OASIS-C2 Part 2
Ambulation and Bed Transferring
Selman-Holman & Associates, LLC

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Objectives

• State OASIS-C2 guidance for M1850 and M1860
• Identify two key assessment techniques to accurately respond to these items
• Discuss best practices to improve the ambulation and bed transferring outcome measures
Impact of Impaired Mobility

- Fall risk and consequences of falls
- Loss of independence for patients
- Challenges to improvement
- Impact for agencies
Diagnoses Impacting Mobility

• Degenerative joint diseases
• Sequela of CVA
• Neurological disorders
• Injuries
• Amputations or contractures
• Residual weakness from surgery or hospitalization
Assessment: Intake / Referral

• Identify any diagnoses at risk for mobility problems
• Ask about patient’s fall history
• Obtain current medication list
  • Identify meds potentially impacting mobility
  • Identify if pain management is an issue
• Orders for therapy disciplines and interventions for gait and transfer training, fall prevention and home safety assessment
Comprehensive Assessment and Initial Evaluation

- Identify diagnoses and conditions that potentially affect mobility
- Perform pain assessment
- Perform fall risk assessment - standardized tool
- Obtain fall history: location, timing, circumstances, any devices used (or not used), causes/triggers for falls
- Assess patient’s transfers and ambulation or wheelchair use – consider safety!
Bedfast as Defined by CMS

• "Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed." If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time.

• The assessing clinician will have to use her/his judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as she/he is able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents him from tolerating the sitting position.
**M1850 Transferring**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently transfer.</td>
</tr>
<tr>
<td>1</td>
<td>Able to transfer with minimal human assistance or with use of an assistive device.</td>
</tr>
<tr>
<td>2</td>
<td>Able to bear weight and pivot during the transfer process but unable to transfer self.</td>
</tr>
<tr>
<td>3</td>
<td>Unable to transfer self and is unable to bear weight or pivot when transferred by another person.</td>
</tr>
<tr>
<td>4</td>
<td>Bedfast, unable to transfer but is able to turn and position self in bed.</td>
</tr>
<tr>
<td>5</td>
<td>Bedfast, unable to transfer and is unable to turn and position self.</td>
</tr>
</tbody>
</table>

(transferring: current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.)
M1850 Assessment Techniques

• Observe the patient lie down on their back in bed or on their usual sleeping surface. Assistance needed?

• Observe the patient rise to a sitting position on the side of the bed. Assistance needed?

• Identify the nearest sitting surface and observe patient perform some type of transfer to that surface. The transfer may involve standing and taking a few steps to the chair or bench or bedside commode, a stand-pivot, or a sliding board transfer. Assistance needed? What type of assistance? How much assist? By whom?

• Observe patient transfer back onto the bed from the sitting surface.
M1850 Transferring

• If there is no chair in the patient’s bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient’s ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient’s environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.

• The need for assistance with gait may impact the Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed.
M1850 Transferring

• If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), assess the patient's ability to move from the supine position on their current sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.

• Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is dependent. If standby human assistance were necessary to assure safety, then a different response level would apply.
M1850 Transferring

• Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete task.

• Select Response 1 if:
  • Patient transfers *either* with minimal human assistance (but not device), *or* with the use of a device (but no human assistance)
  • Patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing or reminders
  • Patient requires another person to position the wheelchair by the bed and apply the brakes to lock the wheelchair for safe transfer from bed to chair
M1850 Transferring

• Response 2 - Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).

• Select Response 2 if:
  • Patient requires more than minimal assistance (more than 25% of the effort to transfer comes from another person helping)
  • Patient requires both minimal human assistance and an assistive device to be safe
  • Patient can bear weight and pivot, but requires more than minimal human assist,
M1850 Transferring

• The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.

• A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer
M1850 Transferring

• If the patient is bedfast, select Response 4 or 5, depending on the patient’s ability to turn and position self in bed.

• Bedfast refers to being confined to the bed, either per physician restriction or due to a patient’s inability to tolerate being out of the bed. Responses 4 and 5 do not apply for the patient who is not bedfast.

• The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed.
<table>
<thead>
<tr>
<th>(GG0170C) Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code the patient’s usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.</td>
</tr>
</tbody>
</table>

**Coding:**

**Safety and Quality of Performance** – If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.

Activity may be completed with or without assistive devices.

- **06 Independent** – Patient completes the activity by him/herself with no assistance from a helper.
- **05 Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- **04 Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- **03 Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- **02 Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **01 Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- **07 Patient refused**
- **09 Not applicable**
- **88 Not attempted due to medical condition or safety concerns**

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**1. SOC/ROC Performance**

**2. Discharge Goal**

<table>
<thead>
<tr>
<th>Lying to Sitting on Side of Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.</td>
</tr>
</tbody>
</table>

Or sofa, recliner or floor
Mobility limitations can adversely affect wound healing and increase risk for the development of pressure ulcers.

