LTRAX LTACH OUTCOMES SYSTEM

Documenting Medical Necessity

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Objectives

- Review target areas for LTACH documentation
- Correlate target areas with Medicare rules and regulations
- Provide strategies to strengthen documentation
- Discuss internal auditing and education tips

LTACH Focus Areas

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Interrupted stays

- Included in Office of Inspector General's FY 2013 Work Plan
- Focus on improper payments in CY 2011
- Attention on readmission patterns directly following the interrupted stay periods

Short stays

- Did patient require LTACH admission vs. continued stay in STACH and/or alternative setting?

Medical necessity

- Medicare, Medicaid, and SCHIP Extension Act (MMSEA)
  - LTACHs only admit high-acuity, medically complex patients
  - LTACH patients are discharged to less-costly Medicare settings as soon as they no longer require LTACH services
- MACs hired to audit medical necessity in 2008
  - AdvanceMed
  - Wisconsin Physicians Services Insurance Corporation

Back to the basics

- Documentation “Golden Rules”
  - If it isn’t documented…it didn’t happen
  - Write, type, and/or say what you think…CLINICAL DECISION-MAKING
  - Reflect the care provided AND the reasoning for the services
- Reasonable and necessary
  - Level of care
  - Length of stay
- Justification includes and supports
  - LTACH admission
  - Continued stay criteria

Medical Necessity

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Key components

- Medically complex conditions
  - Acute
  - Chronic
- Services need to be in an LTACH setting
  - Estimated length of stay
- Services are reasonable and necessary
  - Supported through assessment, interventions, and outcomes
- Supported by interdisciplinary team
  - Team determined based on medical needs
  - Interdisciplinary services support the treatment plan

Documentation requirements

- H&P in the medical record within 24 hours of admission
- Admitting diagnosis
- Consult results
- Informed consents
- Authenticated orders
- Nursing notes (RN Care Plans)
- Radiology and lab reports
- Vitals
- Restraint documentation
- Discharge planning
- Discharge summary – all records complete within 30 days of discharge

Physician certification requirements

- Authenticated inpatient admission order
- Admitting diagnosis and plan in H&P or admitting diagnosis and orders
- Estimated length of stay
- Discharge plans/post-hospital services

LTACH criteria

- ALOS of 25+ days
- Patient review process
  - Screening prior to admission for LTACH appropriateness
  - Validation within 48 hours that patient meets criteria
  - Regular evaluation throughout the patient stay justifying continued stay
  - Assessment of available discharge options when patient no longer requires LTACH services
- Physician involvement
  - Organized medical staff
  - Physician-directed treatment
  - On-site availability daily
  - Consulting physicians on call
- Interdisciplinary team
  - Individualized treatment plan

Medical Necessity: Criteria

Admission

- Internally established
  - Supported through guidelines, checklists, protocols, algorithms
  - Education and training
  - Documentation
  - Policies and procedures

Continued stay criteria

- Function of utilization review
- Policies and procedures
- Integrated into team conference

Medical Necessity: Beyond Physicians

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Interdisciplinary team

- Documentation supports necessary skills required
- Establishes individualized care plans
- Documents progress toward established goals
- Executes the physician-driven treatment plan
- Documentation demonstrates coordination and communication

Documentation: Key Areas

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Key areas

- Pre-admission screening
- History and physical
- Physician progress notes
- Consults
- Care plans
- Daily/Treatment notes from RN, RT, PT, OT, SLP
- Interdisciplinary team meetings
- Discharge plan
- Discharge summary

Pre-admission Screening

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History of present illness

- Reason for admission to the referring hospital
- Course of hospitalization to date
- Diagnostics and results
- Admitting/treating diagnosis

Past medical history

Review of systems

- Co-morbid conditions

Status

- Update per acute hospital's most recent progress note

Justification for LTACH admission

- Medical
  - Current active diagnosis and anticipated interventions
  - Co-morbid conditions and medical management required
  - Patient's risks for complications
- Interdisciplinary team
  - Nursing
  - Wound care team
  - Respiratory therapy
  - PT, OT, or SLP
- Estimated length of stay
- Anticipated outcomes; post-discharge needs

Reason for denial

- Same medical content as an admission
- Documented reason for denial/non-admission

H&P / Post-admission Evaluation

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Justification for LTACH admission

- Medical
  - Admitting diagnosis
  - Co-morbid conditions
  - Active medical management through the treatment plan
  - Consultations for additional medical management
- Interdisciplinary team
  - Nursing
  - Wound care team
  - Respiratory therapy
  - PT, OT, or SLP
- Expected length of stay
- Anticipated outcomes; post-discharge needs
- Validation that patient meets criteria (concurrence with pre-admit)
  - Admission guidelines (merges pre-admit with physician evaluation)
  - Part of H&P

Physician certification

- Admission orders
- Comprehensive H&P
- No need for an additional form

H&P: Development of a Problem List

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Problem List

- An essential component of physician documentation
- Should be supported through the components of the H&P
- Is the basis for the preliminary plan of care
- Is the foundation for team meeting
- Is the basis for daily progress notes

