OASIS-C Guidance Manual Errata

Updated January 2011

Chapter 3 / Page F-18	M1340	**CORRECTED** the last sentence of the 9th bullet under Response-Specific Instructions, to read as follows: These may be reported in M1350 if the home health agency is providing intervention specific to the ostomy.

December 2010

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		The following changes were made to Chapter 1. Because of these revisions and resultant page break changes, it would be most efficient to print the entire new chapter.
Chapter 1 / Page 1-2	--	**CHANGED** the first sentence of the second full paragraph to read: This revised manual, the OASIS-C Guidance Manual, is a streamlined version of the original manual …
Chapter 1 / Page 1-7	--	**DELETED** the last 2 sentences in the last paragraph: Note, OASIS data collection and submission… through …Office web page.
Chapter 1 / Page 1-9, 1-10	--	**CHANGED** the paragraphs under Process of Care Data Items to read as follows; **Process of Care Data Items** Process of care data items (process items) document whether certain evidence-based practices were implemented. Process items collected at SOC/ROC document assessment and care planning interventions such as a) whether the patient was assessed to be at risk for certain conditions like pain, falls, or pressure ulcers; and b) whether interventions to address the conditions were incorporated into the plan of care. These items refer to assessments completed and orders included in the plan of care within the five day SOC period or the two day ROC period. Process items collected at transfer and discharge time points include documentation of interventions that were implemented as part of patient care “since the previous OASIS assessment" (see example in Table 3). This phrase should be interpreted to mean “at the time of, or since, the most recent SOC, ROC, or FU OASIS assessment.” Specific instructions about review periods are included in item guidance for the relevant OASIS questions. Process items collected at transfer and discharge may require a clinician to review prior care in order to accurately complete the items. **Note that this review must consider care provided by all disciplines, and is not limited to care provided by the discipline of the clinician completing the OASIS assessment.** The review

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		can be accomplished in several different ways. The care provider may find it necessary to review clinical records, including the plan of care, updated orders, and visit notes. Alternatively, the agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit. Review of the flowsheet may provide the needed information, such that a review of the clinical record would be unnecessary. Another strategy for agencies using electronic health records is to create a report template that could pull the needed information from data fields incorporated into visit notes. Regardless of the technique that an agency chooses, the process data items completed at transfer and discharge will require knowledge of patient symptoms, initial and subsequent physician's orders, and clinical interventions performed to address patient symptoms that were present at the time of, or since, the most recent SOC, ROC, or FU OASIS assessment.
Chapter 1 / Page 1-11	--	**ADDED** new point #2 to Table 4: 2. For OASIS purposes, a care episode (also referred to as a quality episode) must have a beginning (i.e., an SOC or ROC assessment) and a conclusion (i.e., a Transfer or Discharge assessment) to be considered a complete care episode. **REVISED** (old point #4) new point #5 to Table 4: 5. Responses to items documenting a patient's current status should be based on independent observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments. For process items that require documentation of prior care, the phrase "since the previous OASIS assessment" should be interpreted to mean "at the time of, or since, the time of the most recent SOC, ROC or FU OASIS assessment," as noted on page 1-10. These instructions are included in item guidance for the relevant OASIS questions.
Chapter 3 / Page A-2 *from 6/10 Errata	M0014	**CHANGED** the 1st bullet in Response-Specific Instructions to read: • Enter the two-letter postal service abbreviation of the State in which the branch office is located. If a branch ID (not N or P) is entered in M0016, then M0014 cannot be blank.
Chapter 3 / Page B-3 *from 6/10 Errata	M0100	**CHANGED** the item text to match the OASIS-C: All Items version: Skip Instructions for response 8: 8 – Death at home [Go to M0903]

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Chapter 3 / Page B-3 *from 6/10 Errata	M0100	**CHANGED** the item text to match the OASIS-C: All Items version: Skip Instructions for response 9: 9 – Discharge from agency [Go to M1040]
Chapter 3 / Page B-4	M0100	**REPLACED** bullet #7 in Response-Specific Instructions with: • Response 7: This "Transfer to an Inpatient Facility" OASIS is only completed when the home care patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) and the agency does NOT anticipate the patient will be returning to care. The patient is discharged from the agency. This response does NOT require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility. **ADDED** to the end of bullet #9 in Response-Specific Instructions: • The Discharge OASIS is not required when only a single visit is made in a care episode (SOC/ROC and TRF/DC).
Chapter 3 / Pages B-5	M0102	**ADDED** as the last bullet under Response-Specific Instructions: • In order to be considered a physician-ordered SOC date, the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.
Chapter 3 / Page B-6	M0104	**ADDED** as a new 2nd bullet in Response-Specific Instructions: • The date authorization was received from the patient's payer is NOT the date of the referral (e.g., the date the Medicare Advantage case manager authorized service is not considered a referral date).

