WEBINAR

Documenting Medical Necessity in Home Health

Support the Need for Skilled Care and Protect Your Reimbursement

with

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J.I.D. Consulting and Coding

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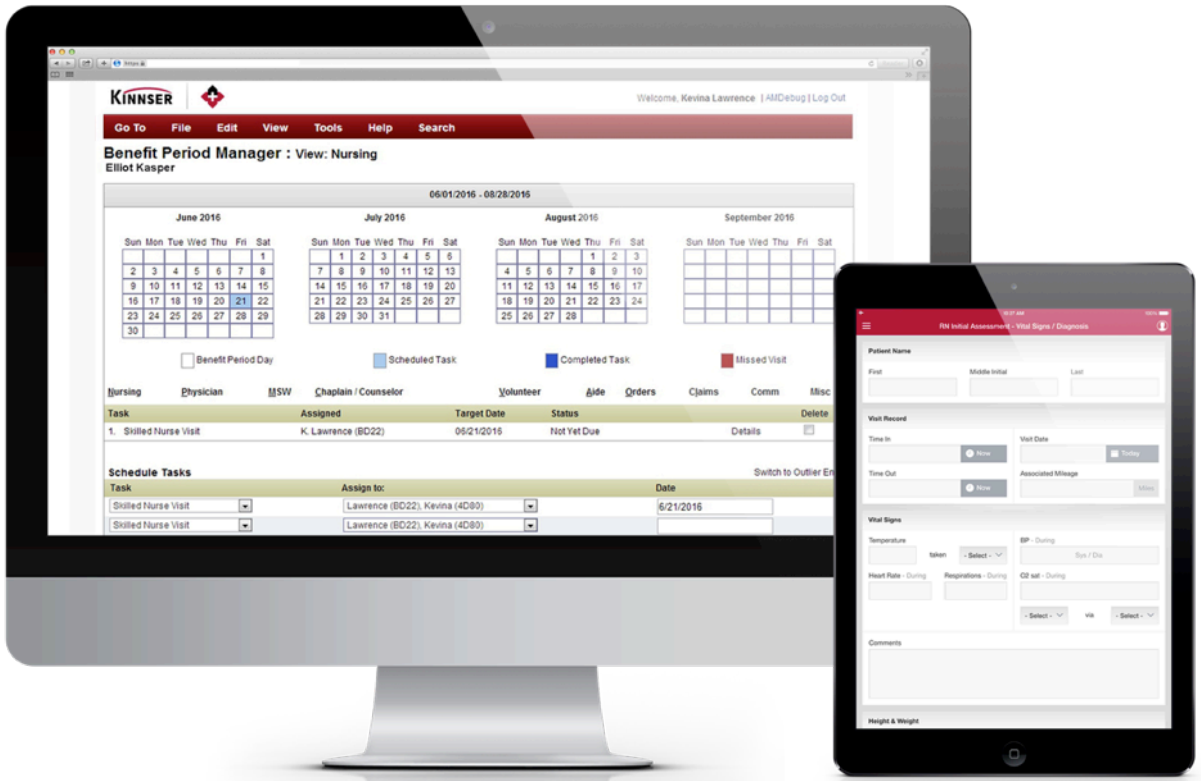

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About the presenter

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DOCUMENTATION: *Why Is It So Important?*

- Reimbursement
- Compliance
- Coordination of Care
- Legality

CHECK OUT OUR PREVIOUS WEBINAR!

What is Medical Necessity in Home Health?

www.kinnser.com/medicalnecessity

HOME HEALTH PROCESS

OASIS ASSESSMENT

ESTABLISH GOALS

INTERVENTIONS FOR GOALS

PROGRESS TO GOALS

OASIS ASSESSMENT

- M responses should match the assessment.
- Therapy assessments should match the OASIS assessments.
- The Plan of Care is established from the assessment.

ESTABLISH GOALS

Goals should be measurable and your outcomes realistic and specific.

Are plans of care patient-specific (i.e., contain measurable goals and instructions for care that are specific to the individual patient) with stated parameters for measurements where appropriate?

