46462-8 OASIS pnl

NAME

Component	Property	Time	System	Scale	Method
Outcome and assessment information set (OASIS) form	-	Pt	^Patient	Set	

BASIC PROPERTIES

Class/Type:	SURVEY.OASIS/Survey
Units Required:	N

DEFINITION/DESCRIPTION

The OASIS is a core set of screening and assessment elements, including standardized definitions and coding categories that form the foundation of the comprehensive assessment for all clients of home health agencies certified to participate in the Medicare or Medicaid program.

PANEL CHILDREN

	LOINC Name							
LOINC#	Component	Property	Time	System	Scale	Method	Submitters Code	Datatype	R/O
46462-8	Outcome and assessment information set (OASIS) form	-	Pt	^Patient	Set				
46456-0	Agency medicare provider number	ID	Pt	Provider	Nom	OASIS			
46493-3	Agency medicaid provider number	ID	Pt	Provider	Nom	OASIS			
46494-1	State location of agency branch	Loc	Pt	Agency	Ord	OASIS			
46495-8	Branch number	ID	Pt	Agency	Ord	OASIS			
46496-6	Patient number	ID	Pt	^Patient	Nom	OASIS			
46497-4	Start of care date	TmStp	Pt	^Patient	Qn	OASIS			
46498-2	Resumption of care date	TmStp	Pt	^Patient	Qn	OASIS			
45965-1	Name	-	Pt	^Patient	Set				
45394-4	Last name	Pn	Pt	^Patient	Nom		AA1c	TX	
45392-8	First name	Pn	Pt	^Patient	Nom		AA1a	TX	
45393-6	Middle initial	ID	Pt	^Patient	Nom		AA1b	TX	
45395-1	Name suffix	Pn	Pt	^Patient	Nom		AA1d	TX	
46499-0	State of residence	Loc	Pt	^Patient	Nom	OASIS			
45401-7	ZIP code	Loc	Pt	^Patient	Nom		AB4	TX	
45397-7	Medicare or comparable number	ID	Pt	^Patient	Nom		AA5b	TX	
45396-9	Social security number	ID	Pt	^Patient	Nom		AA5a	TX	

45400-9	Medicaid number	ID	Pt	^Patient	Nom		AA7	TX
21112-8	Birth date	TmStp	Pt	^Patient	Qn		AA3	DT
46607-8	Gender	Type	Pt	^Patient	Ord	OASIS		
46608-6	Primary referring physician ID	ID	Pt	Provider	Nom			
46500-5	Discipline of person completing assessment	Type	Pt	Provider	Nom	OASIS		
46501-3	Date assessment information completed	TmStp	Pt	^Patient	Qn	OASIS		
46502-1	Reason for assessment	Find	Pt	^Patient	Nom	OASIS		
46463-6	Race or ethnicity	Find	Pt	^Patient	Nom	OASIS		
46464-4	Current payment sources for home care	Find	Pt	^Patient	Nom	OASIS		
46457-8	Inpatient discharge facility	Type	Pt	^Patient	Nom	OASIS		
46503-9	Most recent inpatient discharge date	TmStp	Pt	^Patient	Qn	OASIS		
46458-6	Inpatient facililty diagnoses	-	Pt	^Patient	Set			
46504-7	Inpatient stay within last 14 days: ICD code	Prid	Pt	^Patient	Nom	OASIS		
46505-4	Inpatient stay within last 14 days: ICD code^^^2	Prid	Pt	^Patient	Nom	OASIS		
46506-2	Medical or treatment regimen change in past 14 days	Find	Pt	^Patient	Ord	OASIS		
46459-4	Changed medical regimen diagnoses	-	Pt	^Patient	Set			
46507-0	Regimen change in past 14 days: ICD code 1	Prid	Pt	^Patient	Nom	OASIS		
46508-8	Regimen change in past 14 days: ICD code^^^2	Prid	Pt	^Patient	Nom	OASIS		
46509-6	Regimen change in past 14 days: ICD code^^^3	Prid	Pt	^Patient	Nom	OASIS		
46510-4	Regimen change in past 14 days: ICD code ^^^4	Prid	Pt	^Patient	Nom	OASIS		
46465-1	Conditions prior to medical or treatment regimen change or inpatient stay within past 14 days	Find	Pt	^Patient	Ord	OASIS		
46609-4	Diagnosis and severity index	-	Pt	^Patient	Set			
46511-2	Primary diagnosis ICD code	Prid	Pt	^Patient	Nom	OASIS		
46512-0	Primary diagnosis severity rating	Find	Pt	^Patient	Ord	OASIS		
46513-8	Other diagnosis 1: ICD code	Prid	Pt	^Patient	Nom	OASIS		
46514-6	Other diagnosis 1: severity rating	Find	Pt	^Patient	Ord	OASIS		
46515-3	Other diagnosis 2: ICD code	Prid	Pt	^Patient	Nom	OASIS		
46516-1	Other diagnosis 2: severity rating	Find	Pt	^Patient	Ord	OASIS		
46517-9	Other diagnosis 3: ICD code	Prid	Pt	^Patient	Nom	OASIS		
46518-7	Other diagnosis 3: severity rating	Find	Pt	^Patient	Ord	OASIS		
46519-5	Other diagnosis 4: ICD code	Prid	Pt	^Patient	Nom	OASIS		
46520-3	Other diagnosis 4: severity rating	Find	Pt	^Patient	Ord	OASIS		
46521-1	Other diagnosis 5: ICD code	Prid	Pt	^Patient	Nom	OASIS		
46522-9	Other diagnosis 5: severity rating	Find	Pt	^Patient	Ord	OASIS		
46610-2	Payment diagnosis	-	Pt	^Patient	Set			
46584-9	Payment diagnosis: primary ICD	Prid	Pt	^Patient	Nom	OASIS		
46585-6	Payment diagnosis: first secondary ICD	Prid	Pt	^Patient	Nom	OASIS		
46466-9	At home therapies	Find	Pt	^Patient	Nom	OASIS		
46523-7	Overall prognosis for recovery from this episode	Find	Pt	^Patient	Ord	OASIS		

46524-5	Rehabilitative prognosis	Find	Pt	^Patient	Ord	OASIS
46525-2	Life expectancy	Find	Pt	^Patient	Ord	OASIS
46467-7	High risk factors	Find	Pt	^Patient	Nom	OASIS
46526-0	Current residence	Find	Pt	^Patient	Nom	OASIS
46468-5	Current living arrangement	Find	Pt	^Patient	Nom	OASIS
46469-3	Assisting person(s) other than home care agency staff	Find	Pt	^Patient	Nom	OASIS
46527-8	Primary caregiver	Find	Pt	^Patient	Nom	OASIS
46528-6	Frequency of primary caregiver assistance	Find	Pt	^Patient	Ord	OASIS
46470-1	Type of primary caregiver assistance	-	Pt	^Patient	Set	
46529-4	Sensory status: vision	Find	Pt	^Patient	Ord	OASIS
46530-2	Sensory status: hearing and ability to understand spoken language	Find	Pt	^Patient	Ord	OASIS
46531-0	Sensory status: speech and oral expression of language	Find	Pt	^Patient	Ord	OASIS
46532-8	Sensory status: frequency of pain	Find	Pt	^Patient	Ord	OASIS
46533-6	Experiencing intractable pain	Find	Pt	^Patient	Ord	OASIS
46534-4	Skin lesion or open wound	Find	Pt	^Patient	Ord	OASIS
46535-1	Pressure ulcer	Find	Pt	^Patient	Ord	OASIS
46460-2	Number of pressure ulcers at each stage	-	Pt	^Patient	Set	
46536-9	Number of pressure ulcers - stage 1	Num	Pt	^Patient	Qn	OASIS
46537-7	Number of pressure ulcers - stage 2	Num	Pt	^Patient	Qn	OASIS
46538-5	Number of pressure ulcers - stage 3	Num	Pt	^Patient	Qn	OASIS
46539-3	Number of pressure ulcers - stage 4	Num	Pt	^Patient	Qn	OASIS
46540-1	Unobserved pressure ulcer	Find	Pt	^Patient	Ord	OASIS
46541-9	Stage of most problematic pressure ulcer	Find	Pt	^Patient	Ord	OASIS
46542-7	Status of most problematic pressure ulcer	Find	Pt	^Patient	Ord	OASIS
46543-5	Stasis ulcer	Find	Pt	^Patient	Ord	OASIS
46544-3	Number of stasis ulcers	Num	Pt	^Patient	Qn	OASIS
46545-0	Unobserved stasis ulcer	Find	Pt	^Patient	Ord	OASIS
46546-8	Status of most problematic stasis ulcer	Find	Pt	^Patient	Ord	OASIS
46547-6	Surgical wound	Find	Pt	^Patient	Ord	OASIS
46548-4	Number of surgical wounds	Num	Pt	^Patient	Qn	OASIS
46549-2	Unobserved surgical wound	Find	Pt	^Patient	Ord	OASIS
46550-0	Status of most problematic surgical wound	Find	Pt	^Patient	Ord	OASIS
46551-8	When short of breath	Find	Pt	^Patient	Ord	OASIS
46471-9	At home respiratory treatments	Find	Pt	^Patient	Nom	OASIS
46552-6	Treated for urinary tract infection in past 14 days	Find	Pt	^Patient	Ord	OASIS
46553-4	Urinary incontinence or urinary catheter present	Find	Pt	^Patient	Ord	OASIS
46586-4	When urinary incontinence occurs	Find	Pt	^Patient	Ord	OASIS
46587-2	Bowel incontinence frequency	Find	Pt	^Patient	Ord	OASIS
46588-0	Ostomy for bowel elimination	Find	Pt	^Patient	Ord	OASIS

46589-8	Cognitive functioning	Find	Pt	^Patient	Ord	OASIS
46590-6	When confused	Find	Pt	^Patient	Ord	OASIS
46591-4	When anxious	Find	Pt	^Patient	Ord	OASIS
46472-7	Depressive feelings	Find	Pt	^Patient	Nom	OASIS
46473-5	Behaviors demonstrated at least once a week	Find	Pt	^Patient	Nom	OASIS
46592-2	Frequency of behavior problems	Find	Pt	^Patient	Ord	OASIS
46593-0	Receives psychiatric nursing	Find	Pt	^Patient	Ord	OASIS
46478-4	Grooming	-	Pt	^Patient	Set	
46594-8	Prior: grooming	Find	Pt	^Patient	Ord	OASIS
46595-5	Current: grooming	Find	Pt	^Patient	Ord	OASIS
46479-2	Ability to dress upper body	-	Pt	^Patient	Set	
46596-3	Prior: dress upper body	Find	Pt	^Patient	Ord	OASIS
46597-1	Current: dress upper body	Find	Pt	^Patient	Ord	OASIS
46480-0	Ability to dress lower body	-	Pt	^Patient	Set	
46598-9	Prior: dress lower body	Find	Pt	^Patient	Ord	OASIS
46599-7	Current: dress lower body	Find	Pt	^Patient	Ord	OASIS
46606-0	Bathing ability	-	Pt	^Patient	Set	
46600-3	Prior: bathing	Find	Pt	^Patient	Ord	OASIS
46601-1	Current: bathing	Find	Pt	^Patient	Ord	OASIS
46481-8	Toileting	-	Pt	^Patient	Set	
46602-9	Prior: toileting	Find	Pt	^Patient	Ord	OASIS
46603-7	Current: toileting	Find	Pt	^Patient	Ord	OASIS
46482-6	Transferring	-	Pt	^Patient	Set	
46604-5	Prior: transferring	Find	Pt	^Patient	Ord	OASIS
46605-2	Current: transferring	Find	Pt	^Patient	Ord	OASIS
46483-4	Locomotion	-	Pt	^Patient	Set	
46554-2	Prior: ambulation	Find	Pt	^Patient	Ord	OASIS
46555-9	Current: ambulation	Find	Pt	^Patient	Ord	OASIS
46484-2	Feeding or eating	-	Pt	^Patient	Set	
46556-7	Prior: feeding	Find	Pt	^Patient	Ord	OASIS
46557-5	Current: feeding	Find	Pt	^Patient	Ord	OASIS
46485-9	Planning & preparing light meals	-	Pt	^Patient	Set	
46558-3	Prior: prepare light meals	Find	Pt	^Patient	Ord	OASIS
46559-1	Current: prepare light meals	Find	Pt	^Patient	Ord	OASIS
46486-7	Transportation	-	Pt	^Patient	Set	
46560-9	Prior: transportation	Find	Pt	^Patient	Ord	OASIS
46561-7	Current: transportation	Find	Pt	^Patient	Ord	OASIS
46487-5	Laundry	-	Pt	^Patient	Set	
46562-5	Prior: laundry	Find	Pt	^Patient	Ord	OASIS
46563-3	Current: laundry	Find	Pt	^Patient	Ord	OASIS

46488-3	Housekeeping	-	Pt	^Patient	Set	
46564-1	Prior: housekeeping	Find	Pt	^Patient	Ord	OASIS
46565-8	Current: housekeeping	Find	Pt	^Patient	Ord	OASIS
46489-1	Shopping	-	Pt	^Patient	Set	
46566-6	Prior: shopping	Find	Pt	^Patient	Ord	OASIS
46567-4	Current: shopping	Find	Pt	^Patient	Ord	OASIS
46490-9	Ability to use telephone	-	Pt	^Patient	Set	
46568-2	Prior: telephone use	Find	Pt	^Patient	Ord	OASIS
46569-0	Current: telephone use	Find	Pt	^Patient	Ord	OASIS
46491-7	Management of oral medications	-	Pt	^Patient	Set	
46570-8	Prior: management of oral medications	Find	Pt	^Patient	Ord	OASIS
46571-6	Current: management of oral medications	Find	Pt	^Patient	Ord	OASIS
46492-5	Management of inhalant/Mist medications	-	Pt	^Patient	Set	
46572-4	Prior: management of inhalant medications	Find	Pt	^Patient	Ord	OASIS
46573-2	Current: management of inhalant medications	Find	Pt	^Patient	Ord	OASIS
46574-0	Prior: management of injectable medications	Find	Pt	^Patient	Ord	OASIS
46575-7	Current: management of injectable medications	Find	Pt	^Patient	Ord	OASIS
46576-5	Management of equipment	Find	Pt	^Patient	Ord	OASIS
46577-3	Management of equipment	Find	Pt	^Caregiver	Ord	OASIS
46583-1	Therapy need	Find	Pt	^Patient	Ord	OASIS
46461-0	Emergent care	Find	Pt	^Patient	Nom	OASIS
46474-3	Emergent care reason	Find	Pt	^Patient	Nom	OASIS
46578-1	Inpatient facility	Type	Pt	^Patient	Nom	OASIS
46579-9	Discharge disposition	Find	Pt	^Patient	Nom	OASIS
46475-0	Discharge support services or assistance	Find	Pt	^Patient	Nom	OASIS
46580-7	Acute care hospitalization reason	Find	Pt	^Patient	Ord	OASIS
46476-8	Reason for hospitalization	Find	Pt	^Patient	Nom	OASIS
46477-6	Reason for nursing home admission	Find	Pt	^Patient	Nom	OASIS
46581-5	Date of last home visit	TmStp	Pt	^Patient	Qn	OASIS
46582-3	Discharge, transfer, death date	TmStp	Pt	^Patient	Qn	OASIS

PANEL CHILDREN WITH FULL DETAILS

	LOINC Name								
LOINC#	**Component**	**Property**	**Time**	**System**	**Scale**	**Method**	**Submitters Code**	**Datatype**	**R/O**
46462-8	Outcome and assessment information set (OASIS) form	-	Pt	^Patient	Set				

DEFINITION/DESCRIPTION: The OASIS is a core set of screening and assessment elements, including standardized definitions and coding categories that form the foundation of the comprehensive assessment for all clients of home health agencies certified to participate in the Medicare or Medicaid program.

