1C. Can Your Hospice Documentation Survive a Medical Review Audit?

Presented by:
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Are you ready for an audit?

Audit Types

- Targeted Probe Audits (TPE)
- UPIC
- OIG
Common Reasons Audits -

...It's not if.... it's when

- Long Length of Stay (LOS)
- New Hospice Providers
- Having greater number of claims than others in your area
- Technical Issues
Technical Issues

Election Statements—Who signed the election? Does the patient have a power of attorney? What is the effective date? Is an attending physician identified?

Technical Issues

Interdisciplinary Group (IDG) Meeting Attendance and Participation—Is the review and updating of the plan of care documented as part of the IDG Meeting? Do you have an attendance sheet? How does the plan of care reflect input from necessary disciplines?
Technical Issues

Certifications of Terminal Illness—Do you have the right physician? Who is the attending? Are electronic signatures time stamped? Are recertifications timely? Did you obtain (and document) verbal certifications?

#1 Reason is Documentation Does Not Support Prognosis of Six Months or Less

*Physician narratives
*Ongoing clinical documentation
CMS Conditions of Participation

https://www.federalregister.gov/documents/2008/06/05/08-1305/medicare-and-medicaid-programs-hospice-conditions-of-participation

Success starts at referral
CERTIFICATION OF TERMINAL ILLNESS—418.22

Physician CTI

IS THE NARRATIVE SUFFICIENT (IN FORM AND SUBSTANCE)?

Admission Documentation

IS THERE CLEAR EVIDENCE THAT THE PERSON ADMITTED TO HOSPICE HAS 6 MONTHS OR LESS TO LIVE?

Ongoing Visit Documentation

IS THERE CLEAR EVIDENCE THAT PATIENT REMAINS HOSPICE APPROPRIATE FOR THE DATES OF THE SERVICE BILLED?
Hospice CTI Success

1. Before admission, collect all documentation to support eligibility.

2. Admission RN clearly shows clinical eligibility in admission note.

3. MD Note includes all elements of Palmetto GBA LCD (Local Coverage Determination) for each diagnosis, and shows decline - Why Hospice? Why Now?

4. Attestation - example "I confirm that I composed this narrative statement and that it is based on my review of the patient’s medical record and/or examination of the patient."

PHYSICIAN CTI - WHAT TO DO?

PROGNOSIS/DIAGNOSIS

COMPARE - HX FAILED ATTEMPTED TREATMENTS/MEDICATIONS AND MEDICAL HISTORY

IMPACTING CONDITIONS/COMORBIDS

ADDRESS WEAKNESSES

SHOW KNOWLEDGE CLINICAL RESEARCH AND MORTALITY SCALES
What documents do I collect prior to admission?

- Review LCD
- Collect clinical notes (recent) and over last 1-2 years.
- Include labs, scans (CT/MRI), echocardiogram etc.
- Talk with family, facility staff (MDS)

TERMINAL DIAGNOSIS

Use a template admits/recertification

- Why Hospice? Why Now?
- Objective signs of decline
- Objective Signs/Symptoms of Decline
- Lab Changes
What is CMS really looking for?

1. Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract and/or
   Weight loss not due to reversible causes such as depression or use of diuretics

2. Progressive malnutrition as documented by:
   Decreasing measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics

3. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption/documented weight loss,
   Decreasing serum albumin or cholesterol

4. The hospice nurse needs to describe what they “see” when they come into the home. This can include the patients dress, color, cleanliness, tired/sleepy, sad, affect, where found during visit (bed/chair), still in pajamas in the middle of the day, etc....

5. Appearance
   Documentation at the time of admission, if the patient cannot stand on scales, query the family to see how clothing fits today as compared to 3 and 6 months ago.

6. Appetite
   Appetite usually is a good indicator of decline in a hospice patient. Avoid documentation of good, fair or poor appetite. This cannot be measured. Instead give the number of meals that the patient ate per day along with the % of intake of each meal. Get down to even describing the meal provided in order to gauge the amount eaten/not eaten.
What is CMS really looking for?

### Symptoms
7. Dyspnea with increasing respiratory rate
6. Cough, intractable
5. Nausea/vomiting poorly responsive to treatment
4. Diarrhea, intractable
3. Pain requiring increasing doses of major analgesics more than briefly.
2. Weight loss not due to reversible causes such as depression or use of diuretics (use words such as cachectic, anorexic, poor appetite, fragile, failing, weaker)
1. Comparison Data

### Signs
10. Decline in systolic blood pressure to below 90 or progressive postural hypotension
9. Ascites
8. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
7. Edema
6. Pleural / pericardial effusion
5. Weakness
4. Change in level of consciousness

### Laboratory
1. Increasing pCO2 or decreasing pO2 or decreasing SaO2
2. Increasing calcium, creatinine or liver function studies
3. Increasing tumor markers (e.g. CEA, PSA)
4. Progressively decreasing or increasing serum sodium or increasing serum potassium

What is CMS really looking for?
• Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.
• Increasing emergency room visits, hospitalizations, or physician’s visits related to hospice primary diagnosis.
• Progressive decline in Functional Assessment Staging (FAST) for dementia (from ≥7A on the FAST).
• Progression to dependence on assistance with additional activities of daily living.
• Progressive stage 3-4 pressure ulcers in spite of optimal care.

