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EDUCATIONAL RESOURCES

HOME HEALTH

Mastering Documentation of Reasonable and Necessary Care in Home Health

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Learning Objectives

- Define the Medicare concept of *reasonable and necessary care* as it applies to home health services.
- Describe common documentation practices that lead to home health claim denials.
- Apply core documentation principles to accurately demonstrate medical necessity in home health assessments, visit notes, and plans of care.
- Develop patient-specific documentation that clearly supports skilled interventions, patient response, and measurable progress toward goals.

Top Home Health Claims Denial Reasons

Rank	CGS – Denial Reason	# Denied	Palmetto – Denial Reason	# Denied	NGS – Denial Reason	# Denied
1	Skilled services not medically necessary	364	Records not submitted (ADR auto-denial)	748	Records not submitted (ADR)	154
2	Face-to-Face missing/incomplete	295	Face-to-Face requirements not met	621	Certification missing/invalid	145
3	Certification/recertification invalid	257	Plan of Care / Certification missing	250	Skilled nursing not medically necessary	53
4	Therapy not reasonable & necessary	224	Medical necessity not supported	43	Daily care requirements not met	51
5	Records not received timely	61	Services billed not supported by documentation	34	—	—

Counts reflect MAC-published review periods and are not from a single source or time period [2,4,5]

Top Home Health Claims Denial Reasons

CGS (J15) [2]

Most frequent medical necessity denial themes:

- Skilled nursing not medically necessary
- Therapy complexity not supported
- Skilled services provided after condition stabilized

Top Home Health Claims Denial Reasons

Palmetto GBA (JM) [5]

Most frequent medical necessity denial themes :

- No clinical justification for continued skilled care
- Documentation not supporting frequency/duration
- Services not aligned with diagnoses or goals

Top Home Health Claims Denial Reasons

NGS [4]

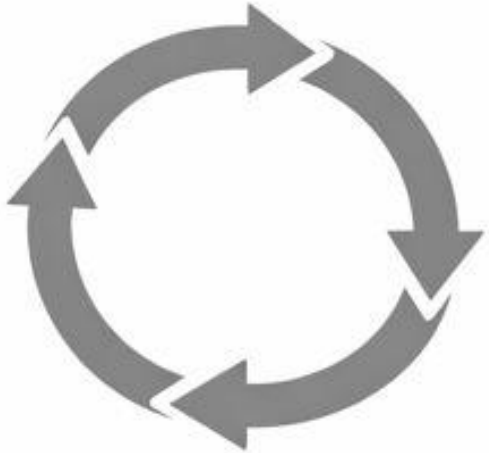
Most frequent medical necessity denial themes :

- Lack of skilled assessment
- Services could be provided by non-skilled personnel
- No evidence of patient-specific skilled intervention

Reasonable & Necessary

Qualifying Condition

Skilled Service



Patient Need

Clear Documentation

What Is Necessary And Reasonable?

- All services billed to Medicare must meet the criteria of "**medically necessary and reasonable.**" [3]
- To determine whether a service is reasonable and necessary, the Medicare home health benefit considers:
  - ✓ each beneficiary's unique medical condition
  - ✓ need to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition
  - ✓ objective clinical evidence of the beneficiary's individual need for care (medical record documentation, POC, OASIS)

- It is the home health agency's responsibility to provide clear documentation of the medical necessity and reasonableness:
  - ✓ progress or lack of progress
  - ✓ medical condition
  - ✓ functional losses
  - ✓ treatment goals

What Is Necessary And Reasonable?

There is no a template-based process for documenting medical necessity.

Every visit performed by all disciplines must have documentation for the visit to stand alone and provide response to the following questions:

- **What**: Specific interventions addressed during the visit, including the patient/caregiver's response to the performed interventions.
- **When**: Time spent providing care and demonstration of the patient's progress towards achievement of desired outcomes, including a rationale – any variances from the expected outcomes).
- **Why**: A description of the patient's needs at the time of the visit and a clear description detailing why the patient requires the skill of a clinician ('why me, why now'; tell the story).
- **How**: A description of how the interventions were performed (i.e., therapy exercises or wound care performed).
- *Additionally, medical necessity includes verifying the patient's home bound status.*

What Is Necessary And Reasonable?

Reasonable and necessary skilled nursing

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when:

- An individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. [3]
- The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. [3]
- A physician or allowed practitioner has determined that the services ordered are reasonable and necessary. [3]

What Is Necessary And Reasonable?

Reasonable and necessary skilled therapy

If all other eligibility and coverage requirements under the home health benefit are met, skilled therapy services are covered when:

- The services require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury. [3]
- Skilled services principals also apply and with addition of:
  - ✓ Every 30 days the licensed therapist must functionally reassess the patient and compare the resultant measurement to prior assessment measurements. [3]
  - ✓ Therapist documents the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. [3]
  - ✓ Therapist specifies rehabilitative or maintenance therapy (must justify). [3]

When Services Are NOT Skilled?

