MO190 **Inpatient Diagnoses** and ICD code categories	• Patient has been d/c'd from an inpatient facility w/in the last 14 days. • Only reports the diagnoses for conditions that were treated during the inpatient stay-not necessarily the hospital admitting diagnosis. • Recorded at SOC/ROC only • No Surgical codes – list underlying condition • No V-codes or E-codes – list underlying condition • 3 digit codes required; digits to the right of the decimal are optional • Obtain info from pt/cg or referring physician
MO210 List the patient's **Medical Diagnoses** and ICD code categories	• Identifies the diagnoses that have caused an addition or change to the pt.'s medical or treatment regimen- can be a new diagnosis or an exacerbation of an existing condition • Can be the same as MO190 if condition was treated during an inpatient stay AND caused changes in the treatment regimen • Collected at SOC/ROC and Discharge – not to an inpatient facility • No surgical codes, no V or E-codes – list underlying condition • Obtain diagnosis from pt/cg or referring physician • 3 digit codes required. Digits to the right of the decimal are optional
MO220 **Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:**	• Identifies conditions that existed prior to medical regimen change or inpatient stay w/in past 14 days • Collected at SOC/ROC and D/C from agency not to inpatient facility • For the N/A response to be correct both situations must be true- no inpatient facility d/c and no change in medical or treatment regimen • Interview pt/cg to obtain past health history. Additional information can be obtained from the physician
MO230 & MO240	• MO230 - primary diagnosis – most related to the POC. May or may not be r/t most recent hospitalization. Should be the most acute condition or the condition that is the chief reason for home care (may or may not be r/t most recent hospitalization – use clinical judgment- base it on intensity of services, frequency, etc. • MO240 – secondary diagnosis; include diagnoses that can impact POC or responsiveness to treatment – e.g. CAD, DM, HTN, even if not the focus of home care; don't list historical codes – no impact on pt progress or outcomes • No surgical codes • E codes or V codes can be used • Code to the highest specificity – assign 3,4, or 5 digits according to current ICD-9 coding guidelines • 2003 HIPAA; must follow ICD-9 coding rules • Primary and first secondary determine Medicare PPS case mix group
MO245	• Optional item • Only complete if: o MO150 – response 1 answered – MCR traditional fee for service o V-code reported in M230 replaces a case mix diagnosis that would have been reported as primary prior to OASIS use of V-codes; case mix diagnosis groups are Diabetes, Ortho, Neuro, Trauma/Burns • No need to complete MO245b unless ICD-9 coding mandates multiple

	coding • A coder can not determine primary or secondary diagnoses – can only enter ICD-9 codes. Must call clinician if disagrees with 1st and 2nd diagnoses. The assessing clinician, in consult w/physician, must determine the primary and secondary diagnoses based on pt assessment findings and care plan. Agencies should prioritize diagnoses w/primary identifying the condition that is the chief reason for providing home care. This requirement didn't change with PPS, except in specific situations where ICD coding sequencing rules require the underlying condition be coded 1st.
MO420 **Frequency of Pain** interfering with patient's activity or movement	• Assess the client by interview; pain history as well as pain management history. Determine if client is satisfied with the level of pain control. Pain scale of 1-10 should always be determined by the client's perception. • Assess client by observation: does the client have facial or muscle tension? Are they favoring an area of their body? Do they avoid being touched because of pain? If pain med needs to be adjusted or other techniques for pain control need to be taught, answer 2 or 3 upon admission. • I have found that some of our nurses were not reading answer 0 correctly, it states "Patient has no pain OR PAIN DOES NOT INTERFERE WITH ACTIVITY OR MOVEMENT. If the client has pain but not enough to stop them from doing what they are able to do 0 is the correct answer. • When discharge is planned: If the client is having daily pain and that causes them to refrain from performing, as they are able, the nurse should reconsider whether discharge is appropriate.
MO430 **Intractable Pain:** Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity	• Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity • Should be assessed as MO420 was and if the nurse determines that in MO420, answer 2 or 3 is appropriate it is very likely that the client is having intractable pain.
MO490 When is the patient dyspneic or noticeably **Short of Breath**	• Tending to ask, not have patient demonstrate: " the patient told me they are not short of breath" • Frequent answer Never • Recommendation: • We have asked therapy to document at what level they become SOB on their initial evaluation • We are trying to reinforce the importance of demonstration
MO510 Has patient been treated for a UTI in past 14 days?	• Answers are self-explanatory. However, if patient is on a prophylactic treatment and develops a UTI, the correct answer is #1 – YES.

