OASIS ITEM

(M2200) 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).

☐ NA - Not Applicable: No case mix group defined by this assessment.

ITEM INTENT

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, and only applies to payers utilizing a payment model based on case mix group assignment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- 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. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.
- Report a number that is "zero filled and right justified." For example, 11 visits should be reported as "011."
- Answer "000" if no therapy services are needed.
- Once patient eligibility has been confirmed and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care. The sequence of visits performed by the disciplines must be dictated by the individual patient's plan of care. For example, for an eligible patient in an initial 60-day episode that has both physical therapy and occupational therapy orders in the plan of care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with 42 CFR 409.43 (f).
- For multidisciplinary cases - Nursing and Therapy may collaborate to answer this item correctly. The PT, OT, and/or SLP are responsible to communicate the number of visits ordered by the physician to the RN completing this item. Coordination of patient care is specified in the Conditions of Participation (42 CFR 484.14).
- When a patient is discharged home from an inpatient facility admission in the last five days of a certification period (i.e., the requirement to complete a Resumption of Care assessment overlaps with the requirement to complete a Recert assessment), CMS allows the agency to complete a single ROC assessment to meet the requirements of both timepoints. In such cases, the total number of therapy visits planned for the upcoming 60-day episode should be reported in M2200.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2200)

- Answer "Not Applicable" when this assessment will not be used to determine a case mix group for Medicare, or other payers using a Medicare PPS-like model. 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 other than "Not Applicable" is required to generate the case mix code.
- Assessment strategies: When the assessment and care plan are complete, review the plan of care 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. As noted in item intent above, the Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.

DATA SOURCES / RESOURCES

- Physician's orders
- Referral information
- Plan of care
- Clinical record