

Proposed Changes to OASIS Items Set starting January 1, 2017

OASIS-C2

Home Health Patient Tracking Sheet

(M0010) CMS Certification Number:	Dashes changed to boxes
(M0014) Branch State:	Dashes changed to boxes
(M0016) Branch ID Number:	Dashes changed to boxes
(M0018) National Provider Identifier (NPI):	Dashes changed to boxes
(M0020) Patient ID Number:	Dashes changed to boxes
(M0030) Start of Care Date:	Dashes changed to boxes
(M0032) Resumption of Care Date:	Dashes changed to boxes
(M0040) Patient Name:	Dashes changed to boxes
(M0050) Patient State of Residence:	Dashes changed to boxes
(M0060) Patient ZIP Code:	Dashes changed to boxes
(M0063) Medicare Number:	Dashes changed to boxes
(M0064) Social Security Number:	Dashes changed to boxes
(M0065) Medicaid Number:	Dashes changed to boxes
(M0066) Birth Date:	Dashes changed to boxes
(M0069) Gender	Added "Enter Code" box
(M0140) Race/Ethnicity:	No changes
(M0150) Current Payment Sources for Home Care:	No changes

Items to be Used at Specific Time Points

Start of Care -----	M0010-M0030, M0040-M0150, M1000-M1036,
Start of care—further visits planned	M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170

M1308 deleted; M1311 added; M1600-M2002 changed to M1600-M2003; GG0170 added

Resumption of Care ----- M0032, M0080-M0110, M1000-M1036,
Resumption of care (after inpatient stay) M1060-M1306, M1311, M1320-M1410,
M1600-M2003, M2010, M2020-M2250, GG0170

**M1100-M1306 changed to M1060-M1306; M1308 deleted;
M1311 added; M1600-M2002 changed to M1600-M2003; GG0170
added**

Follow-Up ----- M0080-M0100, M0110, M1011, M1021-M1023,
Recertification (follow-up) assessment M1030, M1200, M1242, M1306, M1311,
Other follow-up assessment M1322-M1342, M1400, M1610, M1620, M1630,
M1810-M1840, M1850, M1860, M2030, M2200

**M1021-M1030 changed to M1021-M1023; M1030, M1308
deleted; M1311 added; M1600-M2002 changed to M1600-
M2003; GG0170 added**

Transfer to an Inpatient Facility----- M0080-M0100, M1041-M1056, M1501, M1511,
Transferred to an inpatient facility—patient M2005, M2016, M2301-M2410, M2430, M0903,
not discharged from an agency M0906

Transferred to an inpatient facility—patient
discharged from agency **M1500, M1510, M2004 and M2015 deleted; M1501, M1511,
M2005, and M2016 added; M2300-M2410 changed to M2301-
M2410**

Discharge from Agency – Not to an Inpatient Facility

Death at home ----- M0080-M0100, M2005, M0903, M0906

Discharge from agency ----- M0080-M0100, M1041-M1056, M1230, M1242,
M1306-M1342, M1400, M1501-M1620,
M1700-M1720, M1740, M1745, M1800-M1890,
M2005, M2016-M2030, M2102, M2301-M2420
M0903, M0906

M2005 added

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment: Choices changed from horizontally to diagonally. Added “Enter Code” box

(M0090) Date Assessment Completed: Dashes changed to boxes

(M0100) This Assessment is Currently Being Completed for the Following Reason: Added “Enter Code” box

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): Dashes changed to boxes

(M0104) Date of Referral: Dashes changed to boxes

(M0110) Episode Timing: Added “Enter Code” box

PATIENT HISTORY AND DIAGNOSES

(M1000) From which of the following Inpatient Facilities was the patient discharged within the past 14 days? **(Mark all that apply.)** No changes

(M1005) Inpatient Discharge Date (most recent): Dashes changed to boxes

(M1011) List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes): Dashes changed to boxes

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient’s Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes): Dashes changed to boxes

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)** No changes

(M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only – no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses – Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment. No changes

(M1021/1023/1025) Form: Dashes changed to boxes

(M1028) Active Diagnoses – Comorbidities and Co-existing Conditions – Check all that apply. See OASIS Guidance Manual for a complete list of relevant ICD-10 codes. (M1028) New code added

(M1030) Therapies the patient receives at home: (Mark all that apply.) No changes

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **No changes**

(M1034) Overall Status: Which description best fits the patient’s overall status? “Check one” removed. Added “Enter Code” box

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **No changes**

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31? **Added “Enter Code” box**

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year’s flu season? **Added “Enter Code” box**

