Documenting medical necessity is at the center of every patient encounter in home health. Without documentation that paints a complete picture of the patient’s continuing need for skilled services, your agency’s reimbursement is at risk. Accurate and thorough documentation of medical necessity is not easy, and it’s about more than just the initial assessment. It requires critical thinking from beginning to end — across the entire episode.

In this document, renowned home health consultant Jill Dyer, BSN, RN, HCS-D, HCS-O answers the most frequently asked questions about documenting medical necessity. In addition, a free 60-minute webinar — Documenting Medical Necessity: Support the Need for Skilled Care and Protect Your Reimbursement — is available for on-demand viewing now at kinnser.com/jill.

**What info must clinical notes include to document medical necessity?**

Clinical notes should include the following:

1. The history and physical examination (H&P) pertinent to the day’s visit
   (Include the patient’s response to previous skilled care)
2. The skilled services applied on the current visit
3. The patient’s immediate response to skilled care provided
4. A plan for the next visit based on the rationale of prior results

**Could you give some guidance or tips to help us avoid vague and subjective descriptions in our documentation?**

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care and provide a clear picture of the treatment and “next steps” to be taken. Do not use vague or subjective descriptions like “tolerated treatment well,” “improving,” “caregiver instructed on med management,” or “continue with plan of care.”

Here are a few examples of more complete and compliant statements:

- *Patient tolerated ROM exercises with a pain level of 6/10.*
- *Caregiver verbalized an understanding of checking blood sugars prior to administering insulin.*
- *Plan for next visit: to continue education on importance of daily inspection of feet for diabetic patient, provide wound care, etc.*
What kinds of questions do surveyors focus on during chart reviews for medical necessity?

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

What should therapy assessments and plans of care include to document medical necessity?

**Therapy assessments should include the following:**

- The patient’s current functional status
- Objective tests and measures
- A review of relevant systems
- An evaluation of the goals of the patient, the physician, and, as appropriate, the caregiver

**Therapy plans of care should include the following:**

- The diagnosis being treated and the specific problems that are to be addressed
- The treatment techniques, modalities, or procedures that are being used for a specific problem to attain the stated goals
- The specific functional goals for therapy stated in objective, measurable terms (The patient/caregiver may be included or taken into consideration.)
- The amount, frequency, and duration of therapeutic services
- The patient’s rehabilitation potential, which is the therapist’s and physician’s expectation of the patient’s ability to meet the goals at initiation of treatment (The patient’s goals and caregiver’s goals, when appropriate, may also be incorporated.)
What are G-codes and how do we use them?
G-codes are the codes used on claims when billing Medicare. They identify the skill performed at the visit. There are G-codes for all visits that are billed to Medicare – SN, PT, OT, SLP, and home health aide. The skilled nursing G-codes have recently been separated into different codes for RN and LPN/LVN. Therapy codes are similarly separated into therapist and therapy assistant codes. The correct G-code must be assigned to each visit being billed.

For therapy, you must bill using either the therapist or the therapy assistant G-code depending on who made the visit. For skilled nursing, selecting the correct G-code is more complicated. They are separated into RN versus LPN/LVN and also separated by the skill performed at that visit. Skilled nursing can be billed with Direct Skilled Care, Training and/or Education, Observation and Assessment, and Management and Evaluation. The correct G-code is determined based on who made the visit and the skill performed during the visit.

You can download a helpful tip sheet about G-codes at kinnser.com/gcodes.

If more than one skill is performed at a skilled nursing visit, which code should be used?
CMS recognizes that a nurse could likely provide more than one of the nursing services reflected in the G-codes during the same visit. However, you may not report more than one G-code per visit regardless of the variety of services provided during that visit. In cases when more than one nursing service is provided in a visit, the nurse should report the G-code that reflects the primary reason for the visit. Typically, the primary reason for the visit would be the service that the clinician spent most of his/her time performing.

Can more than one G-code be used during an episode?
Yes. In fact, it is probable that you will have more than one nursing G-code during an episode. As your patient demonstrates progress toward the goals you have set, the focus of your care will change. However, each individual visit will receive one – and only one – G-code that designates the primary reason for the visit.

What documentation is required for wounds?
Wound measurements should be taken and documented at least weekly. Size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound should be documented during each visit that the wound is assessed.

What G-code should be used for OASIS?
Regardless of whether your visit is for an OASIS, routine visit, or PRN visit, the G-code you report must be based on the primary skilled care performed during the visit.

What are some examples of Direct Skilled Care?
Here are a few common examples:
• Foley and suprapubic catheter changes and care
• Wound care
• IV and IM medication administration
How do you document homebound status?
Homebound status should be documented on every visit. There should be documentation that the patient requires an assistive device, such as walker, cane, wheelchair, or needs assistance of another person to leave their residence, or has a condition that leaving the home is medically contraindicated. It should also be documented that there is a normal inability to leave the home and that leaving home requires a considerable and taxing effort.

What is the time frame for home health aide supervisory visits? Does the aide need to be on site during the visit?
A home health aide supervisory visit must be completed at least every 14 days. Medicare does not require the aide to be onsite for the visit, but you should verify that your state regulations do not require on site. There may also be times when the plan of care has unique requirements, and in those cases you may need to do an on site visit with the aide to ensure his/her competence.

Where should care coordination, such as calls between clinicians and calls to physicians, be documented?
Care coordination should be documented in communication notes or care coordination notes. The documentation should include the date, time, who the communication was with, and the subject matter discussed. Communication to families, caregivers, physicians, and others involved in the care of the patient should be documented.

How do you document goals and progress to goals?
After you have assessed the patient and identified their needs, you should establish goals for the patient. The goals should be specific, measurable, achievable, and include a time frame. As you provide the interventions on the plan of care, you should document your progress towards the goals. Describe the progress because it may be only partial progress towards the goal or the goal may be completed.

About the author
Jill Dyer, BSN, RN, HCS-D, HCS-O is a senior level home health executive with progressive management experience in home health. Jill was co-owner and administrator of a 350+ patient home health agency, a position in which she served from 2005 to 2012. Jill is certified as a Home Care Coding and OASIS Specialist, and is an accomplished nurse with 33 years of experience as a home health administrator, home health director of nursing, and nurse consultant for home health.

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