



October 2026 CMS Quarterly OASIS Q&As

Question 1: If a patient begins a quality episode with a Medicare/Medicaid payer, but during the quality episode has a change in payer source to one that DOES NOT require a new Start of Care (SOC) assessment to be completed, does this patient's quality episode remain eligible for inclusion in quality measure calculations?

For example, M0150 - Current Payment Sources for Home Care is coded 3 - Medicaid (traditional fee-for-service) on the SOC, then the patient's tracking sheet is updated to indicate the pay source change in M0150 to only reflect a code 8 - Private insurance as Medicaid is no longer a current payment source.

Answer 1: OASIS data collection and submission are required for all patients receiving skilled services regardless of payer with the following exemptions:

- (1) patients under the age of 18,
- (2) patients receiving maternity services only,
- (3) patients receiving personal care, homemaker, or chore services only
- (4) patients receiving outpatient therapy services provided by a HHA and billed under Medicare Part B benefit that do not have a home health plan of care in effect,
- (5) patients receiving a service from a company (other than the Medicare-certified HHA) using HHA staff under a loaned employee agreement,
- (6) single visit quality episodes.

A quality episode will be included in OASIS-based outcome and OASIS-based process measure calculations if the patient's quality episode begins with M0150 - Current Payment Sources for Home Care being coded as one or more of the following:

- Medicare (traditional fee-for-service) - identified with M0150 response 1
- Medicare (HMO/managed care/Advantage plan) - identified with M0150 response 2
- Medicaid (traditional fee-for-service) - identified with M0150 response 3
- Medicaid (HMO/managed care) - identified with M0150 response 4.

Any quality episode that reports Medicare/Medicaid as a payment source in M0150 on the Start of Care (SOC) or Resumption of Care (ROC) OASIS, would be included in OASIS-based outcome and OASIS-based process measure calculations. This is true even if the pay source changes during the quality episode.

Currently, quality episodes that do not indicate Medicare/Medicaid as a payment source in M0150 on the SOC or ROC OASIS would be excluded from CMS OASIS-based quality measure calculations.

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Questions Pertaining to Category 2 - Comprehensive Assessment

Question 2: When a patient's insurance changes during a home health episode, we know that, at times based on the new payer, a new Start of Care (SOC) OASIS is required. When we are discharging the patient under the old pay source is a Discharge OASIS required?

Answer 2: If the new payer source requires a new Start of Care (SOC) OASIS, then a Discharge OASIS is required and a new SOC assessment would be completed under the new pay source. Medicare FFS is one that DOES require a new SOC.

The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission).

When a patient's skilled services under any payer end, a Discharge OASIS is required. This is true whether or not they continue on as an OASIS exempt patient, receiving non-skilled services (e.g., moving from skilled Medicare to personal care only). This provides a clear endpoint to the patient's episode of care for purposes of the agency's quality initiatives.

Please note that this response supersedes guidance found in the OASIS Guidance Manual and in the CMS OASIS Q&As. At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance.

Question 3: Our agency admitted a patient who had a non-Medicare payer as the primary payer with Medicare FFS as a secondary payer. The patient's insurance changed mid-episode and Medicare FFS became the primary payer. Is a new Start of Care (SOC) OASIS required?

Answer 3: When a Medicare patient is admitted for home care services under a non-Medicare insurer as primary and Medicare FFS as a secondary payer, report both pay sources on M0150 - Current Payment Sources for Home Care.

If Medicare FFS was a secondary payer when the patient was admitted for home care services, a new Start of Care (SOC) OASIS would NOT be required, if during the home health episode, there is a pay source change where Medicare FFS becomes the primary payer.

Question 4: How can a Start of Care (SOC) or Resumption of Care (ROC) OASIS be completed when a nurse unexpectedly leaves the agency before completing their documentation of the visit and leaves some of the OASIS items unanswered? Can a clinical manager complete the OASIS, or should we have a second RN complete the OASIS?

Answer 4: The Start of Care (SOC) (or Resumption of Care (ROC)) comprehensive assessment including OASIS requires an in-person patient encounter and assessment from a qualified clinician. The assessing clinician is responsible for accurately completing and signing a comprehensive assessment. A supervisor or other agency clinician who has not visited the patient cannot complete a SOC (or ROC)

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comprehensive assessment including OASIS compliantly using only information documented from patient visits by other agency staff that occurred within the assessment timeframe.

