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Evaluation & Management Services and Home Health

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Hello, I'm Dr. Neil Sandler, Chief Medical Officer for CGS Administrators, LLC's Part A and Home Health and Hospice contracts. Today, I'd like to talk to you about the Home Health Benefit, which allows Medicare beneficiaries to receive medically necessary care while remaining in their own homes. Like any Medicare benefit, the home health benefit has certain requirements which must be met in order for services to be covered under the Medicare benefit. One such requirement is the face to face visit. In this video, we're going to explore how you can document your face to face evaluation in support of certifying the Home Health Benefit for your patient AND report this interchange as an evaluation and management service. Remember, the face to face evaluation is required in order for Medicare to cover medically necessary home health care for your patient.

The evaluation and management service performed prior to transferring a patient to home health care contains the same elements as other evaluation and management services. In order to support eligibility for the home health benefit, documentation for each of these elements should focus not only on the patients' medical needs, but also on why those needs are best treated in the home health setting. The face to face visit represents an opportunity to document the historical factors and physical findings which demonstrate why the patient is confined to the home; a key eligibility criterion for the home health benefit. Where skilled nursing services are needed, the requirement must be of an intermittent nature. If the patient needs physical or occupational therapy, those services, as well as skilled nursing services, must be rendered under a plan of care established and periodically reviewed by a physician. The plan of care, while separate and distinct from the face to face evaluation, should outline a course of treatment that comports with the conclusions drawn from the face to face evaluation.

The chief complaint and history of present illness should focus on the primary reason that the patient requires home health care. A brief review of the patient's recent medical and surgical history including the treatment rendered to date can set the stage to demonstrate the care which may be required going forward and why that care is best rendered in the home setting. The care being proposed should match the specific medical needs of the patient. Other medical or surgical problems, which are not the prime drivers of the need for home based care but which contribute to an overall understanding of the patient's total needs, can be addressed in the section on past medical history.

The past history, family history and social history sections of the evaluation and management service offer an opportunity to document any past and/or chronic conditions which materially affect the patient's ability to recover from the present illness or injury or may affect the therapeutic plan. For instance, even though currently well controlled, one might note a history of diabetes when determining the appropriate setting and/or therapeutic options for wound care. Documentation of the patient's premorbid conditions and functional abilities prior to the



current illness also can provide useful information in supporting the need for home based care. How a patient functioned in the home prior to the current illness may help in setting goals for improvement. The presence or absence of family members or caregivers who can participate in the patients' recovery can also be documented in this section as well as any teaching needs for those individuals.

The review of systems can be used to add any additional information not addressed elsewhere which might be relevant to the patient's premorbid and current conditions. This information can support the need for home health care as well as the therapeutic plan outlined in the plan of care. A focus upon structural and functional impairments can help to paint a picture showing the patient is homebound. These might include the need for assistive devices or the need for assistance from another individual to leave the home. Cardiopulmonary limitations, common in the Medicare population, can be quantified in detail to support homebound status. Remember, the patient must be confined to the home in order for home health care to be reimbursed by Medicare.

Although we may not think of it as complex, the task of leaving the home is multifactorial and requires both cognitive and physical abilities, both of which may be impaired by illness and injury, particularly in the Medicare population. Physical findings may help support homebound status and the need for skilled care. Cardiopulmonary impairments may be evident both at rest and with exertion. Neurologic and musculoskeletal impairments, particularly as they affect activities critical to everyday living like ambulation, dressing and maintaining hygiene, may also support the medical necessity of home based care. The examination should focus on any physical findings which may cause structural and functional impairments. Paresis or paralysis in a stroke patient may support the need for physical or occupational therapy as well as contribute to the patient's inability to leave the home. Sacral or distal extremity wounds may require skilled nursing care to hasten healing and prevent complications. These findings should relate to the chief complaint and history of present illness. The documentation should clearly demonstrate why the patient has a skilled need and why he or she is confined to the home.

Although laboratory data, imaging, and other diagnostic studies are not mandatory components of the documentation required to meet eligibility for the home health benefit, these data elements frequently add to the historical information and physical findings which demonstrate the need for home health care. For instance, a patient with obstructive lung disease may require oxygen therapy, either on a short term or long term basis. Skilled assessment of the efficacy of that treatment may form the basis for part of the medically necessary home health care service. Documentation of blood gas values or pulse oximetry readings may be an important part of the management of the patient.

Following documentation of key historical, physical and diagnostic data, the physician performing the evaluation and management service typically considers all the information in developing a differential diagnosis and a treatment plan. These same principles apply for a patient entering home health care. For a patient who meets eligibility criteria for the home health benefit, this portion of the evaluation and management visit should summarize the medical needs of the patient and the proposed plan of treatment going forward. This documentation can serve as a useful template on which to structure the plan of care, which will actually direct skilled services in the home. Medical decision making will be evident when this section of the documentation clearly summarizes why the patient is homebound and what skilled services are medically necessary to affect an optimal outcome for the individual patient. It is important that for each medically necessary service, the documentation is clear on exactly what skilled service is required and why that service is medically necessary. Specificity is key. The proposed treatment plan should outline, in detail, exactly what scope of services is required.

Remember, good documentation is always the best way to ensure your patient receives the medically necessary care he or she requires. Documentation that is individualized to your patient, that is specific to their functional and structural impairments, that clearly outlines the services they require and why those services are medically necessary, and that clearly articulates that your patient is confined to the home, will help ensure the continuity of care that is so important in support a functional recovery. Your documentation also ensures that all statutory and regulatory criteria are met and will support appropriate reimbursement for the medically necessary services your patient will receive while confined to his or her home.

It is important to keep in mind that while the face to face visit is a requirement for access to the home health benefit, it also represents a billable evaluation and management service. The same criteria required for documentation of a hospital or office based evaluation and management services apply to this service as well. The individual components of the E/M service still

determine the appropriate selection of an E/M code and, as is the case with all Medicare services, the service must be reasonable and necessary to be covered. Finally, it is important to remember that the face to face visit is separate and distinct from, and therefore does not take the place of, a plan of care for home health services or the physician certification for services provided by a home health agency.

That concludes our video. We at CGS hope this video has provided you with useful information to assist you in caring for your patients who require home health care.