Overview

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
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
Medical Necessity

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

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
Medicare Conditions of Participation

**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
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
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
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
Pre-admission Screening

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
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

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**

**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

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
Physician Documentation

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
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**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site:</strong></td>
<td><strong>Site:</strong></td>
</tr>
<tr>
<td>Extradural</td>
<td>Extradural</td>
</tr>
<tr>
<td>Subdural</td>
<td>Subdural</td>
</tr>
<tr>
<td>Unspecified</td>
<td>-Acute</td>
</tr>
<tr>
<td></td>
<td>-Chronic</td>
</tr>
<tr>
<td></td>
<td>-Sub-acute</td>
</tr>
<tr>
<td></td>
<td>-Unspecified</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
</tr>
</tbody>
</table>
## Example: Respiratory Failure

<table>
<thead>
<tr>
<th>ICD-9 Status:</th>
<th>ICD-10 Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>Acute</td>
</tr>
<tr>
<td>Chronic</td>
<td>Chronic</td>
</tr>
<tr>
<td>Acute on chronic</td>
<td>Acute on chronic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 With:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypercapnia</td>
</tr>
<tr>
<td>Hypoxia</td>
</tr>
<tr>
<td>Unspecified with hypercapnia or hypoxia</td>
</tr>
</tbody>
</table>
Consulting Physicians

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

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
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

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

**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
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

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
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

**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
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
Lessons Learned

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

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
Tie medical necessity in with ICD-10 education

- 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

Clinical documentation improvement programs

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

External Resources

- Dr. Robert S. Gold