The SOC comprehensive assessment including OASIS must be completed on or within 5 days after the SOC date, M0030. The ROC comprehensive assessment including OASIS must be completed within 2 calendar days of the facility discharge date, knowledge of the patient's return home, or a physician-ordered ROC date. Assessment strategies to complete any and all OASIS items include observation, interview, collaboration with other agency staff and other relevant strategies, unless otherwise noted in guidance.

If another RN had completed a visit within the assessment timeframe, they could be considered the assessing clinician. If the original assessing clinician is not available to complete the assessment and an additional home visit by another RN was not completed within the assessment timeframe, then there would be no way of resolving this situation compliantly.

If the comprehensive assessment for a patient requiring OASIS data collection was not completed and the assessing clinician is no longer available to finish the comprehensive assessment, the agency may send another RN out as soon as the oversight is identified to complete the comprehensive assessment including OASIS. This comprehensive assessment can be completed with or without allowed collaboration, including review of the departed clinician's documentation. M0090 - Date Assessment Completed reports the date the last information is obtained to complete the comprehensive assessment, even if the agency completes the assessment late, after the required assessment timeframe. Obviously, this situation should be avoided, as it does demonstrate non-compliance with the Conditions of Participation. For the Medicare PPS (PDGM) patient, payment implications may arise from this late assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

Questions Pertaining to Category 4a - General OASIS form questions

Question 5: The OASIS Data Submission Specifications allow the use of a dash (-) for some items, but it is not a represented response in the OASIS instrument. Are agencies required to use the dash?

How does a clinician report that an item has not been assessed if the dash is not represented in the item as an option to pick?

An EMR system that we are exploring has added NA to the list of OASIS item response options for the purpose of indicating a dash response. Is this compliant?

Answer 5: A dash (-) value indicates that no information is available or the item was not assessed.

The most recent version of the OASIS Data Submission Specifications which provide a list of valid item values for each OASIS item can be located in the download section of the Home Health Quality Reporting Data Specifications webpage found at <https://www.cms.gov/medicare/quality/home-health/data-specifications>.

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A dash must be available for clinician use when responding to an OASIS item where the submission specifications allow the dash as a valid response option for the OASIS item.

While the response options in the printed versions of the OASIS instruments do not show the dash as a response option for the applicable OASIS items, to be compliant, there must be a way for clinicians to indicate the dash as the selected response, when applicable.

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

While the Data Specifications dictate the assessment instrument items, their applicable timepoint(s) in the assessment instrument, the exact language of the items, and each item's allowable response options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the Items in the assessment instrument. 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 does not impact the accuracy of the item scoring and 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.

Each agency will determine how to direct clinicians to indicate when a dash is the applicable response. Agencies and/or vendors may reformat the presentation of the item as long as the item language and response options are not modified and the presentation makes it clear what wording is part of OASIS and which is not. If the vendor has added an NA response to the assessment in a way that does not impact the scoring accuracy and which makes it clear that the NA (dash) is not part of the OASIS item, this approach could represent a compliant way to indicate that an item was not assessed or no information is available.

Note that some items both allow a dash AND have an NA response. In those cases, it should be noted that the two responses are not equivalent or interchangeable.

For instance, for M2001 - Drug Regimen Review, Response 9 - NA is used when a patient is not taking any medications, which would be a distinctly different response than a dash, which indicates that the item was not assessed or no information is available.

Questions Pertaining to Category 4b – OASIS Data Items

A2123

Question 6: Our agency as a general practice provides a printed medication list to the patient following the start of care (SOC) visit. This list is left in the patient's home and reviewed by qualified clinicians at each home visit and continuously reconciled and updated as needed. In the circumstance of an unplanned discharge, would the printed medication list present in the patient's home serve as "providing a reconciled medication list to the patient, family and/or caregiver at discharge" for A2123 - Provision of Current Reconciled Medication List to Patient at Discharge?

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Answer 6: In the case of an unplanned discharge (an end of home care where no in-home visit can be made) the last qualified clinician who saw the patient may complete the discharge comprehensive assessment, including the OASIS, based on information from their last visit. The assessing clinician may collect information to complete the OASIS items on the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unplanned discharge. The “last 5 days that the patient received visits” are defined as the date of the last in-home patient visit, plus the four preceding calendar days.