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)? **Yes [Go to M1500 at TRN; Go to M1230 at DC] changed to Yes [Go to M1501 at TRN; Go to M1230 at DC]**

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason: **Added “Enter Code” box**

(M1060) Height and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

- a. Height (in inches). Record most recent height measure since the most recent SOC/ROC
- b. Weight (in pounds). Base weight on most recent measure in last 30 days: measure weight consistently, according to standard agency practice (for example, in a.m., after voiding, before meals, with shoes off etc. **(M1060) New code added**

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient’s residential circumstance and availability of assistance? **(Check one box only.) No Changes**

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them): **Added “Enter Code” box**

(1210) Ability to Hear (with hearing aid or hearing appliance if normally used): **Added “Enter Code” box**

(M1220) Understanding of Verbal Content in patient’s own language (with hearing aid or device if used): **Added “Enter Code” box**

(M1230) Speech and Oral (Verbal) Expression of Language (in patient’s own language): **Added “Enter Code” box**

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient’s ability to communicate the severity of pain)? **Added “Enter Code” box**

(M1242) Frequency of Pain Interfering with patient’s activity of movement: **Added “Enter Code” box**

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**? **Added “Enter Code” box**

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**? **Added “Enter Code” box**

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers) **Added “Enter Code” box**

(M1307) The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers) **The Roman number II was changed to the numerical 2. Added “Enter Code” box**

(M1308) changed to **(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage.** “or unstageable” has been removed. The choices to select from has been changed and reworded to the following.

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
<p>A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers [If 0 at FU/DC Go to M1311B1]</p> <p>A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC -- enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers [If 0 at FU/DC Go to M1311C1]</p> <p>B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC -- enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers [If 0 at FU/DC Go to M1311D1]</p> <p>C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC -- enter how many were noted at time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers due to non-removable dressing/device [If 0 at FU/DC Go to M1311E1]</p> <p>D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC -- enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1]</p> <p>E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC -- enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution Number of unstageable pressure ulcers with suspected deep tissue injury in evolution [If 0 – Go to M1322 (at Follow up), Go to M1313 (at Discharge)]</p> <p>F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC -- enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>[Omit “A2, B2, C2, D2, E2 and F2” on SOC/ROC]</p>	

(M1309) changed to (M1313) Worsening in Pressure Ulcer Status since SOC/ROC: The instructions change to “Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter o.” The Roman number in Stage II was changed to the numerical 2. The Roman number in Stage III was changed to the numerical 3. The Roman number in Stage IV was changed to the numerical 4.

Instructions for d changed to Instruction for e. “For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.”

Roman numbers I and II were changed in the instructions to numerical 1 and 2. (d. Unstageable due to coverage of wound bed by slough or eschar was changed to “d. Unstagable –Known or likely but Unstageable due to non-removable dressing. **Added e.** Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar. **Added f.** Unstageable – Suspected deep tissue injury in evolution. Dashes were changed to boxes.

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

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. The Roman number I was changed to the numerical 1. **Added** “Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.” **Choices changed from horizontally to diagonally.**
Added “Enter Code” box

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.) The Roman number in Stage I, Stage II, Stage III, and Stage IV were changed to the numerical number Stage 1, Stage 2, Stage 3, and Stage 4. **Added “Enter Code” box**

(M1330) Does this patient have a Stasis Ulcer? **Added “Enter Code” box**

(M1332) Current Number of Stasis Ulcer(s) that are Observable: **Added “Enter Code” box**

(M1334) Status of Most Problematic Stasis Ulcer that is Observable: **Added “Enter Code” box**

(M1340) Does this patient have a Surgical Wound? **Added “Enter Code” box**

(M1342) Status of Most Problematic Surgical Wound that is Observable **Added “Enter Code” box**

(M1350) Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency? **Added “Enter Code” box**

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably Short of Breath? **Added “Enter Code” box**

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)** **No changes**

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment? **M1500 was changed to M1501. “previous OASIS Assessment” was changed to “most recent SOC/ROC assessment.”** In number “0”, go to “M2004 at TRN” was changed to “Go to M2005.” In number “2”, “Go to M2004 at TRN” was changed to “Go to M2005.” In “NA”, “Go to M2004 at TRN” was changed to “Go to M2005.” Added “Enter Code” box

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **“M1510 “was changed to “M1511.” “previous OASIS assessment” was changed to “most recent SOC/ROC assessment.”**

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days? Added “Enter Code” box

(M1610) Urinary Incontinence or Urinary Catheter Presence: Added “Enter Code” box

