Frequently Asked Questions:

[On-demand webinar] If it's not documented, it's not done!

On Thursday, Oct. 24, 2019, SimpleLTC and Briggs Healthcare offered a free webinar with industry expert Mary Madison, RN, RAC-CT, CDP, covering strategies and tips to enhance your documentation skills and avoid audits. This document contains answers to specific questions asked during the webinar.

1. **What is endorsement of SBAR charting?**

   SBAR (Situation-Background-Assessment-Recommendation) charting is an element of accepted documentation, typically utilized mainly by EHRs. The medical record, as a whole, must paint a picture of the resident throughout his/her stay in the facility and include all the information provided for at F842 – slide 8 of the presentation. You will likely need documentation in addition to an individual SBAR to paint a complete picture of the resident, his/her condition, services provided and the resident's response to those services.

2. **Can recerts be done by nurse practitioners?**

   Yes. A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician. (See slide 16 of the presentation.)

   Another resource is Appendix PP of the State Operations Manual (SOM). Check out F712 – page 419 of the November 2017 Appendix PP for this answer as well. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

3. **If facility has an ambulance service contracted, who provides the certification facility or ambulance company?**

   This NGS Ambulance Physician Certifications Statement Guidelines chart with additional specific verbiage should help answer your question. My experience has been that the facility obtains the ambulance certification. Check out information found in Chapter 4, section 40.2 – page 15.

4. **If a certification is missing, can we get an amended cert from the physician?**

   Chapter 4 – Medicare General Information, Eligibility and Entitlement (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf) is a great resource as is Chapter 8 – Coverage of SNF Services (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf). When you ask about a missing certification, I'm assuming that the actual certification was not done as I answer this question. Chapter 4 (40.5 specifically) speaks to delayed certifications:

   "Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an ***isolated oversight or lapse***. (Italics and underlining added by me.)

   In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the skilled nursing facility considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made."

5. **Do you have any examples of what to put as reason for Skilled stay recertification?**

   Each reason for skilled certification/recertification is as individualized as each of your residents are. Skilled care is needed/to be continued is based on the reason for admission to your facility for such things as restore independent ambulation related to; regain strength and ability to do own ADLs; restore ability to safely ingest oral food and fluids, etc. Those are some general examples. The physician's reasons for certifying the need for skilled care will be specific to each resident.

6. **Where can we find MD Cert/Recert timeline signing?**

   Chapter 4 – Medicare General Information, Eligibility and Entitlement (see hyperlink in the answer of Question #2. 40.4 (actual page 16):

   40.4 - Timing of Recertifications for Extended Care Services
   (Rev. 1, 09-11-02)

   The first recertification must be made no later than the l4th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the l4-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

   At the option of the skilled nursing facility, review of a stay of extended duration, pursuant to the facility's utilization review plan (if a UR review plan is in place), may take the place of the second and any subsequent physician recertifications. The skilled nursing facility should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

7. **Do therapy treatment diagnosis need to be included in I8000?**

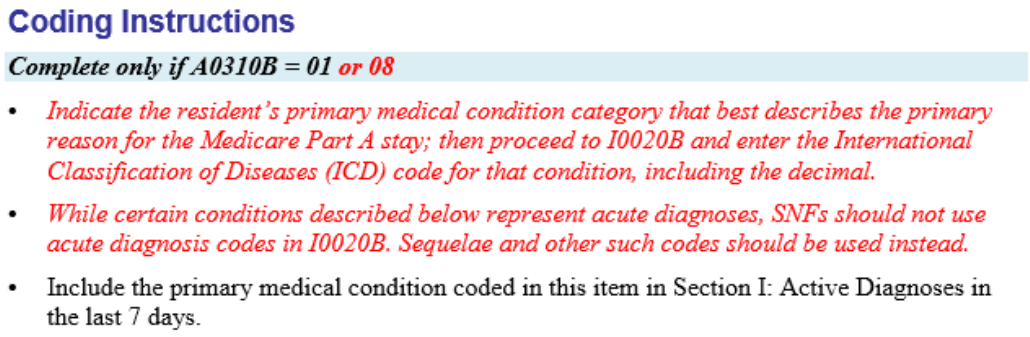
   They certainly can be included in I8000 if a) you have room (remember there's only 10 spots in I8000); b) these diagnoses relate to the medical condition; c) the physician has documented these diagnoses in the recent 60 days and d) the condition/therapy treatment diagnosis affects their current status. In other words, include them in I8000 if the treatment diagnosis is active. That's the intent of Section I. I encourage you to review the intent in Section I of the October 2019 RAI Manual.

