Clinical Documentation: Key Considerations from a Legal Perspective

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Agenda

- Documentation Why It’s Important
- Professional Issues
- Common Problems:
  - Missing Documentation
  - Incomplete/Inaccurate/Incorrect Documentation
  - Fraudulent Documentation
- Compliance considerations

Documentation

Reasons Documentation is important:

  - Communication and Continuity of Care
  - QAPI
  - Risk Management
  - Establishes Professional Accountability
  - Survey
  - Reimbursement
  - Legal (more on that)
  - and more....
Documentation

Legal issues for Documentation:
- Survey and Certification
- Reimbursement
- Professional Licensure
- Litigation
- Fraud

Applicable Statutes:
- Health Care Fraud 18 U.S.C. § 1347, 1349
- False Claims Act 31 U.S.C. § 3729 -3733
- Exclusion Authorities 45 U.S.C. § 1320a-7, 1320c-5
- CMP Statute 42 U.S.C. § 1320a-7a

Licensure/Accountability

Professional Accountability

RNs, LPNs, PTs, OTs, PTAs, OTAs, etc., are licensed professionals. Indiana licensure standards of professionalism include some requirements related to clinical documentation.

Your staff needs to understand their license can be at risk if they fail to document properly.
Licensure/Accountability

Registered nursing: assess patient in a systematic/organized matter; formulate nursing diagnosis based upon ... data collected in a systematic and continuous manner; plan care based upon nursing diagnosis, ...

Nurse is expected to communicate with members of health care team...

Unprofessional conduct: unsafe judgment, failing to meet minimal standards, false documentation...

Licensure/Accountability

LPNs have similar responsibilities.

It is unprofessional for an LPN to use unsafe judgment, fail to meet minimum standards of practice; falsify, omit or destroy patient records;

LPNs must accept responsibility for their nursing actions; communicate and collaborate with other members of health care team.

Licensure/Accountability

Therapists are also expected to meet certain standards:

A PT must maintain “adequate patient records.”

“Professional incompetence” may include, but is not limited to, a pattern or course of repeated conduct by a practitioner demonstrating a failure to exercise such reasonable care and diligence as is ordinarily exercised by practitioners in the same or similar circumstances in the same or similar locality.
Licensure/Accountability

RNs, LPNs, PTs, OTs, and other licensed therapists need to remember that their documentation is also a matter of their professional obligations.

Surveyors have been known to report licensed professionals to their respective licensure bodies when the surveyor determines they have failed to meet professional standards.

Licensure/Accountability

Example 1: RN administrator of agency referred to ISDH, due to ISDH’s conclusion RN failed to adequately supervise care provided by employees.

Example 2: PT referred to PT board, because of actions of PTA. PT was not aware of rogue PTA, but FSSA auditor identified issue when reviewing therapy claims.

Documentation

Legal/Risk Management

False or incomplete documentation can be lead to any number of legal problems, from decertification to fraud investigations.

Remember: If you documentation is poor or incomplete, a surveyor or investigator is going to assume the worst.
**Documentation**

**Common Problems:**

- Missing Documentation
- Incorrect/Inaccurate/Insufficient Documentation
- False Documentation

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**Missing Documentation**

**Simple Issue:** Visit or communication occurred, nothing in the patient’s chart to show.

**Examples:** Missed visits, documentation not turned in, documentation not filed.

If you cannot produce documentation of an event, the surveyor/auditor/investigator/counsel, etc. will assume that the event did not occur.

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**Missing Documentation**

Missing documentation can result in all of the following:

- Survey citations example: failure to follow POC;
- Alternative Sanctions;
- Repayments to payor;
Reasons for missed documentation:

- Field staff did not turn in documentation;
- Field staff did not document care;
- Field staff missed visit and did not inform office;
- Misfiled documentation;
- Office staff just did not file documentation;

Missing Documentation

When you identify missing documentation, you have to be careful how you address the problem.

An inappropriate fix can be worse than the missing note.

Missing Documentation

You must first determine why the documentation is missing.

Finding and filing documentation only works if the employee documented in the first place.

If not, you will have additional issues.
Missing Documentation

Options:

1. Obtain missing documentation from staff.
2. Identify and document a missed visit.

If visit occurred, but not documentation prepared, need to document visit occurred. DO NOT SIMPLY COMPLETE A VISIT NOTE.

