information.) 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 that the family will need to assume responsibility for the care of the wound.

(Visit www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf, see page 60).

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 requiring 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 certifications 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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