Diagnosis **CODING PRO** for Home Health

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# Extra

Inova VNA Home Health Senior Coding Manager Therese Rode, HCS-D, RHIT provided this OASIS B-1 to OASIS-C crosswalk that focuses on the M0 Items that impact the HHRG in the Clinical Domain. The tool does not incorporate other M0 items that have an impact on the Clinical Score if a specific M0 item is reported with a specific diagnosis. This version of OASIS-C, released Nov. 19, has a target implementation date of Jan. 1, 2010, and it is impossible to project the various changes that CMS may make to items that will impact the Clinical, Functional, and Service dimensions. OASIS-C *will* allow more specificity and will mean more meaningful data is assessed. Present on Admission (POA), which currently applies to hospitals, appears to be coming for HHAs. While some items are deleted from the OASIS B-1, HHAs will be able to report more accurate outcomes with the new items from OASIS-C Version 10.

As OASIS C-1 Version 10 is reviewed, keep in mind what OASIS stands for (Outcome and Assessment Information Set). Although the OASIS is used as a billing tool, its primary intent is to measure outcomes. Version 10 looks promising, as it attempts to capture POA, risk of developing lesions/ulcers, proactive and preventative measures, further specificity regarding the patient's condition, notification of physicians, and physician involvement in the Plan of Care, etc. Reminder: OASIS-C Version 10 is not final, so other changes are likely.

| OASIS B1 | | | | | | | OASIS-C Version 10 | | | | | | | |
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| | | Collection Timepoints | | | | | | | Collection Timepoints | | | | | |
| **OASIS B1 Item #** | **OASIS-B1 Item Text (CMS)** | **SOC** | **ROC** | **FU** | **TRF** | **DC** | **OASIS-C Item #** | **OASIS-C Version 10 Item Text (CMS)** | **SOC** | **ROC** | **FU** | **TRF** | **DC** | **Comments from Rode and *Diagnosis Coding Pro*** |
| M0190 | (M0190) List each Inpatient Diagnosis and ICD 9 CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no surgical, E codes, or V codes):<br>Inpatient Facility Diagnosis ICD-9-CM<br>a. (__ __ __ • __ __)<br>b. (__ __ __ • __ __) | X | X | | | | M1010 | List each Inpatient Diagnosis and ICD code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E codes, or V codes):<br>Inpatient Facility Diagnosis ICD Code<br>a. __ __ __ __ __ __ __<br>b. __ __ __ __ __ __ __<br>c. __ __ __ __ __ __ __<br>d. __ __ __ __ __ __ __<br>e. __ __ __ __ __ __ __<br>f. __ __ __ __ __ __ __ | X | X | | | | The requirements remain the same. However, OASIS-B1 allows two diagnoses while OASIS-C allows six. OASIS-C appears upgraded to accept ICD-10-CM codes. |
| | New on OASIS-C | | | | | | M1012 | List each Inpatient Procedure and the associated ICD procedure code<br>Inpatient Procedure Code<br>a. __ __ __ __ __ __ __<br>b. __ __ __ __ __ __ __<br>c. __ __ __ __ __ __ __<br>d. __ __ __ __ __ __ __ | X | X | | | | **New OASIS Item**<br>Inpatient Procedure codes are new to the OASIS and have also been upgraded to accept ICD-10-PCS. This information will be difficult to obtain. |
| M0210 | (M0210) List the patient's Medical Diagnoses and ICD 9 CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E codes, or V codes):<br>Changed Medical Regimen Diagnosis ICD-9-CM<br>a. (__ __ __ • __ __)<br>b. (__ __ __ • __ __)<br>c. (__ __ __ • __ __)<br>d. (__ __ __ • __ __) | X | X | | | X | M1016 | List the patient's Medical Diagnoses and ICD codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E codes, or V codes):<br>Changed Medical Regimen Diagnosis ICD Code<br>a. __ __ __ __ __ __ __<br>b. __ __ __ __ __ __ __<br>c. __ __ __ __ __ __ __<br>d. __ __ __ __ __ __ __<br>e. __ __ __ __ __ __ __<br>f. __ __ __ __ __ __ __ | X | X | | | | Again, the requirements remain the same, except that the item no longer must be reported on discharge. Where M0210 only allowed for four diagnoses to be reported, M1016 will allow for six and also has been formatted to include the additional digits required for reporting in ICD-10-CM. |

