Accurate Documentation: Key to Surviving MCR Denials & Audits

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Objectives

• Identify & discuss the most common ADR reasons
• Identify & discuss top 10 denial reasons
• Discuss responding to ADRs & denials
• Discuss defensive charting & documentation
• Discuss goals & interventions

Top 10 Reasons for Denials

1. Care not reasonable & necessary
2. Documentation does not support medical necessity
3. Home bound status
4. Services not documented
5. Problematic POC
6. Frequency of services not warranted
7. Medical review down-code
8. No certification (POC or F2F)
9. Insufficient orders
10. No response to ADR in 30 days

ADRs

• Additional documentation request
• Probe or Focused directed
• Responding – Do not procrastinate or ignore!
  - identifying
  - timeliness
  - preemptive actions
• Reconsiderations & appeals
• The request is made but you can still mitigate damages
• Use exact address on ADR
• Look closely at all signatures & dates
• Review start of care date
• Review documentation supporting homebound status
• Write cover letter to accompany ADR
• Collect ALL documentation
• Write addendum if necessary
• Number all pages and keep exact copies of everything
Don’t Let Response Error Become a Denial Letter

- Reason for denial: “Medical records not received in response to ADR in the required time frame”.
- How to avoid:
  - Monitor Direct Data Entry (DDE) daily
  - Be aware of deliveries
  - Timeliness of response imperative
  - Gather all info & submit at one time with attached copy of ADR
  - Submit with signature receipt

Home Bound Status

- Reason for denial: “The services billed were not covered because the medical records submitted for review did not support homebound status”
- How to avoid:
  - F2F documentation
  - Who decides home bound status?
  - What is taxing effort?
  - The "taxing effort" must be defined in your documentation and individualized to that patient.
  - An individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive devise (such as crutches, a cane, a wheelchair or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated.
  - Review functional, neurological and cognitive status of patient
  - Responses of M1850 & M1860
  - Closely track missed visits
  - Restate

Reasonable & Necessary Care

- Is it the care or is it the documentation?
- Does the F2F documentation support the episode
- POC
  - diagnoses
  - sequencing
  - goals & interventions
- Disciplines – is the POC supporting each?
- Are the diagnoses & sequencing different from previous episode?
- Reason for denial: “This claim was fully or partially denied because the clinical documentation submitted for review did not support the medical necessity of the skilled services billed.”
- No longer a reasonable potential or expectation for change in condition
- Sufficient time had been allowed for teaching or observation
- Appropriate ICD-9 codes to identify diagnoses
• Documentation of acceptable reasons for services or recert:
  - new onset or acute exacerbation of diagnoses
  - new and/or changed medications
  - hospitalization (include date & reason)
  - acute change in condition
  - change in caregiver status or an UNSTABLE caregiver situation
  - complicating or progressive factors
  - complexity of services that can only be safely & effectively provided by a skilled discipline

• The need for a SN to administer an injection (insulin or Calcimar)
• The need for foley/suprapubic cath changes
• The need for G-tube changes
• Complicated dressing changes
• Management & evaluation of a complex POC:
  - high-risk for rehospitalization or exacerbation of problem
  - need for complex, unskilled care
  - unstable caregiver situation
  - situation requiring skilled supervision of care

Orders Do Not Cover All Visits
• Reason for denial: “Physician orders did not cover all visits billed” or "physician orders not properly signed and dated".
• How to avoid:
  Ensure:
  - all orders are included with medical records
  - that all signatures are legible & dated
  - that all verbal orders are countersigned & dated by physician before final claim is submitted

Denial Based on Therapy Review
• Reason for denial: “Based on review, some therapy visits were denied and reimbursement adjusted.”
• How to avoid:
  - documentation should focus on how current illness affects patient functionally
  Submit:
  - valid & signed orders to cover therapy billed
  - documentation to support the need for therapy services
  - all documentation to support services rendered
  - valid & signed orders to cover therapy billed
  - documentation to support the need for therapy services
  - all documentation to support services rendered
• Assure that all reassessments are done in timely manner (13th & 19th visits & 30 day)
• No documentation that there has been progression towards goals
• The therapy treatment plan must:
  - relate to the exact diagnosis that has required therapy intervention
  - identify visit frequency & duration
  - identify the present & prior functional level
  - state specifically procedures, treatments, and/or exercises to be performed
  - clearly list the reasonable goals to be achieved
  - specify the rehab potential
  - specify the discharge plan on POC in clear, easy to understand words

Defensive Documentation to Avoid Denials
• OASIS
• Comprehensive Assessments
• Recertification documentation
• Therapy reassessments
• Routine visit notes