The intent of A2123 - Provision of Current Reconciled Medication List to Patient at Discharge is to identify if the home health agency provided a current reconciled medication list to the patient, family, and/or caregiver at discharge.

A2123 is an OASIS item used in a quality measure, Transfer of Health Information to the Patient, which is intended to reflect the timely transfer of a reconciled medication list when discharged. If the agency did not have an opportunity to reconcile the medication list when the patient was discharged, the item would need to be answered Code 0 - No.

If, in the scenario provided, it is confirmed that the medication list that was left in the patient's home accurately represented the current medications that the patient was taking at the time of the unplanned discharge, then Code 1 - Yes could be selected for A2123. It is recognized that this would often not be feasible.

GG0130/GG0170

Question 7: How would a situation where two agency staff members are present during certain functional activities (e.g., dressing, bathing) due to staff or patient request (for example the patient prefers to not be alone with agency staff or the patient has made false statements about agency staff) be coded for the GG0130 - Self-Care and/or GG0170 - Mobility activities? Would this situation be coded with Code 01 - Dependent since there are two people present or could a different performance code apply?

Answer 7: If the assistance of two or more helpers is required for the patient to safely complete an activity, it would be coded as 01 - Dependent. If a second person is not required for the patient to safely complete the activity, and is only present due to preference or agency policy, code the activity based on the type and amount of assistance the patient requires to complete the entire activity as independently as possible, as long as they are safe.

GG0170C

Question 8: For GG0170C - Lying to Sitting on side of bed, if a patient completes the supine to sitting activity with assistance but requires back support to remain seated at the side of the bed, can the activity be coded with a performance code or would it need to be coded with one of the “activity not attempted” codes?

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Answer 8: The GG0170C - Lying to Sitting on side of bed activity ends when the patient achieves a sitting position on the side of the bed, with or without assistance or assistive devices. If the patient requires assistance to move into a seated position, including assistance with back support, code based on the type and amount of assistance required to complete the ENTIRE GG0170C activity. The amount of assistance a patient requires after the lying to sitting activity ends is excluded from consideration when assessing the patient's ability to complete the GG0170C activity.

Use of an activity not attempted code should only occur if the patient is unable to move from a lying position to a seated position on the side of the bed even with the assistance of one or more helpers and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

Please note that this response supersedes the guidance found in the Q4 of the April 2026 CMS Quarterly OASIS Q&As. At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance

M1740

Question 9: For M1740 - Cognitive, Behavioral and Psychiatric Symptoms, response 1 - Memory Deficit is defined as "failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required."

If the patient has significant memory issues so that supervision is required but is able to recognize their husband and daughter, does response 1 still apply or must every behavior listed be present in order to check response 1?

Answer 9: M1740 - Cognitive, Behavioral and Psychiatric Symptoms identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders that are demonstrated at least once a week (reported or observed).

Behaviors which are severe enough to make the patient unsafe to self or others, cause considerable stress to the caregivers and/or require supervision or intervention should be included.

The behaviors listed in the individual symptom response options for M1740 are examples.

Not all of the listed behaviors in the individual symptom response options have to be reported or observed to be included for consideration when selecting a response.

CMS does not provide an exhaustive list of example behaviors for determining cognitive, behavioral and psychiatric symptoms.

M1860

Question 10: If a patient is able to safely walk on level surfaces with a rolling walker and assistance, but is unable to safely negotiate stairs or steps or uneven surfaces, even with assistive devices and human assistance, how is M1860 - Ambulation/Locomotion coded? Would the patient be considered ambulatory or would they be considered chairfast since they cannot ambulate over a variety of surfaces?

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Answer 10: The intent of M1860 - Ambulation/Locomotion is to identify the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. Variety of surfaces refers to typical surfaces that the patient would routinely encounter in their environment and may vary based on the individual residence.

To determine the best response, consider the activities permitted, the patient's current environment and its impact on the patient's normal routine activities.

If on the day of assessment, a patient is unable to safely negotiate stairs and/or uneven surfaces, even with assistance, these surfaces would not be considered routinely encountered when coding M1860.

If the patient is able to ambulate safely for more than just one or two steps on flat, level surfaces, they would be considered ambulatory and would not meet the definition of chairfast.