Non Disease-Specific Guidelines

• Physiologic impairment of functional status as demonstrated by:
  • Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%
  Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.
• Dependence on assistance for two or more activities of daily living (ADLs)
  • Feeding
  • Ambulation
  • Continence
  • Transfer
  • Bathing
  • Dressing
Comorbids

Although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease (CVA, ALS, MS, Parkinson’s)
- Renal failure
- Liver Disease
- Neoplasia
- Acquired immune deficiency syndrome
- Dementia

### Probability of Death Within 6 Months

<table>
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<th>40</th>
<th>50</th>
<th>&gt;60</th>
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</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>88%</td>
<td>90%</td>
<td>93%</td>
<td>89%</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>80%</td>
<td>74%</td>
<td>65%</td>
<td>52%</td>
</tr>
<tr>
<td>Dementia</td>
<td>74%</td>
<td>55%</td>
<td>51%</td>
<td>37%</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>82%</td>
<td>83%</td>
<td>71%</td>
<td>64%</td>
</tr>
</tbody>
</table>

ALZHEIMERS AND RELATED DEMENTIAS

- Stage seven or beyond according to the Functional Assessment Staging Scale
- Unable to ambulate without assistance;
- Unable to dress without assistance;
- Unable to bathe without assistance;
- Urinary and fecal incontinence, intermittent or constant;
- No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.

Patients should have had one of the following within the past 12 months:
- Aspiration pneumonia;
- Pyelonephritis or other upper urinary tract infection;
- Septicemia;
- Decubitus ulcers, multiple, stage 3-4;
- Fever, recurrent after antibiotics;
- Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl.
POSITIVE & NEGATIVE CHARTING

- Avoid subjective, biased documentation
- Focus on decline using objective data
- Document falls, infections and diet changes
- Make sure documentation is consistent

Painting the Picture

- Requires total assistance with ADLs
- Requires total care for ADLS—bathing, dressing, feeding and toileting
- Declining Appetite
- Was eating 30% of meals last visit, now only taking sips water
- Increased Confusion
- Disoriented to person, place and time. Last visit oriented to person. Speaking less than 6 intelligible words
Sleep Documentation

Patient seen today for assessment of terminal diagnosis of Alzheimer’s Dementia comorbid of CHF, CAD and Diabetes. The patient’s spouse reports that the patient is spending more time during the day in bed sleeping. When asked about the amount of time, the spouse further describes the patient is sleeping 8-10 hours at night and then takes a 3-4 hour nap during the day. The daughter also states that when the patient is up in the chair for more than an hour, she is frequently dosing off and can not stay upright without pillow propping her up due to poor truncal support. This is a change from just 2 months ago when the patient was not even sleeping during the night, was having sundowners syndrome, sleeping a few hours during the day only and was able to sit at table for meals.

Key Descriptive Words

- Anorexic/Cachectic/Frail
- Dyspneic at rest/with minimal exertion
- Last week was able to eat without oxygen and now requires oxygen continuously
- Bony prominences in neck, arms and shoulders evident
- Family purchased clothing in size 12 six months ago and now wears a size 6 (Small)
- Follow descriptions with “as evidence by” and then describe what you see with examples.
Each Visit

- Hospice nursing documentation must be very descriptive. This requires the nurse to look at the patient's improvements and declines from visit to visit.

- Some items will need to be documented at least weekly:
  - Mid-arm circumference and weight if able to stand safely on scales
  - Any wound characteristics to include: size, drainage, odor, wound bed, periwound, tunneling/undermining
  - Use of a standardized tool depending on the patient's terminal illness. This can include: FAST, Karnofsky, PPS, New York Heart Association Class

Words to avoid in hospice

- Stable
- No change(s)
- Eating well
- No issues noted
Plan of Care

Individualize your plan of care
Make sure you place items in POC that you will do

Include wound care orders
who will perform wound care, did you add “until healed”, are all wounds documented?

Include all disciplines
.....are you meeting all of your frequencies?

IDG Documentation

Are you meeting every 14 days?
Do you have core disciplines signatures?

Is POC being updated during or after IDG to show new problems/goals etc.
Are there interventions to manage pain and symptoms? Are the advanced directives and equipment listed?

Does it include patient and family goals?
IDG Documentation

Have you completed medication reconciliation?

***Physically looked at medications in home/facility

Are you missing visits?

Thank You

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Change in pain (frequency/intensity)

1. Increases and/or changes needed to pain medication
2. Worsening symptoms (i.e. breathing, edema)
3. Increased dependence in ADLS
4. Weight changes (over what period of time)
5. Appetite changes
6. Diet Changes (dysphagia)
7. Mental status changes
8. Incontinence (new or increased)- Does this change your FAST score?
9. Worsening labs i.e., decreased albumin
10. New compromised skin integrity (wounds)- * update the POC
11. Decreased MUAC
12. Increased abdominal girth
13. Change in oxygen demand
14. Changes in level of care i.e., respite, general inpatient, or continuous care
15. New Medications
16. Infections
17. Mobility Changes
18. Increased frequency of other hospice team members
19. Additional equipment ordered due to change of condition
20. DNR
21. Document if patient is refusing medications, oxygen or declines seeking aggressive treatment
Admission Template

Name:
Admit date:
Admit Time:
Location:
MPOA/Emergency Contact:
DOB:
SSN:
DX:
CoMorbid:
Allergies:
Attending:
Certifying:
Medical Director:
RN:
SW:
Chap:
Aide:
Volunteer:
Supplies:
Equipment:
Veteran:
Funeral Home:
Pain on Admission:
Emergency Code:
Pharmacy:
Religion:
DNR:
Tobacco use:
Alcohol use: