Documentation Matters

Your Medical Documentation Matters

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Introduction

This is the case study used during the "Your Medical Documentation Matters" presentation. It is a tool used for reviewing the details of the case during the presentation and the documentation requirements for the various provider types furnishing services. It highlights important Federal and State Medicaid documentation regulations and rules. To illustrate these points, the case study follows a patient's course of treatment through several medical services and the respective provider types furnishing the services. The case study begins with the patient's emergency transport and ends with his discharge from services.

Medicaid is a unique program and is quite different from Medicare. Medicare has nationwide laws and standards that every provider in every State must follow. Medicaid programs and regulations, on the other hand, vary by State. In addition, each State has the option of developing and implementing Medicaid waiver programs. Waiver program rules can also vary from State to State and even within the same State's programs.

Much of the general information for one provider type is the same as other provider types. As providers, you should be familiar with the nuances of the Medicaid program in the States where you furnish services. It is the provider's responsibility to know and follow all Medicaid rules in the States where they practice. If there are any questions regarding documentation, contact your State Medicaid agency (SMA). Visit that State's Medicaid website for contact information or look it up at http://medicaiddirectors.org[1] on the Internet.

Let's meet our patient.

Case Study

J.K. is a 52-year-old male patient. He is 6 feet tall and weighs 265 pounds. J.K. currently smokes 1 pack of nonfiltered cigarettes per day and drinks approximately 1 case of beer per week. He was diagnosed with hypertension, high cholesterol, and Type 2 diabetes at age 40. His home medications include lisinopril, simvastatin, glipizide, and metformin. His blood pressure, cholesterol, and diabetes were well-controlled until about 2 years ago.

J.K. is married, and he and his wife have three children under age 17. He worked as a computer programmer for a small corporation for 18 years. The corporation went out of business 2 1/2 years ago. Since then, he has been working part time for a local retailer while he continues searching for full-time permanent employment in his field. His wife has been working at their church as a part-time secretary for 20 years. J.K. and his wife are ineligible for health insurance benefits through their employers. Over the past 2 1/2 years, their standard of living has decreased, and they have depleted their savings. The entire family receives medical services through the State's Medicaid program.

J.K. struggles daily with his feelings of anger, hopelessness, and worthlessness. He is more withdrawn, finds little joy in life, and he refuses to engage in family activities, even though he used to initiate them. His agitation is growing, and his family members avoid him.

Emergency Transport

It was a typical Friday evening. J.K.'s family members were out, and he was home alone. When he attempted to get up from his recliner, he found he could not stand or walk due to severe right leg pain. J.K. was unable to reach anyone in his family by phone. After about an hour of continually trying to reach one of them, he called 911 and an ambulance was sent to his home. During transport to the hospital, the emergency medical technician (EMT) took a brief history from him and documented the information. The brief history included J.K.'s chief complaint (C.C.), his vital signs, his current medications, and the medical need for the ambulance transport. Upon arrival at the hospital, the EMT verbally reported the information to the nurse on duty.

Emergency Department Physician

The emergency department (ED) physician evaluated J.K. His history and physical revealed blood glucose of 260 milligrams per deciliter (260 mg/dL), and a foot ulcer of approximately 2 centimeters in diameter with surrounding necrotic tissue extending 2 centimeters from the edge on the bottom of his right foot. The rest of his foot was red and warm to the touch. The redness and warmth extended up his leg to approximately 6 inches below the knee. He had no sensation in his foot with the pinprick test, and he lacked ankle reflexes. His white blood cell count (WBC) was 22,000 cells per cubic millimeter. J.K. showed signs of sepsis, so the ED physician ordered a lactate level. The nurse in the ED took J.K.'s vitals every 15 minutes to track the hypotension. The lactate test came back positive.

Hospitalist Admits J.K. to Intensive Care Unit

The ED physician contacted the hospitalist immediately. The hospitalist admitted J.K. to the intensive care unit (ICU). Once J.K. was admitted to the ICU, the hospitalist started him on piperacillin/tazobactam and vancomycin, fluid resuscitation, and ordered an X-ray of his right leg. The X-ray showed clear osteomyelitis. The hospitalist documented wound drainage, purulence, fluctuance, odor, length of time the ulcer had been present, and that J.K. had not received any wound care prior to admission.