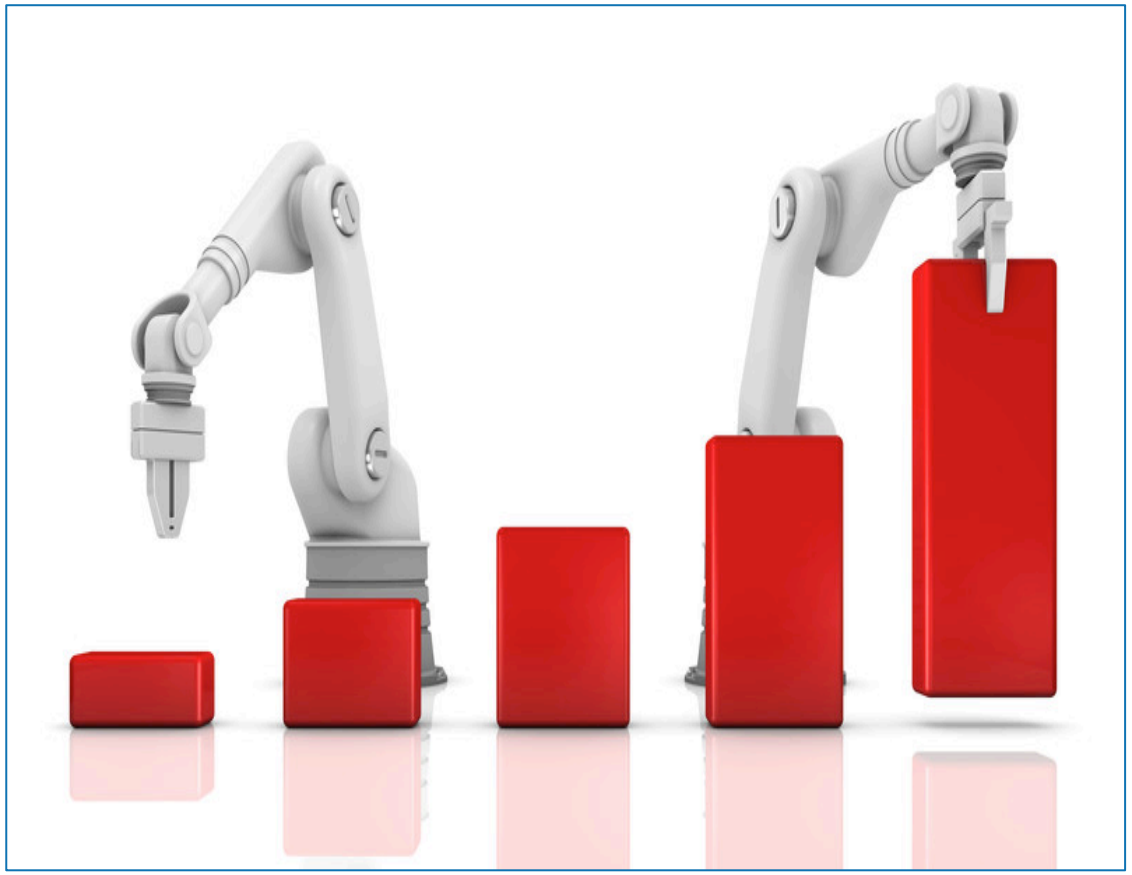
INTERVENTIONS

Interventions may include:

- Assessment/Observation
- Instruction/Education
- Treatments
- Medication Administration

PROGRESS TO GOALS

Clinical/Progress Notes should include how the patient is responding to the goals.



CLINICAL NOTES SHOULD INCLUDE

History and Physical exam pertinent to the day's visit
- Including response to previous skilled care

Skilled services applied on visit

Immediate response to skilled care provided

Plan for next visit

Vague or subjective descriptions should NOT be used
- Patient tolerated treatment well
- Caregiver instructed on med management
- Continue with Plan Of Care

QUESTIONS TO ASK

- *Is nursing care provided to each patient as ordered on the plan of care?*
- *For patients with co-morbidities, is there evidence that inter-related factors are addressed in managing the patient's care (e.g., addressing nutrition and skin care in a wound care patient who has diabetes)?*
- *Do clinicians consistently document vital signs; insulin injections; blood glucose values; wound appearance, location(s) and treatment; and pain location(s), frequency, severity, interventions, and response to interventions?*
- *Do records show consistency in assessment of patient's status and progress over many visits (e.g., wounds in consistent locations, patient weights seem logical, pain management, presence of Foley catheter, etc.)?*

TIMELINESS AND ACCURACY

The more you fight it, the harder your job becomes!

Organization is your friend!

Get the documentation done as soon as your visit is complete!

Complete it in the home when possible!

SKILLED NURSING

Skilled Nursing Visits fall into one of seven G-codes:

G0493 RN Observation & Assessment

G0494 LPN/LVN Observation & Assessment

G0495 RN Training and/or Education

G0496 LPN/LVN Training and/or Education

G0299 RN Direct Skilled Nursing Services

G0300 LPN/LVN Direct Skilled Nursing Services

G0162 RN Management and Evaluation

G0493 RN OBSERVATION AND ASSESSMENT

G0494 LPN/LVN OBSERVATION AND ASSESSMENT

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OBSERVATION AND ASSESSMENT

Per the Medicare Benefit Policy Manual 40.1.2.1 Observation and Assessment of the Patient's Condition…

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a **reasonable potential for change in a patient's condition** that requires skilled nursing personnel to **identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures** until the patient's clinical condition and/or treatment regimen has stabilized.

Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the 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.**

OBSERVATION AND ASSESSMENT

How do you document it?

Complete Physical Assessment

Do not use checkboxes without additional information.

How did the patient respond to treatments, medications, education, lifestyle modifications?

OBSERVATION AND ASSESSMENT

How do you document it?

After 3 weeks documentation should include:

Signs and symptoms such as:

- Abnormal/fluctuating vital signs
- Weight changes
- Edema
- Medication issues (side effects, ineffective, etc.)
- Abnormal/fluctuating lab values

OBSERVATION AND ASSESSMENT

Per the Medicare Benefit Policy Manual 40.1.2.1 Observation and Assessment of the Patient's Condition…

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.**

G0495 RN TRAINING AND/OR EDUCATION

G0496 LPN/LVN TRAINING AND/OR EDUCATION

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TRAINING AND/OR EDUCATION

Per Medicare Benefit Policy Manual 40.1.2.3 - Teaching and Training Activities…

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services.

