



The Skilled Documentation Puzzle: Key to Medicare Coverage

Skilled Documentation

As everyone working in the long term care field knows, 2010 is expected to bring major changes to the industry with the implementation of MDS 3.0 and RUG IV. Your facility's interdisciplinary team is most likely already reading through the MDS 3.0 manual and the RUG IV documentation to learn what changes you will need to make to keep up. However, one thing that will not change is the need for thorough and consistent daily documentation of skilled care for your residents who are covered under their Medicare skilled benefit. Since this is an important piece of the day-to-day facility process regardless of any changes in the Medicare system, we will discuss a few ideas here to help your facility ensure that your documentation is appropriate.

Criteria for Skilled Medicare Coverage

First, let's look briefly at the criteria for covering a resident under the Medicare skilled benefit. The resident must first be eligible for Medicare and have available skilled benefit days from a qualifying three-midnight hospital stay. Second, the physician must certify that the resident requires daily skilled rehabilitation or nursing care in an inpatient setting. This means that for reasons of economy and efficiency these services cannot be provided on an outpatient basis. Lastly, the skilled services provided must be reasonable and necessary to promote the resident's medical stability and safety and facilitate their recovery from illness.

When a facility is providing skilled care to a resident, the care team each contributes their piece of the skilled documentation puzzle. The physician writes the orders for skilled nursing and rehabilitation care, documents the resident's condition in his or her progress notes, and certifies that the resident continues to require a skilled level of care: first with the initial certification and then with each re-certification until skilled services are discontinued. If the resident is receiving skilled therapy services, the licensed therapists obtain the physician's orders and document the daily therapies provided, as well as regular progress notes. Finally, the licensed nurses document skilled nursing interventions, vital signs, order changes, ADLs, and any specific information related to current orders or treatments (such as response to antibiotic therapy, lung sounds, pain, wound condition etc.)

Skilled nursing documentation should relate to the resident's care under one or more of the five broad categories of skilled care:

- Observation and assessment
- Management and evaluation
- Teaching and training
- Direct skilled nursing services
- Direct skilled rehabilitation services

The general goals of documentation are to communicate the resident's needs and the care provided, demonstrate clinical decision making, demonstrate the need for daily skilled care, and support the appropriate billing of services. Usually when a resident requires a skilled level of care, thorough documentation is a matter of best practice to ensure that the interdisciplinary team communicates and collaborates on the plan of care.

Ensuring Good Skilled Documentation

Demonstrating the resident's need for daily skilled care depends greatly on consistent documentation that addresses the resident's condition and skilled services. To make sure that this documentation is consistent, consider training your nursing staff according to documentation template or checklist which covers the key issues, such as:

- Clinical issues
- Rehab services/treatments
- ADLs/other functional areas
- Cognition/mood
- Changes in condition/new orders

Of course, using a documentation checklist should not lead to "cookie-cutter" notes. Documentation must reflect the individual resident's needs, functioning, and treatments. However, a checklist can help your staff ensure that they are not missing any important information when they write their notes.

Another key point to remember is to "document smarter". One good note per day is better than poor notes written every shift. A good daily skilled note will establish the resident's need for daily skilled care. Consider dividing the assignment of daily skilled notes to different shifts so that the nurses on each shift can concentrate on the documentation for only a few residents. Then, the other shifts would only add additional notes if anything occurred on their shift such as order changes or a fall.

So what do you consider when you are creating a documentation checklist for a resident? Consider the resident's "story": include the criteria necessary to capture the RUG category. Consider the resident's response to treatments and

intensity of therapy. Describe the resident's functional ability, goals and progress which justify that RUG. Link the documentation to one or more of the five categories of skilled care, and be sure that the notes refer to any active diagnoses that require the skilled service.

Key Documentation Points: Consider the RUG Category

Since the documentation in the medical record must support the RUG that is being billed, keep the projected RUG category in mind when documenting. The daily notes for a resident who is receiving rehab services will be different from the notes for another resident who is receiving nursing services that qualify for a Clinically Complex RUG. Here are some ideas for each RUG category to help you get started:

Rehabilitation/ Rehab Plus Extensive Services

- Clinical condition that supports this 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
- For Rehab Plus Extensive RUGs: Monitoring resident condition related to SE criteria (IV medication/fluids, ventilator/respirator, suctioning, tracheotomy)

Extensive Services

- Specific care needs in the category. (clinical and ADL).
 - Fluctuation in condition(s).
 - Resident's response to fluctuations (awareness and ability to manage on their own).
- Consider risk for falls, medical instability, complications.
- Clinical responses to treatment, and modification to the plan of care.

Special Care

- Beyond wound care:
 - Teaching resident about signs/symptoms infection, treatment procedures, role of nutrition
 - Response of the wound: Improving? Worsening?
 - Recent treatment change with likelihood of future modification
- Functional abilities which impact predicted rate of wound healing

- Treatments to improve function, teaching of pressure relieving techniques in bed and chair
- Fever: treatment of risk associated with fever, infection
- Diagnoses
- Change in treatment plan (I/O, IVs etc.)

Clinically Complex:

- Focus on the diagnoses that require:
 - Observation/Assessment
 - Management and Evaluation
 - Teaching/Training
- How does the resident respond to changes in their own health conditions (e.g. hypoglycemia)
- Refer to recent changes in medication and treatment plans, teaching progress, ability to learn, barriers to learning
- Mood problems

The “Lower 18”: Impaired Cognition, Behavior Problems, Reduced Physical Function

- High risk areas for cognitively impaired residents
 - Falls/ poor safety awareness
 - Pain: careful assessment and monitoring with cognitive impairment
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- ADL function and dependencies
 - Level of physical assistance for ADL tasks
 - Changes in level of function
 - Resident’s understanding and cooperation
- Behavioral problems/response to interventions

Medicare Documentation Audits: a Team Effort

The Medicare model is surrounded by the documentation of your facility’s Interdisciplinary Team. All members of the IDT have a role in supporting a Medicare claim, so all members can have a role in auditing resident records. This is an integral part of internal compliance programs. Start by taking a look at how your facility communicates the status of your Medicare residents. Do you have daily stand-up or PPS meetings? Daily interdisciplinary communication is vital to ensuring that your documentation reflects any changes in condition.

For your current Medicare residents, try a chart audit to determine if the documentation is appropriate and consistent. Pull team together consisting of members of each of the disciplines, and have the team review a case. Start with a general overview- get to know the residents “story”. Then answer these questions:

- Is the resident eligible for Medicare skilled coverage?
- Is there evidence of the need for daily skilled care?
- What is the quality of nursing notes, therapy notes, MDS accuracy?
- Is the care plan complete?

Identify the strengths and weaknesses of your record, and then see what can be improved.

- Find an excellent note and identify why it is excellent
- Find a not so good note and identify what is missing
- Find a really BAD note, and rewrite it to make it a good note

Once you have identified any issues with your documentation, then you can use the examples of good and bad notes to teach your direct care staff. Once your staff understands that smart, consistent documentation is beneficial to the care of your residents as well as your Medicare reimbursement, this can help to build their interdisciplinary communication skills which will help your facilities daily processes run smoothly.

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