Avoiding Legal Pitfalls for Home Health Services in Wound Care

When referring patients for home health services, wound care providers must ensure and document accuracy in assessment and “medical necessity.”

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It’s already been a busy day in the wound clinic when a nurse rushes in to hand the physician a stack of home care nursing orders to sign. The forms, some of them more than five pages long, have been generated by various home health agencies in response to the one-page wound care orders that had previously been sent to them. The original orders consisted of instructions on how to clean the wound, secure a specific dressing over it, and change the dressing at a given interval for a specific time frame. A day later, the wound center receives documents with exhaustively detailed care plans for the patient’s many different health complications. One document in particular lists 20 medications the patient is taking (none of which the wound clinic physician prescribed), orders for tube feeding, catheter-care instructions, and a host of other detailed orders. At the bottom of this form is a place for the wound care physician’s signature. What’s wrong with this picture? How could new orders that were not written by the wound care physician need his approval? How should this situation be addressed? This article will help answer these questions.

A CASE IN POINT

This type of scenario recently played out in a court case against a Texas wound care physician who had been sued regarding his role in the home nursing care of a wound care patient who was living with many comorbidities. The physician had seen the patient just one time. During the visit, the physician suggested a conservative plan of care for the treatment of foot ulcers due to advanced and non-reconstructable vascular disease. Easy-to-follow orders were sent to the home-nursing agency, which then named the provider...
the “physician of record” for all the patient’s medications and nursing interventions, even though the patient never returned to the wound care clinician. At some point, the care plan reverted to the primary care provider, but it was not clear when. The patient eventually required an amputation for her vascular disease and later died. The family sued the wound care physician, asserting that he was negligent in to properly supervising the complex treatment plan he had signed — the majority of which had been transferred from another physician. Be sure to follow the protocol outlined below when collaborating with a nursing agency on a patient’s wound care.

Sign Clear Orders

Legally, when a physician signs orders provided by an agency, he/she becomes the “physician of record” for those orders. All wound care physicians should protect themselves by having a clear delineation of responsibilities in any written agreement with an agency. Do not sign orders pertaining to other problems for which you are not the treating physician. It would also be wise to provide orders covering only the treatment period until the patient’s next scheduled visit so that the end date of your order is clear.

Validate “Homebound” Status

At the Center for Medicare & Medicaid Services (CMS), there are some officials who’ve voiced concerns over the “misuse” of home-nursing services. Patients and their families often pressure providers to order home nursing to a patient who may not qualify, creating an uncomfortable situation for wound care clinicians. Inappropriate use of home health services is a major focus of Medicare audits, but most wound care physicians do not give this aspect of the patient’s care much thought. It is true that many wound care patients are unable to care for themselves. For example, data from the US Wound Registry has shown that 70% of venous ulcer patients cannot dress themselves unaided. Many pressure ulcer patients are even more seriously disabled. Most wound care clinicians are accustomed to utilizing home-nursing services to provide interval dressings between visits to the wound center. While patients with private insurance may not have to be homebound to receive home nursing, Medicare patients must meet the definition of “homebound” in order for skilled home nursing to be provided. The Social Security Act of 1935 [Sections 1814(a)(2) (C) and 1835(a)(2)(A)], as amended by Section 4615 of the Balanced Budget Act of 1997, establishes the basic eligibility and coverage requirements for Medicare home health benefits. The act states that home health services shall be provided to beneficiaries who (1) are homebound, (2) have medical necessity (ie, need intermittent, skilled-nursing care; physical therapy; speech therapy; or continued occupational therapy), and (3) are under a physician’s plan of care. While these criteria may seem straightforward, their application is not. Both the use and interpretation of the first two criteria vary widely among Medicare Administrative Carriers.

In general, a patient is considered to be homebound if:

1. Leaving the home isn’t recommended because of the patient’s condition.
2. The patient’s condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person).
3. Leaving home takes a considerable and taxing effort.

“Homebound” patients may still leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. More information about this can be found at: www.medicare.gov/publications/pubs/pdf/10969.pdf. Clinicians who sign-off for homebound status when direct knowledge is available that contradicts the patient being homebound are exposing themselves to big dangers, such as prosecution for civil or criminal fraud. Even if there’s a good-faith belief that the patient was homebound, the wound care physician could be found liable of fraud if reasonable steps to evaluate the patient’s status aren’t found to be taken. Nursing home operators can be potentially liable if they provide home nursing care under Medicare for patients they know do not meet homebound criteria. The agency should notify the provider if the wound care patient does not meet any homebound criteria. It is wise to codify this responsibility in any agreement with an agency. If an agency reveals that a patient does not meet the requirements for homebound status, it would be ill-advised to send orders to a different agency hoping you will get a different answer.

