



October 2025 CMS Quarterly OASIS Q&As

Category 2

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 (HHA)?

Answer 1: CMS is confirming that all outpatient therapy services – PT, OT, SLP – provided by an HHA and billed under the Medicare Part B benefit that do not have a home health plan of care in effect do not require completion of the OASIS.

Please note that this response supersedes the guidance that was published in Question 1 of the July 2025 CMS Quarterly OASIS Q&As.

Question 2: A home health agency (HHA) receives a referral for skilled services for an active patient who has been receiving non-skilled care from the agency. Does the HHA need to complete a Start of Care (SOC) OASIS or can they complete an OASIS at the next OASIS time point?

Answer 2: When a patient is receiving “skilled services” as defined in Chapter 7 of the Medicare Benefit Policy Manual (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673>), 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.

Unless otherwise noted in guidance, when a patient begins to receive “skilled services” from a Medicare certified home health agency (HHA) or a Medicaid home health provider in states where that state’s laws require those agencies to meet the Medicare HH CoPs, the Start of Care (SOC) OASIS should be the first OASIS collected and submitted for the patient.

Question 3: If a patient is seen for more than one visit but none of the visits are billable, would OASIS submission be required? For example, our home health agency (HHA) provided three skilled visits to a patient before we found out they were being seen by another HHA. Are we required to collect and submit any OASIS on this patient?

Answer 3: Regardless of payer, patients who do not meet an OASIS exemption, and who begin receiving “skilled services” from a Medicare certified home health agency (HHA) with an OASIS Start of Care (SOC)

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M0090 - Date Assessment Completed on or after July 1, 2025, require OASIS data collection and submission to the Internet Quality Improvement and Evaluation System (iQIES). The OASIS exemptions include patients under the age of 18, patients receiving only maternity services, and patients receiving only chore, housekeeping or personal care services. OASIS is not required when there is only one visit in a quality episode.

In your scenario, it does not appear that the patient described met any of the OASIS exemptions and more than one visit was made so it does not meet the definition of a single visit quality episode. Therefore, the comprehensive assessment including OASIS is required for both the SOC (RFA 1) and DC (RFA 9). This is true even if one or more of the visits were non-billable.

Category 4

M0150

Question 4: How should M0150 - Current Payment Sources for Home Care be coded when a patient is having skilled care being reimbursed by Medicare and non-skilled services being reimbursed through another payer, for example a Medicaid waiver program?

Answer 4: M0150 - Current Payment Sources for Home Care identifies any and all payers to which any services provided during this home care episode are being billed. Note that the text of M0150 - Current Payment Sources for Home Care asks for the "current payment sources" (emphasis added) and contains the instruction, "Check all that Apply."

The clinician should indicate at Start of Care (SOC) all pay sources that the agency will bill for services by checking all of the appropriate responses. The item is NOT restricted to the primary payer source.

In the scenario described, code 1 or 2 (depending on the type of Medicare payer) for the services the agency will be billing to Medicare and code 3 - Medicaid for the services the agency will be billing to the Medicaid waiver program.

GG0100

Question 5: When determining a patient's prior ability to complete an activity for the purposes of coding GG0100 - Prior Functioning: Everyday Activities should safety and/or availability of assistance be considered? For example, we admitted a patient who lives alone. Prior to the patient's most recent illness they were ambulating on their own but had frequent falls and reported that they were not safe walking. The patient did not have anyone available to provide them with assistance to ambulate. For this example, should GG0100 be coded 3 - Independent because the patient was walking without the assistance of anyone or coded 2 - Needed some Help because they required help, even though no help was available?

Answer 5: The intent of GG0100 - Prior Functioning: Everyday Activities is to record the patient's ability with everyday activities prior to the current illness, exacerbation, or injury.

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If the patient required assistance prior to the most recent illness, injury or exacerbation, to complete any of the GG0100 activities, then code 2 - Needed Some Help. This is true even if assistance was required but not provided due to lack of caregiver availability.

