Defensible Documentation in Home Health

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Objectives

At the completion of this session, participants will:

1) Understand the purpose in providing defensible documentation in a succinct and accurate clinical record.

2) Educate staff on the importance and rationale behind defensible documentation.

3) Implement measures to safeguard clinical documentation when under review scrutiny.

4) Understand the documentation requirements for Medicare and other payers as well as the consequences that can arise in the form of various types of regulatory audits for failing to have defensible documentation.
What is Defensible Documentation?

• Documentation that can *withstand tough scrutiny* and prove to a variety of stakeholders that the agency is providing consistent, high-quality, and compliant care.

• Defensible documentation *begins with creating a plan of care (POC) that is appropriate for a patient’s diagnoses and/or conditions and ensures that clinicians and caregivers are following that POC* and creating a medical record to reflect compliance.

• The documentation is defensible because the *recording of the care provided is a mirror image of the plan that was ordered*, along with meeting all regulatory guidelines.
Home Health Risk Areas

Who defines risk areas, and how are they looking at them?

• CMS
• Office of Inspector General (OIG)
• Medicare contractors (MACs)
• Others: MedPAC, CERT, law enforcement
Why is Defensible Documentation Important?

- Increased regulatory scrutiny
  - CMS Audit and Recovery Programs
- HIPAA requirements and increased scrutiny
- Federal, state, payer requirements
  - Conditions of participation
  - Conditions of payment
  - OASIS
  - NCDs and LCDs
  - State specific home health regulations
  - State Practice Acts
- Value based purchasing and STAR ratings
- Accrediting organization standards
- PDGM
Why is Defensible Documentation Important?

• Risk Areas Included in PEPPER
  – https://pepper.cbrpepper.org/

• Home Health:
  – Average Case Mix
  – Average Number of Episodes
  – Episodes w/ 5 or 6 Visits
  – Non-LUPA Payments
  – High Therapy Utilization Episodes
  – Outlier Payments

• High risk areas can lead to UPICs
Preparing for Increased Scrutiny

- **Strong Compliance Team** – compliance officer and team is fully educated on their duties to ensure compliance across Medicare and Medicaid reimbursed services.

- **Solid Compliance Plan** – CMS coverage guidelines, billing and coding protocols, staff hiring and training protocols, documentation guidelines, and HIPAA/HITECH education and outsourced resources, as needed.

- **Schedule Internal & Third Party Audits** – periodic and random audits of patient records, billing documentation, provider signatures, and EOBs.

- **Effective Compliance Enforcement** – Staff must have real consequences for failure to adhere, including additional training, mandatory observation, and escalation proceedings.
Purpose of Defensible Documentation

• Technical and eligibility requirements both upon admission and ongoing throughout the plan of care.
• Clinician practice act requirements are met.
• Providing the correct and accurate type of documentation from the beginning.
• Referral and intake, admission of the patient onto service, OASIS review and coding, medication assessment, discipline specific evaluations, and plan of care are all consistent.
• Measures to intervene and apply rigorous review on the back-end.
What if Not Defensible?

What happens if documentation is not defensible?

- Financial impacts
  - CMS reported a $29.4 billion recovery to Medicare trust funds since 2009 inception
  - How would your agency be impacted?
    - Individual episode or sample size based off census
      - LUPA
    - Future Referrals
      - HHCAPs and 5 Star ratings
    - Operational expense
Measures to Safeguard Documentation

- Prebilling Audits
- QAPI Program
- Education and Training
- Remediate EMR Challenges
Prebilling Audits

Regulations apply to everyone.

