Prevent Denials of Medicare Reimbursements through Effective Clinical Documentation

Amy Lane BSN, RN

Becky Smith MSN, RN, LNHA, RAC-CT, RAC-CTA

MOMENTUM

2023 ANNUAL MEETING & EXPO

Renaissance Schaumburg
Convention Center - Schaumburg, IL

Objectives

- Identify systems that must be in place to ensure proper documentation to secure coverage and payment
- Develop processes that ensure documentation is consistent, accurate, and provides for maximum reimbursement of services
- Determine common pitfalls that can delay cash flow and may result in bad debt

Identify systems that must be in place to ensure proper documentation to secure coverage and payment

- Medicare Eligibility
- Physician certification
- Physician orders
- Documentation to support coverage

Medicare Eligibility Requirements

3 Day Qualifying Hospital Stay

Must be in a Medicare certified bed

Days available in Benefit Period

30 Day Transfer Rule

Practical Matter

Medicare Coverage/Skilled Care

3 Day Qualifying Hospital Stay

Medicare Certified Bed

- Beneficiary must reside in a Medicare Certified Bed in order to receive payments for services rendered

Benefit Period

- Up to 100 days if patient meets level of care criteria
- Ends after 60 consecutive days of non-skilled level of care
- No limit to number of benefit periods

30 Day Transfer Rule

Met if the SNF stay begins within 30 days of discharge from the hospital or if the beneficiary resumes skilled care in a SNF within 30 consecutive days after the first day of noncoverage (Medicare Benefit Policy Manual, Chapter 8, 20.2).

If a beneficiary discharged home following a qualifying hospitalization	If a beneficiary utilized days in a SNF and discharged from skilled services	Must have days remaining in current benefit period	Do not count day of discharge from hospital in the 30 day count

Practical Matter

- “As a practical matter, daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be”:
  - An excessive physical hardship
  - Less economical; or
  - Less efficient or effective than an inpatient institutional setting

Medicare Benefit Policy Manual, Chapter 8, 30.7

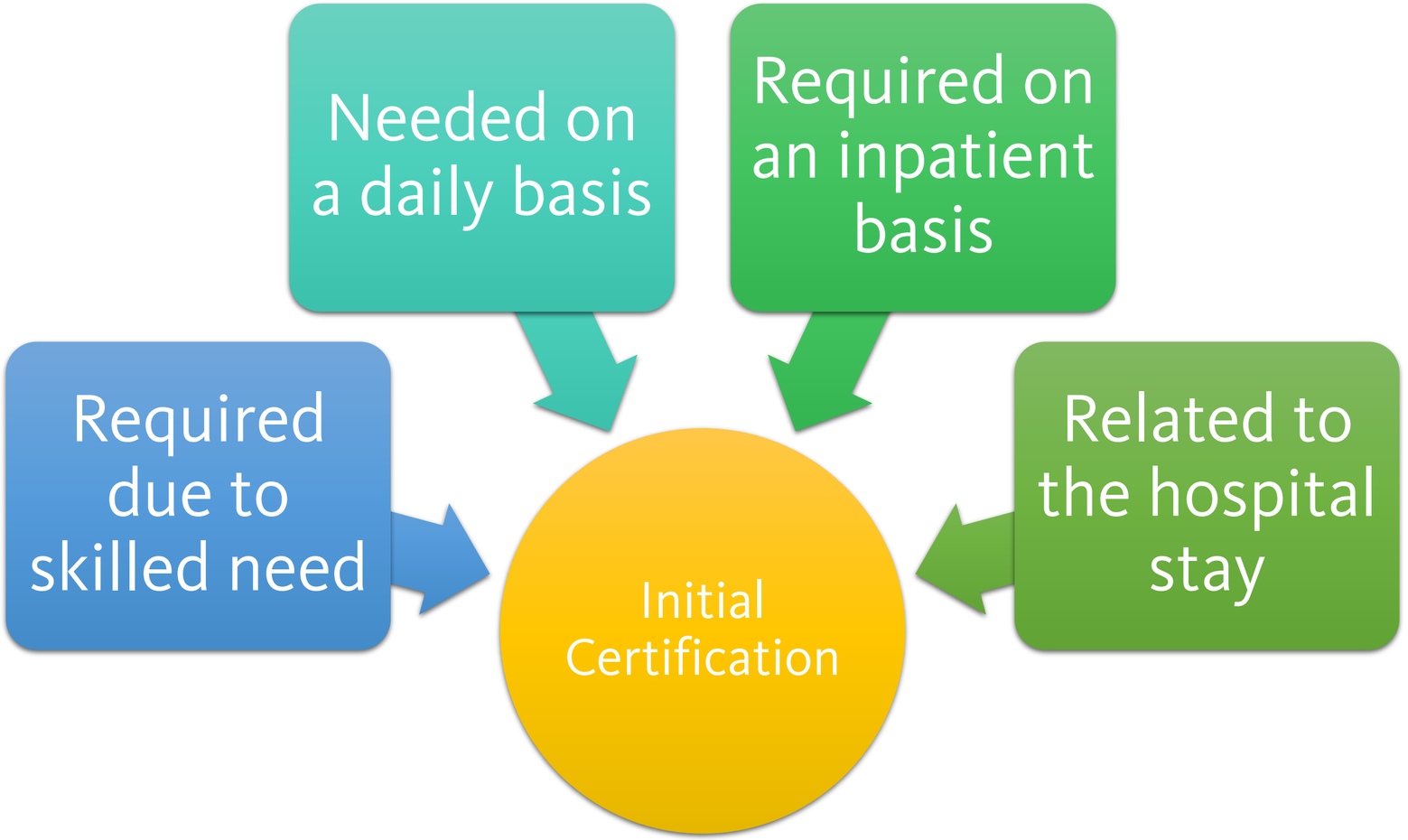
Medicare Coverage/Skilled Care

Care in a SNF is covered when all of the following are met (Medicare Benefit Policy Manual, Chapter 8, 30)			
Requires skilled nursing or rehabilitation services	Requires skilled services on a daily basis	Skilled services can only be provided on an inpatient basis in a SNF	Services are reasonable and necessary

