DOCUMENTING MEDICAL NECESSITY

A Practical Guide for Home Health

Heather Calhoun, RN, BSN, HCS-D, COS-C

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Heather Calhoun, RN, BSN, HCS-D, COS-C, Author
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Chapter 1

Background of Medical Necessity

It is difficult to discuss medical necessity without discussing the Balanced Budget Act of 1997 (BBA) first. Before the BBA, in the mid-1980s to early 1990s, home health agencies (HHA) grew at an astronomical rate. The lack of regulation and clear guidelines coupled with the institution of a new payment system in hospitals that occurred in the early to mid-1980s, which encouraged an earlier patient discharge, contributed to the growth of HHAs.

The BBA changed all ways that HHAs did business. Before the BBA, HHAs operated on a *per diem* payment system. Within this system, HHAs received paid reimbursement for each nursing visit, at the Medicare published rate. Agencies had no accountability for the management of their costs. In fact, the structure of the payment system before the BBA encouraged the HHA to provide more visits over longer periods of time. With recognition of the overutilization and abuse of the system, the federal government overhauled it. This brought about the BBA through the development of the prospective payment system (PPS) form of reimbursement.

Because of the drastic changes in payment, a number of HHAs either closed or drastically changed the way they operated. Gone is the *per diem* payment that let the agency dictate patient eligibility. The new model of rules created multiple, strict guidelines that agency leaders were made to learn overnight in order to stay in business. This new payment structure was developed to address rising costs and make HHAs more accountable for spending. Not only was the payment system restructured, relying on a 60-day patient episode period, but patient eligibility criteria also changed. It's important to understand that the BBA placed caps on the amount of reimbursement for services that an agency can get over a 60-day period.

Criterion Changes

Before the BBA, the only criteria for home health services were that the patient had to be homebound, have intermittent services, and be under the care of a physician. A number of HHAs had numerous patients on census that needed only simple services, such as venipuncture for labs on an intermittent basis. This service was previously considered coverable by Medicare guidelines. After the BBA, however, venipuncture was no longer covered, because it is not defined as a skilled nursing need, and most caseloads dropped by half. Gone are the days when the home health nurse could provide venipuncture for a renal profile every month simply because the patient was on Lasix.

Section 4615 (below) was enforceable for services provided six months after the BBA.

> *(Section 4615) Provision Venipuncture (drawing of blood for the purpose of obtaining a blood sample) will be excluded from the eligibility criteria for intermittent skilled nursing services, under the home health benefit. If venipuncture for the purpose of obtaining a blood sample is the only skilled service that is needed by the beneficiary, that individual will not qualify for home health.*

Utilization of home health aides and nurses dropped drastically, because the agency now had to prove that the patient *needed* the services, not just that they wanted the services. This process was further complicated by the fiscal intermediaries requesting

information to ensure that the agencies complied with the new home health rules before paying claims. Many home health agencies around the country had to shut their doors. They were simply not prepared for the changes that the BBA brought with it and the loss of revenue that resulted from it.

Present-Day Payment Criteria

There have been a number of changes or clarifications to the home health requirements since the BBA; however, there are five simple criteria that are to be met in order to admit and keep a patient on home health services. They are:

1. The patient must be homebound
2. The patient must be under the care of a physician
3. The services needed by the patient must be intermittent
4. The services needed by the patient must be skilled
5. The services needed by the patient must be medically necessary

The following reviews each of the five criteria:

Homebound status

The Centers for Medicare & Medicaid Services (CMS) guidelines within the *Home Health Benefit Manual* (Chapter 7, 30.1.1) states that:

The patient must EITHER:

- Because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person in order to leave his or her place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated

If the patient meets one of these first options (known as Criteria One), then the patient must *also* meet two additional requirements, defined in Criteria Two, which are:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

If a patient does leave the home, it must be for the purposes of receiving care that cannot be provided in the home. Examples include:

- Radiation
- Chemotherapy
- Doctor appointment
- Dialysis

These are just a few of the examples of acceptable reasons a patient would need to leave the home and would still qualify for home health services under this criteria.

A patient can also occasionally leave the home for other reasons that are nonmedical, such as:

- Attending church or religious services
- Occasional outings of short duration for the patient's mental health

An HHA must prove within its documentation the reasons a patient is homebound and continues to be homebound. Each routine visit noted by all disciplines must also address homebound status for continuation of services.

Homebound scenarios

A 68-year-old woman lives alone in her home but has to go to hemodialysis every Monday, Wednesday, and Friday. She has to ride the wheelchair van to and from dialysis. This is an acceptable example of homebound status.