**STEPS FOR ASSESSMENT**

- Assess the patient’s functional status based on direct observation and/or on report by the patient, caregiver/family.

- Patients should be allowed to perform activities as independently as possible, as long as they are safe.

- If caregiver assistance is required because patient's performance is unsafe or of poor quality, enter the response according to amount of assistance required to be safe.

- **Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect the scoring of the activity.**

- If the patient’s self-care performance varies during the assessment time frame, report the patient’s usual status, not the patient’s most independent status and not the patient’s most dependent status.
**GG0170C**

- **Enter 06 – Independent**, if the patient completes the activity by him/herself with no human assistance.

- **Enter 05 – Setup or clean-up assistance**, if the caregiver SETS UP or CLEANS UP; patient completes the activity. Caregiver assists only prior to or following the activity, but not during the activity. For example, the patient requires assistance putting on a shoulder sling prior to the transfer, or requires assistance removing the bedding from off his/her lower body to get out of bed.

- **Enter 04 – Supervision or touching assistance**, if the caregiver must provide VERBAL CUES or TOUCHING/STEADYING assistance as patient completes the activity. Assistance may be required throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or patient may require only incidental help such as contact guard or steadying assist during the activity.
GG0170C

• **Enter 03 – Partial/moderate assistance**, if the caregiver must provide **LESS THAN HALF** the effort. Caregiver lifts, holds, or supports trunk or limbs, but provides less than half the effort.

• **Enter 02 – Substantial/maximal assistance**, if the caregiver must provide **MORE THAN HALF** the effort. Caregiver lifts or holds trunk or limbs and provides more than half the effort.

• **Enter 01 – Dependent**, if the caregiver must provide **ALL** of the effort. Patient is unable to contribute any of the effort to complete the activity; or the assistance of two or more caregivers is required for the patient to complete the activity.
GG0170C Scoring Examples

1. The patient pushes up from the bed to get himself from a lying to a seated position. The caregiver must provide steadying (touching) as the patient scoots himself to the edge of the bed and lowers his feet onto the floor.

- **GG0170C1 – SOC/ROC Performance:** ENTER 04 – Supervision or touching assistance
- **Rationale:** The patient required steadying/touching assistance in order to safely complete the task of lying on his back to sitting on the side of the bed.
2. The patient pushes up on the bed to attempt to get himself from a lying to a seated position as the OT provides much of the lifting assistance necessary for him to sit upright. The OT provides assistance as the patient scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the OT must provide more than half of the effort to complete the task.

- **GG0170C1 - SOC/ROC Performance:** ENTER 02 – Substantial/maximal assistance
- **Rationale:** The patient required the caregiver to provide lifting and assistance that represents more than half of the effort required to complete the task of lying on his back to sitting on the side of the bed.
GG0170C Scoring Examples

3. The patient is obese and recovering from surgery for spinal stenosis with lower extremity weakness. The caregiver partially lifts the patient’s trunk to a fully upright sitting position on the bed and minimally lifts each leg toward the edge of the bed. The patient then scoots toward the edge of the bed, placing both feet flat onto the floor. The patient completes most of the activity himself.

- **GG0170C1 - SOC/ROC Performance:** ENTER 03 – Partial/moderate assistance
- **Rationale:** The patient required the caregiver to provide limited assistance that represents more than just verbal cues/touching/steadying, but less than half of the effort required to complete the task of lying on his back to sitting on the side of the bed.
4. The patient states he wishes he could get out of bed himself rather than depending on his wife to help. At the SOC the patient requires his wife to do most of the effort. Based on the patient’s prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that by discharge, the patient would likely only require assistance helping his legs off the bed to complete the supine to sitting task.
GG0170C Scoring Examples

- **GG0170C1 - SOC/ROC Performance:** ENTER 02 – Substantial/maximal assistance
- **GG0170C2 - Discharge Goal:** Enter 03 – Partial/moderate assistance
- **Rationale:** At the SOC, the patient required the caregiver to provide more than half of the effort required to complete the task. The assessing clinician and patient expect functional improvement so that by discharge the patient needs a caregiver to assistant, providing less than half of the effort.
Assistive Device

- If the patient sleeps in an electric recliner (which we are assessing as the patient’s bed), and the patient pushes a button for the chair to return to a sitting position, is this considered assistance?

- If patients are able to use an assistive device themselves, the response code entered on the OASIS would be coded as a 06, Independent.
Assistive Device Does Not Count

- If a patient uses a belt to go from lying to sitting on the side of the bed, but someone had to hand the belt to the patient, would that still be considered independent?