• Defensible Documentation is a shared responsibility.
• Intake staff-
  – hospital discharge summaries
  – complete face to face documentation
• It takes a community to birth a good face to face but it’s worth the labor pains!
• Best practices-care transition team member-narrative note of significant findings.
• Clarify unspecified codes.
• Obtain the physician’s H&P (ex.to determine any late effects from a stroke).
QAPI Program

- New COP requirement
- Participation/Representation
  - Clinical leaders
  - Clinicians to provide Peer-to-Peer review
- EMRs and data analytic applications
  - Can you really afford NOT to have a good data analytics program in today’s regulatory environment?
QAPI Program

• Most common documentation problem
  – Disconnect between assessment and the plan of care.
    ▪ Interventions are generic and on every patient’s plan of care.
    ▪ Important treatment orders are missed.
    ▪ Condition level citations.

• Other common areas of concern
  – Recertification documentation is weak to support medically reasonable and necessary.
  – Lack of complete narratives of clinically significant findings to support recertification.
  – SOCs - Lack of identification of the qualifying skill and other skills.
  – Omission of specific orders for wound care.
Education and Training

- Interactive online training, incorporating legal and regulatory requirements.
- Content presented in segments or groups with phased approach;
  - OASIS room to room interactive learning
- Instruction, then application with a mentor.
- Orientation progression to follow the paper trail from intake to billing so that the “big picture” is understood.
- What are necessary components of a billable visit?
EMR Remediation

• Documentation should paint the picture
  – Interventions provided
  – Patient response to teaching and care
  – Plan for next visit
  – Care coordination

• New COPs
  – Patient specific interventions and education
  – Measurable outcomes and goals that are identified by agency and patient
  – Advance Directive Information on the POC
  – Risk Assessment for Emergency Room and/or Hospitalization on the POC with specific interventions
EMR Remediation

• Intervention/Goal Pathways in the EMR
  – Save Time
  – Can increase standardization of care and best practice guidelines
  – Can lead to generic interventions or goals that are not measurable

• Prefill features
  – Save Time
  – Can lead to nightmare scenarios

• Templates
  – Beneficial to prompt the clinician to include all necessary components of complex procedures
  – Balance templates with good clinical narrative summaries
  – Documentation should be customizable and specific for each patient
  – Templates should enhance the clinical picture, *not replace it*
EMR Challenges

- Authentication, Electronic signatures, Titles
- Gaps and EMR utilization/implementation
- Clinical inconsistencies and incomplete clinical assessments (ex. wounds)
- Robust audit program
  - Cloned documentation
  - Pre-fill concerns
How Can Technology Help Achieve Defensible Documentation?

• Efficient functionality
  – Referral entry
  – F2F
  – SOC/POC
    ▪ Homebound status
    ▪ OASIS questions
    ▪ Problem statements/Interventions and goals/Treatment orders
    ▪ Wound documentation
    ▪ Narrative
  – Clinical oversight
    ▪ Patient progress reports
    ▪ Packet review process

• Operational model
  – Clinicians primary function is patient care
  – Timely documentation

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Medicare Documentation Requirements

• Homebound status
  – Documentation is often vague and generalized
  – Best Practice is using recent CMS guidance to document homebound status with criteria 1 and criteria 2
    ▪ Taxing effort, weakness, inability to drive still being used
  – Best Practices-documentation provides a structure that supports the regulation terminology, like criteria 1 and criteria 2

• Important to train clinicians to think about the homebound and medical necessity requirements before they knock on the door.
  – Anticipate a plan B if they are not homebound
How Does a Home Health Agency Achieve Defensible Documentation?

• Interactive Training
• Break bad habits
• Peer-to-peer review
• Leveraging Technology

• Good defensible documentation requires a mix of free-text assessment and a detailed plan for the next visit, to demonstrate the clinician’s critical thinking skill.

• Go beyond reporting the response to treatment in a single visit.
  – CMS is looking for agencies to “tell a longitudinal story over time”.