BE SURE VISIT OCCURRED - INVESTIGATE.

Missing Documentation

If you conclude the visit did occur, you can document in the chart that the visit occurred. Explain investigation and results. (Likely that patient indicates no missed visits.)

May have employee complete visit note, but not likely worth effort. May appear fraudulent, may not be accurate.

May have to suffice with proof of visit.

Missing Documentation

This may protect you from a survey citation.

This will help in a fraud investigation.

Will not help in a Medicaid audit/overpayment.
Missing Documentation

If a missing note is identified during a survey. Just accept the finding. Even an appropriate attempt to have the staff document they did the visit can be problematic in a survey.

Missing Documentation

If employee failed to follow procedures, employee should be formally disciplined according to your discipline and discharge policies.

An employee who does not document may later be fired and you may need to demonstrate the performance issues that led to their termination.

Missing Documentation

IMPORTANT

HOLDING AN EMPLOYEE’S PAYCHECK IS NEVER THE CORRECT WAY TO DEAL WITH LATE DOCUMENTATION. YOU WILL VIOLATE STATE AND FEDERAL WAGE AND HOUR LAWS.
**Incomplete/Incorrect/Inaccurate Documentation**

This is the most common area of mistake. Employees routinely cut corners and the result is documentation that does not accurately describe the care provided.

**Incomplete/Incorrect/Inaccurate Documentation**

Documentation in this category can:

- Fail to adequately address eligibility
- Fail to adequately address medical necessity
- Fail to support the continued need for care
- Fail to support the units billed
- Show duplicate visits on the same day
- Contradict other notes and more.

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**Fail to Support Eligibility**

Home health documentation needs to not just “repeat regulatory phrases”, but make a case for the patient’s eligibility. Eligibility for Medicare home health is spelled out in the Medicare rules.

All of your clinical staff should understand this.
To qualify for Medicare home health services a beneficiary must be:
(1) homebound;
(2) in need of intermittent skilled nursing or therapy;
(3) under the care of a physician;
(4) receiving care pursuant to a plan of care that has been established by a physician and is periodically reviewed by the physician.

Physician must have had a face to face encounter with patient 90 days before or 30 days after SOC and certify patient is homebound and care is medically necessary.

Home health documentation most often fails in three areas:
1. F2F - narrative
2. Homebound status
3. Medical Necessity
F2F Narrative

In the comments to the FY2015 Proposed HH PPS Rule, CMS noted that approximately $3 Billion were recovered for documentation errors related to face to face narrative’s being “insufficient.”

**OLD Narrative Requirement:** Physician was to provide a narrative that explained how the observations of the face to face encounter supported the physician’s certification of homebound status and medical necessity.

F2F Narrative

The narrative needed to do more than simply restate the patient’s diagnosis. Must link condition to homebound status and need for care.

F2F Narrative

Example of Poor Narrative: Patient is homebound and in need of nursing services due to Parkinson’s Disease.

That is not an acceptable narrative. Insufficient information – if patient is in early stages of Parkinson’s, may not have any symptoms. Need more detail.
F2F Narrative

Other common F2F failings:

Lack of signature – need to return to physician to sign. This problem may be reduced if F2F is incorporated into Plan of Care.

Under current (through 1/1/2015) guidance. If the F2F lacks a title or date, the agency can add those.

F2F Narrative

Because of the many ways F2F documentation can fail to meet the applicable requirements, it is important to audit the documentation as it is returned. Get it corrected earlier, not later.

End of the Narrative?

For 2015, CMS has eliminated the narrative requirement. CMS will look to the medical record to address any concern about eligibility.

NOTE: Not eliminating face to face, only the narrative. Physician now documents a face to face encountered occurred during the 90 days before admission or 30 days after admission. The proposed revised regulation eliminates the separate and distinct requirement and the need for a title.
End of the Narrative?

The physician is only required to document:
1. a face to face encounter occurred;
2. the date of the encounter;
3. that the encounter was related to the primary reason the patient requires home health;
4. it was not more than 90 days before of 30 days after the home health SOC; and,
5. encounter was performed by physician or allowed non-physician practitioner.

End of the Narrative?

PROBLEM: Home health is now dependent upon what’s in the physician’s documentation.

