Defining and Documenting Medical Necessity

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Objectives

• Be able to define the concept and components of “Medical Necessity”
• Understand the Medicare regulation for Medical Necessity
• Understand the Medical Necessity criteria for Therapy and Nursing
• Be able to document the compliance with Medical Necessity criteria
Why document anyway?

- Document the care you provided
- Document the client response to care/treatment
- Client status and changes
- Orders and changes
- Communicate to others on the team
- Document for quality
- Document for reimbursement
- Document a legal record
• In 2014 Medicare recovered $3.3 billion due to fraud, waste and abuse
• Fiscal Intermediaries increasing scrutiny for HH services
• Increasing numbers Home Health Agencies dealing with ADR [Additional Documentation Required] or TMR [Targeted Medical Review]
Medicare Necessity

- Documentation requirements changing:
- Proposed changes to CoP’s;
- Change requests 9119; 9189 of 2015
  - Certification and Recertification rely on supporting documentation from physicians
• “As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient’s achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.”
Covered Services if Qualifies

• Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample);
• Part-time or intermittent home health aide services;
• Physical therapy; Speech-language pathology; Occupational therapy;
• Medical social services;
• Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home
5 Criteria to be met for eligibility:

• Be confined to the home;
• Need intermittent skilled services*
• Be under the care of a physician;
• Receiving services under a POC established and periodically reviewed by a physician;
• Have had a FTF encounter for their current diagnosis with a physician or allowed NPP

*Medically reasonable, necessary, intermittent, Nursing, PT and SLP or with continuing need for OT.
• **Homebound**
  – Not just a checklist; Meet Criteria 1 and 2; add
  – **Descriptive content** include information about the injury/illness and the type of support and/or supportive device/assistance required to assist the patient in leaving home.
  – Explain in detail how the patient’s current condition makes leaving home medically contra indicated.
  – Clarify exactly what about the illness qualifies the patient as homebound.
  – **Reminder:** Using any portion of the regulation as a blanket statement copied from the CMS manual is vague. An explanation is required that describes the patient's normal inability to leave home and exactly what effects are causing the considerable and taxing effort to leave home.
Medicare Homebound

- Infrequent and relatively short in duration
- For medical appointments/treatments
- For religious services
- To attend adult daycare programs
- For other unique or infrequent events
  - Funeral, graduation, hair care

- At every visit ask the questions:
  - Since my last visit, have you left home?
  - For what reasons? For how long?
  - What type of assistance/who helped?
Reasonable and Necessary

– Patient condition at time Physician ordered
– Treatment ordered is reasonably expected to be appropriate treatment throughout the certification period
– WITHOUT regard to status as acute, chronic, terminal or expected to extend over a long period of time
– Not based solely on diagnosis alone
Reasonable and Necessary for all Disciplines

- To the diagnosis, illness or injury & treatment
- Patient’s unique medical condition & needs
- Consistent with nature and severity of condition
- Within accepted Medical, Nursing and Therapy standards of practice; need for skilled professional
- Proposed CoP changes: group the disciplines into one category: Skilled Professional
- The Benefit Manual separates the disciplines
• **Skilled Nursing [SN] Care**
  • Require skills of a registered nurse or a licensed practical (vocational) nurse under the supervision of an RN
  • Necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care
  • Patient’s special medical complications require the skills of a registered nurse
  • Coverage of skilled nursing care does not turn on the presence or absence of a patient’s potential for improvement from the nursing care, but rather on the patient’s need for skilled care
Nursing Specific Activities

- Observation and Assessment
- Management and Evaluation of a Patient Care Plan
- Teaching and Training Activities
- Administration of Medications
- Tube Feedings
- Nasopharyngeal and tracheostomy aspiration
- Catheter care. Insertion and sterile irrigation and replacement of catheters, care of a Suprapubic catheter, urethral catheters
Nursing Specific Activities

• Wound care
• Ostomy Care
• Heat Treatments
• Medical Gases
• Rehabilitation Nursing
• Venipuncture: Is not a qualifying criteria by itself
• Student Nurse Visits
• Psychiatric Evaluation, Therapy and Teaching
Management and Evaluation –

• Skilled nursing visits for management and evaluation of the care plan where underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose

• Management of a complex care plan involving unskilled services is designed to provide oversight and avoid complications in the overall medical plan of care

• Requires additional narrative by physician for certification and recertification
Management and Evaluation

- Used when a beneficiary care plan is unstable; care provided by non skilled personnel
- Trained professional personnel required to manage and evaluate the plan to meet his/her specific medical needs, promote recovery and ensure medical safety
Teaching and Training