Components

- Primary diagnosis
- Secondary diagnosis(es)
- Co-existing conditions
- Subsequent symptoms requiring intervention
- Chronic conditions
- Potential conditions requiring preventative measures, restrictions, and/or precautions

Problem List Example

- TBI secondary to fall on 10/01/2014
- Acute respiratory failure
- Acute kidney injury
- Bilateral hemiparesis
- Severe cognitive deficits
- Communication deficits
- Hyponatremia-cerebral salt wasting
- Hypothyroidism
- Impaired self-care skills
- Neurogenic bladder
- Neurogenic bowel
- Post-traumatic headache
- Hypophosphatemia
- LUL lung nodule
- Anxiety disorder
- Paroxysmal supraventricular tachycardia
- Hyperlipidemia
- H/O remote stroke
- Osteoporosis

Physician Progress Notes

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Frequency

- Daily visits
- Interdisciplinary rounds
- Consulting physicians

Documentation

- Review of systems
- Ongoing medical conditions with associated interventions
- Test results and treatment plan
- Consult integration
- Interdisciplinary team involvement and progress
- Continued needs/plan
- New orders

Physician Progress Notes

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Includes

- Subjective
- Objective
- Assessment (diagnosis, current conditions)
- Plan (interventions) - subsequent notes update and reflect progress since the previous note

Examples: Continue to build from initial problem list

A: Acute respiratory failure s/p intubation

P: Pulmonology consulted and will follow, patient on mechanical ventilation, respiratory therapy initiated along with vent weaning protocol

A: Acute kidney injury

P: Initiate insulin therapy, nephrology consulted, labs ordered to monitor BUN/Creatinine levels, dietician involved for nutritional management, monitor I&Os

Common traps

- Duplication of progress notes
  - Templates
  - Use of feed forward
- Lack of specificity
  - CHF – need to know if it's diastolic/systolic and acute/chronic
  - Chronic kidney disease – need stages
  - Renal failure – acute or chronic (and stage if chronic)
  - Respiratory failure – acute, chronic, acute on chronic
- Meds ordered without mention of indication
- Lack of Plan of Care (POC) or no follow through of POC
- Use of term "stable" or "no acute distress"
- Patient off unit for ortho follow-up appointment

Physician Documentation: ICD-10

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Benefits

- Diagnosis/Assessment
  - Requires increased specificity
  - Potential to improve overall documentation
- Plan/Interventions
  - Potential corresponding interventions due to identification of cause and requirement to specify
  - Triggers the mind to address in writing the medical decision-making process

Example: Intracranial hemorrhage — Non-Traumatic

ICD-9	ICD-10
Site: Extradural Subdural Unspecified	**Site:** Extradural Subdural -Acute -Chronic -Sub-acute -Unspecified Unspecified

Example: Respiratory Failure

ICD-9	ICD-10
Status: Acute Chronic Acute on chronic	**Status:** Acute Chronic Acute on chronic Unspecified
	With: Hypercapnia Hypoxia Unspecified with hypercapnia or hypoxia

Consulting Physicians

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Timeliness

- Routine vs. stat
- Continued/ongoing visits and medical management

Documentation

- Support medical complexity
- Specialized physician oversight
- Assessment, interventions, and plan
- Coordination of care reflected in attending and team documentation

Example: Nephrology Consult

Assessment

- Acute kidney injury on chronic kidney disease, stage 5, secondary to diabetic nephropathy, etiology ATN
- UTI
- C. diff colitis
- Leukocytosis likely secondary to UTI and C. diff
- DM type II, uncontrolled; diabetic neuropathy
- Coronary artery disease
- Hypertension
- CHF, systolic dysfunction

Plan

- HD 3x a week on T-Th-Sat
- UTI-completed course of fluconazole
- Cont. Flagyl for C. diff
- Check blood cultures
- Glycemic and HTN control: increase clonidine to 0.3x daily for BP control
- Check BMP, CBC, mag, phos in a.m.
- Decrease lovenox to 30mg daily for DVT proph
- Preserve LUE for anticipated AV fistula
- Nepro 3x daily
- Further management per primary MD

Care Plans

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Interdisciplinary

- Nursing
- Respiratory therapy
- PT, OT, SLP

Documentation

- Supports medical complexity
- Supports interdisciplinary team
- Individualized
- Updated throughout patient stay
  - Goal attainment
  - Revisions
- Patient/family education

Interdisciplinary Team Documentation

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Skilled services are supported

- Knowledge and training of a professional is necessary
- Need should be indicated in initial evaluation
- Evidence that skilled services were performed should be reflected in notes

Services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by qualified nurses and therapists.