Skilled nursing visits for teaching and training activities 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.

TRAINING AND/OR EDUCATION

How do you document it?

Who did you teach?

What did you teach?

Why did you teach?

How did you teach?

What was the **response** to your teaching?

The reason why the training was unsuccessful should be documented in the record.

G0299 RN DIRECT SKILLED NURSING SERVICES

G0300 LPN/LVN DIRECT SKILLED NURSING SERVICES

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DIRECT SKILLED NURSING SERVICE

Per the Medicare Benefit Policy Manual **40.1.2.8 -Wound Care**

For skilled nursing care to be reasonable and necessary to treat a wound, 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. Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings.

Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary.

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Per the Medicare Benefit Policy Manual **40.1.2.8 -Wound Care (cont)**

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;
- Wounds with a drain or T-tube with requires shortening or movement of such drains;
- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;
- Recently debrided ulcers

DIRECT SKILLED NURSING SERVICE

Per the Medicare Benefit Policy Manual **40.1.2.8 -Wound Care**

- Pressure sores (decubitus ulcers) with the following characteristics:

  There is partial tissue loss with signs of infection such as foul odor or purulent drainage;

  There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

DIRECT SKILLED NURSING SERVICE

Per the Medicare Benefit Policy Manual **40.1.2.8 -Wound Care**

NOTE: Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);
- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;

DIRECT SKILLED NURSING SERVICE

Per the Medicare Benefit Policy Manual **40.1.2.8 -Wound Care**

- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);
- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;
- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;
- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

DIRECT SKILLED NURSING SERVICE

Per the Medicare Benefit Policy Manual **40.1.2.8 -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 §40.1.2.1) or skilled teaching of wound care to the patient or the patient's family. (See §40.1.2.3.)

WOUND CARE: DIRECT SKILLED NURSING SERVICE

How do you document it?

- Weekly Measurements
- Assessment/description of the Wound
- Wound care performed
  - For example: Cleansed with, applied, secured
- Patient tolerance
  - For example: Patient pain level with procedure, need for medications prior to or after procedure.

G0162 RN MANAGEMENT AND EVALUATION

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.

Medicare Benefit Policy Manual 40.1.2.2 Management and Evaluation of a Patient Care Plan

MANAGEMENT AND EVALUATION

How do you document it?

Must Document WHY the skills of an RN are needed to promote the medical safety and stabilization.

Documentation should include the specific actions, conferences, activities, etc. that were performed by the RN to promote the medical safety and stabilization of the patient.

Documentation should include the patient's response to the interventions and response to goals.

G-codes for PT, OT, SLP **G0151**-**G0153**, **G0159**-**G0161**

PTA and COTA **G0157** and **G0158**

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THERAPY ASSESSMENT AND PLAN OF CARE

The assessment should include:

Patient's current functional status

Objective Tests and Measures

Relevant Systems Review

Evaluation of patient's, physician's and as appropriate the caregiver's goals.

The Plan of Care should include:

Diagnosis being treated and the specific problems identified that are to be addressed

Treatment techniques/modalities or procedures being used for specific problem to attain the stated goals

Specific functional goals for therapy in objective measurable terms (patient/caregiver maybe included or taken into consideration)

Amount, frequency, and duration of therapeutic services

Rehabilitation potential - therapists/physician's expectation of the patient's ability to meet the goals at initiation of treatment (patient and, when appropriate, caregiver goals may be incorporated)

PT, OT, SLP THERAPY

How do you document it?

Objective measurements and functional accomplishments

Description of the skilled services performed

Patient's response to the services and the relation toward the treatment goals.

PT, OT, SLP THERAPY

Use statements which demonstrate the patient's response to the therapy such as:

"Able to perform exercises as prescribed for 15 reps"

"Able to safely transfer from bed to toilet with standby assistance"

"Can now abduct shoulder 120 degrees"

"Able to don a pullover shirt with minimal assistance"

PT, OT, SLP THERAPY

Avoid terms such as:

"Doing well“

"Improving“

"Less pain“

"Increased range of motion“

"Increased strength“

"Tolerated treatment well“

"Continue with POC"

HOME HEALTH AIDE

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HOME HEALTH AIDE

Personal care assistance

Simple dressing changes that do not require the skills of a licensed nurse

Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively

HOME HEALTH AIDE

How do you document it?

First things first, you MUST have a Home Health Aide Plan of Care.
Aide must be instructed on the Plan of Care.
Documentation by the Aide must follow the Plan of Care.
Must be documentation of supervisory visits every 14 days.
The care provided must include **Personal Care.**

DOCUMENT YOUR TEAMWORK

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SUMMARY

Effective documentation should be concise.

Focus on the patient's problems.

Clearly describe the patient.

Include homebound status.

Demonstrate the patient's progress or decline.

Provide facts, not opinions.

Follow the Plan of Care.

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