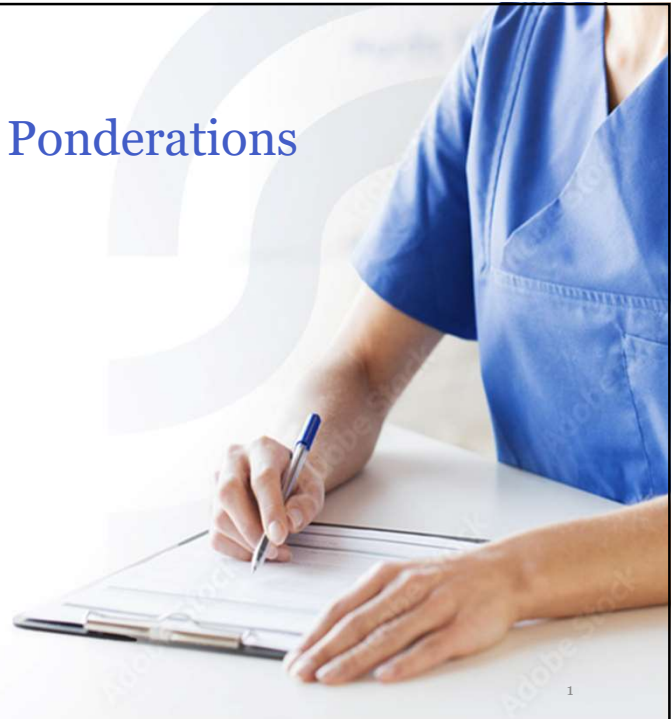


Policies, Procedures and Ponderations

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Agenda

- Gain insight and tips into the Cognitive, Mood, Medication and Special Treatment sections to ensure your agency is aware of needed training.
- Agencies will recognize where policies and procedures may need development to tackle these sections as well.



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CO100. Should Brief Interview for Mental Status (CO200-CO500) be Conducted?

CO100. Should Brief Interview for Mental Status (CO200-CO500) be Conducted?	
Attempt to conduct interview with all patients.	
Enter Code	0. No (patient is rarely/never understood) → Skip to C1310 Signs and Symptoms of Delirium (from CAM ©)
<input type="checkbox"/>	1. Yes → Continue to CO200, Repetition of Three Words

- **Code 0, No**, if the interview should not be conducted because the patient is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip BIMS (items CO200-CO500).
- **Code 1, Yes**, if the interview should be conducted because the patient is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to BIMS CO200, Repetition of Three Words.

Provides staff with a more reliable estimate of patient function



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BIMS: CO200 – CO500

Brief Interview for Mental Status (BIMS)	
CO200. Repetition of Three Words	
Enter Code	Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: <i>sock, blue, and bed</i> . Now tell me the three words." Number of words repeated after first attempt
<input type="checkbox"/>	0. None 1. One 2. Two 3. Three After the patient's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
CO300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code	Ask patient: "Please tell me what year it is right now."
<input type="checkbox"/>	A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
Enter Code	Ask patient: "What month are we in right now?"
<input type="checkbox"/>	B. Able to report correct month 0. Missed by 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code	Ask patient: "What day of the week is today?"
<input type="checkbox"/>	C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
CO400. Recall	
Enter Code	Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.
<input type="checkbox"/>	A. Able to recall "sock" 0. No – could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code	B. Able to recall "blue" 0. No – could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter Code	C. Able to recall "bed" 0. No – could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
CO500. BIMS Summary Score	
Enter Score	Add scores for questions CO200-CO400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview
<input type="checkbox"/>	



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BIMS: Co200 – Co500

Section C in the Guidance Manual has full instructions for clinicians regarding how to administer the BIMS verbally or in writing.

- It is recommended to have a set(s) of cue cards available for when a written test is necessary. They are on display in Section C (11 in total) . Be sure when they are printed out the text is large enough to accommodate those that may need larger print.

I have written 3 words for you to remember.

Please read them.

Then, I will remove the card and ask you to repeat or write down the words as you remember them.