Visit Note Documentation
• Reason for denial: “The records provided do not support that the skilled services were reasonable and necessary for the treatment of an illness or injury. During the last recertification period, there were no exacerbations, injuries or new diagnoses that would require continued skilled services.”
• Were parameters on POC followed & physician notified when applicable?
• Were there any new patient or CG concerns?
• Were there any doctor’s office or urgi-care visits?
• Can each visit stand alone?
• Discharge planning begins at start of care
  - spell out plans with patient and CG
  - are interventions realistic and goals attainable
  - re-evaluate and modify POC as needed
• Once goals are met or decision made that goals cannot be met, consider discharge
• Comprehensive assessments
• Recertification documentation
• Therapy reassessments
• Routine visit notes
  - What was the focus of today’s visit?
  - What are the plans for next visit?
• Paint a picture of the current status of the patient, the treatment provided, and the patient’s response to treatment.
• Identify why the patient needs or continues to need HH services.
• Use the plan of care to guide your interventions and your documentation. Address the goals & interventions on each visit.
• Document each time you teach the patient, family, and/or caregivers.
• Specify the plan for the next visit. Confirm your expectations for the next visit with the patient to make sure you are in agreement.
• Note clinically significant observations and state them objectively. Avoid documenting judgments. Remember, this is the patient’s chart.

• Clinicians must be certain the POC (primary/secondary diagnoses) & the discipline specific care plan are substantiated by each visit note & that each visit can withstand scrutiny on its own.

• Documentation to substantiate coding and care have become critical to agency providers.

• Documentation has become the key communication tool for care.

• Documentation has become the first and last line of defense with the scrutiny of the industry auditors.

• Documentation provides the demonstration of the skills of the clinician and justifies the retention of the agency payment received.

Fact or Fiction?

• Homebound status is determined by referring physician

• Agency cannot refuse to admit patient

• All diagnoses must be documented

• There must be a diagnosis for each medication

• Only certain diagnoses support therapy visits

• Patient must be seen for 9 weeks to get paid for entire episode

• Visit frequencies can’t be changed mid-episode

• HTN cannot be used as primary diagnosis anymore

Management & Evaluation

• For Management and Evaluation (M&E) service to be covered under Medicare, a RN must manage the care plan and caregivers (rather than simply performing an evaluation). A patient must meet all other eligibility criteria for home health care in order to receive M&E as a skilled service.

• Policy manual includes these concepts for M&E (G-162)
  - The underlying conditions or potential for exacerbation puts patient at risk for hospitalization
  - The plan must be complex, unskilled, but requires RN oversight
  - The caregiving situation is unstable

Underlying Conditions

• The patient must have underlying conditions or complications that place them at risk for hospitalization or exacerbation of a health problem if the plan is not implemented properly.

• Documentation should include:
  - multiple medical diagnoses
  - limitations in activities of daily living, mental status, etc.

• Example: “an aged patient with a history of DM 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.”
Complexity of Service

- The plan must be complex, unskilled, requiring RN oversight.
- Complex care means there are many facets involved in the patient’s care, which is unskilled. There may be medications, treatments, or pieces of equipment that do not require the skills of a nurse to deliver if each is taught individually but, with another condition that adds risk, an RN is vital to coordinate and oversee a plan to minimize risk for hospitalization.
- Example: a patient with mild dementia recovering from pneumonia, suffering from an increase in disorientation “has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the episode with pneumonia.”

Caregiver Situation

- The caregiving situation is unstable
  
  An unstable caregiving situation can result from ongoing changes in the plan, the involvement of many services or caregivers, or an unsafe environment that does not provide adequate support. The RN will anticipate caregiver needs or identify potential factors in the environment that could complicate the patient’s safety or care.
  
  - Example: “skilled nursing visits for management and evaluation of the patient’s care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose.”

Writing Goals

Goals should be:

- Patient-focused. Write goals in terms of what you want patient to achieve.
- Clear and concise. Use simple words and phrases.
- Observable and measurable. Specify the behavior the patient will exhibit to help measure the effectiveness of your intervention.
- Time limited. Set long- and short-term goals, and identify each on the treatment plan.
- Realistic. Assess the home environment, family and caregiver support, and available resources.
- Agreeable to both patient & therapist. Allow the patient to participate in goal development. This allows for the validation of expectations.

Interventions

- Is there an intervention to address each diagnoses?
- Prioritize interventions accordingly
- Must be reasonable & attainable
- Must be adjusted as needed
Thanks for Attending!
Feel free to contact us with any questions.
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