The hospitalist immediately consulted with an orthopedic surgeon.

Orthopedic Surgeon Consult—Notes

Using the hospital's electronic health records (EHRs), the surgeon documented the consult report after examining J.K. The consult report reads as follows:

Day of Consult (10/30/15): Code 99222-57

C.C.: Swollen painful right foot and leg

HPI: J.K. is a 52 y/o male with known Type 2 diabetes mellitus x 12 years that was brought to the ED by ambulance with acute onset of severe pain and inability to stand or bear weight on the leg. His vital signs showed a temperature of 100.7 (T 100.7), blood pressure of 90 over 45 (BP 90/45), heart rate of 95 beats per minute (HR 95 beats/min), and a respiration rate of 20 beats per minute (RR of 20 breaths/min). He was admitted by Hospital Medicine service and started on piperacillin/tazobactam and vancomycin. He was noted to have an ulcer on the bottom of the foot. He notes the ulcer has been present for about 2 months and has not changed in size. He has noted no drainage or odor until the last 3 days when it has begun draining pus and had a horrible smell. He treated it with Epsom salts and Neosporin. His foot and leg have become more swollen over the last 48 hours, and he has experienced low-grade fever, chills, and nausea, as well as progressively increasing pain. His foot is numb and has been so for about 2 years. History of present illness was extended (HPI: Extended); and his pain is rated as a 10 on a scale of 1 to 10, with 1 being the least and 10 being the most (Pain is 10/10).

Past Medical History (PMH): Complete

Medical Illness: Hypertension (HTN), elevated cholesterol well controlled with medications x 12 years

Surgery: Tonsils and adenoids (T&A), cholecystectomy

Medications: lisinopril, simvastatin, glipizide, metformin

Allergies: Penicillin causes a rash

Social Family History (SFH): Maternal grandparents coronary artery disease (CAD), diabetes mellitus (DM) Paternal grandparents: Hypertension (HTN) Mother: Obesity, DM, CAD, myocardial infarction (MI) Sister: Obesity, DM, HTN Brother: MI 45 y/o

Habits: Smokes 1 pack per day x 20 years (PPD x 20 yr); drinks 1 case of beer per week; no illegal or street drugs

ROS: (Extended)

Head, eyes, ears, nose, and throat (HEENT): No visual or hearing problems, but wears reading glasses

Cardiac: No recent chest pain, palpitations, or shortness of breath (SOB)

Respiratory (Resp): No dyspnea, orthopnea

Gastrointestinal (GI): Positive for recent nausea, no vomiting, diarrhea, or constipation

Genitourinary (GU): No dysuria or frequency; urinates two times per night (nocturia x2)

Neurologic (Neuro): Bilateral lower extremity (LE) numbness in stocking distribution, no weakness, tremors, or seizures

Endocrine: Diabetes poorly controlled x 2 years

Physical Evaluation (PE): (Detailed)

General: Alert, and oriented to person, place, and time (Ox3)

Head, eyes, ears, nose and throat (HEENT): Pupils equal, round, and reactive to light (PERRL), no palpable lymph nodes

Heart: Regular rate and rhythm of the heart (RRR), no murmur

Lungs: Clear to auscultation and percussion

Abdomen (Abd): Soft, non-tender, active bowel sounds (BS); no hepatosplenomegaly

Neuro: Decreased light touch sensation in both lower extremities in a stocking distribution to mid-calf. Absent plantar reflex in both ankles

Skin: Two-by-two centimeter (2x2 cm) ulcer on plantar aspect of the right foot over 2nd metatarsal head with necrotic base. Fluctuance is present to level of the heel. Foot is warm throughout and redness extends to mid-calf. It is tender to palpation. There is purulent drainage from the ulcer with a significant malodor. The leg is red, swollen, and warm to mid-calf. Homan's is negative. Foot and leg are insensate in a stocking distribution to mid-calf. The left foot has abnormal callousities across the metatarsal heads and is insensate in a stocking distribution to the level of the ankle. The skin is intact without areas of breakdown. Dorsalis pedis pulse is (1 plus) 1+ bilaterally.

