THE TRIALS AND TRIBULATIONS OF HOME HEALTH DOCUMENTATION

Association for Home and Hospice Care
Of North Carolina

September 15, 2015

Documentation is the Key to having Successful Episodes of Care

- Everyone in health care has heard the old saying:

  "If it's not documented, it's not done!"

- In today's world, that statement has led to a newer statement of:

  "If it's documented , but not legible or signed appropriately, it's not done!"

Who's Looking at your Documentation?

- The short answer is: Just about everyone!
  - Medicare Administrative Contractors (MAC) are looking before they pay a claim and after they have paid claims.
  - Qualified Independent Contractors (QIO) conduct redetermination requests
  - The Comprehensive Error Rate Testing contractor (CERT) are looking at your documentation for claims that have been paid by the MAC to ensure the claim was paid correctly.
  - The Zone Program Integrity Contractors (ZPIC) are looking to see why you have had changes in your profile compared to peers in the same area.
  - The Recovery Auditor (RAC) are looking to see if the patients you have billed meet all of the requirements for eligibility for home health services.
  - Survey and Accreditation organizations

What Are the MACs Looking for?

- The are looking to see that your documentation includes signed and dated certifications and orders for services.
- Is the Plan of Care legible, signed by the physician prior to the dates the claim is billed, is it specific to the needs of the individual beneficiary with orders for all of the services needed.
- For re-certifications, is there a statement signed and dated by the physician determining the length of time home health services will be needed.
- There is a face-to-face document that supports the reason the patient is confined to home and in need of skilled services for any new start of care episode.
- Are there long and short term goals in the initial physical, occupational and/or speech therapy evaluations stated in objective, measurable terms, with their expected dates of accomplishment.
- Do the clinical notes document skilled services ordered and needed.

PGBA Reports

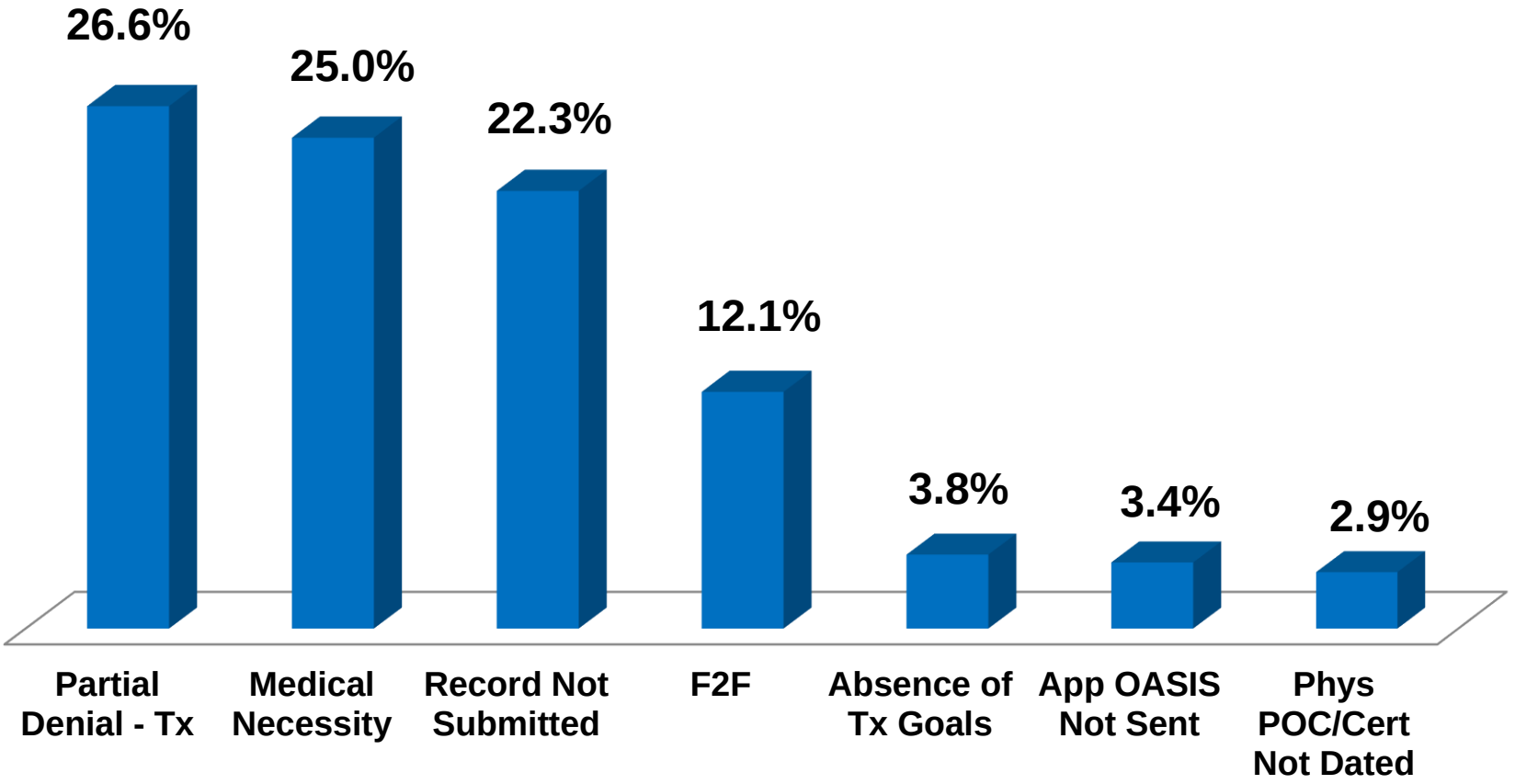
- Lack of documentation in the medical record is the #1 reason for claims being denied for payment. Providers can fix that by documenting the following:
  - History of illness from onset to decision for surgery
  - Prior courses of treatment and results
  - Current symptoms and functional limitations
  - Physical exam detailing objective findings supporting history of illness
  - Results of any special tests

