Clinical Documentation

Regulatory & Legal Recommendations

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Objectives

1. Identify strategies for enhancing documentation from a regulatory and payment perspective.

2. Describe methods for strengthening documentation from a legal perspective.

3. Deliver an inservice at your agency that enhances clinical documentation.
Why Are We Here Today?

- Accreditation/State Regs
- Communication/Coordination
- Compliance with regulations
- Legal liability protection
- Performance improvement
- Reimbursement
- Tells the patient’s story
"Imagination is More Important Than Knowledge"

Albert Einstein

Number of Agencies & Costs Rising: Why More Scrutiny in Our Documentation?

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<tbody>
<tr>
<td>Number of Home Health Agencies</td>
<td>10,917</td>
<td>7,528</td>
<td>12,199</td>
<td>62%</td>
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<td>Total Spending in Billions</td>
<td>$17.7</td>
<td>$8.5</td>
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Medpac (2013). Report to Congress: Medicare Payment Policy
Integrity 101

- Know the Medicare Home Care or Hospice Benefit Rules.
- These are federal monies belonging to all of us as taxpayers.
- Refer to 42 CFR 409 Medicare Coverage of Home Health Agencies (CoPs)
- Consult your state associations – the experts on local/state/Medicaid/waiver & other state based programs.
Integrity 101

- If it seems duplicative—it probably is—
- Trust your judgment –your license may depend upon it!
- Visit the Office of Inspector General’s website— oig.hhs.gov.
- If you see things that you do not seem “congruent” with the regs...or are asked to do something that is not right--you might want to consider other employment.

Integrity 101

- Areas of suspected fraud, waste and abuse:
  - Documenting homebound for patient who is not.
  - Altering records to obtain a higher payment amount
  - Soliciting, offering or receiving payment for referrals
  - Documenting/billing for visits not made.
  - Billing Medicare that don’t require skills of a nurse or therapist.
The Ugly and True

- “Pt states pain level of 4/10, tolerable. Pt rates today’s pain as 8/10. Pt doing well. Plan: SNV next week as per POC.”
- “Patient seemed to have a coughing spasm after changing trach and suctioning. “
- “Missed visit because of no skilled need.”
- “The patient’s wound seemed to double in size overnight.”
- “Patient reports is homebound for visit because he just returned from the grocery store for our visit. “
- The family reported that the patient’s _________pills are missing.

The Ugly and True

- “Pain is not well managed- morphine dose increased from 15mg q4 hrs to 30mg q 4 hours. Plan: SNV next week.”
- “Pt somnolent, non-arousable. Pt doing well. “
- “No BM x 3 days. The next week-no BM x 7 days.” (Really? What? You get the picture! And no doc contacted, etc. etc. etc.!!)
- Reviewer reported “These days the problem is the lack of writing a narrative and only checking off or using a drop down. Each note can read the same and does not create a picture of the patient and the care, etc.”
Documentation: Why So Valued?
Numerous Standards to Meet!

Safety ⇒ Quality

- National Patient Safety Goals initiative
- Institute of Medicine (IOM) goals
- National Healthcare Safety Network (NHSN)
- OSHA Quick Takes
- Medication-Related Safety Initiatives
- Preventable occurrences: Falls, UTIs, Med-related errors
- Hand-overs – Transition / Risk Points on the continuum
- Medicare non-payment “never events” (e.g. UTI, VAP, pressure ulcers, etc.)

Documentation: Why So Valued?

- Quality
  - Changing headsets: Getting to where only quality care is paid for?
  - The questions become:
    - What did I do on this visit that improved patient outcomes?
    - Did I document this value?
  - Home Care Compare – One measure of quality
  - Patient and referral source satisfaction & feedback
  - No sentinel events, no adverse events
  - Tracking of incidents, infections, etc. with trending and analysis for prevention.
  - Home Health Quality Initiative:
    www.homehealthquality.org
**Documentation: 10 Important Roles**

1. Provides basis for:
   - Coverage
   - Reimbursement/payment
   - Quality
2. Reflects care provided to a specific patient
3. Shows standard of care provided
4. Provides organization with information for data collection and benchmarking
5. Protects clinician/organization from alleged practice/fraud complaints
6. Source document for communication, coordination, and handovers
7. Acts as basis for PI reviews
8. Sole document that chronicles care from admission/SOC through discharge
9. Describes patient’s clinical status and needs.
10. Supports tenets of quality care and recognizes that quality **IS IN THE DETAILS.**
Documentation Processes: The Goal!