CMS comments with final rule make it very clear that agency reimbursement will depend upon physician’s documentation.

This is potentially very problematic for providers, who may have even less ability to influence documentation than they did to influence narrative content.

End of the Narrative?

Physicians must document their encounter with patient for purposes of billing.

However, this documentation may not provide any explanation regarding why the physician determined home health was needed.
End of the Narrative?

Auditors may still be looking for a narrative.

Auditors not just looking to confirm visit with patient occurred.

Note difference between statute and what CMS is concerned about.

End of the Narrative?

In comments to final rules, CMS stated that HHA may communicate results of initial assessment to physician and that physician can incorporate these results into the physician's record.

Physician MUST REVIEW AND SIGN.

This creates an opportunity to address compliance.

End of the Narrative?

Not clear how this “communication” will impact the audit, but CMS made clear reference to such communication and stated auditors could rely upon such communication.

Allows agency to provide something that links office visit to home health.
End of the Narrative?

Physician MUST REVIEW AND SIGN. This shows the physician has adopted the communication.

THIS IS IMPORTANT.

Face to Face Going Forward

1. Add an assessment summary to your POC submissions. When submitting a plan of care to the physician, include an initial assessment summary. This ONE PAGE Document will summarize the findings of the initial assessment, why the agency believes the patient is homebound and in need of the services and what services are being provided. Link to diagnosis in referral.

The physician can review, sign and incorporate into his or her file.

Face to Face Going Forward

This will give the agency some additional comfort that they physician's documentation supports the conclusions in the face to face document.

Face to Face Going Forward

Concern: Even with this additional clarification, does physician documentation contain enough information for the communication note to “hook into”.

In other words, if your communication note mentions diagnoses or conditions, are these also documented in the physicians file, so that the documents “connect.”

Face to Face Going Forward

There is some concern that they won’t relate and the communication note will be pointless.

However, physicians have to document to a certain standard to be paid for the physician visit.

This means adding your note is going to help and will likely have something to relate to in the record.

Face to Face Going Forward

**BOTTOM LINE:** It is better to have the communication note in the physician’s record than to not have it. You may still have to appeal a recoupment. If so, better to have that additional documentation in the record.
**Face to Face Going Forward**

One other update: NAHC is currently suing CMS arguing, correctly, that CMS’s implementation of the face to face rule goes well beyond the requirements of the rule.

HHS’s motion to dismiss was denied. On February 20, 2015 CMS filed its Answer. In April, CMS filed motion for summary judgment.

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**Homebound Status**

Although not as prevalent as F2F, home bound status continues to be an issue for audits.

Documentation must support conclusion patient is homebound, as spelled out in Medicare manuals.

Problem: Physician’s referring patients who do not qualify, because they would benefit from home health.

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**Homebound Status**

Many agencies believe, incorrectly, that if the physician signs the certification, the agency no longer has any responsibility for determining eligibility.

**THIS IS NOT TRUE!!!!**
Homebound Status

Making this assumption is extremely risky, because many physicians do not understand the Medicare home health eligibility requirements and they will refer patients to you that are not really eligible.

Other Risk: staff feeling pressure to readmit patients who have improved.

Homebound Status – Revised 2013

1. Patient must either:
   a. because of illness or injury, need the aid of supportive devices such as crutches, canes, etc.; special transportation; or, assistance of others to leave their residence; or,
   b. have a condition such that leaving home is medically contraindicated.
   AND
   2. a. Their must exist a normal inability to the home; and,
   b. Leaving the home must require a considerable and taxing effort.

Homebound Status – Revised 2013

This means your documentation must support a finding of (1.a. or 1.b.) and 2.a and 2.b.

This should be not only in intake and other assessments, but throughout your documentation.

REMEMBER: the only information surveyors have about your patients is what they read in the chart.
Homebound Status – Revised 2013

Information your staff has about a patient’s homebound status that is not written down, does not help your case.

Home health staff often leave out details, because they all “know the patient so well.”

Examples of poor homebound status documentation:

1. Patient is an 80 year old female who does not like to leave her house without her husband.

2. Patient suffers from Parkinson’s.

These are not sufficient. Your documentation should make it clear how each of the three elements (1.a or 1.b and 2.a and 2.b) are met.