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| M0230 | M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.<br>Code each row as follows:<br>Column 1: Enter the description of the diagnosis.<br>Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;<br>Rate the severity of the condition listed in Column 1 using the following scale:<br>0 - Asymptomatic, no treatment needed at this time<br>1 - Symptoms well controlled with current therapy<br>2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring<br><br>3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring<br>4 - Symptoms poorly controlled; history of re-hospitalizations<br>Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.<br>Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix | X | X | X | | | M1020 | Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD code at the level of highest specificity (no surgical/procedure codes) (Column 2). Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M1020 or M1022) or E codes (for M1022 only) may be used. ICD sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.<br>Code each row according to the following directions for each column:<br>Column 1: Enter the description of the diagnosis.<br>Column 2: Enter the ICD code for the diagnosis described in Column 1;<br>Rate the severity of the condition listed in Column 1 using the following scale:<br>0 - Asymptomatic, no treatment needed at this time<br>1 - Symptoms well controlled with current therapy<br>3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring<br>4 - Symptoms poorly controlled; history of re-hospitalizations<br><br>Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.<br>Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD coding guidelines, enter the diagnosis descriptions and the ICD codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code,record the diagnosis description and ICD code for the underlying condition in Column 3 of that row and the diagnosis description and ICD code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row. | X | X | X | | | Requirements for reporting in M0230, M0240, M0246, and its counterpart M1020, M1022, and M0124 remain the same. *(Note: There is a typographical mistake that lists 1022 twice, but M0246 will be M1024.)* It is interesting to note the inclusion of V codes prominently in the instructions. V codes will no longer exist in ICD-10-CM; instead, they will be Z codes and will be reflected in a digit within a main category. The instructions still include mention of case-mix diagnoses in M1024, but in a recent Q&A, Medicare states there is no penalty for inclusion of non-case mix diagnoses and states that risk adjustment is available. |

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| | diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row. | | | | | | | | | | | | | |
| M0240 | see M0230 | X | X | X | | | M1022 | See M1020 | X | X | X | | | See M0230/M1020 |
| M0246 | see M0230 | X | X | X | | | M1024 | See M1020 | X | X | X | | | See M0230/M1020 |
| M0250 | (M0250) Therapies the patient receives at home: (Mark all that apply.)<br>1 - Intravenous or infusion therapy (excludes TPN)<br>2 - Parenteral nutrition (TPN or lipids)<br>3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)<br>4 - None of the above | X | X | X | | X | M1030 | Therapies the patient receives at home: (Mark all that apply.)<br>• 1 - Intravenous or infusion therapy (excludes TPN)<br>• 2 - Parenteral nutrition (TPN or lipids)<br>•3- Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)<br>• 4 - None of the above | X | X | X | | | Requirements remain the same, except the item no longer must be reported on discharge. |
| M0390 | (M0390) Vision with corrective lenses if the patient usually wears them:<br>• 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.<br>• 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.<br>• 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive. | X | X | X | | | M1200 | Vision with corrective lenses if the patient usually wears them:<br>• 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.<br>• 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.<br>• 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive. | X | X | X | | | Requirements for M0390 and M1200 remain the same. |
| M0420 | (M0420) Frequency of Pain interfering with patient's activity or movement:<br>• 0 - Patient has no pain or pain does not interfere with activity or movement<br>• 1 - Less often than daily<br>• 2 - Daily, but not constantly<br>• 3 - All of the time | X | X | X | | X | M1240 | Frequency of Pain interfering with patient's activity or movement:<br>• 0 - Patient has no pain<br>• 1 - Patient has pain that does not interfere with activity or movement<br>• 2 - Less often than daily<br>• 3 - Daily, but not constantly<br>• 4 - All of the time | X | X | X | | X | Requirements for M0420 and M1240 have been specified/broken down for further specificity. "No pain" and "Pain that does not interfere with activity or movement" have been separated. |
| | New on OASIS-C | | | | | | M1242 | Has this patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?<br>• 0 - No standardized assessment conducted<br>• 1 - Yes, and it does not indicate severe pain<br>• 2 - Yes, and it indicates severe pain | X | X | | | | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. |