46456-0	Agency medicare provider number	ID	Pt	Provider	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0010] Agency Provider Number

Instructions:
Definition:
Agency's Medicare Provider Number

Time Points Item(s) Completed:
All

Response-Specific Instructions:
Enter the agency's Medicare provider number, if applicable. If agency is not a Medicare provider, leave blank.

Assessment Strategies:
Agency administrator and billing staff can provide this information. This number may be preprinted on clinical documentation (recommended).

46493-3	Agency medicaid provider number	ID	Pt	Provider	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0012] Agency Medicaid Provider Number

Instructions:
Definition:
Agency's Medicaid Provider Number

Time Points Item(s) Completed:
All

Response-Specific Instructions:
Enter the agency's Medicaid provider number, if applicable. If agency is not a Medicaid provider, leave blank. If there are fewer digits than spaces provided, leave spaces at the end blank.

Assessment Strategies:
Agency administrator and billing staff can provide this information. This number may be preprinted on your clinical documentation (recommended).

46494-1	State location of agency branch	Loc	Pt	Agency	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0014] Branch State

Instructions:
Definition:
The state where the agency branch office is located. This item is optional, to be used at the discretion of the agency.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
Enter the two-letter postal service abbreviation of the state in which the branch office is located. Leave blank if your agency has no branches, all branches are located in the same state, or you elect not to use this item.

Assessment Strategies:
Agency or branch administrator can provide this information.

46495-8	Branch number	ID	Pt	Agency	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0016] Branch ID

Instructions:
Definition:
Branch identification code, as defined by the agency (currently) or assigned by the Centers for Medicare & Medicaid Services (CMS). Federal branch ID numbers are expected to be assigned by CMS in the future. Currently, any combination of numeric and/or alphabetic characters may be used for this code. When assigned by CMS, the identifier will consist of 10 digits -- the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.

Time Points Item(s) Completed:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

Response-Specific Instructions:
Prior to 01/01/2004, enter a branch identification code as defined by your agency. Leave blank if your agency has no branches or elects not to designate this location. If the agency code has fewer digits than spaces provided, leave spaces at the end blank.

Starting 01/01/2004, enter the Federal branch identification number specified for this branch as assigned by CMS. Leave blank if your agency has no branches. Until the Federal branch identification number is assigned, agencies may choose to enter a branch identification code as defined by the agency. If the agency code has fewer digits than spaces provided, leave spaces at the end blank.

Assessment Strategies:
Agency or branch administrator can provide this information.

46496-6	Patient number	ID	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0020] Patient ID Number

Instructions:
Definition:
Agency-specific patient identifier. This is the identification code the agency assigns to the patient and uses for record keeping purposes for this episode of care.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
- The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (e.g., from admission to discharge).
- If there are fewer digits than spaces provided, leave spaces at the end blank.

Assessment Strategies:
Agency medical records department is the usual source of this number.

46497-4	Start of care date	TmStp	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
[M0030] Start of Care Date

Instructions:
Definition:
The date that care begins. When the first reimbursable service is delivered, this is the start of care.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- In multidiscipline cases, agency policy will establish which discipline's visit is considered the start of care.
- Accuracy of this date is essential; many other aspects of data collection are based on this date.

Assessment Strategies:
If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

46498-2	Resumption of care date	TmStp	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
[M0032] Resumption of Care Date

Instructions:
Definition:
The date of the first visit following an inpatient stay by a patient currently receiving service from the home health agency.

Time Points Item(s) Completed:
All

Item must be answered at all time points. Once a resumption of care date has been entered, a date must continue to be entered throughout the entire episode of care.

Response-Specific Instructions:
- If there has not been a resumption of care following an inpatient stay, mark "NA."
- The most recent resumption of care should be entered.
- Agencies who always discharge patients when they are admitted to an inpatient facility will not have a resumption of care date. These agencies must consistently mark the "NA" response.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

Assessment Strategies:
If question exists as to the resumption of care date, clarify with the agency administrative staff.

45965-1	Name	-	Pt	^Patient	Set		
45394-4	Last name	Pn	Pt	^Patient	Nom	AA1c	TX

RELEVANCE EQUATION: 1

45392-8	First name	Pn	Pt	^Patient	Nom	AA1a	TX

RELEVANCE EQUATION: 1

45393-6	Middle initial	ID	Pt	^Patient	Nom	AA1b	TX

RELEVANCE EQUATION: 1

45395-1	Name suffix	Pn	Pt	^Patient	Nom	AA1d	TX

RELEVANCE EQUATION: 1

46499-0	State of residence	Loc	Pt	^Patient	Nom	OASIS	

DEFINITION/DESCRIPTION: Question:
[M0050] Patient State of Residence

Instructions:
Definition:
The state in which the patient is currently residing while receiving home care.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
Enter the two-letter postal service abbreviation of the state in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence.

Assessment Strategies:
Clarify the exact (state) location of the residence with municipal, county, or state officials, if necessary.

45401-7	ZIP code	Loc	Pt	^Patient	Nom	AB4	TX

CONSISTENCY CHECKS: 1. For the RECTYPEs listed as facility option, the field may be submitted under the optional submission provision given in the Section AB General Notes.

RELEVANCE EQUATION: 1

45397-7	Medicare or comparable number	ID	Pt	^Patient	Nom	AA5b	TX

CONSISTENCY CHECKS: *1. See AA5a consistency note #1.

*2. If the first character is numeric, then the first 9 characters must be digits (0-9).

*3 If the first character is a C, it must be at least 2 characters long (the C and one or more other characters).

*4. If the first character is a letter, but not a C, then there must 1-3 alphabetic characters followed by 6 or 9 numbers followed by spaces up to the field length of 12.

RELEVANCE EQUATION: 1

45396-9	Social security number	ID	Pt	^Patient	Nom	AA5a	TX

CONSISTENCY CHECKS: *1. On a Medicare PPS assessment (AA8b = 1,2,3,4,5,7, or 8), either an SSN (AA5a) or a Medicare number or comparable railroad insurance number (AA5b) must be present. Any Medicare PPS assessment (AA8b = 1,2,3,4,5,7, or 8) is rejected if both of the following conditions occur:
a. The SSN (AA5a) is missing with a blank value of sp(9) or an "unable to determine" value of -(9).

AND
b. The resident Medicare number or comparable railroad insurance number (AA5b) is missing with a blank value of sp(9) or an "unable to determine" value of -(9).

*2. Value must be 9 digits, 9 dashes (unable to determine), or 9 spaces (blank). Value cannot start with 000. Value cannot be 111111111, 333333333, or 123456789.

RELEVANCE EQUATION: 1

45400-9	Medicaid number	ID	Pt	^Patient	Nom	AA7	TX

RELEVANCE EQUATION: 1

21112-8	Birth date	TmStp	Pt	^Patient	Qn	AA3	DT

DEFINITION/DESCRIPTION: Coding: Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 1918 should be entered as:

01/02/1918 (Month/Day/Year)

CONSISTENCY CHECKS: *1. This date must be earlier than or the same as all of following dates that are present in the record (not blank): P_REC_DT, AT6, AB1, AB11, A3a, A4a, R2b, R4, VB2, and VB4. This date must also be earlier than or the same as the current date.

*2. The birthdate (AA3) cannot be more than 140 years earlier than the assessment reference date (A3a).

RELEVANCE EQUATION: 1

46607-8	Gender	Type	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0069) Gender

Instructions:
Definition:
The gender of the patient.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
N/A

Assessment Strategies:
Observation or interview.

ANSWER LIST: Gender / OASIS_M0069

SEQ#	Answer	Global ID	Code	System
1	Male		1	
2	Female		2	

46608-6 Primary referring physician ID ID Pt Provider Nom

DEFINITION/DESCRIPTION: Question:
(M0072) Primary Referring Physician ID (UPIN)

Instructions:
Definition:
The 6-digit UPIN number.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
- Write the 6 digits of the UPIN number. Leave spaces at the end blank if not needed.
- Mark "UK-Unknown or Not Available" if UPIN number is not available.
- This is the same number utilized for Medicare claims information.

Assessment Strategies:
Obtain physician ID number from physician, medical office, or other provider location.

46500-5 Discipline of person completing assessment Type Pt Provider Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0080] Discipline of Person Completing Assessment

Instructions:
Definition:
Identifies the discipline of the clinician completing the comprehensive assessment at the specified time points or the clinician reporting the transfer to an inpatient facility, death at home, or discharge (no further visits after start of care).

Time Points Item(s) Completed:
All

Response-Specific Instructions:
Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, only one actually completes and records the assessment.

Assessment Strategies:
The OASIS data set is designed to be discipline neutral in the wording of the items. An RN, PT, SLP, or OT may complete the assessment at any of the timepoints. The skilled provider must perform the comprehensive assessment during an actual visit to the patient's home and may

not rely on a phone interview with the patient/caregiver or other health care providers.

The only exceptions to this requirement for being " in the physical presence of the patient" are the OASIS data provided for Transfer to an Inpatient Facility (with or without agency discharge), Death at Home, and Discharge (no further visits after SOC). See information on M0100 - Reason for Assessment, Responses 6, 7, 8, and 10, for additional clarification.

ANSWER LIST: Discipline of Person Completing Assessment / OASIS_M0080

SEQ#	Answer	Global ID	Code	System
1	RN		1	
2	PT		2	
3	SLP/ST		3	
4	OT		4	

46501-3 Date assessment information completed TmStp Pt ^Patient Qn OASIS

DEFINITION/DESCRIPTION: Question:
[M0090] Date Assessment Completed

Instructions:
Definition:
The actual date the assessment is completed. If agency policy allows assessments to be performed over more than one visit date, the last date (when the assessment is finished) is the appropriate date to record.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- For four of the responses to M0100 (Transfer to Inpatient Facility- patient not discharged from agency; Transfer to Inpatient Facility - patient discharged from agency; Death at Home; Discharge from Agency- no visits completed after start/resumption of care assessment), record the date the agency learns of the event, as a visit is not necessarily associated with these events. See information on M0100- Reason for Assessment for additional clarification.

Assessment Strategies:
Note today's date.

46502-1 Reason for assessment Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0100] This Assessment is Currently Being Completed for the Following Reason

Instructions:
Definition:
Identifies the reason why the assessment data are being collected and reported. Accurate recording of this response is important as the data

reporting software will accept or reject certain data according to the specific response that has been selected for this item.

Time Points Item(s) Completed:
All

Response-Specific Instructions:
- Mark only one response.
- Response 1 - This is the start of care comprehensive assessment. A plan of care is being established, and further visits are planned.
- Response 2 - This is the first visit; a comprehensive assessment is performed. However, no additional visits will be made. Mark this response if the original order is for a 1- time visit only. No additional data will be provided on this patient, as no plan of care is established (e.g., a subsequent discharge assessment is not expected).
- Response 3 - The comprehensive assessment is being conducted when the patient resumes care following an inpatient stay of 24 hours or longer.
- Response 4 - The comprehensive assessment is being conducted during the last five days of the certification period.
- Response 5 - The comprehensive assessment is conducted due to a significant change in patient condition at a time other than during the last five days of the certification period. This assessment is done to update the patient's care plan.
- Response 6 - Data regarding the patient's transfer to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) are reported. The patient is expected to resume care and is not discharged from the agency. When the patient resumes care, a Resumption of Care comprehensive assessment is conducted. Note the "skip pattern" included in the response. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items.
- Response 7 - Data regarding the patient's transfer to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) are reported. The patient is discharged from the agency. Note the "skip pattern" included in the response. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items.
- Response 8 - Data regarding patient death other than death in an inpatient facility. A patient who dies before being admitted to an inpatient facility would have this response marked. Note the "skip pattern" included in the response. A home visit is not required to mark this response; a telephone call may provide the information necessary to complete the data items.
- Response 9 - The comprehensive assessment is being conducted at the patient's discharge from the agency. This discharge is not occurring due to an inpatient facility admission or patient death. An actual patient interaction is required to complete this assessment. Note the "skip pattern" present in the response.
- Response 10 - This response is marked in the event of an unusual occurrence. The agency visits the patient at start (or resumption) of care and establishes a plan of care. However, before another skilled visit is made, the patient is discharged. (For example, a family member may move the patient to another location.) This response is not marked at the same time as Response 2; this situation is very different. Note the "skip pattern" included in the response. This response should not be used if the patient is transferred to an inpatient facility or dies at home.

Assessment Strategies:
Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

ANSWER LIST: Reason for Assessment / OASIS_M0100

SEQ#	Answer	Global ID	Code	System
1	Start of care - further visits planned		1	
2	Start of care - no further visits planned		2	
3	Resumption of care (after inpatient stay)		3	
4	Recertification (follow-up) reassessment		4	

5	Other follow-up	5
6	Transferred to an inpatient facility - patient not discharged from agency	6
7	Transferred to an inpatient facility - patient discharged from agency	7
8	Death at home	8
9	Discharge from agency	9
10	Discharge from agency - no visits completed after start/resumption of care assessment	10

46463-6 Race or ethnicity Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0140] Race/Ethnicity (as identified by patient) - (Mark all that apply.)

Instructions:
Definition:
The groups or populations to which the patient is affiliated, as identified by the patient or caregiver.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- Response 1 - American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Response 2 - Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Response 3 - Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- Response 4 - Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- Response 5 - Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Response 6 - White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Assessment Strategies:
Interview patient/caregiver. The patient may self-identify with more than one group; mark all that are noted.

ANSWER LIST: Race/Ethnicity: White / OASIS_M0140

SEQ#	Answer	Global ID	Code	System
1	American Indian or Alaska Native		1	
2	Asian		2	
3	Black or African-American		3	
4	Hispanic or Latino		4	
5	Native Hawaiian or Pacific Islander		5	
6	White		6	

7	Unknown	UK

46464-4	Current payment sources for home care	Find	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0150] Current Payment Sources for Home Care - (Mark all that apply.)

Instructions:
Definition:
Identifies payers to which any services provided during this home care episode are being billed. Accurate recording of this item is important because assessments for Medicare and Medicaid patients are handled differently upon submission than assessments for patients who do not have Medicare or Medicaid as a payment source. If patient is receiving care from multiple payers (e.g., Medicare and Medicaid; private insurance and self-pay; etc.), include all sources. Include "pending" payment sources if it is reasonably likely that they will provide payment during the episode.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- "Unknown" response option is only available at start of care (or resumption of care) and should be selected only if payment source is totally unknown at this time.
- If one or more payment sources are known but additional sources are uncertain, mark those that are reasonably certain.

Assessment Strategies:
Referral source may provide information regarding coverage. This can be verified with patient/ caregiver. Ask patient/caregiver to provide copy of card(s) for any insurance or Medicare coverage. This card will provide the patient ID number as well as current status of coverage. The agency billing office may also have this information.

ANSWER LIST: Current Payment Sources: Other / OASIS_M0150

SEQ#	Answer	Global ID	Code	System
1	None, no charge for current services		0	
2	Medicare (traditional fee-for-service)		1	
3	Medicare (HMO/managed care)		2	
4	Medicaid (traditional fee-for-service)		3	
5	Medicaid (HMO/managed care)		4	
6	Workers' compensation		5	
7	Title programs (e.g., Title III, V, or XX)		6	
8	Other government (e.g., CHAMPUS, VA, etc.)		7	
9	Private insurance		8	
10	Private HMO/managed care		9	
11	Self-pay		10	

12	Other (specify)	11
13	Unknown	UK

46457-8	Inpatient discharge facility	Type	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0175] From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.)