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Chapter 3 / Page C-4	M1010	**CHANGED** the first sentence of Item Intent to read: Identifies diagnosis(es) for which patient was actively receiving treatment in an inpatient facility within the past 14 days. **ADDED** a new 1st bullet in Response-Specific Instructions: • "Actively treated" should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition.
Chapter 3/ Page C-5	M1012	**ADDED** a new 3rd bullet in Response-Specific Instructions to read: • A medical procedure can be defined as any procedure in Volume 3 of the ICD-9-CM coding manual that the clinician identifies as significantly impacting the patient's health status and care needs based on the information that is available to the agency at the start (or resumption) of care. Typically, this would include recent surgical procedures, but in some cases, this could include diagnostic or rehabilitative procedures.
Chapter 3 Page C-12	M1030	**ADDED** as a new bullet between the existing 6th and 7th bullets in the Response-Specific Instructions: • An irrigation or infusion of the bladder is not included when completing M1030, Therapies at Home.
Chapter 3 / Pages C-16	M1040	**DELETED AND REPLACED** the current bullets in the Response-Specific Instructions to read as follows: • A care episode is one that includes both an SOC/ROC and a Transfer/Discharge. Therefore, when you complete this item at Transfer or Discharge, only go back to the most recent SOC or ROC to determine if the patient received the flu vaccine. • This year's influenza season means the current flu season as established by the Centers for Disease Control (CDC). Each year, flu vaccine manufacturers only release the vaccine per CDC recommendations. Therefore, if the flu vaccine is available for administration, it is flu season. • (October 1 through March 31) means the time period utilized in the computation of the process measures and for the purpose of identifying if the episode of care (SOC/ROC to Transfer/Discharge) is outside of the flu season • If no part of the care episode (from most recent SOC/ROC to transfer or discharge) occurs during the time period from October 1 through March 31, mark "NA."

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		• Only select Responses 0 or 1 if **any** portion of the home health episode (from SOC/ROC to transfer or discharge) occurs during the current influenza season. • Only select Response 1 if the patient received the flu vaccine from your agency during this episode of care (SOC/ROC to Transfer/Discharge). • This item meets NQF requirements for harmonization of influenza measures across care settings.
Chapter 3 / Pages C-17, C-18	M1045	**ADDED** the following as a sub-bullet under the 3rd bullet in Response-Specific Instructions: – You may select Response 2 if a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year's flu season. **ADDED** the following as a sub-bullet under the 5th bullet in Response-Specific Instructions: – It is not required that the agency offered the vaccine, only that the patient was offered the vaccine and he/she refused. **MODIFIED** bullet #7 in Response-Specific Instructions to read: • Select Response 5 if age/condition guidelines indicate that influenza vaccine is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current influenza age/condition guidelines is posted to the CDC website (see link in Chapter 5). It is the agency's responsibility to make current guidelines available to clinicians.
Chapter 3 / Pages C-20, C-21	M1055	**MODIFIED** the 4th bullet in Response-Specific Instructions to read: • Select Response 4 if CDC age/condition guidelines indicate that PPV is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current PPV age/condition guidelines are posted to the CDC's website (see link in Chapter 5). It is the agency's responsibility to make current guidelines available to clinicians. **DELETED** the first sub-bullet under the 5th bullet in Response-Specific Instructions.