- For GG0170C, the use of an assistive device does not affect the scoring of the measure if the patient is able to perform the activity independently. If the patient usually requires a caregiver to hand them the assistive device to perform the activity, this would be scored as Code 5, Setup or clean-up assistance, because the patient requires setup assistance prior to performing the activity.
**M1860 Ambulation/Locomotion**

(M1860) **Ambulation/Locomotion**: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).</td>
</tr>
<tr>
<td>1</td>
<td>With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.</td>
</tr>
<tr>
<td>2</td>
<td>Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.</td>
</tr>
<tr>
<td>3</td>
<td>Able to walk only with the supervision or assistance of another person at all times.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Chairfast</strong>, unable to ambulate but is able to wheel self independently.</td>
</tr>
<tr>
<td>5</td>
<td><strong>Chairfast</strong>, unable to ambulate and is <strong>unable</strong> to wheel self.</td>
</tr>
<tr>
<td>6</td>
<td><strong>Bedfast</strong>, unable to ambulate or be up in a chair.</td>
</tr>
</tbody>
</table>
M1860 Assessment Techniques

• Observe the patient walk a reasonable distance
  • Does patient use a device? Correctly and safely? What type?
  • Does patient use walls or furniture for support?
  • Does patient demonstrate loss of balance or other actions that suggest additional support is needed for safe ambulation?
  • Does the patient demonstrate safe gait pattern?

• Observe the patient’s ability and safety on stairs
• If chairfast, does the patient have a wheelchair? Power or manual? Do the brakes work properly? Can the patient demonstrate ability to wheel the chair independently? Across the floor? Through doorways? Up/down entrance ramp?
M1860 Ambulation / Locomotion

• Response 0: patient can safely walk on any surface in their environment, including stairs, without any device or any human assistance AT ALL.
  • If you mark this response, better document why the patient is homebound!

• Response 1: Safe on all surfaces and stairs with a one-handed device – NO HUMAN ASSISTANCE NEEDED AT ALL FOR ANY SURFACE.
  • Includes all kinds of canes, as long as they only require one hand to use safely and correctly.
M1860 Ambulation / Locomotion

• Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, select Response 2 or Response 3, depending on whether assistance required is intermittent (“2”) or continuous (“3”).

• If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces, select Response 2 (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).
M1860 Ambulation/Locomotion

• If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with the supervision or assistance should be reported, *unless the patient is chairfast.*

• Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance.
  • A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self
  • Wheelchair may be powered or manual version
M1860 Ambulation/Locomotion Example

Patient safely ambulates with a quad cane in all areas of the home except her bedroom and bathroom where she has shag carpet that tangles in the prongs of the cane. In those rooms, she switches to a walker to ambulate safely. The patient does not require any human assistance.

• M1860: 2
M1860 Ambulation/Locomotion Example

The patient does not have a walking device but is clearly not safe walking alone. PT evaluates him with a trial walker brought to the assessment visit and while he still requires assistance and cueing, PT believes he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he lives alone and usually is just up stumbling around on his own.

• M1860: 3
Question 10: My patient does not have an assistive device, but demonstrates the ability to walk safely constantly holding on to his caregiver. His neighbor loaned him a walker to try out during our assessment visit. My patient liked it and was safe walking on level surfaces with no help, but still needed help on the stairs. I have ordered a walker for the patient, and it will be delivered in 2 days. How do I score M1860 for the day of assessment? With or without the use of a walker?
CMS Q&A April 2016

**Answer 10:** For M1860, the clinician must consider what the patient is able to do on the day of the assessment, which is the 24 hours that precedes the visit plus the time in the home. If at the time of assessment, (and prior to any teaching or interventions), the patient demonstrates the ability to ambulate safely with a walker and no assistance, then Response 2 - Requires use of a two-handed device to walk alone on level surfaces should be reported, as this is the patient’s status on the day of assessment. This is true even if the walker does not belong to the patient and may not remain in the home. The clinician should not assume that the patient would be safe walking with a walker if no walker is available to allow assessment of the patient’s status.
M1860 Ambulation/Locomotion Example

A patient is able to ambulate independently with a walker, but he chooses to not use the walker, therefore is not safe. Response #2, or Response #3?

- Report the patient’s physical and cognitive ability, not their actual performance, adherence or willingness to perform an activity. If observation shows the patient is able to ambulate independently with a walker, without human assistance, select Response 2 for M1860.

- However, if the patient forgets to use the walker due to memory impairment, that impacts his ability. The clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, M1860 would be a “3”. If the patient only needed assistance intermittently, the correct response would be a “2”.
M1860 Ambulation/Locomotion

If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of “chairfast?”