BIMS: Co200 – Co500

Instructions

- Record the maximum number of words that the patient correctly repeated on the first attempt. This will be any number between 0 and 3.
- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
- *Do not score the number of repeated words on the second or third attempt.* These attempts help with learning the item, but only the number correct on the first attempt go into the total score. Do not record the number of attempts that the patient needed to complete.
- Category cues are permitted.
- **After 3 attempts, move on to next question.**

BIMS: C0200 – C0500

Coding Tips

- Nonsensical responses should be coded as zero [0].
 - Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.
- Refusal to answer an item:
 - Accept it and move on to the next question.
 - Code as incorrect/no answer/could not recall: zero [0]



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Difference between a zero and a zero

WHAT??

- Remember, it was stated earlier that nonsensical, lack of responses, and refusal to answer items should be coded as zero [0].
- But notice that a zero [0] can ALSO be that the patient just got it wrong!

Enter Code	Ask patient: "Please tell me what year it is right now."
<input type="checkbox"/>	A. Able to report correct year
	0. Missed by > 5 years or no answer
	1. Missed by 2-5 years
	2. Missed by 1 year
	3. Correct

- So, if they have answered to the best of their abilities, but still answered all C0200 and C0300 items incorrectly, scored as a [0], this is NOT a reason to **STOP** (see next slide).
 - The clinician needs to track (or remember) WHY the score is a [0].
- Keep going with C0400 Recall.



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BIMS:Co200 – Co500

- All responses have been nonsensical **OR**
- There has been no verbal or written response to any of the questions up to this point, **OR**
- There has been no verbal or written response to some questions up to this point and for all others, the patient has given a nonsensical response.



Mark as



Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter Code	Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Number of words repeated after first attempt 0. None 1. One 2. Two 3. Three After the patient's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code	Ask patient: "Please tell me what year it is right now." A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
Enter Code	Ask patient: "What month are we in right now?" B. Able to report correct month 0. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days 3. Correct
Enter Code	Ask patient: "What day of the week is today?" C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
C0400. Recall	
Enter Code	Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. Able to recall "sock" 0. No - could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code	B. Able to recall "blue" 0. No - could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter Code	C. Able to recall "bed" 0. No - could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
C0500. BIMS Summary Score	
Enter Score	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview



C0500: BIMS Summary Score

C0500. BIMS Summary Score	
Enter Score	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview

Scores from a carefully conducted BIMS assessment where patients can hear all questions and the patient is not delirious suggest the following distributions:

- 13-15: cognitively intact
 - 8-12: moderately impaired
 - 0-7: severe impairment
- **Code 99, unable to complete interview, if:**
 - (a) the patient chooses not to participate in the BIMS,
 - (b) if four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or
 - (c) if **any** of the BIMS items is coded with a "-" (dash)
 - Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.
 - **Dash** is a valid response for this item.



C1310. Signs and Symptoms of Delirium

C1310. Signs and Symptoms of Delirium (from CAM®)	
Code after completing Brief Interview for Mental Status and reviewing medical record.	
A. Acute Onset of Mental Status Change	
Enter Code <input type="checkbox"/>	Is there evidence of an acute change in mental status from the patient's baseline? 0. No 1. Yes
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	Enter Codes in Boxes <input type="checkbox"/>
	<input type="checkbox"/> B. Inattention – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/> C. Disorganized thinking – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="checkbox"/> D. Altered level of consciousness – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ vigilant – startled easily to any sound or touch ▪ lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous – very difficult to arouse and keep aroused for the interview ▪ comatose – could not be aroused

Adapted from: Inouye SK, et al. *Ann Intern Med.* 1990; 113: 941-948. *Confusion Assessment Method.* Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

- CAM is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The screening tool alerts clinicians to the presence of possible delirium.
- Delirium can be misdiagnosed as dementia.

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C1310. Signs and Symptoms of Delirium

- Review medical record documentation and consult with other staff, family members/caregivers and others in a position to determine the patient's baseline status compared to status on the day of assessment.
- Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.
 - Examples of acute mental status changes include:
 - A patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
 - A patient who is normally quiet and content suddenly becomes restless or noisy.
 - A patient who is usually able to find their way around their living environment begins to get lost.

