

Analytics to Answers
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**Skilled Documentation
and MDS 3.0**

Health Care Association of New
Jersey
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Turning Data into Knowledge

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Objectives

- Outline the requirements for skilled care under Medicare
- Describe the forms of skilled documentation with a focus on daily nurses' notes
- Demonstrate the application of skilled documentation to Medicare reimbursement
- Demonstrate appropriate skilled documentation as applied to everyday practice

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Why Are We Here Today?

- In the SNF world the number of external auditors taking a close look at what you document is increasing
- You can't document to support the need for skilled care unless you know what CMS considers "skilled"
 - 5 Broad Categories of Skilled Care
- We will use various templates to look at documentation focusing on daily nurses' notes
- You will be able to demonstrate the application of skilled documentation to Medicare reimbursement RUG groups
- You will change the way you document on every resident, every day
 - More meaningful to the whole care team
 - The whole team can review each others' work and provide feedback for sustained improvement

Importance of Documentation

Goal of documentation is to:

- Substantiate daily skilled care
 - Required for Medicare reimbursement
- Establish Case Mix Index for Medicaid
- Record treatments, therapies and resident response
- Communicate between disciplines and facilitate continuity of care

What Is Skilled Level of Care?

- Ordered by physician
- Skilled nursing or rehabilitation
 - Provided by or under supervision of licensed personnel
 - Provided on a daily basis
- Skilled services must be provided for a condition for which the resident received inpatient hospital care
 - Or which arose while in SNF receiving care for the inpatient condition
- As a practical matter services can only be provided on an inpatient basis in the SNF

What Is Skilled Level of Care? (cont.)

- The services must be furnished pursuant to a **physician's orders** and be **reasonable and necessary** for the treatment of a patient's illness or injury
 - i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs, and accepted standards of medical practice.
 - The services must also be reasonable in terms of duration and quantity.

Medicare Benefit Policy Manual Chapter 8

30.2.2 - Principles for Determining Whether a Service is Skilled

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service;
- The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service.

Medicare Benefit Policy Manual Chapter 8 (cont.)

- While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

The Big Picture

- Resident qualifies for skilled level of care based on care needs (at least 1 of 5 broad categories)
- Goal:
 - Documentation which reflects skilled services
 - Documentation which supports RUG scores
 - Observe Fiscal Intermediary documentation guidelines

Skilled Nursing/ Rehabilitation Services

- Five broad categories of Skilled Care:
 - Observation and assessment
 - Management and evaluation
 - Teaching and training
 - Direct skilled nursing services
 - Direct skilled rehabilitation services
- Resident must require on a daily basis
 - Nursing: 7 days/week
 - Therapy: 5 days/week

Observation and Assessment

- Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

Management and Evaluation

- The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety.

Teaching and Training

- Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance
- Examples of skilled teaching activities:
 - Self-administration of injectable medications
 - A newly diagnosed diabetic (insulin, diet, foot-care)
 - Self-administration of nebs/inhalers
 - Gait training/prosthesis care
 - Care of a recent colostomy/ ileostomy
 - Care of braces, splints, orthotics

Direct Skilled Nursing Services

- Examples of skilled nursing services:
 - Central or peripheral intravenous therapy
 - Pressure ulcer management
 - Tube feeding (meeting requirements)
 - Nasopharyngeal and tracheostomy suctioning
 - Wound management
 - Respiratory therapy treatments
 - Nursing rehabilitation

Direct Skilled Rehabilitation Services

- Examples of skilled Rehabilitation
 - Physical therapy
 - Gait/transfer training, strength training, ROM
 - Speech/language pathology
 - Use of communication aids, swallowing techniques
 - Occupational therapy
 - ADL self care, splint/brace adjustment/training

General Documentation Tips

- Goal of documentation
 - Communication of resident’s needs and care received
 - Demonstrate clinical decision making
 - Demonstrate need for skilled level of care
 - Support appropriately billed services
- Usually when a resident requires a skilled level of care, thorough documentation is a matter of best practice

Ensuring Good Documentation

- Consider a documentation prompt or template
 - Clinical issues
 - Rehab/treatments
 - ADLs/other functional areas
 - Cognition/mood
 - Changes in condition/new orders
- Be sure that your notes reflect the individual resident
- One good note is better than poor notes every shift
 - Consider assigning daily notes to different shifts

Watch out for...