Laboratory: Glucose 260 mg/dL; WBC 22,000 cells per cubic millimeter with 17 percent bands

X-ray: Anteroposterior (AP), lateral and oblique views of the right foot show bony destruction of the 2nd metatarsal head with gas in the soft tissue

MRI: Destruction of the right second metatarsal head with soft tissue fluid extending above the ankle in the posterior compartment; there is edema in the bone of the first and third metatarsals

Impression: 1) Osteomyelitis of the right second metatarsal which may extend to the first and third metatarsal based on the edema on the MRI. 2) Soft tissue abscess involving the entire plantar aspect of the right foot and appears to extend above the ankle both clinically and on the MRI. 3) Possible sepsis.

Plan: Patient requires emergent surgery for below the knee amputation due to the presence of abscess above the right ankle and osteomyelitis involving 3 metatarsals. Risks of infection, bleeding, phantom limb pain, stroke, MI, death, and non-healing with possible need for additional surgery were discussed with the patient and his family and the consent was signed.

Surgeon Recommendation

After consulting with the hospitalist and completing a comprehensive history, an extended review of systems, and a detailed examination, the orthopedic surgeon recommended a limited amputation known as a below-the-knee amputation (BKA). J.K.'s foot amputation was necessary because of osteomyelitis, the length of time the ulcer had been present, the condition of the soft tissue, and the presence of pus. The surgeon documented the condition of the wound, the progress of the abscess, the lack of treatment, and the amount of wound drainage. J.K. was too ill to consent to the procedure, so his wife signed the consent form. He had surgery the following morning.[2]

Coding the Consult

The surgeon coded CPT code 99222-57 on the Consult Report with no accompanying ICD-10-CM code. No ICD-10-CM code was used because the CPT E/M code covers the service furnished. CPT Code 99222 indicates a full history and comprehensive examination. When the modifier 57 is added to the code, it indicates the physician used J.K.'s history and examination to make the medical decision for immediate surgery.

Surgeon's Operation Notes

The surgeon's operation notes read as follows:

OP Note 10/31/15

Pre-operation diagnosis (Pre-op DX): Osteomyelitis, right foot with abscess

Post-operation diagnosis (Post op DX): Osteomyelitis, right foot with abscess

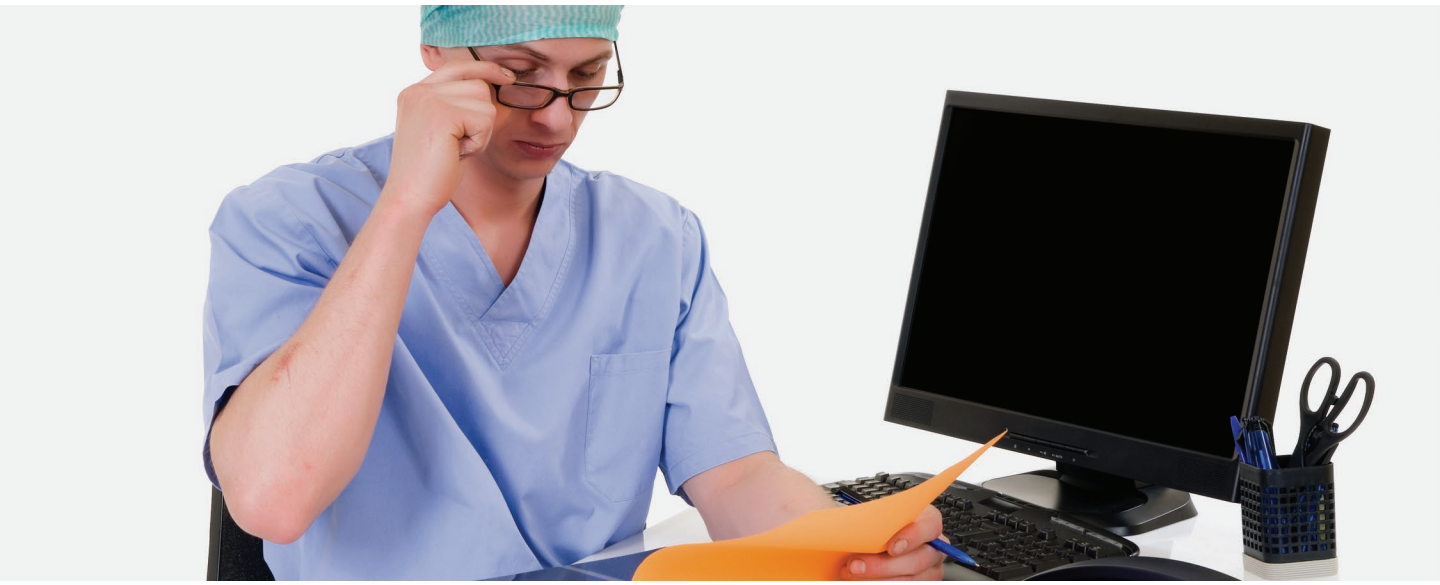
Procedure: Right below-the-knee amputation