Instructions:
Definition:
Identifies whether the patient has recently (within past 14 days) been discharged from an inpatient facility. (Past 14 days encompasses the two-week period immediately preceding the start of care/resumption of care.)

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- Rehabilitation facility is a certified rehab unit of a skilled nursing facility or a freestanding rehab hospital.
- Nursing home includes both skilled nursing facilities (SNF) and intermediate care facilities (ICF).
- Mark all that apply. Patient may have been discharged from both a hospital and a rehab facility within the past 14 days, for example.

Assessment Strategies:
Information can be obtained from patient/caregiver or physician's office.

NOTE: M0175 replaces M0170 with the OASIS 1.10 Data Specification.

ANSWER LIST: Past 14 Days: Discharged from Other / OASIS_M0175

SEQ#	Answer	Global ID	Code	System
1	Hospital		1	
2	Rehabilitation facility		2	
3	Skilled Nursing Facility		3	
4	Other nursing home		4	
5	Other (specify)		5	
6	Patient was not discharged from an inpatient facility		NA	

46503-9	Most recent inpatient discharge date	TmStp	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
[M0180] Inpatient Discharge Date (most recent)

Instructions:
Definition:
Identifies the date of the most recent discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

Assessment Strategies:
Obtain information from patient, caregiver, or referring physician.

46458-6	Inpatient facililty diagnoses	-	Pt	^Patient	Set	

46504-7	Inpatient stay within last 14 days: ICD code	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[MO190] a. ICD

Instructions:
Definition:
Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- Include only those diagnoses that required treatment during the inpatient stay. If a diagnosis was not treated during an inpatient admission, do not list it. (Example - The patient has a long-standing diagnosis of "osteoarthritis," but was hospitalized for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.)
- This is the diagnosis for which the patient received treatment, not necessarily the hospital admitting diagnosis (though it can be the same).
- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V-codes. List the underlying diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Obtain information from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46505-4	Inpatient stay within last 14 days: ICD code^^^2	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0190] b. ICD

Instructions:
Definition:
Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- Include only those diagnoses that required treatment during the inpatient stay. If a diagnosis was not treated during an inpatient admission, do not list it. (Example - The patient has a long-standing diagnosis of "osteoarthritis," but was hospitalized for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.)
- This is the diagnosis for which the patient received treatment, not necessarily the hospital admitting diagnosis (though it can be the same).
- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V-codes. List the underlying diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Obtain information from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46506-2	Medical or treatment regimen change in past 14 days	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0200] Medical or Treatment Regimen Change Within the last 14 days - Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?

Instructions:
Definition:
Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an old diagnosis within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the follow-up/discharge visit].)

Time Points Item(s) Completed:
- Start of care

- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
N/A

Assessment Strategies:
Obtain information from patient, caregiver, or referring physician.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46459-4	Changed medical regimen diagnoses	-	Pt	^Patient	Set		

46507-0	Regimen change in past 14 days: ICD code 1	Prid	Pt	^Patient	Nom	OASIS	

DEFINITION/DESCRIPTION: Question:
[M0210] a. ICD

Instructions:
Definition:
Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment, regimen, health care services received, or medication within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the follow-up/discharge visit].)

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Can be a new diagnosis or an exacerbation to an existing condition.
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the appropriate diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.
- Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.

Assessment Strategies:
Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46508-8	Regimen change in past 14 days: ICD code^^^2	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0210] b. ICD

Instructions:
Definition:
Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment, regimen, health care services received, or medication within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the follow-up/discharge visit].)

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Can be a new diagnosis or an exacerbation to an existing condition.
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the appropriate diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.
- Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.

Assessment Strategies:
Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46509-6	Regimen change in past 14 days: ICD code^^^3	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0210] c. ICD

Instructions:
Definition:
Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment, regimen, health care services received, or medication within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the follow-up/discharge visit].)

Time Points Item(s) Completed:

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Can be a new diagnosis or an exacerbation to an existing condition.
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the appropriate diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.
- Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.

Assessment Strategies:
Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46510-4	Regimen change in past 14 days: ICD code ^^^4	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0210] d. ICD

Instructions:
Definition:
Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment, regimen, health care services received, or medication within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the follow-up/discharge visit].)

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Can be a new diagnosis or an exacerbation to an existing condition.
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the appropriate diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.
- Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.

Assessment Strategies:

Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46465-1	Conditions prior to medical or treatment regimen change or inpatient stay within past 14 days	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0220) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days - (Mark all that apply.)

Instructions:
Definition:
Identifies existence of condition(s) prior to medical regimen change or inpatient stay within 14 days of start of care. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the follow-up/discharge visit].)

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Mark "NA" if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be correct.

Assessment Strategies:
Interview patient/caregiver to obtain past health history. Additional information may be obtained from the physician. Determine any conditions existing before the inpatient facility stay or before the change in medical or treatment regimen.

ANSWER LIST: Prior Condition: No Inpatient Discharge, No Change in Regimen in Past 14 Days / OASIS_M0220

SEQ#	Answer	Global ID	Code	System
1	Urinary incontinence		1	
2	Indwelling/suprapubic catheter		2	
3	Intractable pain		3	
4	Impaired decision-making		4	
5	Disruptive or socially inappropriate behavior		5	
6	Memory loss to the extent that supervision required		6	
7	None of the above		7	
8	No inpatient facility discharge AND no change in medical/treatment regimen in past 14 days		NA	
9	Unknown		UK	

46609-4	Diagnosis and severity index	-	Pt	^Patient	Set	

DEFINITION/DESCRIPTION: Question:

(M0230/M0240) Diagnoses and Severity Index

Instructions:
Diagnoses and Severity Index - List each medical diagnosis or problem for which the patient is receiving home care and ICD code category (three digits required; five digits optional - no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.)

46511-2	Primary diagnosis ICD code	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0230] a. Primary Diagnosis - ICD Code

Instructions:
Definition:
- Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity. The primary diagnosis (M0230) should be the condition that is the chief reason for providing home care.
- A case mix diagnosis is a primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological, or burns/trauma group for Medicare PPS case mix assignment. The Final Regulation for home health prospective payment, July 3, 2000, includes the case mix diagnoses and is found at this site: http://www.cms.hhs.gov/providers/hhapps/hhppsfr.asp

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- No surgical codes.
- V codes can be reported in M0230. Enter V, followed by a two-digit number, decimal point, and enter any additional digits specified in the ICD-9-CM coding manual. (Remember to complete M0245 if the V code replaces a case mix diagnosis. Please see Assessment Strategies.)
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

V codes cannot be used in case mix group assignment. Effective October 1, 2003, if a provider reports a V code in M0230 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0245.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46512-0	Primary diagnosis severity rating	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Severity Rating

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the relevant diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/ treatments have been poorly controlled in the recent past. The current ICD-9-CM code book should be the source for coding.

Assessing severity includes review of presenting signs and symptoms, type, and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

ANSWER LIST: Other Diagnosis 5: Severity Rating / OASIS_M0230_PRIMARY_DIAG_SEVERITY

SEQ#	Answer	Global ID	Code	System
1	0		0	
2	1		1	
3	2		2	
4	3		3	
5	4		4	

46513-8	Other diagnosis 1: ICD code	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0240] b. Other Diagnosis - ICD Code

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes can be reported in M0240(b) through (f). Leave the first space blank, enter V, followed by a two-digit number, decimal point, and any additional digits specified in the ICD-9-CM coding manual.
- E codes may be reported in M0240(b) through (f) only. Enter E followed by the three-digit number, decimal point, and fourth-digit number, as specified. If an E code is reported, do not rate its severity.
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46514-6	Other diagnosis 1: severity rating	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Severity Rating

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the relevant diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/ treatments have been poorly controlled in the recent past. The current ICD-9-CM code book should be the source for coding.

Assessing severity includes review of presenting signs and symptoms, type, and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

ANSWER LIST: Other Diagnosis 5: Severity Rating / OASIS_M0230_PRIMARY_DIAG_SEVERITY

SEQ#	Answer	Global ID	Code	System
1	0		0	
2	1		1	
3	2		2	
4	3		3	
5	4		4	

46515-3 Other diagnosis 2: ICD code Prid Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
c. Other Diagnosis - ICD Code

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes can be reported in M0240(b) through (f). Leave the first space blank, enter V, followed by a two-digit number, decimal point, and

any additional digits specified in the ICD-9-CM coding manual.
- E codes may be reported in M0240(b) through (f) only. Enter E followed by the three-digit number, decimal point, and fourth-digit number, as specified. If an E code is reported, do not rate its severity.
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46516-1	Other diagnosis 2: severity rating	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Severity Rating

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the relevant diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/ treatments have been poorly

controlled in the recent past. The current ICD-9-CM code book should be the source for coding.

Assessing severity includes review of presenting signs and symptoms, type, and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

ANSWER LIST: Other Diagnosis 5: Severity Rating / OASIS_M0230_PRIMARY_DIAG_SEVERITY

SEQ#	Answer	Global ID	Code	System
1	0		0	
2	1		1	
3	2		2	
4	3		3	
5	4		4	

46517-9 Other diagnosis 3: ICD code Prid Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
d. Other Diagnosis - ICD Code

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes can be reported in M0240(b) through (f). Leave the first space blank, enter V, followed by a two-digit number, decimal point, and any additional digits specified in the ICD-9-CM coding manual.
- E codes may be reported in M0240(b) through (f) only. Enter E followed by the three-digit number, decimal point, and fourth-digit number, as specified. If an E code is reported, do not rate its severity.
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46518-7	Other diagnosis 3: severity rating	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Severity Rating

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the relevant diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/ treatments have been poorly controlled in the recent past. The current ICD-9-CM code book should be the source for coding.

Assessing severity includes review of presenting signs and symptoms, type, and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

ANSWER LIST: Other Diagnosis 5: Severity Rating / OASIS_M0230_PRIMARY_DIAG_SEVERITY

SEQ#	Answer	Global ID	Code	System
1	0		0	
2	1		1	
3	2		2	
4	3		3	
5	4		4	

46519-5	Other diagnosis 4: ICD code	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
e. Other Diagnosis - ICD Code

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes can be reported in M0240(b) through (f). Leave the first space blank, enter V, followed by a two-digit number, decimal point, and any additional digits specified in the ICD-9-CM coding manual.
- E codes may be reported in M0240(b) through (f) only. Enter E followed by the three-digit number, decimal point, and fourth-digit number, as specified. If an E code is reported, do not rate its severity.
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46520-3	Other diagnosis 4: severity rating	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Severity Rating

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the relevant diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/ treatments have been poorly controlled in the recent past. The current ICD-9-CM code book should be the source for coding.

Assessing severity includes review of presenting signs and symptoms, type, and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

ANSWER LIST: Other Diagnosis 5: Severity Rating / OASIS_M0230_PRIMARY_DIAG_SEVERITY

SEQ#	Answer	Global ID	Code	System
1	0		0	
2	1		1	
3	2		2	
4	3		3	
5	4		4	

46521-1 Other diagnosis 5: ICD code Prid Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
f. Other Diagnosis - ICD Code

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes can be reported in M0240(b) through (f). Leave the first space blank, enter V, followed by a two-digit number, decimal point, and

any additional digits specified in the ICD-9-CM coding manual.
- E codes may be reported in M0240(b) through (f) only. Enter E followed by the three-digit number, decimal point, and fourth-digit number, as specified. If an E code is reported, do not rate its severity.
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46522-9	Other diagnosis 5: severity rating	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Severity Rating

Instructions:
Definition:
Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- No surgical codes - list the underlying diagnosis.
- No V-codes - list the relevant diagnosis.
- Three-digit code required; digits to the right of the decimal are optional.

Assessment Strategies:
Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/ treatments have been poorly

controlled in the recent past. The current ICD-9-CM code book should be the source for coding.

Assessing severity includes review of presenting signs and symptoms, type, and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

ANSWER LIST: Other Diagnosis 5: Severity Rating / OASIS_M0230_PRIMARY_DIAG_SEVERITY

SEQ#	Answer	Global ID	Code	System
1	0		0	
2	1		1	
3	2		2	
4	3		3	
5	4		4	

46610-2	Payment diagnosis	-	Pt	^Patient	Set	

46584-9	Payment diagnosis: primary ICD	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
a. Primary ICD Code
Instructions:
Definition:
A case mix diagnosis is a primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological, or burns/trauma group for Medicare PPS case mix adjustment. A case mix diagnosis may involve manifestation coding.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes and E codes may not be entered in M0245 (a) or (b) as these pertain to the Medicare PPS case mix diagnosis only.
- Complete M0245 only if a V code has been reported in place of a case mix diagnosis in M0230.
- Do not complete M0245 if a V code has not been reported in M0230 in place of a case mix diagnosis.

Assessment Strategies:
Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions:

a. No surgical codes -- list the underlying diagnosis.
b. No V codes or E codes -- list the relevant medical diagnosis.
c. If the patient's primary home care diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0245 (a) and the manifestation code should be entered in M0245 (b).
d. You can refer to CMS Guidelines for selecting a diagnosis under PPS at: www.cms.hhs.gov/prodocs/hhdiag.pdf.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46585-6	Payment diagnosis: first secondary ICD	Prid	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
b. First Secondary ICD
Instructions:
Definition:
A case mix diagnosis is a primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological, or burns/trauma group for Medicare PPS case mix adjustment. A case mix diagnosis may involve manifestation coding.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

Response-Specific Instructions:
- V codes and E codes may not be entered in M0245 (a) or (b) as these pertain to the Medicare PPS case mix diagnosis only.
- Complete M0245 only if a V code has been reported in place of a case mix diagnosis in M0230.
- Do not complete M0245 if a V code has not been reported in M0230 in place of a case mix diagnosis.

Assessment Strategies:
Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions:

a. No surgical codes -- list the underlying diagnosis.
b. No V codes or E codes -- list the relevant medical diagnosis.
c. If the patient's primary home care diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0245 (a) and the manifestation code should be entered in M0245 (b).
d. You can refer to CMS Guidelines for selecting a diagnosis under PPS at: www.cms.hhs.gov/prodocs/hhdiag.pdf.

ANSWER LIST: International Classification of Diseases, Ninth Revision, Clinical Modification / ICD-9-CM

46466-9	At home therapies	Find	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
(M0250) Therapies the patient receives at home - (Mark all that apply.)

Instructions:
Definition:
Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Include only such therapies administered at home. Exclude similar therapies administered in outpatient facilities.
- If the patient will receive such therapy as a result of this assessment (e.g., the IV will be started at this visit; the physician will be contacted for an enteral nutrition order; etc.), mark the appropriate response.

Assessment Strategies:
Determine from patient/caregiver interview, nutritional assessment, review of past health history, and referral orders. Assessment of hydration status or nutritional status may result in an order for such therapy (therapies).

ANSWER LIST: Therapies Received at Home: Enteral Nutrition / OASIS_M0250

SEQ#	Answer	Global ID	Code	System
1	Intravenous or infusion therapy (excludes TPN)		1	
2	Parenteral nutrition (TPN or lipids)		2	
3	Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)		3	
4	None of the above		4	

46523-7	Overall prognosis for recovery from this episode	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0260) Overall Prognosis - BEST description of patient's overall prognosis for recovery from this episode of illness.

Instructions:
Definition:
Identifies the patient's expected overall prognosis for recovery at the start of this home care episode.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
Note that "Good" and "Fair" are both included in Response 1.

Assessment Strategies:
Interview for past health history and observe current health status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding overall prognosis.

