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Come Off Cloud 9:

Clear Nursing Documentation to Support Rehab Services

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BIO:

Carol Ashdown is a Regional Vice President of Consulting for Exponential Consulting Services specializing in Medicare, Therapy, PPS, MDS, and Medicaid consulting services. She is a Speech Language Pathologist and an expert clinician in the areas of dysphagia management; cognitive linguistic training; Medicare guidelines for documentation; coding; and reimbursement. Carol has more than 22 years of experience in the long term care industry. She has held a variety of positions within those settings including staff therapist; Director of Rehabilitation; Regional and Area Director of Operations; Clinical Specialist; Director of Clinical Operations and Regional Consultant. In these roles, Carol has been responsible for staff development and education in order to facilitate the delivery of quality clinical rehabilitation services; optimize reimbursement; maintain regulatory compliance. Carol has experience in Medicare reviews and the denials process. As Regional Vice President of Consulting, Carol provides multi-state on-site auditing of the MDS, nursing and rehabilitation documentation; and consults on the prevention, management and response to denials; as well as contributes to the development of effective skilled nursing and rehabilitation programs. Carol has presented on topics related to clinical service delivery; Medicare reimbursement; Meeting the Needs of the Long Term Resident; Skilled Nursing and Rehabilitation Documentation; Case Mix; ADL Coding; Mentoring; PEPPER. She belongs to the ASHA special interest divisions for geriatric care and supervision. Carol is a graduate of the ASHA Leadership Development Program. She is RAC-CT certified and has completed training on the implementation of electronic health records. She is a member of the Healthcare Compliance Association

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Objectives:

- Participants will apply OBRA objectives to meeting the needs of our long term residents
- Participants will develop an understanding of how the needs of our long term residents are identified
- Participants will be able to document clearly the functional changes in our long term residents

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True or False:

Nursing and Therapy documentation needs to be supportive and collaborative.

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Answer

True

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Documentation is:

A. Busy work
B. A means of communicating quality of care
C. A means for reimbursement
D. Demonstration of the skilled service provided
E. All but A
F. All of the above

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Answer

All but A

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Lack of quality documentation may lead to:

A. Reflection of poor nursing and therapy care
B. Poor resident outcomes
C. Poor survey results
D. Increase in denials
E. Ultimately loss of revenue
F. All of the above

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Answer

F: All of the above

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Current Healthcare Audits

Auditor	Auditing Contractors	Type of Claims	Claim Selection	Type of audit	Purpose of review
CERT	N/A: CERT Contractor administered by the Centers for Medicare and Medicaid Services (CMS)	All medical claims.	Random	Post payment review; complex only (involving additional documentation).	To measure improper payments.
MAC	J1: Palmetto GBA J9: First Coast Service J2: CIGNA, NAS, WPS Options, Inc. J3: Noridian (NAS) J10: Cahaba GBA J4: Trailblazer J11: Palmetto GBA J5: WPS J12: Highmark J6: Noridian (NAS) Medicare Services J7: Cahaba, Pinnacle J13:NGS WPS J14: NHIC J8: NGS J15: CIGNA Medicare Administrative Contractors	All Medicare fee-for-service claims.	Targeted	Prepayment and post payment; automated and complex.	To prevent improper payments.
RAC	Region A: Diversified Collection Services (DCS) Region B: CGI Region C: Connolly, Inc. Region D: HealthDataInsights, Inc. RAC States and Contact Information	All Medicare fee-for-service claims; Medicare Advantage claims; Medicaid claims.	Targeted	Post payment; automated and complex.	To detect and correct past improper payments.
ZPIC/PSC	Health Integrity; AdvanceMed; SafeGaard Services; Trust Solutions; and Integriguard	All Medicare fee for service claims.	Targeted	Post payment; automated and complex.	To correct improper payments, to identify potential fraud.
Office of Inspector General (OIG)	N/A: Department of Health and Human Services OIG	All medical claims.	Targeted.	Post payment; complex.	To identify potential fraud

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Part B Medical Manual Review

- A manual medical review process for Medicare Part B therapy services was implemented by the Centers for Medicare & Medicaid Services (CMS) for service claims that exceed a $3,700 threshold as of October 1, 2012. This is a new process that was mandated by the Middle Class Tax Relief and Job Creation Act of 2012.
- The $3,700 threshold includes the total allowed charges for services furnished by independent practitioners and institutional services under Medicare Part B (i.e., hospital outpatient departments, skilled nursing facilities). The threshold does not apply to services in critical access hospitals.
- Providers will be able to request pre-approval for services above $3,700. The Medicare Administrative Contractors (MACs) will use the coverage and payment policy requirements currently in the Medicare Benefit Policy manual and any applicable local coverage decisions. They will have 10 business days to respond to a pre-approval request. Requests that do not receive notification within 10 days are automatically approved. Claims submitted above the $3,700 threshold without approval will be stopped, and the standard medical review process will apply, which allows 45 days for the provider to submit records and 60 days for the MAC to respond.