Anesthesia: General

Operative Indications: This is a 52 y/o male with progressive pain, redness, swelling, fever, chills, and purulent drainage from a right foot ulcer. The magnetic resonance imaging (MRI) is consistent with osteomyelitis. Patient is febrile and hypotensive with an elevated WBC and left shift. Infection appears to be at or above the level of the ankle. He is indicated for a below knee amputation.

Operative Procedure: Patient was taken to the operative suite and transferred from the bed to the table in the supine position. After adequate general anesthesia had been obtained, a tourniquet was placed over the right thigh and the right foot was placed into a sterile bag. The right lower extremity was prepped and draped in a sterile manner after time out had appropriately identified the limb for surgery and the patient. Patient was being treated with antibiotics and further prophylaxis was not given.

The right limb was elevated for exsanguinations and the tourniquet was inflated to 250 mm of mercury. The anterior and posterior flaps were drawn on the leg with the anterior flap being approximately 10 centimeters (cm) below the tibial tubercle. The anterior incision was made followed by the posterior incision. Hemostasis was obtained with electrocurretage. The anterior flap was deepened to the tibia and the tibia was isolated circumferentially. Using an oscillating saw, the tibia was transected at the level of the anterior flap. The fibula was then isolated and transected 2 cm proximal to the tibia. The posterior flap was developed using an amputation knife. The specimen was passed off the table.



Vessels were identified and clamped. Each was tied with 0-silk. The sciatic nerve was identified. It was pulled taut, transected, and allowed to retract in the soft tissue. The tourniquet was released after 12 minutes and further hemostasis was obtained with ties as needed and electrocurretage.

The wound was irrigated with normal saline. No pus was identified in the wound. A 5/8 inch penrose drain was placed in the wound. The deep tissue was closed with 0-vicryl, the subcutaneous tissue was closed with 2-0 vicryl, and the skin was closed with staples. Flaps were warm and pink with quick capillary refill. The wound was dressed with xeroform, fluffs, kerlix, and an ace wrap. The patient was transferred to the recovery in stable condition.

Estimated blood loss (EBL): 50 ml

Fluid: 100 ml

Tourniquet time (TT): 12 minutes

Urine output (U/O): 100 ml

Specimen: Leg to pathology

ICD-10-CM: M86.19

CPT: 27880[3]

The surgeon coded ICD-10-CM M86.19 and CPT 27880.

ICD-10-CM “M86” is the code used for osteomyelitis, and the “.19” is added to signify the osteomyelitis is in multiple sites (the ankle and foot). The CPT code indicates the surgical procedure used for a leg amputation.

Any medical provider can pick up the surgeon’s OP notes and have a picture of what occurred before, during, and after surgery.

Post-Surgery Documentation

Using the hospital's EHR system and SOAP Notes (Subjective [S], Objective [O], Assessment [A], and Plan [P]) formatting, the surgeon documented the following information post-surgery pertaining to J.K. listing no codes, but citing "Global" and "No charge" to indicate it is part of the bundled service for the global surgery code.