ANSWER LIST: Overall Prognosis for Recovery From This Episode / OASIS_M0260

SEQ#	Answer	Global ID	Code	System
1	Poor: little or no recovery is expected and/or further decline is imminent		0	
2	Good/Fair: partial to full recovery is expected		1	
3	Unknown		UK	

46524-5	Rehabilitative prognosis	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0270) Rehabilitative Prognosis - BEST description of patient's prognosis for functional status.

Instructions:
Definition:
Identifies the patient's expected prognosis for functional status improvement at the start of this episode of home care.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
N/A

Assessment Strategies:
Interview for past health history and observe the current functional status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding rehabilitative prognosis.

ANSWER LIST: Rehabilitative Prognosis / OASIS_M0270

SEQ#	Answer	Global ID	Code	System
1	Guarded: minimal improvement in functional status is expected, decline is possible		0	
2	Good: marked improvement in functional status is expected		1	
3	Unknown		UK	

46525-2 Life expectancy Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0280) Life Expectancy - (Physician documentation is not required.)

Instructions:
Definition:
Identifies those patients for whom life expectancy is fewer than 6 months.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
A "Do Not Resuscitate" order does not need to be in place.

Assessment Strategies:
Interview the patient/caregiver to obtain past health history. Observe current health status. Consider medical diagnosis and referring physician's expectations for patient. If the patient is frail and highly dependent on others, ask the family whether the physician has informed

them about life expectancy. Based on information received from these data sources, make informed judgment regarding life expectancy.

ANSWER LIST: Life Expectancy / OASIS_M0280

SEQ#	Answer	Global ID	Code	System
1	Life expectancy is greater than 6 months		0	
2	Life expectancy is 6 months or fewer		1	

46467-7 High risk factors Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0290] High Risk Factors characterizing this patient - (Mark all that apply.)

Instructions:
Definition:
Identifies specific factors that may exert a high impact on the patient's health status and ability to recover from this illness.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
Utilize agency assessment guidelines and informed professional decision-making. Consider amount and length of exposure when responding (e.g., smoking one cigarette a month may not be considered a high risk factor). Specific definitions for each of these factors do not exist.

Assessment Strategies:
Interview patient/caregiver for past health history. Observe environment and current health status.

ANSWER LIST: High Risk Factor: None of the Above / OASIS_M0290

SEQ#	Answer	Global ID	Code	System
1	Heavy smoking		1	
2	Obesity		2	
3	Alcohol dependency		3	
4	Drug dependency		4	
5	None of the above		5	
6	Unknown		UK	

46526-0 Current residence Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
(M0300) Current Residence

Instructions:
Definition:

Identifies where the patient is residing during the current home care episode (e.g., where the patient is receiving care).

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Response 1 - Dwelling considered to be the patient's own.
- Response 2 - Dwelling considered to belong to family member. Patient may be a temporary or permanent resident.
- Response 3 - Room rented in a larger dwelling. Patient's room may be the only one rented or one of many. No specific health-related services or supervision are provided, though meals can be included.
- Response 4 - Some care or health-related services are provided in conjunction with living quarters.

Assessment Strategies:
Observe the environment in which the visit is being conducted. Interview the patient/caregiver regarding others living in the residence, their relationship to the patient, and any services being provided.

ANSWER LIST: Current Residence / OASIS_M0300

SEQ#	Answer	Global ID	Code	System
1	Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)		1	
2	Family member's residence		2	
3	Boarding home or rented room		3	
4	Board and care or assisted living facility		4	
5	Other		5	

46468-5 Current living arrangement Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
(M0340) Patient Lives With - (Mark all that apply.)

Instructions:
Definition:
Identifies whomever the patient is living with at this time, even if the arrangement is temporary.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:

- "Other family member" could include in-laws, children, cousins, etc.
- "Paid help" would include help provided under a special program (e.g., Medicaid), even though the patient may not be directly paying for this help. Intermittent (e.g., a few hours each day, one - two days a week, etc.) paid help does not classify as help the patient "lives with."

Assessment Strategies:
This is information all agencies need to know in planning care and services. Try to incorporate this question into the conversation, so the patient does not feel an investigation is being conducted.

ANSWER LIST: Lives: With Paid Help / OASIS_M0340

SEQ#	Answer	Global ID	Code	System
1	Lives alone		1	
2	With spouse or significant other		2	
3	With other family member		3	
4	With a friend		4	
5	With paid help (other than home care agency staff)		5	
6	With other than above		6	

46469-3	Assisting person(s) other than home care agency staff	Find	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
(M0350) Assisting Person(s) Other than Home Care Agency Staff - (Mark all that apply.)

Instructions:
Definition:
Identifies the individuals who provide assistance to the patient (EXCLUDING the home care agency).

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Response 3 - Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment who provides assistance to the patient would be classified as paid help. A patient living in an assisted living facility receives assistance from paid help.
- If patient does not receive assistance from others, mark Response 4 - None of the above.

Assessment Strategies:
If the patient mentions a friend or relative helping or coming to visit, interview to find out more about who helps patient, how often, what helpers do, etc. (applies to MO360, MO370, MO380). In obtaining the health history, interview to determine whether ADL/IADL assistance is needed. If it is, request information on whether patient receives such assistance and from whom.

ANSWER LIST: Assisting Person: None / OASIS_M0350

SEQ#	Answer	Global ID	Code	System
1	Relatives, friends, or neighbors living outside the home		1	
2	Person residing in the home (EXCLUDING paid help)		2	
3	Paid help		3	
4	None of the above		4	
5	Unknown		UK	

46527-8	Primary caregiver	Find	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
(M0360) Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff)

Instructions:
Definition:
Identifies the person who is "in charge" of providing and coordinating the patient's care. A case manager hired to oversee care, but who does not provide any assistance is not considered the primary caregiver. This person may employ others to provide direct assistance, in which case "paid help" is considered the primary caregiver.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- If one person assumes lead responsibility for managing care, but another provides most frequent assistance, assess further to determine if one should be designated as primary caregiver or if Response 0 - No one person, is most appropriate.
- Response 5 - Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment who provides assistance to the patient would be classified as paid help.

Assessment Strategies:
From M0350, it is known that the patient receives assistance. Interview to determine whom the patient considers to be the primary caregiver. For example, ask, "Of the people who help you, is there one person who is 'in charge' of making sure things get done?" "Who would you call if you needed help or assistance?"

ANSWER LIST: Primary Caregiver / OASIS_M0360

SEQ#	Answer	Global ID	Code	System
1	No one person		0	
2	Spouse or significant other		1	
3	Daughter or son		2	
4	Other family member		3	
5	Friend or neighbor or community or church member		4	

6	Paid help	5
7	Unknown	UK

46528-6 Frequency of primary caregiver assistance Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0370) How Often does the patient receive assistance from the primary caregiver?

Instructions:
Definition:
Identifies the frequency of the help provided by the primary caregiver (identified in M0360).

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Responses are arranged in order of least to most assistance received from primary caregiver.
- This item is skipped if no primary caregiver.

Assessment Strategies:
Ask, in various ways, how often the primary caregiver provides various types of assistance (e.g., "How often does your daughter come by? Does she go shopping for you every week? When she is here, does she do the laundry?"). As you proceed through the assessment (particularly the ADLs and IADLs), several opportunities arise to learn details of the help the patient receives.

ANSWER LIST: Frequency of Primary Caregiver Assistance / OASIS_M0370

SEQ#	Answer	Global ID	Code	System
1	Several times during day and night		1	
2	Several times during day		2	
3	Once daily		3	
4	Three or more times per week		4	
5	One to two times per week		5	
6	Less often than weekly		6	
7	Unknown		UK	

46470-1 Type of primary caregiver assistance - Pt ^Patient Set

DEFINITION/DESCRIPTION: Question:
(M0380) Type of Primary Caregiver Assistance - (Mark all that apply.)

Instructions:
Definition:
Identifies categories of assistance provided by the primary caregiver (identified in M0360).

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Response 3 - Includes home repair and upkeep, mowing lawn, shoveling snow, and painting.
- Response 4 - Includes frequent visits or phone calls, going with patient for outings, church services, other events.
- Response 5 - Takes patient to medical appointments, follows up with filling prescriptions or making subsequent appointments, etc.
- Responses 6 and 7 - Legal arrangements that exist for finances or health care.

Assessment Strategies:
Interview questions about types of assistance are likely to produce answers that relate to ADLs and IADLs. More specific questions need to address other aspects of assistance. At start of care, discussion of advance directives can provide information about existing legal arrangements for decision-making.

ANSWER LIST: Type of Primary Caregiver Assistance: Health Care / OASIS_M0380

SEQ#	Answer	Global ID	Code	System
1	ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)		1	
2	IADL assistance (e.g., meds, meals, housekeeping, laundry, phone, shopping, finances)		2	
3	Environmental support (e.g., housing, home maintenance)		3	
4	Psychosocial support (e.g., socialization, companionship, recreation)		4	
5	Advocates or facilitates patient's participation in appropriate medical care		5	
6	Financial agent, power of attorney, or conservator of finance		6	
7	Health care agent, conservator of person, or medical power of attorney		7	
8	Unknown		UK	

46529-4	Sensory status: vision	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0390) Vision with corrective lenses if the patient usually wears them

Instructions:
Definition:
Identifies the patient's ability to see and visually manage within his/her environment, wearing corrective lenses if these are usually worn.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
- A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.

- "Nonresponsive" means that the patient is not able to respond.

Assessment Strategies:
In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to count fingers at arm's length and ability to differentiate between meds, especially if meds are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.

ANSWER LIST: Sensory Status: Vision / OASIS_M0390

SEQ#	Answer	Global ID	Code	System
1	Normal vision: sees adequately in most situations, can see medication labels, newsprint.		0	
2	Partially impaired: cannot see medication labels/newsprint, but CAN see obstacles in path, and surrounding layout, can count fingers at arm's length.		1	
3	Severely impaired: cannot locate objects without hearing or touching them OR patient nonresponsive.		2	

46530-2	Sensory status: hearing and ability to understand spoken language	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them)

Instructions:
Definition:
Identifies the patient's ability to hear and to understand spoken language, in the patient's primary language. Hearing is evaluated with the patient wearing aids if he/she usually uses them.

Time Points Item(s) Completed:
- Start of care
- Resumption of care

Response-Specific Instructions:
"Nonresponsive" means that the patient is not able to respond.

Assessment Strategies:
Interaction with the patient during the assessment process provides information to answer this item. Be alert to what is required to adequately communicate with the patient. If he/she uses a hearing appliance, be sure that it is in place, has a battery, and is turned on.
A patient whose primary language differs from the clinician's requires additional evaluation. Can a family member or friend interpret? Does the agency provide an interpreter? Is another clinician (who speaks the patient's primary language) available?

ANSWER LIST: Sensory Status: Hearing / OASIS_M0400

SEQ#	Answer	Global ID	Code	System
1	No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.		0	
2	W/ min difficulty, able to hear and understand most multi-step instructns and ordinary conversatn. May need occasional		1	

	repetition, xtra time or louder voice.	
3	Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation, needs frequent prompting or assistance.	2
4	Has severe difficulty hearing and understanding simple greetings and short comments. Requires mult repetitions, restatements, demonstrations, addtl time.	3
5	UNABLE to hear and understand familiar words or common expressions consistently, OR patient nonresponsive.	4

46531-0	Sensory status: speech and oral expression of language	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language)

Instructions:
Definition:
Identifies the patient's ability to communicate verbally (by mouth) in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- "Nonresponsive" means that the patient is not able to respond.
- Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?

Assessment Strategies:
Interaction with the patient during the assessment process provides information to answer this item. Patient responses to interview questions are evaluated to determine speaking ability.

ANSWER LIST: Sensory Status: Speech / OASIS_M0410

SEQ#	Answer	Global ID	Code	System
1	Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.		0	
2	Min diff in xpressing ideas/needs (may take xtra time, occasional errors in word choice/grammar/speech intelligibility, needs min prompting or assist).		1	
3	Xpresses simple ideas/needs w/moderate diff (needs prompting or assist, errors in word choice, org. or speech intell). Speaks in phrases/short sentcs.		2	
4	Has severe difficulty expressing basic ideas or needs and requires max assistance or guessing by listener. Speech limited to single words or short phrases.		3	

5	UNABLE to xpress basic needs even w/maximal prompting or assist but is not comatose/unresponsive (e.g., speech is nonsensical/unintelligible).	4
6	Patient nonresponsive or unable to speak.	5

46532-8 Sensory status: frequency of pain Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0420) Frequency of Pain interfering with the patient's activity or movement

Instructions:
Definition:
Identifies frequency with which pain interferes with patient's activities.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
Responses are arranged in order of least to most interference with activity or movement.

Assessment Strategies:
When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities, e.g., the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk.

Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain.

ANSWER LIST: Sensory Status: Frequency of Pain / OASIS_M0420

SEQ#	Answer	Global ID	Code	System
1	Patient has no pain or pain does not interfere with activity or movement		0	
2	Less often than daily		1	
3	Daily, but not constantly		2	
4	All of the time		3	

46533-6 Experiencing intractable pain Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0430) Is the patient experiencing pain that is not easily relieved, occurs at least daily, affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

Instructions:
Definition:

Identifies the presence of intractable pain, as defined in the item.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
N/A

Assessment Strategies:
Intractable pain is pain that is ever present, may make the patient more irritable or less tolerant of frustrations, awakens her/him at night, and makes it difficult to get back to sleep. It may cause the patient to refrain from participating in activities that have been an important part of life, because she/he knows the activity will increase the pain or that the pain will be so significant that he/she can no longer enjoy the activity. A patient who has intractable pain may express much frustration (e.g., crying or anger) at how the pain is interfering with life. As you assess the patient's medications and activities, elicit whether or not the patient's pain fits these descriptions. Ask the patient if the pain is present despite taking analgesic medication regularly as prescribed.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46534-4 Skin lesion or open wound Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0440) Does this patient have a Skin Lesion or an Open Wound? This excludes "OSTOMIES."

Instructions:
Definition:
Identifies the presence of a skin lesion or open wound. A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, ulcers, rashes, surgical incisions, crusts, etc. are all considered lesions. Other than lesions that end in "ostomy" (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites, all other alterations in skin integrity are considered to be lesions. Persistent redness without a break in the skin is considered a lesion.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- If the patient has any skin condition which should be observed and described, mark "Yes" to this item.
- OASIS only collects data on certain types of wounds but other wounds (e.g., burns, diabetic ulcers, gunshot wounds, etc.), should be

documented in a manner determined by each agency. You may mark "1 - Yes" to this item and correctly mark "No" to questions M0445 (Pressure Ulcer), M0468 (Stasis Ulcer), and M0482 (Surgical Wound), if the patient has a different type of wound.
- Pin sites, central lines, PIC lines, surgical wounds with staples or sutures, etc. are all considered lesions/ wounds.

Assessment Strategies:
Interview the patient to determine the existence of any known lesions. Follow by visual inspection of the skin. Inspection may reveal additional areas on which to focus interview questions.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46535-1	Pressure ulcer	Find	Pt	^Patient	Ord	OASIS	

DEFINITION/DESCRIPTION: Question:
(M0445) Does this patient have a Pressure Ulcer?

Instructions:
Definition:
Identifies the presence of a pressure ulcer, defined as skin inflammation, sore, or ulcer resulting from tissue hypoxia due to prolonged pressure. Pressure ulcers most often occur over bony prominences.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
Answer this question "Yes" if this patient has a pressure ulcer at any stage. Answer "No" if the patient's skin lesion is any other kind of ulcer or wound.

Assessment Strategies:
Interview for the presence of risk factors for pressure ulcers (i.e., mobility or activity limitations, skin moisture or incontinence, poor nutrition, limited sensory-perceptual ability). Inspect the skin over bony prominences carefully.