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Part B Medical Manual Review

CMS has resumed the Manual Medicare B Review process for claims that went over the $3700 claim threshold. CMS has indicated that Medicare Contractors will resume issuing ADRs for ALL claims that exceeded $3700 and were received between March 1st and December 31st 2014. All reviews are completed post pay, and will follow a chronological, 5-step process for the requests. There will be 45 days between the ADR request cycles.

- The process is as follows:
  - ***** The **first** additional documentation request (ADR) sent to each provider for these claims will only request the documentation for one claim. Any provider with one or more claims meeting the criteria above can receive an ADR.
  - ***** The **second** ADR sent to a provider can request up to 10% of the total number of eligible claims.
  - ***** The **third** ADR sent to a provider can request up to 25% of the remaining eligible claims.
  - ***** The **fourth** ADR sent to a provider can request up to 50% of the remaining eligible claims.
  - ***** The **fifth** ADR sent to a provider can request up to 100% of the remaining eligible claims.
- Therefore, once the fifth step is complete, **ALL** claims that exceeded the $3700 threshold between March 1st and December 31st 2014 will have been reviewed.

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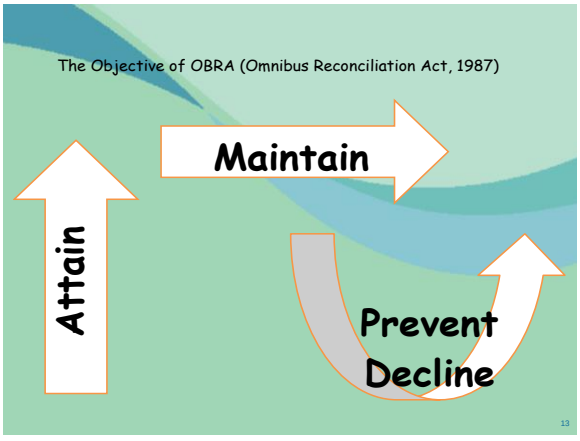

Skilled Criteria

- Ordered by a Physician
- Reasonable and Necessary
- Require the skills of a licensed professional

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Working as a Team:
Role of the Rehab Director, MDS, Nursing

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Therapy/Nursing Communication

- Build a strong Nursing/Therapy relationship
  - -Morning reports/Huddles
  - - Rehab meetings/Interdisciplinary team meetings
- Build verbal and documentation pathways
  - Determine what referral form will be used
  - Develop referral process
- Establish Monthly Round/Screens system

Nursing documentation initiates the therapy referral process!

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3 Steps to Successful Nursing Referrals

- **Step 1**
- Document Functional Change
  - Nursing documents functional change in record.

- **Step 2**
- Therapy Screen-Determine Reason for Change
  - Investigate medical, physical, emotional, environmental reason(s) for decline.
  - Therapy Evaluation

- **Step 3**
- Provide Skilled Intervention to Restore Function
  - Determine treatment strategies to promote functional improvement.

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Potential Areas of Decline

Discipline Specific Focus Areas:

ADL decline/Transfer decline
Weight losses, feeding difficulties
Falls
Low risk incontinence- toileting programs
Medical/clinical issues: UTIs - may have decline in function
Contractures: splinting
Pain: for pain modalities
Ulcers/ Wounds: for modalities
Wheelchair seating and positioning
Cognition
Restraints
Low Vision

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Nursing Documentation

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Nursing Documentation:

- Document that a change was noted
- Documentation over time
- Communicate this change to the therapy departme
- Evaluation order

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What happens when documentation is not in the medical chart?

- Lack of Communication
- Is it a problem?
- Lack of team work
- Therapy Involvement

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Nursing Documentation:

The change is written just as it happened.....

- include time of day
- what activity was occurring (e.g. eating, dressing, walking)
- whether change is a decline or improvement in function
- percentages when appropriate

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Documenting Change

- How...
- What....
- Where....
- When....

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Documentation Examples

Functional Areas Observed Problems : Feeding

- Resident is having difficulty gathering food onto utensil, cutting meat and opening containers
- Resident is having increased difficulty scooping food onto utensil and is no longer able to cut meats or open containers.
- Resident is losing weight.
- Resident no longer is interested in going to the dining room for meals

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Nursing Documentation

- *Increase spillage of food/drink noted. Resident has begun spilling 50% of meal—will monitor for the next 3 meals.*
- *Tired during meals. Resident is unable to complete a meal due to fatigue.*
- *Poor posture during meals at the table. Unable to sit upright in wheelchair. Resident is having trouble reaching food items on table. Leans to the left in the wheelchair. Unable to remain in upright seated position after repositioning.*

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Documentation Examples

Functional Areas Observed Problems: Bathing

- Resident is not washing all extremities. More assistance is required to wash left side of body. Resident unaware.
- Resident is refusing shower and bathing opportunities
- Increased odor noted with resident.

