OASIS Alert

Assessment: THE REGIMENS, THEY ARE A-CHANGIN

Home health agencies usually can consider M0200 the "yes-man" of OASIS, but his cousin M0220 can be more of a trouble-maker if agencies don't cross their T's and dot their I's.

M0200 simply asks whether the patient has "experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days." At the start of care, agencies almost exclusively will answer this question in the affirmative, says consultant **Rose Kimball** with **Med-Care Administrative Services** in Dallas. After all, something must have happened to the patient to make your referral source send her to home care, Kimball notes.

And remember that a "change" does not need to be a significant change, Kimball advises agencies. Something as simple as a new medication or a change in the patient's dosage counts as a change for this OASIS item, Kimball tells **Eli**.

"It could be a new diagnosis or an exacerbation of an old one that caused a new treatment modality or service that was needed," adds home healthclinicalconsultant **CyndiRohret**with **Briggs Corp.** in Des Moines, IA.

Keep On the Look-Out for 'No' Scenarios

Watch out, though while agencies will answer 'yes' to this question most of the time, there are times when 'no' could be appropriate. For example, you might have a patient who is receiving a new SOC assessment simply because she has changed payors, observers note. In that case, she might not have had any change in her medical or treatment regimen.

M0220 asks about any conditions the patient had prior to the medical or treatment regimen change (or inpatient stay) within the last 14 days. Agencies should be careful when answering this question, Rohret advises, because their answers could impact reimbursement.

Your answers "could lead to denials of payment for visits if you indicate that you are teaching to or providing care for a condition that preceded the hospital stay," Rohret warns.

That is, if the patient was able to handle a pre-existing condition on her own before going into the hospital, medical reviewers need to see why she no longer can do so, Rohret explains. In these situations, careful documentation is the key to saving your reimbursement, she concludes.