Postoperative day (POD) #1; 11/1/2015

S: Complains of residual limb pain 8/10 at the worst. Controlled with patient controlled anesthesia (PCA) morphine

O: Afebrile, vital signs stable (VSS); BP 130/85

Dressing with moderate bloody drainage

Complete blood count (CBC): hemoglobin (hgb) 9.4, WBC 12,472, glucose 130

A: Stable following BKA

P: Remove Foley, discontinue antibiotic, begin physical therapy (PT) for range of motion (ROM) of knee, straight leg raise (SLR), and independent standing and bed to chair transfers; diabetes education

No charge—Global

POD #2; 11/2/2015

S: Pain is improved to 4/10

O: Afebrile, VSS, BP stable

Hgb: 9.0; Blood cultures negative, echocardiogram (ECHO) showed no valvular lesions

Wound clean with minimal bloody drainage

A: Stable

P: Continue PT, begin daily stump wraps, discontinue PCA, oral pain meds, case management for discharge (D/C) planning, D/C penrose drain, begin Lovenox for deep vein thrombosis (DVT) prophylaxis

No charge—Global

POD #3; 11/3/2015

S: Pain is controlled to 2/10 most of the time. He is experiencing phantom limb pain which is worse at night.

O: Afebrile, VSS

Hgb 8.8, WBC 8,453, glucose 120

Patient able to maintain SLR during dressing change; ROM of knee 0-90; wound clean and dry

A: Stable post op course

P: Add Elavil for phantom limb pain, continue PT, transfer to acute rehab when bed available

No charge—Global[4]

Global Billing

J.K. was admitted to the hospital on October 30, 2015, and he was discharged from hospital surgical services on November 3, 2015. According to the surgeon's hospital documentation, she coded no billing charges for the inpatient days she saw J.K. post-surgery, even though she saw him daily, because of a billing practice known as global surgery.

Global surgery is a term used to indicate that the technical and professional medical services are billed together rather than individually and includes "all necessary services normally furnished by a surgeon before, during, and after a procedure."[5] The time J.K.'s surgeon spent with him post-surgery, up to 90 days,[6] was covered under the surgical code billed.

In J.K.'s case, the surgeon will bill her own services, and is accountable for ensuring her documentation justifies the services on any claims she submits. The hospital will submit claims to Medicaid for J.K.'s hospital stay and the hospital-based physician services (for example, the ED physician and the hospitalist).[7] In this case, both the hospital and the physicians are accountable for ensuring the documentation justifies the services on the claims submitted.

The hospital will bill J.K.'s inpatient stay. The facility can bill for the day of admission, even though it was late in the evening but cannot bill services the day of his discharge.[8] If a patient is admitted to the hospital at 11:47 p.m., an entire hospital per diem is paid. On the other hand, even if a patient does not leave the hospital on the day of discharge until 11:59 p.m., the hospital may not count it as an inpatient day.[9]

Discharge Summary

A discharge summary is a Medicaid requirement and includes the patient outcome after hospitalization, the case disposition, and the patient's follow-up care plan.[10] "The hospital shall utilize an effective and ongoing discharge planning process that identifies post-hospital needs of inpatients and arranges for appropriate resource referral and follow-up care."[11] J.K.'s discharge summary reads as follows:

Discharge Summary

Admit date: 10-30-15

Discharge date: 11-3-15

Discharge diagnosis: Osteomyelitis right foot

Secondary Diagnosis: Type 2 Diabetes Mellitus, Hypertension, Elevated Cholesterol

Hospital Course: This is a 52 y/o male who presented to the emergency room with fever, chills, pain, and purulent drainage of the right foot and leg. Admission labs showed an elevated white count with a left shift and elevated glucose. X-rays and MRI were consistent with osteomyelitis of the foot. Infection appeared to extend above the ankle and the patient was hypotensive on admission. He was treated with broad spectrum antibiotics and fluid hydration. He was stabilized and taken to the operating room for BKA under general anesthesia. Piperacillin/tazobactam was continued for 24 hours postoperatively for infection prophylaxis.

Postoperatively, his blood glucoses stabilized and he was given diabetes instruction. He remained afebrile, blood cultures were negative, and his hemoglobin remained adequate. ECHO was negative. Physical therapy was started on his first postoperative day for range of motion, independent transfers, standing in parallel bars progressing to a walker, and quadriceps strengthening. He tolerated physical therapy well and by the third postoperative day was independent with bed to chair, able to maintain a straight leg raise, and had a range of motion of the knee 0-90.

His wound was clean and dry throughout the postoperative course. A penrose drain was removed on postoperative day 2 and stump wraps were started on postoperative day 3.