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Recommendations for Defensible Documentation

• Primary diagnosis-F2F/Physician Certification
  – Multi-faceted approach to ensure requirements are met

• Diagnosis and primary reason for home health
  – Consistent throughout the entire record
  – Clarify any inconsistencies immediately

• Review and revise processes if not efficient and effective
  – Coding
  – OASIS
Recommendations for Defensible Documentation

• Case conferencing
  – Start at admission
  – Interdisciplinary
  – Forecasted number of visits = orders = assessment
  – QA reviewer participation
  – Incorporated into the patient record

• F2F encounter = primary reason for home care = physician certification

• Avoid trends of multiple changes to OASIS
Recommendations for Defensible Documentation

- Clearly articulate and document problems & realistic home health goals
- Document to support coverage criteria
- Implement disease pathways
  - Support the clinician’s decision based on assessment
  - Process methodology based on best practices for interventions, goals, problems and visit strings
Recommendations for Defensible Documentation

- **Disease pathways** to support the clinician’s decision making process for interventions, goals, problems and visit strings.

- **Provide objective information** to support interventions and progress towards goals other than “patient verbalizes understanding.”
  - Document objective data such as change in behavior of patient or caregiver in managing disease process.

- **Documentation should support medical necessity**
  - Reason for education
    - Who was taught and why if patient has memory deficits
  - Reason for Observation and Assessment
    - Why is patient at risk for further instability
Recommendations for Defensible Documentation

• High Risk Areas
  – Assisted living facilities
  – Memory care units
  – Discussion and approval of the POC
  – F2F corroborating documentation
  – Physical therapy for patient ambulating 250-300 ft and greater
Discipline Specific Recommendations

Nursing

- Interventions performed included in the POC.
- Include detailed procedure documentation, including each supply used, flush given, appearance of site following venipuncture.
- Use coverage guideline language and identify the qualifying skill and other skills reimbursable by Medicare.
- Physician notification outside of patient parameters specified on POC.
Discipline Specific Recommendations

Physical Therapy

• Avoid abbreviations!
• Standardized/objective tests and patient progression.
• Missed visit patterns inconsistent with other disciplines.
• Physician notification for patient parameter outliers (pain).
• Implement disease pathways for chronic conditions
  • Assist with appropriate utilization
Occupational Therapy

• Avoid abbreviations!
• Personalize patient goals and importance to patient.
• Objectively document improvement or lack of in ADLs.
• Avoid gray areas of duplication with PT.
Discipline Specific Recommendations

Speech Therapy

- Include specific testing results if completed (swallow exam).
- Document type of diet and ensure caregivers understand and articulate the physician-ordered diet.
- Document progression in the dietary plan.
- Update safety measures.
- Utilize HHAs for patient progression toward goals and safety.
Discipline Specific Recommendations

Social Worker

- Set realistic and measurable goals for the patient and family to reach.
- Document specifics of referrals made and information given to patient and family—people, places, organizations, services.
- Document noncompliance clearly.
- Provide follow-up and document.
Discipline Specific Recommendations

Home Health Aide

• Care plan specifies exact level of care to be provided and how often.
• Supervision reflects evaluation of the aide’s compliance with following the care plan.
• Personal care provided each visit.
Examples - Defensible or Not?

Homebound

• “Taxing Effort to leave home, requires walker”.

• Patient requires walker for safe ambulation due to shuffling gait and high fall risk 2nd to Parkinson’s disease.

• Patient requires a walker and supervision to ambulate safely due to advanced Alzheimer’s Disease.

• Due to severe COPD and low oxygen levels, the patient requires assistance in all ADLs, ambulation, and leaving home from his caregiver.
Examples - Defensible or Not?

Skilled need

- Patient tolerated treatment well.
- Caregiver instructed in medication management.
- Continue with POC.
They are all basically looking at the same requirements:

- Accurate and complete assessments, case planning that is individualized to the patient, care plan is being followed, eligibility requirements.
- Trend-condition level citations for agencies with long history of clean surveys.
- Best practice-documentation that speaks the same language as the regulations and supports that patient’s needs were met and the care plan was followed.
Industry Trends

- Joint Commission
- ACHC
- CHAP
- OASIS & Coding
- PDGM
Achieving the Goal
QUESTIONS?

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FREE PEPPER Report Analysis Session offered to NEHCC attendees!

Contact Chris Pearce at cpearse@corridorgroup.com