IDT Documentation

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Session objectives

• Discuss the current regulatory environment and the importance of documentation related to compliance audits
• Identify documentation risk areas for the IDT
• Identify strategies to lower documentation risk

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Who’s Auditing Hospice

<table>
<thead>
<tr>
<th>Third party payers</th>
<th>Federal</th>
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<tbody>
<tr>
<td>Department of Health (DOH)</td>
<td>Office of the Inspector General (OIG)</td>
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<tr>
<td>Medicare Part B Contractor (MBC)</td>
<td>Zone Program Integrity Contractor (ZPIC)</td>
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<tr>
<td>Recovery Auditor (RA)</td>
<td>Comprehensive Error Rate Testing (CERT)</td>
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<tr>
<th>State</th>
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<tbody>
<tr>
<td>Medicare Administrative Contractor (MAC)</td>
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| Medicaid Payment Integrity Contractor (MPIC) |
| State Survey Agency |
| Medicaid Integrity Contractor (MIC) |

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Federal Scrutiny

- Department of Justice (DOJ)
  - False Claims Act violation
  - Medicare fraud and abuse
- Office of the Inspector General (OIG)
  - Hospice in a nursing facility
  - Hospice in an assisted living facility
  - Hospice and Part D drugs
  - Hospice general inpatient level of care

Federal Scrutiny

- Zone Program Integrity Contractor (ZPIC)
  - Not a random audit
  - Audit issues vary
- Recovery Auditor (RA)
  - Inappropriate payment/reimbursement
- Comprehensive Error Rate Testing (CERT)
  - Inappropriate payment/reimbursement

Federal Scrutiny – Near Future

Unified Program Integrity Contractor (UPIC)
- The UPIC will combine and integrate existing CMS program integrity functions carried out by multiple contractors and contracts into a single contract to improve its capacity to swiftly anticipate and adapt to the ever-changing and dynamic nature of those involved in healthcare fraud, waste, and abuse across the Medicare and Medicaid program integrity continuum
CMS Data Monitoring

FY 2017 Final Hospice Wage Index Rule

Monitoring will include:

- hospice diagnosis reporting
- length of stay
- live discharge patterns and their relationship to the provision of services and the aggregate cap
- non-hospice spending for Parts A, B and D during a hospice election
- trends of live discharge at or around day 61 of hospice care, and readmissions after a 60 day lapse since live discharge

Focus

<table>
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<tr>
<th>Focus</th>
<th>Documentation</th>
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<tbody>
<tr>
<td>Hospice diagnosis reporting</td>
<td>All diagnosis must be reported on claim form (Prioritize)</td>
</tr>
<tr>
<td>Length of stay</td>
<td>Justify eligibility admission and throughout service period</td>
</tr>
<tr>
<td>Live discharge</td>
<td>Justify why discharge is taking place and notification provided</td>
</tr>
</tbody>
</table>
| Non-hospice spending       | • Relatedness documented in physician narrative statement  
                           | • Non-relatedness documented by physician somewhere else in the clinical record |
| Discharge at day 61 of reimbursement tier | Justify why discharge is taking place and notification provided |

2015 Medicare Compliance Surveys

- 1,398 surveys conducted
- 32% of hospice providers nationally
- 2015 # of citations in top 25: 1,880

- Reminder – IMPACT Act requires hospice compliance surveys every 36 months
  – Funded through 10 years (2024)
### 2015 Survey Deficiencies - #1-5

<table>
<thead>
<tr>
<th>L Tag</th>
<th>Survey Deficiency</th>
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<tbody>
<tr>
<td>#1</td>
<td>L0629 Supervision of hospice aides</td>
</tr>
<tr>
<td>#2</td>
<td>L0543 Plan of care</td>
</tr>
<tr>
<td>#3</td>
<td>L0530 Content of comprehensive assessment</td>
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<tr>
<td>#4</td>
<td>L0545 Content of plan of care</td>
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<tr>
<td>#5</td>
<td>L0547 Content of plan of care</td>
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### 2015 Survey Deficiencies - #6-10