8. **Do we still need to code the rehab diagnosis that is not billable on section I8000 or we priority to the diagnosis that is Billable 1st?**

   Please refer to my answer to #7 above – that should help answer your question.

9. **In section I, it was clarified yesterday in another webinar that you also put the primary diagnosis in I0100 - 18000. If in a check box, you do not repeat in 18000. Is this correct procedure?**

   Yes, that is correct. Section 3, Page I-2 of the RAI Manual provides these overall directions for Section I0020 as well as I8000:



Coding Instructions

Complete only if A0310B = 01 or 08

- *Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.*
- *While certain conditions described below represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.*
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.

10. Do you have a collection tool to use to gather information for GG? How can we accurately capture in all shift for the first 3 days?

Here is the link to the Briggs Admission Section GG worksheet: https://www.briggshealthcare.com/Functional-Abilities-and-Goals-Section-GG-Admission-Start-of-SNF-PPS-Part-A-Stay_2

In case you're also looking for other Section GG worksheets, such as Discharge and IPA, here are those links:

https://www.briggshealthcare.com/Functional-Abilities-and-Goals-Section-GG-Discharge-End-of-SNF-PPS-Part-A-Stay_2

https://www.briggshealthcare.com/Functional-Abilities-and-Goals-Section-GG-Interim-Payment-Assessment

11. If a resident was admitted to facility after surgical procedure (IE- hip fracture/ORIF) OR cardiac (CABG) and rehospitalized (CHF exacerbation or wound infection). Would it be allowable to continue initial diagnosis from first admission?

That's entirely up to your team and is determined by the primary reason for the care the resident needs and receives when he/she returns to your facility. I can see rationale for retaining the original diagnosis from the admission, but I can also see that the diagnosis following rehospitalization could result in a different medical condition, different services and a different diagnosis – an IPA, in short might be indicated.

12. What are the requirements for frequency of completion of BIMS/PHQ interviews?

It's quicker to identify which of the MDS 3.0 Item Sets the BIMS and PHQ-9 interviews are NOT found. Those would be tracking records and the NPE (Part A Discharge). All other Item Sets contain both interviews. They're important interviews! All interviews are to be done on or shortly before the ARD of that MDS assessment.

13. **I see the BIMS score above 12 but SLUMS, MoCA scores consistently showing cognitive problems (ex 15/30, 4.0/6.0. Is this usual?**

    All the cognitive scoring tools you cite involve additional and different questions as well as different scoring methodology. They are valid cognitive assessment tools but the only interview that "counts" in MDS documentation (and PDPM reimbursement) is the BIMS.

14. **In Z0400, what date should be entered for GG where the clinicians decided on usual function? Day 3 counting day of admission or can it be day 4? Day of discharge for end of stay?**

    The RAI Manual instructs us to record the date in Z0400 as the date the section was completed. So, if Section GG was completed on day 3 or day 4 of the stay, record that date. Same with the discharge Section GG.

15. **What do you think denials under PDPM are going to look like?**

    I don't think we'll see any change in denials under PDPM from denials when we used RUGs for reimbursement, but time will tell. If our documentation is complete and accurate and we submit a clean claim, we should be okay. Remember that documentation requirements haven't changed – only the classification method for reimbursement. Our documentation should backup all care/services provided to any given skilled beneficiary.

16. **Who do you suggest should be doing GG section?**

    I think that a collaboration between therapy and nursing is the optimal approach to assessing and encoding section GG. If there are no therapy services ordered, nursing may likely be the sole assessor of functional status, but I have heard of facilities involving therapists in the assessment process regardless, especially with the mobility items. Strive to make the best combination of clinicians to accurately capture each resident's functional status with Section GG items.

17. **Can you please provide more clarification on when a lesion is considered "open"? If there is scant bloody drainage on a dressing or other scant drainage with the base covered by a scab or growth, is this open or closed? Having Case Mix re-consideration d/t this.**

    Great question! This took me a while to try to find resources for you - not easy to find as I learned.