(M1615) When does Urinary Incontinence occur? Added “Enter Code” box

(M1620) Bowel Incontinence Frequency: Added “Enter Code” box

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical treatment regimen? Added “Enter Code” box

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700) Cognitive Functioning: Patient’s current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands. Added “Enter Code” box

(M1710) When Confused (Reported or Observed Within the Last 14 Days): Added “Enter Code” box

(M1720) When Anxious (Reported or Observed Within the Last 14 Days): Added “Enter Code” box

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool? Added “Enter Code” box

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week
(Reported or Observed): (Mark all that apply) **No change**

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
Added “Enter Code” box

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse? **Added “Enter Code” box**

ADL/IADLs

(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). **Added “Enter Code” box**

(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:
Added “Enter Code” box

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes: **Added “Enter Code” box**

(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair). **Added “Enter Code” box**

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode. **Added “Enter Code” box**

(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. **Added “Enter Code” box**

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. **Added “Enter Code” box**

Section GG: New section added

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility
Code the patient’s usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason.
Code the patient’s discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge

goal.			
Coding: Safety and Quality of Performance – If helper assistance is Required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activity may be completed with or without assistive devices.</i> 06 Independent – Patient completes the activity by him/herself with no assistance from a helper. 05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. If activity was not attempted, code reason: 07 Patient refused 09 Not applicable 88 Not attempted due to medical condition or safety concerns	1.	2.	
	SOC/ROC	Discharge	
	Performance	Goal	
	Enter Codes In Boxes		
		Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	

(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. **Added “Enter Code” box**

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten. **Added “Enter Code” box**

(M1880) Current Ability to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered meals safely: **Added “Enter Code” box**

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate. **Added “Enter Code” box**

(M1900) Prior Functioning ADL/IADL: Indicate the patient’s usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. **Choices changed from horizontally to diagonally.** **Added “Enter Code” boxes**

(M1910) Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool? **Added “Enter Code” box**

MEDICATIONS

(M2001) Drug Regimen Review: “M2000” was changed to “M2001.” Does a complete drug regimen review indicate potentially clinically significant medication issues (for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or non-compliance [non-adherence]) **was changed to “Did a complete drug regimen review identify potential clinically significant medication issues?”** The response “0” not assessed/reviewed [Go to M2010] was changed to No- No issues found during review [Go to M2010]. The response “1” No problems found during review [Go to M2010] was changed to Yes - Issues found during review. The response ‘2’ Problems found during review was deleted. No changes to the response “NA.” Added “Enter Code” box

(M2003) Medication Follow-up: “M2002” was changed to “M2003” The wording was changed from “Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?” to “Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?” ? Added “Enter Code” box

(M2005) Medication Intervention: M2004 was changed to “M2005.” “If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician designee contacted within on calendar day to resolve any identified clinically significant medication issues, including reconciliation” was changed to “**Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?**” “NA was change from “no clinically significant medication issues identified at the time of or any time since the previous OASIS assessment” to “There was no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any mediations.” Added “Enter Code” box

(M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemic, anticoagulants, etc.) and how and when to report problems that may occur? Added “Enter Code” box

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by the agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur? “M2015” was changed to “M2016.” Added “Enter Code” box

(M2020) Management of Oral Medications: Patient’s current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.) Added “Enter Code” box

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

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation, or injury. **Choices changed from horizontally to diagonally. Added "Enter Code" box**

CASE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. **Choices changed from horizontally to diagonally. Added "Enter Code" box**

(M2110) How Often does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)? **Added "Enter Code" box**

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **The dashes were changed to boxes.**

(M2250) Plan of Care Synopsis: (Check only one box in each row. Does the physician – ordered plan of care include the following: **No changes.**

EMERGENT CARE:

(M2301) Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)? **"M2300" was changed to "M2301." The wording "previous OASIS" was changed to "most recent SOC/ROC." Added "Enter Code" box**

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply) **No changes**

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2401) Intervention Synopsis: "M2400" was changed to "M2401." At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? The wording "the previous OASIS" was changed to "most recent SOC/ROC." The wording in section "e" in "NA" "last OASIS" was changed to "most recent SOC/ROC."

(M2410) To which Inpatient Facility has the patient been admitted? **Added "Enter Code" box**

(M2420) Discharge Disposition: Where is the patient after discharge from your agency? **Added "Enter Code" box**

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **No changes**

(M0903) Date of Last (Most Recent) Home Visit: The dashes were changed to boxes for the month, day, and year.

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient. The dashes were changed to boxes for the month, day and year.