A 72-year-old man lives with his daughter in her home and ambulates with a walker with standby assist for safety. He requires the physical assistance of his daughter to navigate down the four steps to get into the car. He gets short of breath and has to stop and rest one time en route to the car. The only time he leaves is to go to church each Sunday. This is an acceptable example of homebound status.

A 58-year-old man being treated for lung cancer has to go to radiation therapy 5 times per week. The patient has oxygen at 3L/NC, with a recent surgery to remove his left lung. He ambulates with a cane and requires assistance of one to exit his home and is short of breath when walking more than 50 ft. This is an acceptable example of homebound status.

The patient must be under the care of a physician

Section 30.3 of the *Home Health Medicare Benefit Manual* states that:

> *A patient is expected to be under the care of the physician who signs the plan of care and the physician certification. It is expected, but not required for coverage, that the physician who signs the plan of care will see the patient, but there is no specified interval of time within which the patient must be seen.*

CMS, in 42 *CFR* 424.22, states that only a doctor of medicine, osteopathy, or podiatric medicine can certify and sign the plan of care for a home health patient.

Physician care scenarios

A patient was discharged from the hospital with a diagnosis of pneumonia. He was instructed by the hospitalist, who is not the patient's primary care physician (PCP) and will not sign the home health certification, to follow up with his physician in three weeks. The patient has not seen his PCP in two years. The home health nurse called to verify the appointment and to ask about giving the approval to sign the home health orders, and the PCP refuses until the patient comes into the office. In this scenario, the home health agency **cannot** admit the patient until the PCP approves the home care initial order.

Home health services must be intermittent

This means that the services provided in the home are furnished less than 8 hours each day and 35 or fewer hours each week as an accumulative total.

The services must be skilled

This means that the patient needs the skilled services of any of the following disciplines:

- Skilled nursing (SN)
- Physical therapy (PT)
- Occupational therapy (OT)*
- Speech therapy (ST)

The patient must qualify for one of the above-listed skills in order to receive medical social services or a home health aide.

**There are rules that govern the use of occupational therapy in the home. An occupational therapist cannot admit a patient to home health services (only PT, ST, or SN), but they can be the last discipline in the home. This means that another qualifying skill must start and establish care in the home in order for the patient to get OT started. OT can, however, be the only skill left in the home after the other disciplines have met their goals. This also means that an OT can recertify a patient in the home if they are the only discipline left. As long as a patient is receiving the services under a plan of care for PT, OT, and ST, then they can have an aide and/or a medical social worker (MSW) come to their home to provide services. However, these disciplines cannot be the only ones left in the home. Once the PT, OT, ST, or SN is the sole remaining discipline in the home and the patient has met established goals, the aide and/or MSW can no longer be covered, because they do not provide skilled nursing services.*

Skilled nursing services scenarios

A patient is admitted to home health for PT and OT for a diagnosis of cerebral vascular accident with left hemiparesis. The PT admits the patient for services, and the OT comes out to evaluate after the PT admission. The PT sees the patient 2 times

per week for 5 weeks, but the OT plans to see the patient 2 times per week for 9 weeks. At the end of the 9 weeks (60 days), the patient continues to need the services of the OT with only partial goals met, so the OT recertifies the patient for another 9 weeks (60 days) for continuation of care alone. This is an acceptable episode in terms of skilled nursing.

Medical necessity

Medical necessity is determined based on the home health plan of care, the Outcome and Assessment Information Set and the medical record information. (See Chapter 7 of the *Medicare Home Health Benefit Manual*.) Chapter 2 covers the details and examples of medical necessity.

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Initial patient assessment in home health can be tricky. If documentation does not adequately provide a reason for skilled nursing care in the home, reimbursement for the entire episode will not be issued. In ***Documenting Medical Necessity: A Practical Guide for Home Health,*** author **Heather Calhoun, RN, BSN, HCS-D, COS-C,** provides down-to-earth, conversational documentation tips with dozens of example scenarios to help nurses understand medical necessity and document in a manner that encourages proper and complete reimbursement.

In addition to initial assessments for skilled services, continued skilled care must also be properly documented. This resource will help nurses provide skilled services based on critical thinking throughout the continuum of care.

Documenting Medical Necessity: A Practical Guide for Home Health provides:

- Grounded, conversational style that speaks directly to nurses
- Dozens of hypothetical examples that provide concrete learning opportunities
- Electronically available scenarios for ongoing learning
- A ready-made resource for orientation and annual training

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100 Winners Circle, Suite 300
Brentwood, TN 37027
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