Clinical "Hot Topics"

for Home Care 2020

Day 1

KHCHA Winter Conference

December 2019

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Learning Outcomes

- State five components of PDGM payment structure
- Describe how to select the primary diagnosis
- Identify the OASIS items used for the functional score in PDGM
- State one assessment tip for accurate OASIS data collection

PDGM Overview

What does PDGM mean for Clinicians?

PDGM—Major Changes

- Relies more heavily on clinical characteristics and other patient information
- Places patients into meaningful payment categories based on primary diagnosis
- Eliminates the use of therapy service thresholds
- 30 day unit of payment (two per certification period)
- Effective for home health periods of care beginning on or after January 1, 2020

Unchanged

- Conditions of Participation
- Comprehensive assessment (including OASIS items) required at SOC, Recertification, Other Follow-Up (SCIC), Resumption of Care, Discharge
  - OASIS-D1 makes certain items optional
  - OASIS transmitted within 30 days of M0090 (Date Assessment Completed)
- Plan of Care every 60 days
- HIPPS code based on SOC and Recertification
  - With addition of ROC and Other Follow-up

PDGM Payment Components

Timing—Early and Late
30 day payment period

Admission Source—Community or Institutional

Clinical Grouping from Principal Diagnosis

Comorbidity Adjustment—Secondary Diagnoses (up to 24 additional diagnoses)

Functional Score (only part of payment equation from OASIS)

HIPPS Code under PDGM

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1	A	A	1	1
Community Early	MMTA_OTHER	Low	No	
2	B	B	2	
Institutional Early	Neuro Rehab	Medium	Low	
3	C	C	3	
Community Late	Wounds	High	High	
4	D			
Institutional Late	Complex Nursing			
	E			
	MS Rehab			
	F			
	Behavioral Health			
	G			
	MMTA - Surgical Aftercare			
	H			
	MMTA - Cardiac			
	I			
	MMTA - Endocrine			
	J			
	MMTA - GI/GU			
	K			
	MMTA - Infectious			
	L			
	MMTA - Respiratory			

HIPPS Code

PPS	PDGM
• HH completes assessment and runs OASIS data through grouper program (included in EHR). • Submits that HIPPS/ HHRG grouper in RAP. • Submits OASIS to QIES. • Submit claim at end of episode. • Claims system checks for matching OASIS and adjusts for number of therapy visits	• HH completes assessment and submits to iQIES. • HH can submit any valid HIPPS on RAP. • iQIES will send the OASIS data for *functional items only* • Claims system will combine these items with claims data such as diagnosis codes, whether it is a first period of care, and whether there's an inpatient DC within 14 days before the from date. • Grouper is within the claims system and will replace any HIPPS code submitted by HHA. Claims system will check for any other admissions (both HH and inpatient)

30 Day "Unit of Payment"

- The initial certification of patient eligibility, plan of care, and comprehensive assessment are valid for two 30-day periods of care (for 60 days of home health care)
- Each recertification, care plan update, and comprehensive assessment update will also be valid for two 30-day periods of care
- Many of the data elements that are used to populate an electronic claims submission will remain the same from one 30-day period to the next

Request for Anticipated Payment

- Requirements for submitting RAP unchanged
  - Verbal orders for home care have been received and documented
  - First billable visit completed (and documented)
  - Plan of Care (485) sent to physician
  - OASIS ready to transmit
- Median length of time to RAP submission is 12 days
  - 10% of RAPs are not submitted until 36 days after the start of a 60-day episode of care
  - 5% of RAPs are not submitted until the end of a 60-day episode of care

RAP Changes

2019	2020
• All agencies can RAP	• Newly enrolled agencies (after Jan 1, 2019) submit a "no-pay RAP"
• RAP is 60% or 50% of the 60- day episode payment	• RAP is 20% of the 30-day unit payment (80% adjusted paid at claim)
• RAP every 60 days	• RAP every 30 days
• New OASIS each time	• New OASIS only every other time (unless there is a ROC or Other FollowUp)

NOA in 2021

- No RAPs beginning January 2021
- Full payment at time of claim at end of 30 days
- Required to file a Notice of Admission (NOA)
  - Within 5 calendar days of the start of care
  - Establishes that bene is under home health POC
- Required for only the first 30-day period in a series
- If discharge and subsequent readmission, new NOA required
- Failure to submit NOA within 5 days will result in a reduction of the 30-day payment

What About Second RAP?

Second 30 Day Unit of Payment (every other time)

- Plan of Care is already done
- OASIS has already been transmitted (the one at the beginning of the 60 days—SOC or recert)
- Claims data system will look for most recent assessment so may be a RAP or Other FU (has to be ready to be transmitted)
- Make that first billable visit and send RAP

Claim Requirements Unchanged

- Before a provider submits a final claim, HHA must have:
  - A completed OASIS assessment transmitted within 30 days of M0090 date,
  - Signed plan of care with certification statement,
  - Signed interim orders,
  - All visit documentation completed
- CMS expectation is that the HHA will obtain the signed physician certification and plan of care timely
- How long does it take after the 60-day episode before the final claim can be submitted in your agency? How will 30-day claim cycle impact timing?

Reminder re: Certification

1. The patient needs intermittent SN, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   - a. *Occurred* no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   - b. ***Was related to the primary reason the patient requires home health services; and***
   - c. Was performed by a physician or allowed non-physician practitioner

Any Other Changes?

No changes to:

- frequency of OASIS (still every 60 days)
- frequency of Plan of Care (still every 60 days)

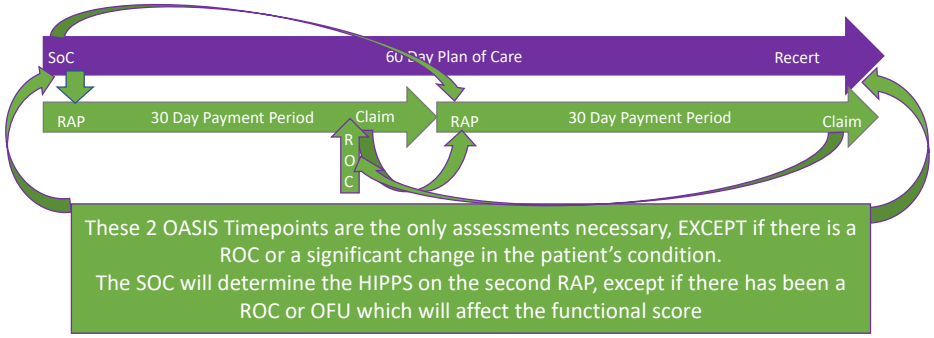
Changes:

- HIPPS on RAP produced from HH software currently (Not required in PDGM—any valid HIPPS code will work)
- Medicare systems will combine OASIS items (M1800s and M1033) and claims data (period timing, inpatient DC, primary and other diagnoses) and send to Grouper program
- Grouper-produced HIPPS code replaces the submitted HIPPS code and is used for payment
- Claims system looks for last OASIS--Occurrence code 50 with the most recent M0090 date

Claims Processing Manual

- In general, a RAP and a claim will be submitted for each period of care. Each claim must represent the actual utilization over the period. If the claim is not received 60 days after the calculated end date of the period (day 90) or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the HHA's next remittance advice (RA).
- If care continues with the same provider for a second period of care, the RAP for the second period may be submitted even if the claim for the first has not yet been submitted. If a prior period is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the HHA's next RA will be used to recoup the overpaid amount.

60-Day Plan of Care vs 30-Day Payment Period



Functional Score & the 30-Day Period

- Start of care: Functional score *from OASIS* would be used for determining the functional impairment level for both the *first and second* 30-day periods.
- The follow-up OASIS completed near the time of recertification would be used for the third and fourth 30-day periods of care.
- If there was a hospitalization in the first 30-day period, the ROC would be used to determine functional score in 2nd 30-day period.
- If there was an Other Follow-Up in the first 30-day period, the Other FU would be used to determine functional score in 2nd 30-day period.

Coding and the 30-Day Period

- The diagnoses from the home health *claim* are used to group a 30-day home health period of care into a clinical group and to determine if there is a comorbidity adjustment.
- If a home health patient has any changes in diagnoses (either the principal or secondary), this would be *reflected on the home health claim* and the case-mix weight could change accordingly.

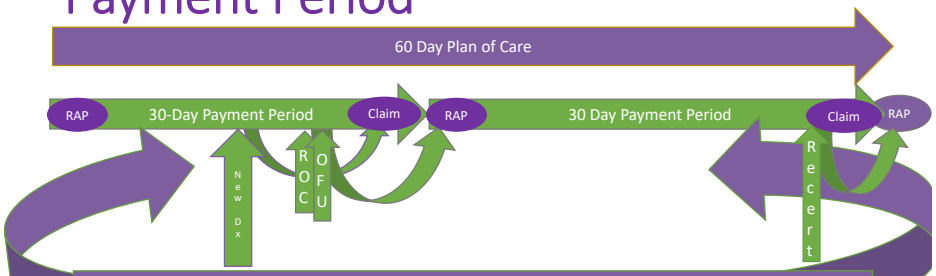
Coding and the 30-Day Period

- CMS expects that the HHA clinical documentation would also reflect these changes and any communication/coordination with the certifying physician would also be documented

Software?

Who is auditing clinical record for changes in the condition, new orders, exacerbations? The coder? The biller? How is the home health claim updated?

60-Day Plan of Care vs 30-Day Payment Period



If there is a ROC there may be a change on the *next* RAP.
If there is a significant change in the patient's condition requiring an Other Follow Up assessment there may be a change on the *next* RAP. The recert will be used for the next RAP.