- When documentation processes/systems work – IT LOOKS EASY!
  - All information is aligned, legible, complete and congruent
  - Care is coordinated and communicated among/across disciplines, is timely and planned, etc.
  - Team members have information needed to coordinate care, review notes, make care decisions, bill, etc.
  - When e-documentation is used, information is accessible, timely, and complete
  - Problems are “closed out” (e.g. evidence of pain reduction, closing the loop on problems)

Documentation Processes: What to Avoid

- Information is missing
  - Data not complete
  - Delayed transmission/submission for billing, regulatory reports for OASIS
  - Plan of Care (the “driver”) not being followed
  - May reflect poor patient care (from a reviewer perspective)
  - Poor communication/no evidence of care coordination
  - Increased opportunity for errors
  - Notes from different clinicians looks like they are caring for different patients (no congruency)
  - Other problems such as accreditation concerns, complaint surveys, increased ADRs, denials, etc.
  - Notes give appearance that patient received poor/substandard care
And besides Medicare..

Who else reviews YOUR documentation?
- Team members: physicians, managers,
- Finance, quality, and compliance reviewers
- Accreditation surveyors
- State surveyors
- CMS/RHHIs (MACs, ZPICs)
- Quality Improvement Orgs
- Patient/Family
- Attorneys and juries

You Are What You Document!!

- Shows the quality of care you gave patient
- Protects from malpractice
  - Minimizes potential to be named in a lawsuit
  - Minimizes the potential from needing to appear in court
  - Helps you win if you do go to court
Medical Record = Legal Record

- Provides a “picture” of care patient received.
- Shows if care met the “standard of care”?
- Legal perspective on documentation
  - Not documented, not done
  - Poorly documented, poorly done
  - Incorrectly documented, fraudulent

What Is the Standard of Care?

- Standard of care = What would a “reasonably prudent” nurse do under similar circumstances. is accepted as “reasonable” under the circumstances

- “Reasonable” = the degree of skill, care, and judgment used by an ordinary prudent nurse under similar circumstances.
How is the Standard of Care Determined?

- State Nurse & Therapy Practice Acts
- Agencies Policies & Procedures
- ANA’s Scope & Standards of Home Health Nursing Practice, 2014
- ANA’s Principles of Nursing Documentation, 2010
- Accreditation standards

References for Standard of Care

**ANA’s Scope & Standards of Nursing**

- Assessment
  - In adequate detail
- Nursing diagnosis
- Expected Outcomes
- Planning
  - Appropriate to assessment
  - Used critical thinking/judgment
- Interventions
  - Timely
- Evaluation
  - Patient response to intervention
  - Did intervention work?

**ANA’s Principles for Documentation**

- Reflects Nursing Process
  - Assessment – Interventions - Evaluation
  - Accurate
  - Concise
  - Complete
  - Contemporaneous
  - Relevant
  - Readable
What Should Be Documented

- Assessments & patient’s clinical status
- Interventions & patient’s response
- Variances from expected outcomes (meds, procedures, protocols) & action taken
- Communication with MD, others
- All unusual patient occurrences (“incidents”)

What Do the Readers Want from YOU?

- Assess patient comprehensively
- Identify the patient’s problems
- Determine the achievable goals
- Good care planning (POC)
- Strictly implement the POC
- Achieve goals & discharge: Best outcomes
How do the readers know?

- How does Medicare know if you are doing what they are paying for?
- How does the jury know if you provided the Standard of Care?

