April 2026 CMS Quarterly OASIS Q&As

Category 2

Question 1: In the draft OASIS-E2 Guidance Manual, Chapter 1 convention #9 stated "An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician."

Please address the following scenario to clarify what is meant by this convention:

> **A clinician is completing a Start of Care assessment. Their iPad uses an ambient listening AI platform, with the patient's consent, that populates some of the OASIS responses while the assessment is being conducted. After completing the assessment, the clinician reviews the OASIS items one by one, making corrections on any items they feel were incorrectly coded by the AI platform.**

Is this scenario compliant with convention #9?

Answer 1: As stated in the final version of the OASIS-E2 Guidance Manual, "an agency's software may not "answer" or "generate" a final code for the OASIS items. Following agency policies, the assessing clinician is responsible for considering available information and ensuring the appropriate OASIS item response(s) were selected, within the appropriate timeframe and consistent with data collection guidance."

Question 2: When there is guidance from two CMS sources that are conflicting, for example guidance that is found in the OASIS Guidance Manual versus guidance published in a CMS Quarterly OASIS Q&A, which guidance should be utilized?

Answer 2: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance**.**

Question 3: Do we have to utilize collaboration when completing OASIS or can the assessing clinician's responses be used even if the patient's condition changes within the assessment timeframe?

Answer 3: While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, they may collaborate to collect data for any and all OASIS items, if agency policy allows. If desired, agencies may continue to limit the OASIS to only that data directly assessed and collected by the assessing clinician.

Category 4b

GG0170C

Question 4: How would GG0170C - Lying to sitting on side of bed be coded if a patient requires support to their back in order to transition into the position of sitting at the edge of the bed when the item description states, "with no back support"?

Answer 4: GG0170C - Lying to sitting on side of bed assesses the patient's ability to move from lying on their back to sitting on the side of the bed with no back support**.**

In this activity, the starting position is a supine position, and the activity ends when the patient is in a "seated position at the side of the bed with no back support."

The "with no back support" refers to when the activity ends, which is the patient sitting on the side of the bed with no back support.

If in the scenario described the patient requires assistance to move from supine to a seated position on the side of the bed, including assistance to support the patient's trunk while coming to sit, code based on the type and amount of assistance required to complete the GG0170C activity.

GG0170I, GG0170J, GG0170K, GG0170L

Question 5: For the GG0170 walking activities, if a patient does "walk" 10, 50 and/or 150 feet, but is unsafe while doing it despite any type of assistance, how should the GG0170 walking activities be coded? Would they be coded as 01 - Dependent? Or coded with an "activity not attempted" code?

Answer 5: When coding activities in Section GG, clinicians should code based on the type and amount of assistance required to complete the activity, allowing the patient to perform the activity as independently as possible, as long as they are safe.

If the patient does not participate in ambulation for the entire stated distance for a specific GG0170 walking activity or if the assessing clinician determines that a walking activity is unsafe even with assistance of 1 or more helpers, then consider the walking activity to not have been completed, and use the appropriate "activity not attempted" code.

J1900

Question 6: In the OASIS-E1 data set, J1900 - Number of Falls since SOC/ROC always contained definitions for J1900A - No injury, J1900B - Injury (except major), and J1900C - Major injury.

Now in the OASIS-E2 data set, J1900B and J1900C no longer contain definitions, and instead the item description states, "As described in the OASIS manual."

Home health clinicians completing the OASIS items within their comprehensive assessments have come to rely on the definitions being there for injury (except major) and major injury. Simply stating in the official data set item language "As described in the OASIS manual" does not promote clinical ease of use, as the clinician needs to reference the definitions which have recently been revised by CMS.

Can an EMR or software vendor add the definitions from the OASIS-E2 Guidance Manual for J1900B and J1900C?

Answer 6: In order to accurately code OASIS items, HH staff must understand the OASIS items including the coding instructions as found in the OASIS Guidance Manual, Q&A documents and other relevant CMS OASIS documents. The goal of these resources is to provide HH staff with the rationale and guidance necessary to accurately complete each OASIS item.

As stated in the final OASIS-E2 Guidance Manual for J1900 - Number of Falls since SOC/ROC, major injury includes but is not limited to traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries.

The injuries listed in J1900B - Injury (except major) and J1900C - Major injury are examples and should not be considered an all-inclusive list.

HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment.

In addition to any required OASIS items, an agency may determine what other language will be included in the agency's comprehensive assessment(s) to meet regulatory, coverage and clinical needs.

While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, as long as such modification is presented in a way that makes it clear which items (assessment questions and response options) are part of the OASIS, and which are not.

Question 7: Our agency has been reviewing the updated information and guidance related to the respecified Falls with Major Injury quality measure. Since the updated definition in the OASIS-E2 Guidance Manual for major injury provides a list of injuries/conditions and states the definition of major injury for J1900 - Number of Falls since SOC/ROC "includes but is not limited to" the conditions offered, in order to have consistency within our assessments, can our clinicians define a major injury for J1900C - Major injury based on the ICD-10 codes used to identify major injuries for the quality measure, as listed in Appendix B of the Fall with Major Injury Respecification Technical Specification Report?

Answer 7: As indicated for J1900 - Number of Falls since SOC/ROC, a major injury includes but is not limited to traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, closed head injuries, and crush injuries.

While not required, an agency may utilize Appendix B. Major Injury Diagnostic Codes of the Home Health - Falls with Major Injury Respecification Technical Specification Report in defining a major injury for J1900C - Major injury.