Review of Requirement for Other Follow-Up

- 484.55(d) states that a marked improvement or worsening of a patient's condition, which changes, and was not anticipated in the patient's plan of care would be considered a "major decline or improvement in the patient's health status" that would warrant update and revision of the comprehensive assessment.
  - Within 2 days of the change
  - Change the assessment completion date on the second 30-day claim if the assessment changes the case mix group (functional score only)
  - *If only the primary diagnosis changed, no need to complete an other follow- up*

Other Follow-Up (RFA 5)

- *Not required to update diagnoses.*
- SCIC: Major improvement or decline in a patient's condition that was not envisioned in the original POC.
- If a significant change in condition occurs that was not anticipated and warrants a change in the POC, complete the Other Follow-Up.
- If completed before the start of a subsequent contiguous 30-day period and results in change in the functional level, the second 30-day claim would have a change in the case-mix group.
- Do not update the *current* 30-day claim. Update the assessment completion date (M0090) on the *second* 30-day claim.
- Oct 2019 Q&A #s 8, 9 & 10

Early vs Late Timing

- Early: Only the 1st 30-day period at SOC
- Late: 2nd and all later 30-day periods
- Costs are typically higher in the first 30 days
- Gap of more than 60 days before early 30-day period
- Early v Late comes from claims data (automatically assigned appropriate timing category by claims system)
- M0110 will be useless in PDGM
- How many new admissions do you have? LOS?

Infection RLE amputation stump

Early Institutional

$2112.75

- 11 visits
- MMTA-Infection
- Low Comorbidity
- Functional score 41

First 30 days at SOC

Late Community

$1146.40

- 11 visits
- MMTA-Infection
- Low Comorbidity
- Functional score 41

Second (or later) 30 days

Early vs Late Timing

PPS

- Early: 1st and 2nd 60-day episode
- Late: 3rd and later 60-day episode
- Switches back to early only if a gap in services of more than 60 days
- Uses response to M0110 to pay RAP
- Adjusted automatically based on claims data

PDGM

- Early: 1st 30-day period
- Late: 2nd and later 30-day period
- Switches back to early only if a gap in services of more than 60 days
- M0110 useless
- Automatically assigned appropriate timing category by claims system

Example #1 Readmitted to same agency

- Admitted to HHA1 01/15/2020
- Discharged by HHA1 02/10/2020
- Claim processed 03/05/2020
- Readmitted to HHA1 04/05/2020
  - Claim for 01/15 period paid as Early
  - Claim from and admission dates match (04/05) but the period of care starts within 60 days of the last HH discharge
  - Period starting 04/05/2020 is grouped as Late

Example #2 Readmitted to Different Agency

- Admitted to HHA1 01/15/2020
- Discharged by HHA1 02/10/2020
- 2/10 claim processed 03/05/2020
- Admitted to HHA2 04/05/2020
  - Claim from and admission dates match (04/05) but the period of care starts within 60 days of the last HH discharge
  - First claim for HHA2, period starting 04/05 is grouped as Late

Example #3 MSP

- Admitted to HHA1 as MSP 03/01/2020
- MSP claim for period 1 03/01/2020-03/30/2020
- Payor changes to Medicare primary 03/31/2020
- Medicare primary claim 03/31/2020–04/29/2020
  - MSP periods are counted to determine Early or Late
  - 03/01 period uses Early HIPPS code when calculating MSP payment
  - 03/31 period uses Late HIPPS code when calculating Medicare primary payment

Example #4 MA

- Admitted to HHA1 as MA 03/01/2020
- HHA bills MA for period 1 03/01/2020-03/30/2020
- Payor changes to Medicare 03/31/2020
- Medicare claim, period 2 03/31/2020–04/29/2020
  - MA periods are **not** counted to determine Early or Late
  - 03/31 is admission date on period 2 claim
  - 03/31 period grouped as Early HIPPS code

Example #5

- Admitted to HHA2 03/20/2020
- Claims data finds no other HHA Paid as Early
- HHA1 finally submits RAP for 01/24/2020 period on 04/22/2020 (their software had a glitch) and submits claim on 04/25/2020.
- Claims system adjusts HHA2 claim to Late

M0110

(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?	
Enter Code N A	1	Early
	2	Later
	UK	Unknown
	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.

Wording of item still works but guidance manual still refers to 60-day episodes

M0110

- Will not change and will not be optional (no equal sign)
- May mark NA on all Medicare (traditional/FFS) assessments (not optional)
- Will still be used for other payers who use the 60-day definition.
- October 2019 OASIS Q&A #s 11 & 12

Partial Episode Adjustments becomes Partial Payment Adjustments (PEPs → PPAs)

- Agency meets patient goals before the end of the payment period and discharges. Patient is readmitted to same agency within same 30-day payment period.
- Agency receives days of services divided by 30 as a PEP.
- Example: Agency completes 3 weeks of therapy as ordered by physician and discharges on day 22 (last billable visit). Patient falls and is readmitted on day 28.
- Agency receives 22/30 payment for payment period 1.
- Payment period 2 begins new 30 days and is considered Late.

Partial Payment Adjustments (PPAs)

- Agency meets patient goals before the end of the payment period and discharges. Patient is readmitted to same agency outside of the 30-day payment period, e.g., day 2 of next 30 days.
- Agency receives entire 30 day payment.
- Example: Agency completes 3 weeks of therapy as ordered by physician and discharges on day 22 (last billable visit). Patient falls and is readmitted on what would have been day 2 of the next 30 days.
- Agency receives full payment for payment period 1.
- Payment period 2 begins new 30 days and is considered Late.

Partial Payment Adjustments (PPAs)

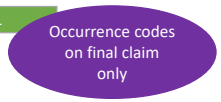
- Agency A admits patient for an early 30-day payment period.
- Halfway through period another doctor orders home care with a different home health agency and Agency A has to discharge on day 14. Agency B admits on what would have been day 15.
- Agency A receives days of services (14) divided by 30 as a PEP.
- Agency A receives 14/30 payment for payment period 1.
- Payment period 2 begins new 30 days and is considered Late.

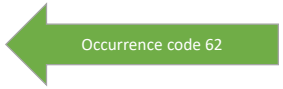
Institutional or Community

Depending on whether an acute or post-acute healthcare setting was utilized in the 14 days prior to home health

Institutional

- Inpatient acute care hospitals
  - NOT observation stays
  - NOT ER visits
- SNF (Skilled Nursing Facility)
- IRF (Inpatient Rehab Facility)
- LTCH (Long Term Care Hospital)
- IPF (Inpatient Psych Facility)





- Rationale for higher payment: Sicker upon admission, being discharged rapidly back to community and are more likely to be re-hospitalized, have more functional decline

14 Days

- "From" date, then count back with the day before as day one
- Example:
  - "From" date is January 20
  - January 19 is day 1
  - 14-day period is January 6 through January 19
  - Have there been inpatient discharges January 6 through January 19?

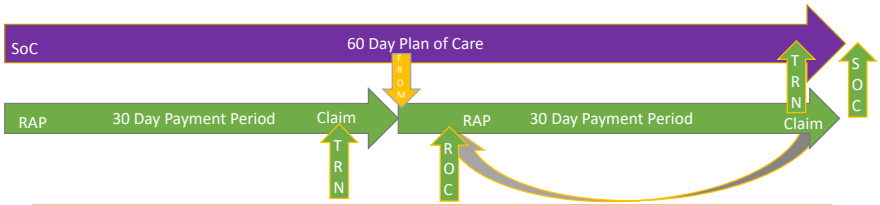
Institutional - ACH

- Inpatient or post-acute stay utilized in the 14 days prior to home health admission

PLUS

- *Acute care hospital* stay during a previous 30-day period and within 14 days prior to a subsequent, contiguous 30-day period of care and for which the patient *was not discharged from HH and readmitted (which means RFA 6 Transfer without DC and RFA 3 ROC)*

60-Day Plan of Care vs 30-Day Payment Period



When the patient transfers into the hospital at the end of the 1st 30 day period, no need to discharge. Complete a ROC. 2nd 30 day period claim will recognize ROC (Occurrence code 50 with M0090 date).
Transfer at end of certification requires new SOC.

What about this?

- What if the patient was in a VA hospital and there was no Medicare claim?
  - Occurrence code 61 entered on claim
- What if the patient was under observation and they changed to inpatient later without notifying us?
- All from claims data…Will look for institutional claim with dates of stay within 14 days. Will also check institutional claims to see if home health claim within 14 days.
- Patient on observation. Home health admits. Claims data will say Community. Hospital switches to inpatient later. Inpatient claim will prompt a search for a HH stay within 14 days and will switch to Institutional.

Institutional - PAC

- ***Not institutional***: post-acute care stays, meaning SNF, IRF, LTCH, or IPF stays, that occur *during a previous 30-day period of care and within 14 days of a subsequent, contiguous 30-day period of care*
- Expect the patient to be discharged and readmitted if returns to home care
- If the patient was *discharged and then readmitted* to home health, the admission date and ''from'' date on the 30-day claim would match and the claims processing system will look for an acute or a post-acute care stay within 14 days of the home health admission date.
- **New admission (SOC) = institutional**
- **ROC = community**
- Also see October 2019 CMS Quarterly Q&As #6, #7

LUPAs

- Low Utilization Payment Adjustment
- Currently 4 or fewer visits per 60 days
- Payment is Per Visit instead of Per Episode
- Approximately 8% of claims are currently LUPAs
  - Visits cluster around 5 visits to avoid LUPAs
- Reducing payment period to 30 days will result in significantly more LUPAs
- LUPA thresholds of 2 – 6 visits per 30-day payment period depending on clinical group (HIPPS code)

LUPA Considerations

- Under the proposed PDGM, CMS assumption that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold, HHAs will provide 1 to 2 extra visits to receive a full 30-day payment
- What is your LUPA rate?
  - What kind of patients usually result in LUPA episodes?
  - Problems: Missed visits
    - Why? Scheduling? Patient not homebound?
  - RN Admit and 4 therapy visits – careful!
  - Are those extra visits to avoid a LUPA *medically necessary* visits?
- When can/should you try to prevent a LUPA?

Primary Diagnosis Determines Clinical Grouping

- 432 case-mix groups when the MMTA sub-groups added
- Diagnoses will pull from CLAIM, not from OASIS
- If the code is not in the Clinical Group list, it is not acceptable as a PRIMARY diagnosis code
  - Unspecified codes mostly removed
  - R codes removed except R13.1- (dysphagia)
  - Laterality important
- Will be RTP'ed - CMS says change the code. Ensure that clinical documentation supports the new code

Clinical Groups

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Comorbidities

- A 30-day period of care would receive a **low** comorbidity adjustment if there is a reported secondary diagnosis that falls within ***one*** of the home-health specific individual comorbidity subgroups, as listed in Table 10, for example, Heart 11, Cerebral 4, etc., associated with higher resource use, *or*
- A 30-day period of care would receive a **high** comorbidity adjustment if a 30-day period has ***two or more*** secondary diagnoses reported that fall within one or more of the comorbidity subgroup interactions, as listed in Table 11, for example, Heart 11 plus Neuro 5, that are associated with higher resource use.

