January 2025 CMS Quarterly OASIS Q&As

Category 2

Question 1: Under all-payer OASIS data collection, what OASIS time points are required for non-Medicare/non-Medicaid patients?

Answer 1: The transition to all-payer will not change the OASIS data collection time points.

OASIS data collection time points are described in OASIS Guidance Manual Coding Instructions for **M0100 - Reason for Assessment**, and include:

- Start of care (SOC)
- Resumption of care (ROC)
- Recertification (Follow-up)
- Major decline or improvement in patient's health status (Other Follow-up)
- Transferred to an inpatient facility (TRN)
- Discharge from agency (DC)
- Death at Home (DAH)

Question 2: During the phase-in for the transition to mandatory OASIS data collection and submission for all patients regardless of payer, will we be able to submit just the voluntary Start of Care (SOC) OASIS for a patient with a M0090 date between January 1, 2025, and June 30th, 2025? Or would we be required to submit all subsequent OASIS assessments for that patient as well?

Answer 2: For HHAs choosing to collect and submit a Start of Care (SOC) OASIS during the 1/1/25 - 6/30/25 voluntary phase-in period, any subsequent assessments (i.e., transfer, resumption, recert, other follow up, discharge and death at home) for this patient are also voluntary, including those assessments for time points occurring on or after 7/1/2025.

Question 3: For the transition to all-payer, do we need to discharge and readmit non-Medicare/non-Medicaid patients who were on service in December 2024 and remained on service on or after January 1, 2025? Would this also apply to non-Medicare/non-Medicaid patients who remain on services on or after July 1, 2025, when OASIS data collection is mandatory for all patients regardless of payer?

Answer 3: No, agencies do not need to discharge and complete a new SOC for non-Medicare/non-Medicaid patients who are on service prior to 2025 and who remain on service on or after January 1, 2025.

The same concept applies for patients who are on service during the voluntary phase and remain on service on or after July 1, 2025.

Question 4: When determining the accurate codes for the OASIS items that require a clinical assessment (e.g., height, weight, functional status, pressure ulcers) can we utilize information from a previous care setting, or must the codes selected be based on an assessment from someone from our agency?

Answer 4: For OASIS items that reflect clinical/patient assessment (e.g., height, weight, functional status, pressure ulcer/injury status), home health agencies should base OASIS responses on assessment by agency staff, and not directly on documentation from previous care settings.

Category 4b

M0150

Question 5: For M0150 - Current Payment Sources for Home Care, when would Private Insurance (response 8) versus Private HMO/Managed Care (response 9) be used?

Answer 5: Private Health Insurance is traditional health insurance provided by private companies where individuals or employers purchase coverage. Private Managed Health Insurance is a type of private health insurance that contracts with a network of providers to deliver care at lower costs. Examples include HMO, PPO, EPO, POS plans that use a network of providers.

For definitions and descriptions of health insurance types, including commercial insurance, managed care plans (HMOs, PPOs), and other structures, please review the information available at: https://www.healthcare.gov/