Pain was initially controlled with PCA morphine, which was discontinued on postoperative day 2. The patient developed phantom limb pain treated with Elavil. He was given Lovenox for DVT prophylaxis.

Case management was consulted for discharge planning to rehabilitation unit.

On the fourth postoperative day, the patient was stable, tolerating an 1,800 calorie American Diabetes Association (ADA) diet and was transferred to acute rehabilitation for continued physical therapy, daily stump wraps/shrinker fitting, prosthetic fitting, and gait training. Prosthetics will evaluate for prosthesis and make recommendations.

Discharge Medications:

Lisinopril 20mg po daily (qd)

Simvastatin 20mg po qd

Glipizide Extended Release 5mg po (three times per day) tid 30 min before each meal

Metformin 750mg po twice a day (bid)

Lovenox 40mg subcutaneously (sq) qd for 3 weeks

Elavil 50mg by mouth at bedtime (po qhs) for phantom limb pain, #30

Hydrocodone/acetaminophen 5/325mg po every three hours when necessary for (q 3 hr prn) pain, #30

DME: Walker, wheelchair

He will return to my office in 3 weeks for wound check and suture removal.

He was referred to Dr. Stephenson in 1 month for follow up of his diabetes.

He will follow with Dr. Dillard in 1 month for hypertension and elevated cholesterol.

Code 99238[12]

The surgeon coded CPT 99238, which means hospital discharge day management 30 minutes or less. In this case, it took the surgeon less than 30 minutes to document J.K.'s discharge summary.

Rehabilitation

Medicaid pays for rehabilitation (rehab) in an acute-care setting[13, 14] when it is medically necessary and when it is to treat an acute condition or an acute exacerbation.[15] When the hospital transferred J.K. to the rehab unit, his assigned physical therapist was responsible for developing a treatment plan.

Rehabilitation—Physical Therapy Treatment Plan

According to the journal Prosthetics and Orthotics International, "An important basis for optimal acute and long-term management of amputees is an in-depth understanding of the patient and the functional consequences of the amputation, systematic and detailed consideration of the patient and their environment, and sound measurement of functional outcomes."[16] This information should be documented on the treatment plan for best results.

A PT treatment plan should include at least the following information, based on where the physical therapist works and the State(s) where he or she practices:

- Beneficiary's name;
- Beneficiary's Medicaid identifier;

- Diagnosis(es);
- Date of onset or date of the acute exacerbation;
- Surgery performed, if applicable;
- Date of surgery, if applicable;
- Functional status before PT started and after PT is completed;
- Frequency and duration of treatment;
- Modalities used; and
- Documentation of any ulcers, including the location, size, and depth.[17]

Physical therapists are required to document their treatment plan and daily notes, and they must be in accord with the attending physician's plan of care. The ordering physician is required to sign the physical therapist's treatment plan.[18] The plan and notes must be readily available in the medical record.

J.K.'s treatment plan included stump shaping; stretching his leg and hip muscles to maintain his range of motion and prevent a second disability; daily stump wraps and shrinker for wound care and to decrease swelling; skin care education in preparation for prosthetic use; cardiovascular training; strength training; gait training; balancing; turning around; leg weight bearing; and using a walker until the stump healed adequately for prosthesis fitting.[19, 20]

Billing Rehab Services

Medicaid hospital rehab is paid a level per diem rate in the State where the services were provided, according to that State's formula times the number of days the patient is on the unit. J.K. was transferred to the rehab unit on November 3, and he was discharged on November 12. The hospital will bill for 9 days rehab inpatient. Once again, the unit receives payment for the day of admission, but not the day of discharge. Since the physical therapist works for the hospital, the hospital bills for the services furnished.

The hospital bills its claims electronically using the Electronic Claim Format, Accredited Standards Committee (ASC) X12N 837 Institutional form. However, if the hospital billed paper claims, it would bill on the CMS-1450 form also known as the UB-04.[21] Both the hospital and physical therapist are responsible for what is billed on the claim. Each State may have specific information it requires the biller to include on the form. If you have billing questions, check with your SMA.

Discharge to Home—Case Management Services

After 10 days in the rehab unit, the hospital discharged J.K. He was not fitted for his prosthesis during his stay in the unit. His stump needed more time for the swelling to go down, shaping, and to completely heal.

