Current ability to maintain safely perineal hygiene* adjust clothes and/or incontinence commode* bedpan* urinal. If managing ostomy* include cleaning opening but not managing equipment.	☐ 0 - Able to manage toileting hygiene and clothing management without assistance. ☐ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. ☐ 2 - Someone must help the patient to maintain toileting hygiene or adjust clothing. ☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1850	Transferring: Current ability to move safely from bed to chair* or ability to turn and position self in bed if patient is bedfast.	☐ 0 - Able to independently transfer. ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device. ☐ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process. ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed. ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (PT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.

ADLs/IADLs continued

#	Question	Answer	To prevent emergent care…	Considerations
M1860	Ambulation/Locomotion: 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 climb 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 climb 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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (PT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.

ADLs/IADLs continued

#	Question	Answer	To prevent emergent care…	Considerations
M1880	Change in Mobility: Is the patient's ability to transfer and/or ambulate safely better* the same* or worse than prior level of functioning (i.e.* before the onset of the illness or injury that initiated this episode of care)	☐ 0 – Ability to transfer and/or ambulate is better or the same now than the prior level of functioning. ☐ 1 – Ability to transfer and/or ambulate is worse now than the prior level of functioning. ☐ UK – Unknown	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (PT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1890	Change in Self-care Ability: Is the patient's ability to perform self-care activities safely (grooming* dressing* and bathing) better* the same* or worse than prior level of functioning (i.e.* before the onset of the illness or injury that initiated this episode of care)	☐ 0 – Ability to perform self-care activities is better or the same now than the prior level of functioning. ☐ 1 – Ability to perform self-care activities is worse now than the prior level of functioning. ☐ UK – Unknown	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1900	Current Planning and Preparing 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.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.

ADLs/IADLs continued

#	Question	Answer	To prevent emergent care…	Considerations
M1910	Ability to Use Telephone: Current ability to answer the phone safely* including dialing numbers* and effectively using the telephone to communicate.	☐ 0 - Able to dial numbers and answer calls appropriately and as desired. ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment. ☐ 5 - Totally unable to use the telephone. ☐ NA - Patient does not have a telephone.	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (ST) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1920	Change in Ability to Perform Routine Household Tasks: Is the patient's ability to perform routine household tasks safely (e.g.* light meal preparation* laundry* shopping* etc.) better* the same* or worse than prior level of functioning (i.e.* before the onset of the illness or injury that initiated this episode of care)	☐ 0 – Ability to perform routine household tasks is better or the same now than the prior level of functioning. ☐ 1 – Ability to perform routine household tasks is worse now than the prior level of functioning. ☐ UK – Unknown	Patient/family must be able to manage activities of daily living.	If deficit is related to recent acute neuro, orthopedic or endurance deficit, therapy (OT) may be indicated. Document role of family/caregiver in managing deficit.Notify physician if there's no improvement.
M1930	Has this patient had a multi-factor Fall Risk Assessment (such as falls history* use of multiple medications* mental impairment* toileting frequency* general mobility/transferring impairment* environmental hazards)	☐ 0 - No multi-factor falls risk assessment conducted. ☐ 1 - Yes, and it does not indicate a risk for falls. [Go to M2000 at SOC/ROC; Go to M2004 at TRN/DC] ☐ 2 - Yes, and it indicates a risk for falls.	A Falls Risk Assessment should be performed on all patients.	Perform a falls risk assessment on all patients and include interventions on the careplan for positive findings.
M1940	Falls Risk Intervention: Does the current physician-ordered plan of care include intervention(s) to mitigate the risk of falls	☐ 0 - No ☐ 1 - Yes	If the patient is positive for risks for falls, interventions should be included on the careplan.	Include falls-risk preventive measures on the careplan as necessary.

Medication Management

#	Question	Answer	To prevent emergent care…	Considerations
M2000	Potential Adverse Effects/Reaction: Does a complete drug regimen review indicate potential clinically significant adverse effects or drug reactions* including 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	a medication profile that includes potential reactions, side effects, interactions and contraindications for all medications is taking should be generated.	Document the potential adverse reactions, side effects, interactions and contraindications on all the medications for each patient and note potential
M2002	Medication Follow-up: Was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues* including reconciliation?	☐ 0 - No ☐ 1 - Yes	notify the physician of medication problems.	If medication problems are discovered, the physician must be notified with 24 hours. Make sure your progress note prompts this.
M2010	Patient/Caregiver Drug Education: Has the patient/caregiver received instruction on high-risk medications (such as hypoglycemics and anticoagulants) including monitoring the effectiveness of drug therapy* potential adverse effects* and how and when to report problems that may occur	☐ 0 - No ☐ 1 - Yes ☐ NA - Patient not taking any high risk drugs	Provide patient/caregiver written teaching materials on high-risk medications.	Provide patient/caregiver written teaching materials on high-risk 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 daily reminders by another person ☐ 3 - Unable to take medication unless administered by another person. ☐ NA - No oral medications prescribed.	Need to assess patient's ability to manage medications to provide teaching if necessary.	Assess patient's ability to manage medications. Include teaching in careplan as necessary.