Diagnosis Considerations

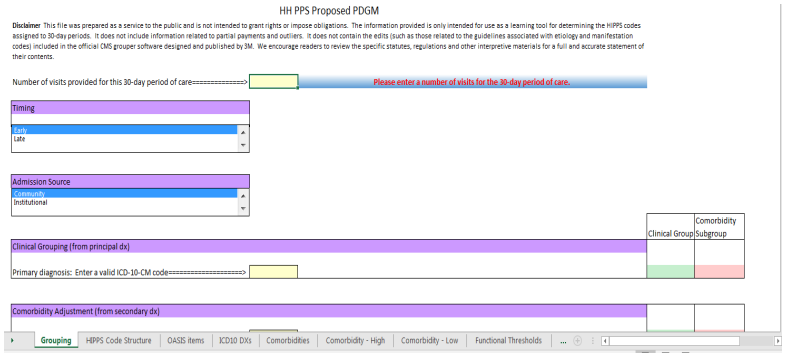
- How many diagnoses are you coding now?
- What is the training/accuracy of your coders?
- Are you limited by software?
  - DDE accepts 25
  - When will your software be updated?
- CoP requirements are NOW
  - Code all pertinent (all Known) diagnoses
- How are diagnoses substantiated with physicians? How is that documented? Who is querying?

PDGM Functional Score from OASIS

- M1033 Risk for Hospitalization
- M1800 Grooming
- M1810/M1820 Dressing
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation

Do your Own Research

CY 2020 PDGM Grouper Tool



Diagnosis Considerations in PDGM

PDGM Components

- Timing—Early and Late
  30 day payment period
- Admission Source—Community or Institutional
- **Clinical Grouping from Principal Diagnosis**
- **Comorbidity Adjustment—Secondary Diagnoses (up to 24 additional diagnoses)**
- Functional Score (only part of payment equation from OASIS)

Clinical Grouping

- Currently, only top 6 diagnosis codes from M1021 and M1023 are used for payment calculation
- In PDGM, principal and secondary diagnoses will pull *from the claim, not from OASIS*
  - Up to 25 codes accepted on claim
- If the code is not in the Clinical Group list, it is not acceptable as a PRIMARY code
  - Unspecified codes mostly removed
  - **All R codes removed** except R13.1- (dysphagia)
  - Laterality important
- Will be RTP'ed. CMS says change the code. Ensure that clinical documentation supports the new code.

Clinical Groups from First-listed Dx

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- A 30-day period of care would receive a **high** comorbidity adjustment if a 30-day period has ***two or more*** secondary diagnoses reported that fall within one or more of the comorbidity subgroup interactions, as listed in Table 11, for example, Heart 11 plus Neuro 5, that are associated with higher resource use.

How important is diagnosis in PDGM?

- Medical review and targeted probe and educate concentrated on Face to Face documentation, Plan of Care signature and date, certification, medical necessity for skilled care and homebound.
- What happens when a big portion of our payment is based on the primary diagnosis and up to 20% extra for high comorbidity adjustments?
  - Expect scrutiny of all diagnoses listed on the claim – especially the primary diagnosis that determines the clinical grouper!

Who Establishes Diagnoses?

- Excerpts from Coding Guidelines:
- Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner **legally accountable for establishing the patient's diagnosis).**
- **Meaning physicians (MD, DO, DPM for foot dx), PAs, ANPs and CNS when allowed by their practice act to diagnose**
- Who is not allowed to diagnose? RN, PT, OT, SLP…

Definitions

- OASIS guidance states that M1021 Primary Diagnosis and M1023 Other Diagnoses should include *only current diagnoses actively addressed in the Plan of Care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself.*
- M1021 and M1023 should *exclude resolved diagnoses or those that do not have the potential to impact the skilled services* provided by the HHA. (OASIS Guidance Manual)

M1021 /M1023 Diagnoses

- Must comply with ICD-10-CM Conventions and Guidelines (including sequencing and assumption rules)
- Primary diagnosis is the focus of home care services.
- Other secondary diagnoses should report conditions supported in the medical documentation for which home health services are being provided, or that affect the services provided by home health agency
- The other secondary diagnoses may or may not be related to a patient's recent hospital stay but must have the potential to impact the skilled services provided by the HHA.

Those "Other Diagnoses"

- Claim = 25 diagnoses total
- PDGM Final Rule: Because ICD–10 coding guidelines require reporting of all secondary diagnoses that affect the plan of care, we expect that more secondary diagnoses would be reported on the home health claim given the increased number of secondary diagnosis fields on the home health claim compared to the OASIS item set.

Conditions of Participation:

- **§484.60(a)(2)** The individualized plan of care must include the following: (i) All pertinent diagnoses;
- **IG G574: (i) "All pertinent diagnoses" means *all known* diagnoses.**

Those "Other Diagnoses"

- AHIMA Guidelines define "other diagnoses as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."
- **Other diagnosis are additional conditions that affect patient care in terms of requiring:**
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.

M1021 /M1023 Diagnoses

- All diagnoses must be documented in the medical record or referral information by the provider (physician or designee). If not, must be verified with provider – *document the confirmation.*
- Diagnoses may change during the course of the home health stay due to a change in the patient's health status or a change in the focus of home health care.
- **At each required OASIS time point**, the clinician must assess the patient's clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.

Data Sources for Diagnoses

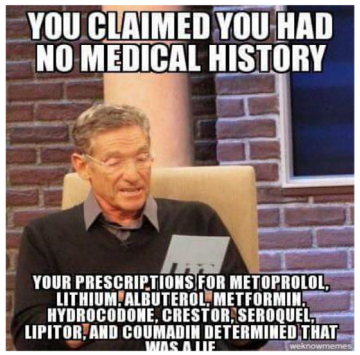
- Referral information
- Physician orders
- Comprehensive assessment
- Patient/caregiver interview
- Current medication list
- Physician or designee

May indicate additional diagnoses to verify with physician

- The current ICD-10-CM List of Codes and Descriptions and the ICD-10-CM Official Guidelines for Coding and Reporting should be the source for coding
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history

Although you cannot code based on medications alone…

Dual role: RN completing medication regimen review and the coder.



Do those medications "match up" with known diagnoses? If not, then need to know diagnosis for that medication.

Diagnoses based on information from physician (provider)

- Diagnoses supported by documentation before assigning (medical record, referral, F2F, confirmation) and after assignment (interventions on the POC and implemented in visit notes)
- Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending (certifying) physician.
- Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment.

Coded from clinician documentation

Code assignment is based on documentation by patient's provider with a few exceptions, such as codes for:

- Body Mass Index (BMI),
- Pressure Ulcer stage,
- Depth of non-pressure chronic ulcers,
- Coma scale,
- NIH stroke scale (NIHSS) codes

Code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale).

BMI codes should only be assigned when **there is an associated, reportable diagnosis (such as obesity).**

Diagnoses based on information from physician (provider)

- Cannot list diagnoses that are “probable,” “suspected,” “likely,” “possible,” “questionable”
- Cannot list diagnoses based on lab findings
  - UTI based on UA or C&S results showing bacteria
  - Anemia based on CBC with low H&H
- If a diagnosis is not documented in the referral or medical record information from a physician or other designee allowed to diagnose, then the agency ***must query to verify the diagnosis before listing it*** on the Plan of Care or home health claim

How are diagnoses confirmed/verified?

- Physician documented the diagnoses
  - H&P/Assessment
  - Clinical/Progress Note
  - Discharge Summary
  - F2F Encounter Note
  - Face sheet/ Problem List

Diagnoses documented by the physician are already confirmed.

Careful with these

- What is your intake process?
  - Know when more specific information is needed
  - Ask questions, gather documentation
  - Start query process if necessary

How are diagnoses confirmed/verified?

1. Established diagnosis, but require more information
   - Osteomyelitis of the foot or lung cancer
   - Query whether acute or chronic / more specificity as to location (left or right)
   - Communication note establishing the specificity signed and dated by the person who confirmed the specificity, noting who they spoke to when confirming the information

How are diagnoses confirmed/verified?

2. Seeking a reason why the patient is taking Lasix
   - Patient reports: “Been taking that water pill for a long time. Doc says it helps my heart.”
   - No diagnosis on the referral or the H&P to indicate why the patient is taking Lasix
   - Call the physician and request information about the indication for Lasix. At what phase are you in POC development? Options?

How are diagnoses confirmed/verified?

3. Found a pressure ulcer upon assessment
   - No mention on referral or inpatient documentation
   - Notify the doctor of a new diagnosis for home health plan of care
   - What kind of information do you provide?
     - Location, what other clinical factors?
   - What do you request?
     - **Verification of the pressure ulcer diagnosis**, wound care orders, other orders?

How are diagnoses confirmed/verified?

- Who are we talking to?
  - The physician? The physician's agent?
- Are we talking to anyone?
- Are we faxing?
  - How often are we following up?
- How do we query?
- How long does the process take?
- How successful are we?
- What do we do when we do not get those diagnoses confirmed?

Timing Practices—Let's talk…

- You have the ability to go back months, even years in the medical record to dig for diagnoses. How far should you go? How do you know those diagnoses were verified? What kinds of diagnoses are still "fair game"? How are you going to substantiate those diagnoses? CC says present admission
- You admitted the patient with an exacerbation of COPD when they had pneumonia 8 months ago. When should you stop coding J44.1?

What does the Coding Clinic say?

Question: Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes? Does each visit or admission stand alone? Would the coder go back to previous encounter records to assist in the coding of a current visit or admission?

Answer: Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.

Conditions documented on previous encounters may not be clinically relevant on the current encounter. **The physician is responsible for diagnosing and documenting all relevant conditions.** A patient's historical problem list is not necessarily the same for every encounter/visit. It is the physician's responsibility to determine the diagnoses applicable to the current encounter and document in the patient's record. When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission. However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.