Services are **NOT** skilled when:

- Condition is stable and predictable
- Tasks can be safely performed by unskilled caregivers (task alone does not determine skill)
- Documentation shows:
  - ✓ Routine care
  - ✓ No clinical decision-making
  - ✓ No ongoing assessment

Stability without skilled oversight = denial risk.

Who Reviews Your Documentation?

MACs (Medicare Administrative Contractors)
RACs (Recovery Audit Contractors)

Review focus:

- Medical necessity
- Skilled need
- Consistency of documentation across the entire record

Core Documentation Principles for Medical Necessity

Patient-Specific Condition

Skilled Rationale

Ongoing Assessment

Consistency

Core Documentation Principles for Medical Necessity

- Medical necessity is patient-specific
  - Not diagnosis-based
    - Two patients with the same diagnosis may have very different medical necessity
  - Not frequency-based
    - The importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make an unskilled service into a skilled service.[3]
  - Not policy-based

Core Documentation Principles for Medical Necessity

- Show clinical instability, risk, or complexity
  - Skilled care is necessary when the patient
    - Is unstable
    - Is at risk for deterioration
    - Has complex comorbidities
    - Requires ongoing skilled assessment
    - Needs clinical judgment, not just assistance

Core Documentation Principles for Medical Necessity

- Connect Assessment → Skilled Need → Skilled Intervention
  - Assessment –What did you find?
    - Change from baseline
    - Instability
    - Risk
    - Complexity
  - Skilled need-why does this require a skilled clinician?
    - Why unskilled caregiver is not enough
    - Why clinical judgment is required
  - Skilled intervention-what skilled action did you take?
    - This is not the task, but the clinical action

Core Documentation Principles for Medical Necessity

- Education must be skilled education
  - Education alone does not establish medical necessity unless it involves:
    - Evaluation of understanding
    - Teach-back
    - Adaptation based on patient response
    - Safety risk if not understood

Core Documentation Principles for Medical Necessity

- Medical necessity must be consistent across:

Document	Must support
Comprehensive Assessment	Identifies problem/risk
OASIS	Reflects acuity and needs
Plan of care	Orders skilled services
Visit notes	Show skilled action
Progress notes	Show response
Recertification	Justifies continuation

Core Documentation Principles for Medical Necessity

- Avoid task-based documentation
  - Tasks ≠ skill
  - Tasks = actions
  - Skills = clinical judgment
  - Your documentation must show assessment + interpretation + decision-making

Core Documentation Principles for Medical Necessity

- Paint the most accurate clinical picture through thorough documentation
- Clearly identify within documentation:
  - Primary focus of care
  - Comorbid conditions and long-term chronic diseases
  - Patient/caregiver knowledge deficits
  - Living situation and support system (or lack thereof)
  - Functional deficits and their impact on daily life
  - Severity of any cognitive or mental status deficits

Core Documentation Principles for Medical Necessity

- Language supports medical necessity
  - Uses clinical judgment and analysis
    - “Evaluated,” “analyzed,” “determined,” “assessed trends”
  - Describes risk, instability, or complexity
    - “At risk for deterioration”
    - “Due to complexity of condition”
  - Shows ongoing skilled assessment
    - “Monitoring response to treatment
    - Determining need for provider intervention

Core Documentation Principles for Medical Necessity

- Language to avoid
  - Vague or repetitive statements
    - “Doing well,” “no issues,” “patient stable”
  - Task-based or non-skilled language
    - “Vitals checked,” “meds given,” “education provided”
  - Policy-based phrases
    - “Per protocol,” “routine visit,” “standard care”
  - Minimizing phrases
    - “Stable, no concerns,” “skilled for teaching only”

Practical Documentation Examples

- Before: BP 162/94, Edema 2+ pitting
- After: BP remains elevated at 162/94 despite medication regimen. Bilateral lower-extremity edema 2+ increased from prior visit.

- Before: Patient needs nursing to monitor BP and edema.
- After: Findings indicate possible fluid overload and inadequate blood pressure control, requiring skilled nursing assessment to evaluate treatment effectiveness and determine need for provider intervention.

Practical Documentation Examples

- Before: Nurse checked BP, assessed edema, and educated patient.
- After: Skilled nursing performed focused cardiovascular assessment, analyzed BP and edema trends, evaluated medication effectiveness, and reinforced condition-specific education to reduce risk of decompensation.

- Before: Education provided on diabetes management.
- After: Skilled nursing provided diabetes education and evaluated patient understanding using teach-back. Patient demonstrated inconsistent understanding of glucose monitoring, requiring continued skilled education due to risk for hypo/hyperglycemia.