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Chapter 3 / Page D-2	M1100	**ADDED** a second sub-bullet under "Availability of Assistance" (after the timeframe definitions) in Response-Specific Instructions: – Clinical judgment must be used to determine which hours constitute "regular daytime" and "regular nighttime" based on the patient's specific activities and routines. No hours are specifically designated as daytime or nighttime. **ADDED** the following as the last sub-bullet under "Availability of Assistance" in Response-Specific Instructions: – Availability of assistance refers to the expected availability and willingness of caregiver(s) for this upcoming care episode.
Chapter 3 / Page E-5	M1240	**ADDED** a new bullet after the 3rd bullet in Response-Specific Instructions: • Select Response 1 or 2 based on the pain reported at the time the standardized tool was administered, per the tool's instructions. **REPLACED** the last bullet under the Response-Specific Instructions with the following: • In order to select Response 1 or 2, the pain assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the allowed time frame (i.e., within five days of SOC, within two days of discharge from the inpatient facility at ROC).
Chapter 3 / Page E-6	M1242	**ADDED** the following sentence to the end of the 2nd bullet in Response-Specific Instructions: Include all activities (e.g., sleeping, recreational activities, watching television), not just ADLs.
Chapter 3 / Page F-1	M1300	**ADDED** a new bullet after the 1st bullet in Response-Specific Instructions: • In order to select Response 1 or 2, the pressure ulcer risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

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Chapter 3 / Page F-7	M1308	**ADDED** a new 3rd bullet after the 2nd bullet's sub-bullets in Response-Specific Instructions: • Column 2 is left blank when the ROC assessment is completed during the 5-day recertification window.
Chapter 3 / Page F-9, F-10	M1310 M1312, M1314	**ADDED** a sub-bullet under the 5th bullet in the Response-Specific Instructions: – Report the depth from the visible surface to the deepest area in the base of the wound. Do not include the depth of any tunneling present. **ADDED** a sub-bullet under the last bullet in Response-Specific Instructions: – Pressure ulcers that lie diagonally or slanted are also measured head to toe for length and the width measurement is perpendicular to the length. You may choose to include other measurements in your clinical documentation, for situations where the OASIS requirement does not meet your needs.
Chapter 3 / Page F-11	M1320	**DELETED** the 9th bullet text in Response-Specific Instructions and **REPLACED** with: • Since suspected deep tissue injury (DTI) does not granulate and would not be covered with new epithelial tissue, the status of "Not healing" is the most appropriate response.
Chapter 3 / Page F-14	M1324	**ADDED** a new bullet after the 5th bullet in Response-Specific Instructions: • Until suspected deep tissue injury (DTI) evolves and opens, the stage will be considered "NA," as the wound bed cannot be visualized.
Chapter 3 / Page F-17	M M1334	**ADDED** the following as the last bullet in Response-Specific Instructions: • Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer. The response option "Newly epithelialized" should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported as a stasis ulcer on OASIS.

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Chapter 3 / Pages F-18	M1340	**DELETED** the text in the 9th bullet and **REPLACED** with the following: • All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. Examples include cystostomy, urostomy, thoracostomy, tracheostomy, illeostomy, gastrostomy, etc. These may be reported in M1340 if the home health agency is providing intervention specific to the ostomy.
Chapter 3 / Pages F-20	M1342	**ADDED** the following bullets after the 2nd bullet in Response-Specific Instructions: • Surgical incisions healing by primary intention do not granulate, therefore the only appropriate responses would be 0-Newly epithelialized or 3-Not healing. • If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days.) If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing by primary intention. • If there is incisional separation, healing will be by secondary intention and the clinician will determine the status of healing, which may be not healing, early/partial granulation, fully granulating, and eventually newly epithelialized.
Chapter 3 / Pages F-21	M1350	**DELETED** the text in the 6th bullet and **REPLACED** with the following: • Ostomies other than bowel ostomies for elimination (e.g., tracheostomies, thoracostomies, urostomies, jejunostomies, gastrostomies) ARE considered to be skin lesions or open wounds if clinical interventions (e.g., cleansing, dressing changes, assessment) are being provided by the home health agency during the care episode.
Chapter 3 / Pages G-1	M1400	**ADDED** a sub-bullet under the 1st bullet in Response-Specific Instructions: – The response is based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.