OASIS Manual

- The assessing clinician is expected to complete the patient's comprehensive assessment and understand the patient's overall medical condition and care needs *before* selecting and assigning diagnoses.
- The determination of the patient's primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, *and input from the physician*.

Diagnosis Considerations

- Select the primary diagnosis ***after*** completing the comprehensive assessment
  - Check the F2F encounter reason for referral to HH
  - Does it reflect the patient's needs identified on assessment?
  - Is it the focus of HH care/services?
  - Is it an acceptable primary diagnosis in PDGM?
    - If not, can you choose a different primary diagnosis? (see next slide)
    - May need a new F2F encounter to change dx
  - Does the POC include interventions and goals related to the primary diagnosis?

Diagnosis Considerations

- Verify with intake and referral documentation
  - Is the diagnosis documented by the physician or other approved provider?
  - On the F2F encounter note, *is the primary diagnosis the reason for referral to home care?*
- If not in referral documentation:
  - Verify diagnosis with provider
  - Document confirmation of diagnosis
- Sequence diagnoses by importance to the POC
  - Don't forget coding guidelines!

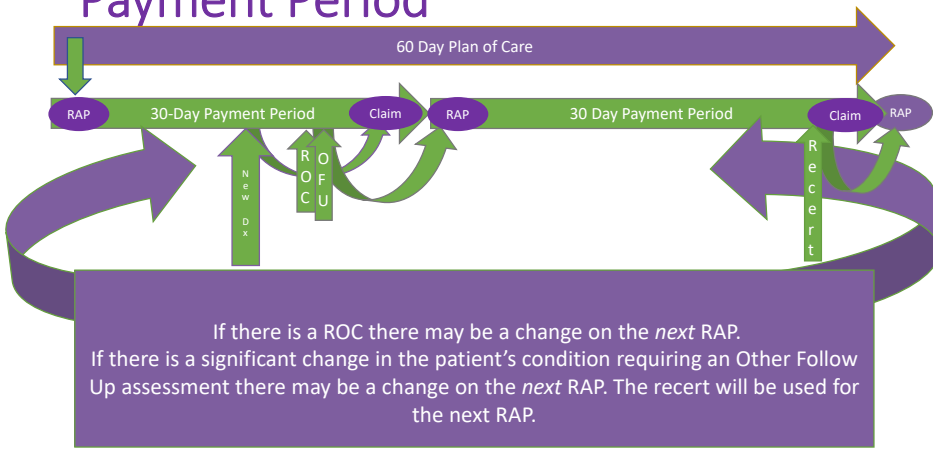
SOC Example

- The admission nurse documents three other diagnoses that were not included in the referral H&P. Coder questions them, RN says that based on patient/family interview these diagnoses are confirmed. She says that she specifically questioned them about these diagnoses because of medications the patient was taking.
- RN/QA/case manager calls the physician to get those diagnoses verified. The PCP office nurse says that those diagnoses are not on the medical record, but the medications are, and they were ordered by the patient's neurologist. You call the neurologist but do not get an answer.
- Must omit these diagnoses from the list on the POC until you hear from the neurologist.

SOC Example

- The neurologist calls back 10 days into your 30-day period and confirms a diagnosis of Parkinson's. How do you document this verification?
  - Best: obtain documentation from neurologist's medical record. Next best: send IPO for signature
- This diagnosis will be added to the list of diagnoses on the claim for the current (first) 30-day period
  - If RAP is already submitted, do not need to cancel and resubmit with new diagnosis of Parkinson's
- This diagnosis will be added to the new RAP at the beginning of the next 30 days.
- Thoughts: what if the POC hasn't been done by the 10th day? Do you change the OASIS M1021/1023? What's the M0090 date?

60-Day Plan of Care vs 30-Day Payment Period



Coding and the PDGM Claim

- If there are diagnoses that were present at the ***beginning*** of the payment period, e.g. a code that could not be verified, then that code confirmed later can be added to the ***current*** claim.
- If there are diagnosis changes ***during*** a period of care that is before the From date of the next 30 day period, those coding changes should be reported on the claim for the ***next*** period.
- A diagnosis can be added/changed with supporting documentation from the provider (communication note or interim physician order)
  - Do NOT do an Other FU to add a new diagnosis
  - How do you show a diagnosis is new, resolved, changed, exacerbated, etc.?

Changes in Clinical Group for some principal diagnoses

- Concern: CMS expects HH agencies to change their coding behaviors to obtain higher payments
- Carefully review the Final Rule for changes in the Clinical Group for some principal diagnoses based on Comments and input from Coding Clinic
- CMS says HH agencies need to do a better job of coding – so there will be some changes!

Example: Change in Behavior Z48.01

- Comment asked that the aftercare following surgery codes be placed in the WOUND group. CMS declined.
- Z48.01 Change of surgical dressing is WOUND group
- "Coding experts" say: No requirement to code the aftercare following surgery code first. "These codes are used in conjunction with other aftercare codes to fully explain the aftercare encounter."

Example—Changed Behavior

- The patient had a digestive system surgery. Wound care is ordered and is the primary reason for care.
- Before PDGM:
  - Z48.815 Aftercare following surgery gastrointestinal
  - Z48.01 Surgical dressing change (down lower in the list)

MMTA_ GI

- With PDGM:
  - Z48.01 Surgical dressing change
  - Z48.815 Aftercare following surgery gastrointestinal

Wound

Now what?

- Agency started out by doing wound care and providing education to caregiver on dressing change procedure, but the wound is healed/almost healed and patient's spouse is doing wound care now at the 30 day mark. We will continue to do teaching on medications, disease processes etc.
- Change your primary diagnosis!!

NOT Changed in the Final Rule

- M06.9 Rheumatoid Arthritis
- M54.5 Lower Back Pain
- M62.81 Muscle weakness
- M62.838 Other muscle spasm

Not assigned to a Clinical Group

How do your primary diagnoses measure up?

- Run a list of your top 50 / 100 / 200
- What coding errors are you making?
- Maybe you are not making errors, but some of those codes which used to be just fine…aren't now
- Evaluate coding. Change behaviors prn.
- CMS says Home Health Agencies need to do a better job of coding. Where does your agency stand?

Diagnosis Action Items

- Improve Intake Queries—does your intake personnel know what questions to ask? Are referral sources going to cooperate? How long does it take?
- Pre-code based on H&P, progress notes, etc. The query process can begin earlier in the SOC process. Tweak the codes based on assessment and F2F.
  - F2F Encounter process for "matching" diagnosis
- Biller also coder:
  - Who does your pre-billing audit? They are looking for signed orders, transmitted OASIS with acceptance. Can they also look for any additional or changed diagnoses that need to be added to the next RAP?

Diagnosis Action Items

- Educate physicians regarding needs
  - SE 1436 PLUS information regarding unacceptable primaries, need for more specific diagnosis information
- Compare your list of *common* primary diagnoses to *acceptable* primary diagnoses
  - Which ones need to change? Is it an acceptable diagnosis for the documentation received? Or is it based on therapy documentation? Or is it just wrong? Most common error…
- Increase the number of diagnoses (within compliance standards) **now**
- Know the coding guidelines—what is the competency of your coding staff? How well do clinicians document essential details for coding?

OASIS Items in PDGM

Functional Score Items

PDGM Components

- Timing—Early and Late 30 day payment period
- Admission Source—Community or Institutional
- Clinical Grouping from Principal Diagnosis
- Comorbidity Adjustment—Secondary Diagnoses (up to 24 additional diagnoses)
- **Functional Score (only part of payment equation from OASIS)**

PDGM Functional Items

- M1033 Risk for Hospitalization
- M1800 Grooming
- M1810 Upper Body Dressing
- M1820 Lower Body Dressing
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Bed Transferring
- M1860 Ambulation/Locomotion

What's missing compared to PPS and OASIS-D?

Functional Status

- Relationship exists between functional status, rates of hospital readmission, and the overall costs of health care services.
  - As functional status declines, resource use increases.
- Functional score is derived from last OASIS transmitted which may be a SOC, Follow-up for Recertification, ROC or Other Follow-up *(remember any changes to diagnoses are not from the OASIS – all diagnoses are captured from the claim)*

Functional Score

- Low, medium, high with approximately 1/3 in each functional group
- Future use of GG items
- Thresholds by functional level
- Each of the responses associated with the functional OASIS items which are then converted into a table of points corresponding to increased resource use (see Table 8).

Functional Scoring (Table 8)

	Responses	Points (2018)	Percent of Periods in 2018 with this Response Category
M1800: Grooming	0 or 1	0	39.6%
	2 or 3	5	60.4%
M1810: Current Ability to Dress Upper Body	0 or 1	0	37.5%
	2 or 3	6	62.5%
M1820: Current Ability to Dress Lower Body	0 or 1	0	18.0%
	2	5	60.5%
	3	12	21.5%
M1830: Bathing	0 or 1	0	4.6%
	2	3	16.5%
	3 or 4	13	54.0%
	5 or 6	20	24.9%
M1840: Toilet Transferring	0 or 1	0	66.2%
	2, 3 or 4	5	33.8%
M1850: Transferring	0	0	2.5%
	1	3	32.3%
	2, 3, 4 or 5	7	65.3%
M1860: Ambulation/Locomotion	0 or 1	0	6.2%
	2	9	22.5%
	3	11	55.8%
	4, 5 or 6	23	15.4%
M1032: Risk of Hospitalization	Three or fewer items marked (Excluding responses 8, 9 or 10)	0	81.2%
	Four or more items marked (Excluding responses 8, 9 or 10)	11	18.8%

Source: CY 2018 home health claims and OASIS data (as of July 31, 2019).

M1033

PDGM

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

Any 4 except 8, 9 & 10 means 11 points

Payment item in PDGM, will be added to RFA 4 and 5

M1033—1 History of Falls

- Any fall in the last 12 months, with or without an injury, whether witnessed or unwitnessed.
  - 2 or more falls occurred OR
  - A single fall resulting in ANY injury
- Fall—an unintentional change in position coming to rest on the ground, floor, or the next lowest surface (such as a bed or chair). Falls resulting from an overwhelming force and falls resulting from therapeutic balance retraining **are** considered falls. Intercepted falls **are not** included for M1033.
- October 2019 Q&A #16

M1033—2 Weight Loss

- Unintentional weight loss of a total of 10 pounds or more in the past 12 months
  - Key: *unintentional* – often patients don't realize they have lost the weight
- When weighing the patient for M1060, ask patient and family/caregiver if this is usual weight, any changes (gain or loss) of 10 pounds or more in the last year? Has patient been dieting during that time?

