Documentation of Skilled Nursing Services

WHITE PAPER

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. —**42** *CFR* **Section 409.32**

Medicare documentation must provide accurate information to support the necessity of skilled services provided to a resident. Nursing documentation is vital and must reflect the reason for admission to skilled services, the delivery of skilled services, and justification for skilled services to continue. All of these elements, combined with the documentation within the entire medical record, help to justify and support your Medicare claim.

This section identifies the key criteria required to support that the nursing services were medically reasonable, necessary, and appropriate to the level of Medicare skilled services. The clinical documentation must support a beneficiary's total condition and individual need for skilled services.

✓ Collaboration Tip

Per the *Medicare Benefit Policy Manual* 30.2.2.:

It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.

Medicare Documentation

Medicare does not have specific criteria for how documentation is formatted. It says only that daily skilled care is required and that documentation must reflect this level of care. Documentation should be legible and easy to understand and should do the following:

- Paint a picture for the reader
- Be descriptive and objective
- Reflect the medical complexity of the patient

Medicare defines skilled services for nursing and therapy in the CMS 100-02 *Medicare Benefit Policy Manual* Section 30.2.1 as follows:

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- *Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and*
- *Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.*

Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

What makes a nursing service skilled?

In the *Medicare Benefit Policy Manual*, 30.2.2, the principles for determining whether a service is skilled include the following:

- *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; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.*

- *The A/B Medicare Administrative Contractor (MAC) (A) 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. 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.*

Skilled nursing is also defined in the CMS 100-02 *Medicare Benefit Policy Manual* Chapter 8, Section 30. There are several different categories that CMS defines as skilled, including the following:

1. Management and evaluation of a patient care plan
2. Observation and assessment of a patient's condition
3. Teaching and training activities
4. Direct skilled nursing services to patients

"Management and evaluation of a patient care plan" is defined as follows:

> *The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.*

The patient's clinical record may not always specifically identify "skilled planning and management activities," as such. Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, then it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management, as illustrated in the following example:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand

the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age, and his immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until such time as skilled care is no longer required in coordinating the patient's treatment regimen, even though the individual services involved are supportive in nature and do not require skilled nursing personnel. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and that require the involvement of skilled nursing personnel to promote the stabilization of the patient's medical condition and safety.

"Observation and assessment of patient's condition" (30.2.3.2) is defined as follows:

> *Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized.*

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, then the skilled observation services are still covered as long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility.

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Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.

Certain signs and symptoms may justify skilled observation and assessment, including the following:

- Abnormal/fluctuating vital signs
- Weight changes
- Edema
- Symptoms of drug toxicity
- Abnormal/fluctuating lab values
- Respiratory changes on auscultation

Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the patient's treatment, then the services

are reasonable and necessary. However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these characteristics are part of a longstanding pattern of the patient's waxing and waning condition and which by themselves do not require skilled services and are not being addressed through any change in treatment.

The key factor of observation and assessment is the relationship of the observation or assessment to the stability of the treatment plan. Not every head-to-toe assessment constitutes a Medicare skilled service unless the treatment plan is being changed based on the assessment. Some residents will never be stable, despite the plan of care being stable. Consider the following example:

A resident who is on sliding-scale insulin may never have stable blood sugars, with episodes of hyper- or hypoglycemia. Monitoring of blood glucose levels and administering sliding-scale insulin is not a skilled service.

Documentation to support observation and assessment may include the following:

- A nursing care plan that describes the patient's condition, specific or potential problems, and planned intervention on a daily or more frequent basis
- Indication of daily or more frequent monitoring of vital signs, lung sounds, bowel sounds, skin condition, nutritional status, hydration, mental status, and mobility provided that the monitoring is related to the instability or probable change in condition; the results are used to initiate changes in nursing intervention
- Documented changes in the monitoring, which reflect instability
- Lack of changes in physical condition does not preclude the O/A; therefore, the documentation must support that there is a reasonable probability for changes in the patient's conditions
- Repeated modifications in the treatment plan as a result in the changes of the patient's condition

The need for skilled observation and assessment may end when the medical condition is stabilized, the patient recovers from the acute condition, or the treatment plan is well established and risks to the patient are minimized.