- Common Documentation issues that lead to denial / RUG reduction:
 - Physician orders too vague
 - Notes do not reflect progress (medical necessity, “reasonable & necessary”)
 - MDS, Therapy & Nursing notes inconsistent
 - In an unpredictable manner
 - Lack of objective, measurable and functional goals
 - MDS inconsistencies among RUG items

Why Is Nursing Documentation Important If Resident Is on Therapy?

- Index maximization
 - e.g. HE2 and HD2 have higher Medicare CMI than RHC
 - Need to document issues such as fever, SOB, need for IV hydration, signs of depression
- EOT OMRA and the “three day rule”
 - If planned therapy is missed, need documentation to establish a non-rehab RUG

EOT-R OMRA and the Impact on Skilled Level of Care

61-90	61	62	63	64	65	66	67
60-day	11/01/11	11/02/11	11/03/11	11/04/11	11/05/11	11/06/11	11/07/11
assessment	68	69	70	71	72	73	74
	11/08/11	11/09/11	11/10/11	11/11/11	11/12/11	11/13/11	11/14/11

Case Scenario

- End of Therapy: 11/5/11
- EOT OMRA ARD is set 1 to 3 days after the last day of therapy (11/8/11)
- Payment changes 11/6/11 (first non-therapy day)
- If therapy resumes by 11/10/11 then complete the resumption date (O0450) and submit the EOT-R
- Non-therapy RUG paid on 11/6, 11/7, 11/8 and 11/9. payment resumes Rehab RUG starting 11/10/11

Documentation Needs:

Why was therapy stopped? Clinical change in condition? Refusal to attend due to fatigue?

Unfinished Resident Interviews

- Documentation of cognitive impairment, mood issues and pain may be needed in case the resident is unable or unwilling to complete interviews
- Nurses' notes:
 - STM loss/need for cueing
 - Signs/complaints of depression
 - Signs/complaints of pain

Documentation Template

- Consider the resident's "story":
 - Criteria necessary for the RUG category
 - Response to treatments/ intensity at that level
 - Functional ability, goals and progress, which justifies staying with that RUG
- Link documentation to one of 5 categories of skilled care
- Link documentation to diagnoses

Rehabilitation

- Documentation should reflect
 - Clinical condition that supports the intensity of services
 - Functional ability, inability, prior level and progress toward goals
 - Individual response to treatment, **ability to learn and carry over new learning** to alternative environments
 - Focus on progress toward goals
 - Clinical conditions that impact function and mobility (SOB, pain, cardiac)
 - Identify abilities and inabilities **24/7**

Rehabilitation Low

- Skilled Therapist 3x/week total at least 45 minutes
 - Evaluate for loss of newly gained functional ability, ROM, transfer skill, strength
- Restorative nursing 2x 15 minutes 6 out of 7 days.
 - Identify functional abilities, why inpatient, note risk factors or risk taking behavior and follow up teaching

Orthopedic

- Documentation should reflect
 - Functional abilities while maintaining weight bearing restriction
 - Pain with function, response of meds, side effect of meds
 - Incision healing/non healing, teaching s/s infection to patient, treatments to surgical wound as ordered
 - Carryover of therapy techniques, transfers, ambulation, ADLs, equipment use

Hip Fracture: Nursing Note-Take 1

- VS: 118/68, 16, 84, T 97.8. Alert, cooperative. Assist with ADLs. Attended PT in AM. Complained of hip pain, APAP given. Ate 100% at breakfast & lunch. Attended activities in PM.

Hip Fracture: Nursing Note-Take 2

- VS: 118/68, 16, 84, T 97.8. Attended PT in AM. In afternoon was noted transferring self from bed to chair without device, with full weight bearing (PWB in orders). Reviewed transfer techniques and weight bearing status with resident, with understanding. Rt. Hip incision intact, in alignment, no edema. C/o LE pain (2 on 10 scale), Tylenol 650 mg p.o. given with good relief. Continue to monitor transfer skills and reinforce PWB, monitor hip for pain. Notify MD if FWB transfers continue. Restorative transfer training continues BID.