Question 8: If a home health patient has a fall, but the physician specifies a pathological fracture diagnosis for the resulting injury, we understand that J1800 - Any Falls Since SOC/ROC would be coded 1 - Yes. When this occurs how should J1900 - Number of Falls since SOC/ROC be coded?

Answer 8: Fractures confirmed to be pathologic (vs traumatic) are not to be considered a major injury resulting from a fall for the purpose of coding J1900 - Number of Falls since SOC/ROC. Therefore, the fall would be reported in J1800 - Any Falls Since SOC/ROC, but the pathological fracture would be specifically excluded as being coded as an injury resulting from the fall.

If, in the scenario, there were no other falls and no injuries related to a fall during the home health quality episode, then J1900 - Number of Falls Since SOC/ROC would be coded as the following:

J1900A - No Injury = 1

J1900B - Injury (except major) = 0

J1900C - Major injury = 0

K0520

Question 9: Would double portions of meals that are required as part of treatment of a disease or clinical condition be considered a therapeutic diet when coding K0520D - Nutritional Approaches; Therapeutic Diet?

Answer 9: K0520D - Nutritional Approaches; Therapeutic diet, defines a therapeutic diet as a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of treatment of disease or clinical condition to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet.

Therapeutic diets are not defined by the content of what is provided nor when it is served but why the diet is required.

If, in the scenario, the “double portions” are prescribed by a physician or other authorized non-physician practitioner to manage a disease or clinical condition, then yes, a “double portions” diet meets the definition of a therapeutic diet when coding K0520D.

M1028

Question 10: We are looking for clarification regarding applicable diagnoses that qualify for PVD and PAD to respond appropriately to M1028 - Active Diagnoses - Comorbidities and Co-existing Conditions.

Would conditions like Raynaud’s disease and other venous insufficiency diagnoses be reported in M1028?

Answer 10: M1028 - Active Diagnoses - Comorbidities and Co-existing Conditions identifies whether PAD, PVD, and/or Diabetes are present and active.

The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) confirmed and documented diagnosis at the time of assessment.

"Active diagnoses" are diagnoses that have a direct relationship to the patient’s current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment. Diseases or conditions that have been resolved are not included for M1028.

HHA clinicians and coders must adhere to the ICD-10-CM Official Guidelines for Coding and Reporting and assign codes as provided in the ICD-10-CM List of Codes and Descriptions (current coding manual).

The conditions of PVD/PAD and DM can be represented by a variety of ICD-10 CM codes; therefore, CMS does not provide an exhaustive list of diagnoses that would be included in M1028.

Utilizing the guidance provided determine if your patient meets the definition of presenting with an "active diagnosis" for any or all of the specific diagnoses included in the item.

M1306 - M1342

Question 11: If a pressure ulcer is treated with a skin substitute graft that is not surgically applied would the wound still be considered a pressure ulcer or is it considered a surgical wound for the purposes of coding the OASIS?

Answer 11: If the pressure ulcer is treated surgically to apply the graft, the wound is considered a surgical wound and no longer a pressure ulcer. If a "non-surgical" skin grafting approach is used (e.g., epidermal grafting with suction-harvested micrograft, versus the traditional split-thickness or full-thickness surgical graft), then the wound continues to be captured as a pressure ulcer, and not a surgical wound, when coding the OASIS wound items.

M1311

Question 12: With the expanded one clinician convention, would it be appropriate if a second clinician performs a remote skin assessment, either by video monitor or by reviewing photographs taken by the assessing clinician during the first skin assessment in order to stage pressure ulcers and code M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage?

Answer 12: For M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage, code based on the findings from the first skin assessment that is conducted on or after and as close to the actual time of the SOC/ROC as possible.

While collaborative feedback from clinical specialists conducting remote review of wound photographs acquired during the "first skin assessment" can contribute to the information the assessing clinician may consider as part of the "first skin assessment," such remote evaluation would not completely replace the required in-person full-body skin assessment, including direct observation/examination, as applicable.

M1610

Question 13: The guidance for M1610 - Urinary Incontinence or Urinary Catheter Presence includes instructions to code 2 - Patient requires a urinary catheter, when the patient 1) "uses a catheter or tube for drainage", or 2) "Requires the use of a catheter for urinary drainage…". The words "presence" and "requires" may contradict each other when a catheter is required, and/or ordered, but not present or used. How would M1610 be coded for cases where, per RN assessment, the patient "requires" a urinary catheter, but there is no order for one? Or a catheter has been ordered, but is not yet present in the home, or is not yet approved by insurance?

Answer 13: Do not select Code 2 - Patient requires a urinary catheter for M1610 - Urinary Incontinence or Urinary Catheter Presence if catheter use has not been initiated (e.g., patient refuses the catheter, a catheter is recommended but not ordered, the catheter supplies are not covered by insurance). Code 0 - No incontinence or catheter or code 1 - Patient is incontinent would be appropriate depending on whether or not the patient is continent.

M2020

Question 14: If a patient requires the use of a type of "beep and tell" alert system to remember to take their medications, how would M2020 - Management of Oral Medications be coded? Would the code selection differ if the system must be set up by someone else at the beginning of each week versus someone having to set up the system daily?

Answer 14: M2020 - Management of Oral Medications identifies the patient's ability to prepare and take all oral (p.o.) medications reliably and safely on the day of the assessment**.**

If on the day of the assessment, the only assistance the patient requires to safely take their oral medication(s) are daily reminders by an automated device that needed to be set up by someone other than the patient, then M2020 would be coded 2 - Able to take medication(s) at correct times if given reminders. This is true regardless of when or how often the automated reminder is set up.