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C1310. Signs and Symptoms of Delirium

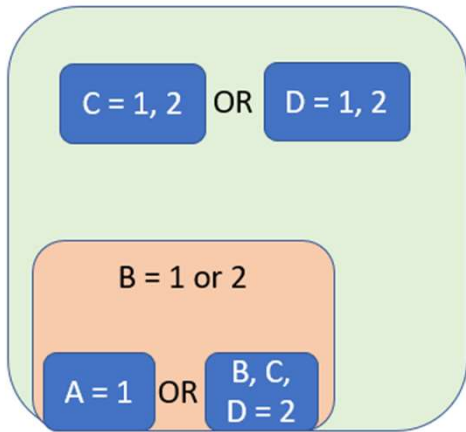
- B. Inattention: An additional step to identify difficulty with attention is to ask the patient to count backwards from 20.
- Notice there is no summary item. So what do the scores represent then?
- Indication of delirium:

CAM Assessment Scoring Methodology
 The indication of delirium by the CAM requires the presence of:
 Item A = 1 **OR** Item B, C, or D = 2
AND
 Item B = 1 OR 2
AND EITHER
 Item C = 1 OR 2 **OR** Item D = 1 OR 2



C1310. Signs and Symptoms of Delirium

CAM Assessment Scoring Methodology
 The indication of delirium by the CAM requires the presence of:
 Item A = 1 **OR** Item B, C, or D = 2
AND
 Item B = 1 OR 2
AND EITHER
 Item C = 1 OR 2 **OR** Item D = 1 OR 2



D0150. Patient Mood Interview

(PHQ-2 to 9)

Depression can be associated with:

- psychological and physical distress,
- decreased participation in therapy and activities,
- decreased functional status, and
- poorer outcomes.

DEFINITION

PATIENT HEALTH QUESTIONNAIRE (PHQ-2 to 9)
 A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

For each of the questions:

- Read the item as it is written.
- Do not provide definitions because the meaning must be based on the patient’s interpretation. For example, the patient defines for themselves what “feeling down” means; the item should be scored based on the patient’s interpretation
- If the patient has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part.



D0150. Patient Mood Interview (PHQ-2 to 9)			
Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.			
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"			
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.			
	1. Symptom Presence	1. Symptom Presence	2. Symptom Frequency
1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank).	2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	↓ Enter Scores in ↓	Boxes
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 16

D0150. Patient Mood Interview

(PHQ-2 to 9)

D0150. Patient Mood Interview (PHQ-2 to 9)			
Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.			
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"			
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.			
1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. No (enter 0 in column 2)	0. Never or 1 day	↓ Enter Scores in ↓ Boxes	↓ Enter Scores in ↓ Boxes
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)		
9. No response (leave column 2 blank).	2. 7-11 days (half or more of the days)		
	3. 12-14 days (nearly every day)		
A. Little interest or pleasure in doing things		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

Item Intent

This item identifies the presence of signs and symptoms of mood distress, a serious condition that is underdiagnosed and undertreated in home health and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among home health patients because these signs and symptoms can be treatable.



D0150: (continuation to PHQ-9 prn)

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. No (enter 0 in column 2)	0. Never or 1 day	↓ Enter Scores in ↓ Boxes	↓ Enter Scores in ↓ Boxes
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)		
9. No response (leave column 2 blank).	2. 7-11 days (half or more of the days)		
	3. 12-14 days (nearly every day)		
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating		<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="checkbox"/>	<input type="checkbox"/>

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

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Scoring

2. Symptom Frequency	
cores in ↓	
res	
A.	<input type="checkbox"/>
B.	<input type="checkbox"/>
If e	
C.	<input type="checkbox"/>
D.	<input type="checkbox"/>
E.	<input type="checkbox"/>
F.	<input type="checkbox"/>
G.	<input type="checkbox"/>
H.	<input type="checkbox"/>
I.	<input type="checkbox"/>

- Skipped = Column 1: Code [9] = no response
 - Column 2: skipped
- One item missing in column 2: add remaining 8 rows
 - Multiply sum x 1.125
 - Round to nearest integer for D0160.
- Two items missing in column 2: add remaining 7 rows
 - Multiply sum x 1.286
 - Round to nearest integer for D0160.
- Three or more items missing in column 2: D0160 = [99].