Physician Certification

- Initial Certification
- Re-certification
- Accepted signatures

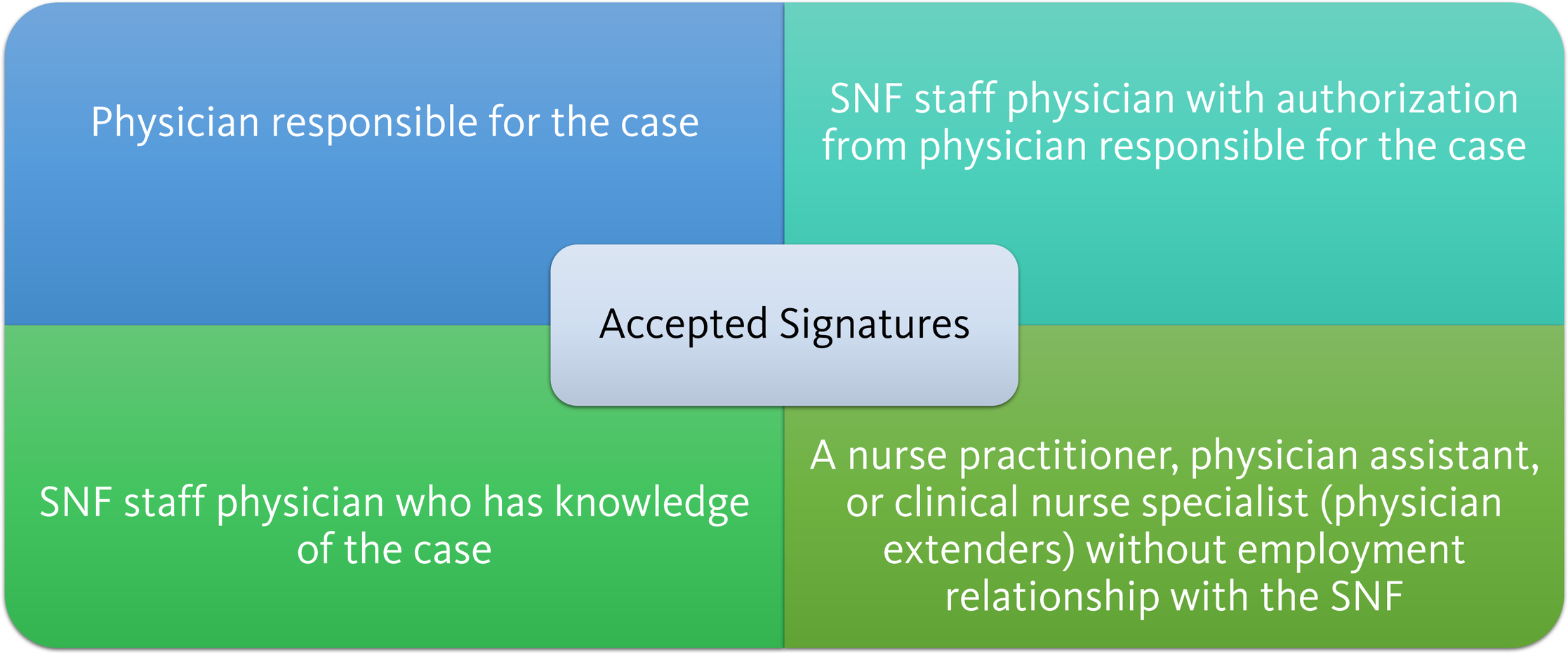
Physician Certification



Physician Certification

- 1st recertification is required no later than the 14th day of posthospital SNF care and occurs every 30 days from the most recent signature date thereafter.
- The physician may sign the initial certification and the first recertification on admission
- Recertification statement **MUST** include
  - Written record of the reasons for continued need for SNF services
  - Estimated period of time the patient will need to stay in the SNF
  - Plans for home care
  - A note, if appropriate, continued stay is needed due to a condition that arose after admission while still covered for the hospital-related care

Physician Certification



Physician Orders

- Skilled nursing or rehabilitation services are those services provided in accordance with physician orders that:
  - Require the skills of qualified technical or professional health personnel (i,.e registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists and
  - Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel
- Make sure all physician orders are signed (may be handwritten or electronic)

Documentation to Support Coverage

- Chart documentation is the vital link between care delivery and payment for care, services, and intensity of services provided. Documentation must prove consistently that care was:
  - Needed on a daily basis
  - Needed at a skilled level
  - Ordered by the physician
  - Delivered as ordered
  - Reasonable and necessary
- Supporting documentation examples include: daily skilled notes, physician orders, therapy plan of care, physician certification, care plans, progress notes

SNF Documentation Elements

SNF Documentation Elements

- Description of functionality
    - A detailed description of functionality includes what the resident can do, what assistance the resident needs to accomplish the tasks, and how many staff are required to assist the resident. Also, goals for attaining and/or maintaining function can be included. Optimal documentation considers the different components of a task. For example, be specific about a resident's abilities related to upper body and lower body dressing

SNF Documentation Elements

- Description of functionality
    - Describe both resident performance and level of staff assistance and variances across shifts and times of the day. Variances should be expected—if documentation demonstrates the same level of resident performance and staff assistance for each shift and each day, it would be wise to assess the resident and interview direct care staff who care for the resident. Variances are actually a good way to support the need for therapy. They can show the resident is capable of doing something but needs to increase consistency.

SNF Documentation Elements

- Evidence of diagnostic monitoring and interpretation
  - Vital signs, oxygen saturation levels, etc.
  - Diagnostic labs (e.g., blood glucose monitoring, anticoagulant therapy, diagnostic studies)
  - Evidence that diagnostic monitoring was read, understood, and the necessary interventions were put in place as a result of the test outcomes

SNF Documentation Elements

- Documentation of cognitive performance
  - Cognitive decision-making skills; ability to follow instructions, carryover of learned tasks; short-term/long-term memory; variance of mental function over the course of the day
  - Documentation for cognitive performance should be incorporated into overall documentation of the resident's performance and participation throughout the day. Specific examples help describe both cognitive performance and memory.

SNF Documentation Elements

- Documentation of cognitive performance examples
    - Example: “Resident required frequent cueing to remember to lock his wheelchair.
    - Example: “Resident was able to select clothes to be worn today without prompting or cueing from staff”.
    - Example: “Resident reminded frequently throughout the shift that his daughter would call him at 9 pm on the phone in his room.”

