April 2025 CMS Quarterly OASIS Q&As

Category 1

Question 1: Our agency has successfully submitted several Start of Care (SOC) OASIS assessments for some of our commercially insured patients. We do not plan on continuing to practice data collection and submission for the remainder of the phase in time. Starting on July 1st, we plan on collecting and submitting OASIS on all patients, even if the patient was active prior to July 1st, 2025. This would mean that the first OASIS assessments submitted for some patients may be a recertification, or a discharge, etc. Will such assessments be rejected by iQIES if there is no SOC in the system? What indicator(s) will CMS be using to identify these assessments so that their OASIS information doesn't impact our surveys or Total Performance score (TPS) for the expanded HHVBP Model?

Answer 1: While there is no technical submission specification that will cause a subsequent OASIS to be rejected when a Start of Care (SOC) was not submitted first, the SOC should be the first mandatory assessment that is submitted for a non-Medicare/non-Medicaid patient, on or after July 1, 2025.

CMS will use SOC data from M0090 - Date Assessment Completed and from M0150 - Current Payment Sources to identify voluntary patient assessments in the phase-in and mandatory periods. Voluntary assessments can be identified as any assessment (including any timepoint) collected on a patient who has a M0090 date for their SOC on or between 1/1/2025 and 6/30/2025, AND the SOC M0150 coding does not include response 1, 2, 3, or 4 (i.e., patient's home health care is not expected to be billed to a Medicare or Medicaid payer). Note that collection and submission of voluntary assessments could include all subsequent time points for a non-Medicare/non-Medicaid patient with a SOC M0090 date in the phase-in period, including those assessments occurring on or after 7/1/2025.

Question 2: Our agency has been completing and submitting OASIS for our non-Medicare/non-Medicaid patients as of January 1st. We assume that CMS is not using the data submitted during this voluntary phase but what will happen after the voluntary phase is over? If we continue to submit OASIS on patients who started care in the voluntary phase but are still active into July, is CMS going to use that patient's data for any quality measures or in the measure calculation for the HHVBP measures? And is there any case in which CMS would end up using a patient's data from the voluntary phase?

Answer 2: CMS expects to use this all-payer data to gain a better understanding of the overall quality of care provided by Medicare-certified providers to the patients they serve, regardless of the patient's payer source.

CMS will monitor the all-payer OASIS data and will notify providers when decisions are made for future uses for quality or payment purposes, including if, when or how non-Medicare/non-Medicaid OASIS data will be used for the expanded HHVBP Model.

It is not intended that voluntary OASIS data will be used for any of the following initiatives:

- APU, including the QAO metric
- Quality measure calculation, including those measures utilized in the HHVBP model
- HHVBP reports
- iQIES quality reports*
- Risk adjustment
- Publicly reported data

*Non-quality measures reports (including the HHA Activity Report, HHA Roster Report, HHA Discharge Report, OASIS Agency Final Validation Report, OASIS Submitter Final Validation Report, HHA Error Summary by Agency, and OASIS Error Detail Report) will include any relevant, voluntary OASIS data.

Category 2

Question 3: Our home health agency provides services (fills a medi-planner and provides monthly supervision to a home health aide) to patients under a Medicaid program.

While these patients meet the payment requirements under the Medicaid program, these types of services would not meet the definition of "skilled care" under the Medicare home health benefit. Should OASIS data be collected and submitted for these patients?

Answer 3: 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.

Regardless of payer, to identify if a patient requires OASIS data collection and submission under all-payer, home health agencies (HHAs) should follow the Medicare home health benefit definition of "skilled services". Skilled services covered by the Medicare home health benefit are discussed in Chapter 7 of the Medicare Benefit Policy Manual. This publication can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.

Question 4: If we admit a non-Medicare/non-Medicaid patient with a Start of Care (SOC) date of June 29th, 2025, but don't finish their SOC comprehensive assessment until on or after July 1, 2025, are we required to collect and submit an OASIS?

Answer 4: Yes. Regardless of payer, patients who do not meet an OASIS exemption, and who begin receiving home health care services with an OASIS Start of Care (SOC) M0090 - Date Assessment Completed on or after July 1, 2025, require OASIS data collection and submission to 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.

Question 5: If a non-Medicare/non-Medicaid patient is admitted in February 2025, has a qualifying inpatient stay in June 2025, resumes care in July 2025 and remains on service until October 2025, will collection/submission of any OASIS assessments be required?

Answer 5: For any non-Medicare/non-Medicaid patient with a Start of Care (SOC) comprehensive assessment completed between 1/1/25 and 6/30/25, the SOC OASIS and any subsequent OASIS assessments (i.e., transfer, resumption, recert, other follow up, discharge and death at home) for this patient are voluntary, including those assessments for time points occurring on or after 7/1/2025.

