

OASIS ITEMS USED FOR ASSESSMENTS OF 60-DAY EPISODES
BEGINNING PRIOR TO JANUARY 1, 2008

Item-By-Item Tips

OASIS ITEM:
<p>(M0175) From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Hospital</p> <p><input type="checkbox"/> 2 - Rehabilitation facility</p> <p><input type="checkbox"/> 3 - Skilled nursing facility</p> <p><input type="checkbox"/> 4 - Other nursing home</p> <p><input type="checkbox"/> 5 - Other (specify) _____</p> <p><input type="checkbox"/> NA - Patient was not discharged from an inpatient facility [If NA, go to M0200]</p>
DEFINITION:
<p>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 or the first day of the certification period.)</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up</p>
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Rehabilitation facility is a freestanding rehab hospital or a rehabilitation distinct part unit of a general acute care hospital. • Other nursing home includes intermediate care facilities for the mentally retarded (ICF/MR) and nursing facilities (NF). • Mark all that apply. Patient may have been discharged from both a hospital <u>and</u> a rehab facility within the past 14 days, for example. • If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed or a nursing home bed (and the level of care provided in the nursing home bed).
ASSESSMENT STRATEGIES:
<p>Information can be obtained from patient/caregiver or physician's office. When uncertain about the type of facility or whether the facility is an <u>inpatient facility</u>, it may be necessary to check with the facility regarding licensure/designation.</p>

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CHAPTER 12, ADDENDUM G1

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<p>(M0230/M0240) 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.)</p> <p>0 - Asymptomatic, no treatment needed at this time 1 - Symptoms well controlled with current therapy 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring 3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring 4 - Symptoms poorly controlled, history of rehospitalizations</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>(M0230) Primary Diagnosis</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>ICD</u></th> <th colspan="5" style="text-align: center; border-bottom: 1px solid black;"><u>Severity Rating</u></th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;">a. _____</td> <td style="border-bottom: 1px solid black;">(____ - ____)</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> <td style="text-align: center;"><input type="checkbox"/> 3</td> <td style="text-align: center;"><input type="checkbox"/> 4</td> </tr> </tbody> </table> <table style="width:100%; 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<ul style="list-style-type: none"> • No surgical codes - list the underlying diagnosis. • No V-codes or E-codes - list the relevant diagnosis. • Three-digit code required; digits to the right of the decimal are optional. 																																																								
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<p>Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.</p> <p>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. The current ICD-9-CM code book should be the source for coding.</p> <p>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.</p>																																																								

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OASIS ITEM:
<p>(M0250) Therapies the patient receives <u>at home</u>: (Mark all that apply.)</p> <ul style="list-style-type: none"><input type="checkbox"/> 1 - Intravenous or infusion therapy (excludes TPN)<input type="checkbox"/> 2 - Parenteral nutrition (TPN or lipids)<input type="checkbox"/> 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)<input type="checkbox"/> 4 - None of the above
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:
<ul style="list-style-type: none">• 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).

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OASIS ITEM:
(M0390) Vision with corrective lenses if the patient usually wears them: <input type="checkbox"/> 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint. <input type="checkbox"/> 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. <input type="checkbox"/> 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.
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:
<ul style="list-style-type: none">• 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 medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.

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OASIS ITEM:
<p>(M0420) Frequency of Pain interfering with patients activity or movement:</p> <ul style="list-style-type: none"><input type="checkbox"/> 0 - Patient has no pain or pain does not interfere with activity or movement<input type="checkbox"/> 1 - Less often than daily<input type="checkbox"/> 2 - Daily, but not constantly<input type="checkbox"/> 3 - All of the time
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:
<p>When reviewing patients 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.</p> <p>Evaluating the Patient's ability to perform ADLs and ADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.</p>

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OASIS ITEM:
<p>(M0440) Does this patient have a Skin Lesion or an Open Wound? This excludes "OSTOMIES."</p> <p><input type="checkbox"/> 0 - No [If No, go to M0490]</p> <p><input type="checkbox"/> 1 - Yes</p>
DEFINITION:
<p>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.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency - not to an inpatient facility</p>
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• 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., bums, diabetic ulcers, gunshot wounds, etc.), should be documented in a manner determined by each agency. You may mark "I - 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, PICC lines, implanted infusion devices or venous access devices, surgical wounds with staples or sutures, etc. are all considered lesions/wounds.
ASSESSMENT STRATEGIES:
<p>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.</p>