PGBA 7/10/15

- Always document the patient's progress in the medical record.
  - Patient's response to treatment.
  - Change (if any) in the diagnosis or treatment and
  - always document the patient's non-compliance (if applicable).

Top Denial Reasons – PGBA

Jan - March 2015 (2145 claims prior to 1/1/15)



Getting and Documenting Clinical information at the Point of Referral

- Expanded information is needed at the time of referral to assist in ICD-10-CM Coding
  - Complete list of diagnoses with specifics such as:
    - What type of heart failure does a patient have – systolic, diastolic or combined systolic and diastolic?
    - What type of wound/ulcer does a patient have – surgical, pressure ulcer, stasis ulcer, arterial, diabetic, or other?
    - If a wound is present, is there a complication of the wound documented by the physician?
    - If the patient has CAD, do they also have a diagnosis of angina?
    - If there is a traumatic fracture, copies of the physician progress notes describing the location, classification and type of fracture?
    - If the patient has diabetes, has an A1c been drawn within the last 3-4 months? What are the results.
      - If so, request a copy of the results and determine if the MD or the HHA will be monitoring

Information Needed at Intake

- Has a face-to-face documentation been completed?
  - Request a copy of the F-2-F visit documentation and any information used to support the need for home health services.
- Who is the physician who will be following the patient for home health?
- Request copies of the initial order for home health services, admission H&P, consultation and operative reports.

Eligibility—Confined to Home Section

- Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered “confined to the home” (homebound) if the following two criteria are met:

First Criteria One of the Following must be met:	Second Criteria Both of the following must be met:
1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence...	1. There must exist a normal inability to leave home
2. Have a condition such that leaving his or her home is medically contraindicated	2. Leaving home must require a considerable and taxing effort.

Confined to Home

- The patient may be considered homebound (that is, confined to the home) if absences from the home are:
  - Infrequent;
  - For periods of relatively short duration;
  - For the need to receive health care treatment;
  - For religious services;
  - To attend adult daycare programs; or
  - For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

Confined to the Home

- Some examples of persons confined to the home are:
  - A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
  - A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
  - A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Documenting Homebound Status

- Document specific circumstances that cause a patient to be confined to home.
  - What can they do and not do?
  - What equipment or type of assistance do they require to leave home?
  - How often do they leave some and for what reasons?
- Avoid using checkboxes for standard terms such as “poor or low endurance”, “lack of transportation”, “does not want to leave home”.
- Be sure homebound status is clearly documented throughout the record, not just at the start of care.

