Basic Training: Home Health Edition

Defining and Documenting, “Medical Necessity”

March 28, 2013

Presented by:
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Fazzi Associates, Inc.
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Instructions and Handouts for:
Basic Training: Home Health Edition
Defining & Documenting “Medical Necessity”
March 28, 2013 1:00pm - 2:15pm EST

It is very important that you have these materials printed and ready to use prior to the start of the training.

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1. Dial 1 (415) 655-0062 at least 10 minutes prior to the start of the tele-training.
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Objective for this session

1. Define the concepts and components of “Medical Necessity.”

Presenter Bio

Nancy Buseth, RN, PT is a Senior Consultant for Fazzi Associates, Inc. She has had 14 years of home health experience ranging from staff therapist to Director of Rehabilitation and Director of Referral Management and Community Relations. She was the team leader for a Service Excellence program for patient satisfaction and also a member of the Performance Improvement team. Her experience also includes OASIS education for both therapists and clinicians, along with therapy documentation training. She has done hundreds of record audits for OASIS compliance and accuracy and education for staff reviewing records. She has led projects for Fazzi Associates involving dozens of agencies for both Therapy documentation and OASIS compliance. She has published two articles for Caring Magazine and Home Health Line. She has been a speaker at both the National and State level for home care. She was a core member for a Care Navigation team within a hospital system to decrease re-hospitalizations. She worked as an RN in the field of Geriatrics prior to getting her Physical Therapy degree.

Directions on how to Receive Contact Hours

This continuing nursing education activity was approved for 1.25 Contact Hours.

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1. Each participant must complete an electronic evaluation in order to receive contact hours.

2. Click on the following link in order to access the online evaluation form:
   https://www.research.net/s/FDZ7HLG
ORIENTATION SERIES

DEFINING AND DOCUMENTING “MEDICALLY NECESSARY” CARE

PRESENTED BY:

Nancy Buseth, RN, PT, BS
Senior Consultant

DISCLOSURES

Successful Completion of Education Activity
• Listen to entire program
• Complete evaluation

Disclosures
• No conflict of interest for presenters & planners
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OBJECTIVES

- Define the concept & components of “Medical Necessity”
  - Medicare regulation for Medical Necessity
  - Medicare Medical Necessity criteria for Therapy & Nursing
  - Documenting the compliance with Medical Necessity criteria

WHAT IS MEDICAL NECESSITY?

- “Necessity” is defined as:
  - an imperative requirement or need for something;
  - Indispensability

MEDICAL NECESSITY IS:

“Indispensable Disruption”
Is this necessary?

**NECESSARY**

- Speaks to the need for a skilled clinician to be involved with the care.
- Patient progress does not automatically support necessity.
  - Is it occurring because of unique and specific interventions or by “accident?”
  - Could it have occurred without the clinician being involved?

**NURSING SPECIFIC ACTIVITIES**

- Observation and Assessment.
- Management and Evaluation of a Patient Care Plan.
- Teaching and Training Activities.
**OBSERVATION AND ASSESSMENT – G0163**

- Skilled nursing services considered reasonable and necessary when a reasonable probability exists that significant changes in the beneficiary’s medical condition may occur.
- Skills of a nurse may be required to evaluate the need for modification of the treatment plan, medication changes, the need for hospitalization, medical intervention, etc.

**MANAGEMENT AND EVALUATION – G0162**

- Skilled nursing or physical therapy visits for management and evaluation of the care plan are reasonable and necessary where underlying conditions or complications require that only a registered nurse or physical therapy 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.

**MANAGEMENT AND EVALUATION – G0162**

- Used when a beneficiary care plan is unstable.
- Trained professional personnel (RN/therapist) required to plan, manage, and evaluate the patient’s care to meet his/her specific medical needs, promote recovery and ensure medical safety.
TEACHING AND TRAINING ACTIVITIES – G0164

- Require the skills of a nurse and considered reasonable and necessary when directed for the treatment of an acute medical condition or injury.
  - 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
  - Reteaching related to significant changes in procedures, the patient’s condition and/or caregiver is not appropriately carrying out the task

APPLICATION OF THE PRINCIPLES

- Administration of Medications
- Tube feedings.
- Nasopharyngeal and tracheostomy aspiration.
- Insertion and sterile irrigation and replacement of catheters, care of a Suprapubic catheter, urethral catheters.
- Wound Care.