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| | New on OASIS-C | | | | | | M1244 | Planned Pain Intervention: Does the current physician-ordered plan of care include intervention(s) to monitor and mitigate pain?<br>• 0 - No<br>• 1 - Yes | X | X | | | | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. |
| | New on OASIS-C | | | | | | M1246 | Pain Intervention: Since the previous OASIS assessment, have pain management steps in the physician-ordered plan of care been implemented to monitor and mitigate pain?<br>• 0 - No<br>• 1 - Yes<br>• NA - No pain intervention included in physician-ordered plan of care | | | | X | X | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. |
| | New on OASIS-C | | | | | | M1300 | Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?<br>• 0 - No assessment conducted [ Go to M1308 ]<br>• 1 - Yes, using a standardized tool (e.g., Braden, Norton, other)<br>• 2 – Yes, based on an evaluation of clinical factors (e.g., mobility, incontinence, nutrition, etc.) | X | X | | | | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. New Pressure Ulcer item provides more specificity and, as a result, more meaningful data. |
| | New on OASIS-C | | | | | | M1302 | Does this patient have a Risk of Developing Pressure Ulcers?<br>• 0 - No [ Go to M1308 ]<br>• 1 - Yes | X | X | | | | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. New Pressure Ulcer item provides more specificity and, as a result, more meaningful data. |
| | New on OASIS-C | | | | | | M1304 | Planned Pressure Ulcer Prevention: Does the current physician-ordered plan of care include intervention(s) to prevent pressure ulcers?<br>• 0 - No<br>• 1 - Yes | X | X | | | | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. New Pressure Ulcer item provides more specificity and, as a result, more meaningful data. |
| | New on OASIS-C | | | | | | M1306 | Pressure Ulcer Prevention: Since the previous OASIS assessment, were intervention(s) on the current physician-ordered plan of care to prevent pressure ulcers implemented?<br>• 0 - No<br>• 1 - Yes<br>• NA - No pressure ulcer prevention in physician-ordered plan of care | | | | X | X | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. New Pressure Ulcer item provides more specificity and, as a result, more meaningful data. |

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| M0450 b-e<br><br>(M0450 a: see below) | M0450 b-e) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)<br><br>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. 0 1 2 3 4 or more<br>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. 0 1 2 3 4 or more<br>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.) 0 1 2 3 4 or more<br>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?<br>• 0 - No<br>• 1 - Yes | X | X | X | | X | M1310 | Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage (2 - 4):<br>(MATRIX)<br>(Enter “0” if none; enter “4” if “4 or more”; enter “UK” for rows d.1 – d.3 if “Unknown”)<br>ROWS:<br>Stage description - unhealed pressure ulcers<br>a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.<br>b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.<br>c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.<br>d.1 Unstageable: Known or likely but not stageable due to non-removable dressing or device<br>d.2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar.<br>d.3 Unstageable: Suspected deep tissue injury in evolution.<br>BY COLUMNS:<br>Number Present<br>Number of these that were present on admission | X | X | X | | X | **New OASIS Item**<br>Whether it will impact the score in the Clinical Dimension is yet to be determined. New Pressure Ulcer item is to be used for pressure ulcers stage II through unstageable. This item will not be used to capture stage I pressure ulcers. The item provides more specificity and, as a result, more meaningful data.<br><br>Item also contains an area for reporting Present on Admission (POA). This may make HHAs accountable for new and/or worsening pressure ulcers. Whether CMS decides to use this item for reduction in payment has not been determined, but it will certainly impact an HHA’s outcomes. |
| | New on OASIS-C | | | | | | M1312 | Pressure Ulcer Length: Longest length in any direction \| ___ \| ___ \| . \| ___ \| (cm) | X | X | | | X | **New OASIS Item**<br>Will impact outcomes, however CMS has not taken into account that the pressure ulcer that may be measured may be a different pressure ulcer from episode to episode. Also, a standard means of measuring needs to be determined. |
| | New on OASIS-C | | | | | | M1314 | Pressure Ulcer Width: Width of the same pressure ulcer, greatest width measured at right angles to length<br>\| ___ \| ___ \| . \| ___ \| (cm) | X | X | | | X | **New OASIS Item**<br>Will impact outcomes. |