YOUR documentation!

The Care Planning Process

Assess -> Identify Problems -> Identify Goals -> Develop Plan -> Implement Plan -> Evaluate
Assessment
SOC /ROC/Recert OASIS

Identify problems

Identify goals

Plan of Care (485)

Plan the care

Implement POC
Follow POC, Visit Notes

Evaluate
Discharge/Transfer OASIS

Assess

Status at SOC, ROC or Recert

Mistakes on OASIS = false documentation

Assess deficits and needs

Risk for hospitalization

Risk for falls/injury

Medication problems

Functional deficits

Dyspnea

Depression

Wounds

Caregiver problems

Incontinence

Knowledge deficit

Frailty

Pain

Palliative/EOL Care
Identify Problems

- Every OASIS assessment item that identifies a deficit is a problem.
- Not all problems are identified by the OASIS
- All problems deserve care planning
  - Or explain why the patient does not need care for this deficit.
- All problems are related to diagnoses
  - Capture diagnoses in M1020/1022/1024

Identify Goals

- Identify – with the patient – achievable goals.
- Goals patients want include:
  - Less pain
  - Healed wounds
  - Less dyspnea (better CHF/COPD management)
  - Effective nutrition with weight gain
  - Less anxiety & depression
  - Enhanced functional ability (ADLs & IADLs)
  - Good self-management of meds & treatments
  - Less ED visits and hospitalizations
Plan the Care

- Determine strategies to move the patient from current status to desired outcomes.
- List strategies on the POC.

Implement the POC

- Assess and observe patient’s status
- Teach recovery & self-management strategies
- Perform procedures & treatments
- Manage and evaluate the care plan

Follow the POC!
And document against POC!
Evaluate – on every visit!

- Is the POC working to progress patient towards desired outcomes.
- If not, revise the POC with Interim/Sup Orders.
- Discharge OASIS
  - Were the goals met?
  - What are the outcomes of our care?

The POC Drives the Care

SOC Assessment
- Discipline-specific assessment
- OASIS assessment
- Home health specific assessment

Plan of Care (485)
- Diagnoses/Problems
- Goals
- Orders

Visit Votes
- Assessments
- Interventions performed
- Response to interventions
Documentation & Knowledge of Coverage

- Coverage is predicated on accurate, completed documentation
- Clinicians/managers/owners need to know the rules
- Effective documentation tells the story
- The details determine the claim’s/record’s destiny

Medicare Criteria for Home Care

- Under care of a physician
- Homebound
- Medically reasonable and necessary care
- Skilled intermittent care
- Communication & coordination of care

All home care criteria must be met in documentation or do not bill Medicare/payer for services!!!
Medicare Criteria
Must be Reflected in:

- OASIS, Assessments and Evaluations
- POC
- Visit Notes
- Communication & Care Coordination
- Discharge Summary/Discharge OASIS

Under care of a physician

Must have orders for:
- All services
  - Add or delete a discipline
  - Change the frequency or duration of any discipline
- Exact and detailed orders for what you do
  - Exact wound care – any changes, need new orders!
    - Sterile water vs. saline
    - Op-site vs. tegaderm
    - Apply ice pack or heating pad
    - Pulse ox, blood glucose testing
- EVERYTHING and ANYTHING!!!!
Under care of a physician

Must do EVERYTHING as ordered:

- Check POC at start of each visit
- Do what is ordered! Or document why not
- Do only what is ordered – or get a new order!

Signed orders need to be in the chart before billing Medicare/payer.

Homebound

1. Criteria 1: Either-Or
   - Because of illness or injury, to leave home, needs:
     - Assistive device
     - Special transportation
     - Assistance of another person
   OR
   - Leaving home is medically contraindicated

AND

2. Criteria 2: And–BOTH
   - Normally patient is unable to leave home
   - Leaving home requires considerable and taxing effort
Still can be homebound if leaves home...

