Category 4b – OASIS Data Items

M1000

Question 1: When answering M1000 – From which of the following Inpatient Facilities was the patient discharged…”, where does assisted living fit in?

Answer 1: When an individual resides at an Assisted Living Facility, they are living/residing in the community, and are not considered inpatients, nor is an ALF an inpatient facility. If the patient was not discharged from an "inpatient facility" (e.g. long-term nursing facility, skilled nursing facility, short-stay acute hospital, long-term care hospital, inpatient rehabilitation hospital/unit, or psychiatric hospital unit) during the past 14 days select "NA".

M1306 – M1324

Question 2: We are recertifying a patient who had a Stage II pressure ulcer at SOC that is now closed and only red. We understand not to “back-stage” but when a Stage II pressure ulcer closes and is only red, is it now considered a Stage I pressure ulcer? Or is it considered healed and gone in which we would no longer score it on OASIS?

Answer 2: It is accurate to say that back-staging of pressure ulcers is never appropriate. When a Stage II ulcer re-epithelializes, it is considered "healed" and no longer reported in the OASIS data set. If you are describing a patient who now has non-blanchable redness at the same site where the Stage II ulcer healed, then this would now be considered a new Stage I, as it has been caused by new pressure at the same site, and is not reversing the staging of a healed Stage II ulcer.

M1030; M1340

Question 3: Our patient has a “Mammosite”, a device implanted in her lumpectomy site. She receives radiation bead insertion through this catheter. It requires a sterile dressing change daily. Is this device a surgical wound for M1340 and M1342? Is this an infusion device for M1030?

Answer 3: Based on the details provided in the question, the incision created to insert the balloon catheter is considered a surgical wound in OASIS. Utilize existing CMS guidance to determine the healing status.

MammoSite® breast brachytherapy (balloon catheter radiation) is a type of accelerated breast radiation treatment. Since the saline and radiation seed remains in the balloon catheter, it is not an infusion and would not be reported in M1030, Therapies at home.

M1340

Question 4: Is the site resulting from a kyphoplasty procedure counted as a surgical wound when answering M1340?

Answer 4: If the kyphoplasty procedure was performed percutaneously and resulted in a pinpoint needle puncture site where the bone cement was injected, it would not be considered a surgical wound. If the kyphoplasty procedure involved an open approach, requiring a surgical incision, the resulting wound would be considered a surgical wound for M1340.
Question 5: Are tunneled PICCs considered a surgical wound?

Answer 5: Peripherally inserted central catheters, both non-tunneled and tunneled, are excluded as surgical wounds (M1340), but could be reported in M1350, Skin Lesion or Open Wound, if the site is receiving agency intervention.

M1700; M1710

Question 6: What is the difference in what is measured in M1700 – Cognitive Functioning and M1710- When Confused?

Answer 6: M1700, Cognitive Functioning, is intended to report the patient's cognitive functioning, as evidenced by their level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands on the day of assessment (at the time of the assessment and in the preceding 24 hours).

M1710, When Confused, is intended to identify the time of day or situations when the patient experienced confusion, if at all, during the past 14 days (Day of assessment and prior 14 days). M1710, Confusion, may not directly relate to M1700, Cognitive Functioning. Confusion is defined in Mosby's Medical Dictionary as "a mental state characterized by disorientation regarding time, place, person, or situation. It causes bewilderment, perplexity, lack of orderly thought, and inability to choose or act decisively and perform the activities of daily living. It is usually symptomatic of an organic mental disorder, but it may accompany severe emotional stress and various psychological disorders."

If a patient is demonstrating confusion on the day of the assessment, it would be reported both in M1700 and M1710. If a patient was NOT confused on the day of assessment, but had experienced confusion during the prior 14 days, it would only be reported in M1710.

If a patient has a cognitive impairment on the day of the assessment, that does NOT result in confusion, e.g.; forgetfulness, learning disabilities, concentration difficulties, decreased intelligence, it would only be reported in M1700.

M1750

Question 7: How should an agency respond to M1750 if psychiatric nursing services are being provided by a separate entity such as a community mental health center or other provider, and the home health agency is providing services that are not directly related to the psychiatric issue(s) but could be affected by them?

Answer 7: M1750, Psychiatric Nursing Services, reports if the patient is receiving psychiatric nursing services in the home at the time of the SOC/ROC assessment. This is referring to qualified personnel of the home health agency, per physician orders, specifically for the assessment and treatment of psychiatric conditions. When completing the SOC/ROC comprehensive assessment, if an order exists on the plan of care for the agency to provide psychiatric services, then respond "Yes" to M1750. The assessing clinician does not have to be the agency’s qualified psych nurse that is/will be providing the psychiatric nursing services.

M1910

Question 8: CMS OASIS Q&A 159.6 states that if the patient is not able to participate in tasks required to allow the completion and scoring of the assessment, then “0” is the correct response. Does this mean that, using the TUG for example, if the patient is not able to get up from the chair AND walk AND return to the chair AND sit, then all of the tasks were not completed and a response of “0” is appropriate? What if, after 14 seconds, the patient is just standing and beginning to walk; is it appropriate to consider them a fall risk since they were in process of trying to complete the TUG and not require them to finish the assessment since they've already surpassed the 14-second fall-risk threshold, and answer M1910 with “2”? Or does the patient need to complete all tasks of the assessment in order for us to choose either “1” or “2” as a response?
Answer 8: The patient would have to be able to complete enough of the tasks in the standardized assessment in order to generate a risk factor finding. The risk factor finding is based on the scoring protocols of the assessment utilized, and depending on the assessment tool used, this may or may not require them to complete all the tasks. It is up to the individual provider/agency to determine which tool(s) will be used, and what the valid administration and scoring protocols are for each tool considered.

M2400

Question 9: If we have a foley cath patient for several cert periods, what type of orders would we need related to fall prevention, pressure ulcer prevention, etc. If we have assessed and taught the patient/caregiver in the past and they are knowledgeable then, this would not be a billable skill for nursing as there is no "knowledge deficit." Could we put a note on the 485 saying that the patient/caregiver has been assessed and is knowledgeable in the intervention whichever it is or do we have to have fall prevention/pressure ulcer prevention techniques, etc on our 485 and teach on it again?

Answer 9: M2400, Intervention Synopsis, reads "Since (meaning at or since) the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?" The time period under consideration is from the current Transfer or Discharge back to and including the most recent previous OASIS assessment. If there are no orders for the applicable best practices during that time period, the answer to M2400 is "No". If there was an order but there is no evidence of implementation, the M2400 response is "No".

In order to select the M2400 response "Yes" for long-term patients, orders for the applicable best practices must be present at or since the time of the most recent assessment, AND there must be evidence of implementation within the time period beginning with the most recent assessment visit and ending with the Transfer/Discharge. During that time period, if specific orders were present, and the clinician confirmed the patient/caregiver possessed the knowledge regarding the best practice that was taught in a prior episode at the Recertification visit or on a subsequent visit, then upon confirmation that the patient/caregiver possessed the knowledge, the intervention may be considered implemented.

CMS does not expect an adherence rate of 100% for the process measures. Note that none of the process measures for long-term episodes (those that include a Recertification or Other Follow-up) are publicly reported and will only be used internally by the agency to evaluate care processes as they apply to the patients kept on service for long periods of time.