SNF Documentation Elements

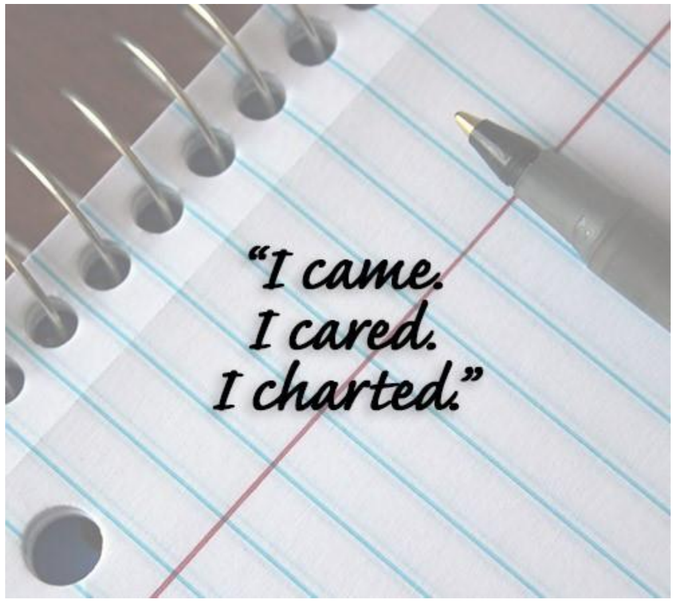
- Documentation of skilled care services/treatment
    - Medication management
    - Treatments (e.g., wound care, tracheostomy care, tube feeding, respiratory care)

SNF Documentation Elements

- Assessment and management of conditions that support reason for skilled care
  - Respiratory
  - Neurologic
  - Pain
  - Circulatory/Cardiovascular
  - Gastrointestinal
  - Musculoskeletal
  - Renal, hepatic, and other

SNF Documentation Elements

- Documentation by exception is no longer acceptable. It is best practice to fully document the findings of your assessment to justify that the resident requires skilled care.



SNF Documentation Elements

- Example of components that might be part of the daily skilled note for a resident with a hip fracture and dementia:
  - Complete vital signs
  - Status of surgical site (until healed)
  - Presence/absence/changes in edema, capillary refill, pulse, color or temperature, appearance of skin at pressure points, etc.
  - Positioning of involved extremity
  - Pain characteristics—location, intensity, and frequency; pain scale used (visual or numeric)
  - Behavior—hallucinations, signs and symptoms of depression, verbal/physical abuse, resistance to care, refusal of care, wandering, etc.
  - Other assessments based on resident observation, comorbidities, and professional assessment
  - Notification of physician and responsible party of a change in resident status; documentation of physician response

SNF Documentation Elements

- Weekly documentation
  - Oftentimes reviewers find daily documentation repetitive, and it is very hard to see resident response to treatment or care. Weekly or other periodic summary notes are a good way to capture resident changes that may be minuscule or infrequent on a daily basis but reviewed over a period of time, they show a more accurate picture of the resident.

  - Not required but can help to fill in the gaps and ensure continuity of care

SNF Documentation Elements

- Weekly summary documentation (con't)
  - Example: "Resident has made slow progress this week in following instructions for dressing lower extremities but has put on a shirt and buttoned it without assistance or cueing for the last three mornings."
  - Additional examples might be an overall weekly response to a new pain management regimen or any adverse effects to a reduction in psychotropic medications.
  - The summary should reflect progress since last review, changes in treatment plan, documentation of reason for continued eligibility, discharge plans from Medicare Part A, and education provided to resident/caregiver to facilitate independence in care and/or successful discharge

SNF Documentation Elements

- Does your documentation answer these three questions:
- Why me?
  - Why does this require the skills of a nurse or therapist?
- Why here?
  - Why must the care be delivered in the SNF and not in a lesser level of care?
- Why now?
  - Why, specifically, is this resident in this SNF at this time receiving daily care?

Charting is my favorite part of my job.

Said no nurse ever!

SNF Documentation Elements

SNF Documentation Elements

- Non-Supportive documentation
  - Generalized weakness, chronic, stabilized, monitored, scant, slight improvement, slightly red, slow progress, no problems, routine, maintenance, refuses, unable to learn, reinforced previously taught

SNF Documentation Elements

- Example
  - **Does not support daily skilled SNF need**:
    - Night shift left dressing for me to change again, which I did. Again.
  - **Supports daily skilled SNF need:**
    - Wound bed 5 cm in circumference, 1 cm deep. Pink granulation tissue noted 2 cm around inside circumference. 1 cm open area noted in center of wound bed, red with no drainage/odor. Surrounding skin intact. Pain during treatment noted at 2/10.

SNF Documentation Elements

- Example
  - **Does not support daily skilled SNF need:**
    - Antibiotics continue.
  - **Supports daily skilled SNF need:**
    - Assisted resident to turn, cough, and deep breathe after nebulizer treatment. Lung sounds diminished. VS: T: 101.2, BP: 140/80, P: 96, R: 24, pulse ox: 98%. Resident cannot lie flat due to SOB. O2 via NC at 2L continues. IV Vancomycin infusing via pump at 75 cc/hr. IV site has no redness, pain, or swelling. Resident up in chair for two hours before asking for assist back to bed

SNF Documentation Element

- Nursing documentation to support therapy
  - Therapy and nursing documentation do not have to match but should not contradict to the point where it seems that both cannot be accurate. For example, the physical therapist charts that the resident is non-weight bearing, and nursing describes the resident walking freely throughout the facility.
  - Nursing documentation must contain nursing observations about functional ability. How did the resident fare with these tasks?
    - Walking to/from bathroom
    - Getting undressed
    - Eating dinner

SNF Documentation Elements

- Nursing documentation to support therapy (con't)
  - The CNA is usually in the best position to answer these functional status questions. Nurses must communicate regularly with them regarding a resident's functional performance throughout the day and night. Nursing charting should reflect how the resident is handling the areas therapy is working on while the resident is not in therapy. To do this, the nurse must be aware of what the resident is working on in therapy