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<tr>
<th>L Tag</th>
<th>Survey Deficiency</th>
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<tbody>
<tr>
<td>#6</td>
<td>L0523 Timeframe for completion of assessment</td>
</tr>
<tr>
<td>#7</td>
<td>L0647 Level of activity</td>
</tr>
<tr>
<td>#8</td>
<td>L0555 Coordination of services</td>
</tr>
<tr>
<td>#9</td>
<td>L0552 Review of plan of care</td>
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<tr>
<td>#10</td>
<td>L0625 Hospice aide assignments and duties</td>
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### Why Do We Care?

- Every hospice will receive a Medicare compliance survey every 3 years
- Every hospice is potentially at risk for a federal or state audit
- Every hospice is at risk for medical review form their MAC
- More hospice providers are being audited
Why Do We Care?

• The quality of a hospice’s documentation will determine:
  – Payment retention (post payment review)
  – Payment receipt (prepayment review)
  – Ability to maintain Medicare certification and/or state hospice licensure

Hospice Documentation Risk Areas

• Sufficient evidence of hospice eligibility
  • Admission
  • Ongoing
• Hospice physician documentation of unrelatedness
  • Meds, diagnoses, etc....
• Insufficient evidence of meeting Medicare ‘Conditions of Coverage’
• Sufficient evidence for GIP and CHC days of care

Documentation Risk Areas

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<tr>
<td>Eligibility</td>
<td>Physician documents “why eligible” in physician narrative which provides the map for IDT documentation going forward</td>
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</table>
| Unrelatedness             | • Relatedness documented in physician narrative statement
                               • Non-relatedness documented by physician somewhere else in the clinical record |
| Meeting coverage regulations | Reasonable & necessary
                               POC established
                               Terminal illness certified |
| GIP or CHC days of care    | Acuity of symptoms
                               Intensity of services |
Documentation Foundation

Purpose of Documentation

• Verifies quality and coordination of care
• Ensures continuity of care
• Evidences compliance with federal/ state regulations and accrediting organizations
• Provides substantiation of the sequence of care in the court of law
• Provides the basis for reimbursement

Effects of Documentation

Descriptive, consistent documentation
Compliant, reputable, successful hospice that delivers quality patient care at EOL
Positive survey or audit outcomes
Defensible claims
To Document or Not to Document...

• We are required to document all patient care interventions from the moment we enter a professional relationship with a patient and his or her family
• Our documentation ends with our termination of such relationship
• Frequency of documentation is governed by our workplace policies and procedures and the status of the patient and family

Content of Documentation

• Patient’s condition
  – Pain, symptoms, etc...
• Status of the family or caregiver
• Environment of care
• Interventions and evaluations
• Patient/family response to interventions and care
• Communication with the physician, other team members, and external sources

Characteristics of Documentation

• Objective
• Concise (more is not always better)
• Accurate
• Authentic
• Timely
• Comprehensive, but pertinent
• Consistent
• Tells the patient’s/family’s story
Eligibility and Relatedness

What About the LCDs?

- Local Coverage Determinations
  - Hospice Guidelines
  - Developed by each RHHI or MAC
  - Cancer, heart disease, decline, debility, AFTT, etc.
- NOT exclusionary
- NOT comprehensive
- NOT definitive

LCDs—NOT Exclusionary

- Patients who meet the guidelines are expected to have a life expectancy of six months or less if the terminal illness runs its normal course
- Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less
- Coverage for these patients may be approved if documentation of clinical factors supporting a less than 6-month life expectancy not included in these guidelines is provided
**LCDs—NOT Comprehensive**

- Not the only diagnoses that can—or should be—used to enroll patients in hospice care
- Look up diagnoses in the coding manual!
- This may be difficult for some providers to accept as they may not understand how malnutrition, anemia, or depression, for example, could be reported as a principal hospice diagnosis.