REMEMBER: CMS revised the homebound status guidance, because it felt it was losing too many recoupment appeals.
Homebound Status – Revised 2013

The documentation should clearly explain the support/supportive devices needed to leave or that leaving the home is contraindicated.

Don’t just say normal inability to leave the home and severe and taxing effort. (This is a common description.)

Homebound Status – Revised 2013

Example: Patient intake assessment. Patient is noted as having no sensory impairment, walks, mobility only slightly limited.

Later reassessment notes use of a one handed cane, but no documentation of any difficulty ambulating or transferring.

Noted as homebound due to “residual weakness.” No explanation how this fit with the lack of any documentation of difficulty with ambulation, etc.

Homebound Status – Revised 2013

Explain the patient’s condition (diagnoses, need of support, etc.) and that because of ________, the patient is normally unable to leave the home and when they do leave, it involves a severe and taxing effort because.....

DON’T ASSUME AN AUDITOR OR SURVEYOR WILL CONNECT THE DOTS.

You may know why the patient can’t leave home, but the documentation must articulate it.
Homebound Status – Revised 2013

Patient status can change. Your staff should be assessing and documenting homebound status on each visit.

DON’T JUST CHECK A BOX. The check box, by itself, does not meet the requirements.

Medical Necessity

Medicare will reimburse for care that is “reasonable and necessary.”

Eligible beneficiary is entitled to receive the care, without regard for whether there is someone available to furnish the services.

Auditors look to OASIS and documentation when reviewing medical necessity.

Medical Necessity

Documentation (assessments, care notes, etc.) needs to make case that care is reasonable and necessary.

Does the documentation explain why the care is necessary?

Not always obvious.

If patient achieves goals, care is no longer reasonable and necessary.
Medical Necessity

Example: Patient has been on home health for multiple episodes for teaching and monitoring related to hypertension and kidney failure. Notes indicate progress in understanding disease and care and that kidney functions and BP are stable. Issue: Why is patient continuing on home health?

Medical Necessity

Example: Patient receiving only PT for post-operative recovery. Note in clinical record from therapy visit shows patient has met objective goals. Therapy is continued, but with different therapist. (Not surprisingly, the additional visits get agency past 13th therapy visit.)

No explanation in file as to why first therapist was wrong or why therapy continued.

If goals were met, therapy was no longer needed.

Medical Necessity

Example: Patient admitted to home health for therapy. Patient discharged from home health all goals met. Patient readmitted 4 – 5 weeks later. POC looks like last POC and the goals for both POCs are same. Assessment and therapist notes do not explain need, just begin therapy again.

Does not justify medical necessity.

NOTE: The issue was the patient failing to stick with program after discharge resulting in regression.
Medical Necessity

Example: HHA POCs all outline the same plan for all patients: SN 1 x wk x 8 wk – evaluate and monitor patient, training on disease process, etc. HHA 4 x wk x 8 wk – ADL, etc. POC looks as if it is cut and pasted into each patient’s plan. Little or no variation from POC to POC or from episode to episode.

Need to explain each patient. Individually, the plan of care may not be a problem, if underlying documentation is good, but when all of the POCs look the same, it is a problem.

Medical Necessity

Example: Post stroke, paraplegic patient with indwelling catheter. Physician orders skilled nursing to change catheter.

Auditor found this to be a case without a skilled need.

Benefit Policy Manual lists this as a specific example of skilled nursing need.

Medical Necessity

You must be sure your documentation makes it clear why the services provided are reasonable and necessary and continue to be reasonable and necessary. Detail is important.

Providers may fail to include key details, which result in auditor concluding care is neither reasonable nor necessary.
Therapy Notes

Therapy notes are a special source of problems. HHAs can receive bonus payments for providing certain numbers of visits.

This has led to increased scrutiny.

Also can lead to paybacks, if therapists’ notes don’t support need or if assessments are not done timely.

Therapy Notes

Therapist notes should clearly and legibly explain the patients needs, the goals for the care – long term and short term and describe these goals in terms of objective measures.

Each visit should document progress in terms of the objective measures. Need to be able to defend ongoing need for care to justify each visit.