M1033—3-Hospitalization

- Only acute inpatient hospital stays in last 6 months
  - No LTCHs or inpatient psych hospitalizations
- Hospitalization = being admitted for 24 hours or more to an inpatient acute bed for more than diagnostic testing. Observation stays are not included.
- If discharged from the acute hospital and then readmitted later that day to the acute hospital, that counts as two hospitalizations.
- October 2019 Q&A #s 13, 14 & 15

M1033—4-Multiple ED Visits

Response 4 - Two or more ED trips in the last 6 months

- Hospital emergency departments only (as defined in M2301)
  - Does not include walk-in clinics, Urgent care centers, same-day physician office visits
- Includes all visits to ED whether instructed to go by physician, agency or patient/family decision
- October 2019 Q&A #s 17, 18, 19

M1033—5-Decline in Mental…

Response 5 – Decline in mental, emotional or behavioral status in past 3 months

- Patient, family, caregiver or physician has noted a decline regardless of the cause
- Anything that may impact the patient's ability to remain safely in the home, increase likelihood of hospitalization
  - May be temporary or permanent
  - Physician consultation or treatment may or may not have occurred
- October 2019 Q&A #s 17, 18, 19

M1033 - 6 Difficulty complying

Response 6 – Reported/observed history of difficulty complying with any medical instructions (for example medications, diet, exercise) in the past 3 months

- Interview patient/family/caregiver: any time(s) patient has missed/skipped a medication? Eaten foods not on ordered diet? Failed to follow recommended fluid intake or restriction? Failed to follow through with prescribed exercise and/or activities?
- Review medical record, referral information
- Check med planner for compliance

M1033 - 7 Five + medications

Response 7 – Currently taking 5 or more medications

- Rx or OTC
- By any and all routes
- Includes prn medications
- Includes nutritional supplements, vitamins, homeopathic and herbal products, TPN, oxygen

M1033 – 8 and 9

- These do not provide any case-mix points in PDGM scoring (only responses 1-7 count)
- Response 8 – Currently reports exhaustion
- Response 9 – Other risk(s) not listed in 1-8
  - Anything that might potentially increase the risk of hospitalization
  - Slower movement during sit to stand and walking
  - Ex: dialysis treatment, terminal diagnosis, low literacy, blindness, unstable caregiver, limited financial resources, unsafe environment, etc.

OASIS Conventions for ADL Items

- Identify ***ability***, not actual performance or willingness
- Assess patient's ability to ***safely*** complete the specified activities listed in the OASIS item and only those specific tasks
- Patient's ability to access needed items and/or location where the task occurs is INCLUDED, unless specifically excluded in guidance
  - M1845 Toileting hygiene—excludes getting to the location where the toileting occurs
  - M1870 Feeding/Eating—excludes getting to location where meal is consumed and excludes transporting food to table
- Consider what the patient is able to do on the day of assessment; if ability varies over the 24 hour period, select the response that describes the patient's ability more than 50% of the time
- If patient's ability varies between multiple tasks included in the item, report ability to perform a majority of the included tasks, giving more weight to tasks that are performed more frequently

Conventions for ADL Items (con't)

- Consider medical restrictions when determining ability
- While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's ability to perform a task
- Response scales present the most optimal (independent) level first, then proceed to less optimal (most dependent) levels. ***Read the responses from the bottom up!***
- "Assistance" means help from another human being
- Service animals are considered "devices" not "assistance"
- Do not assume the patient would be able to safely use equipment that is not in home at the time of assessment

OASIS Conventions for ADL Items

- Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments, (for example, impaired vision or pain)
  - environmental barriers (for example, accessing grooming aids, mirror and sink, stairs, narrow doorways, location where dressing items are stored).
    - Environmental barriers may be different dependent on the tasks.

CMS Q&A Feb 2019 "Understanding OASIS Function M and GG Item Coding"

- The intention is not for the codes on the GG and M items to be duplicative or always "match"
- Each OASIS item should be considered individually and *coded based on guidance specific to that item*
- **There are differences between items that have the same or similar names**
  - What is **included** or **excluded** in the activity
  - What coding instructions apply to the activity, i.e. **differing conventions** related to assistive device use
  - Majority of tasks rule doesn't apply

GG0130 and GG0170 Responses

- **06** Independent: no assistance from another person
- **05** Set-up/Clean-up assistance: assistance from ONE other person before *and/or* after the activity but not during the actual performance of the activity
- **04** Supervision/touching assistance: verbal/non-verbal cueing or touching/steadying/contact guard assistance from ONE person
- **03** Partial/moderate assistance: physical assistance from ONE person who provides LESS than half the effort of the activity
- **02** Substantial/maximal assistance: physical assistance from ONE person who provides MORE than half the effort of the activity
- **01** Dependent: physical assistance from ONE person who provides ALL the effort to complete the activity, OR patient requires the assistance of TWO or MORE persons to complete the activity

Reason Not Attempted Codes

- **07** Patient refused
  - Pt refused to attempt activity, unable to get info from cg
- **09** Not applicable
  - Pt couldn't perform activity at assessment AND couldn't perform activity prior to current illness/injury
- **10** Not attempted due to environmental limitations
  - Ex: lack of equipment, indoor/outdoor weather
- **88** Not attempted due to medical condition or safety concerns
  - Pt couldn't perform activity at assessment BUT could perform activity prior to current illness/injury
- **Dash "—"** Item not assessed

Danger of the Dash "-"

- Dash allowed on all GG items at all time points
  - No info available, or can't assess for reason other than 07, 09, 10, or 88
- Should be the response of last resort!
  - Modified time periods
  - Expansion of One Clinician Rule allows more collaboration with others
  - Four responses for reason not assessed
- A dash response does not provide "positive credit" for this quality measure Application of Percent of Long-term Care Hospital Patients with Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

88 vs 01

- What if the patient cannot perform the task at the present time due to a new condition, and a caregiver provides all the effort in completing the task for the patient. Should the patient be scored:
  - 88 Not attempted due to medical condition or safety concerns OR
  - 01 Dependence: physical assistance from ONE person who provides ALL the effort to complete the activity, OR patient requires the assistance of TWO or MORE persons to complete the activity

Code the reason activity was not attempted **if**:
A patient does not attempt the activity **AND**
A helper does not complete the activity **AND**
The patient's usual status cannot be determined based on patient/caregiver report.

Bedfast Defined

- "Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed." If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time.
- The assessing clinician will have to use her/his judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as she/he is able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents him from tolerating the sitting position.

Key to Remember

- **What is the difference between "willingness" and "adherence" (which do not impact OASIS scoring) and "cognitive/mental/emotional/behavioral impairment" (which may impact OASIS scoring)?**
- In absence of pathology, patients may make decisions about how and when they perform their activities of daily living that may differ from what the clinician determines to be acceptable. A patient may choose to shave and brush his teeth infrequently because he doesn't value doing it at a frequency that the clinician deems as socially appropriate. There are differences in the frequency at which grooming or bathing is performed, or expected to be performed based on age, religion, culture and familial practices, and this is not necessarily indicative of pathology.

Things to Remember

- Patient 1 demonstrates that they can safely ambulate while using a walker, but then as a *matter of choice*, decides to walk without it.
- Patient 2 demonstrates that they can safely ambulate while using a walker, but then consistently walks without it, *forgetting* that they have a walker.
- For OASIS scoring, non-conformity or non-adherence should not automatically be considered indicative of a deeper psychological impairment. The assessing clinician will have to use clinical judgment to determine if the patient's actions are more likely related to impairment, or to personal choice made in awareness of the potential related risk.

ADL Assessment Strategies

- Observation/demonstration is the *preferred method*
- Patient/caregiver interview
- Physical assessment
- Physician orders
- Plan of Care
- Referral information
- Review of past health history
- Document any inconsistencies

SOC
ROC
FU
DC

M1800 Grooming

PDGM

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).		
Enter Code ☐	0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.
	1	Grooming utensils must be placed within reach before able to complete grooming activities.
	2	Someone must assist the patient to groom self.
	3	Patient depends entirely upon someone else for grooming needs.

5 Points

Excludes bathing, shampooing hair, and toileting hygiene.
Includes getting to the area where grooming takes place and accessing grooming aids, sink, or mirror.
Added to the FU (RFA 4 and 5) since a payment item in PDGM

M1800 Grooming

- Patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment.
- Select the response that best describes the patient's level of ability to perform the majority of grooming tasks.
- Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.

Assessment Tips for M1800

- Observe the patient get to the location where grooming takes place and where items are kept; assess for environmental barriers.
- Ask the patient to go through the motions involved in grooming: assess upper extremity range of motion, balance when bending over the sink.
- Observe patient's appearance, hygiene and grooming to determine if patient has been able to do tasks on day of assessment; ask patient or caregiver if any assistance has been needed.
- Determine patient's ability to perform a majority of grooming tasks safely, consider frequency.

M1800 Grooming

- Response 0: patient can independently get to grooming location, access all supplies used, and has the ability to do the majority of grooming tasks with no help from another person.
- Response 1: patient needs assistance to get to grooming location **or** access supplies used, but once at the location with supplies in reach, patient has the ability to do the majority of tasks with no help from another person.
- Response 2: patient needs help from another person to do some of the grooming tasks, but is able to do part of the actions him/herself.
- Response 3: patient is not able to do any grooming tasks and requires another person to do all grooming tasks for patient.