Section / Page#	Item #	Change
Chapter 3 / Pages H-1	M1500	**CHANGED** the 1st Response-Specific Instruction bullet to read: • Select Response options 0, 1, or 2 if the patient has a diagnosis of heart failure, regardless of whether the diagnosis is documented elsewhere in the OASIS assessment. **ADDED** the following bullet after the 2nd bullet: • If the patient has a diagnosis of heart failure, select Response 1 – Yes, to report symptoms associated with heart failure even if there are other co-morbidities that also could produce the symptom (e.g., dyspnea in a patient with pneumonia and heart failure).
Chapter 3 / Pages H-2	M1510	**REVISED** the 4th bullet in Response-Specific Instructions to read: • Response 1 includes communication to the physician or primary care practitioner made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the *same day.* Same day means by the end of *this* calendar day. In many situations, other responses also will be marked that indicate the action taken as a result of the contact (i.e., any of responses 2-5). **ADDED** the following two bullets at the end in Response-Specific Instructions: • Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms can be reported. • Response 4 includes “Patient education,” referring to the effective sharing of pertinent heart failure-related information to increase patient knowledge, skill, and responsibility. Simply providing a patient with printed materials regarding heart failure without assessment of their understanding of the content should not be considered patient education.

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Chapter 3 / Pages I-2	M1610	**ADDED** the following two bullets after the 6th bullet in Response-Specific Instructions: • Select Response 2 if a catheter was inserted during the comprehensive assessment. • If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent.
Chapter 3 / Pages J-4, J-5	M1730	The following bullet modifications were made to the Response-Specific Instructions: **DELETE** the last sentence in the 2nd bullet and **REPLACE** with the following sentence: The standardized tool must be both appropriate for the patient based on their cognitive and communication deficits and appropriately administered as indicated in the instructions. **ADD** the following as a sub-bullet under the 3rd bullet: - In order to select Responses 1, 2 or 3, the standardized depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment. **ADD** the following as a sub-bullet under the 4th bullet: - If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be selected. **ADD** the following as a sub-bullet under the 5th bullet: - If the PHQ-2 is not used to assess the patient, you may choose to administer a different standardized depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment.

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Chapter 3 / Page K-3	M1810	**ADDED** the following two new bullets before the last bullet in the Response-Specific Instructions: • If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing. • The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
Chapter 3 / Pages K-4, K-5	M1820	**ADDED** the following two new bullets before the last bullet in the Response-Specific Instructions: • If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing. • The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

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Chapter 3 / Pages K-6, K-7	M1830	**DELETED** the 6th and 7th bullets in the Response-Specific Instructions and **INSERTED** the following: • The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have. • If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities. • If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower. Select Response 4 or 5, based on the patient's ability to bathe outside the tub/shower. - For Response 4, the patient must be able to safely and <u>independently</u> bathe outside the tub/shower, including independently accessing water at the sink, or setting up a basin at the bedside, etc. - Select Response 5 if the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair, or on a commode.
Chapter 3 / Pages K-10, K-11	M1845	**ADDED** the following as a sub-bullet under the 1st bullet in Response-Specific Instructions: - Toileting hygiene includes the patient's ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (e.g., urostomies, colostomies, ileostomies).

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Chapter 3 / Pages K-12, K-13	M1850	The following bullet modifications were made to the Response-Specific Instructions: **MODIFIED** the 1st bullet by adding the following phrase at the end: … and back into bed from the chair or sitting surface.. **ADDED** the following sub-bullet under the 1st bullet: - If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (e.g., a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface. **ADDED** the following as a sub-bullet under the 5th bullet: - In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.
Chapter 3 / Pages K-21	M1900	**CHANGED** the first sentence of the Item Intent to read: Identifies the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care.
Chapter 3 / Pages K-22	M1910	**REPLACED** the last sentence in the first paragraph of Item Intent with the following sentence: The standardized tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered as indicated in the instructions. **DELETED** the 4th and 5th bullets in Response-Specific Instructions and **INSERTED** the following: • In order to select Response 1 or 2, the fall risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment. **ADDED** the following sub-bullet under the last bullet: - the patient is not able to participate in tasks required to allow the completion and scoring of the standardized assessment(s) that the agency chooses to utilize.