In preparation for his return home, the hospital case manager met with J.K. and his wife several times. The case manager coordinated the post-hospital medically necessary services for him. She scheduled a follow-up appointment with his surgeon and a home visit from a Durable Medical Equipment (DME) provider for prosthetic fitting, education, and training. She also recommended a referral for outpatient mental health services based on a depression index she administered during J.K.'s inpatient stay, comments made by his wife, and observations of J.K. and his interaction with others. He agreed to the follow-up appointments with the surgeon and the DME provider, and he reluctantly agreed to in-home mental health therapy after his wife pressured him. The case manager made the initial appointments for him before he left the hospital.

Patient Motivation

At home, J.K. continued the stretches his physical therapist taught him. He moved his stump often to increase circulation, help prevent stiffness, and decrease contractures and phantom pain. He continued his exercises, and as his stump healed, he conditioned it in preparation for his new prosthetic. After being home for about five weeks, he was motivated to be fitted for his prosthesis.

Durable Medical Equipment Provider

The DME provider arrived at J.K.'s home, as scheduled, but before he went he completed several provider responsibilities, making sure all of his "ducks were in a row" prior to furnishing any services. The first thing he did was check the State's eligibility system to see if J.K. was still eligible for Medicaid benefits. Since Medicaid is a month-to-month insurance program, providers can never assume a beneficiary is still eligible and are encouraged to check member eligibility monthly. Even if the services are necessary, the State cannot pay for them if an individual is not eligible.

The second thing the DME provider did was check his files. DME providers bear great responsibility for ensuring they have the required documentation on file. A lower limb (LL) prosthetic "is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part."[22] A physician's, or other State-authorized provider's, prescription can serve this purpose for an LL. For a prescription to meet State medical necessity criteria, it must include "the diagnosis, prognosis … and length of time the item is … required" and be signed and dated by the ordering provider. Do not use stamps for the required signatures.[23]

If a DME item requires prior authorization, the request must include an authorized provider's written prescription or order and include enough medical information for "an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable."[24] States have forms providers must use to submit a request for prior authorization, and the DME provider is responsible for having State-specific proof in his or her files showing the item had prior authorization. Proof differs by State. One State may require the provider to reference the prior authorization number on all claims submitted,[25] and another State may require a producible prior authorization approval letter.[26] Check with your SMA for specifics.

Once the DME provider, a Board-Certified Prosthetist,[27] verified he had all the necessary documents on file, he was ready to keep the scheduled appointment with J.K. During his visit, the DME provider evaluated J.K. and fitted him for his new LL. The provider documented J.K.'s functional level at 2, which was supported in the clinical documentation from the rehab unit, and fitted him for his prosthesis.

It took 8 days for J.K. to receive his prosthetic. The DME provider returned to J.K.'s home with the LL and adjusted it to fit. He then took the time to educate J.K. and his wife, covering the topics of 90-day repair coverage and adjustments, the care of his prosthesis and liner, how long he should wear his LL and shrinker daily, and what he should do if his residual limb becomes sore or there is broken skin. He also advised J.K. to seek outpatient PT for additional gait training.

Before the provider left, he asked J.K. to sign a document proving he received the prosthetic, gave him his number, encouraged him to call with any questions or concerns, encouraged him to attend outpatient PT, wished him well, and left.

Billing Durable Medical Equipment Services

The DME provider can bill his furnished services either electronically on form ASC X12N 837 Professional form or by paper claim on the CMS-1500 form.[28] The DME provider is responsible for what he bills on the claim and should make sure his files are complete for every order. Some States require the provider to submit documentation with the claim. It depends on the item billed.

All DME providers must retain the filed documentation, according to the record retention rule for the State where the services are furnished, and submit records to the SMA, if requested. If you have billing questions, check with your SMA.

Mental Health Services

J.K. was reluctant to meet his in-home therapist and told his wife emphatically, several times before she arrived, that he was not crazy! When the licensed independent mental health practitioner (LIMHP) arrived at the house, J.K. repeated what he had been saying to his wife. His wife quietly acknowledged the conversation and agreed he was not crazy. She then added her belief that J.K. has been depressed for years. After making her assertion, she quickly excused herself from the room. The therapist noted the reaction J.K. had to his wife's declaration.