It is important to differentiate pressure ulcers from other types of skin lesions.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46460-2	Number of pressure ulcers at each stage	-	Pt	^Patient	Set	

46536-9	Number of pressure ulcers - stage 1	Num	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
a) Stage 1
Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.

Instructions:
Definition:
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle "0" for that stage.
- If the response to "e" is "No", mark that answer.

Assessment Strategies:
Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth or slight edema in these areas.

The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel. If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst.

ANSWER LIST: No. Surgical Wounds / OASIS_M0450

SEQ#	Answer	Global ID	Code	System
1	Zero		0	
2	One		1	

3	Two	2
4	Three	3
5	Four or more	4

46537-7	Number of pressure ulcers - stage 2	Num	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
b) Stage 2
Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Instructions:
Definition:
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle "0" for that stage.
- If the response to "e" is "No", mark that answer.

Assessment Strategies:
Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth or slight edema in these areas.

The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel. If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst.

ANSWER LIST: No. Surgical Wounds / OASIS_M0450

SEQ#	Answer	Global ID	Code	System

1	Zero	0
2	One	1
3	Two	2
4	Three	3
5	Four or more	4

46538-5	Number of pressure ulcers - stage 3	Num	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
c) Stage 3
Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Instructions:
Definition:
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle "0" for that stage.
- If the response to "e" is "No", mark that answer.

Assessment Strategies:
Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth or slight edema in these areas.

The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel. If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst.

ANSWER LIST: No. Surgical Wounds / OASIS_M0450

SEQ#	Answer	Global ID	Code	System
1	Zero		0	
2	One		1	
3	Two		2	
4	Three		3	
5	Four or more		4	

46539-3	Number of pressure ulcers - stage 4	Num	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
d) Stage 4
Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.).

Instructions:
Definition:
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle "0" for that stage.
- If the response to "e" is "No", mark that answer.

Assessment Strategies:
Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth or slight edema in these areas.

The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel. If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the

stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst.

ANSWER LIST: No. Surgical Wounds / OASIS_M0450

SEQ#	Answer	Global ID	Code	System
1	Zero		0	
2	One		1	
3	Two		2	
4	Three		3	
5	Four or more		4	

46540-1 Unobserved pressure ulcer Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts?

Instructions:
Definition:
Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle "0" for that stage.
- If the response to "e" is "No", mark that answer.

Assessment Strategies:
Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth or slight edema in these areas.

The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel. If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been

in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46541-9 Stage of most problematic pressure ulcer Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0460) Stage of Most Problematic (Observable) Pressure Ulcer

Instructions:
Definition:
Identifies the most problematic pressure ulcer of those noted in M0450. "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- If the patient has only one pressure ulcer, then that ulcer is the most problematic.
- In evaluating the most problematic ulcer, do not include any ulcer to which response "e" in M0450 applied. If that is the only ulcer, mark "NA."

Assessment Strategies:
Incorporate the information from M0450 and the status of each pressure ulcer and utilize clinical reasoning to determine the most problematic (observable) ulcer.

ANSWER LIST: Stage of Most Problematic Pressure Ulcer / OASIS_M0460

SEQ#	Answer	Global ID	Code	System
1	Stage 1		1	
2	Stage 2		2	
3	Stage 3		3	
4	Stage 4		4	
5	No observable pressure ulcer		NA	

46542-7 Status of most problematic pressure ulcer Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:

(M0464) Status of Most Problematic (Observable) Pressure Ulcer

Instructions:
Definition:
Identifies the degree of healing visible in the ulcer identified in M0460 as the most problematic observable pressure ulcer.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Mark the response which most accurately describes the healing process you see occurring in the most problematic pressure ulcer (identified in M0460).
- A Stage 1 pressure ulcer or an infected pressure ulcer is not healing (Response 3).
- A pressure ulcer which is covered by necrotic tissue (eschar) cannot be staged, but its status is not healing.
- If part of the ulcer is covered by necrotic tissue, then it is not healing (Response 3).

Assessment Strategies:
Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M0460.

ANSWER LIST: Status of Most Problematic Pressure Ulcer / OASIS_M0464

SEQ#	Answer	Global ID	Code	System
1	Fully granulating		1	
2	Early/partial granulation		2	
3	Not healing		3	
4	No observable pressure ulcer		NA	

46543-5 Stasis ulcer Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0468) Does this patient have a Stasis Ulcer?

Instructions:
Definition:
Identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
N/A

Assessment Strategies:
Interview for presence of circulatory disorders and lower extremity skin change in the past health history. Inspect the skin carefully, especially the lower extremities.
It is important to differentiate stasis ulcers from other types of skin lesions.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46544-3 Number of stasis ulcers Num Pt ^Patient Qn OASIS

DEFINITION/DESCRIPTION: Question:
(M0470) Current Number of Observable Stasis Ulcer(s)

Instructions:
Definition:
Identifies the number of visible (observable) stasis ulcers.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
Stasis ulcer(s) concealed by a nonremovable dressing are not visible (observable).

Assessment Strategies:
Inspect the skin carefully, especially the lower extremities. Count the ulcerations that can be seen.

ANSWER LIST: No. Surgical Wounds / OASIS_M0450

SEQ#	Answer	Global ID	Code	System
1	Zero		0	
2	One		1	
3	Two		2	
4	Three		3	
5	Four or more		4	

46545-0 Unobserved stasis ulcer Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:

(M0474) Does this patient have at least one Stasis Ulcer that Cannot be Observed due to the presence of a nonremovable dressing?

Instructions:
Definition:
Identifies the presence of a stasis ulcer which is covered by a dressing that home care staff are not to remove (e.g., an Unna's paste-boot).

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
N/A

Assessment Strategies:
The past health history and current referral information provide knowledge of the reason for any nonremovable dressing. Uncertainty regarding the reason for the nonremovable dressing can be resolved through communication with the physician.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46546-8 Status of most problematic stasis ulcer Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0476) Status of Most Problematic (Observable) Stasis Ulcer

Instructions:
Definition:
Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, one which is infected, etc., depending on the specific situation.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
If the patient has only one stasis ulcer, that ulcer is the most problematic.

Assessment Strategies:
Inspect each ulcer to determine its status. Based on this information and that from the health history, use clinical reasoning to determine the

most problematic (observable) stasis ulcer.

ANSWER LIST: Status of Most Problematic Stasis Ulcer / OASIS_M0476

SEQ#	Answer	Global ID	Code	System
1	Fully granulating		1	
2	Early/partial granulation		2	
3	Not healing		3	
4	No observable stasis ulcer		NA	

46547-6 Surgical wound Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0482) Does this patient have a Surgical Wound?

Instructions:
Definition:
Identifies the presence of any wound resulting from a surgical procedure.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Orthopedic pin sites, central line sites, stapled or sutured incisions, debrided graft sites and wounds with drains are all considered surgical wounds. A surgical incision with approximated edges and a scab (i.e., crust) from dried blood or tissue fluid is considered a current surgical wound.
- A Medi-port site is considered a surgical wound.
- "Old" surgical wounds which have resulted in scar or keloid formation are not considered current surgical wounds.

Assessment Strategies:
If health history or diagnoses indicate recent surgery (including closed reduction and fixation of a fracture), inspect surgical sites.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46548-4 Number of surgical wounds Num Pt ^Patient Qn OASIS

DEFINITION/DESCRIPTION: Question:
(M0484) Current Number of (Observable) Surgical Wounds - (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

Instructions:
Definition:
Identifies the number of observable surgical wounds.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- A wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders.
- Each opening in a single surgical wound is counted as one wound. Examples 1) Each orthopedic pin site is a separate wound. 2) A vertical laparotomy incision which is partially closed, but has a small opening at the mid-point and another at the distal point would count as 2 wounds.

Assessment Strategies:
Count the number of visible wound openings.

ANSWER LIST: No. Surgical Wounds / OASIS_M0450

SEQ#	Answer	Global ID	Code	System
1	Zero		0	
2	One		1	
3	Two		2	
4	Three		3	
5	Four or more		4	

46549-2 Unobserved surgical wound Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0486) Does this patient have at least one Surgical Wound that Cannot be Observed due to the presence of a nonremovable dressing?

Instructions:
Definition:
Identifies the presence of a surgical wound which is covered by a dressing (or cast) which is not to be removed, per physician's orders.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
Answer yes if there is a wound for which the dressing cannot be removed by home care clinicians (e.g., a plastic surgeon may order that he/she is the only one to remove the dressing over a new skin graft).

Assessment Strategies:
Review referral information; interview patient; inspect surgical site(s). Contact physician if uncertain about removing dressing.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46550-0 Status of most problematic surgical wound Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0488) Status of Most Problematic (Observable) Surgical Wound

Instructions:
Definition:
Identifies the degree of healing visible in the most problematic surgical wound. The "most problematic" wound is the one that may be complicated by the presence of infection; location of wound, large size, difficult management of drainage, or slow healing.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Requires identification of the most problematic surgical wound.
- If there is only one surgical wound, the status of that one should be noted.

Assessment Strategies:
If there is more than one wound, determine which is the most problematic. Visualize this wound to identify the degree of healing.

ANSWER LIST: Status of Most Problematic Surgical Wound / OASIS_M0488

SEQ#	Answer	Global ID	Code	System
1	Fully granulating		1	
2	Early/partial granulation		2	
3	Not healing		3	
4	No observable surgical wound		NA	

46551-8 When short of breath Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0490) When is the patient dyspneic or noticeably Short of Breath?

Instructions:

Definition:
Identifies the patient's level of shortness of breath.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- If the patient usually uses oxygen continuously, mark the response that best describes the patient's shortness of breath while using oxygen.
- If the patient uses oxygen intermittently, mark the response that best describes the patient's shortness of breath WITHOUT the use of oxygen.
- The responses represent increasing severity of shortness of breath.

Assessment Strategies:
Review symptoms and their severity in past health history. Request to see the bathroom setup, allowing you the opportunity to evaluate the occurrence of shortness of breath with a walk of a distance you can estimate (if less than 20 feet, ask the patient to extend the distance back to a chair). During conversation with the patient, does he/she stop frequently to catch his/her breath?

ANSWER LIST: When Dyspneic / OASIS_M0490

SEQ#	Answer	Global ID	Code	System
1	Never, patient is not short of breath		0	
2	When walking more than 20 feet, climbing stairs		1	
3	With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)		2	
4	With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation		3	
5	At rest (during day or night)		4	

46471-9 At home respiratory treatments Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
(M0500) Respiratory Treatments utilized at home - (Mark all that apply.)

Instructions:
Definition:
Identifies any of the listed respiratory treatments being used by this patient in the home.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers, etc.).

Assessment Strategies:
Interview patient/caregiver. Review referral information and medication orders. Observe for presence of such equipment in the home.

ANSWER LIST: Respiratory Treatments: Airway Pressure / OASIS_M0500

SEQ#	Answer	Global ID	Code	System
1	Oxygen (intermittent or continuous)		1	
2	Ventilator (continually or at night)		2	
3	Continuous positive airway pressure		3	
4	None of the above		4	

46552-6	Treated for urinary tract infection in past 14 days	Find	Pt	^Patient	Ord	OASIS	

DEFINITION/DESCRIPTION: Question:
(M0510) Has this patient been treated for a Urinary Tract Infection in the past 14 days?

Instructions:
Definition:
Identifies treatment of urinary tract infection during the past 14 days.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- If patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago, mark Response 0 - No.
- Answer "Yes" when the patient had a UTI for which the patient received treatment during the past 14 days.
- Note that if the patient is on prophylactic treatment to prevent UTIs, the appropriate response is "NA."

Assessment Strategies:
Interview for symptoms and treatment in past health history. Review referral orders. Question the patient about new medications. Confirm with physician if necessary.

ANSWER LIST: Treated for Urinary Tract Infection in Past 14 Days / OASIS_M0510

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	
3	Patient on prophylactic treatment		NA	
4	Unknown		UK	

46553-4	Urinary incontinence or urinary catheter present	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0520) Urinary Incontinence or Urinary Catheter Presence

Instructions:
Definition:
Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0.
- If the patient is incontinent AT ALL (i.e., "occasionally", "only once-in-a-while", "sometimes I leak a little bit", etc.), mark Response 1.
- If the patient requires the use of a urinary catheter for any reason (retention, post-surgery, incontinence, etc.), mark Response 2.

Assessment Strategies:
Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem. If the patient receives aide services for bathing and/or dressing, ask for input from the aide. This information can then be discussed with the patient.

ANSWER LIST: Urinary Incontinence or Urinary Catheter Present / OASIS_M0520

SEQ#	Answer	Global ID	Code	System
1	No incontinence or catheter (includes anuria or ostomy for urinary drainage)		0	
2	Patient is incontinent		1	
3	Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)		2	

46586-4	When urinary incontinence occurs	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0530) When does Urinary Incontinence occur?

Instructions:
Definition:
Identifies the time of day when the urinary incontinence occurs.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up

- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
If patient is only "occasionally" incontinent, determine when the incontinence usually occurs.

Assessment Strategies:
Once the existence of incontinence is known, ask when the incontinence occurs.

ANSWER LIST: When Urinary Incontinence Occurs / OASIS_M0530

SEQ#	Answer	Global ID	Code	System
1	Timed-voiding defers incontinence		0	
2	During the night only		1	
3	During the day and night		2	

46587-2 Bowel incontinence frequency Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0540) Bowel Incontinence Frequency

Instructions:
Definition:
Identifies how often the patient experiences bowel incontinence.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Responses are arranged in order of least to most frequency of bowel incontinence.
- Response "NA" is used if patient has an ostomy for bowel elimination.

Assessment Strategies:
Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. Don't resort to simply using the "UK" response because you don't want to ask embarrassing questions. The patient's responses to these items may make you aware of (an as yet unidentified) problem which needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient.

ANSWER LIST: Bowel Incontinence Frequency / OASIS_M0540

SEQ#	Answer	Global ID	Code	System
1	Very rarely or never has bowel incontinence		0	
2	Less than once weekly		1	

3	One to three times weekly	2
4	Four to six times weekly	3
5	On a daily basis	4
6	More often than once daily	5
7	Patient has ostomy for bowel elimination	NA
8	Unknown	UK

46588-0 Ostomy for bowel elimination Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0550) Ostomy for Bowel Elimination
Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

Instructions:
Definition:
Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or a change in medical treatment plan.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Applies to any type of ostomy for bowel elimination (i.e., colostomy, ileostomy, etc.).
- If patient does not have an ostomy for bowel elimination, the correct response is 0- Patient does not have an ostomy for bowel elimination.
- If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or change in the medical or treatment regimen.

Assessment Strategies:
Unless an ostomy is mentioned in the referral orders, interview the patient about the presence of an ostomy (or you may have done so when responding to MO540). If the patient has such an ostomy, determine by asking the patient or the physician, whether there have been recent problems with the ostomy, which have necessitated an inpatient facility stay or a change in the medical or treatment regimen.

ANSWER LIST: Ostomy for Bowel Elimination / OASIS_M0550

SEQ#	Answer	Global ID	Code	System
1	Patient does NOT have an ostomy for bowel elimination.		0	
2	Patient's ostomy was NOT related to an inpatient stay and did NOT necessitate change in medical or treatment regimen.		1	
3	The ostomy WAS related to an inpatient stay or DID necessitate change in medical or treatment regimen.		2	

46589-8 Cognitive functioning Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:

[M0560] Cognitive Functioning
(Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

Instructions:
Definition:
Identifies the patient's current level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Refers to patient's usual level of functioning.
- Level of cognitive impairment increases as you move down the list of responses.