Documenting Medical Necessity

- The Medicare contractor's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient.
  - Coverage is based upon objective clinical evidence regarding the patient's individual need for skilled care.
  - Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.
  - A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services.
  - A patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care or is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

Documenting Medical Necessity

- Medical necessity documentation must be evident at each assessment time point and for each visit provided to the patient.
  - "intermittent" skilled nursing means care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).
  - Each visit note needs to have a clear indication of the skilled service provided that is consistent with physician orders and clearly requires the skills of a licensed person.

30.2.1 - Content of the Plan of Care

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

- The plan of care must contain all pertinent diagnoses, including:
  - The patient's mental status;
  - The types of services, supplies, and equipment required;
  - The frequency of the visits to be made;
  - Prognosis;
  - Rehabilitation potential;
  - Functional limitations;
  - Activities permitted;
  - Nutritional requirements;
  - All medications and treatments;
  - Safety measures to protect against injury;
  - Instructions for timely discharge or referral; and
  - Any additional items the HHA or physician chooses to include

Plan of Care Documentation

- Key Documentation areas:
  - Diagnoses included are supported by services ordered and consistent with the overall plan of care.
    - Orders related to monitoring and evaluation or specific treatments.
    - Clear indication of other relevant diagnoses and how they impact the services provided or overall plan of care.
  - Clear indication of the end point for daily skilled nursing visits.
  - Documentation of the expected total length of service that will be required for all skilled services on all recertification plans of care;
    - Brief description of the skilled need and reason for continuation
    - MD signature and date for the statement
    - Completed from the first recertification –addresses total length of services, not just for that certification period.

Plan of Care – therapy Services

- If the plan of care includes a course of treatment for therapy services:
  - The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;
  - The plan must include measurable short term and long term therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments;
  - The plan must 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.
- The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accordance with 42 CFR 424.22.

Management and Evaluation of a POC

- Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification;
- Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that ***only a registered nurse can ensure that essential unskilled care is achieving its purpose***. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

30.2.2 - Specificity of Orders

- The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.
- Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided during the 60-day episode to home health patients. When a range of visits is ordered, the upper limit of the range is considered the specific frequency.
- Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

Need for Skilled Services

- The patient must need one of the following types of services:

1. Skilled nursing care as defined in §40.1

2. Physical therapy as defined in §40.2.2; or

3. Speech-language pathology services as defined in §40.2.3; or

4. Have a continuing need for occupational therapy provided

a. The services which the patient requires meet the definition of "occupational therapy" services of §40.2, and

b. The patient's eligibility for home health services has been established by virtue of a prior need for skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), speech-language pathology services, or physical therapy in the current or prior certification period.

Covered Skilled Nursing Services

- An individualized assessment of the patient's clinical condition must:
  - Demonstrate that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical nurse ("skilled care") under the supervision of a registered nurse are required,
  - The services are necessary when:
    - (a) the particular patient's special medical complications require the skills of a licensed nurse to perform a type of service that would otherwise be considered non-skilled; or
    - (b) the needed services are of such complexity that the skills of a licensed nurse are required, to furnish the services safely, and

Skilled Nursing Services

- The services are consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice.
- Are in consideration that a physician has determined that the services ordered are reasonable and necessary.
- Must be intermittent as discussed in §40.1.3.
- **Note:** *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.*

Documentation needed on SN visits

- Home health clinical notes must document:
  - the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
  - the patient/caregiver's response to the skilled services provided, and
  - the plan for the next visit based on the rationale of prior results,
  - a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
  - the complexity of the service to be performed, and
  - any other pertinent characteristics of the beneficiary or home

Documentation of O and A services

- Information from the patient's home health record must document the rationale that demonstrates that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period.
  - Signs and symptoms such as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment.
  - Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered.
  - Observation and assessment by a nurse is *not reasonable and necessary for the treatment of the illness or injury where fluctuating signs and symptoms are part of a longstanding pattern of the patient's condition which has not previously required a change in the prescribed treatment.*

Case Example: O & A

- A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed. The patient's *necessity for skilled observation and treatment must be documented at each home health visit,* until the patient's clinical condition and/or treatment regimen has stabilized.