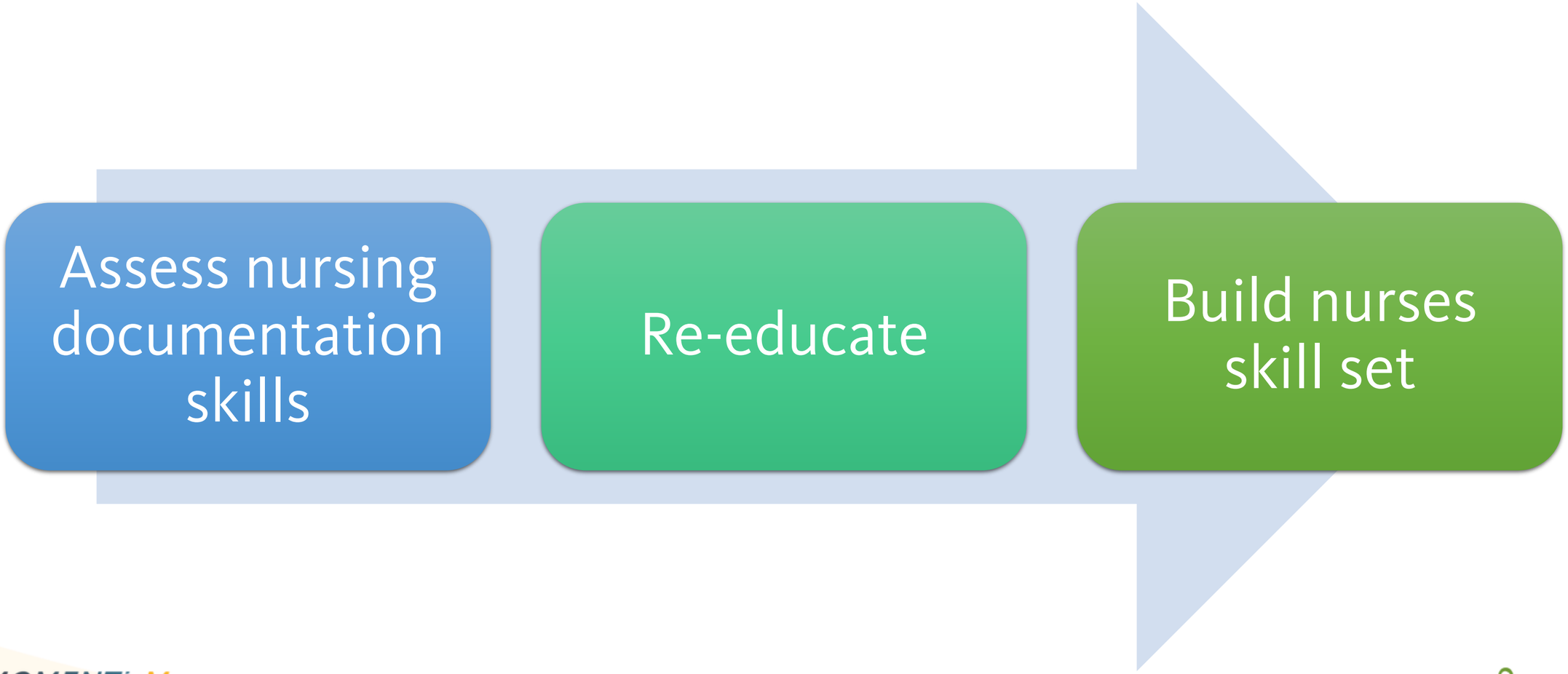
SNF Documentation Elements

- Doesn’t support therapy:
  - Required two-person assist to get out of bed. Mechanical lift still broke. Independent in chair.
- Supports therapy:
  - Resident receiving OT to assist with bed mobility, transfer, and locomotion in wheelchair. Bed Mobility: resident pulled self from a lying to a sitting position with use of grab bars. Sit-to-stand and Transfers: CNA & LPN assisted resident to stand from sitting on the side of the bed, turn, and pivot into wheelchair. Required staff assist to place left leg in position on leg rest but could participate. Locomotion: Resident used arms and right leg to propel self in the wheelchair with supervision 50 feet and able to navigate 2 turns

Develop processes that ensure documentation is consistent, accurate, and provides for maximum reimbursement of services

- Documentation Training
- Documentation Audits
- Medicare Charting Guidelines Tool
- PDPM Meetings
- PDPM Profiler Tool
- Triple Check

Which Nurses Need Documentation Training



Which Nurses Need Documentation Training

- To build nurses' documentation skills go back to the basics. Use the nursing process
  - Assessment
  - Nursing diagnosis
  - Planning
  - Implementation
  - Evaluation

Which Nurses Need Documentation Training

- Examples
  - SOAP Note
    - Subjective, objective, assessment and plan
  - DAR Note
    - Data, action, response

Which Nurses Need Documentation Training

- SOAP Example (Pain in right knee after therapy session)
  - Subjective- Resident stated the “throbbing pain started about 15 minutes ago after completing his therapy session. The resident rated the pain as 6”.
  - Objective- Right knee appears slightly swollen. No redness or warmth was noted. Resident is rubbing his right knee and noted facial grimacing when resident was attempting to straighten right leg.
  - Assessment- Resident is having increased pain in right knee following activity. Resident was noted to have facial grimacing and was rubbing right knee with movement.
  - Plan- Apply ice, medicate with 5/325mg Norco as ordered. Resident stated pain in knee is improved to a “2”, 30 minutes after treatment.

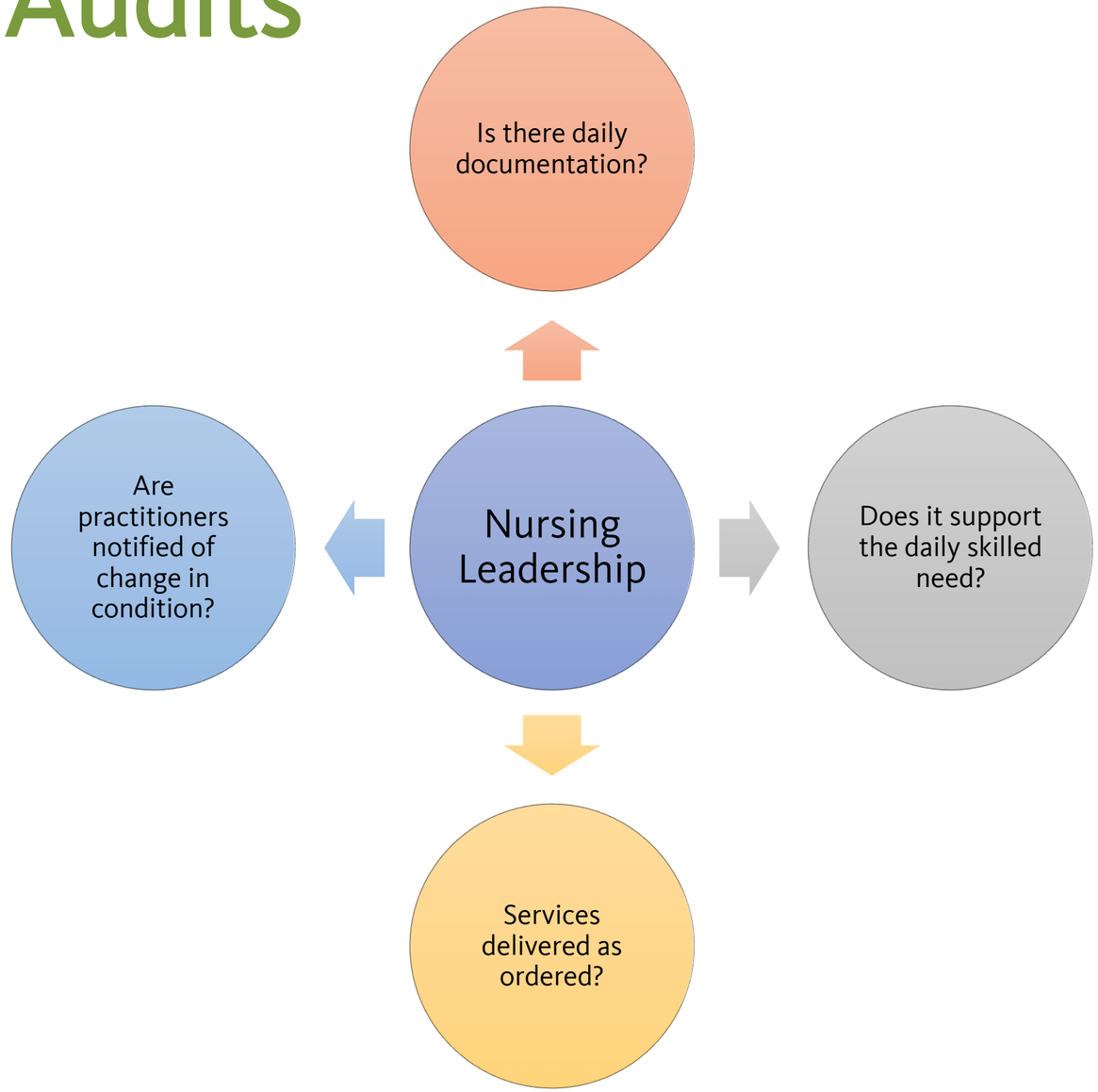
Which Nurses Need Documentation Training