Assessment Strategies:
The interview for description of current illness, past health history, and ability to perform ADLs and IADLs allows the clinician to assess cognitive functioning. If the patient is having trouble remembering questions, ask if this is common or because a stranger is asking a lot of questions. Does the patient have trouble remembering friends and/or relatives' names? Does the patient forget to eat or bathe, or get disoriented when walking or traveling (in a car) around the neighborhood or city? If there is a caregiver in the home, question that person also.

ANSWER LIST: Cognitive Functioning / OASIS_M0560

SEQ#	Answer	Global ID	Code	System
1	Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.		0	
2	Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.		1	
3	Requires assist/directn in specific situations (e.g., all tasks involving shifting of attn) or consistently requires low stimulus environmnt due to distractibility.		2	
4	Requires considerable assist in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.		3	
5	Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.		4	

46590-6 When confused Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0570] When Confused (Reported or Observed)

Instructions:
Definition:
Identifies the time of day the patient is likely to be confused, if at all.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- If it is reported that the patient is "occasionally" confused, identify the situation(s) in which confusion occurs.
- "Nonresponsive" means that the patient is unable to respond.

Assessment Strategies:
Information can be collected by observation or by report. Ask the patient whether or not he/she ever feels somewhat confused (e.g., "you don't know where you are or how you got here"), and under what circumstances that occurs. Is there a change in attention span? Has recent memory declined? Mild confusion can be masked in patients with well-developed social skills, so careful assessment is needed. If a caregiver or family member is present, they may be able to describe their observations.

ANSWER LIST: When Confused (Reported or Observed) / OASIS_M0570

SEQ#	Answer	Global ID	Code	System
1	Never		0	
2	In new or complex situations only		1	
3	On awakening or at night only		2	
4	During the day and evening, but not constantly		3	
5	Constantly		4	
6	Patient nonresponsive		NA	

46591-4	When anxious	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0580] When Anxious (Reported or Observed)

Instructions:
Definition:
Identifies the frequency with which the patient feels anxious.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- "Nonresponsive" means that the patient is unable to respond.
- Responses appear in order of increasing frequency of anxiety.

Assessment Strategies:
Information can be collected by observation or by report. Ask the patient if she/he ever has episodes of feeling very anxious about things. Anxiety is often prevalent in patients with chronic respiratory disease, so you may be able to relate the anxiety to increased respiratory difficulty. Does the patient wake up at night feeling fearful and anxious and possibly is unable to go back to sleep? Is there an increase in irritability or restlessness? Consult with family member(s) or caregiver with knowledge of patient behavior.

ANSWER LIST: When Anxious (Reported or Observed) / OASIS_M0580

SEQ#	Answer	Global ID	Code	System
1	None of the time		0	
2	Less often than daily		1	
3	Daily, but not constantly		2	
4	All of the time		3	
5	Patient nonresponsive		NA	

46472-7	Depressive feelings	Find	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0590] Depressive Feelings Reported or Observed in Patient (Mark all that apply.)

Instructions:
Definition:
Identifies presence of symptoms of depression.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
Feelings may be observed by the clinician or reported by the patient, family, or others.

Assessment Strategies:
Interview for presence of these depressive feelings in the past health history. Observe for presence of these feelings throughout the assessment. Validate initial impressions with interview questions, (e.g., "I noticed that---. Can you describe your mood for me?"). Inquire about the presence of suicidal thoughts if depression is present. (If suicidal thoughts are present, inquire whether these have evolved into a plan for self-harm.)

ANSWER LIST: Depressive: Thoughts of Suicide / OASIS_M0590

SEQ#	Answer	Global ID	Code	System
1	Depressed mood (e.g., feeling sad, tearful)		1	
2	Sense of failure or self reproach		2	
3	Hopelessness		3	
4	Recurrent thoughts of death		4	

5	Thoughts of suicide	5
6	None of the above feelings observed or reported	6

46473-5 Behaviors demonstrated at least once a week Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0610] Behaviors Demonstrated at Least Once a Week (Reported or Observed) (Mark all that apply.)

Instructions:
Definition:
Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
Behaviors may be observed by the clinician or reported by the patient, family, or others.

Assessment Strategies:
In the past health history, interview for the presence of these behaviors at the stated frequency. Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence.

ANSWER LIST: Behavior Demonstrated: Delusions / OASIS_M0610

SEQ#	Answer	Global ID	Code	System
1	Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision required		1	
2	Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions		2	
3	Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.		3	
4	Physical aggression: aggressive/combative to self/others (e.g., hits self, throws objects, punches, dangerous maneuvers w/wheelchair or other objects)		4	
5	Disruptive, infantile, or socially inappropriate behavior (EXCLUDES verbal actions)		5	
6	Delusional, hallucinatory, or paranoid behavior		6	
7	None of the above behaviors demonstrated		7	

46592-2 Frequency of behavior problems Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0620] Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.)

Instructions:
Definition:
Identifies frequency of behavior problems which may reflect an alteration in a patient's cognitive or neuro/ emotional status. "Behavior problems" are not limited to only those identified in M0610. For example, "wandering" is included as an additional behavior problem. Any behavior of concern for the patient's safety or social environment can be regarded as a problem behavior.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
Behavior problems may be observed by the clinician or reported by the patient, family, or others.

Assessment Strategies:
In the past health history, interview for the presence of these behaviors at the stated frequency. Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence.

ANSWER LIST: Frequency of Behavior Problems / OASIS_M0620

SEQ#	Answer	Global ID	Code	System
1	Never		0	
2	Less than once a month		1	
3	Once a month		2	
4	Several times each month		3	
5	Several times a week		4	
6	At least daily		5	

46593-0 Receives psychiatric nursing Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0630] Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

Instructions:
Definition:
Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation or experience.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
N/A

Assessment Strategies:
If the clinician performing the assessment is not the qualified psychiatric nurse, review the current plan of care to determine whether such services are currently being provided.

ANSWER LIST: Receives Psychiatric Nursing / OASIS_M0200

SEQ#	Answer	Global ID	Code	System
1	No		0	
2	Yes		1	

46478-4	Grooming	-	Pt	^Patient	Set	

46594-8	Prior: grooming	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to tend to personal hygiene needs, excluding bathing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently-performed activities but unable to do less frequently-performed activities should be considered to have more grooming ability.
- "UK - Unknown" is an option only in the "Prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient gathering equipment needed for grooming. The patient can verbally report the procedure used for grooming and demonstrate the motions utilized in grooming (e.g., hand to head for combing, hand to mouth for teeth care, etc.). The clinician should also observe the general appearance of the patient (to assess grooming deficiencies) and verify upper extremity strength, coordination, and manual

dexterity to determine if the patient requires assist with grooming. A poorly-groomed patient who possesses the coordination, manual dexterity, upper-extremity range of motion, and cognitive/emotional status to perform grooming activities should be evaluated according to their ability to groom.

ANSWER LIST: Prior: Grooming / OASIS_M0640_PR_GROOMING

SEQ#	Answer	Global ID	Code	System
1	Able to groom self unaided, with or without the use of assistive devices or adapted methods.		0	
2	Grooming utensils must be placed within reach before able to complete grooming activities.		1	
3	Someone must assist the patient to groom self.		2	
4	Patient depends entirely upon someone else for grooming needs.		3	
5	Unknown		UK	

46595-5 Current: grooming Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0640] Current - Grooming
Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or makeup, teeth or denture care, fingernail care).

Instructions:
Definition:
Identifies the patient's ability to tend to personal hygiene needs, excluding bathing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently-performed activities but unable to do less frequently-performed activities should be considered to have more grooming ability.
- "UK - Unknown" is an option only in the "Prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient gathering equipment needed for grooming. The patient can verbally report the procedure used for grooming and demonstrate the motions utilized in grooming (e.g., hand to head for combing, hand to mouth for teeth care, etc.). The clinician should also observe the general appearance of the patient (to assess grooming deficiencies) and verify upper extremity strength, coordination, and manual dexterity to determine if the patient requires assist with grooming. A poorly-groomed patient who possesses the coordination, manual dexterity, upper-extremity range of motion, and cognitive/emotional status to perform grooming activities should be evaluated according to their ability to groom.

ANSWER LIST: Current: Grooming / OASIS_M0640

SEQ#	Answer	Global ID	Code	System
1	Able to groom self unaided, with or without the use of assistive devices or adapted methods.		0	
2	Grooming utensils must be placed within reach before able to complete grooming activities.		1	
3	Someone must assist the patient to groom self.		2	
4	Patient depends entirely upon someone else for grooming needs.		3	

46479-2	Ability to dress upper body	-	Pt	^Patient	Set	

46596-3	Prior: dress upper body	Find	Pt	^Patient	Ord	OASIS	

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing.

ANSWER LIST: Prior: Dress Upper Body / OASIS_M0650_PR_DRESS_UPPER

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

5	Unknown	UK

46597-1	Current: dress upper body	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0650] Current - Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps

Instructions:
Definition:
Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing.

ANSWER LIST: Current: Dress Upper Body / OASIS_M0650

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

46480-0	Ability to dress lower body	-	Pt	^Patient	Set	

46598-9	Prior: dress lower body	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- If the patient must apply a lower-extremity prosthesis, this prosthesis should be considered as part of the lower-body apparel.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing.

ANSWER LIST: Prior: Dress Lower Body / OASIS_M0660_PR_DRESS_LOWER

SEQ#	Answer	Global ID	Code	System
1	Able to obtain, put on, and remove clothing and shoes without assistance.		0	
2	Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.		1	
3	Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.		2	
4	Patient depends entirely upon another person to dress lower body.		3	
5	Unknown		UK	

46599-7 Current: dress lower body Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0660] Current - Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Instructions:
Definition:
Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability

- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- If the patient must apply a lower-extremity prosthesis, this prosthesis should be considered as part of the lower-body apparel.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing.

ANSWER LIST: Current: Dress Lower Body / OASIS_M0660

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

46606-0	Bathing ability	-	Pt	^Patient	Set	

46600-3	Prior: bathing	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to bathe entire body and the assistance which may be required to safely bathe in shower or tub. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- The patient who bathes independently at the sink must be assessed in relation to his/her ability to bathe in tub or shower.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to bathe in tub or shower.

ANSWER LIST: Prior: Bathing / OASIS_M0670_PR_BATHING

SEQ#	Answer	Global ID	Code	System
1	Able to bathe self in SHOWER OR TUB independently.		0	
2	With the use of devices, is able to bathe self in shower or tub independently.		1	
3	Aid: a) for intermittent supervision/encouragement/reminders, OR b) to get in/out of shower/tub, OR c) for washing difficult to reach areas.		2	
4	Participates in bathing self in shower or tub, BUT requires presence of another person throughout the bath for assistance or supervision.		3	
5	UNABLE to use the shower or tub and is bathed in BED OR BEDSIDE CHAIR.		4	
6	Unable to effectively participate in bathing and is totally bathed by another person.		5	
7	Unknown		UK	

46601-1 Current: bathing Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0670] Current - Bathing
Ability to wash entire body. Excludes grooming (washing face and hands only).

Instructions:
Definition:
Identifies the patient's ability to bathe entire body and the assistance which may be required to safely bathe in shower or tub. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- The patient who bathes independently at the sink must be assessed in relation to his/her ability to bathe in tub or shower.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to bathe in tub or shower.

ANSWER LIST: Current: Bathing / OASIS_M0670

SEQ#	Answer	Global ID	Code	System
1	Able to bathe self in SHOWER OR TUB independently.		0	
2	With the use of devices, is able to bathe self in shower or tub independently.		1	
3	Aid: a) for intermittent supervision/encouragement/reminders, OR b) to get in/out of shower/tub, OR c) for washing difficult to reach areas.		2	
4	Participates in bathing self in shower or tub, BUT requires presence of another person throughout the bath for assistance or supervision.		3	
5	UNABLE to use the shower or tub and is bathed in BED OR BEDSIDE CHAIR.		4	
6	Unable to effectively participate in bathing and is totally bathed by another person.		5	

46481-8	Toileting	-	Pt	^Patient	Set	

46602-9	Prior: toileting	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to safely get to and from the toilet or bedside commode. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely use the toilet or commode.

ANSWER LIST: Prior: Toileting / OASIS_M0680_PR_TOILETING

SEQ#	Answer	Global ID	Code	System
1	Able to get to and from the toilet independently with or without a device.		0	
2	When reminded, assisted, or supervised by another person, able to get to and from the toilet.		1	
3	UNABLE to get to and from the toilet but is able to use a bedside commode (with or without assistance).		2	
4	UNABLE to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.		3	
5	Is totally dependent in toileting.		4	
6	Unknown		UK	

46603-7 Current: toileting Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0680] Current - Toileting
Ability to get to and from the toilet or bedside commode.

Instructions:
Definition:
Identifies the patient's ability to safely get to and from the toilet or bedside commode. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely use the toilet or commode.

ANSWER LIST: Current: Toileting / OASIS_M0680

SEQ#	Answer	Global ID	Code	System
1	Able to get to and from the toilet independently with or without a device.		0	

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

46482-6	Transferring	-	Pt	^Patient	Set	

46604-5	Prior: transferring	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- If the patient is bedfast, the ability to turn and position self in bed is assessed.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for safe transfer. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.

ANSWER LIST: Prior: Transferring / OASIS_M0690_PR_TRANSFERRING

SEQ#	Answer	Global ID	Code	System
1	Able to independently transfer.		0	
2	Transfers with minimal human assistance or with use of an assistive device.		1	
3	UNABLE to transfer self but is able to bear weight and pivot during the transfer process.		2	
4	Unable to transfer self and is UNABLE to bear weight or pivot when transferred by another person.		3	
5	Bedfast, unable to transfer but is able to turn and position self in bed.		4	
6	Bedfast, unable to transfer and is UNABLE to turn and position self.		5	
7	Unknown		UK	

46605-2	Current: transferring	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0690] Current - Transferring
Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Instructions:
Definition:
Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- If the patient is bedfast, the ability to turn and position self in bed is assessed.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for safe transfer. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.

ANSWER LIST: Current: Transferring / OASIS_M0690

SEQ#	Answer	Global ID	Code	System
1	Able to independently transfer.		0	
2	Transfers with minimal human assistance or with use of an assistive device.		1	
3	UNABLE to transfer self but is able to bear weight and pivot during the transfer process.		2	
4	Unable to transfer self and is UNABLE to bear weight or pivot when transferred by another person.		3	
5	Bedfast, unable to transfer but is able to turn and position self in bed.		4	
6	Bedfast, unable to transfer and is UNABLE to turn and position self.		5	

46483-4	Locomotion	-	Pt	^Patient	Set	

46554-2	Prior: ambulation	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:

Prior

Instructions:
Definition:
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. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- If patient is chairfast, assess safe locomotion in the wheelchair.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to wheel self independently.

ANSWER LIST: Prior: Ambulation / OASIS_M0700_PR_AMBULATION

SEQ#	Answer	Global ID	Code	System
1	Able to independently walk on even/uneven surfaces and climb stairs with or without railings (i.e., needs no human assist or assist device).		0	
2	Requires device (e.g., cane, walker) to walk alone OR requires human supervision/assistance to negotiate stairs/steps/uneven surfaces.		1	
3	Able to walk only with the supervision or assistance of another person at all times.		2	
4	Chairfast, UNABLE to ambulate but is able to wheel self independently.		3	
5	Chairfast, unable to ambulate and is UNABLE to wheel self.		4	
6	Bedfast, unable to ambulate or be up in a chair.		5	
7	Unknown		UK	

46555-9 Current: ambulation Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0700] Current - Ambulation/Locomotion
Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Instructions:
Definition:
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. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- If patient is chairfast, assess safe locomotion in the wheelchair.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to wheel self independently.