MO520 Urinary incontinence or urinary catheter presence	• Answers are self-explanatory. • However, if patient is incontinent at ALL; including a little bit of leaking, the correct answer is #1. • If the patient is both incontinent and requires a urinary catheter, the correct answer is #2. Patient interview and (when appropriate) aide interview is important in determining if patient has any problem with urinary incontinence. Be aware if there is an odor of urine or if the patient admits to using pads.
MO530 When does urinary incontinence occur?	• The MO# is only answered if MO520 has a score of 2, otherwise skip to MO540. • Answers are self-explanatory. • However, ANY incontinence during the DAY should be scored as a #2 – during the day and night.
MO540 Bowel incontinence frequency:	• Answers are self-explanatory. • To determine frequency you will need to interview patient, (when appropriate) the aide, and examine the condition of the commode and cleanliness around the commode. • Take note of any soiled clothing. • Ask the patient if having difficulty with controlling stools or problems with diarrhea.
MO550 Ostomy for bowel elimination	• Answers are self-explanatory. • However, a determination will need to be made if the patient had a hospital stay within the last 14-days, and if this hospital stay was related to the ostomy or was it completely unrelated to the ostomy.
MO560: Cognitive Functioning (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)	• Appropriate response selection should be apparent by the end of the visit. Note distractibility, need to repeat directions and evidence of written notes/calendars for remembering. • Alert/oriented is an aspect of responses 0-2. Many patients scoring as a 1 are probably a 2. Does the patient need reminders to take medications? Do they ask the same question many times? Are they easily distracted? • Ask the patient to carry out a series of 2-3 simple instructions and observe the response and ability to stay focused on the conversation. Use the clock drawing task or MMSE. Ask if they remember your name after several minutes. • Do not minimize the extent of the problem because the patient is elderly, has a pleasant disposition, or is apologetic for failing to remember correct answers. • Most patients will be a "1" and possibly a "2"on admission due to the stressful/unfamiliar nature of the admission process
MO570 **When Confused (Reported or Observed)**	• Focus on orientation. Interview the caregiver as needed. • Ask place, year, address and birth date – validate. Does pt. seem confused by the admission process? Able to remain attentive to admission process? • Ask patient about memory/confusion when they wake up in the morning or at night. "Do you know where you are when you wake up?" Mild confusion can be masked by patients with well-developed social skills.

MO580 **When Anxious (Reported or Observed):**	• Most patients will be a "1" on start of care due to admission process. Anxious feeling may be precipitated by apprehension about uncertain future, progression of disease process- real or imagined. • There may be situations where there is a threat to personal safety and security. It can evolve from anything that makes life less predictable or causes one to feel less in control over the direction of one's life. • Check for anti-anxiety medications. Use word "nervous or worry". • Check respiratory or cardiac medications. • What is response to the "Clock Drawing" task? Ask "do you often worry about things?"
MO590 **Depressive Feelings Reported or Observed in Patient:**	• Ask the patient to compare their current mood to the past. • Observe signs and symptoms of energy levels, sleep, appetite and weight changes. Diagnosis, medications, irritability, social isolation. Is the patient not getting dressed, drapes drawn? Ask : Have you been feeling sad, blue? Are you feeling you have done things wrong? How do you feel about the future? Do you have thoughts life not worth living? Have thoughts of hurting yourself?
MO610 **Behaviors Demonstrated <u>at Least Once a Week</u> (Reported or Observed):**	• Any patient that needs someone to fill a medication planner for them should be scored a "1". • Those who require supervision of ADL/IADL for ***safe*** performance or completion of task are at least a "1" if not lower. • Those patients who demonstrate poor safety awareness (not using walker, smoking with O2), should be scored a "2". • Poor safety awareness/impaired decision making on day of assessment **and** recent past. Impaired decision making can include giving away money, not paying bills. Score as a "2".
MO620 **Frequency of Behavior Problems (Reported or Observed**	• This **includes** the behaviors in MO610 and also includes wandering, self abuse, verbal disruption, physical aggression. • This also relates to the patient who forgets their walker, smokes with O2, and needs a medication planner filled. *If MO610 is answered 1-6, then MO620 cannot be a 0.*
MO640 Grooming	• Question regarding where does "hair washing" fall….not under grooming and not under bathing. • Some agencies using "%"…..if able to do greater than 50% of the time. • Needs more clarification.
MO650 Ability to Dress Upper Body	• Clarify on assessment "what patient usually wears". • Reinforce reading from bottom up. • Some agencies use if greater than 50% assistance, then rate as dependent. Example, if need verbal cues then rate #2 "someone must help" and if needs physical assistance then rate #3 "patent depends entirely". • Physical and cognitive assessment very important related to "safety". • Needs more clarification.

