HOME HEALTH AGENCIES FACE DOCUMENTATION HURDLES

By Rob Drew

For decades, incomplete and error-ridden documentation has been an unrelenting problem for home health care providers. The lack of accurate and complete documentation has been the source of a financial burden that, in some cases, has actually caused agencies to close their doors.

In the early 2000s, many agencies turned to EMRs in an effort to help solve clinical documentation issues. While EMR technology has evolved, incomplete, nonspecific, and error-ridden documentation continues. Both surveyors and Medicare Administrative Contractors (MACs) rely on the quality of clinician documentation to determine whether regulatory requirements are met. Most denials, as well as citations by survey units, are a direct result of inadequate and incomplete documentation. As a result, the primary financial issues faced by homecare companies can be directly correlated to insufficient documentation.

Most clinicians in a home health setting don't understand the direct consequences of incomplete or incorrect documentation. While education and training would seem like a simple fix, the demands of the job and the time it takes to complete required documentation are major hurdles.

Homecare administrative staff are responsible for ensuring that appropriate documentation is being completed. Educating nurses, therapists, social workers, and home health aides on required documentation techniques could save agencies thousands if not millions of dollars in claim denials and survey sanctions.

Changes on the Horizon

Over the next nine months, the home health industry will be under immense pressure to get ready for the Patient-Driven Groupings Model (PDGM) that requires detailed documentation to support the ICD-10 coding applied to the claim.

The specificity of primary and secondary ICD-10 codes (comorbidities) will drive the clinical group assignment and the comorbidity adjustment. OASIS-D documentation will continue to drive functional scores, making accuracy critical. The financial impact of the specificity of ICD-10 coding and the accuracy of documentation cannot be overstated.

PDGM comes on the heels of another significant industry change: the 2018 Federal Conditions of Participation. Homecare agencies are facing a paradigm shift in business practices unlike any the industry has seen before—and documentation is at the center of attention.

While agencies tend to consider denials to be their primary financial risk, they fail to recognize that a survey finding of unsafe practices can be even more devastating in a much shorter period of time. For example, financial sanctions can range from $17,443 to $20,521 per day when a surveyor feels patients are harmed or have a potential for harm as a result of agency practice—and the likelihood of Immediate Jeopardy being handed out has increased significantly with the new rules.

Mind Those Reviews

While survey sanctions can produce crippling financial effects, the more frequent challenge lies in medical reviews.

CGS, a MAC, reports that the four most common claim errors are the result of poor documentation. Errors include but are not limited to the following:

- no signature of the certifying physician;
- physician encounter notes did not support all elements of eligibility (face to face);
- documentation completed by clinicians did not meet medical necessity; and
- missing or incomplete initial certifications or recertifications.

Face-to-Face Encounter Documentation

Face-to-face encounter documentation is a major part of eligibility requirements for homecare patients. According to at least one MAC, face-to-face encounter denials rank second in the reason for denials. In fact, improperly documented face-to-face encounter denials account for at least 21.4% of all denials from Palmetto.

When it was first instituted in 2011, face to face required a form to be completed. However, that requirement was eliminated in 2015, although many agencies and clinicians still believe it's in effect. As a result, documentation is being submitted to MACs using a face-to-face encounter "form" with documentation. Unfortunately for the agencies, these forms are insufficient for claims approval, resulting in a costly oversight.

To avoid this denial, there must be appropriate documentation of a physician encounter. An actual physician progress note from the referring physician summarizing a patient

problem, diagnosis, and homebound status that requires intervention by the homecare agency must be included. This encounter note must be dated between 90 days before or 30 days after the start of care for home health.

Unfortunately, physician progress notes are often incomplete. In these cases, the Centers for Medicare & Medicaid Services allows the agency to provide additional clinical documentation to enhance the insufficient information supplied by the physician.

Augmented documentation from the agency supporting missing elements for a face-to-face encounter in the physician's progress note must be incorporated into the medical record. This documentation must be corroborated by clinical and medical documentation in the physician's record as well as in the homecare clinical record.

An example of additional documentation for face-to-face encounters that might be considered is all or portions of the OASIS-D assessment. This integrated assessment tool, which is rich in specific information about the individual patient, serves to support other information in the narrative supplied by the physician.

Additional documentation may include medication profiles and therapy and/or social worker evaluations.

A Face-to-Face Encounter Case Study

The patient was seen by the physician on August 12 for a urinary tract infection (UTI). There was no hospital admission. A referral was made by the physician's office with subsequent admission to the agency on September 15 with a primary diagnosis of coronary artery disease and comorbidities of chronic kidney disease and diabetes. There was no mention of UTI on the referral since it had been resolved earlier.

A request was made by the MAC for a single episode of care. A face-to-face encounter form was submitted to support the requirement. The physician encounter/progress note and discharge summary from the inpatient facility were absent. The form indicated the reason for the referral was "dyspnea and frequent falls." The reason for the patient being homebound was stated as "requires taxing effort to leave home."

Although the nursing notes and therapy notes were well documented, the entire episode of care, including nine nursing visits and 19 therapy visits, was denied because the face-to-face encounter documentation did not support the requirement substantiating the patient's need for skilled services and the homebound status.

This claim was appealed at all levels and ultimately denied by the administrative law judge.

Medical Necessity

During surveys and in MAC audits, documentation supporting medical necessity does not carry a blueprint for mandatory action. In other words, documentation guidelines are not black and white. Findings must be documented and individualized to each patient. Documentation should identify homecare that is reasonable and necessary to the individual patient condition and provided in accordance with generally accepted standards.

Assessment findings should include accurate OASIS-D data collection supported by integrated findings for the individual patient. Some EMRs provide guidance for such documentation. However, clinicians must use good judgment when determining how to describe the patient's current condition and how homecare can assist in taking the patient to his or her prior level of functioning. Cut-and-paste documentation is not acceptable.

Daily clinical and progress notes also must be individualized to the patient's condition. EMRs were designed and intended to be point-of-care documentation. However, in many agencies, this has not turned out to be the case. Staff continue to "take notes" during patient visits and complete documentation at the end of the day or later.

The gap between the patient visit and the actual time of documentation is a cause for concern. Research shows that within one hour, people forget 50% of the information gained from a particular encounter. Within 24 hours, 70% of the information is lost, with that percentage climbing to 90% after a week's time.

Agencies should be concerned with staff not using the EMR's point-of-care option, an oversight that can lead to nonspecific, incomplete, and inconsistent assessments and documentation.

A Medical Necessity Case Study

The patient was admitted to the agency and recertified with a primary diagnosis of low back pain and multiple vaguely coded comorbidities. The submitted documentation included all nursing visits for the episode.

Nursing was ordered for assessment and instruction. The patient had no new or changed medication requiring teaching instruction—there was enough time for instruction during the previous episodes. According to a nurse's documentation, the patient was stable. There was no mention of any exacerbations of a chronic medical condition. There were no hospitalizations or emergency department visits throughout the episode.

Neither the patient's condition nor the skilled care provided would necessitate the need for skilled nursing services. Skilled nursing and all therapy was denied because the documentation did not support services that are medically reasonable and necessary.

Take Action

Poor and inaccurate documentation can have devastating effects on an agency's bottom line, either through a survey gone awry or multiple denials from a MAC. Agencies that understand these consequences and take the initiative to resolve the underlying issues will be ahead of the game.

— Rob Drew is president and CEO of Gateway Home Health Coding & Consulting.