Medicare Reimbursement in Home Care

This article presents the Medicare requirements and guidelines for reimbursement of occupational therapy, specific charting recommendations, and the Medicare review process.

The requirements for Medicare coverage are stringent. The therapist's charting is the only means by which a Medicare reviewer can judge the progress of patients. Reimbursement is denied when skilled care or patient progress is not documented. With a clear understanding of the Medicare guidelines, occupational therapists will be better able to document services and record patient progress to ensure optimum reimbursement.

Understanding Medicare

The 1965 amendments to the Social Security Act provided health insurance protection for the aged, and the 1972 amendments extended coverage further to the disabled and individuals with end stage disease. Known as Medicare, health insurance coverage consists of two parts or plans: a hospital insurance plan and a medical insurance plan (also referred to as Part A and Part B). The former provides basic protection against hospital and related posthospital costs, and is financed through tax contributions on covered earnings (1, p 1).

"The basic responsibility for administering the Medicare program was given to the Secretary of Health and Human Services and within this authority, the Health Care Financing Administration (HCFA) has primary program and administrative responsibility." (1, p 2) The U.S. is divided into HCFA regions. Locally, HCFA enters into agreements with public or private organizations to serve as "intermediaries" (for hospital insurance or carrier for medical insurance). These intermediaries, using HCFA guidelines, determine services covered and amounts payable, and make payments to providers and beneficiaries. Intermediaries also give HCFA use and benefit information, and provide hearings for individuals or providers appealing reimbursement amounts. Conversely, the HCFA maintains an ongoing supervision with intermediaries and reviews their budget and compliance with federal regulations yearly.

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In 1979, HCFA's San Francisco regional office conducted a study that found disagreement in payment decisions made by eight in-

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Intermediaries at a rate of 39% of the randomly selected claims; however, the range of disagreement went from 13% with one intermediary to 86% of claims with another (2).

In 1980, staff members of the American Occupational Therapy Association (AOTA), in response to numerous calls and letters from occupational therapists describing reimbursement problems, met with officials of HCFA. As a result, HCFA issued a Medicare Part A Intermediary Letter, which was sent to all intermediaries. The letter described the problems that had occurred, and the proper and appropriate coverage for occupational therapy. In spite of this letter, however, many of the reimbursement problems it addressed remained.

General HCFA Regulations
A patient qualifies for home health services if certain conditions exist. The patient must need skilled nursing services, or physical speech therapy. In addition, a patient must be homebound, and a plan of treatment must be established by the physician and recertified every 60 days. Occupational therapy alone is not enough to establish a patient’s need for home health services, however, it can continue once the other services have been dismissed.

Medicare Guidelines for Occupational Therapy
Medicare requirements for occupational therapy are the following: (a) treatment must be prescribed by a physician; (b) treatment must be performed by a qualified occupational therapist or a qualified occupational therapy assistant under the direction of an occupational therapist; and (c) treatment must be reasonable and necessary for the individual’s illness or injury (3). Occupational therapy services that are deemed reasonable and necessary were described in this journal a few months ago (4, p 339). Also, occupational therapy is considered reasonable and necessary when it will result in a significant practical improvement in a patient’s level of function; for example, in 60 days a patient diagnosed as cerebral vascular accident (CVA) will progress from a dependent status in hygiene, grooming, and dressing to independence (provided necessary articles are placed within the patient’s reach) with hygiene and grooming, and minimal assistance with dressing.

Services will be covered if a valid expectation of improvement exists at the time of the occupational therapy evaluation, whether or not the expectation is realized; however, the services will be covered only up to the time that it could be reasonably concluded that the patient is not going to improve. For example, a patient with a diagnosis of left hip and left colles fracture with a history of chronic obstructive pulmonary disease and schizophrenia is referred to occupational therapy. The lack of activities of daily living (ADL) secondary to hip fracture is identified as a problem; treatment includes prescription of adapted equipment and training in self-care. To treatment it becomes apparent that the patient lacks the cognitive skills of memory and sequencing, and the psychosocial skill of frustration tolerance to be independent in use of long-handled equipment. Bending down to put on or take off socks and shoes causes wheezing and shortness of breath. After documenting three treatment sessions and with these results, further occupational therapy services probably would not be covered for this patient.

Once a patient recovers, an occupational therapist is not required in any activity program to maintain function. The therapist may, however, design a maintenance program and make infrequent periodic re-evaluations (i.e., 1 to 2 times per month) of its effectiveness to change or update the program. These re-evaluations would be covered, but the services of a registered occupational therapist or a certified occupational therapy assistant in carrying out the program (i.e., visiting 1 to 2 times per week to observe the patient) are not considered reasonable and would be excluded from
coverage (3, p 15.2). There is a variation from one agency to another regarding maintenance programs. If occupational therapy is the only discipline in the case, and there are no problems other than the one for which the program was designed, the agency may choose to close the case.

Implications for Charting
Increased awareness and knowledge of Medicare guidelines can help therapists make informed choices when charting occupational therapy services.

Although the coverage criteria set forth earlier may be met within the documentation made by an occupational therapist, other extenuating circumstances may be mentioned within the charting that would significantly decrease the likelihood of reimbursement.

For example, if an individual were specifically diagnosed with a psychiatric illness but appeared to lack motivation, an occupational therapy program designed to work specifically on motivation would not be covered. This problem would be more effectively handled with a multidisciplinary approach (3, p 15.2).

When documenting services it is helpful for a therapist to ask, “What difference am I making in the rehabilitation of this patient?” If a patient is receiving a maximum amount of instruction yet is making minimal or no gains, reimbursement may be questioned by the intermediary.

