Codify
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OASIS Alert

Medical Necessity: Do Your Coding and Documentation Practices Support Medical Necessity?

Back up your checkbox responses.

Medical necessity is drawing increased attention in medical review. Try these expert tips to help your claims stand up under RAC scrutiny.

Ask 3 Coding Questions

Performing routine one-on-one case conferences can help you to head off problems and make certain that the patient qualifies for recertification, advises consultant **Lynda Laff with Laff Associates** in Hilton Head Island, S.C. The diagnoses you report in M1020, M1022, and M1024 should all paint an accurate picture of the care your patient requires. In the conference, ask these diagnosis code-related questions to help determine whether medical necessity exists ☐ before the Recovery Audit Contractors do:

1. What is the patient's primary diagnosis for this episode?

- This would include asking the right questions during the case conference ☐ has the patient had any signs and/or symptoms of exacerbation of diagnosis, or has the patient's condition been completely stable?
- Has the physician ordered new medications or changed dosages? (This does not include over the counter "simple" meds like Tylenol etc.)
- Was the symptom isolated or sustained over a period of days?

2. Is the diagnosis the same as the prior episode?

- Is there evidence of adequate clinical case management (how many visits, telephone contacts, etc.)?
- Was teaching adequate? "If there is documentation in the record that the 'patient and/or caregiver verbalized understanding' of the teaching ☐ then you are on thin ice if you are recertifying a patient for the same diagnosis only for teaching," Laff stresses.

3. Are you "recycling" diagnoses? Make sure you're not switching to a secondary diagnosis, where there may be no evidence of exacerbation of that problem, Laff cautions.

Beef Up Supporting Documentation

It's plain to see that checkboxes aren't sufficient to document medical necessity. If your software is checkbox-reliant, be sure to provide additional text documentation to reinforce the checkbox answers, says, **Beth Johnson, MBA, BSN, RN, CRRN, HCS-D, HCS-O**, with **Johnson, Richards, & Associates**, in Brighton, Mich. Another safeguard is to include plan of care interventions that support coding, she says.

Example: Patient-specific documentation such as "Cannot sit long enough to have blood pressure taken" or "cannot stand safely for more than 10 seconds" help substantiate the patient's clinical status, Johnson says. Significant changes in vital signs taken before and after a specific time or activity can substantiate that the patient is not clinically stable and warrants observation and assessment (skilled services) to prevent further complications, she says.

Another good example: One nurse backed up her checkbox answer that a patient was not short of breath with the free-text documentation "able to play his harmonica for 2 minutes," Johnson says.

"Plans of care (POCs) need to be tailored to the patient's specific clinical and functional needs," Johnson reminds. "If we're going to bill and receive payment for case-mix and functional points, we have an obligation to treat those issues."

"We recently worked with an agency to emphasize teaching about diabetes when diabetes is not the primary diagnosis," Johnson says. "We were not always seeing diabetic teaching interventions included in the POC."

For example: "A diabetic patient admitted to home health with a post-operative infection or a pressure ulcer can be expected to see increases in blood sugar due to the infection or wound," Johnson says. Teaching interventions should ensure patients have an understanding of the physiology of their disease, know the signs of hyper- and hypoglycemia, have an emergency action plan, and all team members (including therapists and home health aides) are alert to signs and symptoms of hyperglycemia, she says.

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