Practical Documentation Examples

- Before: Wound care assessed and dressing changed.
- After:
  - Wound description: Stage 3 pressure ulcer on sacrum, 3.2cm x 2.8cm x 1.5cm. Wound bed is 80% red granulation tissue, 20% yellow slough at 3 o'clock position. Undermining of 1.5cm noted from 12 to 2 o'clock. Moderate serosanguinous drainage with no odor.
  - Wound care provided as follows: SN cleansed wound with wound cleanser, applied calcium alginate to wound bed and covered with foam border dressing. Patient reports pain at 2/10 during dressing change, a decrease from 5/10 in previous dressing change.
- For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made.[3]

Practical Documentation Examples

- **Before:** Patient ambulated 150 feet with rolling walker. Gait training completed. Tolerated well.
- **After:** Patient demonstrates decreased gait stability with inconsistent step length and impaired balance during turns, placing patient at risk for falls. Skilled physical therapy assessed gait mechanics, analyzed balance deficits, and provided gait training with verbal and tactile cueing to improve safety and reduce fall risk.

Practical Documentation Examples

- **Before:** Transfer training completed. Patient required assistance.
- **After:** Patient requires moderate assistance for sit-to-stand transfers due to lower extremity weakness and impaired motor planning. Skilled physical therapy analyzed transfer mechanics and provided hands-on training and cueing to improve technique and reduce caregiver burden.

Improving the POC to Support Skilled Interventions

- Patient-specific interventions and education that require clinical judgment
  - Start with the patient's clinical problem or risk
  - Tie every intervention and education item to a specific finding from the assessment to ensure interventions are patient-specific.
  - Interventions should explain what skilled clinicians must assess, evaluate, or determine

Improving the POC to Support Skilled Interventions

- Measurable outcomes and goals identified by the HHA and the patient
  - “Measurable outcome” is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention.1
  - Patient specific
  - Tied to clinical findings
  - Can be measured and evaluated
  - Example: Patient will ambulate 150 feet with rolling walker and improved gait stability, as measured by decreased loss of balance episodes, to reduce fall risk within 4 weeks.

Common Documentation Pitfalls

- Documentation that triggers denials
  - Cut-and-paste documentation with repeated language across visits
  - Overreliance on templates or canned interventions from the EMR
  - Task-focused notes that list what was done without clinical rationale
  - Generic education statements not tied to patient-specific findings

Common Documentation Pitfalls

- Lack of medical necessity
  - Why reviewers deny claims
    - No clear explanation of why skilled home health services are required
    - Missing linkage between the patient's condition, assessment findings, and skilled interventions
    - Documentation that could be interpreted as custodial or routine care
    - Failure to demonstrate clinical judgment, assessment, or decision-making

Common Documentation Pitfalls

- Missing progress towards goals (frequent audit finding)
  - No documentation of patient response to interventions
  - Lack of comparison to prior visits or baseline status
  - Goals restated but not evaluated
  - No explanation of whether the patient is improving, declining, or not responding as expected

  - Example:
    - Before: Goal met/not met
    - After: Goal not met as of today due to persistent lower extremity weakness and impaired balance. Patient remains at high fall risk.

Case Scenarios

- A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status. Would skilled nursing be considered reasonable and necessary?

Case Scenarios

The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

Case Scenarios

- Referral information
  - 78-year-old patient discharged home after 4-day hospitalization for pneumonia
  - Lives alone; previously independent
  - Uses rolling walker since discharge
- Current findings
  - Ambulates 120 feet with RW, standby assist
  - Reports fatigue and shortness of breath with exertion
  - TUG: 18 seconds
  - No falls reported

  - Are home health physical therapy services medically necessary?

Case Scenarios

- Home health physical therapy services are medically necessary based on:
  - Recent hospitalization for pneumonia resulted in a decline from prior independent function, with new need for a rolling walker and standby assistance for ambulation. Patient demonstrates decreased endurance and activity tolerance, reporting fatigue and shortness of breath with exertion.
  - A TUG score of 18 seconds indicates increased fall risk, which is significant given the patient lives alone. Skilled physical therapy is required to assess cardiopulmonary response, evaluate gait and balance, and progress safe ambulation, requiring ongoing clinical judgment to prevent falls and rehospitalization.

Documentation Best Practices

- Individualize every visit note—avoid copy/paste
- Link all interventions and education to specific assessment findings
- Clearly explain skilled need and patient risk
- Document measurable progress (or lack of progress) toward goals
- Clearly identify the clinical reason for each visit, not just the service provided
- Document changes in condition, even when subtle, and compare to the prior visit

Documentation Best Practices

- Explain why skilled care is required and why it cannot be safely performed by the patient or caregiver.
- Use objective, measurable data (pain scores, wound measurements, functional distance, assistance levels)
- Avoid “routine” or “per protocol” language; describe clinical decision-making
- Document patient response to interventions and education during the visit

Documentation Best Practices

- Address barriers to progress (cognitive, physical, psychosocial, environmental)
- Ensure consistency between OASIS, Plan of Care, visit notes, and goals
- Reassess and update goals when the patient plateaus, declines, or improves faster than expected

Final Reflections

- Would a reviewer who has never met your patient understand *why skilled care was required* based on your documentation alone?
- Does each visit note clearly tell the clinical story—assessment, judgment, intervention, and response?
- If this record were reviewed today, would it support continued skilled services or trigger questions?
- Your documentation is the patient's voice during an audit review. Make it clear, patient-specific, and defensible.

Questions?

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Thank you!

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