# July 2025 CMS Quarterly OASIS Q&As

## Category 2

**Question 1: Does OASIS data need to be collected and submitted for Medicare Part B Outpatient Therapy service patients that are being seen by a home health agency?**

**Answer 1:** If a Medicare beneficiary receives skilled outpatient therapy services from an approved Medicare-certified home health agency that is billed as outpatient services, then OASIS is required. OASIS data collection and submission is required for all patients over the age of 18, regardless of payer, except for those receiving only maternity services, or those receiving only personal care, chore or housekeeping services.

Questions about billing outpatient therapy services should be directed to the MAC.

**Question 2: If none of the services a patient's payer authorizes (e.g., long term medication set up/management, flushes, simple dressing changes) are considered "skilled" under the Medicare home health benefit, would OASIS data collection and submission be required?**

**Answer 2:** If none of the services provided meet the definition of "skilled" as defined in Chapter 7 of the Medicare Benefit Policy Manual, then OASIS is not required. If any of the services provided meet the definition of "skilled" as defined in Chapter 7 of the Medicare Benefit Policy Manual, then OASIS is required, assuming the patient does not meet one of the OASIS exemptions.

**Question 3: We received a referral for occupational therapy (OT) only for a patient with private (non-Medicare) insurance. The private insurance will pay for home health in this instance, although, since this patient does not have orders for nursing, SLP or PT, they would not be eligible for home health (HH) under the Medicare benefit.**

**Since a patient is not eligible for the Medicare home health benefit when only OT is ordered, is OASIS data collection and submission required for this patient?**

**Answer 3:** OASIS data collection and submission are required for all patients over the age of 18, regardless of payer, except for those receiving only maternity services, or those receiving only personal care, chore or housekeeping services. Regardless of payer, to identify if a patient requires OASIS data collection and submission under all-payer, home health agencies (HHAs) should follow the Medicare home health benefit definition of "skilled services".

Except as they relate to identifying if “skilled care” is being provided, other coverage criteria for the Medicare Home Health Benefit (e.g., homebound status, need for intermittent nursing, continuing Occupational Therapy), are not considered when identifying if OASIS is required.

Please note that while the need for OT alone does not establish initial eligibility for the Medicare home health benefit; if allowed by non-Medicare payers, occupational therapy may establish eligibility under other payers.

**Question 4: We understand that Medicare does not require a new Start of Care (SOC) when a patient's payer changes from Original Medicare (FFS) to a Medicare Advantage plan (per the Medicare Claims Processing Manual, Chapter 10, Section 10.1.23 - Changes in Beneficiary's Payment Source). However, for varying reasons including EMR limitations, some home health agencies (HHAs) elect to document all changes in payer source according to Medicare's requirement when a patient changes from any payer TO Original Medicare (i.e., to always complete a new SOC to coincide with the effective date of the new payer).**

**The April 2025 CMS Quarterly OASIS Q&A Q7 states: "If continued OT is the only active service at the time of a pay source change from Medicare Advantage to Original Medicare (FFS), the OT can complete the SOC OASIS and continue to provide care as the only active discipline for the remainder of the home health stay."**

**For HHAs whose policy is to complete a new SOC when the pay source changes from Original Medicare to a Medicare Advantage plan, does this new guidance regarding continued OT completing the SOC also apply?**

**Answer 4**: When a patient transitions from Original (Traditional) Medicare (FFS) to a Medicare Advantage (MA) plan while a home health patient, a new Start of Care (SOC) OASIS assessment is not required. If the patient is still receiving skilled services, the home health agency (HHA) should indicate the change in payer source on the OASIS at the next assessment time point. While not required, if an HHA elects to complete a new SOC when a patient experiences a payment source change from Original Medicare to a Medicare Advantage payer, and if continuing OT is the only active service remaining at the time of the pay source change, the OT may complete the SOC OASIS and continue to provide care as the only active discipline, as the original eligibility for the home health benefit remains uninterrupted.