Ensure “Medical Necessity”

When an agency receives a referral, the first step in the admissions process is to perform a comprehensive assessment of the patient to identify the patient’s needs for skilled home healthcare. Based upon this assessment, the nurse will create a plan of care based on what is determined to be “medically necessary” for the patient. Medicare only pays for medically necessary services, so if the assessment does not support the medical necessity of a particular service, the agency should not provide it. Additionally, if the wound care physician’s documentation does not support the medical necessity of the services being ordered, the agency would be required to pay any reimbursement back to CMS and the physician would be liable for having certified that services were medically necessary when they were not. Providing medically unnecessary services can be considered an illegal inducement to the beneficiary as well as Medicare fraud. The US Department of Health & Human Services’ Office of the Inspector General and the US Department of Justice routinely review the medical necessity of claims.

(Visit www.aihc-assn.org/Portals/3/HomeHealthCertification.pdf for more
For skilled-nursing care of a wound to be considered reasonable and necessary, the size, depth, nature of drainage, and condition and appearance of the surrounding skin must be documented in the clinical findings so that an assessment of the need for skilled care can be made. The plan of care must also contain the specific instructions for the treatment of the wound. Specific requirements to establishing medical necessity for home health skilled nursing can be found at www.cms.gov, but here are six situations in which home health for wounds is covered:

1. open wounds that are draining purulent exudate and for which the patient is receiving antibiotics;
2. wounds that require irrigation or instillation and/or packing;
3. recently debrided ulcers;
4. wounds with exposed internal vessels or a mass that might hemorrhage;
5. postoperative wounds where there are complications; and
6. other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

It is important to keep in mind that CMS mandates that skilled home nursing service must be provided with the expectation of the patient’s restorative potential. In other words, home-nursing services are provided on the condition that the patient “improve materially in a reasonable and generally predictable period of time.” Thus, home nursing is not considered reasonable and necessary if the patient is not able to heal the wound. This means home nursing may not be justified if a wound shows no improvement over the course of care. It is also not necessary when a patient has a transient problem that could reasonably be expected to improve spontaneously. In those cases, the agency may notify the physician that the family will need to assume responsibility for the care of the wound.


The medical necessity of home nursing services for wound care also ends when the wound is healed. Once again, providers could expose themselves to prosecution for civil or criminal fraud for prescribing medically unnecessary services. This would be especially true if the government could show that the physician had direct knowledge that services were unnecessary but signed orders for services anyway.

**FACE-TO-FACE REQUIREMENT**

The Affordable Care Act includes a requirement that healthcare providers conduct face-to-face meetings with patients about their condition(s) in order to receive Medicare payment for home health and hospice care. Intended to be a tool for reducing fraud, waste, and abuse by assuring physicians and other healthcare providers have actually met with potential home health patients to ascertain their specific care needs, the requirement establishes that a face-to-face encounter must have “occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home healthcare by including the date of the encounter,” and must include an explanation as to why the physician’s clinical findings support the need for home healthcare, including that the patient is homebound and the need for either intermittent skilled-nursing services or therapy services as defined in 42 C.F.R. §409.42(a) and (c).

When meeting with patients, remember:

1. Face-to-face certification is only required at the actual start of care.
2. The encounter can be done by a non-physician, but a physician must sign the certification.
3. The certifications must: a) be clearly titled, b) include an attestation that the encounter occurred, and c) state that the patient is homebound and in need of skilled care.
4. Face-to-face certification does not have to be on a separate form, it can be included in some other document, such as a plan of care.

On Oct. 11, 2012, the owner of a Dallas-area home health services company admitted his role in a $374 million home health fraud scheme in which he and others conspired to bill Medicare for unnecessary services. Court documents showed that indicted physicians fraudulently certified beneficiaries and billed for services not provided. When Medicare implements a new requirement (such as “face-to-face time” certification), there is usually a reason for the increased documentation burden. Home health services fraud is on the rise. Those physicians who meet face-to-face with a patient cannot credibly claim to have “thought” he/she was homebound, for example. Adding this requirement could easily be a precursor to more aggressive prosecution, and it will certainly make prosecution easier when an MD files something that is incorrect about a patient’s true condition. Skilled home health services can be a vital part of a patient’s wound care, but providers must be sure to read orders before signing them and be sure to adhere to Medicare’s policies regarding homebound status and the medical necessity of treatment.

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**References**