



STATE OF NEW YORK DEPARTMENT OF HEALTH

161 Delaware Avenue Delmar, NY 12054-1393

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

February 17, 2009

DAL: *HCBS 09-03*
Subject: *NYS OASIS Requirements*

Dear Administrator:

The purpose of this letter is to inform you of a new requirement for New York State Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs). On or after March 1, 2009, OASIS Item "M0826 Therapy Need" must be submitted for all assessments of patients whose payer source is Medicare traditional fee-for service and/or all Medicaid. This therapy need item is included in assessments conducted at Start of Care, Resumption of Care and Follow-up.

Background:

In a Federal Register notice published June 18, 1999, CMS announced the mandatory use, collection, encoding, and transmission of OASIS data for all Medicare/Medicaid patients receiving skilled services. Further guidance was provided in this notification advising that the response to M0150 determines payer sources for the episode of care:

OASIS ITEM:

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- 0 - None; no charge for current services
- 1 - Medicare (traditional fee-for-service)
- 2 - Medicare (HMO/managed care)
- 3 - Medicaid (traditional fee-for-service)
- 4 - Medicaid (HMO/managed care)
- 5 - Workers' compensation
- 6 - Title programs (e.g., Title III, V, or XX)
- 7 - Other government (e.g., CHAMPUS, VA, etc.)
- 8 - Private insurance
- 9 - Private HMO/managed care
- 10 -Self-pay
- 11 -Other (specify)
- UK -Unknown

The Department seeks to determine therapy need for patients whose therapy needs will be billed to Medicaid (response #3 or #4 for M0150) and by this correspondence directs CHHAs and LTHHCPs to complete OASIS Item M0826 for **all** patients for whom the response to M0150 is #1 and/or #3 or 4.

Discussion:

Currently item M0826 directions found in the OASIS User’s Manual (2008), Chapter 8, page 8.11 reads :

OASIS ITEM:
<p>(M0826) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero [“000”] if no therapy visits indicated.) (_ _ _) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/> NA -Not Applicable: No case mix group defined by this assessment.</p>
DEFINITION:
<p><i>Identifies the total number of therapy visits (physical, occupational or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group. Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the treatment of the patient’s illness or injury.</i></p>
TIME POINTS ITEM(S) COMPLETED:
<p>Start of care Resumption of care Follow-up</p>
RESPONSE—SPECIFIC INSTRUCTIONS:
<ul style="list-style-type: none"> • Answer "000" if no therapy services are needed. • Answer "Not Applicable" when this assessment will not be used to determine a Medicare case mix group. Usually, the “Not Applicable” response will be checked for patients whose payment source is not Medicare fee-for-service (i.e., M0150, Response 1 is not checked), or for an assessment that will not be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response to this item is required to generate the case mix code.
ASSESSMENT STRATEGIES:
<p>When the patient assessment and the care plan are complete, review the plan to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services are ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.</p>

For patient assessments conducted for start of care (SOC), resumption of care (ROC), or follow-up (f/u) on or after March 1, 2009 the italicized portions of the OASIS User Manual will not be applicable for New York State CHHAs or LTHHCPs. Definition of the item for CHHAs and LTHHCPs will be:

Identifies the total number of therapy visits (physical, occupational or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group or will be billed to Medicaid.

Response specific instructions will be:

Answer "Not Applicable" when this assessment will not be used to determine a Medicare case mix group or for care billed as Medicaid. Usually, the "Not Applicable" response will be checked for patients whose payment source is not Medicare or Medicaid (i.e., M0150, Response 1 or 3 is not checked), for an assessment that will not be used to determine a Medicare case mix group or for care that will not be billed to Medicaid.

Implementation:

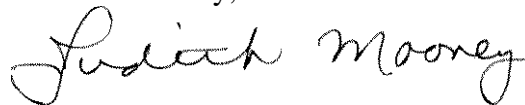
The implementation date for this requirement is March 1, 2009. Implementation will require education of agency staff that perform, supervise and submit patient assessments. Questions regarding these directions for completing OASIS Item M0826 can be directed to the New York State OASIS Help Desk at oasis@health.state.ny.us or by telephone call to (518) 408-1658.

Survey staff will provide education to providers regarding this requirement if needed until July 1, 2009. After that date, agencies determined to be out of compliance with this requirement will be cited for non-compliance with 10 NYCRR 763.14 (a)(3)(vi).

Additional Information:

For questions or additional information on this directive, contact the New York State Department of Health, Division of Home and Community Based Services, Bureau of Home Care/Hospice Surveillance and Quality Indicators/Evaluation at (518) 408-1638.

Sincerely,



Judith R. Mooney

Director

Division of Home and Community Based Services