**LCDs—NOT Definitive**

- Support a prognosis consistent with eligibility when that prognosis continues to be reasonable
- Example:
  - AFTT: BMI less than 22 and a Karnofsky or Palliative Performance Score of 40 or less.
- Clinical support
  - IOM: failure to thrive in elderly persons is defined... as weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction, and low cholesterol

**Symptom Assessment Scales**

- 0-10 pain scale
- Wong Face scale (pain)
- NYHA scores - New York Heart Association (NYHA) Functional Classification
  - classifies a patients’ heart failure r/t to the severity of their symptoms
- Edmonton Symptom Assessment System (ESAS)
  - assesses nine symptoms common in cancer patients: pain, fatigue, nausea, depression, anxiety, drowsiness, appetite, wellbeing and shortness of breath, other symptoms
Symptom Assessment Scales

- FAST = Functional Assessment Staging for Dementia
- MRI(S) = Mortality Risk Index (Score)
- ADEPT = Advanced Dementia Prognostic Tool

Functional Scales

- PPS = Palliative Performance Scale
- Karnofsky Performance Status Scale
- Eastern Cooperative Oncology Group Scale (ECOG)
  - assesses the functional status of a patient

Documentation Quality
**Focused Quality Documentation**

- Concentrated on a specific problem, symptom, issue related to the patient and family
- Drills down to detail
- Requires more than ‘point and click’ on electronic documentation or check boxes on a form

**Examples:**
- Document limits to daily activities of living for a patient with end-stage heart disease.
- Describe the extent of oxygen for a patient COPD and shortness of breath.
- State facts with objective information:
  - “Clothing no longer fits due to weight loss”
  - “Sleeping XX number of hours of day”
  - “Pain is severely limiting activities of daily living”

**Comparative Documentation**

- Contrasts the patient’s present condition to his/her prior condition
- Individualizes patients by focusing on their trajectory of decline
  - Ie: weight loss on a graph
- Presents specific information, not generalizations
  - One week ago, patient was eating ½ - ¾ of 2 meals per day
  - Now eating only ¼ of 1 meal each day
Insufficient Documentation

• Does not paint a complete picture of the patient

• Insufficient documentation uses words/ phrases like:
  – Slow, progressive decline
  – Appears to be losing weight
  – No change

• Lacks sufficient detail to support hospice eligibility and terminal prognosis

Insufficient documentation example #1

• “Inability to ambulate independently” could mean:
  – Needs help of one caregiver (supervision, guidance, support)
  – Needs assistance of two caregivers
  – Needs assistance of two caregivers and assistive devises
  – Ambulates 30 steps
  – Ambulates 2 steps to get over to the chair

Insufficient documentation example #2

• “Patient losing weight” could mean:
  – Patient is eating less than before.
  – Patient is not eating at all.
  – Patient has lost two pounds.
  – Patient has lost twenty pounds.
  – Patient appears cachectic
Inconsistent Documentation

- Inconsistent documentation
  - Nursing notes: non-ambulatory
  - Chaplain notes: walked in hall
- Pain assessment without documentation of interventions
  - “First-line” documentation (nurse, aide, SW, volunteer) does not match “second-line” documentation (IDG notes, narratives, clinical summaries)

Electronic Health Records (EHR)

Benefits:
- Improves efficiency and quality of health care
- Storage capability
  - Time
  - Space
- Accessible from anywhere
- Allows for customized views of information

Issues with Electronic Documentation

- Not enough detail (appears standardized)
- Cut & paste option (duplicating information)
- Not timely (depending on accountability of staff)
- Inconsistent between disciplines (appears multidisciplinary vs. interdisciplinary)
EHR Documentation Improvement

• Increase detail in electronic documentation
  – Expand on “point and click” selections in a note
    • Record observations about details the “drop down” does describe
      – I.e.: state the number of feet a patient can ambulate
  • Make it a requirement for IDG members