ANSWER LIST: Current: Ambulation / OASIS_M0700

SEQ#	Answer	Global ID	Code	System
1	Able to independently walk on even/uneven surfaces and climb stairs with or without railings (i.e., needs no human assist or assist device).		0	
2	Requires device (e.g., cane, walker) to walk alone OR requires human supervision/assistance to negotiate stairs/steps/uneven surfaces.		1	
3	Able to walk only with the supervision or assistance of another person at all times.		2	
4	Chairfast, UNABLE to ambulate but is able to wheel self independently.		3	
5	Chairfast, unable to ambulate and is UNABLE to wheel self.		4	
6	Bedfast, unable to ambulate or be up in a chair.		5	

46484-2	Feeding or eating	-	Pt	^Patient	Set	

46556-7	Prior: feeding	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:

Definition:
Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item excludes evaluation of the preparation of food items. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Responses 3, 4, and 5 include non-oral intake.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Determine the amount and type of assistance that is provided to the patient while he/she is eating. During the nutritional assessment, determine whether special preparations (i.e., pureeing, grinding, etc.) must occur for food to be swallowed or whether tube feedings are necessary.

ANSWER LIST: Prior: Feeding / OASIS_M0710_PR_FEEDING

SEQ#	Answer	Global ID	Code	System
1	Able to independently feed self.		0	
2	Able to feed self independently but requires: a) meal set-up OR b) intermittent aid/supervision OR c) liquid/pureed/ground meat diet.		1	
3	UNABLE to feed self and must be assisted or supervised throughout the meal/snack.		2	
4	Able to take in nutrients orally AND receives supplemental nutrients through a nasogastric tube or gastrostomy.		3	
5	UNABLE to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.		4	
6	Unable to take in nutrients orally or by tube feeding.		5	
7	Unknown		UK	

46557-5 Current: feeding Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0710] Current - Feeding or Eating
Ability to feed self meals and snacks.

Instructions:
Definition:
Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item excludes evaluation of the preparation of food items. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit.

The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Responses 3, 4, and 5 include non-oral intake.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Determine the amount and type of assistance that is provided to the patient while he/she is eating. During the nutritional assessment, determine whether special preparations (i.e., pureeing, grinding, etc.) must occur for food to be swallowed or whether tube feedings are necessary.

ANSWER LIST: Current: Feeding / OASIS_M0710

SEQ#	Answer	Global ID	Code	System
1	Able to independently feed self.		0	
2	Able to feed self independently but requires: a) meal set-up OR b) intermittent aid/supervision OR c) liquid/pureed/ground meat diet.		1	
3	UNABLE to feed self and must be assisted or supervised throughout the meal/snack.		2	
4	Able to take in nutrients orally AND receives supplemental nutrients through a nasogastric tube or gastrostomy.		3	
5	UNABLE to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.		4	
6	Unable to take in nutrients orally or by tube feeding.		5	

46485-9	Planning & preparing light meals	-	Pt	^Patient	Set	

46558-3	Prior: prepare light meals	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Response 1 indicates patient can intermittently (i.e., sometimes) prepare light meals, while Response 2 indicates patient cannot prepare light meals.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals (whether or not he/she currently does this)? Utilize observations made during the assessment of cognitive status, ambulation, grooming, dressing, and other activities of daily living (ADLs) to assist in determining the best response to this item.

ANSWER LIST: Prior: Prepare Light Meals / OASIS_M0720_PR_PREP_LT_MEALS

SEQ#	Answer	Global ID	Code	System
1	a) Able to indep plan and prep all lt meals for self or reheat delivered meals OR b) Physically/cognitively/mentally able to prepare lt meals.		0	
2	UNABLE to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.		1	
3	Unable to prepare any light meals or reheat any delivered meals.		2	
4	Unknown		UK	

46559-1 Current: prepare light meals Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0720] Current - Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals

Instructions:
Definition:
Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Response 1 indicates patient can intermittently (i.e., sometimes) prepare light meals, while Response 2 indicates patient cannot prepare light meals.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals (whether or not he/she currently does this)? Utilize observations made during the assessment of cognitive status, ambulation, grooming, dressing, and other activities of daily living (ADLs) to assist in determining the best response to this item.

ANSWER LIST: Current: Prepare Light Meals / OASIS_M0720

SEQ#	Answer	Global ID	Code	System
1	a) Able to indep plan and prep all lt meals for self or reheat delivered meals OR b) Physically/cognitively/mentally able to prepare lt meals.		0	
2	UNABLE to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.		1	
3	Unable to prepare any light meals or reheat any delivered meals.		2	

46486-7	Transportation	-	Pt	^Patient	Set	

46560-9	Prior: transportation	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's physical and mental ability to safely use a car, taxi or public transportation. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to safely use transportation and the type of assistance required. Utilize observations made during the assessment of ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item.

ANSWER LIST: Prior: Transportation / OASIS_M0730_PR_TRANSPORTATION

SEQ#	Answer	Global ID	Code	System
1	Able to independently drive a regular or adapted car, OR uses a regular or handicap-accessible public bus.		0	
2	Able to ride in car only when driven by another person OR able to use bus/handicap van only when assisted/accompanied by another person.		1	
3	UNABLE to ride in a car, taxi, bus, or van, and requires transportation by ambulance.		2	
4	Unknown		UK	

46561-7 Current: transportation Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0730] Current - Transportation
Physical and mental ability to SAFELY use a car, taxi, or public transportation (bus, train, subway).

Instructions:
Definition:
Identifies the patient's physical and mental ability to safely use a car, taxi or public transportation. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to safely use transportation and the type of assistance required. Utilize observations made during the assessment of ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item.

ANSWER LIST: Current: Transportation / OASIS_M0730

SEQ#	Answer	Global ID	Code	System

1	Able to independently drive a regular or adapted car, OR uses a regular or handicap-accessible public bus.	0
2	Able to ride in car only when driven by another person OR able to use bus/handicap van only when assisted/accompanied by another person.	1
3	UNABLE to ride in a car, taxi, bus, or van, and requires transportation by ambulance.	2

46487-5	Laundry	-	Pt	^Patient	Set	

46562-5	Prior: laundry	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's physical, cognitive, and mental ability to do laundry, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- The ability to do laundry is impacted by the patient's environment (i.e., is the washing machine on the same floor, in the same building, etc.). The patient's ability to do laundry in his/her own environment should be considered in responding to this item.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ability to do laundry, even if this task is not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living to assist in determining the best response to this item. Awareness of the location of laundry facilities (from the environmental assessment) is also needed.

ANSWER LIST: Prior: Laundry / OASIS_M0740_PR_LAUNDRY

SEQ#	Answer	Global ID	Code	System
1	a) Able to independently take care of all laundry tasks OR b) Physically, cognitively, and mentally able to do laundry and access facilities.		0	
2	Able to do only light laundry, (minor hand wash or light loads). Due to physical/cognitive/mental limitations, needs assist with heavy laundry.		1	

3	UNABLE to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.	2
4	Unknown	UK

46563-3	Current: laundry	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0740] Current - Laundry
Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

Instructions:
Definition:
Identifies the patient's physical, cognitive, and mental ability to do laundry, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- The ability to do laundry is impacted by the patient's environment (i.e., is the washing machine on the same floor, in the same building, etc.). The patient's ability to do laundry in his/her own environment should be considered in responding to this item.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ability to do laundry, even if this task is not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living to assist in determining the best response to this item. Awareness of the location of laundry facilities (from the environmental assessment) is also needed.

ANSWER LIST: Current: Laundry / OASIS_M0740

SEQ#	Answer	Global ID	Code	System
1	a) Able to independently take care of all laundry tasks OR b) Physically, cognitively, and mentally able to do laundry and access facilities.		0	
2	Able to do only light laundry, (minor hand wash or light loads). Due to physical/cognitive/mental limitations, needs assist with heavy laundry.		1	
3	UNABLE to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.		2	

46488-3	Housekeeping	-	Pt	^Patient	Set

46564-1	Prior: housekeeping	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the physical, cognitive and mental ability of the patient to perform both heavier and lighter housekeeping tasks, even if the patient does not routinely carry out these activities. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to complete housekeeping, even if these tasks are not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

ANSWER LIST: Prior: Housekeeping / OASIS_M0750_PR_HOUSEKEEPING

SEQ#	Answer	Global ID	Code	System
1	a) Able to independently perform all housekeeping tasks OR b) Physically, cognitively, and mentally able to perform all housekeeping tasks .		0	
2	Able to perform only LIGHT housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.		1	
3	Able to perform housekeeping tasks with intermittent assistance or supervision from another person.		2	
4	UNABLE to consistently perform any housekeeping tasks unless assisted by another person throughout the process.		3	
5	Unable to effectively participate in any housekeeping tasks.		4	
6	Unknown		UK	

46565-8	Current: housekeeping	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0750] Current - Housekeeping
Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Instructions:
Definition:
Identifies the physical, cognitive and mental ability of the patient to perform both heavier and lighter housekeeping tasks, even if the patient does not routinely carry out these activities. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to complete housekeeping, even if these tasks are not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

ANSWER LIST: Current: Housekeeping / OASIS_M0750

SEQ#	Answer	Global ID	Code	System
1	a) Able to independently perform all housekeeping tasks OR b) Physically, cognitively, and mentally able to perform all housekeeping tasks .		0	
2	Able to perform only LIGHT housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.		1	
3	Able to perform housekeeping tasks with intermittent assistance or supervision from another person.		2	
4	UNABLE to consistently perform any housekeeping tasks unless assisted by another person throughout the process.		3	
5	Unable to effectively participate in any housekeeping tasks.		4	

46489-1	Shopping	-	Pt	^Patient	Set	

46566-6	Prior: shopping	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan for, select, and purchase items from the store, even if these tasks are not routinely performed. How are medications, groceries, or needed medical supplies obtained? Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

ANSWER LIST: Prior: Shopping / OASIS_M0760_PR_SHOPPING

SEQ#	Answer	Global ID	Code	System
1	a) Able to plan for shopping needs and indep perform shopping tasks OR b) Physically/cognitively/mentally able to take care of shopping		0	
2	Needs some assistance: a) By self is able to do only light shopping and carry small packages OR b) UNABLE to go shopping alone		1	
3	UNABLE to go shopping, but is able to identify items needed, place orders, and arrange home delivery.		2	
4	Needs someone to do all shopping and errands.		3	
5	Unknown		UK	

46567-4 Current: shopping Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0760] Current - Shopping
Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

Instructions:
Definition:
Identifies the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan for, select, and purchase items from the store, even if these tasks are not routinely performed. How are medications, groceries, or needed medical supplies obtained? Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

ANSWER LIST: Current: Shopping / OASIS_M0760

SEQ#	Answer	Global ID	Code	System
1	a) Able to plan for shopping needs and indep perform shopping tasks OR b) Physically/cognitively/mentally able to take care of shopping		0	
2	Needs some assistance: a) By self is able to do only light shopping and carry small packages OR b) UNABLE to go shopping alone		1	
3	UNABLE to go shopping, but is able to identify items needed, place orders, and arrange home delivery.		2	
4	Needs someone to do all shopping and errands.		3	

46490-9	Ability to use telephone	-	Pt	^Patient	Set	

46568-2	Prior: telephone use	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Does the patient have access to a telephone? Information obtained during assessment of cognitive, behavioral, and other ADL assessments may be helpful in determining the most accurate response for this item. The safety assessment also provides data regarding emergency plans - how is the ability to use a telephone related to these plans?

ANSWER LIST: Prior: Telephone Use / OASIS_M0770_PR_PHONE_USE

SEQ#	Answer	Global ID	Code	System
1	Able to dial numbers and answer calls appropriately and as desired.		0	
2	Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.		1	
3	Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.		2	
4	Able to answer the telephone only some of the time or is able to carry on only a limited conversation.		3	
5	UNABLE to answer the telephone at all but can listen if assisted with equipment.		4	
6	Totally unable to use the telephone.		5	
7	Patient does not have a telephone.		NA	
8	Unknown		UK	

46569-0 Current: telephone use Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0770] Current - Ability to Use Telephone
Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

Instructions:
Definition:
Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column - is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item.

Does the patient have access to a telephone? Information obtained during assessment of cognitive, behavioral, and other ADL assessments may be helpful in determining the most accurate response for this item. The safety assessment also provides data regarding emergency plans - how is the ability to use a telephone related to these plans?

ANSWER LIST: Current: Telephone Use / OASIS_M0770

SEQ#	Answer	Global ID	Code	System
1	Able to dial numbers and answer calls appropriately and as desired.		0	
2	Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.		1	
3	Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.		2	
4	Able to answer the telephone only some of the time or is able to carry on only a limited conversation.		3	
5	UNABLE to answer the telephone at all but can listen if assisted with equipment.		4	
6	Totally unable to use the telephone.		5	
7	Patient does not have a telephone.		NA	

46491-7	Management of oral medications	-	Pt	^Patient	Set	

46570-8	Prior: management of oral medications	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to prepare and take oral medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Exclude injectable and IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item.

Observe patient opening medication containers. Ask the patient to state the proper dosage for each medication and the correct times for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item. If patient's ability to manage medications varies from med to med, consider total number of meds and total daily doses in determining what is true most of the time.

ANSWER LIST: Prior: Management of Oral Medications / OASIS_M0780_PR_ORAL_MEDS

SEQ#	Answer	Global ID	Code	System
1	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.		0	
2	Able to take medication(s) at correct times if: a) indiv dosages prep in advance OR b) given daily reminders OR c) uses drug diary or chart.		1	
3	UNABLE to take medication unless administered by someone else.		2	
4	No oral medications prescribed.		NA	
5	Unknown		UK	

46571-6 Current: management of oral medications Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0780) Current - Management of Oral Medications

Instructions:
Definition:
Identifies the patient's ability to prepare and take oral medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Exclude injectable and IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening medication containers. Ask the patient to state the proper dosage for each medication and the correct times for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item. If patient's ability to manage medications varies from med to med, consider total number of meds and total daily doses in determining what is true most of the time.

