AHCC Talk

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July 2025 CMS OASIS Q&As

Our Panel

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July 2025 CMS OASIS Q&As

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Category 2 – Comprehensive Assessment

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.

Category 2 – Comprehensive Assessment

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.

Category 2 – Comprehensive Assessment

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?

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Category 2 – Comprehensive Assessment

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.

Category 2 – Comprehensive Assessment

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?

Category 2 – Comprehensive Assessment

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.

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Category 2 – Comprehensive Assessment

Answer 4 (continued): 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

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Category 2 – Comprehensive Assessment

Answer 4 (continued): 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 - OASIS Data Set – Forms and Items

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.

Category 4 - OASIS Data Set – Forms and Items

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.

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Category 4 - OASIS Data Set – Forms and Items

GG0110, GG0170M, GG0170N, GG0170O

Answer 6 ***(continued)*****:** 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.

Category 4 - OASIS Data Set – Forms and Items

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?

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Category 4 - OASIS Data Set – Forms and Items

GG0130/GG0170

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.

Category 4 - OASIS Data Set – Forms and Items

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.

Category 4 - OASIS Data Set – Forms and Items

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.

Category 4 - OASIS Data Set – Forms and Items

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 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.

Skilled Services

- Services that require the expertise of licensed professionals (e.g., RNs, PTs, OTs, SLPs) to maintain or improve the patient's condition, or prevent deterioration.
- Examples:
  - Wound care requiring sterile technique or complex dressing changes (wound vacs, frequent dressing changes, infected or non-healing wounds)
  - Medication administration or teaching
    - Insulin or anticoagulants
    - Monitoring for adverse reactions or effectiveness of new medications
    - IV therapy or injections that require clinical judgment
  - Oxygen therapy initiation, teaching, titration
  - Catheter care requiring skilled oversight

Skilled Services

- Examples:
  - Monitoring of unstable conditions or potential for exacerbation
    - If monitoring for potential of complication or further acute episode - covered for 3 weeks or so long as the potential for complication or further acute episode remains
  - Teaching disease management (Cardiac, Pulmonary, Diabetes, Neurological, etc.)
    - Assessment and management of acute or chronic conditions
    - Blood glucose monitoring and insulin adjustment
    - Teaching dietary management and foot care
    - Monitoring for stroke recovery progress
      - Therapy for ADL retraining or swallowing/cognition
    - Teaching caregivers about seizure precautions or Parkinson's care

Skilled Services

- Examples:
  - Post-surgical care
    - Drain care and removal
    - Monitoring for signs of infection or complications
    - Therapy for gait training, joint mobility, adaptive equipment instruction
  - Nutrition and hydration support
    - Skilled oversight of tube feedings
    - IV hydration or TPN
  - Pain management
    - Assessment of pain levels and response to interventions
    - Teaching use of pain pumps or non-pharmacologic strategies

Documentation for Skilled Services

- Clinical notes must document:
  - History and physical exam pertinent to the visit and the response or changes in behavior to previously administered skilled service(s)
  - The skilled service(s) performed at the visit and the patient/caregiver response
    - Avoid vague phrases like “patient tolerated treatment well”
    - Avoid descriptions of skilled care like “Instructed on medication management”, “instructed on pain management”, “continue with plan of care”
  - The plan for the next visit based on the rationale of prior results
  - A detailed rationale that explains the need for the skilled service in light of the patient’s overall medical condition and experiences
  - The complexity of the service(s) to be performed
  - Any other pertinent characteristics of the beneficiary or home
- The documentation should clearly show why the service cannot be safely performed by non-skilled personnel

Summary

“If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse (“skilled care”) are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.”

Thank You

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Scenario Spotlight

July Scenario

An 88-year-old is admitted to home health following a long hospitalization for bowel obstruction. The patient currently is on a regular diet. Upon interviewing his wife, she states that she must prepare all the meals, cut the meat into bite-size pieces and that the patient will then start feeding himself but the caregiver will usually start assisting the patient in finishing the meal due to his extreme weakness. She estimates that the patient feeds himself less than half of the meal.

How would you score this patient for M1870. Eating and GG0130A. Eating?

July Scenario Answer

M1870 — The scoring for M1870 would be "02. Unable to feed self."

The patient is able to start feeding himself the meal but requires assistance during the meal. His caregiver estimates he is feeding himself less than 50% of the meal, so the CG is feeding the patient more than 50% of the meals.

GG1030A — The correct scoring for GG0130A would be "02. Substantial/maximal assistance."

The caregiver states that the patient feeds himself less than half of the meal so the caregiver is doing more than half of the effort of feeding.

August Scenario

A 78-year-old male patient receiving home health services for a recent stroke and right-sided weakness begins experiencing a new onset of chest pain. He is transferred to the emergency department at 10:00 PM on June 12 and receives nitroglycerin sublingual that relieves the chest pain after 2 doses. He also has a cardiac workup in the emergency department and after a consult with cardiology, he is admitted for a diagnostic cardiac catheterization scheduled for 4:00 PM on June 13. The cardiac catheterization reveals no acute blockages and after spending the night in the hospital, he is discharged at 10:00 am on June 14 to resume home health services with a new prescription for nitroglycerin and a follow-up appointment with cardiology in 1 week.