Voluntary assessments can be identified as any assessment (including any time point) collected on a patient who has a M0090 - Date Assessment Completed for their SOC on or between 1/1/2025 and 6/30/2025, AND the SOC M0150 - Current Payment Sources coding does not include response 1, 2, 3, or 4 (i.e., the patient's home health care is not expected to be billed to a Medicare or Medicaid payer).

Question 6: If our home health agency is contracted to provide staff to another company (for example, our agency provides a nurse to manage PICC line dressing changes and/or draw labs for a pharmacy company) is OASIS data collection and submission required?

Answer 6: In your scenario, as the pharmacy provided the service using HHA staff under a loaned employee agreement, OASIS is not required.

Question 7: If a patient's pay source changes from Medicare Advantage to Medicare FFS while the patient is on services with a home health agency and OT is the only active discipline, are they allowed to complete the SOC comprehensive assessment including OASIS, even though the need for occupational therapy does not establish program eligibility under the home health benefit?

Answer 7: When there is a pay source change from Medicare Advantage (MA) to Medicare FFS the original eligibility for the home health benefit is uninterrupted. If continued OT is the only active service at the time of the pay source change from MA to Medicare FFS, the OT can complete the SOC OASIS and continue to provide care as the only active discipline for the remainder of the Home Health Stay.

Questions related to payment must be discussed with the agency's Medicare Administrative Coordinator (MAC) or Medicare Advantage Payer.

Question 8: How should the OASIS items be completed when there is an unplanned discharge and specific items were not assessed within the look back period?

Answer 8: 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 document based on information from their last visit. The assessing clinician may supplement 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 patient visit, plus the four preceding calendar days.

In the case of an unplanned discharge, utilize the following guidance to complete the OASIS:

Items where a dash is a valid response: When there is no information available because the assessment of the item was not completed prior to the unplanned discharge, a dash may be the only valid response. A dash indicates "no information available" and CMS expects dash use to be a rare occurrence.

> Patient Interview items where a dash is a valid response (BIMS & PHQ-2 to 9): When assessing C0200- C0500 - Brief Interview for Mental Status (BIMS) and/or D0150 - Patient Mood Interview (PHQ-2 to 9), a patient interview is required to complete these items. If a clinician is not able to complete the assessment of these items due to an unplanned discharge and there is no documentation that the interview was completed in the last 5 days that the patient received visits, then a "dash" is the only allowable response.

Items where a dash is NOT a valid response: If assessment of an item was not completed prior to the unplanned discharge and there is no information available from the last 5 days the patient received visits, code the item using any available documentation/information. For patient interview items, where the dash is not a valid response, if the patient is unable to respond due to an unplanned discharge and it is allowable, code X or code 8 - Patient unable to respond, depending on the item. Review the guidance manual and Q&As for item-specific guidance.

Category 4b

M0150

Question 9: We have patients with Medicaid coverage residing in an Assisted Living Program (ALP) or involved with a PACE program. Home care services are reimbursed directly from the ALP or from the PACE program and our agency is not billing Medicaid for these services while a patient is a participant in these programs. How should M0150 - Current Payment Sources for Home Care be coded?

Answer 9: In your scenario, as the care is provided by an Assisted Living Program (or PACE program) using home health agency staff under a loaned employee agreement, OASIS is not required.

Question 10: We have patients that are receiving home care services under UHC Dual Complete, a combined Medicare and Medicaid managed care insurance payer.

For M0150 - Current Payment Sources for Home Care, should both response 2 - Medicare (HMO/managed care) and 4 - Medicaid (HMO/managed care) be checked or should only one be checked since we are billing a single payer (UHC Dual Complete)?

Answer 10: M0150 - Current Payment Sources for Home Care identifies payers who will be billed by your home health agency for services provided during the home health episode. If the patient's care is being reimbursed by multiple payers (for example, Medicare and Medicaid; private insurance and self-pay; etc.), include all sources.

In your scenario, check both response 2 - Medicare (HMO/managed care) and response 4 - Medicaid (HMO/managed care).

J0510-J030

Question 11: If a pain interview is conducted at the time of the start of care (SOC) visit and J0150-J0530 - Pain interview is coded based on the patient's responses at that time, can we update the responses to the applicable pain items, if the patient's status changes during the assessment timeframe?

Answer 11: To support consistency of data collection related to conducting the pain interview across all post-acute care (PAC) providers, coding for J0510-J0530 - Pain Interview should be based on the first complete pain interview conducted within the assessment timeframe. Coding for these items should not be changed even if a patient's status might change within the assessment timeframe.