Teaching and Training

- Require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen.
- The test of whether a service is skilled relates to the skill required to teach and not to the nature of what is being taught.
- Visits for are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.
- Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary.
  - The reason why the training was unsuccessful should be documented in the record.
  - The services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

Teaching & Training

- Initial instruction: consider the complexity of the activity to be taught and the unique abilities of the patient.
- Reinforcement of training: document an analysis of the patient's retained knowledge and anticipated learning progress to determine the appropriate number of visits.
  - Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.
- Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task.
  - The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education

Case Example: Teaching

- A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition, to recognize signs and symptoms of adverse reactions to new medications, and to follow the necessary dietary restrictions.
- If it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary, since the patient has demonstrated an inability to be taught.
- Documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses.
    - Describe the reason for the failure of the educational attempts.

Injections

- Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.
- Therefore, the services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.
  - the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, and
  - there must be a medical reason that the medication cannot be taken orally.
  - The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

Injection Example

- A patient who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss that causes inability to fill syringes or self inject insulin.
  - If there weren't an able and willing caregiver to inject her insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin if no other alternatives available.
  - In the 2015 Final HH PPS rule, CMS provided lengthy comments on documentation to support the need for daily insulin injections including Table 34 that lists 164 potential ICD-9-CM diagnoses that indicate a potential inability to self inject and would support the medical necessity for SN to administer daily insulin injections.
  - The rule also included a discussion on the overall medical necessity for daily SN insulin injections.

Prefilling Syringes

- Prefilling syringes with insulin (or other medication that is self-injected) does not require the skills of a licensed nurse and, therefore, is not considered to be a skilled nursing service.
  - If the patient needs someone only to prefill syringes (and needs no other skilled nursing care on an intermittent basis, physical therapy, or speech language pathology services), the patient, does not qualify for any Medicare coverage of home health care.
  - Prefilling of syringes for self-administration of insulin or other medications is considered to be assistance with medications that are ordinarily self-administered and is not considered a skilled service.
  - However, where State law requires that a licensed nurse prefill syringes, a skilled nursing visit to prefill syringes is paid as a skilled nursing visit (if the patient needs another skilled nursing, physical therapy, or speech-language pathology qualifying service).

Wound Care

- Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service.
- The size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made.
- Open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse is a key component to coverage of direct wound care.

Wound Care

- While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (See) or skilled teaching of wound care to the patient or the patient's family. (See §40.1.2.1 and §40.1.2.3. in Chapter 7 of the Medicare on-line benefit policy manual for additional information.)
- Documentation must reflect a detailed description of the wound and the type of wound care that needs to be provided.
  - This is an excellent example of situations in which there continues to be coverage for SN care even after the actual skilled wound care is taught to someone else.

Case Example - Wound Care

- A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment. The home health record at each visit must document a description of the wound and the complexity of the wound care that supports the need for the skilled nursing services.

Diabetic Care

- PGBA released a new Local Coverage Determination Policy (L35413): Monitoring Glucose Control in the Medicare home health population with Type II diabetes Mellitus in early 2015.
- Goal of LCD: Ensure evidenced based medicine addresses risks of complications of DM and delivery of HH services.
  - Supports ascertaining glucose control and risk of secondary conditions known to occur in patient with DM by monitoring glucose and hemoglobin A1C.
  - Reasonable and necessary HH POCs must include monitoring and reporting of not only intermittent capillary blood/serum glucose levels but also quarterly (and no less than 120 days) HbA1c levels.
- Applies to all patients where agency is seeing the patient for a Type II DM code on the OASIS and on the claim.