- Frequently for ...
  - Doctor’s appointments or medical care
  - Certified adult day care
- Infrequently and for short duration for...
  - Faith-based services
  - Haircuts/beauty parlor

As long as it takes “considerable & taxing effort” for the patient to get in/out of the home.

Common reasons for homebound...

- Functional deficits
  - Difficulty ambulating, transferring
  - Vision deficit
  - Fraility
- Dyspnea, SOB on ambulation
- Post-op restrictions
- Pain restricting activities
- Cognitive problems
- Patient-environmental considerations
  - Stairs in/out of house
Medicare reviews your documentation for....

- What considerable effort does it take to enable this patient to leave the home?
- What taxing effect does leaving the home have on the patient?

If they don’t see it, they can decide:
The patient isn’t homebound!!!

Documenting Homebound

- SOC documentation needs to paint a clear picture of a patient who requires considerable and taxing effort to leave the home.
  - “Severe DOE, SOB walking across room despite oxygen therapy. Unable to tolerate most ADLs without frequent rests.”
  - “L leg paralysis post recent stroke; unable to bear weight; relies on a wheelchair for movement within his home.”
Documenting homebound...

- Activity restriction: no weight-bearing on left leg; becomes exhausted using crutches.
- Severe osteoarthritis both knees; requires two-person assistance to leave home.
- Stairs into home do not have handrail; patient does not leave home for fear of falling.
- Weight >300 pounds; limits activities to home due to difficulty ambulating.
- Severe weakness and fatigue, becomes exhausted with minimal activity.

Medically Reasonable & Necessary

- Reasonable
  - Services address reasonable goals.

- Necessary
  - Services are necessary for the patient’s diagnoses and assessed needs.
  - Each visit is necessary to meet the patient’s goals.
Skilled Nursing: Considerations for Care/Documentation

1. Observation and Assessment
   • Likelihood of changes in patient's condition
   • Evaluation of pt's need for modification in tx plan
   • Reasonable potential for complications, further acute episodes
   • 3-week observation and assessment for new admissions and for major change(s) in patient status/treatment
   • Longstanding conditions with no attempt to change would not be reasonable
   • Need for frontloaded visits?

2. Management and Evaluation of Care Plan
   • Underlying clinical conditions
   • Skills of RN required to monitor non-skilled care
   • Unskilled services are complex
   • Involvement of skilled nursing needed to promote recovery and ensure safety
   • Documentation needed to support this covered care
   • Most complex patients/high-potential for relapse, etc.
   • Generally multiple co-morbidities, re-admissions, safety concerns, etc.
Skilled Nursing: Considerations for Care/Documentation

3. Teaching and Training
• Skills required to teach vs. the nature of what is being taught
• Continued teaching when not willing or able is not reasonable
• Initial instruction reinforcement (e.g., new for patient, why the teaching is needed, etc.)
• There is no requirement that patient/family caregiver be taught
• Document reasons for re-teaching or retraining (e.g., new caregiver, new problem, etc. The MC Manual lists numerous reasons)

Skilled Nursing: Considerations for Care/Documentation

3. Teaching and Training
• Document patient & caregiver response to teaching
• Any conditions interfering with the teaching
• Safety concerns/conferences with elder protective services, etc.
• Focus on goals, outcome achievement
• Coordinate and communicate essential education
• Important component of the plan of care and carefully managed case management
4. Administration of Meds: IV, IM, SQ
   • Drugs/biologicals excluded
   • Skilled services to administer are covered
   • Medications for safe and effective treatment
   • Administration within accepted Medicare practice standards
   • B12 -- specific anemias, GI disorders and neuropathies per the HHA Manual including pernicious anemia, fish tapeworm anemia and patients with malabsorption or surgical mechanical disorders

4. Administration of Meds: IV, IM, SQ (cont’d)
   • Insulin -- injections covered when patient physically or mentally unable and no other person willing/able, daily insulin visits are the exception to the intermittent rule
   • Prefilling Insulin Syringes -- covered when state law precludes aides from performing and if patient otherwise needs skilled nursing care
5. Tube Feedings Nasopharyngeal and Tracheostomy Aspiration
   • Covered services include replacement, adjustment, stabilization and suctioning of the tubes