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Chapter 3 / Pages L-2	M2000	**ADDED** as the last bullet in Response-Specific Instructions: • If a medication related problem is identified and resolved by the agency staff by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem.
Chapter 3 / Pages L-3	M2002	**ADDED** the following sub-bullet under the 4th bullet: - In order to select Response 1, the two-way communication AND reconciliation (or plan to resolve the problem) must be completed by the end of the next calendar day after the problem was identified and before the end of the allowed time frame (i.e., within five days of SOC, within two days of discharge from the inpatient facility at ROC). **ADDED** after the 5th bullet in Response-Specific Instructions: • If a medication related problem is identified and resolved by the agency staff by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem.
Chapter 3 / Pages L-4	M2004	**ADDED** the following as the last bullet: • If the last OASIS assessment completed was the SOC or ROC, and a clinically significant problem was identified at that SOC or ROC visit, the problem (and/or related physician communication) would be reported at both the SOC/ROC (on M2002), and again at Transfer or Discharge (on M2004), since the time frame under consideration for M2004 is at or since the previous OASIS assessment.
Chapter 3 / Pages L-7	2015	**ADDED** the following as a new 2nd bullet in Response-Specific Instructions: • The timeframe should be considered at or since the time of the previous OASIS assessment.

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Chapter 3 / Pages L-9	M2020	**ADDED** the following bullet after the 6th bullet in Response-Specific Instructions: • Select Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner, were adequate assistance for the patient to take all medications safely. **ADDED** the following bullet after the last bullet: • If a medication is ordered prn, and on the day of assessment the patient needed a reminder for this prn medication, select Response 2. If the patient did not need any prn medications on the day of the assessment and therefore no reminders were necessary, assess the patient's ability on all of the medications taken on the day of assessment.
Chapter 3 / Pages L-10	M2030	**ADDED** the following bullet after the 1st bullet in Response-Specific Instructions: • Includes one-time injections administered in the home. **ADDED** the following bullet after the now 5th bullet in Response-Specific Instructions: • Select Response 3 if the physician ordered the RN to administer an injection in the home.
Chapter 3 / Pages L-12	M2040	**REVISED** the first sentence in Item Intent to read: Identifies the patient's ability to manage all prescribed oral and injectable medications prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. **ADDED** the following as 1st and 2nd bullets in Response-Specific Instructions: • A care episode is not the same as a payment episode. The care episode begins with the most recent SOC or ROC and ends with a Transfer or Discharge. For example, if a patient is resuming home care services after a recent inpatient admission, report the patient's ability to manage medications prior to the most recent illness, injury, or exacerbation that is resulting in this resumption of home care services. • Includes all prescribed and OTC (over-the-counter) oral medications and all prescribed injectable medications that the patient is currently taking and are included on the plan of care.

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Chapter 3 / Pages M-2	M2100	**ADDED** the following bullet as the 1st bullet in Response-Specific Instructions: • At SOC/ROC, report what is known on the day of assessment regarding the availability and ability of caregivers to provide help in the various categories of assistance for the upcoming episode of care. At Discharge, report what is known on the day of the discharge assessment regarding the availability and ability of caregivers to provide assistance to the patient at the time of the discharge. **ADDED** as a sub-bullet under the Row d bullet: - Devices such as T.E.D hose, prosthetic devices, orthotic devices, or other supports that have a medical and/or therapeutic impact should be considered medical procedures/treatments, not as ADL/dressing items in Row a.
Chapter 3 / Pages N-3, N-4	M2250	The following bullet modifications were made to the Response-Specific Instructions: **ADDED** as a sub-bullet under the 1st bullet: – The physician plan of care includes all additional orders as an extension of the original Plan of Care. **ADDED** as a new 2nd bullet: • "Yes" is an appropriate response if the intervention is in the POC even if the assessment indicated the intervention was not applicable. **MODIFIED** the now 5th bullet, last sentence to read: These Plan of Care orders must be in place within five days of SOC or within two days of inpatient discharge at ROC in order to meet the measure definition. **MODIFIED** the now 7th bullet to read: • If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (within five days of SOC, within two days of discharge from the inpatient facility at ROC). For example, if the RN identifies fall risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient's Plan of Care includes interventions to prevent fall risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.

