Part 2: Picture Perfect Documentation

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Faculty

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Old Health Care Adage

- **"If it was not documented, it was not done"…..**
- **Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services**
- **Medical records chronologically report the care a patient received and are used to record pertinent facts, findings, and observations about the patient's health history**
  - **CMS Manual Ch 7**

Document As Though Every Note Is Under Inspection By An Auditor

Qualifications for Home Health Services

- **Reasonable and necessary**
- **Confined to home**
- **Requires skilled care**
- **Covered services under Medicare benefits**
- **Health care payers and their auditors require reasonable documentation to ensure that a service is consistent with the patient's insurance coverage and to validate the above qualifications are met**

Paint a Picture of Your Visit / Patient

- **As related to each visit……**
- **What you want the auditor to know:**
  - **What you observed during the visit**
  - **Justification of patient services / needs**
  - **The skill(s) provided**
  - **Results of the visit (patient centered)**

Supplies: Essential Elements in Documentation

- MD / multi-discipline contact
- Photos of wounds/measurements
- Subjective information
- Description of patients response to treatment
- Progress towards goals
- Plan for next visit
- Homebound status / medical necessity
- Teaching content / who was taught / response to teaching

Paint a Picture of Your Visit / Patient

- Think about the Plan of Care / MD orders
- Think about how ordered services will help meet goals
- Describe the patient's environment, if relevant
- Explain management of abnormal values / results

Supplies: Essential Elements in Documentation

- Just as artists requires their supplies, the Home Health clinicians need their supplies...
- Physicians orders / plan of care
- Hospital discharge information / MD office visit notes
- Billable skill / Plan of Care / MD orders
- Accurate assessment findings

Admission Criteria: You Must Have…

- Skilled Service that is Reasonable AND Medically Necessary

Billable Services

- Document to support the need for beginning / continuing skilled services each visit
- The care required must require the skills of a licensed nurse / clinician
- Must be reasonable and necessary to the treatment of the patients illness / injury
- Must be intermittent
- Must be a Medicare covered skill (see section 40.1.2.3 of CMS manual Chapter 7)
  - CMS manual Chapter 7 section 40.1

Skilled Service

- The medical record should explain why this person needs skilled services during each visit
- When there has been a change in the treatment regimen requiring skilled services, documentation should include the assessments appropriate for the patient and their medical problems
- When education is provided, document the specific education given as well as the patient's or caregiver's response to it

CMS Example - Skilled Service

- Example 8:
- Following a CVA, a patient has an in-dwelling Foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period
- The medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of care

CMS Example - Skilled Service

- Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper catheter care would be covered as long as they are reasonable and necessary, although the patient is stable, even if there is an expectation that the care will be needed for a long and indefinite period
- However, at every home health visit, the patient's current medical condition must be described and there must be documentation to support the need for continued skilled nursing services
  - CMS CH 7 40.1- Skilled Nursing Care

Reassess Skilled Need If…

- M1810 to M1860 – "0" – independent with grooming / bathing / transfers / toileting / ambulation
- C1F1S1 (therapy visits = 0)
- Patient not homebound
- No change in medications/treatment
- Patients condition is "normal"
- Caregiver "understands" or is "capable" of managing pts condition

Reassess Skilled Need If…

- Pt "independent" all aspects of care
- Wound superficial / first aide only, wound is "healed"
- Venipuncture only

Medical Necessity

- If all eligibility requirements are met, then skilled services are covered when it is determined that the patient requires "the specialized judgment, knowledge, and skills" of a registered nurse, lpn, or therapist
- Skilled services are necessary to maintain the patient's current condition or prevent or slow further deterioration

Question Medical Necessity if

- When the skill has been taught and the patient improves there is no longer a billable skill and no medical necessity
- Obtain an order to discharge the patient
- Give notice of non - coverage as this time approaches within 48 hours of discharge
- Also, if goals are met prior to end of frequency, obtain order to discharge, give notice of non - coverage

