Patient Advocacy Through Documentation

Collaboration Between Nursing and Rehab

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AGENDA

- Review Various Audit Types
- Components of Good Rehab Documentation
- Collaborative Documentation
- Examples/tools

Patient Advocacy??

- How is documentation, advocacy?

Patient Advocacy??

- How is documentation, advocacy?
- It’s ALL we have to validate that our services were skilled.
- Audit entities don’t see our patients.
- They only see what we write.
- What we write secures payment for our services today….
- And services for patients of the future!

Medicare Claims Review Entities

- Medicare Administrative Contractor (MAC)
- Recovery Audit Program (RAs-formerly the RAC)
- Comprehensive Error Rate Testing Contractors (CERT)
- Zone Program Integrity Contractor (ZPIC)

MAC (Cahaba for TN)

Goal: PREVENTION

How? Through Progressive Corrective Action (PCA)

- Pre and post-payment review
- Probe Review
- Targeted Medical Review
- Education

Recovery Audit Program (RA)

RA for Tennessee: Connolly

Goal: DETECT AND CORRECT

How?

- Post-payment claims review
- Pre-payment in some states
- Widespread or Targeted review

$3700 Threshold

- No longer being conducted by RAs.

- CMS has contracted with StrategicHealthSolutions to perform targeted postpayment medical review of Part B therapy services over the $3,700 threshold.

- StrategicHealthSolutions has begun sending out Additional Development Requests (ADRs) to providers that have been selected for a targeted review.

Threshold Reviews Cont.

- According to CMS, they have tasked Strategic Health Solutions, a medical review contractor, to target the following:
- Providers with a high percentage of patients receiving therapy beyond the threshold as compared to their peers during the first year of MACRA (Peers means that SNFs will be compared to other SNFs; outpatient clinics to other outpatient clinics, etc)
- Therapy provided in skilled nursing facilities (SNFs), therapists in private practice, and outpatient physical therapy or speech-language pathology providers (OPTs) or other rehabilitation providers
- Of particular interest in this medical review process will be the evaluation of the number of units/hours of therapy provided in a day

Comprehensive Error Rate Testing (CERT) Program

Goal: MEASURE

How?

- Randomly select statistically valid sample of claims
- Post-payment review
- Publish results annually
  - Used to guide provider education

Top CERT Denial Reasons for SNF

- Insufficient documentation to support medical necessity of the service.

Zone program Integrity Contractors (ZPIC)

Goal: IDENTIFY POTENTIAL FRAUD

- **Perform data analysis and conduct medical review**
- **Conduct interviews**
- **Conduct onsite visits**
- **Investigate fraud and abuse**
- **Refer cases to law enforcement and OIG**
- **ZPIC in TN = AdvanceMed Corporation**

Back To Advocacy

- Regardless of who is looking or why…..
- It is the documentation they will look at.
- Each patient comes to us with a history and a story.
- Our job is to tell that story.
- That's the ONLY way to advocate for the services they deserve!
- As well as advocating for patients of the future.

What To Expect From Good Rehab Documentation (Applies To Nursing As Well)

- **Each patient is an individual.**
- **Their medical record is their story.**
- **This story has 2 characters: The patient and the therapist/nurse.**
- **COVERAGE REQUIREMENTS**
  - MEDICAL NECESSITY = the patient
  - SKILLED SERVICES = you
    - Denials occur when either Medical Necessity or Skilled Services is not convincingly described.
    - Or….when there are obvious conflicts in the story (such as discrepancies between what therapy says vs. what nursing says or between what MDS says and the rest of the medical record says)

Medical Necessity

The Patient's Story explaining the need for skilled intervention at this time-whether it's the SOC or at intervals throughout the episode.

- The change in function related to the recent medical history.
- The Medical Diagnosis
- The co-morbidities and complexities
- The Functional Deficits impacting daily life
- The Underlying Impairments that are causing these Functional Deficits

Medical Necessity

- **What changed and why?**
- **Why now?**

- **Medical Necessity defines the need for Skilled Services**
  - Medical Necessity must be defined at SOC and at regular points throughout the episode of care to justify the need for skilled intervention.
- **What makes this patient so complex that they will only improve (or maintain) through your skilled treatment?**
  - This must be clear throughout the episode of care.

Skilled Service

<u>**Your Story**</u> explaining what you are doing during treatment sessions or nursing interventions.

- Describes **why you?**

The services that only therapists or nurses are qualified to provide because of our specialized training and knowledge.