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		ADDED the following bullet under the bullet entitled Row a: • If the plan of care includes specific parameters ordered by the physician for this specific patient or after reviewing the agency's standardized parameters with the physician, s/he agrees they would meet the needs of this specific patient, select "Yes." If there are no patient-specific parameters on the plan of care and the agency will not use standardized physician notification parameters for this patient, select "No." If the agency uses their own agency standardized guidelines, which the physician has NOT agreed to include in the plan of care for this particular patient, select "No." **DELETED** the bullet entitled Row d: and **REPLACED** with the following: • Row d: If the physician-ordered plan of care contains orders for further evaluation or treatment of depression, select "Yes." Examples of interventions for depression may include new or existing medications, adjustments to already-prescribed medications, or referrals to agency resources (e.g., social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. Select "NA" if the patient has no diagnosis of depression AND assessment indicated no symptoms of depression (or does not meet criteria for further evaluation or treatment if a standardized depression screening tool is used). **ADDED** the following as a sub-bullet under the last bullet: - Moist wound healing treatment is any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, unna boots, medicated creams/ointments.

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Chapter 3 / Pages O-1	M2300	**DELETED** Item Intent and **REPLACED** with the following: Identifies whether the patient was seen in a hospital emergency department at or since the previous OASIS assessment. Responses to this item include the entire period at or since the last time OASIS data were collected, including use of hospital emergency department that results in a qualifying hospital admission, necessitating Transfer OASIS data collection. **REPLACED** the 6th, 7th, and 8th bullets to incorporate the wording "at or since" the last OASIS assessment. • If a patient is admitted to the hospital for a stay requiring an OASIS Transfer, Response 0 – No, should only be marked if the patient was directly admitted to the hospital (was not treated or evaluated in the emergency room), and had no other emergency department visits at or since the last OASIS assessment. • Select Response 1 for a patient who, at or since the last time OASIS was collected, has experienced both a direct admission to the hospital without treatment or evaluation AND accessed a hospital emergency department that did not result in an inpatient admission. • If a patient utilized a hospital emergency department more than once at or since the last OASIS assessment, select Response 2 if any emergency department visit at or since the last OASIS assessment resulted in hospital admission, otherwise select Response 1. **REPLACED** the 4th bullet under Data Sources/Resources to incorporate the wording "at or since" the last OASIS assessment. • Referral information for the ROC, if the patient had a hospital admission and home health care ROC at or since the previous OASIS assessment.

Section / Page#	Item #	Change
Chapter 3 / Pages O-3, O-4	M2310	**ADDED** the following bullets after the 2nd bullet in the Response-Specific Instructions: • Response 2 should be selected when the patient sought care in the hospital emergency department for an injury caused by a fall, regardless of where the fall occurred. • Select Response 19 if a patient seeks emergent care in the hospital emergency department for a new wound that was not the result of a fall. • If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out (e.g., patient was sent to ED for suspected DVT but diagnostic testing and evaluation were negative for DVT).
Chapter 3 / Pages P-1, P2, P3	M2400	**DELETED** the 1st bullet and **REPLACED** with the following two bullets in Response-Specific Instructions: • Select "Yes" if the physician-ordered plan of care (POC) includes the specified best practice interventions as specified in each row, at or since the previous OASIS assessment, and there is evidence of implementation in the clinical record. • "Yes" may be selected even if the formal assessments did not suggest a need for the particular intervention. If the intervention was on the POC but not implemented, or if the intervention was implemented but not on the POC, select "No. **ADDED** as a sub-bullet below the 8th bullet entitled For rows b-e: – An evaluation of clinical factors is not considered a formal assessment for M1300 pressure ulcer risk.
Chapter 3 / Pages P-4	M2410	**ADDED** the following bullet after the 3rd bullet in Response-Specific Instructions: • Admission to inpatient drug rehabilitation is considered an inpatient admission. Select "1 – Hospital," whether it was a freestanding drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital.

Section / Page#	Item #	Change
Chapter 3 / Pages P-5	M2420	**DELETED** the 2nd bullet and **REPLACED** with the following in the Response-Specific Instructions: • Formal assistive services refers to community-based services provided through organizations or by paid helpers. Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels. – Therapy services provided in an outpatient setting would not be considered formal assistance. • Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (i.e., meals not provided by the church organization itself, but by individual volunteers).
Chapter 5		**CHAPTER 5 – RESOURCES / LINKS** The link to PBQI/Process Measures was added under CMS Websites (p. 5-1). http://www.cms.gov/HomeHealthQualityInits/15_PBQIProcessMeasures.asp#TopOfPage Two new CDC links were added to the Infection Control and Immunizations section (p. 5-3). http://www.cdc.gov/vaccines/recs/vac-admin/default.htm#guide http://www.cdc.gov/flu/professionals/acip/