Therefore, the patient's medical record must document as appropriate, including the following:

- The history and physical exam pertinent to the patient's care (including the response or changes in behavior to previously administered skilled services)
- The skilled services provided
- The patient's response to the skilled services provided during the current visit
- The plan for future care based on the rationale of prior results
- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences

- The complexity of the service to be performed
- Any other pertinent characteristics of the beneficiary

The documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:

- Patient tolerated treatment well
- Continue with POC
- Patient remains stable

Those phrases do not provide a clear picture of the results of the treatment, nor the next steps that are planned. Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded so that all concerned can follow the results of the provided services.

Documentation

Example #1:

Resident respiratory status and lung sounds are assessed every shift. Rales and rhonchi continue to be heard through both lungs. O2 saturations have ranged from 88% to 96%. As-needed (PRN) albuterol treatments are being used two to three times per day, with marked improvement in respiratory rate and cognitive status.

Resident must be coached with deep breathing and inspirometer use every shift, as he does not remember proper use of inspirometer. Inspirometer max level achieved is 1500.

Example #2:

A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs are required. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

30.2.3.3—Teaching and training activities

Teaching and training activities that require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen would constitute skilled services. Some examples are as follows:

- Teaching self-administration of medications that are injected or a complex range of medications
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot care precautions
- Teaching self-administration of medical gases to a patient
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation
- Teaching patients how to care for a recent colostomy or ileostomy
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters
- Teaching patients the use and care of braces, splints, and orthotics and any associated skin care
- Teaching patients the proper care of any specialized dressings or skin treatments

Documenting teaching and training includes the following:

- Description of procedure taught
- Description of patient/caregiver response
- Description of the self-care
- Description of teaching aids utilized

Follow-up documentation includes the following:

- Description of return demonstrations
- Retention of materials taught
- Response to questions regarding the procedure/information taught

Teaching and training scenario

Resident has had a cerebrovascular accident (CVA) with swallowing difficulties and left-sided paralysis. Wife had arranged for home care eight hours per day, with self and family members doing remainder of care. Therapy has established a transfer program using a mechanical lift as well as an orthotic-wearing schedule for left arm/hand and foot. A bolus tube-feeding schedule has been developed for this resident, which needs to be taught to the family.

Documentation example

Wife instructed in tube-feeding formula and side effects by dietitian. Nursing demonstrated how to check placement of gastric tube prior to administering feeding as well as checking residual. Wife instructed in use of stethoscope today. Voices concerns about "not sure I am listening to the right thing." Will continue with additional demonstration and skill practice this evening using teaching

stethoscope so nurse can verify wife's observation. Will progress to the mechanics of administering the bolus feeding as wife demonstrates comfort with current information.

100-02 *Medicare Eligibility and Benefits Manual,* Chapter 8 §30.3—Direct Skilled Nursing Services to Patients/30.3—Direct Skilled Nursing Services to Patients.

> *Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42 CFR §409.32.) If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such services are necessary to maintain the patient's current condition or prevent or slow further deterioration as long as the beneficiary requires skilled care for the services to be safely and effectively provided and all other requirements for coverage under the SNF benefit are met. Coverage does not rely on the presence or absence of an individual's potential for improvement from nursing care but rather on the beneficiary's need for skilled care.*
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> *A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.*
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> *A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by an unskilled person, then the service cannot be regarded as a skilled nursing service even though a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides it.*

Some examples of direct skilled nursing services include the following:

- Intravenous or intramuscular injections and intravenous feeding.
- Enteral feeding that comprises at least 26% of daily calorie requirements and provides at least 501 mL of fluid per day.
- Nasopharyngeal and tracheotomy aspiration.
- Insertion, sterile irrigation, and replacement of suprapubic catheters.
- Application of dressings involving prescription medications and aseptic technique.

- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder.
- Heat treatments that have been specifically ordered by a physician as part of active treatment and that require observation by skilled nursing personnel to evaluate the patient's progress adequately.
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment and require the presence of skilled nursing personnel (e.g., the institution of bowel and bladder training programs).
- Initial phases of a regimen in medical gases, such as bronchodilator therapy.
- Care of a colostomy during the early postoperative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

Some examples of what to include in direct skilled nursing documentation are as follows:

- IV: Intake and output, vital signs, skin condition of IV site, tolerance of IV medication
- Enteral feeding: Intake and output, signs/symptoms of intolerance, (nausea, vomiting, cough, shortness of breath, diarrhea), skin integrity/problems,
- Insertion or irrigation of suprapubic catheter: Sterile technique used, amount of urine collected, patient tolerance to procedure, description of catheter site, intake and output, description of urine (color, odor, sediment, or other description)
- Decubitus ulcer: Location, odor present, drainage color and amount, complaints of pain, stage, size (length, depth, width), description of tissue, frequency and type of treatment, any special equipment used
- Care of colostomy in presence of early postop complications: Description of skin around site, any s/s of infection, check for abdominal distention and bowel sounds, stool color, consistency, frequency, and amount

Definition of "aggregate of unskilled services"

42 *CFR* §309 also identifies what is commonly called the aggregate of unskilled services: "(b) A condition that does not ordinarily require skilled services may require them because of special medical complications." Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33[d]) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel.

For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, then skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications and the skilled services they require must be documented by physicians' orders and nursing or therapy notes.

Documentation Tips

As the acuity, complexity, and variability of the resident's condition increases, the frequency of the documentation should increase accordingly. Frequent documentation to support assessments and interventions can help to support the knowledge and skill of the nursing staff. Be sure to follow your State Practice Acts or facility policies and procedures in order to provide the best supportive documentation for your patients.

Supportive documentation

Documentation should be precise and specific for each patient. General terminology that is not specific and difficult for the reader to define will not support the Medicare claim. Use measurable terms and avoid vague terms.

Example #1:

Pt lying in bed with eyes closed. On O2 @ 2l per n/c. No complaints. BP 145/90, P 100, R 20.

Example #2:

Pt lying supine with HOB at 30 degrees. Skin color pink, no edema noted in extremities. O2 on @ 2l per n/c. Respirations even but slightly labored. Wheezing noted in RLL. Continues on Albuterol treatments q 6 hours. BP 145/90, P 100, R 20. States she has a slight headache. Tylenol 1000 mg given at 0300 per physician order. Relief from headache noted at 0400.

CAUTION

The following words/phrases may make MACs or other review agencies scrutinize the need for skilled coverage. These are words that may make skilled services difficult to support:

- No change in status
- Ongoing, continues to be
- Same as, remains
- Little change
- Normal
- Voiced no complaints
- Appears
- Test results
- Essentially unchanged
- Status quo
- Fair/poor rehab potential
- Maintaining, status unchanged, approaching a maintenance level
- Patient refuses treatment every day
- Not motivated, low motivation
- Noncompliant with plan of care
- Unable to retain instruction or information

CAUTION

Be cognizant of the following words or phrases in nurses' notes if patient is receiving skilled therapy services:

- Wandering aimlessly through facility (PT recipient)
- Not an ambulation candidate (PT recipient)
- Poor therapy candidate
- Independent with all ambulation and ADLs
- Speech clear (speech pathology recipient)

Conclusion

Regardless of whether documentation is completed by narrative note, flowsheet, or checklist, it should be a complete record for the patient. Documentation paints a picture of the care provided. Good nursing documentation should reflect the nursing process, including the following:

- Assess: Information collection.
- Analyze what was assessed and determine next steps.
- Plan: Set nursing goals, desired outcomes, and planning intervention (care plan).

- Implement: Perform nursing interventions. Record the interventions in the notes and the client response.
- Evaluate: Evaluation of effectiveness and reset if needed.

Using critical thinking skills and documenting precisely and professionally allows one to take credit for the care provided.

Source: *Nursing and Therapy Documentation*, "Section 2," 2018, by Renee Kinder, MS, CCC-SLP, RAC-CT, and Elizabeth Barlow, RN, CRRN, RAC-CT, DNS-CT