Medical Necessity Examples

Clinical Note

SUMMARY: This is a 71 yo white female with history of HTN, CAD, Dyslipidemia, Osteporosis, Osteoarthritis, Acid reflux, Depression (no depression noted this visit) and chronic back pain. Pt was admitted to the hospital on 05/09/11 with c/o chest pain, syncope, and headaches. She had several test run on her, she had an EKG, CT of brain (pt had brain surgery about 10 years ago d/t aneurysms, CT showed no changes), Chest Xray (WNL), and a Doppler US of carotids (pt does have mild to moderated stenosis), she was then d/c home on 5/11/11. On 5/26/11 pt fell in home after c/o being dizzy and fractured her right lower arm, she was seen in ER, cast was applied and she was d/c home, she is being followed by Dr [redacted] (orthopedic doc), she has an appt with him again on 7/7/11. Cast was clean and dry, fingers were pink, no edema noted, good capillary refill noted, instructed pt on cast care and s/s to report to SN. She ambulates with slow gait, suggested that she get her a cane to help improve her balance, she said that she will get her one, discussed basic home safety and fall precautions. Pt did not want therapy at this time, she said that she really would like some help with her housework, etc for now, will order MSW to evaluate pt for services available to her. Patients friend [redacted] checks on pt at least 3 times per week and helps her as she can with ADL'S and IADL'S. Will need SN to O/A/T on clinical guidelines for 3 weeks. Pt does not want HHA services at this time, [redacted] d[redacted] as needed.

Medical Necessity

- **The documentation shows the patient has had the condition for a long time**
- **Their symptoms are stable**
- **The treatment regimen has not changed**
- **The physician is repeatedly referring the patient for observation services**
- **Does this meet the Medicare guidelines?**
  - **NO**

Referral Non - Admit

- **"But the Doctor ordered the services"……**
- **No, the Doctor called the referral to the agency have the clinician go out and assess the patient**
- **The clinician then has to determine if there is a qualifying home health skill that will be covered by Medicare**
- **If it is not, then the clinician should contact the referral source and inform of the referral non-admit and give the reason and document in the chart**

Denial- Medical Necessity

The skilled nursing visits were partially warranted based on the submitted documentation. The patient met homebound criteria and the skilled nursing visits on 12/9/2013, 12/11/2013, and 12/19/2013 were medically reasonable however the remaining visits were not medically appropriate at the record did not support the need for frequent medication adjustment, observation, or stabilizing treatment. The documentation submitted indicated that the nursing visits consisted of general assessment and instruction of wing standing, chronic but stable conditions.

In addition, the provided documentation did not support that a complete Face-to-Face evaluation was performed as the homebound eligibility was an insufficient description of how the patient's clinical condition warranted homebound status. Without a valid face to face encounter, the legal medical certification is incomplete. Medicare criteria for coverage were not met and the services provided are not covered. The medical record review was performed under the supervision of the medical director.

Denial visits 12-14 & 12-27 as documentation does not support HD status & medical necessity.

Total claim denial d/t F2F

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Medical Necessity

- **Example 6:**
- **A patient with hypertension suffered dizziness and weakness**
- **The physician found that the blood pressure was too low and discontinued the hypertension medication**

Medical Necessity

- **Skilled observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range**
- **The patient's necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and / or treatment regimen has stabilized**
  - **Ch 7, section 40.1.2.1**

Clinical Documentation

- It is expected that the home health records for every visit will reflect the need for the skilled medical care provided
- Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his / her goals as outlined in the Plan of Care
- In this way, the notes will serve to demonstrate why a skilled service is needed
- Be consistent in your documentation: Example - No varying diets or inconsistent wound measurements
- Do not use "agency" specific terms : "Clinical guidelines"

Resumption of Care

- Remember:
  - With ROC, the nurse must write interim orders for the 1 day 1 and subsequent orders
  - Check yes for interim orders and make sure orders are printed out and sent to MD for signature
  - Assess to see if previous care or services are still required

ROC - Denial

- Begin Date: 04/21/2012 12:00 AM
- End Date: 05/10/2012 11:59 PM Author: RN
- Discontinue Date:
  - 1 Week 4
- 4/21/2012 vo received to continue current home health services Dr. / RN

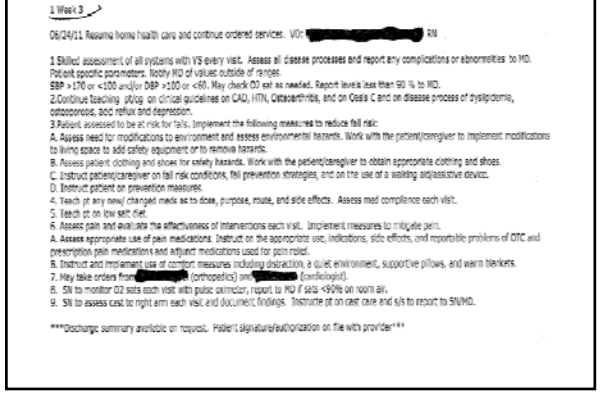
ROC - Denial

- Sn beginning week of 4/21/2012 for new medication teaching, continued skilled observation and assessment of cardiopulmonary status, nutrition, elimination, skin integrity, safety, medication regimen, and therapeutic effects of medication and to assess for s/s exacerbation of disease processes with focus on respiratory status due to recent cough / congestion
- Continue to assess for depression and implement measure to manage depression as needed