All States furnishing mental health services use the Diagnostic and Statistical Manual of Mental Disorders (DSM). "DSM is the standard classification of mental disorders used by mental health professionals in the United States and contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system."[29]

In the past, States paid mental health services on a fee-for-service basis, and some still do. However, today many States carve out mental health services. SMAs carve out services in an attempt to control costs while furnishing quality benefits and services to Medicaid members.[30]

Regardless of whether a State pays for mental health services on a fee-for-service basis or has a carve-out plan, there are some generally accepted Medicaid standards used. First and foremost, mental health services must be medically necessary. Each State has the flexibility of defining medical necessity, and definitions do vary. However, the definitions tend to be similar. It is the providers' responsibility to know the subtleties of the definitions in the States where they practice.

Second, generally, a beneficiary with a disability should have the option to receive services at the least restrictive level. What does that mean? It means that if an outpatient program is sufficient to meet the individual's needs, that person should not be required to be hospitalized to receive Medicaid benefits. Mentally ill patients should only be required to be hospitalized if there is no other way to meet their needs. This is a State responsibility that applies to the provider to the extent that the provider is acting as a gatekeeper on behalf of the State, or is developing discharge plans, or plans of care that determine placement. Common language used to describe the need for hospitalization is the phrase, "if a person is a risk to self or others" hospitalization may be the only option. A Medicaid beneficiary should never be required to be hospitalized for convenience.[31] Recent changes in Medicaid rules have expanded the options for place of service. Check with your SMA for qualifying places of service.

And third, most States require mental health providers, even those providing services through managed care plans (MCPs), to keep clinical records of the services furnished to Medicaid beneficiaries. States can determine the length of time providers retain records, but if the State does not have a rule determining the length of record retention, providers may, at their discretion, want to consult with health law counsel. Additional requirements may apply when services are provided through managed care.

Now that we know the general rules that apply to mental health services, let's talk about the services J.K. received.

J.K.'s State Medicaid benefits are furnished through an MCP. His benefits package allows him to seek up to five mental health sessions with a qualified professional of the healing arts without prior authorization. However, the MCP expects the provider to register the visits. By registering the visits, the MCP can track the number of sessions per year. If additional services are required at the end of the five sessions, the professional must obtain prior authorization through the MCP.

The program is called the client assistance program and is similar to an employee assistance program (EAP). J.K.'s case manager referred him to the Medicaid client assistance program because the program is specifically designed to help beneficiaries deal with personal stressors that are interfering with their general well-being.[32] The client assistance program does not require an Axis I diagnosis or a formal treatment plan.

During their initial meeting, the therapist eased J.K.'s fears about therapy and explained the principles of solution-focused brief therapy (SFBT). She explained the therapeutic focus is not on the past but instead focuses on the present and the future hopes and desires of the individual. The therapist encouraged J.K. to imagine his future as he would like it to be. Together, they determined the steps and strategies he would need to take to make his desired future a reality.

J.K. and his therapist met every other week for 10 weeks. J.K. progressed nicely throughout the 10 weeks. He completed assignments weekly that would take him closer to his goal. His relationship with his family improved, and he slowly started reengaging with family members. He agreed to begin participating in family game night; he signed up for classes at the local community college to update his programming skills; and he joined the local YMCA under the hardship program.

At discharge, J.K. and his therapist reviewed his progress. They discussed the gap between where he was and where he was going and the additional steps he still needed to take. She left an emergency number and reminded J.K. of his benefits should he need them again.

Billing Mental Health Services

CAP services do not require the same level of documentation as other mental health services. The therapist is required to document each session, any progress made, and sign and date the notes. The services are paid based on a professional fee schedule and billed on the paper claim form CMS-1500. Claims must be filled out completely—or they can be denied—and then submitted to the Medicaid program within 60 days of furnishing the service.[33]

J.K. benefitted greatly from the services he received throughout the course of his illness. The providers followed all of the Federal and State rules related to documentation in the States where they practice, and they were paid for their excellent work.

Case closed.

To see the electronic version of this case study and the other products included in the "Documentation Matters" Toolkit, visit the Medicaid Program Integrity Education page at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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December 2015

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