- DAR Example (Focus- pain in right knee after therapy session)
  - Data(assessment/interview)- Resident stated the throbbing pain started about 15 minutes ago after completing his therapy session. The resident rated the pain as “6”.
  - Action- Ice was applied to right knee, Administered 5/325mg tab of Norco per physicians' orders.
  - Response- Resident rates pain now as a “2”, 30 minutes after pain medication given

Which Nurses Need Documentation Training

- DAR Example (Focus- wheezing due to right lower lobe pneumonia)
- Data- Resident states she has a cough and is short of breath. Lung sounds indicate wheezing bilateral posterior bases. Oxygen saturation 86% on room air. Cyanotic around lips. Productive cough with yellow sputum. Unable to lay flat.
- Action- Head of bed raised. Albuterol nebulizer treatment administered. Oxygen at 2L via nasal cannula applied after nebulizer treatment. Physician notified and chest x-ray ordered. POAH notified of condition change.
- Response- Oxygen saturation 93%. Lungs sounds clear bilateral. Resident states less short of breath and is no longer cyanotic. Physician notified of chest x-ray results. New orders for antibiotic received. POAH updated on condition and new orders.

Documentation Audits



Medicare Charting Guidelines Tool

Resident Name: _____ **Date of Admission:** _____/_____/_____

Admitting Dx (Principal): _____

Other Dx: _____

Guidelines:
1. Chart Q Day
2. Use this guideline to focus your charting
3. Guideline to be completed by Medicare Nurse, Unit Manager, or other Nursing Supervisor

REASON FOR SKILLING ON MEDICARE:

❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy ❑ Respiratory Therapy ❑ Unstable IDDM
❑ Injections (IM only) ❑ New G-Tube Feeding ❑ Decubitus Ulceration/Pressure Ulcers { ❑ Stage III ❑ Stage IV B Multi-Stage II }
❑ Other Wounds (s/p Surgical w/complications) ❑ I.V. Therapy ❑ Straight Catheterization
❑ Colostomy/Ileostomy Care ❑ Medication Adjustment ❑ Dehydration/Malnutrition ❑ Isolation
❑ Patient Teaching/Nursing Rehab ❑ Medically Unstable Condition ❑ Circulation Problems
❑ Cardiovascular Compromise ❑ Gastrointestinal Complications ❑ Hemodialysis (w/complications)

TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE

❑ **Physical and Occupational Therapy**
• Describe exactly how resident performs ADLS
• Describe the amount of assistance provided
• Describe how resident accomplishes the following:
  • **Bed Mobility****
  • **Transferring****
  • Ambulates
  • Dresses Self
  • **Eats** (Including G-Tubes)**
  • **Toilet Use** (Including Post-Use Hygiene)**
  • Personal Hygiene and Bathing
• DESCRIBE SKILLED NURSING INTERVENTIONS USED TO COMPENSATE FOR ADL DEFICITS
 	
** **Indicates one of the Section GG items that impacts PDPM for nursing**
	❑ **Speech Therapy**
	• Describe exactly how resident communicates and makes needs known
	• Describe skilled nursing interventions used to compensate for speech deficits
	• Describe resident's ability to swallow foods and skilled nursing interventions used to compensate for impaired swallowing abilities
	
	❑ **Unstable IDDM**
	• Describe amount of order changes and physician visits (Requires in the past 14 days: 2 order changes and 2 MD visits OR 4 order changes)
	• Describe any skilled nursing interventions used to teach resident self-administration
	• Describe outcome of resident teachings
	• Describe any signs and symptoms associated with fluctuating blood sugar levels
		❑ **Respiratory Therapy/ Impaired Respiratory Status**
		• Describe skilled trach care rendered
		• Describe accurately breath sounds over all lung aspects (i.e., wheezes, rales, rhonchi)
		• Describe respiratory rate, rhythm, and quality
		• Describe the effectiveness of any respiratory treatments given (i.e., Nebulizers, Chest PT, Other Respiratory Medications, Oxygen)
		• Describe resident's comfort level as r/t respiratory status
		• Describe any changes in LOC, anxiety or other mental status changes
		• Describe each incident of suctioning and any other invasive techniques
		• Describe resident's overall condition as r/t respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status