Medicare Advantage plans are required to cover home health care services at the same level as Original Medicare. However, there are some differences to be aware of:

- Medicare Advantage enrollees may need to use an HHA that is in-network for the specific Medicare Advantage plan
- Some plans may require prior authorization or a referral from the patient’s doctor before the patient can receive home health services
- While Original Medicare fully covers home health services, Medicare Advantage plans may charge copayments, deductibles, or coinsurance

CMS regulations at 42 CFR 422.112(b)(8) provide important continuity of care protections to ensure that patients newly enrolled in Medicare Advantage plans can maintain their existing care arrangements during the initial transition period. MA plans must provide a minimum 90-day transition period for any active course(s) of treatment when an enrollee has enrolled in an MA plan after starting a course of treatment, even if the service is furnished by an out-of-network provider. This includes enrollees new to a plan and enrollees new to Medicare. The MA plan must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days.

## Category 4

### M1840

**Question 5: If a patient can physically get to and from the toilet in the bathroom with/without assistance but experiences incontinence on the way, should the episode of incontinence be considered when coding M1840 - Toilet Transferring?**

**Answer 5:** M1840 - Toilet Transferring identifies the patient's ability to safely get to and from and transfer on and off the toilet or bedside commode. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. These items address the patient's ability to safely perform toilet transferring, given the current physical and mental/emotional/cognitive status, activities permitted, and environment.

The patient's experience of incontinence should only be considered if it affects their ABILITY to safely get to and from and transfer on and off the toilet or bedside commode.

### GG0110, GG0170M, GG0170N, GG0170O

**Question 6: A patient has stairs and an elevator in their home. Is an elevator considered a mechanical lift for GG0110C - Prior Device Use; Mechanical lift? Does it count as an assistive device, like a stair lift for GG0170M - 1 Step (curb), GG0170N - 4 steps, and GG0170O - 12 steps?**

**Answer 6:** GG0110 - Prior Device Use identifies the patient's use of devices and aids immediately prior to the most recent illness, exacerbation, or injury that initiated the current episode of care.

The definition for GG0110C - Mechanical lift includes any device a patient or caregiver requires for lifting or supporting the patient's body weight. Examples include, but are not limited to: stair lift, Hoyer lift, bathtub lift, sit-to-stand lift, stand assist, electric recliner and full-body style lifts.

For the response categories in GG0110, CMS does not provide an exhaustive list of assistive devices that may be used when coding this item. Clinical judgment may be used to determine whether other devices meet the definition provided.

The intent of GG0170M - 1 step (curb), GG0170N - 4 steps, and GG0170O - 12 steps is to assess the patient's ability to go up and down 1 step (curb), 4 steps, and 12 steps with or without a rail. An elevator

is not considered a step/curb and should not be used in place of a step or curb when assessing these activities.

**GG0130/GG0170**

**Question 7: When coding the GG0130 - Self Care and GG0170 - Mobility activities it is being suggested that we not code higher than "supervision" due to the assessing clinician being present during the assessment and supervising the patient at that time. Is this the correct approach for coding GG activities?**

**Answer 7:** When assessing the GG0130 - Self-care and GG0170 - Mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

A clinician's presence for the purpose of completing the assessment should not automatically be considered as providing a "supervision" level of assistance when coding Section GG activities. For GG0130 and GG0170, the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely.

**GG0170M, GG0170N, GG0170O**

**Question 8: If a patient is a wheelchair user and goes up a ramp, can the ramp be considered when coding the GG0170 - stair activities?**

**Answer 8:** A ramp is not considered a step/curb and should not be used in place of a step or curb when assessing this activity.

The intent of GG0170M - 1 step (curb), GG0170N - 4 steps, and GG0170O - 12 steps is to assess the patient's ability to go up and down 1 step (curb), 4 steps, and 12 steps with or without a rail.

**K0520**

**Question 9: Is a fluid restricted diet considered a therapeutic diet for K0520D - Nutritional Approaches; Therapeutic Diet?**

**Answer 9:** The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient.

If, in the situation described, the fluid restriction is prescribed to manage a disease or clinical condition, then yes, a fluid restricted diet is considered a therapeutic diet for item K0520D. Therapeutic diets are not defined by the content of what is provided or when it is served, but WHY is the diet required.

**O0110**

**Question 10: When coding O0110 - Special Treatments, Procedures, and Programs, should O0110E1 - Tracheostomy care only be checked when the patient still has a tracheostomy tube present or would it also be checked for patients who have been decannulated (trach removed) but care to the trach stoma site is part of the current care/treatment plan?**

**Answer 10:** O0110E1 - Tracheostomy care should be coded if care is to the tracheostomy/stoma is part of the current care/treatment plan, even after decannulation.

This would apply whether the patient performs their own tracheostomy care or receives assistance.