CMS Q&A July 2019

- **QUESTION 10:** OASIS guidance says ability to access the location and items needed to complete grooming tasks are considered in M1800, so if patient needs to be assisted to the bathroom for safety, or needs grooming items placed within reach, then could complete the tasks with no further assistance, they would be scored a "1" for grooming. Some clinicians refer to M1800 "1" for grooming as "set up". My concept of set up means doing things like opening the toothpaste tube and putting toothpaste on the toothbrush, not just placing an item within reach. For OASIS scoring, if a patient needs assistance to open and/or set up grooming items (i.e. put toothpaste on toothbrush, opening the top of the toothpaste tube or other items such as items to apply make-up), is this considered providing access to the items and scored as a "1", or is it considered providing assistance and scored a "2" as long as the majority of the grooming tasks required this assistance?
- **ANSWER 10:** Each OASIS item should be considered individually and coded based on the guidance provided for that item. Response 1 for M1800 relates to patient access of "utensils" needed for grooming (e.g., accessing grooming aids, mirror, sink). Response 1 for M1800 is placing grooming items within reach and is ***not to be considered the same as Response 05-Set-up or Clean-up assistance for GG0130*** items which includes assistance a helper provides only prior to or following the activity, but not during the activity.
- In your scenario, putting toothpaste on the toothbrush and opening the top of the toothpaste goes beyond placing the items within reach and would be considered providing assistance for **M1800 Response 2**.

Quiz

- Mr. Kingsley's wife helps him to the bathroom because of his unsteady gait. Once there, he sits on the stool in front of the sink and completes his grooming by himself (everything he needs is kept on the counter). When he's finished, he calls for his wife who helps him back to his recliner.

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).		
Enter Code ☐	0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.
	1	Grooming utensils must be placed within reach before able to complete grooming activities.
	2	Someone must assist the patient to groom self.
	3	Patient depends entirely upon someone else for grooming needs.

How can this score be improved by discharge?

Contrast and Compare

		B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them. Oral hygiene without teeth included

Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.

Do consider assistance needed to get to area for scoring Grooming.

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up teeth or denture care or fingernail care).	
Enter Code ☐	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.

SOC
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PDGM

M1810/M1820 Dress Upper/Lower Body

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:	
Enter Code ☐	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 Someone must help the patient put on upper body clothing. 3 Patient depends entirely upon another person to dress the upper body.

6 Points

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:	
Enter Code ☐	0 Able to obtain, put on, and remove clothing and shoes without assistance. 1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 Patient depends entirely upon another person to dress lower body.

12 pts

5 points

M1810/M1820 Dressing

- Ability to obtain, put on, and remove upper body and lower body clothing items.
- Assess ability to put on whatever clothing is *routinely worn*.
- Specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- Consider the clothing to be "routine" if:
  - It is what the patient usually wears and will continue to wear
  - Patient modifies the clothing worn due to a physical impairment and the new styles are expected to become the patient's new routine clothing
  - There is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing

M1810/M1820 Dressing

- Prosthetic, orthotic, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) and/or lower body (for example, lower extremity prosthesis, ankle-foot orthosis [AFO], or TED hose) should be considered as dressing items.
  - Elastic bandages, including ACE Wraps, worn for support and compression should be considered as a dressing item, but wraps utilized solely to secure a wound dressing would not be considered a dressing (clothing) item for M1810 or M1820.
- Answer based on majority of tasks (each piece of clothing or prosthetic/orthotic is a dressing task).
- Do NOT consider the importance of one item over another. 4b132.2.
- Patient must dress in stages due to shortness of breath – Still can be independent

Environment Modification

- If the environment is modified (e.g., the patient decides to start storing clothing in the dresser instead of hanging in the closet), and the patient can now access clothes from a location without anyone's help, then this new arrangement could now represent the patient's current status (e.g., clothing's new "usual" storage area and patient's ability). The appropriate score would be a "0" if the patient was also able to put on and remove a majority of his clothing items safely. Remember day of assessment.
  - Temporary storage because of weakness—1 (Patient could then work to gain independence in accessing clothing from its usual storage location, or decide to make long-term environmental modifications, and possibly achieve improvement in the outcome if successful.)
  - Permanent storage—0

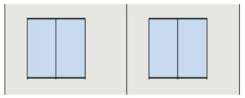
Assessment Tips M1810/M1820

- Ask the patient if he/she has difficulty dressing upper body. Ask where clothing items are stored.
- Observe the patient's general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely.
- Opening and removing garments during physical assessment of heart and lungs provides an opportunity to evaluate upper extremity range of motion, coordination, and manual dexterity needed for dressing.
- Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. The patient also can be asked to demonstrate the body motions involved in dressing.

M1810/M1820 Dressing

- Response 0: No assistance from another person needed for patient to get to dressing location, obtain clothing and other items and don/doff items safely.
- Response 1: patient needs assistance to get items out of storage location, but once items are in reach, patient can put on and take off the majority of items without help.
- Response 2: patient requires some help from another person to don/doff items, is not able to safely obtain and put on / take off the majority of clothing items without help. This help may be verbal cueing/reminders, stand-by assistance, or hands on help.
- Response 3: patient is not able to participate in dressing and undressing him/herself and requires another person to dress and undress the patient.

Contrast and Compare



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

What is routinely worn

Need assist getting clothes out: 05

Clothing items PLUS elastic bandages, prosthetics, collars **IF patient puts on and off with clothing**

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:		
Enter Code ☐	0	Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1	Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2	Someone must help the patient put on upper body clothing.
	3	Patient depends entirely upon another person to dress the upper body.

Contrast and Compare

	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

If an item covers all/part of foot (even if it extends up the leg), it is considered footwear for GG0130H. If an item goes on the lower body and does not cover any part of the foot, it is considered a lower body dressing item for GG0130G.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:		
Enter Code ☐	0	Able to obtain, put on, and remove clothing and shoes without assistance.
	1	Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
	2	Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
	3	Patient depends entirely upon another person to dress lower body.

Ms. Moana

Ms. Moana wears a muumuu and has gone commando for a year or more because she has a hard time handling her underwear. How should I answer M1810, M1820, GG0130F and GG0130G?

- Score M1810 and GG0130F according to how much assistance she needs to put on her muumuu. If Ms. Moana doesn't wear underwear or any other lower body garment, Score M1820 response 3 and GG0130G with the appropriate activity not attempted code.
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M1830 Bathing

PDGM

(M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**		
Enter Code ☐	0	Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
	1	With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
3 pts	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.
13 pts	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.
20 pts	5	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6	Unable to participate effectively in bathing and is bathed totally by another person.

M1830 Bathing

- Specifically **excludes** washing face and hands, shampooing hair, and drying off
- The focus is on patient's ability to access the tub/shower, transfer in and out, and bathe entire body once needed items are within reach. The ability to access bathing supplies and prepare water ***in the tub/shower*** are **excluded** from consideration when assessing bathing ability.
- The amount of assistance patient requires to get to the location bathing occurs would be considered. If patient requires assistance (another person to provide verbal cueing, stand-by or hands-on assistance) to safely ambulate down the hallway and no other assistance with transfer and bathing, this is intermittent assistance, therefore M1830 Response 2 - Able to bathe in shower or tub with the intermittent assistance of another person should be reported. (April 2016 Q and A)

M1830 Bathing

- Response 0 – patient needs no assistance from another person to get to tub/shower and bathe all of body from neck to toes; patient is totally independent in bathing safely and no assistive devices are needed.
- Response 1 – patient needs no assistance from another person, and is independent bathing with devices in the home and all devices are used safely/correctly.
- Response 2 - patient requires one, two, or all three types of assistance listed in a, b and/or c, but not the continuous presence of another person. If patient needs help to get to bathing location, score 2. If patient requires standby assistance to bathe safely in tub or shower or requires verbal cueing or reminders, then select Response 2 if the assistance is required only intermittently.

M1830 Bathing

- Response 3 – patient needs the **continuous** presence of another person to provide assistance in bathing in the tub or shower in order to be safe. May use device or not.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower.
- Do not assume the patient would be safe using equipment that is not in the home on day of assessment.

M1830 Bathing

- Response 4 - patient must be able to safely and <u>independently</u> bathe outside the tub/shower, *including independently accessing water safely* at a sink, or setting up a basin at the bedside, etc.
- Response 5 - patient is unable to bathe in the tub/shower and needs *intermittent or continuous* assistance to wash their entire body safely at a sink, in a chair, or on a commode.
- Response 6: patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs.

M1830: Assessment Techniques

- Use a combined interview and observation approach
- Does the patient have a functioning bath tub or shower? Sink?
- Ask the patient how they currently bathe, and what type of assistance is needed to wash entire body
- Do they have the necessary safety equipment in the home?
- Does the patient have medical restrictions that affect bathing? Vision? Pain?
- Observe the patient's general appearance in determining if the patient has been able to bathe self independently and safely

M1830: Assessment Techniques

- *If safety devices are in the home day of assessment*, observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely
- Ask the patient to demonstrate the motions involved in bathing the entire body.
- Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower. The patient who only performs a sponge bath may be *able* to bathe in the tub or shower with assistance and/or a device.
- Consider safety: home setting, equipment, ability
- Score at SOC/ROC before you teach or get equipment

Examples

The patient's tub is nonfunctioning or unsafe for use. His bath supplies are kept on the counter and patient bathes himself at the sink without any additional help.

- M1830: ?

What if he can't get to the sink and his wife has to set up a basin at the bedside for the patient to bathe himself?

- M1830: ?

The patient is ordered not to shower until 7 days after surgery when the sutures will be removed. When the nurse arrives, he is just getting out of the shower and his dressing is soaking wet. He showered without any assistance except his wife helped him get into the shower.

- M1830: ?

Examples

The patient's tub is nonfunctioning or unsafe for use. His bath supplies are kept on the counter and the patient bathes himself at the sink without any additional help.

- M1830: 4

What if he can't get to the sink and his wife has to set up a basin at the bedside for the patient to bathe himself?

- M1830: 5

The patient is ordered not to shower until 7 days after surgery when the sutures will be removed. When the nurse arrives, he is just getting out of the shower and his dressing is soaking wet. He showered without any assistance except his wife helped him get into the shower.

- M1830: 4

Examples

The patient is on physician-ordered bed rest.

- M1830 = ?

The patient chooses not to navigate the stairs to the tub/shower.

- M1830 = ?

Examples

The patient is on physician-ordered bed rest.

- M1830 = 5 or 6 depending on whether patient can participate in bathing himself in the bed.