Extensive Services

- Documentation should reflect
 - Specific care needs in the category (Trach, Ventilator/respirator, **Isolation**)
 - Fluctuation in condition(s)
 - Resident's response to fluctuations
 - Consider risk for medical instability, complications
 - Clinical responses to treatment, and modification to the plan of care

Special Care

- Beyond wound care:
 - Teaching s/s infection, treatment procedures
 - Response of the wound: Improving? Worsening?
 - Recent treatment change/likelihood of future modification
- Diabetes
 - Daily injections or insulin order changes
- COPD
 - SOB while lying flat
- Parenteral/IV
 - Document need for IV hydration
- Fever with pneumonia, weight loss, vomiting or TF
 - Establish baseline temp and record vitals q shift

Pressure Ulcer: Nursing Note- Take 1

- VS 98.8-124/72-88-20. Res. remained in bed, NAD noted. Foley catheter patent. Appetite fair, assist with ADLs. Treatment to wound done a/o. NP visited, N.O. for U/A C&S.

Pressure Ulcer: Nursing Note- Take 2

- VS 98.8-124/72-88-20. Continues on Kinair bed for Stage IV pressure ulcer to coccyx. Wound bed remains covered w/yellow slough, decrease in purulent drainage noted. Requires assist of 2 to position in bed for pressure relief. Ate 75% of meals with physical assist. Foley catheter patent, draining dark amber cloudy urine. NP notified of change in urine, N.O. for U/A C&S. Will continue to monitor wound healing, and for s/sx of UTI.

Clinically Complex

- Focus on the diagnoses that require:
 - Observation/Assessment
 - Management and Evaluation
 - Teaching/Training
- Oxygen, chemotherapy, IV meds, transfusions
 - Medical necessity
 - Response to changes in condition
- Refer to recent changes in medication and treatment plans, teaching progress, ability to learn, barriers to learning
- Depression: PHQ-9 score ≥ 10
 - Resident interview or staff assessment

Diabetes: Nursing Note- Take 1

- Alert, VS 97.9-130/88-86-20. FSBS and insulin a/o (see MAR). Fed self 100%. Assist with ADLs. Remained in room in PM.

Diabetes: Nursing Note- Take 2

- VS 97.9-130/88-86-20. 11am FSBS: 212, 4u Regular insulin given per ss. Res. noted to be barefoot in room. Reminder and teaching done re: proper foot wear and care of feet. Skin intact @ this time. Requires physical assist of 1 with ADLs, transfers bed to chair with assist of 2. Fed self 100% of meals, NCS diet. Res. Teary after lunch. Did not attend usual activities in PM. Notified SW to speak with res. and family. NP in to see res., N.O. Effexor 37.5mg po qd.
- Add: 2p FSBS: 198, 2u Regular insulin given.

Cardio/pulmonary Assessment

- Documentation should link the diagnosis to one or more of the 5 broad categories
- Observation and assessment
 - Vitals, temperature, lung sounds
 - O2 saturations, change with function
 - Abilities and inabilities
 - Note if activities are avoided due to SOB
 - Medication changes
 - Need for equipment (mask, nebs, suction)

Pneumonia: Nursing Note-Take 1

- Alert and cooperative, no complaints. Feeds self, assisted with ADLs. Seen by PT and OT. Continues ATB and O2 a/o. Up in chair in afternoon, attended music activity. VSS, afebrile.

Pneumonia: Nursing Note-Take 2

- VS: 98.2-122/86-84-24. Cont. O2@2L/m via n/c, O2 sat 98%. Resp. even, crackles noted L. base. Occasional non-productive cough noted. Antibiotic cont a/o for pneumonia. Requires physical assist of 1 with ADLs due to fatigue and decreased mobility. Requires pacing to conserve energy. Transfers to chair with assist of 1. Continues with PT and OT 5x a week. Alert and compliant with care, noted to be tearful in afternoon, saying "I'm still so weak". Will continue to monitor vitals and respiratory status.