Medicare Charting Guidelines Tool

TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE
❑ **IM or IV Medication Administration** • Describe nature of medication used (include reason for use) and nursing skills and observations used in administration of medication • Describe effectiveness of medication and any side effects observed • Describe how resident tolerated such therapy (i.e., IV infiltration, fluid volume overload, pain, phlebitis, etc.)	❑ **New Gastrostomy Tube Feeding** • Describe the amount of fluids/feedings delivered • Describe resident's ability to communicate and make needs known to staff • Describe how resident tolerated tube feeding – specifically any adverse effects to feeding such as diarrhea, abdominal distension, Cardiac symptoms, abnormal lung sounds • Describe type of ostomy care rendered around G-Tube site and condition of site • Describe clinical necessity for G-Tube/J-Tube	❑ **Decubitus Ulceration/ Pressure Ulcers** (Stage III or IV or Multi- II's) • Describe condition of wound • Describe response to current treatments • Describe nursing interventions used to prevent further ulcer development • Describe skilled nursing interventions used to aid in wound healing • Describe consumption amounts of meals and fluids provided • Describe overall skin condition including poor skin turgor, bruises, rashes, cyanosis, redness, edema or other abnormality • Document any interventions implemented r/t abnormal lab values (i.e., low H&H, low serum albumin, low Fe+ levels, etc.) • Describe dietary interventions implemented (i.e., increased vitamin C, protein foods offered) • At least q week, describe in detail wound measurements, locations, and response to treatments
❑ **Surgical Wounds or Open Lesions** (doesn't include rashes, ulcers, cuts) • Describe location and nature of wound • Describe any pain r/t to surgical wound and interventions used to combat pain • Describe nursing interventions and observations r/t surgical wound healing process • Describe any drainage, areas of increased erythema, or warmth • Describe response to any treatments ordered • At least q week describe in detail wound healing process/response to tx	❑ **Straight Catheterization/ GU Complications** • Describe nature of resident's condition that warrants the use of straight catheterization techniques • Describe use of sterile technique during catheter administration • Describe any resident teaching r/t catheter use • Describe any clinical conditions present that require skilled nursing observation (i.e., frequency, dysuria, indicators of UTI, etc.)	
❑ **Nursing Rehabilitation** (As applicable) • Describe outcome of Insulin Injection instruction • Describe outcome of colostomy / Ileostomy care training • Describe outcome of Supra-pubic catheter care training • Describe outcome of self wound care training • Describe outcome of medication self-administration training • Describe outcome of stump care training • Describe outcome of bowel and bladder training • Describe outcome of any skilled teaching provided to resident		

Medicare Charting Guidelines Tool

MEDICALLY COMPLEX or UNSTABLE CONDITIONS

- ❑ **Cerebral Palsy or Multiple Sclerosis or Quadriplegia Present:** Describe ADL status as well as skilled nursing interventions used to assist resident overcome ADL compromise (see above section)
- ❑ **Fever Present (2.4 degrees higher than baseline temperature):** Describe interventions to control and/or monitor fever
- ❑ **Fever and Vomiting Present:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Fever and Weight Loss Present:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Fever and Tube Feeding with High Enteral Intake:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Fever and Dx of Pneumonia Present:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Fever and Dehydration Present:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Comatose:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Septicemia:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation
- ❑ **Burns:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation of burn site, response to treatment and pain management
- ❑ **End Stage Disease:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation as well as comfort measures
- ❑ **Dehydration:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation as well as measures to correct dehydration
- ❑ **Hemiplegia/Paresis AND ADL dependence:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation as well as skilled interventions to assist resident cope with ADL dependence
- ❑ **Internal Bleeding:** Describe skilled nursing interventions used to maintain homeostasis and skilled observation r/t anemia (i.e., fatigue, skin color, signs of shock, etc.)
- ❑ **Chemotherapy:** Describe in detail response to chemotherapy treatment and skilled nursing observation r/t discomfort and general malaise associated with chemo treatment
- ❑ **Dialysis:** Describe skilled nursing interventions used to maintain homeostasis and skilled observations r/t signs of hyperkalemia (monitor K+ levels), intake and output (as necessary), monitor for edema and respiratory compromise, H&H and signs of infection
- ❑ **Transfusions:** Describe skilled nursing interventions and skilled observation r/t transfusions including renal failure, increased anxiety levels, dyspnea, severe headache, severe pain in neck, severe chest pain, and severe lumbar pain, evidence of shock, oliguria, fever, urticaria, edema, wheezing, dizziness, JVD
- ❑ **Oxygen Therapy:** Any use of oxygen in the past 14 days requires documentation of respiratory status (See previous section)
- ❑ **Radiation Therapy:** Describe skilled nursing interventions and skilled observation r/t radiation treatment:
  - **Neurologic:** Tremors, Convulsions, Ataxia, Anxiety, Confusion
  - **GI:** Nausea, Vomiting and Diarrhea, Dehydration
  - **CV:** Circulatory Compromise/Collapse, Anemia
  - **General:** Pain, Skin Irritation, Skin Exposure to Elements
- ❑ **Infection on Foot OR Open Lesion on Foot:** Describe all skilled nursing interventions r/t treatment of foot ulcer/lesion and interventions r/t prevention of further foot complications
- ❑ **Unstable Neurological Status:** Describe skilled nursing interventions and skilled observation including Level of Consciousness, Pupilary Reactions, Muscular Weakness, and Seizure Activity
- ❑ **Unstable Gastrointestinal Status:** Describe skilled nursing interventions and skilled observation r/t Nausea, Vomiting, Diarrhea, Bowel Sounds, Distention, Sudden Weight Loss, Pain, and monitoring for GI bleed (hemocult)
- ❑ **Unstable Cardiovascular Status:** Describe skilled nursing interventions and skilled observation r/t Heart Rate and Rhythm, Edema, Chest Pain, Lung Sounds, (Cardiac) Medication Use, Rapid Weight Gain, Pedal Pulses, Extremity Skin Color/Warmth, Capillary Refill, Pain/Numbness/Tingling
- ❑ **Unstable Condition Requiring Skilled Medication Administration:** Including monitoring for adverse side effects, electrolyte imbalances, internal bleeding (coumadin/heparin), antibiotic responses in acute conditions, steroid therapy, chemotherapy (as above), pain management and psychotropic medication adjustments

Medicare Charting Guidelines Tool

COGNITIVE AND BEHAVIORAL SYMPTOMOLOGY

Generally DO NOT enable Medicare Benefits but must be accurately recorded as they DO affect RUG-III Scoring

- ❑ **Cognitive Loss:** Describe severity of cognitive loss and accurately describe current level of orientation (i.e., person, place, time) as well as area of deficit (i.e., Short-term or long-term memory affected)
- ❑ **Signs of Depression:** Describe accurately any signs of depression displayed to include but not limited to: Negative statements made, repetitive questions, calling out, persistent anger, self-depreciation, unrealistic fears, repetitive non-health related complaints, unpleasant mood in morning, insomnia or change in usual sleep pattern, sad/anxious appearance, crying/tearfulness, repetitive physical movements, withdrawn from activities and social interaction
- ❑ **Behavior Symptoms Present:** Describe skilled nursing interventions to establish resident safety upon observance of the following behaviors: Wandering halls oblivious to safety, verbally abusive towards others, physically abusive towards others, socially inappropriate behavior or resistance to care
- ❑ **Hallucinations or Delusions Present:** Describe all skilled nursing interventions implemented to assist resident cope with any hallucination or delusions and include skilled nursing observations regarding same