The patient chooses not to navigate the stairs to the tub/shower, and sponge bathes at the sink in the kitchen.

- M1830 = 2 or 3. If the patient *chooses* not to navigate the stairs, but is *able* to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. 4bQ134
  - How much help does the patient need to get to the shower upstairs? Does she need help with bathing once she gets there? Continuous or intermittent assistance?

Example

The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.

- If due to fear, she refuses to enter the shower even with the assistance of another person; either Response 4, 5, or 6 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then Response 3 would describe her ability.

Example

The patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on over the cast, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower.

- M1830: ?

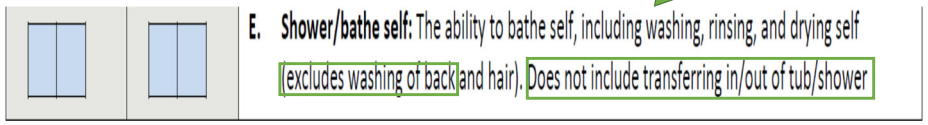
Example

The patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on over the cast, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower.

- M1830: 2

Contrast and Compare

Location does not matter.



E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

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

Enter Code ☐

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

03 or 02

04 Not included

Practice

- Ms Wyatt currently bathes with a plastic tub which the caregiver sets up for her with soap, water, wash cloth and towel. She then bathes by herself. Prior to her hip replacement she hired a contractor to remove her old tub and replace it with a walk-in shower, complete with a built-in ledge for sitting while bathing, grab bars and a hand-held shower. The shower has not been completed at this point. What would her score be on M1830?
- Bonus on GG0130E: Should her performance be coded 05, Set-up or clean-up assistance as the only help she requires is setting up the basin or 10, Not attempted due to environmental limitations since she is NOT bathing in a tub/shower?
- What if the caregiver returns to replace the water for rinsing?

Practice Answers

- M1830 Bathing? **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.
- GG0130E: Score based on patient's ability to bathe herself, regardless of where the bathing takes place. Your patient bathes at the sink and only requires assistance for setting up and filling the plastic tub she uses for bathing. If no other assistance is required while the patient washes, rinses and dries off her body, select Code **05 Set-up/Clean-up.**
- If the patient requires any assistance at any time during the bathing activities of washing, rinsing, drying (for instance needs someone to refresh the tub of water for rinsing), Code **03 Partial/moderate assistance, one person provides less than half the effort of the activity**

Current Scores

- Improvement in Bathing

Your agency	KS State Average	National Average
	81.4%	**79.7%**

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M1840 Toilet Transferring

PDGM

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

Enter Code ☐

5 pts

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.

Assessment Tips for M1840

- Ask pt/cg toileting location, equipment used, assist
- Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, safety awareness
- Determine the level of assistance needed by the patient to safely get to and from *and* on and off the toilet or commode.
- Consider environmental barriers/limitations
- Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

M1840 Toilet Transferring

- Response 0: patient can get to/from and on/off the bathroom toilet independently and safely with no assistance from another person. May use a device or not. If patient uses the bedside commode for convenience at night but can use toilet during day (>12 hrs out of 24), score response 0.
- Response 1: patient needs standby assistance, verbal cueing or reminders, or hands-on help from another person to safely get to and from the bathroom toilet, and transfer on and off the toilet.

M1840 Toilet Transferring

- Response 1 requires patient participation (effectively participate by contributing effort toward the completion of some of the included tasks)
  - If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders.
  - If the patient needs assistance getting to/from the toilet ***or*** with toileting transfer ***or*** both.
  - If the patient can independently get to the toilet, but requires assistance to get on and off the toilet.
- Response 2: patient is not able to get to/from and on/off the toilet, but has a bedside commode in the home on day of assessment and is able to get to/from and on/off the bedside commode with or without help from another person. May or may not use device.

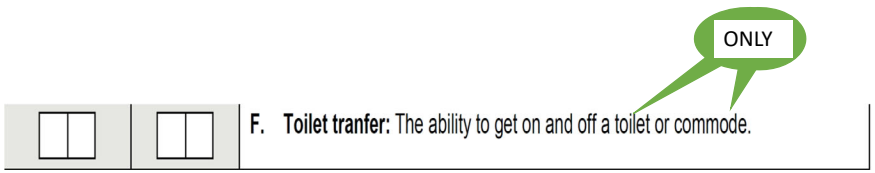
M1840 Toilet Transferring

- Response 3: patient has a bedpan/urinal in home day of assessment, and is able to place and remove a full bedpan/urinal independently. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal. Another person may bring the bedpan to the patient and remove the full bedpan once patient is off the bedpan.
  - If bedfast patient needs assistance to get on/off bedpan, the appropriate Response is "4-Is totally dependent in toileting" even if they can place and remove the urinal.
- Response 4: patient is not able to get both to/from and on/off toilet or bedside commode or bedpan, or applicable equipment is not available in home day of assessment.
  - Patient who uses adult diapers **may** be response 4.

No Toilet

- In the absence of a toilet in the home, the assessing clinician would need to determine if the patient is able to use a bedside commode (Response 2), or if unable to use a bedside commode, if he is able to use a bedpan/urinal independently (Response 3).
- If the patient is not able to use the bedside commode or bedpan/urinal as defined in the responses, *or if such equipment is not present in the home to allow assessment*, then Response 4 – totally dependent in toileting would be appropriate.

GG0170F Toilet Transfer



- Does not include getting to/from the toilet or BSC
- Can assess with a BSC if patient has equipment
- Toileting hygiene and clothing management are not considered part of the toilet transfer activity

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M1845 Toileting Hygiene

(M1845) **Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.	
Enter Code ☐	0 Able to manage toileting hygiene and clothing management without assistance. 1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. 2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing. 3 Patient depends entirely upon another person to maintain toileting hygiene.

Majority of tasks doesn't apply for this item - has to be able to manage **both** clothing and toilet hygiene for 0 and 1.

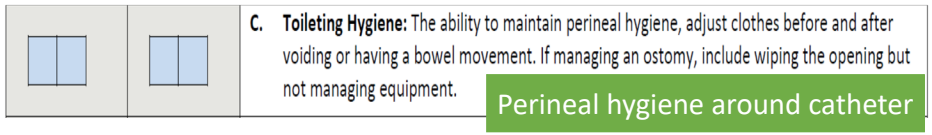
M1845 Toileting Hygiene

- Includes pulling clothes up or down, managing incontinence pads, adequately cleaning (wiping) the perineal area, ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies). Excludes managing ostomy equipment.
- Focus on patient's ability to access needed supplies and implements, manage hygiene and clothing once at location where toileting occurs. The ability to access toilet or bedside commode, transfer on and off bedpan and to use urinal are **excluded** from consideration when assessing the patient's toileting hygiene ability.
- The word "assistance" in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.

M1845 Toileting Hygiene

- Response 0 if the patient is independent in managing toileting hygiene and managing clothing.
- Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.
- If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, select Response 2.
  - Includes standby assistance or verbal cueing.

Contrast and Compare



C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Perineal hygiene around catheter

Toileting hygiene includes managing undergarments, clothing and incontinence products, and performing perineal hygiene; includes type/amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence. If the patient can complete toileting hygiene and clothing management tasks only after a helper retrieves or sets up supplies necessary to perform included tasks, code 05 – setup or clean-up.

(M1845) **Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.		
Enter Code ☐	0	Able to manage toileting hygiene and clothing management without assistance.
	1	Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2	Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3	Patient depends entirely upon another person to maintain toileting hygiene.

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M1850 Transferring

PDGM

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.		
Enter Code ☐ 7 pts	0	Able to independently transfer.
	1	Able to transfer with minimal human assistance or with use of an assistive device. (3 pts)
	2	Able to bear weight and pivot during the transfer process but unable to transfer self.
	3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4	Bedfast, unable to transfer but is able to turn and position self in bed.
	5	Bedfast, unable to transfer and is unable to turn and position self.

M1850 Transferring

- Identifies the patient's ability to safely transfer from bed (or current sleeping surface) to chair (and chair to bed), or position self in bed if bedfast.
- For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to the closest chair or sitting surface, and back into bed from the chair or sitting surface.

M1850 Transferring

- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.
- The need for assistance with gait may impact the Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed.

M1850 Transferring

- Response 0 – patient able to transfer independently and safely without using any device or help from another person.
- Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete task.
- Select Response 1 if:
  - Patient transfers ***either*** with minimal human assistance (but not device), ***or*** with the use of a device (but no human assistance)
  - Patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing or reminders
  - Patient requires another person to position the wheelchair by the bed and apply the brakes to lock the wheelchair for safe transfer from bed to chair

M1850 Transferring

- Response 2 - Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).
- Select Response 2 if:
  - Patient requires more than minimal assistance (more than 25% of the effort to transfer comes from another person helping)
  - Patient requires ***both*** minimal human assistance ***and*** an assistive device to be safe
  - Patient can bear weight and pivot, but requires more than minimal human assist,

M1850 Transferring

- Response 3 – patient cannot bear weight or cannot pivot (one or the other or both), and is not bedfast by the OASIS definition.
- A patient who can tolerate being out of bed is not "bedfast." If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient's circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast ("confined to the bed") even though he cannot help with the transfer

M1850 Transferring

- If the patient is bedfast, select Response 4 or 5, depending on the patient's ability to turn and position self in bed.
- Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed. Responses 4 and 5 do ***not*** apply for the patient who is not bedfast.
- The frequency of the transfers does not change the response, only the patient's ability to be transferred and tolerate being out of bed.

M1850 Assessment Techniques

- Observe the patient lie down on their back in bed or on their usual sleeping surface. Assistance needed?
- Observe the patient roll up into a sitting position on the side of the bed. Assistance needed?
- Identify the nearest sitting surface and observe patient perform some type of transfer to that surface. The transfer may involve standing and taking a few steps to the chair or bench or bedside commode, a stand-pivot, or a sliding board transfer. Assistance needed? What type of assistance? How much assist? By whom? Is a device used/needed to be safe?
- Observe patient transfer back onto the bed from the sitting surface.