- Initial teaching due to the complexity of the activity and unique ability of the patient/caregiver
- Reinforced teaching based on retained knowledge and anticipated learning progress
- Re-teaching related to significant changes in procedures, the patient’s condition and/or caregiver is not appropriately carrying out the task
- Document patient’s response; ability to learn; any cognitive deficits that impact the number of visits required to conduct training and teaching
• Skilled therapy must be of such inherent complexity that it can only be safely and effectively performed by a or under the general supervision of a skilled therapist
• Reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury
• Client’s condition and therapy services warrant the specialized skills knowledge and judgment of a qualified therapist to ensure medical safety
• Where the specialized skills, knowledge and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.
• Services ordinarily considered unskilled may be considered skilled if there is clear documentation that medical complications require skilled personnel for services ordered.
  – Can unskilled personnel provide the services?
Restorative Therapy
• Intent is to **improve** the patient’s ability to function
• Qualified therapist establishes the plan of care and completes required reassessments
• Therapy assistants **can** provide care

Maintenance Therapy
• Intent is to prevent further loss of function
• Qualified therapist establishes the plan of care and completes the required assessments
• Therapy assistants **cannot** provide care
• Require the specialized skills, knowledge, and judgment of the qualified therapist to **design or establish** a safe and effective maintenance program

• The unique clinical condition of the patient may require the specialized skills of a qualified therapist to **perform** a safe and effective maintenance program

• A maintenance program should be established near the end of the restorative visits; not need additional visits
The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;

Include **measurable therapy treatment goals** which pertain directly to the patient’s illness or injury, and the patient’s resultant impairments;

Include the expected **duration** of therapy services; and

The plan must describe a course of treatment which is consistent with the qualified therapist’s assessment of the patient’s function.
Physical Therapy Services

- Assessment and Reassessments
- Therapeutic Exercises
- Gait Training
- Range of Motion
- Maintenance Therapy
- Ultrasound, shortwave and microwave diathermy treatments
- Hot packs, Infra-red treatments, paraffin baths and whirlpool baths
- Wound care provided within scope of state practice acts
Occupational Therapy Services

• Planning, implementing and supervision of therapeutic programs
  – To restore physical function
  – To restore sensory-integrative function
  – For active treatment for psychiatric illness
  – To improve level of independence in ADL

• Designing, fabricating and fitting of orthotic and self-help devices

• Vocational and prevocational assessment and training

• Cognitive and Functional Assessments
• Assessment of rehabilitative needs
  – Reevaluation with a change in functional speech or motivation, clearing of confusion or remission of some other medical condition that previously contraindicated SLP services
• Routine reevaluations as part of restorative therapy cannot be billed as a separate visit
• Service result from illness or injury and directed toward specific speech/voice production
• Established a hierarchy of speech-voice-language communication tasks
• Train patient and family to augment speech-language communication, treatment or establish effective maintenance program
• Rehabilitation of speech and language skills for aphasia
• Develop control of vocal and respiratory systems for correct voice production
The significant amount of documentation expected in home care can be intimidating

- OASIS
- Admitting patients to service
- Discipline specific assessments
- Clinical notes; sometimes daily or twice daily
- Goals and Outcomes; continuous monitoring
- Communication with physicians and team
- Regulatory issues
  - HHABN
  - Discharge Notification
• **Group Question:** How do you explain “why” we are completing all this documentation during the visit?

• **How do you introduce “the computer” to the patient/family?**
• Accuracy of information
• Capturing the time it takes to provide care
• High quality documentation is a critical part of care delivery
• Talking points: “I’m listening carefully; Let me just type this in for a moment; your information is important and we want to be accurate …”
• When more than one discipline is involved in the plan of care, the record should support the need for each component of the team
• If there are inconsistencies, the medical necessity of the service may be questioned
• OASIS M2200 Need for Therapy:
  • In the 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-pathology visits combined)?”
• Documentation to support the need for ‘X’ amount of visits
• Interdisciplinary therapy communication is key
• “Therapy would not be covered to affect improvement or restoration of function when a patient *suffered a transient and easily reversible loss or reduction of function.*”

• “If an individual’s expected restorative potential would *be insignificant in relation to the extent and duration of therapy services required to achieve such potential*, therapy would not be considered reasonable and necessary, and thus would not be covered.”

• We believe that rehabilitation professionals, by virtue of their education and experience, are typically able to determine when a functional impairment could reasonably be expected to *improve spontaneously as the patient gradually resumes normal activities.*”
• Tools need to facilitate good documentation
• Paper versus electronic...
  – Legibility can be an issue
  – Checkboxes can be an issue
• The responsibility will always remain with the professional
Examples Issues By Discipline

- Nursing
  - Med teaching - need to be specific

- Physical Therapy
  - Gait - more than distance, device, and level of assistance

- Occupational Therapy
  - ADLs and IADLs should not be assessed as a group of tasks

- Speech Therapy
  - Clarity of functional impact of testing

**Bottom Line** - quantity AND quality of patient performance
Medication Teaching

• Documentation of Instructions include:
  – Name of medication
  – Precautions for taking
  – How to monitor the effectiveness
  – Side effects and adverse effects
  – When, who and how to contact health care provider