PDPM Meetings

- Best Practices
  - Designate a PDPM leader
  - Begin review of medical chart at preadmission and upon admission to dive deep into all potential opportunities surrounding Nursing and NTA capture
  - Initiate PDPM profiler and utilize during PTR and triple check; consider doing triple check weekly to decrease burden at EOM
  - Complete thorough admission assessments: Dietary, social services, physician, MDS, GGs (therapy and nursing)

PDPM Meetings

- Best Practices (con’t)
  - Project CMGs by day 2-3
  - Ongoing daily discussions on resident’s status
  - Do not cancel clinical meetings and discussion with IDT
  - Do not unnecessarily take advantage of relaxed MDS completion guidelines, as this will be necessary to complete billing in a timely fashion

PDPM Meetings

Social Services
- BIMS
- PHQ-9
- Behavior
- DC plan
- Psychotropics
- Hypnotics
- Makes self understood

Therapy
- GG scoring
- Primary reason for SNF stay
- BIMS (conducted by OT or ST)
- SLP co-morbidities
- Diet
- Co-morbidities

Nursing
- Orders
- Whole Body Review
- Recent surgery
- Skin treatments
- IV Meds
- Insulin injections
- Assessment data
- Surgical, burns, other

Dietary
- Diet consistency
- Feed tube
- IV fluids/TPN
- Malnutrition or Morbid Obesity
- Height/Weight
- Weight loss

MDS
- Hospital H & P
  - MARS
- Hospital DC summary
- Primary reason for SNF stay
- Section G/GG
- Supporting Dx
- Active medications
- DRR
- Surgical Dx
- Isolation
- Active Treatments
- Special Treatments
- Bowel & bladder

PDPM Meetings

- Meeting Agenda

1. Review all Medicare and Managed Care Admissions and Re-admission
2. Complete the IDT Portion on the PDPM Profiler
3. Set ARD date and Due date for all MDS sections to be completed
4. Set a projected PDPM Grouper
5. Ensure Baseline Care Plan is completed
6. Review section GG
7. Nursing – Chart Review for new admissions assessment completion, Verify and review Daily Skilled documentation that need for skilled care is present. Verify daily teaching and education is documented. Review orders and ensure that they are correct. Is Pain Management indicated
8. Therapy – Review documentation and Changes
9. Social Services – BIMS, PHQ-9/Depression, Cognitive Function, Advanced Directives and initial discharge plan. Notify team of time and date of family meeting to be held within 72 hours of admission
10. Dietician – Review diet orders and that patient is receiving correct order. Note if present a swallowing condition, very coded under section K. Review weight and height, BMI? Does Speech language therapist need involved, ensure documentation in in chart to support

- Discharge

1. Discharge Date with discharge plan, NOMNC given 48 hours prior to estimated discharge. All equipment and medication ordered, transportation, family and/or receiving facility notified of pending arrival.

PDPM Profiler

ARD Date: Day 1 2 3 4 5 6 7 8

PDPM Patient Profile ☐ Vaccine(s) Status Documented?-* Check Connex for information ☐ PASRR Complete? ☐Medicare Secondary Payor ☐ Baseline Care plan

Name:	Room #	Physician:	Referral Source:	Admission Date:	# of Med A Days at Admit
Hospitalization Date(s):		☐ H&P ☐ DC Summary	☐ Drug Regimen Review	☐ P.O.s Rev & Noted	
Prior Living Arrangements: ☐ Home ☐ AL ☐ IL ☐ SNF ☐ CCRC ☐ Other (Specify)					
Hospital Diagnoses:					
List any surgeries completed during this most recent hospitalization:					
Did patient receive IV hydration/nutrition in hospital? ☐ Yes ☐ No					
Last date received (refer to hospital MAR):_____ Does this impact ARD selection? ☐Yes ☐No					

Projected Clinical Category – Principal ICD-10 Code (I0020B):_____ ☐ MDS Clinical Note? ☐ MCR Charting Tool?

☐ Physician Certification:_____ (ideally within 2 days of admission) ☐1st Recert:_____ (on or before day 14) ☐2nd Recert:_____ (on or before 30 days from prior) ☐3rd Recert:_____ (on or before 30 days from prior)

☐ Medical Management ☐ Other Orthopedic ☐ Non-Ortho Surgery/Acute Neuro ☐ Major Joint Replacement/Spinal Surgery

PDPM Profiler

Nursing – Which skilled nursing care services are indicated? Check all that apply (refer to PDPM RUG IV Worksheet for details)

Extensive Services

- ☐ Trach Care
- ☐ Ventilator or
  - ☐ Respirator
- ☐ Isolation

Special Care High

- ☐ Comatose
- ☐ Septicemia
- ☐ Diabetes with both of the following:
  - •Insulin injections
  - •Insulin order changes on 2+ days
- ☐ Quadriplegia
- ☐COPD with SOB lying flat
- ☐Fever + one of the following:
  - ☐ 2.4° above baseline or 100.4°F & above
    - Pneumonia ☐
    - Vomiting ☐
    - Weight Loss ☐
    - Feeding Tube ☐
- ☐ Parenteral/IV feedings & fluids per RAI
- ☐ Respiratory therapy for all 7 days

Special Care Low

- ☐ Cerebral Palsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Respiratory failure/oxygen therapy
- ☐ Feeding tube
- ☐ Foot infection, diabetic foot ulcer or other open foot lesion with dressings to feet
- ☐ Radiation treatment
- ☐ Dialysis
- ☐ Two+ **stage 2 pressure ulcers**
- ☐ Any stage **3 or 4 pressure ulcer**
- ☐ 1 **stage 2 pressure ulcer & 1 venous/arterial ulcer**

Clinically Complex

- ☐ Pneumonia
- ☐ Hemiplegia/hemiparesis
- ☐ Burns
- ☐ Chemotherapy
- ☐ Oxygen Therapy
- ☐ IV Medications
- ☐ Transfusions
- ☐ Open lesions (other than ulcers, rashes, and cuts) or
  - ☐ Surgical wounds

NOTE: Are there order changes that warrant further review for MDS capture or IPA ? ☐Yes___☐No