ANSWER LIST: Current: Management of Oral Medications / OASIS_M0780

SEQ#	Answer	Global ID	Code	System
1	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.		0	
2	Able to take medication(s) at correct times if: a) indiv dosages prep in advance OR b) given daily reminders OR c) uses drug diary or chart.		1	
3	UNABLE to take medication unless administered by someone else.		2	
4	No oral medications prescribed.		NA	

46492-5	Management of inhalant/Mist medications	-	Pt	^Patient	Set	

46572-4	Prior: management of inhalant medications	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to prepare and take all prescribed inhalant/mist medication reliably and safely and the type of assistance required to administer the current dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Exclude oral, injectable, and IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening inhalant mist/medications and preparing any other equipment required for administration. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

ANSWER LIST: Prior: Management of Inhalant Medications / OASIS_M0790_PR_INHAL_MEDS

SEQ#	Answer	Global ID	Code	System

1	Able to independently take the correct medication and proper dosage at the correct times.	0
2	Able to take medication at the correct times if: a) indiv dosages are prep in advance by another person OR b) given daily reminders.	1
3	UNABLE to take medication unless administered by someone else.	2
4	No inhalant/mist medications prescribed.	NA
5	Unknown	UK

46573-2 Current: management of inhalant medications Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0790) Current - Management of Inhalant/Mist Medications

Instructions:
Definition:
Identifies the patient's ability to prepare and take all prescribed inhalant/mist medication reliably and safely and the type of assistance required to administer the current dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Exclude oral, injectable, and IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening inhalant mist/medications and preparing any other equipment required for administration. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

ANSWER LIST: Current: Management of Inhalant Medications / OASIS_M0790

SEQ#	Answer	Global ID	Code	System
1	Able to independently take the correct medication and proper dosage at the correct times.		0	
2	Able to take medication at the correct times if: a) indiv dosages are prep in advance by another person OR b) given daily reminders.		1	
3	UNABLE to take medication unless administered by someone else.		2	
4	No inhalant/mist medications prescribed.		NA	

46574-0	Prior: management of injectable medications	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
Prior

Instructions:
Definition:
Identifies the patient's ability to prepare and take all injectable mediations reliably and safely and the type of assistance required to administer the correct dosage at the appropriate time/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Exclude IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

ANSWER LIST: Prior: Management of Injectable Medications / OASIS_M0800_PR_INJECT_MEDS

SEQ#	Answer	Global ID	Code	System
1	Able to independently take the correct medication and proper dosage at the correct times.		0	
2	Able to take injectable medication at correct times if: a) indiv syringes are prep in advance by another person OR b) given daily reminders.		1	
3	UNABLE to take injectable medications unless administered by someone else.		2	
4	No injectable medications prescribed.		NA	
5	Unknown		UK	

46575-7	Current: management of injectable medications	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
(M0800) Current - Management of Injectable Medications

Instructions:
Definition:
Identifies the patient's ability to prepare and take all injectable mediations reliably and safely and the type of assistance required to administer the correct dosage at the appropriate time/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

Time Points Item(s) Completed:
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

Response-Specific Instructions:
- Exclude IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

Assessment Strategies:
A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

ANSWER LIST: Current: Management of Injectable Medications / OASIS_M0800

SEQ#	Answer	Global ID	Code	System
1	Able to independently take the correct medication and proper dosage at the correct times.		0	
2	Able to take injectable medication at correct times if: a) indiv syringes are prep in advance by another person OR b) given daily reminders.		1	
3	UNABLE to take injectable medications unless administered by someone else.		2	
4	No injectable medications prescribed.		NA	

46576-5 Management of equipment Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0810) Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique.

Instructions:
Definition:
Identifies the patient's ability to set up, monitor and change equipment reliably and safely, and the amount of assistance required from another person. The focus is on what the patient is able to do, not on compliance or willingness.

Time Points Item(s) Completed:
- Start of care

- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- Include only oxygen, IV infusion therapy, enteral/parenteral nutrition equipment and supplies.
- If more than one type of equipment is used, consider the equipment for which the most assistance is needed.

Assessment Strategies:
Is any of the listed equipment used in care? (Note responses to M0250 and M0500.) If so, a combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient setting up and changing equipment. Ask the patient to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional assessments contribute to determining the response for this item.

ANSWER LIST: Patient Management of Equipment / OASIS_M0810

SEQ#	Answer	Global ID	Code	System
1	Patient manages all tasks related to equipment completely independently.		0	
2	If someone else sets up equipment (i.e. fills portable oxygen tank, provides patient w/prep solns), patient able to manage all other aspects of equipment.		1	
3	Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.		2	
4	Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.		3	
5	Patient is completely dependent on someone else to manage all equipment.		4	
6	No equipment of this type used in care.		NA	

46577-3 Management of equipment Find Pt ^Caregiver Ord OASIS

DEFINITION/DESCRIPTION: Question:
(M0820) Caregiver's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique.

Instructions:
Definition:
Identifies the caregiver's ability to set up, monitor and change equipment reliably and safely. The focus is on what the caregiver is able to do, not on compliance or willingness. "Caregiver" is defined in M0360.

Time Points Item(s) Completed:
- Start of care
- Resumption of care
- Follow-up
- Discharge from agency - not to inpatient facility

Response-Specific Instructions:
- The definition of equipment includes only oxygen, IV infusion equipment, enteral/parenteral nutrition and ventilator therapy equipment or supplies.
- If the patient has no caregiver, mark "NA."
- If more than one type of equipment is used, consider the equipment for which the most assistance is needed.

Assessment Strategies:
Is any of the listed equipment used in care? (Note responses to M0250 and M0500.) If so, a combined observation/interview approach with the caregiver is required to determine the most accurate response for this item. Observe the caregiver setting up and changing the equipment. Ask the caregiver to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional ability of the caregiver (as evaluated during the visit) contribute to determining the response for this item.

ANSWER LIST: Caregiver Management of Equipment / OASIS_M0820

SEQ#	Answer	Global ID	Code	System
1	Caregiver manages all tasks related to equipment completely independently.		0	
2	If someone else sets up equipment, caregiver is able to manage all other aspects.		1	
3	Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task.		2	
4	Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).		3	
5	Caregiver is completely dependent on someone else to manage all equipment.		4	
6	No caregiver		NA	
7	Unknown		UK	

46583-1 Therapy need Find Pt ^Patient Ord OASIS

DEFINITION/DESCRIPTION: Question:
[M0825] Therapy Need
Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

Instructions:
Definition:

Time Points Item(s) Completed:

Response-Specific Instructions:

Assessment Strategies:

NOTE: M0825 was added to OASIS with the 1.10 data specification. The response to this item is used in determining whether HIPPS are calculated for an assessment.

ANSWER LIST: Therapy Need / OASIS_M0825

SEQ#	Answer	Global ID	Code	System
1	No		00	
2	Yes		01	
3	Not Applicable		NA	

46461-0 Emergent care Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0830] Emergent Care
Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? (Mark all that apply.)

Instructions:
Definition:
Identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care agency services. Emergent care includes all unscheduled visits. A "prn" agency visit is not considered emergent care.

Time Points Item(s) Completed:
- Follow-up
- Transfer to an inpatient facility - with or without agency discharge
- Discharge from agency

Response-Specific Instructions:
- If a patient went to the ER, was "held" at the hospital for observation, then released, the patient did receive emergent care.
- Exclude outpatient visits for scheduled diagnostic testing.

Assessment Strategies:
Ask the patient/caregiver if the patient has had any services for emergent care. Clarify that a doctor's office visit for an emergent problem, which is scheduled less than 24 hours in advance, is considered an emergent care visit.

ANSWER LIST: Emergent Care: Outpatient / OASIS_M0830

SEQ#	Answer	Global ID	Code	System
1	No emergent care services		0	
2	Hospital emergency room (includes 23-hour holding)		1	
3	Doctor's office emergency visit/house call		2	
4	Outpatient department/clinic emergency (includes urgicenter sites)		3	
5	Unknown		UK	

46474-3 Emergent care reason Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0840] Emergent Care Reason
For what reason(s) did the patient/family seek emergent care? (Mark all that apply.)

Instructions:
Definition:
Identifies the reasons for which the patient/family sought emergent care.

Time Points Item(s) Completed:
- Follow-up
- Transfer to an inpatient facility - with or without agency discharge
- Discharge from agency

Response-Specific Instructions:
- If more than one reason contributed to the emergent care visit, mark all appropriate responses. For example, if a patient sought care for a fall at home and was found to have medication side effects, mark both responses.
- If the reason is not included in the choices, mark Response 9 - Other than above reasons.

Assessment Strategies:
Ask the patient/caregiver to state all the symptoms and reasons for which they sought emergent care. A phone call to the doctor's office or emergency room may be required to clarify the reasons for emergent care.

ANSWER LIST: Emergent Care Reason: Other / OASIS_M0840

SEQ#	Answer	Global ID	Code	System
1	Improper medication administration, medication side effects, toxicity, anaphylaxis		1	
2	Nausea, dehydration, malnutrition, constipation, impaction		2	
3	Injury caused by fall or accident at home		3	
4	Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)		4	
5	Wound infection, deteriorating wound status, new lesion/ulcer		5	
6	Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)		6	
7	Hypo/Hyperglycemia, diabetes out of control		7	
8	GI bleeding, obstruction		8	
9	Other than above reasons		9	
10	Reason Unknown		UK	

46578-1 Inpatient facility Type Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0855] To which Inpatient Facility has the patient been admitted?

Instructions:
Definition:
Identifies the type of inpatient facility to which the patient was admitted.

Time Points Item(s) Completed:
- Transfer to inpatient facility - with or without agency discharge
- Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Admission to a certified rehabilitation unit of a skilled nursing facility or a freestanding rehab hospital is considered a rehabilitation facility admission.
- Admission to either a skilled nursing facility (SNF) or an intermediate care facility (ICF) within a nursing home is a nursing home admission.

Assessment Strategies:
Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type facility the patient has been admitted.

ANSWER LIST: Inpatient Facility / OASIS_M0855

SEQ#	Answer	Global ID	Code	System
1	Hospital		1	
2	Rehabilitation facility		2	
3	Nursing home		3	
4	Hospice		4	
5	No inpatient facility admission		NA	

46579-9 Discharge disposition Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0870] Discharge Disposition
Where is the patient after discharge from your agency? (Choose only one answer.)

Instructions:
Definition:
Identifies where the patient resides after discharge from the home health agency.

Time Points Item(s) Completed:
Discharge from agency - not to an inpatient facility

Response-Specific Instructions:
- Patients who are in assisted living or board and care housing are considered to be living in the community.
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.

Assessment Strategies:
At agency discharge, determine where the patient will be living/residing.

ANSWER LIST: Discharge Disposition / OASIS_M0870

SEQ#	Answer	Global ID	Code	System
1	Patient remained in the community (not in hospital, nursing home, or rehab facility)		1	
2	Patient transferred to a noninstitutional hospice		2	
3	Unknown because patient moved to a geographic location not served by this agency		3	
4	Other unknown		UK	

46475-0	Discharge support services or assistance	Find	Pt	^Patient	Nom	OASIS

DEFINITION/DESCRIPTION: Question:
[M0880] After discharge, does the patient receive health, personal, or support Services or Assistance? (Mark all that apply.)

Instructions:
Definition:
Identifies services or assistance a patient receives after discharge from the home health agency.

Time Points Item(s) Completed:
Discharge from agency - not to inpatient facility

Response-Specific Instructions:
Assistance or services in Responses 2 or 3 may be paid or unpaid.

Assessment Strategies:
Ask the patient/caregiver what type of services or support the patient might be receiving after discharge. M0380 contains a list of services or assistance that can be used as a reference. Include services which the agency may have arranged.

ANSWER LIST: Family Assistance After Discharge / OASIS_M0880

SEQ#	Answer	Global ID	Code	System
1	No assistance or services received		1	
2	Yes, assistance or services provided by family or friends		2	
3	Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health, homemaker assistnc, transportation assistnc)		3	

46580-7	Acute care hospitalization reason	Find	Pt	^Patient	Ord	OASIS

DEFINITION/DESCRIPTION: Question:
[M0890] If the patient was admitted to an acute care Hospital, for what Reason was he/she admitted?

Instructions:
Definition:
Identifies the urgency of the hospital admission.

Time Points Item(s) Completed:
Transfer to inpatient facility - with or without agency discharge

Response-Specific Instructions:
- A patient hospitalized immediately subsequent to a doctor's office, outpatient clinic, or ER visit has been hospitalized for emergent care.
- A hospitalization that is scheduled is either urgent or elective depending on whether there were more than 24 hours between the scheduling and the actual admission.

Assessment Strategies:

Interview the patient, family, or medical service provider to determine whether the acute hospitalization was related to emergent, urgent, or elective care.

ANSWER LIST: Acute Care Hospitalization Reason / OASIS_M0890

SEQ#	Answer	Global ID	Code	System
1	Hospitalization for EMERGENT (unscheduled) care		1	
2	Hospitalization for URGENT (scheduled within 24 hours of admisson) care		2	
3	Hospitalization for ELECTIVE (scheduled more than 24 hours before admission) care		3	
4	Unknown		UK	

46476-8 Reason for hospitalization Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0895] Reason for Hospitalization (Mark all that apply.)

Instructions:
Definition:
Identifies the specific condition(s) necessitating hospitalization.

Time Points Item(s) Completed:
Transfer to inpatient facility - with or without agency discharge

Response-Specific Instructions:
Mark all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 15 would be marked.

Assessment Strategies:
Interview the patient, family, or medical service provider to determine the condition requiring acute hospital admission.

ANSWER LIST: Hospitalized: Psychotic / OASIS_M0895

SEQ#	Answer	Global ID	Code	System
1	Improper medication administration, medication side effects, toxicity, anaphylaxis		1	
2	Injury caused by fall or accident at home		2	
3	Respiratory problems (SOB, infection, obstruction)		3	
4	Wound or tube site infection, deteriorating wound status, new lesion/ulcer		4	
5	Hypo/Hyperglycemia, diabetes out of control		5	
6	GI bleeding, obstruction		6	
7	Exacerbation of CHF, fluid overload, heart failure		7	
8	Myocardial infarction, stroke		8	
9	Chemotherapy		9	
10	Scheduled surgical procedure		10	
11	Urinary tract infection		11	
12	IV catheter-related infection		12	
13	Deep vein thrombosis, pulmonary embolus		13	

14	Uncontrolled pain	14
15	Psychotic episode	15
16	Other than above reasons	16

46477-6 Reason for nursing home admission Find Pt ^Patient Nom OASIS

DEFINITION/DESCRIPTION: Question:
[M0900] For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)

Instructions:
Definition:
Identifies the reason(s) the patient was admitted to a nursing home.

Time Points Item(s) Completed:
Transfer to inpatient facility - with or without agency discharge

Response-Specific Instructions:
N/A

Assessment Strategies:
Interview the patient, family, or medical service provider to determine the reason(s) for nursing home placement. Often the agency clinician will have assessed conditions for which nursing home placement is necessary or appropriate.

ANSWER LIST: Admitted to Nursing Home: Other / OASIS_M0900

SEQ#	Answer	Global ID	Code	System
1	Therapy services		1	
2	Respite care		2	
3	Hospice care		3	
4	Permanent placement		4	
5	Unsafe for care at home		5	
6	Other		6	
7	Unknown		UK	

46581-5 Date of last home visit TmStp Pt ^Patient Qn OASIS

DEFINITION/DESCRIPTION: Question:
[M0903] Date of Last (Most Recent) Home Visit

Instructions:
Definition:
Identifies the last or most recent home visit of any agency provider, including skilled providers or home health aides.

Time Points Item(s) Completed:
- Transfer to an inpatient facility - with or without agency discharge

- Death at home
- Discharge from agency

Response-Specific Instructions:
If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits of the year.

Assessment Strategies:
When more than one agency staff member is providing care, refer to agency clinical record for date of last visit. If today's visit is the last (discharge) visit, enter today's date.

46582-3	Discharge, transfer, death date	TmStp	Pt	^Patient	Qn	OASIS

DEFINITION/DESCRIPTION: Question:
[M0906] Discharge/Transfer/Death Date
Enter the date of the discharge, transfer, or death (at home) of the patient.

Instructions:
Definition:
Identifies the actual date of discharge, transfer, or death (at home).

Time Points Item(s) Completed:
- Transfer to an inpatient facility - with or without agency discharge
- Death at home
- Discharge from agency

Response-Specific Instructions:
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- The date of discharge is determined by agency policy or physician order.
- The transfer date is the actual date the patient was transferred to an inpatient facility.
- The death date is the actual date of the patient's death at home. Exclude death occurring in an inpatient facility. Include death which occurs while a patient is being transported to an inpatient facility (before being admitted).

Assessment Strategies:
Agency policy or physician order may establish discharge date. Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.

CORE PARTS

Part Type	Part No.	Part Name
Time		

	LP6960	Pt *[Point in time (Random)]*
	DESCRIPTION: to identify measures at a point in time. This is a synonym for "spot" or "random" as applied to urine measurements	
Super System		
	LP6985	patient

CHANGE HISTORY

Change Type:	NAM
Source:	TW
Last Updated:	2006/11/22

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