OASIS Alert

Medical Review: Guard Alzheimer's Patients' Claims from Denial

Only 8 percent of claims squeaked past this review.

Thorough documentation is the only way to protect one at-risk group of claims from expensive Medicare denials.

Cahaba GBA reviewed non-start of care claims with a primary diagnosis of Alzheimer's disease and denied 92 percent of claims "based on dollars," the regional home health intermediary says in its December newsletter for providers.

The top problem: "The documentation for the skilled nurse visits did not support medical necessity," Cahaba says in the Newsline. "To be covered as skilled nursing services, the services must require the skills of a nurse, and must be reasonable and necessary to the treatment of the patient's illness or injury."

Observation and assessment is a covered skilled service, Cahaba allows. But it's covered only if "the likelihood of change in a patient's condition requires a skilled nurse to identify and evaluate the patient's need for possible modification in the patient's Plan of Care (POC) until the patient's treatment regimen is essentially stabilized," Cahaba tells providers.

Tip: Indications such as abnormal/fluctuating vital signs, weight changes, or edema and respiratory changes may justify further observation and assessment, for example, Cahaba says.

Bottom line: "There must be clear documentation of the patient condition that warrants" observation and assessment, Cahaba stresses. "Typically, this is clear through documentation of changes in diagnosis, exacerbations, medication or treatment changes that continue to put the beneficiary at risk for further plan of care changes."

Address Technical Denials Or Pay The Price

HHAs also should make sure to have the technical components of the plan of care right, Cahaba says. This was the second-most common reason for denials.

"Please ensure your agency is documenting clearly the complete order, including frequency, duration, discipline and modalities prior to providing services," Cahaba says. "The POC and all service orders must be signed **and dated** by the physician before submitting the final claim."