Analysis and Adjustments

Therapy MUST provide this in notes:

- Analysis

- The thought process that goes on as the patient progresses through a task. What is observed, assessed, perceived and judged.

- Adjustments

- The adaptations, changes, variations and progressions that are made during treatment. Changing the task, the environment, the cues etc according to the analysis.

Skilled Analysis-Must Be Described

SO WHAT?? TELL ME WHY??

- WHY did the patient progress? WHAT underlying impairment improved to cause the functional progress?
- WHAT are the current challenges?
- WHAT is so complex about this patient's condition that they cannot continue on their own or with a caregiver?
- WHY is there a variation in the patient's abilities throughout the day or over the past week?

Skilled Adjustments

- The skilled adjustments are the decisions made based upon skilled analysis.
- If we don't describe the treatment decisions and adjustments, the intervention will appear repetitive.

- REPETITIVE SERVICES = DENIAL

Your Thoughts

MEDICAL NECESSITY and SKILLS NEEDED: Skilled nursing perspective?

CMS Example

MEDICAL NECESSITY and SKILLED SERVICES : Nursing perspective

Example:

- Patient with pneumonia, chest congestion, confined to bed, confusion.
- Immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of relapse. Skilled overseeing of the non-skilled services (position changes and deep breathing) would be reasonable and necessary
  - "Documentation must illustrate the complexity.."

Your Thoughts

MEDICAL NECESSITY and SKILLED SERVICE: Rehab?

CMS Example

MEDICAL NECESSITY and SKILLED SERVICE: Rehab

CHF, diabetes, prior amputee both LE's.

Training in bed mobility, transfer skills, functional activities at wheelchair level.

CMS Words-Benefit Policy Manual

- " …coverage of skilled nursing and skilled therapy services…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."
- "…While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case…"

Documentation Examples

Would this be a problem?

Therapy says: Gait training and strengthening exercises

Nursing note says: Patient walks ad lib.

Both statements are technically true.

Medically necessary?

Skilled need?

The REAL Story

Therapy: Patient has a low score on the Berg balance test, has difficulty with foot clearance during gait. In addition, O2 sats drop to 88 after 4 minutes of moderate activity. Hip flexors at 3/5 strength which impairs the ability to obtain good foot clearance.

On unit: Patient walks ad lib, but appears out of breath after a few minutes. Often reaches for rails or furniture to steady self. Gait is not fluid.

Is This Better?

Therapy says: High risk for falls due to results of Berg. Increasing balance challenges and leaving base of support. Focusing on hip flexor strength to improve foot clearance. Training in diaphragmatic breathing to improve O2 sats.

Nursing note: Patient able to walk independently but gait is impaired. Note breathlessness after short intervals.

Is medical necessity more obvious? How about skill?

Collaborative Documentation

- **If discrepancy exists, nursing documentation will win.**
- **Medicare views nursing documentation to be representative of what is actually happening functionally on a day to day basis.**
- **Communication is fundamental – more on this later…**
- **Barriers to this:**
  - MDS
  - 24/7 vs. 1 hour a day
  - Patient time for nurses vs. nurse aides vs. therapy staff
  - Time to talk/collaborate

A Word About ADLs

- Are you confident in ADL coding?
- Does it align with what rehab is saying?
- Patient may be more independent in rehab then on the MDS.
- What if MDS says they are MORE independent than rehab?
- Likely denial

ADL examples

- Patient rolls side to side in bed by using half rails. They do this independently. Coded as such on MDS
- Rehab has goals for bed mobility and rates them "mod assist"
- Both statements may be accurate.
- ADL may have been coded based upon only part of the description.
- Rehab may be focusing on supine to sit, not rolling.
- Bed Mobility MDS: "how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture."

ADL Example

- OT working on clothing adjustment while toileting. Focusing on balance and use of adaptive equipment to facilitate this action.
- On unit, patient transfers on and off toilet independently. Coded as such on MDS.
- MDS: Toilet Use: "how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination, changes pad, manages ostomy or catheter; and adjusts clothes.
- Discrepancy = denial

ADL Example

- Patient eats and drinks by himself. Coded as independent.
- OT working on fine motor skills and grip strength to facilitate independence with eating as he wishes to live alone. Currently unable to open milk, cut food or open condiments.
- Discrepancy = denial
- MDS: Eating: “ how resident eats and drinks, regardless of skill.”
- Would this patient actually be “1” or supervision?