Another area requiring attention is vocational and prevocational assessment and training. Vocational and prevocational assessment and training are not reimbursed if they are related solely to specific employment opportunities, work skills, or settings. The services must be seen as reasonable and necessary in relation to illness or injury being treated. For example, training an amputee patient in the use of a prosthesis for telephoning is necessary for everyday activities and employment purposes. This service would be covered. However, training an individual with low back pain in lifting without incorporating training in body mechanics and increasing tolerance would not be covered (4, p 15.2).

Medicare Review Process
An intermediary generally has three levels of review for home health agency (HHA) services. The first level begins when the intermediary receives a request for reimbursement from a HHA. The initial bill for services sent to an intermediary usually gives only patient identifying information, the medical diagnosis, and a general statement and charge for services, such as “Occupational Therapy skilled care . . . $50.” This bill is reviewed by an intermediary representative who matches the diagnosis, the length of stay, and the billed services.

A HHA can avoid being reviewed further by taking several precautions before information is sent to the first level. For example, the occupational therapy diagnosis being treated should be mentioned on the bill and within the patient record. If a nurse has been giving vitamin B-12 injections for pernicious anemia for two months and then, without any other additions to the record, services for occupational therapy are included on subsequent bills, the intermediary will question what occupational therapy services could possibly be given for a diagnosis of pernicious anemia. Therapists must be certain that the diagnosis being treated (e.g., head injury) is added to the patient record and included on the bill to the intermediary when they enter the care of the patient.

When a patient is treated for a longer period of time than is recommended by the intermediary for the patient’s diagnosis (this length of stay is arbitrary with each intermediary and is usually withheld from providers), the initial reviewer will forward the case to the second level of review. At this level documentation from the patient record is requested and reviewed according to the Home Health Agency Manual guidelines (3).

It is beneficial for the HHA if the therapist’s documentation is clear and succinct. Significant practical improvement should be demonstrated in a summary written at least every 30 days within the home visit progress notes and at 60-day intervals in the summary to the physician. Progress can be clearly documented by directly comparing the patient’s status at the time of the last monthly summary 30 or 60 days ago, immediately followed by an account of the patient’s current status. Both sections should contain measurable objective data. The following is an example:

Previous status—Patient is independent in feeding with moderate shortness of breath and is dependent in dressing and grooming. Patient uses the urinal most of the time; is dependent in all home-making activities.

Present status—Patient is now eating meals at dining room table. Patient is independent in grooming, hygiene, and dressing activities. Tub seat and shower hose are used for bathing; patient needs
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moderate assist to wash back and legs with moderate fatigue. Patient has been instructed in pacing and energy conservation techniques. Patient is using pursed lip breathing to control panic and extreme shortness of breath.

This method of documentation is advantageous to the individual staff member and to the agency as a whole. It not only instantaneously demonstrates the progress necessary for reimbursement, but also when used consistently, it significantly decreases charting time. The present status will become next month’s previous status and can be copied verbatim (providing the past tense is used).

The periodic summaries and individual home visit entries should be worded to promote optimum reimbursement. Medicare intermediaries are looking for significant practical improvement; therefore, words such as plateau, maintain, or stable or phrases such as patient still . . . indicate less than significant gains and should be avoided. For example, instead of recording, “Patient made slight gains in range of motion,” the therapist should simply state, “The patient made gains in range of motion”; thereby avoiding the picture of minimal progress and promoting a positive outlook.

In this second level of review the skills of a professional occupational therapist should be shown as necessary. A statement such as “Patient did exercises,” may indicate to a reviewer that the patient could be supervised by a nonmedical person. However, a statement such as “Patient instructed in an exercise program; patient then demonstrated the ability to perform exercises with therapist’s supervision,” indicates that the skills of a professional were required.

It is unlikely that a second level reviewer will be an occupational therapist, therefore the practical nature of the skills taught to a patient need to be demonstrated periodically. For example, to a nonoccupational therapist, explaining that a patient was practicing wrist supination with resistance in order to strengthen the supinator muscles may not seem practical until it is pointed out that the exercise is necessary so the patient can turn on and off the oven, and thus be independent in cooking.

Therapists should use evaluation tools that are easily visualized to aid reviewers in recognizing improvement. For example, a patient who has upper extremity weakness and loss of shoulder range of motion (ROM) initially stacked 10 three-inch cones, and at the two month re-evaluation, the patient stacked 15 ten-inch cones. The same evaluation tools for patients with similar problems should be used (e.g., goniometer measurements for ROM, Purdue Pegboard test results for hand function, and an ADL checklist). This will help the reviewer become familiar with the evaluation results and more easily determine the progress being made.

The third and final level of review is much the same as level two, except that it is performed by a physician. A review forwarded to the last level is generally due to the fact that skilled care or significant practical improvement, or both, is not evident in charting. The physician will review the records to verify the findings of the previous review level, and on doing so, will notify the HHA that reimbursement is being denied. An agency then has 24 hours to respond to the intermediary, and either appeal or accept the denial.

Summary
Denials for Medicare coverage are costly both to the HHA and the patient’s rehabilitation. To decrease the number of denials and increase reimbursement from intermediaries and overall agency income, staff members as well as agency administration must have a solid understanding of the Medicare guidelines for reimbursement. In addition, general writing skills must be fine-tuned to accentuate adherence to the guidelines.

It is the responsibility of the HHA and the individual therapist to provide a clear picture of the services provided to each patient to those who review documentation of care. This clear picture of necessary skilled service will improve use of occupational therapy services.

REFERENCES
2. Curtiss FR: Third party reimbursement for home paternal nutrition and I.V. therapy. NITA Intravenous Therapy: 194, May-June 1983