July 2026 CMS Quarterly OASIS Q&As

Question 1: When will CMS begin using non-Medicare/non-Medicaid OASIS data for the purpose of calculating a home health agency's HHQRP Annual Payment Update (APU) compliance?

Answer 1: Currently, only OASIS data from Medicare and Medicaid payers are included in HH QRP Annual Payment Update (APU) calculation. To calculate APU, CMS intends to include patient data from all non-Medicare/non-Medicaid patients who begin receiving skilled home health care services with an OASIS SOC M0090 date on or after January 1, 2027. If the M0090 date for the SOC is before January 1, 2027 for a non-Medicare/non-Medicaid patient, no OASIS data from any of their time points throughout their entire home health admission will be used for APU purposes, including any assessments that may be completed on or after January 1, 2027.

The transition to using all-payer OASIS data for APU calculation does not impact how assessment data of skilled Medicare/Medicaid patients is utilized.

For more information on the HH QRP quality reporting requirements, please see the HHQRP Quality Reporting Requirements webpage.

Questions Pertaining to Category 4b - OASIS Data Items

GG0170A

Question 2: If a patient is restricted from rolling onto their right shoulder due to medical precautions or restrictions, for example post-surgery, how should GG0170A - Roll left and right be coded?

Answer 2: The intent of GG0170A - Roll left and right, is to determine the patient's ability to roll from lying on back to left and right side and return to lying on back on the bed.

If at the time of the assessment a patient is unable to complete a GG0130 and/or a GG0170 activity (for example, due to a physician prescribed restriction) or the activity cannot be completed safely but the activity could be completed prior to the current illness, exacerbation or injury, code 88 - Not attempted due to medical condition or safety concerns.

K0520

Question 3: If a patient is receiving a mechanically altered diet (e.g., chopped or soft food) for reasons other than a swallowing impairment, would this still be considered a mechanically altered diet for K0520C - Nutritional Approaches; Mechanically altered diet? If the patient chooses to use a

mechanically altered diet, not to facilitate oral intake but because it is their preference, would this also be considered when coding K0520C?

Answer 3: If the patient's diet texture or consistency of food is altered for any reason to facilitate oral intake (e.g., swallowing difficulties, dexterity or functional limitations), it would be considered a mechanically altered diet when coding K0520C - Nutritional Approaches; Mechanically altered diet.

For the purposes of coding K0520C, a mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground or chopped meat, and thickened liquids.

If the texture or consistency of food is not altered, or if the diet texture is altered for a reason other than to facilitate oral intake (e.g., due to patient preference or a prep for a procedure/surgery), it would not be considered a mechanically altered diet when coding K0520C.

M1033

Question 4: What is the definition of an "injury" for M1033 - Risk of Hospitalization, response 1 - History of falls (2 or more falls - or any fall with injury - in the past 12 months)?

Answer 4: M1033 - Risk for Hospitalization identifies patient characteristics that may indicate the patient is at risk for hospitalization.

To check M1033, response 1 - History of falls (2 or more falls - or any fall with injury - in the past 12 months), the patient must have had two or more falls or any fall with an injury in the past 12 months.

To check M1033, response 1, HHAs should refer to the definitions of injury related to a fall in J1900 - Number of Falls Since SOC/ROC when determining if a fall with an injury occurred.

For M1033, a fall with an injury indicates that there was any reported injury (major injury and/or injury except major) within the past 12 months that occurred as a result of or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

Question 5: If, in the past 12 months, a patient had one fall and was then diagnosed with a fracture that was confirmed to be pathological due to osteoporosis, would M1033 - Risk for Hospitalization, response 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months) be checked?

Answer 5: M1033 - Risk for Hospitalization identifies patient characteristics that may indicate the patient is at risk for hospitalization.

To check M1033, response 1 - History of falls (2 or more falls - or any fall with injury - in the past 12 months) the patient must have had two or more falls or any fall with an injury in the past 12 months.