Skilled services can be:

- Diagnostic and assessment
- Designing treatment
- Establishment of compensatory skills
- Providing patient instruction
- Reevaluations

Daily/Treatment Notes

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SOAP format

- Updated information in each note
- Demonstrates critical thinking and necessary skills for services provided
- Incorporates medical conditions with current impact on daily status

Common traps

- Missing documentation
  - RN timed turning, 1:1 monitoring, timed voiding programs, glycemic control
  - Respiratory therapy; details of treatment, weaning trials, progress notes/discharge notes
  - PT, OT, SLP – skilled services and patient/family education
- Templates
  - Checklists only with little narrative
- Lack of carryover
- Lack of integration across interdisciplinary team

Interdisciplinary Team Meetings

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Frequency

- Weekly
- Interdisciplinary rounding
- Huddles

Documentation

- Progress toward discharge plan
- Barriers to discharge
  - Medical conditions
  - Inability to transition to next level of care
  - Impairments and functional limitations
  - Support
- Interventions to address barriers
- Expected discharge date
- Post-discharge needs
- Justification for continued stay at LTACH

Interdisciplinary Team Meetings

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Common traps

- Documentation does not support evidence of discussion and updates to the plan
- Status report vs. barriers and interventions
- Failure to incorporate medical, nursing, and therapeutic interventions
- Lack of knowledge about patient
- Appropriate individuals missing from team conference

Solutions

- Status updates on form completed prior to meeting
- Documentation at meeting is relevant to the discussion
- Talk from the patient care plan(s)
- Case manager or other identified individual facilitates
- All attendees come prepared and report
- Confirm discharge plan and goals with estimated length of stay
- Ensure documentation states why patient needs to remain in LTACH

Discharge Plan

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Timeliness

- Developed upon admission
- Reviewed and updated in team meetings

Documentation

- Supported through case management
- Includes family/caregiver involvement
- Additional resources required and provided to patient/family
- Conceptually provides checks and balances to the expected length of stay, ongoing needs, patient's goals, attainment of goals, and continued services in the LTACH

Discharge Summary

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The last chance…

- Hospital course
  - Medical – include consulting physician involvement
  - Outcomes of interdisciplinary team
  - Discharge disposition
  - Evidence of discharge planning
    - Follow-up appointments
    - Equipment
    - Medications
- Authenticated within 30 days after discharge

Audit Preparation

Before the storm

- Develop an internal team
  - Action upon receipt of documentation request
  - Communication
  - Roles and responsibilities
- Conduct internal and external reviews
  - Engage physicians
  - Include interdisciplinary team members
  - Incorporate into UR, Quality, or Compliance committee meetings
- Create a drill to assess readiness

Documentation

- Medical record audit checklist
  - CMS, TJC, state rules and regulations
- Results and associated actions
- Continuous performance monitoring
  - Physician FPPE/OPPE
  - Staff performance evaluations

Audit Preparation

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Documentation request

- Letter received…clock starts ticking
  - Time sensitive from here on out
- Identify one point person
- Quickly begin copying or printing the requested medical record

Medical record review

- Completeness
- Contains requested items
- Includes scanned documents and/or documents from other electronic systems
- Perform self-audit prior to submission across the entire medical record

Audit Preparation

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Submission of medical record

- Create a table of contents
- Number the pages
- Cross-reference your medical record with list of requested documents in the request letter
- Send electronic or paper copy within stated time frame

Tracking

- If mailed, track the package for date of receipt
- Follow up to ensure receipt of medical record
- Record date submitted, decision received, and results

Additional tracking information

- Claim amount
- Dates of service
- MS-LTC-DRG
- Attending physician

2008 Implementation of MAC post-payment reviews

- Documentation does not support integration of interdisciplinary team
- Continued-stay criteria/justification lacking toward end of patient stay
- Services could have been provided in an alternative setting

Solutions

- Integrate team documentation through team conference
- Maintain strength of medical necessity beyond acute resolution of conditions
  - Chronically critically ill
  - Chronic care management and PREVENTION
- Demonstrate through documentation why patient cannot be in an IRF or SNF

Lessons Learned

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Internal audits

- Performance
- Opportunities
- Rewards for teams or individuals

Results of CMS audits or denials

- Process
- Tracking
- Outcomes
- Actions
- Ongoing evaluation of sustainability

Reach out to other LTACHs or post-acute providers

- Gain insight through others' experiences and results
- Outreach
  - User forums
  - Professional organizations
  - LinkedIn

Education

Case studies

- Use of weak and strong pre-admission screenings, H&Ps, team conference notes, etc.
- Interactive learning with fill-in-the-blank answers to complete, or revise documentation examples in staff meetings

Pocket cards or quick reference "cheat sheets"

- Examples supporting medical necessity for physicians
- Cheat sheets for team conference flow, discussion, and documentation

Initial orientation and ongoing training

- Competencies surrounding documentation included with EMR training or paper medical record orientation

Concurrent reviews

- Real-time feedback
- Incorporate education into internal auditing process

Education: Physicians

Tie medical necessity in with ICD-10 education

- Diagnosis/Assessment
  - Requires increased specificity
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Clinical documentation improvement programs

- Incorporate into current coding queries
- Identify physician champions
- Clinical/Case Management leadership

External Resources

- Dr. Robert S. Gold

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Questions?
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Next Call: Thursday, December 4th
Patient Perception

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