M1850 Assessment Techniques

- Ask patient/caregiver what assistance has been needed the day of assessment to do this task.
- Consider environmental barriers, furniture placement, physical strength, balance, ROM, pain, vision, cognition and safety awareness.
- If a chair or bench cannot be placed next to the bed, patient's ability to ambulate to nearest sitting surface may impact scoring.

M1850 Transferring

- If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), assess the patient's ability to move from the supine position on their current sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.
- ***M1850 does not "match" the GG0170 Mobility items in rows A-E***
  - Device use
  - Sitting to standing position
  - Chair vs bed

GG0170a - e and M1850

☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).

(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code ☐	0 Able to independently transfer. 1 Able to transfer with minimal human assistance or with use of an assistive device. 2 Able to bear weight and pivot during the transfer process but unable to transfer self. 3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4 Bedfast, unable to transfer but is able to turn and position self in bed. 5 Bedfast, unable to transfer and is unable to turn and position self.

Current Scores

- Improvement in Bed Transferring

Your agency	KS State Average	National Average
	78.8%	77.5%

SOC
ROC
FU
DC

M1860 Ambulation/Locomotion

PDGM

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 Able to walk only with the supervision or assistance of another person at all times. 4 Chairfast, unable to ambulate but is able to wheel self independently. 5 Chairfast, unable to ambulate and is unable to wheel self. 6 Bedfast, unable to ambulate or be up in a chair.

9 pts

11 pts

23 pts

M1860 Ambulation/Locomotion

- Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces.
  - Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence.
- Assess patient's ***ability*** to ambulate; endurance is not included in this item.
- Patient may use a wheelchair 75% of the time due to distances and endurance, and ambulates 25% of the time – that patient has the ability to ambulate.
- The patient that is only able to take a few steps to complete the transfer to and from a wheelchair is NOT able to functionally ambulate, that patient is chairfast.
- The patient that stays in bed watching TV all day and gets up to walk to the table for meals has the ability to ambulate – he just chooses to stay in bed most of the time; that doesn't make him bedfast.

M1860 Ambulation / Locomotion

- Response 0: patient can safely walk on any surface in their environment, including stairs, **without any device or any human assistance AT ALL.**
  - If you mark this response, better document why the patient is homebound!
- Response 1: Safe on all surfaces and stairs **with a one-handed device – NO HUMAN ASSISTANCE** NEEDED AT ALL FOR ANY SURFACE.
  - Includes all kinds of canes, as long as they only require one hand to use safely and correctly.

M1860 Ambulation / Locomotion

- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, select Response 2 or Response 3, depending on whether **assistance required is intermittent ("2") or continuous ("3").**
- Response 2: patient is safely able to ambulate with a two-handed device on all surfaces (includes all types of walkers, crutches, knee scooter as long as device is intended for use with two hands). If patient requires ***intermittent*** assistance of another person on stairs, steps, or uneven surfaces choose response 2. If patient needs assistance at some times of day/night, choose Response 2, regardless if any device is used or not.

M1860 Ambulation/Locomotion

- Response 3: patient needs continuous assist or supervision when ambulating to be safe, regardless if any device is used or not; patient does not have a walking device and is clearly not safe walking alone, *but the patient is not chairfast;* patient forgets to use the walker due to memory impairment and requires supervision at all times when ambulating.
- Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance.
  - A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self
  - Wheelchair may be powered or manual version

M1860 Ambulation/Locomotion

- **Patient has no device in home and is not safe ambulating even with assistance from another person all the time**.
- "5-Chairfast, unable to ambulate and is unable to wheel self".
- **Patient ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home.**
- If the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, she would be scored a "2" for M1860 if she needs two hands to use the stair lift and a "1" if she only needs one hand to safely use the stair lift.

Knee Scooter

- If a patient is safely using a knee scooter to facilitate non-weight bearing on one lower extremity, what response would be selected for M1860 - Ambulation?
- First, determine if the knee scooter will be considered an assistive device for the purpose of ambulation. If the assessing clinician determines the knee scooter is an assistive device, then determine if the patient is safe using the scooter without the assistance of another person and assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.

One or Two Handed?

How safe are they?

Patient is wheelchair bound and cannot ambulate but can wheel self. Patient also has advanced dementia or cognitive decline and although the patient can wheel self independently, he/she is unable to do so with any purpose, (i.e., patient could not follow simple instructions to get to another room, or could not self-evacuate in the event of an emergency). What response should be selected?

- The assessing clinician must consider the non-ambulatory patient's ***ability to safely use the wheelchair***, given the patient's current physical and mental/emotional/cognitive status, activities permitted, and the home environment.
- In the scenario, the patient's advanced dementia/cognitive decline is noted as a concern because the patient is unable to wheel self with purpose. Other than addressing safety on surfaces the patient would routinely encounter in their environment, CMS guidance does not detail specific criteria regarding patient ambulation or wheelchair use (i.e., how far the patient must walk, or wheel self; of if they use ambulation or wheelchair mobility with specific purpose, regularity, or efficiency). **It is left to the judgment of the assessing clinician to determine the patient's ability (i.e., does the patient's mental status impacted his/her safety?) and select a response accordingly.**

M1860 Assessment Techniques

- Observe the patient walk a reasonable distance, if safe
  - Does patient use a device? Correctly and safely? What type?
  - Does patient use walls or furniture for support?
  - Does patient demonstrate loss of balance or other actions that suggest additional support is needed for safe ambulation?
  - Does the patient demonstrate safe gait pattern?
  - Consider all surfaces in patient's environment
- Observe the patient's ability and safety on stairs
- If chairfast, does the patient have a wheelchair? Power or manual? Do the brakes work properly? Can the patient demonstrate ability to wheel the chair independently and as directed? Across the floor? Through doorways? Up/down entrance ramp?

M1860 Ambulation/Locomotion Example

Patient safely ambulates with a quad cane in all areas of the home except her bedroom and bathroom where she has shag carpet that tangles in the prongs of the cane. In those rooms, she switches to a walker to ambulate safely. The patient does not require any human assistance.

- M1860: 2

M1860 Ambulation/Locomotion

- **My patient does not have a walking device but is clearly not safe walking alone. I evaluate him with a trial walker that I have brought with me to the assessment visit and while he still requires assistance and cueing, I believe he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he usually is just up stumbling around on his own. What score should I select for M1860?**
- Your assessment findings cause you to believe the patient should have someone with them at all times when walking (**Response "3"**). When scoring M1860, clinicians should be careful not to assume that a patient, who is unsafe walking without a device, will suddenly (or ever) become able to safely walk *with* a device. Observation is the preferred method of data collection for the functional OASIS items, and the most accurate assessment will include observation of the patient using the device. Often safe use will require not only obtaining the device, but also appropriate selection of specific features, fitting of the device to the patient/environment and patient instruction in its use.

M1860 Example

A patient is able to ambulate independently with a walker, but he chooses to not use the walker, therefore is not safe. Response #2, or Response #3?

- Report the patient's physical and cognitive ability, not their actual performance, adherence or willingness to perform an activity. If observation shows the patient is able to ambulate independently with a walker, without human assistance, *select Response 2 for M1860.*
- However, if the patient forgets to use the walker due to memory impairment, that impacts his ability. The clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, M1860 would be a "3". If patient only needed assistance intermittently, the correct response would be a "2".

M1860 Ambulation/Locomotion

- **Patient has no device in home and is not safe ambulating even with assistance from another person all the time**.
- "5-Chairfast, unable to ambulate and is unable to wheel self".
- **Patient ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home.**
- If the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, she would be scored a "2" for M1860 if she needs two hands to use the stair lift and a "1" if she only needs one hand to safely use the stair lift.

M1860 Ambulation/Locomotion

- **Our patient requires maximum assistance to ambulate (over 75% of the effort necessary for ambulation is contributed by someone other than the patient) and only ambulates with the therapist during gait training activities. The patient is extremely unsafe when attempting to ambulate without the therapist's assistance.**
- Still ambulatory—Response 3 unless able to take only a few steps
- Minimal assistance (like in transferring) vs maximum assistance doesn't apply with ambulation

GG0170I through GG0170L

☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

- Use of assistive device(s) and adaptive equipment (cane or leg brace) does not affect coding of activity
- 90 degree turns may be same or different directions
- If environment does not allow a walk of 150 ft without turns, may demonstrate ability to walk 150 ft with turns
- If not able to attempt walking on uneven surface due to not available or weather limits access, and not able to gather info from patient/family, code 10 not attempted due to environmental limitations

GG0170Q through GG0170S

	☐	**Q. Does patient use wheelchair and/or scooter?** **0. No** → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

- GG0170Q = gateway item, see skip pattern

Current Scores

- Improvement in Ambulation/Locomotion

Your agency	KS State Average	National Average
	78.5%	**77.7%**

Functional Quality Measure

- "Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function"
- Reports the percent of episodes with a SOC/ROC and a DC functional assessment and a treatment goal that addresses function; the treatment goal proves that a care plan with a goal has been established for the patient, and documentation of a goal for one functional item reflects the care plan addresses function.
- Not risk-adjusted

Functional Quality Measure

Numerator = number of quality episodes with functional assessment data for each self-care and mobility activity **and** at least one self-care or mobility goal at SOC/ROC, **and** valid numeric score or reason not attempted score for each of the functional assessment items on the DC assessment

Denominator = All quality episodes
(no measure – specific exclusions, all OASIS patients)

NOTE: for HH episodes ending in a qualifying admission to an inpatient facility (Transfer) or Death at Home, the discharge functional status data would not be required for the episode to be included in the numerator (just need a valid numeric score or reason not attempted code for SOC/ROC and a valid numeric score for at least one self-care or mobility goal on the SOC/ROC assessment).

Items Included in Quality Measure

Self-Care Items

- Eating GG0130A
- Oral hygiene GG0130B
- Toileting hygiene GG0130C

Mobility Items

- Sit to lying GG0170B
- Lying to sitting GG0170C
- Sit to stand GG0170D
- Chair/bed-to-chair transfer GG0170E
- Toilet transfer GG0170F

Items Included in Quality Measure

For patients who are walking:

- Walk 50 ft GG0170J
- Walk 150 ft GG0170K

For patients who use a wheelchair:

- Wheel 50 ft with 2 turns GG0170R
- Wheel 150 ft GG0170S

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What questions do you have?