Diabetic Care Requirement

- Adopted based on research published in the JAMA 2/9/15 that there is a high incidence of overtreatment of DM in older adults with tight glycemic code (less than 7%) that results in increased risk of hypoglycemia and other complications associated with poor outcomes and more harm than benefit in the older diabetic type 2 population. Major problem in US with emphasis in southeastern area of the country.
- A1c levels are not reliable in situations of abnormal red blood cell turnover, such as pregnancy, recent blood loss or transfusion, or in some anemias. Palmetto will accept serum fructosamine as a measure of glycemic control in these situations instead of hemoglobin A1c levels.
- All claims with diabetes type II listed as a primary or secondary diagnosis will be denied if there is no evidence the HBA1c or Fructosamine being monitored.

Verbal Physician Orders

- Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician *where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.*
- Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.
- However, *services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.*

Other Medical Record Signature Issues

- Each entry in the patient's medical record requires the acceptable handwritten or electronic signature of the person writing the note along with the date.
  - Palmetto GBA also recommends the inclusion of the applicable credentials.
  - Facsimiles of original written or electronic signatures are acceptable for
  - Stamped signatures are generally not acceptable.
    - Stamped signatures are only permitted in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability who can provide proof to CMS or a CMS contractor of an inability to sign his/her signature due to their disability.

Other Medical Record Signature Issues

- If a signature is illegible or missing from the medical documentation, the review contractor will consider evidence in a signature log, attestation statement or other document submitted to determine the identity of the author of a medical record entry.
- If a signature is missing from an order, the review contractor shall disregard the order during the review of the claim and proceed as if the order was not received.
  - Signature attestations are not allowable for orders.

Determining Valid Signatures

- Signature Log
  - May be submitted with the documentation submitted that lists the typed or printed name of the author associated with initials or an illegible signature.
    - Reviewers shall consider all signature logs regardless of the date they were created.
- Electronic Signatures
  - Need a system and software products that protect against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws.
  - Both the individual whose name is on the alternative signature method and the provider bear responsibility for authenticity of the information for which an attestation has been provided.

Signature Attestation Statement

- An attestation statement may also be used to support late entries into documentation.
- A valid attestation statement must be signed and dated by the author of the medical record entry and must include sufficient information to identify the beneficiary.
- Sample statement:

  "I, (print full name of physician/practitioner) hereby attest that the medical record entry for (date of service) accurately reflects signatures/notations that I made in my capacity as (insert provider's credentials, e.g., M.D.) when I treated/diagnosed the above listed beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Amendments, Corrections and Delayed Entries

- Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service.
- When making a review determination, the MACs, CERT, Recovery Auditors, and ZPICs shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles.
  - Review organizations will NOT consider any entries that do not comply with Recordkeeping principles.
  - Will not consider undated or unsigned entries handwritten in the margin of a document.

Source: *Section 3.3.2.5. Chapter 3, Medicare Program Integrity Manual*

Recordkeeping Principles

- All paper or electronic health records or documents submitted to review organizations containing amendments, corrections or addenda must:
  - Clearly and permanently identify any amendments, corrections or delayed entry as such, and
  - Clearly indicate the date and author of any amendment, correction or delayed entry, and
  - Not delete, but clearly identify all original content.
- When correcting a paper medical record,
  - use a single strike line through the original documentation so that the original content is still readable.
  - The author of the alteration must sign and date the revision.
  - Amendments or delayed entries must be clearly signed and dated upon entry into the record.

Recordkeeping Principles

- When correcting an electronic record, the record must:
  - Distinctly identify any amendment, correction or delayed entry, and
  - Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.
- If the MACs, CERT or Recovery Auditors identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the ZPIC and may consider referring to the Regional Office and State Agency.

Important resources for Home Health agencies:

- CMS Home Health Agency Center https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- Home Health Prospective Payment System https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
- Implementing and Maintaining OASIS (Outcome and Assessment Information Set)
- Filing Claims: CMS Medicare Claims Processing Manual, Chapter 10 – Home Health Agency Billing(PDF, 577 KB)
- CMS Medicare Benefit Policy Manual, Chapter 7 – Home Health Services (PDF, 416 KB)

What Questions do you have?

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