EHR Documentation Detail

• Document subjective comments from the patient and family to support continued eligibility
  – I.e.: “I sat outside last week, but this week I just don’t have the energy to go out”
  – I.e.: “He has been sleeping more during the day and is not interested in waking up to eat”
• Ensure authentication process is in place and outlined in policy/procedure (CoPs - §418.104)

Documentation Example #1

• Summary note
  – Alert w/confusion. Fair appetite with recent weight loss. Recent falls. Dyspnea at rest. Changes in activities.
• More detail
  – Alert. Confused, oriented to person only. Fair appetite. Recent wt. loss. Current wt. 104, previous wt. 110 one month ago. Recent falls due to unsteady gait and OOB w/o assist. Dyspnea at rest, 02 prn. Withdrawing from activities, refuses to go to dining room.
**Documentation Example #2**

- **Plan of Care – IDT Review:**

- **Important Data Omitted:**
  - PRN pain med increased recently. Had increased N/V necessitating change in diet and increased use of antiemetic. Decreased intake to less than 2 meals/day.

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**“Fast is fine, but accuracy is everything.”**

Wyatt Earp

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**Consistent & Accurate Documentation**

- Accurate clinical documentation is a requirement for good communication.

- Characteristics of accurate documentation:
  - Reflects the scope of care and services provided
  - Justifies hospice eligibility of the patient
  - Records observations without conclusions
  - Timely (point of care)
### Documentation Example

- Chaplain note for patient with end stage dementia:
  
  “Patient sitting up in chair today and made eye contact during visit. Patient listened to prayers and hymn and appeared to enjoy the visit”

- Reality:
  - Patient was propped in chair with 3 pillows and displayed a vacant stare toward chaplain during visit. Chaplain prayed with patient and sang a hymn. Patient did not verbally or nonverbally interact with chaplain during visit

### Documenting Decline

### Is Decline Required?

- There is no federal hospice regulatory requirement for patient decline.

- MAC medical Review looks for documentation of decline.
What do we do with this?

Actual MAC denial

- Denial reason: Does not support a 6 months or less prognosis as follows:
  - No recent hospitalizations or ER visits
  - No SOB, decubitus ulcers, pain, weigh loss
- Outcome: Based on documentation patient appears chronic and not terminal

Length of stay > 180 days

- As length of stay increases, documentation of continued eligibility is critical and becomes more difficult
- Questions auditors ask:
  - Is the patient terminal or chronic?
  - Why is this patient still on hospice care?
  - Does the documentation indicate a terminal prognosis and continued hospice eligibility?

No Longer Terminally Ill; Does Not Meet 6 Month or Less Prognosis
MAC LCD Unipolicy

- Patients in the terminal stage of their illness who stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care

- If a patient improves or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit

Terminal or Chronic?

- Distinguishing improvement to chronic status from a period of stabilization
  - Case by case basis
  - Physician’s decision in collaboration with attending physician and IDT
  - Consider looking at the patient’s status differently.
    - i.e.: Patient with end stage CHF, on 2 liters of oxygen lives in her room and only ambulates from her bed to the chair, and the commode chair
    - No SOB, no pain, no change in appetite

Addressing Medical Plateaus

- Document past vs. present to give comparisons
  - Note changes over time – need dates
  - Weight – 2 months ago, today; pounds & % lost
  - Medications – new meds, increase in dose, increase in frequency
  - Functional status – specifics of decline in bathing, ambulation, feeding, etc…

- Write a summary periodically to pull all the information together in a narrative

- Have someone review the record who isn’t familiar with patient
Addressing medical plateaus

- Document what you are doing that keeps the patient’s symptoms controlled.
- Patient has not been hospitalized because…
- Patient has no shortness of breath because…
- Patient does not have decubitus ulcers because…

Related or Unrelated?