APPLICATION OF THE PRINCIPLES

- Ostomy Care
- Medical Gases
- Rehabilitation Nursing
- Venipuncture
  - Is not a qualifying criteria
- Student Nurse Visits
- Psychiatric Evaluation, Therapy and Teaching
**Therapy Visits: Focus of Care**

**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 reassessments.
- Therapy assistants CANNOT provide care

**Maintenance = Skilled**
- “require the specialized skills, knowledge, and judgment of the qualified therapist to design or establish a safe and effective maintenance program”
- “the unique clinical conditions of a patient may require the specialized skills of a qualified therapist to perform a safe and effective maintenance program”

**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.

**SPEECH THERAPY SERVICES**

- 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.

**SPEECH THERAPY SERVICES**

- Establish 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.
**DOCUMENTATION IN HOME CARE**

- The significant amount of documentation expected in home care can be intimidating.
  - OASIS
  - Admitting patients to service
  - Discipline specific assessments
  - Daily notes
  - Regulatory issues
    - HHABN
    - Discharge Notification

**TOO MUCH?**

- The home is a unique setting in which to provide clinical services.
  - One clinician in the home for the visit
  - Often only one visit from the agency on a given day
  - No “shift changes”/24 hour coverage

- We are responsible for creating records that show what we are doing for our patients.

**PATIENT PERCEPTION**

- We need to explain to the patient “why” we are completing documentation during the visit.
  - Accuracy of information
  - Capturing the time it takes to provide care

- High quality documentation is a critical part of care delivery.
**SUPPORTING OTHER SERVICES**

- 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.

**SUPPORTING NECESSITY**

- Aspects of documentation that reflect level of skill required:
  - Plan of Care
  - OASIS
  - Comprehensive Assessment
  - Initial visit and daily visit notes
  - Goals – Measureable and Meaningful

**COVERAGE ISSUE**

“Therapy would not be covered to effect improvement or restoration of function when a patient suffered a transient and easily reversible loss or reduction of function.”
WHO DECIDES?

• “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.”

• “We expect rehabilitation professionals to be able to recognize when their skills are appropriate to promote recovery.”

REASONABLE AND NECESSARY?

“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.”

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)?” (underlines added)
THERAPY ISSUES

Given the relationship between therapy visits and payment levels, scrutiny of these particular services has resulted in repayments to Medicare.

PPS DOCUMENTATION EXPECTATIONS

• Objective assessments done by "qualified therapists."
• Goals that are measureable, meaningful and functional.
• "Accepted standards of clinical practice."

DOCUMENTATION TOOLS

• 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.
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.*

MED TEACHING

Instructions include:

• Name of medication
• Precautions for taking
• How to monitor for effectiveness
• Side effects and adverse effects
• When, who, and how to contact health care provider

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?
**FALLS PREVENTION**

- 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?

**ADL TRAINING**

- What is it?
- What do you document?
- Level of assist means what without details?
- What does the patient need to do?
- Caregiver involvement?

**ORAL MOTOR TRAINING**

- What does that mean?
- What difference will it make for the patient?
- Caregiver involvement?
**DOCUMENTATION CONTENT**

- 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 mental picture of the care we are providing and the patient response to it.

**DOCUMENTATION AND CLINICAL PRACTICE**

- 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.

**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.
- Key areas around 13 and 19 total therapy visits.
- Done by “qualified therapist” who actually participates in the assessment directly.
- Done as part of a treatment visit.

**Reassessment Documentation**

- 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.

**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?
SUMMARY

- Medicare pays your agency for the visits that you, as a professional, do. They will not pay for a visit that could have been done by a non-professional.

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

- Take “credit” for your professional expertise.