• Patient’s ability to learn and retain information

• Cognitive deficits, other diagnoses impacting POC; may require more visits

• Patient’s response to teaching
Gait Training

- What did you do?
- What do you document?
- Gait analysis: what is it?
- What distance do they need to walk? Where do they need to get to?
- How did the patient respond?
- Need verbal cues?
- Reminders?
- Ability to use assistive device?
- What was skilled?
- Patient selected goals
• How are you assessing fall risk?
• What tests are you using for balance?
• What are their specific fall risks – do you know?
• Do you know what their TUG score is?
• IF high fall risk; how does that correlate to OASIS items for “safely” ambulating, transferring, dressing, etc.?
• What is it?
• What do you document?
• Level of assist means what without details?
• What does the patient need to do?
• Caregiver involvement?
• Patient selected goals; outcomes; progress toward goals
Oral Motor Training

• What does that mean?
• What difference will it make for the patient?
• Caregiver involvement?
• Goals; outcomes; discharge evaluation; planning
Tests and Measures

• Standardized
  – Must follow the directions
• Validated
  – Assess research behind the tool
• Value in repeating over course of care
  – Support ongoing need and impact of care
Reassessment Timeframes

- Minimally every 30 days
- Done by “qualified therapist” who actually participates in assessment directly
- Done as part of a treatment visit
- Required for every therapy discipline on board at the time
Objective assessments

“Effectiveness” of therapy in relation to the goals

“Clinically supported statement of expectation that the patient can continue to progress” or resume progress after plateau or regression

Plans to continue or discontinue
   – Refer to clinical findings and treatment plan revisions

Changes in goals or an updated plan of care – MD signature required
• Home health clinical notes must document as appropriate:
  • History and physical exam pertinent to the day’s visit, (including the response or changes in behavior to previously administered skilled services)
  • Skilled services applied on the current visit,
  • Patient/caregiver’s response to the skilled services provided,
  • Plan for the next visit based on the rationale of prior results,
  • **Detailed rationale** that explains the need for the skilled service in light of the patient’s overall medical condition and experiences,
  • Complexity of the service to be performed, and any other pertinent characteristics of the beneficiary or home
Skilled Documentation

• Adequately describe the reaction of a patient to his/her skilled care.
• Provide a clear picture of the treatment and “next steps” to be taken.
• Avoid vague or subjective descriptions of the patient’s care

• Not appropriate to describe the need for skilled care:
  • Patient tolerated treatment well
  • Caregiver instructed in medication management
  • Continue with POC
• Objective measurements of physical outcomes; a clear description of the changed behaviors due to education programs
• Solid description of the clinical condition of the patient that supports the diagnosis codes selected (reason for home care).

• The information in each piece of documentation should flow and create a picture of the care we are providing and the patient response to it.
• From the first visit to the last, determine “why” the patient is being seen
• Do they need you, the clinician, to be there?
• If that question does not have a clear answer, the plan of care should be reassessed
• Reflect deliberations of nurse/therapist and their outcomes for continuing skilled care

• Reasons for skilled observation and assessment at every visit until condition stabilized
Teaching and Training

- Professional’s Consideration for Number of Visits
- REASONS for teaching
  - Document considerations of reinforcement vs. initial instruction
  - Complexity of activity
  - Patient’s unique considerations
  - Reteaching/retraining due to changes in treatment or condition
  - RESPONSE to education
Teaching and Training

• When the patient/CG cannot be trained, the reason why the training was unsuccessful should be documented

• Question: for a client with moderate dementia, would teaching and training be an appropriate intervention?
• **In-dwelling Foley Catheter:** The medical condition of the patient must be described and documented to support the need for nursing skilled services.

• However, *at EVERY HOME VISIT* the patient's current medical condition must be described and there must be documentation to support the need for continued skilled nursing services.
• Venipuncture and INR’s covered:
  – (refer to manual)
• Dosage is being adjusted and monitored
• Stable; in therapeutic range: monthly
• Values remain in nontherapeutic range: document reasons why continued monitoring is necessary.
• Rationale for blood draw as well as the results every visit
• Chronic non healing skin ulcer with DM Type 1, and spinal muscular atrophy:
  – In the past, the patient’s wounds have deteriorated, requiring the patient to be hospitalized. Previously a skilled nurse trained the wife to perform wound care. The MD orders a new episode of skilled care, at a frequency SNV 1wk2..every 2 weeks for observation and assessment
  – **Is this covered?**
• Stabilized Patient with a clinical condition for future complications or acute episode:

• Skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.
• Patient Centered Care
• Discharge evaluation and planning
• Patient Selected Goals
• Outcome Goals
• Measurable Goals  SMART
  – Documenting client selected goals
  – Documenting Shared Decision making
Read Your Documentation

• Documentation quality is not defined by “good” words and “bad” words
• Can you read it and see why the patient needs the care?
• Are you meeting requirements?

• Conduct chart reviews with staff; mentor 1:1; have staff review peers.
Medicare pays your agency for the visits that you, as a professional, complete. They will not pay for a visit that could have been completed by a non-professional.

What did you do, as a nurse or therapist, that no one else (outside of your profession) could have done?

Take “credit” for your professional expertise!
• Comments or Questions
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