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OASIS ITEM:						
(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)						
	Pressure Ulcer Stages				Number of Pressure Ulcers	
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.	0	1	2	3	4 or more
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
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
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
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?					
	<input type="checkbox"/> 0 - No					
	<input type="checkbox"/> 1 - Yes					
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:						
<ul style="list-style-type: none"> • 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 W is "No," mark that answer. 						
ASSESSMENT STRATEGIES:						

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OASIS ITEM:
<p>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.</p> <p>Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)</p> <p>Recognizing erythema (a Stage I 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.</p> <p>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.</p> <p>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. An ulcers stage can worsen, and this item should be answered appropriately if this occurs.</p>
<p>(M0460) Stage of Most Problematic (Observable) Pressure Ulcer:</p> <ul style="list-style-type: none"><input type="checkbox"/> 1 - Stage 1<input type="checkbox"/> 2 - Stage 2<input type="checkbox"/> 3 - Stage 3<input type="checkbox"/> 4 - Stage 4<input type="checkbox"/> NA - No observable pressure ulcer
DEFINITION:
<p>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.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
RESPONSE--SPECIFIC INSTRUCTIONS:

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OASIS ITEM:
<ul style="list-style-type: none">• 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.
(M0476) Status of Most Problematic (Observable) Stasis Ulcer: <ul style="list-style-type: none"><input type="checkbox"/> 1 - Fully granulating<input type="checkbox"/> 2 - Early/partial granulation<input type="checkbox"/> 3 - Not healing<input type="checkbox"/> NA - No observable stasis ulcer
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:

OASIS ITEM:
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.
<p>(M0488) Status of Most Problematic (Observable) Surgical Wound:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - Fully granulating <input type="checkbox"/> 2 - Early/partial granulation <input type="checkbox"/> 3 - Not healing <input type="checkbox"/> NA - No observable surgical wound
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:
<p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • 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.

OASIS ITEM:
<p>(M0490) When is the patient dyspneic or noticeably Short of Breath?</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Never, patient is not short of breath <input type="checkbox"/> 1 - When walking more than 20 feet, climbing stairs <input type="checkbox"/> 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet) <input type="checkbox"/> 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation <input type="checkbox"/> 4 - At rest (during day or night)
DEFINITION:
Identifies the patient's level of shortness of breath.
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • 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:
<p>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?</p>

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OASIS ITEM:
(M0530) When does Urinary Incontinence occur? <input type="checkbox"/> 0 - Timed-voiding defers incontinence <input type="checkbox"/> 1 - During the night only <input type="checkbox"/> 2 - During the day and night
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:
<ul style="list-style-type: none">• If patient is only "occasionally" incontinent, determine when the incontinence usually occurs.• Any incontinence that occurs during the day should be marked with Response 2.
ASSESSMENT STRATEGIES:
Once the existence of incontinence is known, ask when the incontinence occurs.

OASIS ITEM:
<p>(M0540) Bowel Incontinence Frequency:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Very rarely or never has bowel incontinence <input type="checkbox"/> 1 - Less than once weekly <input type="checkbox"/> 2 - One to three times weekly <input type="checkbox"/> 3 - Four to six times weekly <input type="checkbox"/> 4 - On a daily basis <input type="checkbox"/> 5 - More often than once daily <input type="checkbox"/> NA - Patient has ostomy for bowel elimination <input type="checkbox"/> UK - Unknown
DEFINITION:
<p>Identifies how often the patient experiences bowel incontinence.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • 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:
<p>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. 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.</p>

OASIS ITEM:
<p>(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?</p> <p><input type="checkbox"/> 0 - Patient does not have an ostomy for bowel elimination.</p> <p><input type="checkbox"/> 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.</p> <p><input type="checkbox"/> 2 - The ostomy was related to an inpatient stay or -did necessitate change in medical or treatment regimen.</p>
DEFINITION:
<p>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.</p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • 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 <u>not</u> 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:
<p>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 M0540). 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.</p>