ROC - Denial

- Sn to continue to assess fall risk conditions, fall prevention strategies, and on the use of a walking aid/assistive device
- Implement measures to reduce fall risk as needed
- Taken Date: Status: Current
- Completion Date: Interim: N
- Printed Date: 06/22/2012 08:27 AM Reprinted Date: 06/22/2012 08:27 AM

Order Content



1 Week 3

06/24/11 Resume home health care and continue ordered services. VO: [redacted] RN

1.Skilled assessment of all systems with VS every visit. Assess all disease processes and report any complications or abnormalities to MD. Patient specific parameters. Notify MD of values outside of ranges.
SBP >170 or <100 and/or DBP >100 or <60. May check O2 sat as needed. Report levels less than 90 % to MD.
2.Continue teaching prog on clinical guidelines on CAD, HTN, Osteoarthritis, and on Oasis C and on disease process of dyslipidemia, osteoporosis, acid reflux and depression.
3.Patient assessed to be at risk for falls. Implement the following measures to reduce fall risk:
A. Assess need for modifications to environment and assess environmental hazards. Work with the patient/caregiver to implement modifications to living space to add safety equipment or to remove hazards.
B. Assess patient clothing and shoes for safety hazards. Work with the patient/caregiver to obtain appropriate clothing and shoes.
C. Instruct patient/caregiver on fall risk conditions, fall prevention strategies, and on the use of a walking aid/assistive device.
D. Instruct patient on prevention measures.
4. Teach pt any new/ changed meds as to dose, purpose, route, and side effects. Assess med compliance each visit.
5. Teach pt on low salt diet.
6. Assess pain and evaluate the effectiveness of interventions each visit. Implement measures to mitigate pain.
A. Assess appropriate use of pain medications. Instruct on the appropriate use, indications, side effects, and reportable problems of OTC and prescription pain medications and adjunct medications used for pain relief.
B. Instruct and implement use of comfort measures including distraction, a quiet environment, supportive pillows, and warm blankets.
7. May take orders from [redacted] (orthopedics) and [redacted] (cardiologist).
8. SN to monitor O2 sats each visit with pulse oximetry, report to MD if sats <90% on room air.
9. SN to assess cast to right arm each visit and document findings. Instruct pt on cast care and s/s to report to SN/MD.

Discharge summary available on request. Patient signature/authorization on file with provider

Medical Necessity Examples

Clinical Note

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CMS Guideline - Plan of Care

- **The plan of care must contain all pertinent diagnoses, including:**
- **The patient's mental status**
  - **Prognosis**
  - **Rehab Potential**
  - **Functional Limitations**
  - **Activities Permitted**
  - **Nutritional Requirements**
  - **Services / Supplies Required**

CMS Guideline - Plan of Care

- **Frequency of Visits to be made**
- **All Medications / Treatments**
- **Safety Measures**
- **Instructions for timely discharge / referral**
  - **CMS Manual Chapter 7**

CMS Guideline – Plan of Care

- **POC should be concise and specific to the goals you wish to accomplish**
- **Plan of care should be achievable within the specified time frame**

Documentation

- **Summarize recent illness / hospitalization**
- **Summarize new treatments / meds / diagnoses**
- **Describe the pt/caregiver / living environment**
- **Describe the knowledge deficit / teaching need**
- **Describe the required skill services**
- **Describe the goals to be achieved / time frame**

Documentation

- **Document skills performed / tolerance of skill / teaching done / pt / caregiver reaction to teaching / plan for next visit**
- **Document any abnormal values / what is being done about the abnormal values / communication to MD**
- **Document medical necessity / homebound status**
- **Progress or lack of progress towards goals**
- **Document on Co-morbidities affecting plan of care**
- **Take photographs of wounds per policy / take measurements as ordered**

G Codes

- Obs / ass
- Obs / ass asv
- Edu / Train
- Edu / Train asv
- ME
- Make sure you code to the service that you are spending the most time on during your visit

Observation / Assessment

- Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's clinical condition and / or treatment regimen has stabilized
  - Ch 7, section 40.1.2.1

Observation and Assessment

- Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, the skilled observation services are still covered for 3 weeks
- There must be documentation to validate the need
  - Ch 7, section 40.1.2.1