PDPM Profiler

MDS Item	Condition/Extensive Service	Points	MDS Item	Condition/Extensive Service	Points
SNF Claim	☐ HIV/AIDS	8	I8000	☐ Immune Disorders	1
H0100C	☐ Bladder and Bowel Appliance: Ostomy	1	I8000	☐ End-Stage Liver Disease	1
H0100D	☐ Bladder and Bowel Appliance: Intermittent Catheterization	1	I8000	☐ Narcolepsy and Cataplexy	1
K0510A2, K0710A2	☐ Parenteral IV Feeding: Level High K0710A2 = 51% or more	7	I8000	☐ Cystic Fibrosis	1
K0510B2	☐ Nutritional Approaches: Feeding Tube	1	I8000	☐ Major Organ Transplant Status, Except Lung	2
K0510A2, K0710A2, K0710B2	☐ Parenteral IV Feed: Level Low K0710A2 = 26% – 50% (while a resident) AND K0710B2 = 501 cc/day or more	3	I8000	☐ Specified Hereditary metabolic/Immune Disorders	1
M1040B	☐ Diabetic Foot Ulcer Code	1	I8000	☐ Morbid Obesity	1
M0300D1	☐ Highest Stage of Unhealed Pressure Ulcer – Stage 4	1	I8000	☐ Opportunistic Infections	2
M1040A, M1040C	☐ Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code (M1040B)	1	I8000	☐ Psoriatic Arthropathy and Systemic Sclerosis	1
O0100B2	☐ Radiation	1	I8000	☐ Chronic Pancreatitis	1
O0100H2	☐ Intravenous Medication	5	I8000	☐ Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1
O0100F2	☐ Ventilator or Respirator	4	I8000	☐ Bone/Joint/Muscle Infections/Necrosis – Except Aseptic Necrosis of Bone	2
O0100D2	☐ Suctioning	1	I8000	☐ Complications of Specified Implanted Device or Graft	1
O0100E2	☐ Tracheostomy Care	1	I8000	☐ Lung Transplant Status	3
O0100I2	☐ Transfusion	2	I8000	☐ Aseptic Necrosis of Bone	1
O0100M2	☐ Isolation	1	I8000	☐ Cardio-Respiratory Failure and Shock	1
I1300	☐ Inflammatory Bowel Disease	1	I8000	☐ Myelodysplastic Syndromes and Myelofibrosis	1
I1700	☐ Multi-Drug Resistant Organism (MDRO) Code	1	I8000	☐ Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	1
I2500	☐ Wound infection Code	2	I8000	☐ Diabetic Retinopathy – Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1

PDPM Profiler

SLP – SLP related comorbid conditions, check all that apply:			
☐ Apraxia ☐ Dysphagia (I69.) ☐ ALS ☐ Oral Cancers	☐ Aphasia (I4400) ☐ CVA, TIA, or Stroke (I4500) ☐ Hemiplegia or Hemiparesis (I4900) ☐ TBI (I5500)	☐ Trach Care ☐ Ventilator or Respirator ☐ Laryngeal Cancer ☐ Speech and Lang Deficit	Is there cognitive impairment? ☐Y ☐N BIMS Score: _____ Is pt on a Mechanically Altered Diet? ☐Y ☐N

Swallowing disorder? Check all that apply:	
☐ Loss of liquids/solids from mouth when eating or drinking ☐ Holding food in mouth/cheeks or residual food in mouth after meals	☐ Coughing or choking during meals or when swallowing medications ☐ Complaints of difficulty or pain with swallowing

Is the patient at risk for malnutrition? ☐Yes ☐No If yes, please specify: _____
(Examples: weight loss, skin integrity issues, dx of dementia, high or low BMI, abnormal lab findings, poor appetite, dysphagia dx)

MDS GG Items	5 Day	IPA	IPA	DC
Transfer Average*				
Bed Mobility Average*				
Eating*				
Toileting Hygiene*				
Walking Average				
Oral Hygiene				

*denotes Nursing only items

MDS GG Scoring	
5 Day GG Nursing Score Total	/16
5 Day GG PT/OT Score Total	/24
DC GG Nursing Score Total	/16
DC GG PT/OT Score Total	/24
IPA GG Nursing Score Total	/16
IPA GG PT/OT Score Total	/24

Projected PDPM Case-Mix Groups: PT/OT:_____ SLP:_____ NSG:_____ NTA: _ NOMNC: ☐ Yes___ ☐ No

Projected HIPPS:_____ Pre-transmission Review HIPPS:_____ Triple Check HIPPS: _____ ABN: ☐ Yes ☐ No ☐ N/A

Triple Check

- While there are many complex aspects to SNF reimbursement at the facility level, initially getting the claims out accurately, in a timely manner, and with assurance that all documentation exists to support the claim can save a lot of time scrambling to find the information later. Every month (or more frequently, depending on the facility's Medicare caseload) before the claims go out, the business office manager, the director of nursing, the rehab manager, and the nurse assessment coordinator—at a minimum—should review them together. Many facilities refer to this process as the Triple Check meeting.

Triple Check

- What is Triple Check?
  - An internal audit process to ensure billing accuracy, and compliance with regulatory guidelines prior to submission of claims to Medicare/Managed Care providers for review and payment
  - It is a multi-level process requiring a group effort of the IDT members
  - Provides a check and balance to the entire admission process for new Medicare A/Managed Care residents
  - Identifies gaps and successes in communication between departments

Triple Check

- The accuracy of the UB-04 information is critical to reimbursement. HIPPS codes, service date, number of covered days, and all other codes and dates on the UB-04 should be checked against the chart for accuracy.

- Verifying that documentation exists to support the need for the items and services and the delivery of the items and services is essential to avoid payment delays and suspicions of fraud and abuse

Triple Check

- Examples of common pitfalls
  - Billing for skilled therapy for > two weeks with little or no documented progress
  - MDS shows IV fluids in the look-back into the hospital, but chart documentation does not support it
  - BIMS and PHQ-9 interviews were completed outside of the look-back period (preferably should be completed the day before or the day of ARD)
  - MDS ARD and leave-of-absence days
  - Inaccurate number of covered days on UB04 due to LOA or interrupted stay
  - Wound (M0300), Other Ulcers (M1040), and wound care (M1200) coded on MDS, but treatment sheets show inconsistent treatments

Triple Check

- Documentation to support billing for treatment and services: Code the MDS from the chart documentation, not the other way around

Determine common pitfalls that can delay cash flow and may result in bad debt

- Physician Certification
- Daily skilled documentation by nursing and therapy
- Physician Orders

Questions?

LeadingAge® Illinois

MOMENTUM

2023 ANNUAL MEETING & EXPO

MARCH 7-8, 2023

Renaissance Schaumburg
Convention Center - Schaumburg, IL

Amy Lane RN, BSN alane@covliving.org

Becky Smith MSN, RN, LNHA, RAC-CT, RAC-CTA bsmitho2@covliving.org

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