6. Nasopharyngeal and Tracheostomy Aspiration (e.g. suctioning)

7. Catheter Care
   • Covered services include insertion, replacement, and sterile irrigation
   • The frequency needs to be appropriate to the type of catheter used

8. Wound Care
   • Three Associated Skills:
     1. Hands on (actual dressing change)
     2. Teaching the care
     3. Observation and assessment for signs of wound deterioration, need for change in dressing to promote optimal healing (infection control, comparison to other wounds, etc.)
   • Documentation must show:
     Wound size, depth, nature of drainage and condition of surrounding skin, description of wound bed
9. Ostomy Care
   • Teaching is skilled
   • PRN visits are appropriate

10. Heat Treatments
    • Requirements for skilled observations and teaching

11. Medical Gases

12. Rehabilitation Nursing

13. Venipuncture (NOT a stand-alone skill)
    • Essential Elements to determine reasonableness:
      1. Physician’s order
      2. Documentation
      3. Recognized treatment
      4. Frequency of testing
      5. Lab results (may) create change in MD orders which may necessitate new teaching
Skilled Nursing: Considerations for Care/Documentation

14. Student Nurse Visits
   • Performed under the supervision of the nurse
   • More important than ever with the shortage

15. Psychiatric Nursing
   • Psychiatrically trained nurses are required to provide these services. These specialty nurses must be approved by the Medicare RHHI. Services include evaluation, psychotherapy, and teaching activities needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment
   • Psychiatric nurses should be competent with other nursing skills
Skilled Therapy: Considerations for Care/Documentation

- **Service may be reasonable if:**
  - Service is complex
  - Consistent with severity of illness/injury
  - Considered specific, safe, and effective for the pt's condition
  - Provided with the expectation that the condition will improve in a reasonable, predictable period of time
  - Teaching exercises, techniques, precautions based on pt's illness or injury
  - Should have rehab/neuromuscular Dx and if focused on goals which are achievable and working toward is the patient making progress?

**Documentation guidelines:**

- Comprehensive assessment utilizing measurable tests (e.g., TUG, Tinetti, etc.)
- Specific goals stated
- Functional capacity and deficits: safety, range of motion, ADLs, mobility, strength, balance
- Changes in functional capacity – describe the clinical condition and status
- Evidence of care coordination with physician, other team members
- Support homebound status and medical necessity
- Describe home exercise program – describe type of exercise, number of repetitions, pounds/weights of each type of exercise
- Plans for follow-up past discharge
Social Work:
Considerations for Care/Documentation

- **Interventions include:**
  - Obtaining community and financial resources
  - Obtaining alternative living arrangements
  - Review of financial status
  - Arrange for meal service, home-delivered medications, etc.
  - Protective concerns
  - Other items where there are impediments to the POC being successfully implemented (e.g., cannot afford medications, no food in the home, safety issues, etc.)

Social Work:
Considerations for Care/Documentation

- **Documentation:**
  - Support medical necessity
  - Communication coordination with physician, other team members
  - Intervention/resolution supporting POC being successfully implemented
  - Pt's problems and goals for SW intervention are clearly stated
  - Unusual home/social environment is documented/identified
  - Clinical findings/developments that impact pt's ability to participate/follow POC
  - Physician orders describing specifically the need for SW
  - All other clinician team member visit notes are congruent with SW documentation (e.g., infestation, pets, financial problems, etc.)
Home Health Aides

Services May Be Reasonable If:
• Services meet definition of covered aide services
• Specific physician’s orders for services
• Clear and specific documentation
• SN, PT, ST needed on intermittent basis
• Where there is a continued need for OT alone (in subsequent recertification periods) the patient meets the requirement for the need of a qualifying discipline and home health aide services can be provided

Home Health Aides

Reasonable and Necessary:
• Incidental services can be provided during the course of the visit as long as the primary purpose of the visit is to provide personal care
• Incidental services: light cleaning, shopping, taking out trash, etc.
• The frequency of visits must be reasonable, depending on patient’s condition
• Documentation in the skilled notes must be able to support the frequency of aide services – this is especially important with daily visits
Home Health Aides

Services Meet the Definition of Covered Aide Services:
- Personal Care
- Hands on personal care needed to
  - Facilitate treatment
  - Prevent deterioration
  - Maintain health

Note: Medicaid Home Care:
Personal Care a main focus of review.