Cardiac

- Documentation should reflect
 - Heart rate, rhythm, vital signs
 - Does clinical condition interfere with function?
 - Note any use of oxygen, saturations, nebulizers, suctioning
 - Teaching: pacing, energy conservation, diet
 - Medication changes, dose reductions with likelihood of change, level drugs

Pain Management

- Pain: any type of physical pain or discomfort
 - Chronic or acute?
 - Local or general?
 - At rest or provoked by activity?
 - How does the patient manage ADLs, functional activities in/not in pain
 - Medication changes that require observation/assessment
 - Teaching pain regimen, management, goals

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Documentation of High Risk

- In a risk management environment focus is on high risk residents, and high risk conditions
- Some resident risk factors make the claim “at risk” for denial
 - Speech therapy in absence of supportive diagnosis or conditions
- Some risks require ongoing skilled level of care if properly documented
 - Falls
 - Cognitive Impairment

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Documenting Risk Management Concerns

- Falls
 - Therapist assessment after a fall prompts the need for reevaluation of care plan
 - Low bed
 - Call bell position/ ability to use
 - Cognitive awareness/ evaluation
 - Goals/redefine
 - Time of fall/ interventions
 - Nursing training
 - Are there other skilled therapy interventions that nursing and therapy can co-develop?
 - May indicate the need for resident to come back into therapy, extend sessions


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Cognitively Impaired Residents

- High Risk
 - Falls/ poor compliance
 - Denials by Fiscal Intermediary
- Clear picture of resident's prior level of function is critical
 - Level of understanding
 - Cooperation
 - Aggressive behaviors
 - These are great areas to show any small progress in documentation

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Documenting Progress in Cognitively Impaired Population

- Document progress in the following
 - Number of times cueing is needed
 - Frequency per task
 - Type of cueing
 - Verbal prompts/Gestures
 - Level of physical assistance
 - Supervision
 - Limited assistance i.e. Hand over hand
 - Weight bearing
 - Behavioral response
 - Desired functional effect?
- Always relate progress to functional goals and quality of life!

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Documentation Consistency Is Key

- Resident conditions can fluctuate from day to day/shift to shift
- Ensure that any new or changed conditions are documented consistently between shifts and disciplines
 - e.g. monitoring after change in mental status, effects of new medication, carry-over from therapy
 - Ensures that all IDT members are aware
 - Demonstrates skilled level of care through interdisciplinary management, monitoring and interventions

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Documentation Is Important for Medicaid Too

- Many states' Medicaid reimbursement is based on RUGs
 - Crosswalked from MDS 3.0 assessment to calculate RUG III
 - Documentation should be present to capture items on MDS
 - e.g. behavioral issues, ADLs, skin ulcers and treatments, cognitive deficits/mood symptoms (if staff assessment)
 - Although documentation of daily skilled need is not necessary for Medicaid, inadequate documentation can lead to missed reimbursement

Skilled Documentation Audits

- Who should audit their documentation?
 - Nurses
 - Therapists
 - Social workers
- What aspect of the record should be included in the audit?
- When should records be audited?
- Why?
 - Ensure proper application of the Medicare guidelines
 - Protect Provider Liability
 - Prevent Denial

Conclusion

- Medicare requirements for daily skilled level of care have not changed
 - Maintain CMS/FI standards
- Good documentation demonstrates the resident's ongoing needs as well as the care provided
 - Keep the 5 categories of skilled care in mind
- Ensure that as much information as possible is captured if the unexpected happens
 - EOT/COT OMRA, unfinished interviews

For More Information

- Medicare Benefit Policy Manual- Chapter 8
 - <https://www.cms.gov/manuals/Downloads/bp102c08.pdf>
- Skilled Nursing Facility Manual
 - <https://www.cms.gov/manuals/pbm/itemdetail.asp?itemid=CM5021915>
- CMS MDS 3.0 website:
 - http://www.cms.hhs.gov/NursingHomeQualityInits/25_NH_QIMDS30.asp
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