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Section D: Mood

D0160: Total Severity Score

D0160. Total Severity Score	
Enter Score	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)
<input type="text"/>	

This is a summary of the frequency scores that indicates the extent of potential depression symptoms. The score **does not diagnose a mood disorder** but provides a standard of communication with clinicians and mental health specialists for appropriate follow up.

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Section D: Mood

DO160: PHQ-9 Interpretation

Codes to PHQ-9[®] can indicate possible depression. Codes can be interpreted as follows:

– **Major Depressive Syndrome** is suggested if - of the 9 items - 5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period.

– **Minor Depressive Syndrome** is suggested if, of the 9 items, these are identified at a frequency of half or more of the days (7-11 days) during the look-back period:

- B. feeling down, depressed or hopeless,
- C. trouble falling or staying asleep, or sleeping too much, or
- D. feeling tired or having little energy

In addition, PHQ-9[®] **Total Severity Score** can be used to track changes in severity over time.

Total Severity Score can be interpreted as follows:

- 1-4: minimal depression
- 5-9: mild depression
- 10-14: moderate depression
- 15-19: moderately severe depression
- 20-27: severe depression

OASIS Medication Items

N0415: High-Risk Drug Classes

M2001: Drug regimen review

M2003: Medication follow-up

M2005: Medication intervention

M2010: High-risk drug education

M2020: Management of oral medications

M2030: Management of injectable medications

Medication Reconciliation

Must create the most accurate list possible of all medications a patient is taking:

- Drug name, dosage, frequency, and route
- Identify which ones are new, changed, or long-standing
- Compare that list against the physician's admission, transfer, and or discharge orders to ensure the patient is taking the correct medication at all transition points in care (or any time a comprehensive assessment is required)

Reconciliation is **not** asking the patient what medications they are taking. *It is putting your hands on the bottle!*



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N0415. High-Risk Drug Classes

SOC/ROC and Discharge		
N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking	1. Is Taking	2. Indication Noted
Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes	↓	↓
2. Indication noted	Check all that apply	
If Column 1 is checked, check if there is an indication noted for all medications in the drug class		
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the Above	<input type="checkbox"/>	

Item Rationale

Patients who take medications in these high-risk drug classes are at risk for side effects that can adversely affect health, safety, and quality of life.



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No415. High-Risk Drug Classes

- Include any of these medications used by any route **in any setting** (e.g., at home, in a hospital emergency room, at physician office or clinic).
- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root) for N0415.



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No415. High-Risk Drug Classes

Patient Education

- Create helpful documents. “Every start-of-care, resumption-of-care or recertification packet should have a one-page medication awareness education page,” Karen Carter says.
 - The classifications need to be listed with their interactions and common side effects and when to notify the home health agency or health care provider versus when to call 911.

Staff Education

- Be sure that staff are educated and competent in the various high-risk drug classes
- Some key questions for clinicians to consider include:
 - ✓ Are they taking them as ordered?
 - ✓ Are they skipping doses?
 - ✓ Are they taking too much?
 - ✓ Do they understand possible side effects and interactions?
 - ✓ Can they afford their meds?
 - ✓ Are they avoiding taking them because they are too big to swallow?
 - ✓ Do they understand how the medications can help?

Per decisionhealth [Home Health Line](#) May 16, 2022

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Medication Reconciliation

Let's talk a little more about medication reconciliation....

- **Discharge Summary** (CoPs §484.55)
 - **Standard: Discharge or transfer summary content.**
 - (1) The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.
 - (2) The HHA must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.



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A2123. Provision of Current Reconciled Medication List to Patient at Discharge

For the PATIENT



A2123. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your agency provide the patient's current reconciled medication list to the patient, family and/or caregiver?	
Enter Code	0. No - Current reconciled medication list not provided to the patient, family, and/or caregiver → Skip to B1300, Health Literacy
<input type="checkbox"/>	1. Yes - Current reconciled medication list provided to the patient, family, and/or caregiver → Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

A2121 & A2122: Med List to the **Provider** at Transfer and Discharge

Now, for the **PATIENT** at Discharge: A2123.