MDS

- Does not make collaboration easy!
- It is possible to make great gains in rehab (i.e. from max assist to min assist) but the MDS will remain the same at “extensive”
- “Extensive” on MDS equates to min/mod OR Max assist in rehab documentation. It implies nursing staff needs to actively guide and touch with more than “palms up” approach.
- “Limited” assist on MDS implies “palms up” only approach. It equates to CGA assist in rehab documentation.
- Good first step is to understand each others’ lingo

Rehab Lingo

- Independent: No assistance
- Modified I: No assistance but needs equipment or more time
- Supervision: Observe from a distance, may need cues or set up, no physical assist
- SBA: Close supervision, no physical assist
- CGA: Minor contact may be necessary. May be unsteady
- Min: Patient routinely needs 25% assist (can be physical or cognitive assist)
- Mod: Patient routinely needs 50% assist
- Max: Patient routinely needs 75% assist
- Dependent: Needs 100% assist

24 and 7 vs. 1 hour

- Patients belong to nursing. They are yours 24 and 7!
- Rehab sees them about 1 hour a day.
- Rehab needs to communicate what the patient is capable of and how.
- Nursing needs to communicate when/why it's not possible.
- If the barriers to capability are related to underlying impairments rehab treats, (and this is documented), it all helps to tell that story. The story of skilled need.

TIME

- Nurse aides often spend the most time with patients.
- They record information such as ADL statistics
- But who writes the notes??? Nurses.
- How confident are you that aides are passing on information that is detailed and accurate?
- Do they understand the full definitions in the ADL section of the MDS?

Example

Aide sees: Patient required assist with lowering legs out of bed for transfer. Needed limited assist for transfer from bed to w/c. Needed help to put shoes on. Loses balance when making the turn in to the bathroom. Cues to use walker correctly and safely. Drinks thin liquids but coughs when using a straw.

Medical record charting is accurate but says only: “Alert and verbal. Patient ambulates ad lib. Takes thin liquids.”

TIME – Rehab Perspective

- Often use assistants, but therapists see what they do, read/co-sign notes. Our barrier is not as great as the aide/nurse divide.
- But…..therapists dislike documenting as much as nurses.
- Rehab departments have productivity standards just like most industries. It's reality.
- Documentation time is NOT considered a billable service.
- Point of service is often an option.

Breaking News!! Section GG
(slides 40 – taken from SNF QRP training on 6/21/16 per CMS)

- •The Improving Medicare Post-Acute CareTransformation Act of 2014 (IMPACT Act) requires that CMS implement cross-setting quality measures, and the items in Section GG are used to calculate this measure.
- •These items assess the need for assistance with self-care and mobility activities.
- •Items focus on resident’s self-care and mobility:
- –Admission performance
- –Discharge goals
- –Discharge performance

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Section GG: Which Staff Members Should Complete This Section?

- •Refer to facility, Federal, and State policies and procedures to determine which staff member may complete an assessment, as resident assessments are to be done in compliance with facility, Federal, and State requirements.
- •Physical therapists, occupational therapists, speech language pathologists, and nurses are the typical staff involved in the assessment of self-care and mobility items.

GG0130: Self-Care – Admission (Start of SNF PPS Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by h.../herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SET... UP; resident com...tes activity. He...

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
Not attempted due t... **...dical**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

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GG0130: Self-Care – Discharge (End of SNF PPS Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper ...

3. Discharge Performance	
Enter Code	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
Enter Code	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
Enter Code	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

GG0170: Mobility (3-Day Assessment Period) Admission (Start of SNF PPS Stay)

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to safely get on and off a toilet or commode.
		H1. Does the resident walk? 0. **No**, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. **No**, and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		Q1. Does the resident use a wheelchair/scooter? 0. **No** → Skip to GG0130, Self Care 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair/scooter used. 1. **Manual** 2. **Motorized**

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GG0170: Mobility (3-Day Assessment Period) Discharge (End of SNF PPS Stay)

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

3. Discharge Performance Enter Codes in Boxes	
[ ][ ]	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
[ ][ ]	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
[ ][ ]	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
[ ][ ]	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
[ ][ ]	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
[ ]	**H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
[ ][ ]	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
[ ][ ]	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
[ ]	**Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
[ ][ ]	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
[ ]	**RR3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
[ ][ ]	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
[ ]	**SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

Scoring Example

06. **Independent**

Code the resident's usual performance at the end of the SNF PPS stay for each activ[ity] ... [activity w]as not attempted at the end of the SNF PPS stay, code the reason.	
Coding:	
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.	**If activity was not attempted, code reason:** 07. **Resident refused.** 09. **Not applicable.** 88. Not attempted due to **medical condition or safety concerns.**

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Verbiage

- Residents should be allowed to perform activities as independently as possible, as long as they are safe.