Medication Management continued

#	Question	Answer	To prevent emergent care…	Considerations
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 and proper dosage at the correct times. ☐ 1 - Able to take injectable medication at correct times if: (a) individual syringes are prepared in advance by another person, OR (b) given reminders based on the frequency of the injection. ☐ 2 - Unable to take injectable medications unless administered by someone else. ☐ NA - No injectable medications prescribed.	Need to assess patient's ability to manage medications to provide teaching if necessary.	Assess patient's ability to manage medications. Include teaching in careplan as necessary.
M2040	Change in Ability to Manage Oral* Inhalant* or Injectable Medications: Is the patient's ability to prepare and take all prescribed medications (oral and* if applicable* inhalant or injectable medications) reliably and safely (including administration of the correct dosage at the appropriate times/intervals) better or worse than before the onset of the illness or injury that initiated this episode of care	☐ 0 – Ability to prepare and take all prescribed medications now is better or the same now than the prior level of functioning. ☐ 1 – Ability to prepare and take all prescribed medications now is worse now than the prior level of functioning. ☐ UK – Unknown	Medication mis-management is a significant re-hospitalization risk factor. If patient's ability has deteriorated, aggressive intervention is necessary.	Include verbal teaching, written materials, practicing and repeating instructions.

Equipment Management

#	Question	Answer	To prevent emergent care…	Considerations
M2100	Patient Management of Equipment (includes ONLY oxygen* IV/infusion therapy* enteral/parenteral nutrition equipment or supplies* ventilator therapy equipment or supplies): Patient's ability to set up* monitor and change equipment reliably and safely* add appropriate fluids or medication* clean/store/dispose of equipment or supplies using proper	☐ 0 - Patient manages all tasks related to equipment completely independently. ☐ 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment. ☐ 2 - Patient requires considerable assistance from another person to manage equipment	Equipment mis-management is a re-hospitalization risk factor.	Include verbal teaching, written materials, practicing and repeating instructions on equipment management.

technique. (NOTE: This refers to ability* not compliance or willingness.)	☐ 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment. ☐ 4 - Patient is completely dependent on someone else to manage all equipment. ☐ NA - No equipment of this type used in care	

Equipment Management continued

M2110 Types and Sources of Assistance
(Check only **one** box in each row)

Needing assistance = patient needs assistance on any item on the "e.g." list	No assistance needed in this area	Caregiver(s) currently provides assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likelyto 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)	a1. ☐	a2. ☐	a3. ☐	a4. ☐	a5. ☐	a6. ☐
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	b1. ☐	b2. ☐	b3. ☐	b4. ☐	b5. ☐	b6. ☐
c. Medication administration (e.g., oral, inhaled or injectable)	c1. ☐	c2. ☐	c3. ☐	c4. ☐	c5. ☐	c6. ☐
d. Medical procedures/ treatments (e.g., changing wound dressing)	d1. ☐	d2. ☐	d3. ☐	d4. ☐	d5. ☐	d6. ☐
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	e1. ☐	e2. ☐	e3. ☐	e4. ☐	e5. ☐	e6. ☐
f. Supervision and safety	f1. ☐	f2. ☐	f3. ☐	f4. ☐	f5. ☐	f6. ☐
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	g1. ☐	g2. ☐	g3. ☐	g4. ☐	g5. ☐	g6. ☐

Equipment Management continued

#	Question	Answer	To prevent emergent care…	Considerations
M2120	How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?	☐ 1 - At least daily ☐ 2 - Three or more times per week ☐ 3 - One to two times per week ☐ 4 - Received, but less often than weekly ☐ 5 - No assistance received ☐ UK - Unknown*	A caregiver's schedule should be considered when establishing the skilled home health visit schedule. Initially, the caregiver needs to be included in home health visits for teaching. As time goes on the caregiver should replace some skilled visits.	Document the caregiver's schedule and then schedule skilled home health visits accordingly.

Therapy Need

#	Question	Answer	To prevent emergent care…	Considerations
M2200	Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group* what is the indicated need for therapy visits (total of reasonable and necessary physical* occupational* and speech-language pathology visits combined	(__ __ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined). ☐ NA - Not Applicable: No case mix group defined by this assessment.) (Enter zero [000] if no therapy visits indicated.)	In addition to physical intervention, therapy includes teaching, training and strategies to manage physical deficits. Therapy should be considered for all patients who have ADL deficits.	Most ADL/IADL questions are OT indicators.