Section A. Administrative Information



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A2123. Provision of Current Reconciled Medication List to Patient at Discharge

For the
PATIENT

A2123. Provision of Current Reconciled Medication List to Patient at Discharge
At the time of discharge, did your agency provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code	0. No - Current reconciled medication list not provided to the patient, family, and/or caregiver → Skip to B1300, Health Literacy
<input type="checkbox"/>	1. Yes - Current reconciled medication list provided to the patient, family, and/or caregiver → Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

To the patient/family/CG

M0100. This Assessment is Currently Being Completed for the Following Reason

Enter Code	9. Discharge from agency
<input type="checkbox"/>	

M2420. Discharge Disposition
Where is the patient after discharge from your agency? (Choose only one answer.)

Enter Code	1. Patient remained in the community (without formal assistive services) → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge
<input type="checkbox"/>	4. Unknown because patient moved to a geographic location not served by this agency → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge
	UK Other unknown → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge

A2123



A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

For the
PROVIDER

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	Check all that apply
A. Electronic Health Record	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>

After completing A2122, Skip to B1300, Health Literacy at Discharge

A2124. Route of Current Reconciled Medication List Transmission to Patient

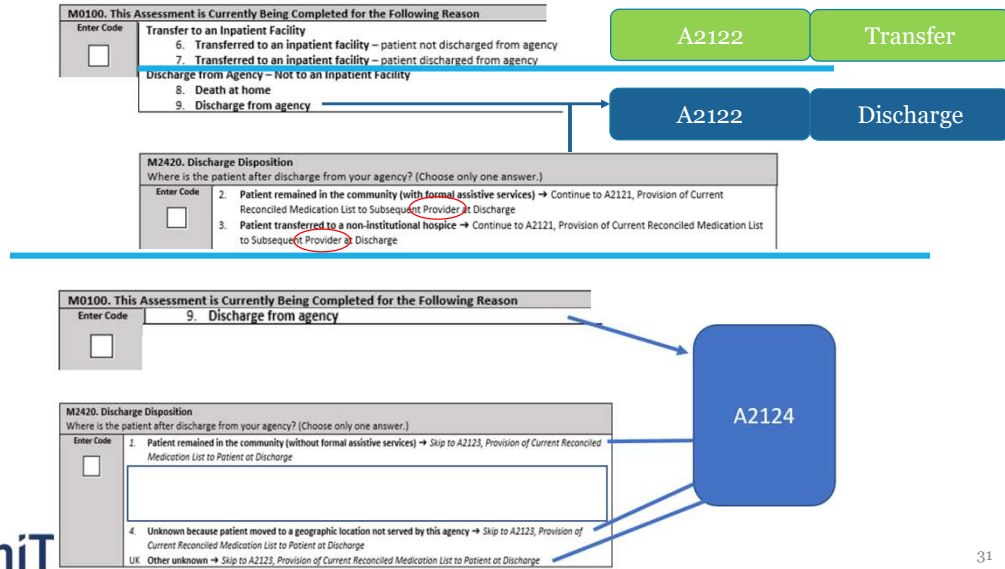
For the
PATIENT

A2124. Route of Current Reconciled Medication List Transmission to Patient
Indicate the route(s) of transmission of the current reconciled medication list to the patient, family, and/or caregiver.