- If the resident's mobility performance varies during the assessment period, **report the resident's usual status**, not the resident's most independent performance and not the resident's most dependent episode.

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Collaboration Strategies

- **The Medicare Meeting:**
  - All have one
  - Make it count
  - Ask: “What’s the need?” “What’s the skill?”
  - Write the note during the meeting
  - Function or problem oriented
  - Consider nurse aide in attendance
  - Tools to facilitate this conversation to follow

Collaboration Strategies

- **Join a therapy session**
  - Perfect opportunity to talk to patient and therapist about status and progress and continued needs
  - Perfect opportunity for point of service documentation

Tools

- Can be used in Medicare meeting
- Or other face to face times (in a therapy session)
- Used by aides as they work with patients
- Left at nurse's station as documentation guides

FUNCTIONAL ABILITY

Date: ________________ Resident: ____

Medical Diagnosis: ____

Therapy/Treatment Diagnosis: ____

This checklist is designed to assist the charting nurse in describing the patient's functional ability on the unit. The intent is to help facilitate nursing documentation that is functional in nature and reflects the patient's performance as it relates to their rehab program. The rehab activity or program is checked and corresponds to suggested patient activities, or functional performances which might be noted in the nursing narrative.

Occupational Therapy

Rehab Activity **Suggested Nursing Observation/Documentation**

____Feeding Describe patient's ability to feed self. This comment should include any set up needed, as well as any assistive devices the patient is using. Is there any cueing required? (example: The patient feeds self 50% of meal using a built up spoon and plate guard.)

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Tools

- Can be checked by rehab and left on unit.
- Each discipline has a page.
- Each discipline has functional areas.
- Functional areas have suggested focus areas for documentation.
- Lends itself to individualized documentation, less “cookie cutter” than sample phrases.
- How might this be useful to you?

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Physical Therapy

Documentation to support the need for PT

Resident requiring additional assistance to walk due to _______________ (loss of balance, falls, unsteadiness, weakness in legs, etc.)

Resident has had episode(s) of near falls

Resident demonstrates decreased walking distance with unsteady gait. (i.e. was walking to the dining room but now only walking in room)

Resident appears fatigued or SOB with ambulation

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Documentation to support progress made with SLP

SLP provide training on use of external memory aid. Patient able to use to remember ….

SLP provide training to on appropriate positioning to reduce patient specific swallowing issues. Less coughing noted during meals.

SLP provided training on how to elicit yes/no responses from patient. Patient now able to select clothing for the day.

Tools

- Useful guide for both establishing the need for rehab as well as support for continued need.
- Can be used during Medicare meeting.
- Can be used at nurse's station.
- Discipline specific.
- Not accompanied by functional areas and can be "cookie cutter".
- How might you use this??

CHECKLIST FOR COLLABORATIVE DOCUMENTATION FOR THERAPY SERVICES

_____Transfer ability

_____Ambulation

_____Assertive device needed—if so what

_____Number of feet ambulated

Tools

- Easy to read
- Focus areas can be pre-checked by rehab.
- Can be left at nurse’s station.
- Useful reminder, but not very specific to each week’s status.
- How might you use this??

Nursing Documentation <u>suggestions</u> to support…..PT…..OT…..ST

*****PT*** Nursing Documentation Examples**

Bed mobility	**Resident holds onto bed rail to pull self onto R or L side. Pillow is placed between knees.**
Transfers	**Resident sits with assistance but cannot stand up without assistance of 2 nursing staff, OR Resident needs assistance of 2 nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.**
Walk in room Walk in corridor	**Working with therapist on ambulation training. Unsafe with nursing staff.**

Tools

- Discipline specific.
- Identified functional areas.
- One page.
- Can be left at nurse’s station.
- Could become repetitive.
- How might you use this???

Problem | **What to document**

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Tools

- May be useful to support the medical necessity for rehab.
- Specific to positioning.
- Some opportunity for individualization.
- How might you use this???

Additional Tips/Thoughts

- **Does rehab audit their documentation?**
  - Timeliness
  - Completeness
  - Quality audits
- **Is there an opportunity to view nursing doc and rehab doc side by side?**

Education

- Newer therapists (and older) often do not understand the importance of doc.
- Is this true for nurses as well?
- What education is provided to nursing staff?
- Education or “tip sheets” for aides on ADL definitions.
- Does your rehab provider mandate documentation training?

Questions

Thank You