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| M0450a (stage 1)<br><br>(M0450 b-e: see above) | M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)<br><br>a) Stage 1: Non-blanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.<br>0, 1, 2, 3, 4 or more | X | X | X | | X | M1322 | Current Number of Stage I Pressure Ulcers:<br><br>Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.<br>• 0 • 1 • 2 • 3 • 4 or more | X | X | | | X | Requirements for M1322 are specific to stage I pressure ulcers only. Item will no longer be required to be reported on recertification. Item correlates with item numbers M1300, M1302, M1304, M1306. Worsening of these pressure ulcers will impact outcomes reporting. |
| M0460 | [At follow-up, skip to M0470 if patient has no pressure ulcers]<br><br>(M0460) Stage of Most Problematic (Observable) Pressure Ulcer:<br>• 1 – Stage 1<br>• 2 – Stage 2<br>• 3 – Stage 3<br>• 4 – Stage 4<br>• NA – No observable pressure ulcer | X | X | X | | X | M1324 | Stage of Most Problematic (Observable) Pressure Ulcer:<br>• 1 – Stage I [Go to M1330 at SOC/ROC/FU ]<br>• 2 – Stage II<br>• 3 – Stage III<br>• 4 – Stage IV<br>• NA – No observable pressure ulcer [Go to M1330 at SOC/ROC/FU ] | X | X | X | | X | |
| M0476 | [At follow-up, skip to M0488 if patient has no stasis ulcers]<br><br>(M0476) Status of Most Problematic (Observable) Stasis Ulcer:<br><br>1 – Fully granulating<br>2 – Early/partial granulation<br>3 – Not healing<br>NA – No observable stasis ulcer | X | X | X | | X | M1334 | Status of Most Problematic (Observable) Stasis Ulcer:<br>• 0 – Re-epithelialized or healed<br>• 1 – Fully granulating<br>• 2 – Early/partial granulation<br>• 3 – Not healing | X | X | X | | X | M1334 will allow for reporting re-epithelialized or healed stasis ulcers, but there does not appear to be an area to report “No observable stasis ulcer” at this level. |
| M0488 | (M0488) [At follow-up, skip to M0490 if patient has no surgical wounds]<br>Status of Most Problematic (Observable) Surgical Wound:<br>1 - Fully granulating<br>2 - Early/partial granulation<br>3 - Not healing<br>NA - No observable surgical wound | X | X | X | | X | M1342 | Status of Most Problematic (Observable) Surgical Wound:<br>• 0 - Re-epithelialized or healed<br>• 1 - Fully granulating<br>• 2 - Early/partial granulation<br>• 3 - Not healing | X | X | X | | X | M1342 will allow for reporting re-epithelialized or healed stasis ulcers, but there does not appear to be an area to report “No observable surgical wound” at this level. |