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 12, ADDENDUM G1

OASIS ITEMS USED FOR ASSESSMENTS OF 60-DAY EPISODES BEGINNING PRIOR TO JANUARY 1, 2008

Item-By-Item Tips

OASIS ITEM:
<p>(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)</p> <ul style="list-style-type: none"><input type="checkbox"/> 1 - Memory deficit failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required<input type="checkbox"/> 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions<input type="checkbox"/> 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.<input type="checkbox"/> 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)<input type="checkbox"/> 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)<input type="checkbox"/> 6 - Delusional, hallucinatory, or paranoid behavior<input type="checkbox"/> 7 - None of the above behaviors demonstrated
<p>DEFINITION:</p> <p>Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.</p>
<p>TIME POINTS ITEM(S) COMPLETED:</p> <p>Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility</p>
<p>RESPONSE--SPECIFIC INSTRUCTIONS:</p> <ul style="list-style-type: none">• Behaviors may be observed by the clinician or reported by the patient, family, or others.
<p>ASSESSMENT STRATEGIES:</p> <p>Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history interview for the current presence of these behaviors at the stated frequency, i.e., at least weekly. Consult with family or caregiver familiar with patient behavior.</p>

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CHAPTER 12, ADDENDUM G1

OASIS ITEMS USED FOR ASSESSMENTS OF 60-DAY EPISODES BEGINNING PRIOR TO JANUARY 1, 2008

Item-By-Item Tips

OASIS ITEM:	
<p>(M0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front opening shirts and blouses, managing zippers, buttons, and snaps:</p>	
<u>Prior</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/>
0	- Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
<input type="checkbox"/>	<input type="checkbox"/>
1	- Able to dress upper body without assistance if clothing is laid out or handed to the patient.
<input type="checkbox"/>	<input type="checkbox"/>
2	- Someone must help the patient put on upper body clothing.
<input type="checkbox"/>	<input type="checkbox"/>
3	- Patient depends entirely upon another person to dress the upper body.
<input type="checkbox"/>	<input type="checkbox"/>
UK	- Unknown
DEFINITION:	
<p>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 <u>14 days prior to the start (or resumption) of care visit</u>. The focus for today's assessment - the "current" column - is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>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</p>	
RESPONSE--SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> "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:	
<p>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.</p>	

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CHAPTER 12, ADDENDUM G1

OASIS ITEMS USED FOR ASSESSMENTS OF 60-DAY EPISODES BEGINNING PRIOR TO JANUARY 1, 2008

Item-By-Item Tips

OASIS ITEM:	
<p>(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:</p>	
<u>Prior</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/>
	UK - Unknown
<p>0 - Able to obtain, put on, and remove clothing and shoes without assistance.</p> <p>1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.</p> <p>2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.</p> <p>3 - Patient depends entirely upon another person to dress lower body.</p>	
DEFINITION:	
<p>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 <u>14 days prior to the start for resumption - of care visit</u>. The focus for today's assessment - the "current" column - is on what the patient is <u>able</u> to do today.</p>	
TIME POINTS ITEM(S) COMPLETED:	
<p>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</p>	
RESPONSE--SPECIFIC INSTRUCTIONS:	
<ul style="list-style-type: none"> • 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:	
<p>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.</p>	

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CHAPTER 12, ADDENDUM G1

OASIS ITEMS USED FOR ASSESSMENTS OF 60-DAY EPISODES BEGINNING PRIOR TO JANUARY 1, 2008

Item-By-Item Tips

OASIS ITEM:
(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? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes <input type="checkbox"/> NA - Not Applicable
DEFINITION:
Identifies whether patients care plan indicates need for high-therapy use.
TIME POINTS ITEM(S) COMPLETED:
Start of care Resumption of care Follow-up
RESPONSE--SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none">• Answer "No" if no therapy services are needed OR if the intensity of therapy services does not meet the threshold for Medicare high-therapy use.• Answer "Not Applicable" only for patients who are not Medicare fee-for-service (i.e., M01 50, Response I is not checked).
ASSESSMENT STRATEGIES:
When the patient assessment and the care plan are complete, review the plan to determine whether therapy services are needed. If not, answer "No." If therapy services are needed, will their frequency meet the threshold level for the patient to be considered a high-therapy user? If not, answer "No." If the therapy services meet (or exceed) this frequency, answer "Yes."