Question 6: How should GG0100 - Prior Level of Functioning: Everyday Activities be coded if a patient received supervision/cueing assistance via in-home camera monitoring from a helper?

Answer 6: The intent of GG0100 - Prior Level of Functioning: Everyday Activities is to record the patient's ability with everyday activities prior to the current illness, exacerbation, or injury.

If the supervision and/or verbal cuing of one person via in-home camera monitoring was required for the patient to safely complete an activity prior to the current illness, exacerbation, or injury, code 2 - Needed Some Help.

M1033

Question 7: How do the revisions being made to the definition of falls for J1800 - Any Falls Since SOC/ROC, affect the definition of falls for M1033 - Risk for Hospitalization?

Answer 7: Effective January 1, 2026 the definition of a fall for M1033 - Risk for Hospitalization will be updated and defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. A fall due to an overwhelming external force (e.g., a patient pushing another patient) would be considered a fall.

An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themselves or had not been intercepted by another person. If a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would be considered a fall for M1033. If no major injury resulted during this therapeutic intervention, then any fall or intercepted fall would not be considered as a fall for M1033 Response 1.

J1800/J1900

Question 8: A patient is participating in a balance retraining activity with a therapist and the patient loses their balance. The therapist is unable to prevent the patient from falling, resulting in the patient sustaining a hip fracture. Would this be reported as a fall in J1800 - Any Falls Since SOC/ROC and a major injury in J1900 - Number of Falls since SOC/ROC even though the fall and subsequent major injury occurred while the patient was participating in a supervised therapeutic intervention where the patient's balance was being intentionally challenged during balance training?

Answer 8: Yes, this would be coded as a fall in J1800 - Any Falls Since SOC/ROC and as a major injury in J1900 - Number of Falls since SOC/ROC. Effective January 1, 2026, whenever a major injury results from a fall or intercepted fall, regardless of why or when the fall occurs, it would be reported as both a fall and a major injury in J1800 and J1900.

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Question 9: A patient was knocked over and fell when a heavy door swung and hit the patient. Would this need to be reported as a fall for the purposes of J1800 - Any Falls Since SOC/ROC?

Answer 9: Yes, effective January 1, 2026, for the purposes of coding J1800 - Any Falls Since SOC/ROC a fall due to an overwhelming force, such as being knocked over by a heavy door, would be considered a fall.

Note that this is a change from previous guidance that stated a fall from an overwhelming force was an exclusion for the purposes of coding J1800.

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

Question 10: Are the injuries listed in J1900C - Major Injury, specifically, bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematomas the only type of injuries that are considered “major” for the Falls with Major Injury quality measure?

Answer 10: No, the injuries listed in J1900C - Major injury are examples and should not be considered an all-inclusive list. In the *Home Health J1800/J1900 Errata* that will be released soon and in the OASIS-E2 Manual, effective April 1, 2026, we have added new examples of major injuries. The new language is as follows: 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.

For additional details on ICD-10 codes that will be considered a major injury with the respecified Falls with Major Injury measure, please refer to the updated Falls with Major Injury Technical Measure Specifications document.

O0110

Question 11: Should any “antineoplastic” medication being given as a cancer treatment be captured in O0110A1 - Chemotherapy? For example, Anastrozole (Arimidex) is an antineoplastic drug but not considered a chemotherapy medication, but rather a hormone therapy.

Answer 11: The intent of O0110 - Special treatments, Procedures, and Programs is to identify if any of the listed special treatments, procedures, and programs apply to the patient.

Check all treatments, programs and procedures that are part of the patient’s current care/treatment plan at the time of the SOC/ROC (or discharge) assessment, even if not used at the time of assessment.

O0110A1 - Chemotherapy is only indicated when chemotherapy medication is administered as an antineoplastic for cancer treatment given by any route.

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Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the OASIS.