Hospice services are to be comprehensive and inclusive and we have reiterated since 1983 that “virtually all” care needed by the terminally ill individual would be provided by hospice, given the interrelatedness of body systems. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life.

FY 2017 Proposed Hospice Wage Index rule [CMS-1652-P]
Related Conditions

• ...unless there is clear evidence that a condition is unrelated to the terminal prognosis; all services would be considered related. It is also the responsibility of the hospice physician to document why a patient's medical needs would be unrelated to the terminal prognosis.

78 Federal Register 152 (7 August 2013), pp.48236-7, 48240.

Related Conditions

• ...this determination of what is related versus unrelated to the terminal prognosis remains within the clinical expertise and judgment of the hospice medical director in collaboration with the IDG.
• ...necessary for these decisions to be made on a case-by-case basis


CMS Concerns

• Findings suggest that some hospices may be using the Medicare Hospice program inappropriately as a long-term care (“custodial”) benefit rather than an end of life benefit for terminal beneficiaries.
• MedPAC reports – concern that hospices may be admitting beneficiaries who do not legitimately meet hospice eligibility criteria.
CMS Concerns

- Office of the Inspector General (OIG) –
  - concern the potential for hospices to target beneficiaries who have long lengths of stay or certain diagnoses because they may offer the hospices the greatest financial gain
  - Hospices not responsible for covered services
    - Drugs
    - Diagnoses

Documenting “Un-relatedness”

- What does the hospice physician document?
- CMS has providing varying guidance on this
  - NHPCD MLC:
    - should be more than “it is unrelated because it is”
  - CMS Open Door Forum call:
    - should be a brief narrative that is reasonable in explaining why the condition is unrelated

Document it where?

- Not in the physician narrative statement
  - This is the place to document eligibility and why the patient needs hospice care
- Your choice!
  - Any other place in the clinical record that your hospice program designates as appropriate
Levels of Care: CHC & GIP

- Describe the crisis in detail
  - Precipitating event
  - Interventions to mitigate
- A new POC should be established detailing the problems, interventions and expected outcomes

Levels of Care: CHC & GIP

- IDT progress notes should include the issues identified in the POC
- Start addressing discharge plan in the documentation at transition to CHC or GIP
- Is a physician order required for CHC or GIP?

Levels of Care: CHC & GIP

- Describe frequency, severity, and intensity of symptoms
  - Diaphoresis, chest pain; vomiting resulting from severe coughing
- Document previous attempts to relieve symptoms and assessment/outcomes of those attempts
  - Pain unrelieved by multiple doses of the patient’s current analgesic
Levels of Care: CHC & GIP

- Document interventions utilized to relieve patient’s discomfort
  - Medications, O2, positioning, massage, bathing, music, lighting, verbal support, nebulizers, fans, suctioning, etc...
- Document all teaching to patient, family, or caregiver
- Document family issues or concerns
- Document plan for transition back to RHC

Conditions of Coverage

- To be covered, Medicare hospice services must meet the following requirements.
  - They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions
  - The individual must elect hospice care in accordance with §418.24

Conditions of Coverage

- A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in §418.56.
  - The services provided must be consistent with the plan of care
  - A certification that the individual is terminally ill must be completed as set forth in §418.22
Documentation Pearls

- Describe the patient
  - Overall and based on the diagnoses
- Use prognostic tools accurately
  - Use the right tool for the right diagnosis in the right way
- Expect all members of the IDT to document patient appearance on every visit
  - Especially differences and changes
- Ensure that information included in summaries, narratives, and prognostic worksheets is supported by visit documentation.

Best Practices for Maintaining Clinical Documentation

- Develop and enforce a formal documentation policy
- Standardize location for particular information in clinical record
- Educate staff about documentation expectations
  - At hire
  - Ongoing
- Regularly conduct chart audits regularly

The only thing that is constant is change

Heraclitus
Approx 500 B.C.
Questions

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Vice President, Regulatory and Compliance

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