Observation / Assessment Example

- 65 YO female, admitted with principal diagnosis of Diabetes Mellitus without complication
- Other diagnoses: unspecified hypertension, rash and other nonspecific skin eruption, osteoarthrosis, generalized, multiple sites; unspecified acquired hypothyroidism
- Per the Plan of Care: skilled nursing services ordered for observation and assessment of body systems, pain management, vital sign assessment, instruction of disease process, medication management and education, and home safety

Observation / Assessment Example

- The auditor noted: “the submitted record documented that the services were initiated by physician referral due to diabetes mellitus with no documented change in treatment or medication noted”

The Auditors Summary

- The plan of care: activities permitted:up as tolerated with a walker
- “The OASIS: patient was awake, alert, oriented, normal vision, adequate hearing in no acute distress, no shortness of breath, independent with ADLS and IADLs,no gross neurological deficits, and no cognitive deficits”
- The patient was ambulatory with walker; The TUG score was 19 seconds
- Homemaker services 2 days a week 3hours per day to assist with IADLS

The Auditors Summary

- The patient requests home health services for diabetic teaching
- SN instructed on diabetic teaching including diet, glucometer use and recording in a log book, signs and symptoms of infection and medications
- "The skilled nursing visits continued for observation and assessment and instruction on diabetic management"

The Auditors Summary

- "The pt remained without acute distress, shortness of breath, or signs and symptoms of hypo / hyperglycemic
- The patient remained independent with monitoring of blood sugars via glucometer with results ranging between 104 - 138"

CMS Guideline – Teaching and Training

- Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services
- Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered

CMS Guideline – Teaching and Training

- The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught
- Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered
- Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury
  - CMS Manual CH 7 40.1.2.3

CMS Guidelines – Teaching / Training

- Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary
- The reason why the training was unsuccessful should be documented in the record
  - CMS Manual Ch 7 40.1.2.3

Teaching / Training

- Management of a new treatment regimen
- Self - injection of medication
- Care of a new ostomy
- Self - catherization
- Wound care
- Care of intravenous line
- See complete list
  - Ch 7,section 40.1.2.3

CMS Example- Teaching / Training

- Example 1:
- A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent
- The physician has ordered teaching of self-injection and management of insulin, signs, and symptoms of insulin shock, and actions to take in emergencies
- The education is reasonable and necessary to the treatment of the illness or injury, and the teaching services and the patient / caregiver responses must be documented

CMS Example- Teaching / Training

- Example 2:
- A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition, to recognize signs and symptoms of adverse reactions to new medications, and to follow the necessary dietary restrictions
- The documentation must thoroughly describe all efforts that have been made to educate the patient / caregiver, and their responses
  - CMS Ch 7, 40.1.2.3

CMS Example- Teaching / Training

- Example 3:
- 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 that would require re-teaching
- 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
  - CMS Manual Ch 7

Denial Proof Your Documentation

- All records have the potential to be audited, so…..
- Review Face to Face for completeness
- Think about Medical Necessity
- What you plan to accomplish
- Who will benefit from the services provided

Denial Proof Your Documentation

- How does the services impact / improve their status
- When will services be provided/duration
- What services will be provided
- What progress has the patient made as a result of the services
- Why patient can't go to MD office to get services – homebound status

Reviewing the Finished Work: Overall Picture

- When reviewing the note, can you visualize the patient / surroundings / over all condition?
- When reviewing the chart, do you see the need for the clinician in each visit?
- When reviewing the completed episode, can you see the benefit in the skilled services provided to the patient?
- Can you tell why the patient was homebound?

Reviewing the Finished Work: Overall Picture

- Is the medical necessity clearly documented?
- Was skilled instruction documented?
- Medications assessed / taught?
- Noncompliance addressed, as indicated?
- Plan for next visit / discharge planning done?
- Progress towards goals addressed?

Closing Thoughts

- Reimbursement for HH is for "skilled" services ONLY and the skill will be measured by the documentation you have submitted
- Clinical notes should be submitted with the expectation that they will be audited and the care you provided may be questioned
- Remember that each note stands alone and what you have submitted as clinical documentation is the only record of the care available

Closing Thoughts

- Auditors use our "pictures / documentation" for their denials
- If our POCs are too elaborate and unachievable, our claims could be denied
- If we do not show that the visits are medically necessary, that the pt is homebound or that the patient had a Face to Face, then our claims could be denied
- Directors need good documentation to fight denials
- Take credit for the good work that you do
- Document, Document, Document and then…

Reference

- Cms.gov
- CMS Internet - Only Manual, Publication 100-20, Medicare Benefit Policy Manual, Chapter 7 sections 30.1, 40.1, 40.1.1