Route of Transmission	Check all that apply
A. Electronic Health Record	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>



A2122 and A2124: Route of Current Reconciled Medication List to Subsequent Provider and Patient



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A2122 and A2124: Route of Current Reconciled Medication List to Subsequent Provider and Patient

- Code A2122A/A2124A, **Electronic Health Record**
 - Code A2122B/A2124B, **Health Information Exchange**
 - Code A2122C/A2124C, **Verbal** (e.g., in-person, telephone, video conferencing)
 - Code A2122D/A2124D, **Paper-Based** (printout, fax or efax.)
 - Code A2122E/A2124E, **Other Methods** (e.g., texting, email, CDs).
- With these items, it is important the clinician knows the method of contact the agency uses to transmit the medication reconciliation list.
 - As the transfer typically does not involve a visit (and at times the discharge might not either), a policy is needed for the procedure of getting this information to the provider/patient.
 - Who is responsible
 - How to transmit
 - Completed by timeframe

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O0110. Special Treatments, Procedures, and Programs

SOC/ROC	a. On Admission Check all that apply ↓	c. At Discharge Check all that apply ↓
O0110. Special Treatments, Procedures, and Programs		
Check all of the following treatments, procedures, and programs that apply on admission.		
Cancer Treatments		
A1. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Therapies		
C1. Oxygen Therapy	<input type="checkbox"/>	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>	<input type="checkbox"/>
D3. As needed	<input type="checkbox"/>	<input type="checkbox"/>
E1. Tracheostomy Care	<input type="checkbox"/>	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>	<input type="checkbox"/>
G1. Non-invasive Mechanical Ventilator	<input type="checkbox"/>	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>	<input type="checkbox"/>
Other		
H1. IV Medications	<input type="checkbox"/>	<input type="checkbox"/>
H2. Vasopressor medications	<input type="checkbox"/>	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
J1. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>	<input type="checkbox"/>
O3. Mid-line	<input type="checkbox"/>	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>	<input type="checkbox"/>
Name of the Above:		
Z1. None of the Above	<input type="checkbox"/>	<input type="checkbox"/>

The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.



O0110. Special Treatments, Procedures, and Programs

- Check all treatments, programs and procedures that are part of the patient's current care/treatment plan.
- **Include** treatments, programs and procedures **performed by others and those the patient performed themselves** independently or after set-up by agency staff or family/caregivers.
 - E.g., dialysis performed in a dialysis center.

This is new to HH - we do not currently account for care performed outside the home environment.



O0110. Special Treatments, Procedures, and Programs

Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>

- O0110A, Chemotherapy: any type of chemotherapy medication administered as an antineoplastic for cancer treatment.
- O0100B, Radiation: intermittent radiation therapy, as well as via radiation implant.
- O0100C, Oxygen therapy: continuous or intermittent oxygen administered via mask, cannula, etc., including in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP). Do not code hyperbaric oxygen for wound therapy in this item.
 - C2, Continuous: oxygen therapy continuously delivered \geq 14 hours/day
 - C3, Intermittent: oxygen therapy continuously $<$ 14 hours/day
 - C4, High concentration: oxygen exceeds 4 lpm via nasal canula



O0110. Special Treatments, Procedures, and Programs

D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As Needed	<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G1. Non-invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>

- O0100D, Suctioning: tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here.
- O0100E, Tracheostomy care: This item may be coded if the patient performs his/her own tracheostomy care or receives assistance.
- O0110F, Invasive Mechanical Ventilator. If any type of electrically or pneumatically powered closed-system mechanical ventilator support device is used that ensures adequate ventilation in the patient who is or who may become (such as during weaning attempts) unable to support his or her own respiration.
- O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)



O0110. Special Treatments, Procedures, and Programs

Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>

- O0100H, IV medications. If any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item.
 - Epidural, intrathecal, and baclofen pumps may be coded here.
 - **Do not** include:
 - Subcutaneous pumps
 - IV medications of any kind that were administered during dialysis or chemotherapy.
 - Dextrose 50% and/or Lactated Ringers given via IV as they are not considered medications
 - Flushes to keep an IV access port patent
 - IV fluids without medication.



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O0110. Special Treatments, Procedures, and Programs

I1. Transfusions	<input type="checkbox"/>
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Mid-line	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the Above	<input type="checkbox"/>

- O0100I, Transfusions. Do not include transfusions that were administered during dialysis or chemotherapy.
- O0100J, Dialysis. Record if peritoneal or renal dialysis occurs at the home or at another facility.
- O0110O, IV Access. If a catheter is inserted into a vein for a variety of clinical reasons, including long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.



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