Which of the following is the best option?

a. Complete M0100: 6. Transfer not discharged with M0906 date 6/12 and M0100. 3. Resumption of care by 6/16.
b. Complete M0100: 6. Transfer not discharged with M0906 date 6/13 and M0100. 3. Resumption of care by 6/16
c. Complete M0100: 5. Other follow-up when the patient returns home
d. No OASIS assessments are needed

Product Spotlight

Boost productivity, avoid costly errors, and save up to 60% compared to traditional print resources with the Home Health Coding Center—the leading online solution for home health ICD-10 coding and OASIS review. Start your 14-day free trial at decisionhealth.com/AHCCoding and discover this unique resource designed by home health experts.

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What's new with AHCC

AHCC Advisory Board update

Terms ending:

- Claudia Baker, RN, MHA, HCS-D, HCS-O, Senior Manager with SimiTree
- Elise Christensen, HCS-D, HCS-H, HCS-O, COS-C, Coding Manager with Hartford Healthcare
- Nanette Minton, RN, HCS-D, HCS-H, HCS-O, Senior Clinical Coding Manager with MAC Legacy

Terms beginning:

- J'non Griffin, RN, MHA, HCS-D, HCS-H, HCS-C, COS-C, Director, SimiTree Healthcare Consulting
- Celeste Miller, RN, BS, HCS-D, HCS-O, Executive Director of Quality Assurance, Aegis Healthcare
- Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, Vice President of Clinical Services, McBee

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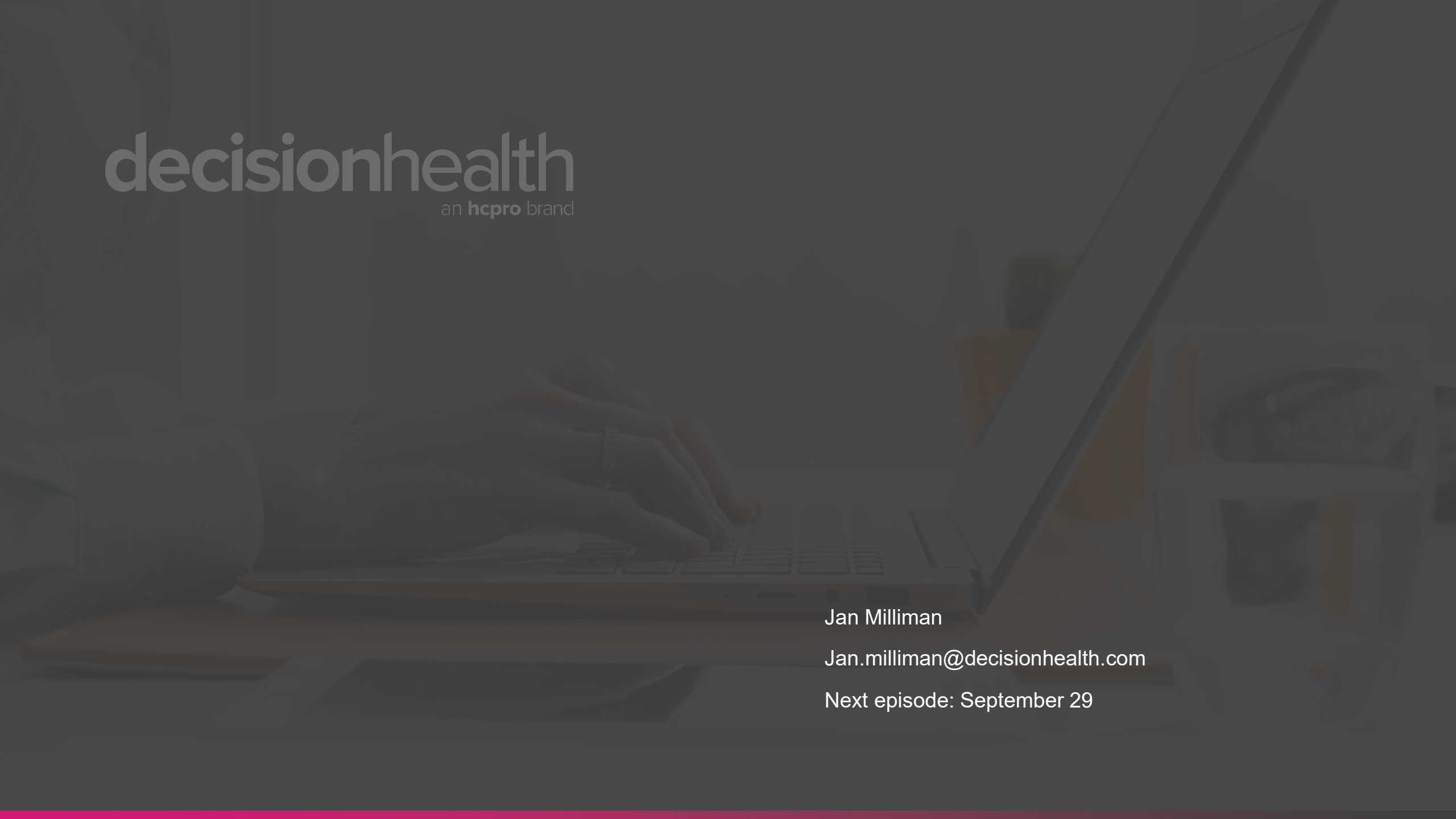

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