Home Health Aides

Physician’s Orders for Services
- Complete orders identifying visit frequency, duration, and specific care to be rendered
- Personal care, ADL assistance, primary duties

Clear and Specific Documentation That:
- Describes the patient’s functional limitations
- Documents the patient’s ability/inability to perform ADLs and/or personal care
- Support the information and data gathered from the OASIS
Communication & Coordination of Care

- Notify physician, team members & caregivers of:
  - Changes in patient’s status
  - Changes in POC

- Document:
  - All communication & coordination f care!
  - Telephone calls and voice mails
  - Unexpected joint visits
  - Care conferences

Detailed documentation of procedures required:

Documentation of foley catheter change:

- Patient’s/catheter’s condition pre-procedure
- Perineal prep performed
- Catheter type, French size and balloon size
- Amount of fluid used to fill balloon
- Color and amount of urine post catheterization
- Patient’s condition post procedure
Areas for Improvement
Recertification

• Review patient admission criteria (e.g. meet criteria, safety, etc.)
• Is the patient homebound?
• Can family members provide needed care?
• Is the patient improving/changing?
• Evidence of care coordination/communication
• Response to medications, new treatments
• Interdisciplinary referrals timely and documentation supports
• MD orders obtained (complete, timely, specific)
• Lab results and coordination communication
• Progress toward goal/discharge
• Caregiver response coping/support

Areas for Improvement
Recertification (cont’d)

• Medical necessity
• Reasonable and necessary based on patient’s condition
• Intermittent skilled nurse or need for therapy
• Documented changes in care, condition, etc.
• Documentation supports covered care
• Would you admit if patient was a new admission?
• Other considerations
Medical Record = A Good Story

- Admission Assessment/Evals = Set the scene, engage the reader in patient’s problems
- Diagnoses = Open major plot & subplots
- Goals = Foreshadow the end of the story
- Plan = Plot line for each diagnosis
- Implementation = Tell the story; Each Visit Note pulls the plot lines through
- Discharge Summary/OASIS = “...And the patient lived happily ever after.”

The Fundamentals Remain

- Telling the story of the patient and the care
- Receiving appropriate reimbursement for quality care (e.g. outcomes)
- The source for communication, coordination, and evaluation
- Key to avoiding in-depth reviews, etc.
- The basis for payment or denial
- The documentation should show the story of “careful” case management
Where to From Here?

- Continued advances in technology, telehealth, EHR, and related policies, etc.
- The lower cost issue (STILL)
- Population demographics (boomers, older adults, pediatrics, trauma, etc.)
- PPS is continuing to realign the incentives
- Patient safety considerations (e.g. infections, medical errors, misadventures, etc.)
- Customer service, convenience perspectives
- Medicare is changing (e.g. homebound, ALS, etc.)
- The groundswell of support for change for community-based, chronic care and prevention focused care model
- But will not stay the same . . .

Where to From Here?

Why Home Care Will Survive/Thrive

- DRGs continue with goals of decreased beds, cost, and LOC
- Heightened patient consumerism – patient choice (e.g. sometimes whether we agree or not)
- ACA, independence at home model
- Chronic care management
- Transitions in care
- Rebalancing of LTC spending continues
- Demo grants for Aides, etc.
- Present: 2,734,000 home care nurses; 26% projected growth by 2020
“To Live in an evolutionary spirit means to engage with full ambition and without any reserve in the structure of the present and yet to let go and flow into a new structure when the right time has come.”

Jantsch