Incomplete/Inaccurate/Incorrect

Reasons why documentation leaves out details:

1. EMR doesn’t allow verbose responses;
2. EMR allows cutting and pasting of responses;
3. paper form only has checkboxes;
4. Staff is very familiar with the patient and does not write everything down. “We all know Ms. Smith.”
5. Staff completes all documentation at one sitting either at the beginning of the end of the week.
Incomplete/Inaccurate/Incorrect

Many agencies that use EMRs are discovering a new issue: every visit note looks the same, due to automatically populating blanks with scripted information, cut and paste, etc..

Scripted responses can make completing documentation faster, but if not thought through carefully, when an episode worth of notes is reviewed, the notes provide no information and look extremely questionable.

Incomplete/Inaccurate/Incorrect

EMRs and Forms that rely upon checkboxes have led to a certain level of laziness/lackadaisical attitudes towards documentation.

EMRs and forms, if not properly implemented, can lead to every visit note looking almost identical – variations for date, vitals, but all other information the same.

Incomplete/Inaccurate/Incorrect

Documentation that is erroneous can be corrected, but improperly correcting it can create more problems than it solved.

You must correct properly. NO WHITEOUT. NO WRITING OVER. Single line strike through. Revise above. Initial and date.

EMR process may differ.
Incomplete/Inaccurate/Incorrect

When correcting, it is extremely important that the correction is clearly a correction and not an attempt to make the document look like it was correct at the first draft.

Mistakes happen and can be corrected. Just need to be clearly documented as corrections.

False/Fraudulent Documentation

False/Fraudulent Documentation can arise in a number of ways, but the most common is from employees who are trying to get paid without working.

Similar issues can arise with contracted staffing companies.

False/Fraudulent Documentation

This can come to your attention in a number of ways:

1. patient complains about a missed visit for which you have a note.
2. employee turns in documentation showing they were in two places at the same time or with some other inaccuracy
3. whistleblower
4. staff sees employee elsewhere when they are supposed to be at office.
False Documentation

Example: Agency discovered “amended” therapy notes. When they performed an audit, it became clear that the amendments, in many cases, were done to change dates. In every case, the dates were changed so that assessment visits occurred prior to 13 and 19 visits.

THAT IS FRAUD.

False Documentation

Example: Agency RN goes out to perform assessment for recertification. During assessment patient asks, “How is Sally doing? Is her daughter better?” Sally is the HHA who has, according to the schedule and her documentation (that the patient signed), seen the patient three times a week throughout the cert. period, including two days ago. RN asks what the patient means and the patient explains Sally said she needed time off to care for her sick daughter, but couldn’t afford to miss the paycheck. Patient has not seen Sally in several weeks.

False/Fraudulent Documentation

False documentation must be dealt with swiftly:

1. Investigate issue (speak with employee)
2. Audit – determine scope of problem
3. Determine if payback is necessary
4. Report/Self-disclose
5. Discipline employee/Report employee to appropriate authorities
False/Fraudulent Documentation

Interviewing responsible employee:

If you believe an employee has been involved in fraud, you must suspend them immediately. They will remain suspended until you complete your investigation. You need to learn everything you can from the employee about the problem.

False/Fraudulent Documentation

It is important to address fraud promptly. Once you determine the scope of the problem (assuming a diligent investigation) you will need have sixty (60) days to repay the money. Failure to do so will transform the overpayment into a False Claims Act matter.

False/Fraudulent Documentation

Addressing fraud promptly and, when appropriate, self-disclosing, protects agency from repercussions from employee misconduct.

May have overpayments and/or penalties, but company can avoid other criminal penalties.
Prevention

There are several steps to take.

1. Education – make sure employees know expectations for documentation.

2. Auditing and Monitoring. Make sure you are receiving documentation timely. Make sure documentation meets standards.

3. Progressive Discipline

Prevention

Again: You cannot hold a paycheck as an inducement to obtain documentation.

You can discipline employees through your discipline and discharge process when they fail to submit documentation.

Conclusion

The notes from each encounter are the official, legal record of the care provided to that patient. It needs to be complete. Staff will not remember each visit. Anything that is important that is not written down will be forgotten.

Need to document each visit at the time it occurred. Document progress, lack of progress, continuation of issues that support homebound status, etc.
Conclusion

These notes are also important for patient care. If we don’t know what has happened before, how can we determine patient’s progress, or lack thereof? How does DON know what is going on? What about new staff assigned to case?

What about a fraud investigator? Plaintiff’s attorney? Surveyor?

Providers, and their staff, must recognize the importance of these documents.

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