MO660 Ability to Dress Lower Body	• Discussion regarding if "weight bearing" plays a role….needs more clarification.
MO670 Bathing	• If physician orders "no shower" then rate #4 (could be due to incision, etc.) • If patient has cognitive impairments, rate #3 based on "safety". • Fear of getting in shower/tub (?? Psych history) impacts level of assistance needed. • Patient preference does not impact ability.
MO680 Toileting	• Does not include hygiene (such as ability to wipe self). • Answer should be cross referenced with response MO520 Urinary Incontinence, MO490 Dyspnea, and MO700 Ambulation/Locomotion
MO690 Transferring	• Is "sit to stand" included in this process? Some patients can "pivot" but unable to go from sit to stand. What if patient unable to get fully erect? • Cognitive and confidence related to "safety" • Huge gap between response #2 "minimal assistance" and response #3 "unable to transfer". What about moderate assistance? • Discussion regarding if a commode is an assistive device and raised toilet is assistive device versus adaptive equipment??? • Needs more clarification.
MO700 Ambulation/Locomotion	• Big gap between #2 (supervision/assistance at all times) and #3 (chair fast).
MO710 Feeding or Eating	• Self explanatory but make sure other ADL questions reflect consistency.
MO720 Planning and Preparing Light Meals	• Self explanatory but make sure other ADL questions reflect consistency.
MO730 Transportation	• Self explanatory but make sure other ADL questions reflect consistency.
MO740 Laundry	• Self explanatory but make sure other ADL questions reflect consistency.
MO750 Housekeeping	• Self explanatory but make sure other ADL questions reflect consistency.
MO760 Shopping	• Self explanatory but make sure other ADL questions reflect consistency.
MO770 Ability to Use Telephone	• Make sure to cross reference with MO390 (Vision) and MO400 (Hearing and Ability to Understand Spoken Language). • Self explanatory
MO780 Management of Medications	• During the SOC the clinician will ask the patient to demonstrate how they take their medications. Ask the patient if anyone helps them prepare their medications Observe the patient prepare their medications. Assess and evaluate their organization skills. Assess and evaluate the need for compliance aids. If assistance is needed, is it necessary? • Once the medications are organized, ask the patient if they can identify their

	medications, purpose, dose, schedule, side effects and for how long the medication should be taken. • Does the patient demonstrate the ability to complete medication administration correctly? Can the patient open the medication bottle; can the patient select the correct dose, close the bottle and return the medication to storage? • Recommend that the patient takes their medication after performing an established routine i.e.: after brushing teeth, washing face • During the SOC the clinician should explore the patient's beliefs and what they think about the medication and the resources to maintain medication regimen. • During SOC, the clinician asses's and evaluates any literacy, financial concerns, concerns about being addicted to the medication and cultural beliefs which the patient might have. • During the SOC, the clinician assess and evaluates the patient for memory deficits, functional deficits and health beliefs and expectations. • To monitor and determine compliance the clinician can select one medication with a known start of date and count pills to verify compliance.
MO903 **Date of Last (Most Recent) Home Visit**	• Definition: identifies the last or most recent home visit of any agency provider, including skilled providers or home health aides • When multiple staff, refer to clinical record for correct date.
MO906 **Discharge/Transfer/Death Date:** Enter the date of discharge, transfer, or death (at home) of the patient	• The date of discharge is determined by agency policy or physician order • The transfer date is the actual date transferred into an inpatient facility • The death date is the actual date of the patient's death at ho0me. Excludes death occurring in an inpatient facility. Include death which occurs while a patient is being transported to an inpatient facility (before being admitted)