- Item M1860 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose Response 0, 1, 2, or 3, whichever is the most appropriate.
M1860 Ambulation/Locomotion

- Patient has no device in home and is not safe ambulating even with assistance from another person all the time.
- “5-Chairfast, unable to ambulate and is unable to wheel self”.
- Patient ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home.
- If the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, she would be scored a "2" for M1860 if she needs two hands to use the stair lift and a "1" if she only needs one hand to safely use the stair lift.
M1860 Ambulation/Locomotion

• Our patient requires maximum assistance to ambulate (over 75% of the effort necessary for ambulation is contributed by someone other than the patient) and only ambulates with the therapist during gait training activities. The patient is extremely unsafe when attempting to ambulate without the therapist’s assistance.

• Still ambulatory—Response 3 unless able to take only a few steps

• Minimal assistance (like in transferring) vs maximum assistance doesn’t apply with ambulation
Knee Scooter

• If a patient is safely using a knee scooter to facilitate non-weight bearing on one lower extremity, what response would be selected for M1860 - Ambulation?

• To determine the accurate response for M1860, the assessing clinician must determine if the knee scooter will be considered an assistive device for the purpose of ambulation. If the assessing clinician determines the knee scooter is an assistive device, then the clinician must determine if the patient is safe without the assistance of another person and assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.
One or Two Handed?
How safe are they?

Patient is wheelchair bound and cannot ambulate but can wheel self. Patient also has advanced dementia or cognitive decline and although the patient can wheel self independently, he/she is unable to do so with any purpose, (i.e., patient could not follow simple instructions to get to another room, or could not self-evacuate in the event of an emergency). What response should be selected?

• The assessing clinician must consider the non-ambulatory patient’s ability to safely use the wheelchair, given the patient’s current physical and mental/emotional/cognitive status, activities permitted, and the home environment.

• In the scenario, the patient’s advanced dementia/cognitive decline is noted as a concern because the patient is unable to wheel self with purpose. Other than addressing safety on surfaces the patient would routinely encounter in their environment, CMS guidance does not detail specific criteria regarding patient ambulation or wheelchair use (i.e., how far the patient must walk, or wheel self; of if they use ambulation or wheelchair mobility with specific purpose, regularity, or efficiency). It is left to the judgment of the assessing clinician to determine the patient’s ability (i.e., does the patient’s mental status impacted his/her safety?) and select a response accordingly.
Assess Other Factors Affecting Mobility

• Vision, hearing impairments
• Weak muscles, stiff joints, foot problems, neuropathy, balance problems
• Home safety risks: clutter, throw rugs, poor lighting, bathroom inaccessibility, lack of stair rails, unsafe footwear, pets, O2 tubing
• Incontinence or rushing to bathroom
• Use of medical equipment (oxygen, wound treatment, walker, cane, crutches, wheelchair, hospital bed)
Assess Other Factors Affecting Mobility (Cont’d)

• Unsafe or inconsistent use of assistive device
• Environmental set up: type of bed or sleeping surface, width of doorways, flooring, presence of stairs
• Cognitive/memory impairments, impulsivity, or depression
• Regular use of alcohol
• Taking one or more high risk medications such as: sedative, tranquilizer, narcotic, hypnotic, diuretic, antihypertensive, cardiac med, anti-anxiety med, anticholinergic, or hypoglycemic agent.
Barriers to Mobility Assessment

• Inability to safely demonstrate walking at SOC/ROC
• Lack of appropriate device(s) at SOC/ROC visit
• Cognitive or sensory impairment
  • Inability to follow requests and perform activities
• Inaccurate reporting of mobility by clinician
  • Failure to have patient *demonstrate* mobility skills
  • Lack of understanding what is measured in OASIS items
  • Incorrect interpretation of OASIS guidance
Best Practices for Transfers and Ambulation

- Assess mobility with direct observation of transfer and gait, safety and ability, use of equipment, need for PT/OT
- Review OASIS guidance for items M1850-1860
- Conference with all disciplines to ensure OASIS responses are accurate
- Perform a fall risk assessment, tailor interventions to address risk factors identified
Best Practices for Transfers and Ambulation (con’t)

• Communicate fall risk level to agency staff, physician, patient, and caregivers/family

• Engage patient and family with a written prescription for safety

• Develop specific measurable goals that apply to the patient’s home situation and assistance available

• Continuously evaluate progress with therapy interventions, modify if needed
Tailored Interventions to Improve Mobility

• Assessment of mobility, strength, balance, cognitive status, orthostatic blood pressure
• Exercises focused on balance, strength, gait and transfer training
• Adaptation/modification of home environment and elimination of hazards
Interventions to Improve Mobility

• Obtain (or repair) needed assistive devices
• Consider medication regimen changes
• Assess patient/family willingness to make recommended changes, and compliance with safety precautions for transfers and ambulation, and fall prevention measures
• Add MSW for community resources
  • Equipment, assistance, resources
What questions do you have?

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