M1033 utilizes the same definition of "injury related to a fall" as J1900 - Number of Falls since SOC/ROC. Therefore, if the fracture was determined to be pathological in nature, then the fall did not result in an injury, and it would not be considered as a fall with injury.

M1060

Question 6: If an agency admits a patient whose height and/or weight are outside the technical submission specification parameters, per the OASIS guidance, the agency is instructed to code M1060 - Height and Weight with a dash for the applicable item. The use of a dash does not allow for any risk adjustment to be made for a patient with a high BMI for the Discharge Function Score quality measure. Is there a way to avoid this measure implication?

Answer 6: The current technical submission specification parameters for M1060 - Height and Weight are:

- Height: 50 to 80 inches
- Weight: 65 to 440 pounds

If a patient's height and or/weight fall outside the current technical submission specification parameters, agencies should enter the minimum or maximum value in the item. For example, if a patient weighs 440+ pounds, enter 440 (the maximum value) in M1060B - Weight; or if a patient is shorter than 50 inches, enter 50 (the minimum value) in M1060A - Height.

Please note that this response supersedes the guidance found in the OASIS-E2 Guidance Manual that instructs agencies to code a dash for height and/or weight when a patient's height and/or weight is outside of the reporting parameters. At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance.

M1311

Question 7: A pressure ulcer that was present at SOC healed during the quality episode. Prior to the end of the quality episode, the pressure ulcer reopened to the same stage in the same location, and remained open at that stage at discharge. Would this pressure ulcer be considered as "present at the most recent SOC/ROC" when coding M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage at discharge?

Answer 7: For M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage, if a patient has a pressure ulcer/injury that was documented on SOC/ROC then closes (i.e., heals) during the quality episode and opens again during the quality episode and remains open at discharge, the pressure ulcer/injury should not be coded as "present at the most recent SOC/ROC" when completing the Discharge assessment. This is true even if the pressure ulcer is at the same stage at both SOC/ROC and Discharge.

Please note that this response supersedes the guidance found in the OASIS-E2 Guidance Manual, Chapter 3, Section M: Skin Conditions. At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance.

M1610

Question 8: I have a follow-up question related to Question 13 of the April 2026 CMS Quarterly OASIS Q&As. The response provided a clarification that for M1610 - Urinary Incontinence or Urinary Catheter Presence, Code 2 - Patient requires a urinary catheter should not be coded if catheter use has not been initiated. The examples given in the Q&A, (patient refuses the catheter, a catheter is recommended but not ordered, the catheter supplies are not covered by insurance) all represented situations where catheter initiation did not seem like it would be occurring.

Our follow up question is how should M1610 be coded if the patient requires the use of the catheter, however the catheter equipment is just not in the home yet, or if at the time of the assessment it is unclear when catheter use will be "initiated". For example, it is identified during a SOC visit that the catheter equipment wasn't ordered, so it is ordered and will arrive in a day or so, or if insurance coverage or denial is not known at the time of the assessment. Does this change how M1610 would be coded?

Answer 8: For M1610 - Urinary Incontinence or Urinary Catheter Presence, report what is true on the day of assessment. For M1610, do not select Code 2 - Patient requires a urinary catheter if catheter use has not been initiated.

For M1610, information collected by the assessing clinician during the timeframe for the specified assessment type may be used to inform OASIS coding. If desired, the assessing clinician may consider additional information gathered during the assessment timeframe and determine if any revisions to OASIS items are warranted, consistent with OASIS guidance.

O0110

Question 9: If a patient is receiving radiation treatment for a condition other than cancer, such as low dose radiation for osteoarthritis, should O0110B1 - Special Treatments, Procedures, and Programs; Radiation be checked?

Answer 9: Each radiation treatment should be evaluated to determine its reason for use before coding it in O0110B1 - Special Treatments, Procedures, and Programs; Radiation.

Check O0110B1 - Radiation, if any type of radiation is administered intermittently or via radiation implant for cancer treatment. Radiation treatment provided for reasons other than the treatment of cancer should not be considered when coding this item.