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Nursing Documentation

- *Resident is no longer able to wash peri area while standing.*
- *Resident now needs extensive assist to complete peri care and maintain balance bathing.*
- *Resident is unable to wash lower body without losing balance. Resident needs increased assist with lower body care, she tends to lose balance*

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Documentation Examples

Functional Areas Observed Problems: Positioning

- Resident leaning to one side, sliding out, head bent forward, legs bent behind leg rests, arm hanging over arm rests.
- Resident is complaining of pain while in wheelchair.
- Resident has multiple skin tears and small bruises noted on lower extremities.

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Nursing Documentation:

Resident was observed repeatedly sliding out of the wheelchair, repositioned frequently and is unable to maintain proper and safe position.

Observed resident manipulating wheelchair this am, resident is running into wall and doorway causing skin tear and bruise, will monitor for continued difficulty.

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Documentation Examples

Functional Areas Observed Problems: Swallowing

- Resident pockets food in his mouth.
- Resident has pieces of food in his mouth after meals.
- Resident was unable to clear food in mouth before taking another bite.
- Resident with coughing episodes during meals.
- Resident refuses to eat pureed diet
- Resident with weight loss.

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Nursing Documentation

- *Resident is coughing or choking during or after meals. Resident was observed coughing while drinking juice during breakfast, will monitor during meals this date.*
- *Increased amount of time to eat meal. Resident took over one hour to complete meal. Resident with food from lunch still in mouth one hour after meal.*
- *Trouble chewing. Resident was observed having trouble chewing turkey sandwich, staff cut into small bites, will continue to monitor today.*
- *Resident states she would like to try regular type food items, like everyone else. She is currently on a pureed diet.*

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Documentation Examples

Functional Areas Observed Problems: Transfers

- Increased assist from staff required. Resident was independent getting in and out of bed, now needs extensive assist of one person.
- Resident with fall while getting out of bed.

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Nursing Documentation

- *Resident now needs assist of 2, prior required assist of one to move from bed to wheelchair.*
- *Resident is unsteady during transfer and now needs hands on assist for safety.*
- *Resident with fall, the 2nd fall in 2 weeks. Resident state he was getting out of bed and lost his balance.*

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Speech Therapy Triggers

- Choking on food/liquids/medications
- Frequent coughing/throat clearing during meals
- Wet, gurgly vocal quality
- Cannot chew or will not chew
- Holds/pockets food in mouth
- Food falls out of mouth
- Speech is difficult to understand
- Difficulty putting words together in a sentence
- Does not follow directions
- Frequently asks speakers to repeat
- Disorientation
- Poor problem solving/confusion

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What Can Speech do?

Scenario #1:

- ***Problem Observed:*** *Patient is coughing and/or choking during meals and/or when taking medication.*

What does nursing documentation look like:

Nursing Documentation: *Resident was observed coughing while drinking juice during breakfast, will monitor during meals this date.*

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What Can Speech do?

Refer to Speech for……

- Swallow evaluation
- Potential MBS
- Instruction and training
- Education and training with resident and caregiver.

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What Can Speech do?

- ***Scenario #2:***
- ***Problem Observed:*** *Nursing staff is unable to make sense of resident's speech. Resident is unable to answer questions.*

What does nursing documentation look like:

Nursing Documentation: *Resident was unable to answer simple questions when family in to visit. Family states they have observed a decline in communication over the last few days.*

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What Can Speech do?

Refer to ST for:

- ***Speech Therapy evaluation***
- ***Treatment may include:***
  - ***Receptive language training***
  - ***Expressive language training***
  - ***Speech Precision training***

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What Can Speech do?

Scenario #3

- ***Problem Observed:*** *Resident continually comes to nursing station asking what day it is, when is his/her daughter coming to visit?*
- *What does nursing documentation look like:*

Nursing Documentation: *Resident has increased confusion. She continually approaches nursing station before lunch and everyday at shift change asking about time, day, where she is and where her daughter is. She becomes fearful and is crying. Will continue to monitor and discuss increase confusion with physician.*

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What Can Speech do?

Refer to ST for:

- ***Cognitive Evaluation:***
- ***Treatment may include:***
  - ***Verbal orientation to time/date/place and sort term memory exercises***
  - ***Resident/caregiver instruction and training in the use of orientation strategies, external memory aids, environmental cues.***
  - ***Spaced Retrieval techniques.***

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Occupational Therapy Triggers

- Cannot feed self/manage food items
- Poor sitting balance/posture
- Falls or slips forward
- Unable to dress/bathe/groom
- Decreased ability to take care of household tasks
- Decrease in strength/coordination
- Contractures
- Unable to get in/out of bed; on/off toilet
- Vision problems
- Shakes/tremors
- Decreased level of endurance/energy
- Poor problem solving

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What Can OT do?