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| | New on OASIS-C | | | | | | M1360 | Diabetic Foot Care Plan: Does the physician-ordered plan of care include regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care?<br>• 0 - No<br>• 1 - Yes<br>• NA - Bilateral amputee OR Patient does not have diagnosis of diabetes | X | X | | | | **New OASIS Item**<br>M1360 allows for further specificity of diabetic complications to ensure that the prevention of lesions is incorporated in the physician plan of care. |
| M0490 | (M0490) When is the patient dyspneic or noticeably Short of Breath?<br>0 - Never, patient is not short of breath<br>1 - When walking more than 20 feet, climbing stairs<br>2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)<br>3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation<br>4 - At rest (during day or night) | X | X | X | | X | M1400 | When is the patient dyspneic or noticeably Short of Breath?<br>• 0 - Patient is not short of breath<br>• 1 - When walking more than 20 feet, climbing stairs<br>• 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)<br>• 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation<br>• 4 - At rest (during day or night) | X | X | X | | X | No changes in reporting requirements. |
| M0530 | (M0530) When does Urinary Incontinence occur?<br>0 - Timed-voiding defers incontinence<br>1 - During the night only<br>2 - During the day and night | X | X | X | | X | M1615 | When does Urinary Incontinence occur?<br>• 0 - Timed-voiding defers incontinence<br>• 1 - Occasional stress incontinence<br>• 2 - During the night only<br>• 3 - During the day only<br>• 4 - During the day and night | X | X | | | X | Item changes provide further specificity and more meaningful/realistic data. Note that stress incontinence is a separate option. Item will no longer be required to be reported at recertification, but will continue to be required at SOC, ROC, and at discharge. |
| M0540 | (M0540) Bowel Incontinence Frequency:<br>0 - Very rarely or never has bowel incontinence<br>1 - Less than once weekly<br>2 - One to three times weekly<br>3 - Four to six times weekly<br>4 - On a daily basis<br>5 - More often than once daily<br>NA - Patient has ostomy for bowel elimination<br>UK - Unknown | X | X | X | | X | M1620 | Bowel Incontinence Frequency:<br>• 0 - Very rarely or never has bowel incontinence<br>• 1 - Less than once weekly<br>• 2 - One to three times weekly<br>• 3 - Four to six times weekly<br>• 4 - On a daily basis<br>• 5 - More often than once daily<br>• NA - Patient has ostomy for bowel elimination<br>• UK - Unknown | X | X | X | | X | No changes in item. |

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| | | Collection Timepoints | | | | | | Collection Timepoints | | | | | | |
| **OASIS B1 Item #** | **OASIS-B1 Item Text (CMS)** | **SOC** | **ROC** | **FU** | **TRF** | **DC** | **OASIS-C Item #** | **OASIS-C Version 10 Item Text (CMS)** | **SOC** | **ROC** | **FU** | **TRF** | **DC** | **Comments from Rode and *Diagnosis Coding Pro*** |
| M0550 | (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?<br>0 - Patient does not have an ostomy for bowel elimination.<br>1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.<br>2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen. | X | X | X | | X | M1630 | Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?<br>• 0 - Patient does not have an ostomy for bowel elimination.<br>• 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.<br>• 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen. | X | X | X | | | The only change for this item is that it will no longer be required to be reported at discharge. |
| M0800 | (M0800) Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.<br>Prior<br>0 - Able to independently take the correct medication and proper dosage at the correct times.<br>1 - Able to take injectable medication at correct times if:<br>(a) individual syringes are prepared in advance by another person, OR<br>(b) given daily reminders.<br>2 - Unable to take injectable medications unless administered by someone else.<br>NA - No injectable medications prescribed.<br>UK - Unknown<br>Current<br>0 - Able to independently take the correct medication and proper dosage at the correct times.<br>1 - Able to take injectable medication at correct times if:<br>(a) individual syringes are prepared in advance by another person, OR<br>(b) given daily reminders.<br>2 - Unable to take injectable medications unless administered by someone else.<br>NA - No injectable medications prescribed. | X | X | X (Current Only) | | X (Current Only) | M2030 | Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.<br>• 0 - Able to independently take the correct medication and proper dosage at the correct times.<br>• 1 - Able to take injectable medication at correct times if:<br>(a) individual syringes are prepared in advance by another person, OR<br>(b) given reminders based on the frequency of the injection.<br>• 2 - Unable to take injectable medications unless administered by someone else.<br>• NA - No injectable medications prescribed. | X | X | X | | X | Item M0800 differs from M2030 in that it will no longer require the reporting of "prior" ability of the patient to manage injectable medications. Rather, it is only focusing on the present. The Item will still be reported at SOC, ROC, FU and Discharge. |