Scenario #1:

Problem Observed: *Resident is sliding out of his wheelchair.*

What does nursing documentation look like:

Nursing Documentation: *Resident was observed repeatedly sliding out of the wheelchair, repositioned frequently and is unable to maintain proper and safe position.*

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What Can OT do?

Refer to OT for:

- *Positioning Evaluation*
- *Treatment may include:*
  - *Functional transfer training,*
  - *Cognitive retraining,*
  - *Strengthening endurance exercises*
  - *Proper positioning*
  - *Trial and assessment of positioning devices*
  - *Resident and caregiver education.*

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What Can OT do?

Scenario #2:

Problem Observed: Caregivers are having a difficult time performing hygiene care on patient's hands/arms and applying splint due to contractures.

What does nursing documentation look like:

Nursing Documentation: *Maintaining hygiene and ROM in upper and lower extremities becoming difficult. Increased tone and joint contractures noted. Odor noted from palms of hands, skin is red. Will notify physician, and consult with OT.*

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What Can OT do?

Refer to OT for:

- *Evaluation for possible splinting/positioning/ROM*
- *Treatment may include:*
  - *Range of motion on the affected joint*
  - *Establishing an appropriate splint to maintain range of motion and protect from skin breakdown and facilitate care*
  - *Establish a wearing schedule for splint/device*
  - *Extensive resident and caregiver education.*

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What Can OT do?

Scenario #3:

Problem Observed: *Resident is unable to open containers or having difficulty using eating utensils.*

What does nursing documentation look like:

Nursing Documentation: *Resident is having increased difficulty scooping food onto utensil and is no longer able to cut meats or open containers.*

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What Can OT do?

Refer to OT for:

- ***Self Feeding Evaluation:***
- ***Treatment may include:***
  - ***Fine motor exercises***
  - ***Strengthening and endurance exercises***
  - ***Assessment and trial for adaptive equipment training***
  - ***Resident and caregiver education and training to ensure carryover of techniques.***

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Physical Therapy Triggers

- Decreased ability to walk
- Poor balance/posture
- Falls
- Difficulty getting in/out of bed
- Difficulty getting into a standing position
- Decrease in strength/coordination
- Contractures
- Pain
- Skin breakdown/issues
- Shakes/tremors
- Decreased level of endurance/energy
- Weak/unsteady

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What Can PT do?

Scenario #1:

Problem Observed: *Resident was found on floor next to his bed.*

What does nursing documentation look like:

Nursing Documentation: *Resident is no longer safe for independent transfers from bed to wheelchair. He now needs extensive assist.*

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What Can PT do?

Refer to PT for:

- ***Physical Therapy Evaluation***
- ***Treatment may include:***
  - ***Therapeutic exercises to increase lower extremity strength and ROM***
  - ***Transfers and balance exercises***
  - ***Trial and assessment of assistive device***
  - ***Resident/caregiver training and education***

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What Can PT do?

Scenario #2:

Problem Observed: *Resident has become increasingly unsteady and tired while walking in halls.*

What does nursing documentation look like:

Nursing Documentation: *Resident was ambulating independently and now is unsteady, staff provided a walker, will refer to PT for evaluation and treatment.*

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What Can PT do?

Refer to PT for:

- ***Physical Therapy Evaluation***
- ***Treatment may include:***
  - ***Therapeutic exercises to increase strength, balance***
  - ***Gait training/exercises***
  - ***Training on effective use of assistive devices.***
  - ***Resident/caregiver training***

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What Can PT do?

Scenario # 3:

Problem Observed: *Resident's ability to move about in bed has deteriorated.*

What does nursing documentation look like:

Nursing Documentation: *Resident is no longer able to use side rails to roll or come to a sitting position in bed, extensive assist is provided.*

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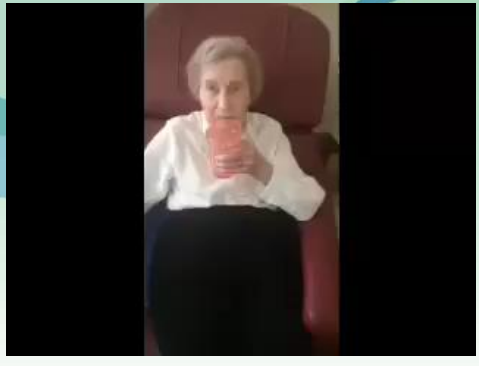

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Thank You !
Questions and Answers
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