    In Section M of the October 2019 RAI Manual, open is the term used for Stages 2/3 and MASD. M1040C & D also reference open lesions. There is no entry to define open or closed in the RAI Manual Glossary and no specific reference to open vs. closed wounds within the RAI Manual itself.

    I did find this resource online: http://www.jobst-usa.com/healthy-living/wound-care/wound-types/, describing open vs. closed this way: "Open wounds have exposed body tissue in the base of the wound. Closed wounds have damage that occurs without exposing the underlying body tissue." There's more information as well as examples on this hyperlink as well. Going with this definition, it sounds like the wound you reference may well be closed unless you can see beneath the scab.

18. **Can you clarify for section GG regarding no dashes on both Admission Performance and discharge goal? I was told that we can dash some discharge goals as long as we have some areas answered. It is hard to put a discharge goal as patients can be unstable. We tend to feel that they can improve to their PLOF or near that. If we don't meet the goal upon discharge, will it reflect on our QRP?**

    Dashes can be used in Section GG. CMS provided us with additional codes to use for performance so there shouldn't be any dashes in that column. I can't think of any examples of performance that would not fit into one of the accepted codes. Dashes in discharge goals is different. For SNF QRP purposes, we must select at least one goal and that goal must have a presence on the resident's care plan (if more than one discharge goal is selected, that/those must be provided for on the care plan as well). The other discharge goals that are not identified on the MDS may be dashed without any negative consequence. Because residents improve or decline (hopefully more of the former) as we care for them, those goals could change – especially the resident goals so don't forget to include those on the care plan. If we don't provide at least 80% of the data for our SNF QRP measures, we face reimbursement cuts, in short. We also have new outcome measures, namely change in mobility scores as well as discharge mobility scores.

19. If the pharmacy recommendation is something that has already been addressed, does the physician still need to sign this or is the nursing note on the report that it was completed prior to this report sufficient?

It sounds like your question references the monthly drug regimen review required/done by the pharmacist (F756), check out (iii) below – the physician must provide the documentation in the resident's medical record.

F756
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

There is also a Drug Regimen Review that is required during the care of a skilled beneficiary – N2001, N2003 and N2005 on the MDS Item Set. "The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident's admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner." This drug regimen review involves timing and documentation as well which can be done by both the nurse and the physician. This DRR is part of the SNF QRP (Quality Reporting Program).

Lastly, there's the Gradual Dose Reduction (GDR) that is part of drug review. F758 is the specific tag. The physician must document that a GDR is clinically contraindicated. Critical Element Pathway CMS-20082 can help you determine compliance with this requirement. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html (scroll down to Downloads to find LTC Survey Pathways.)

20. What constitutes as proof that the summary was presented to the patient? Should you print and have them sign or is it good enough for the nurse to document this was done?

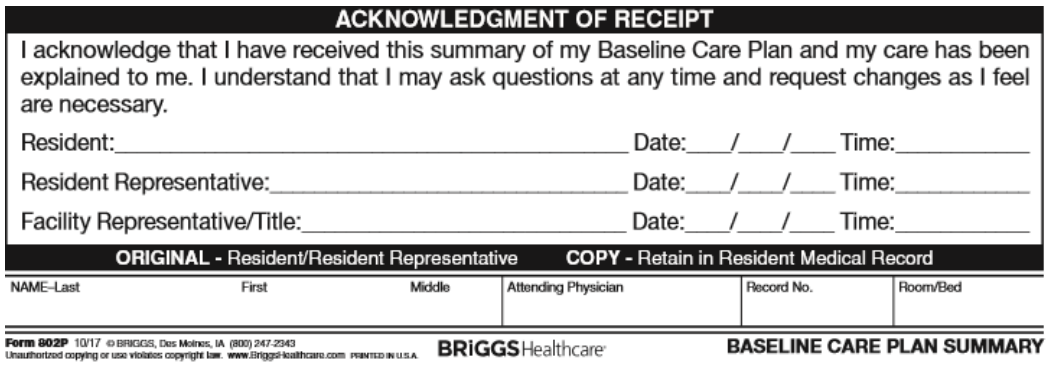
Interpretive guidance at F655 says this:

The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include:

- o Initial goals for the resident;
- o A list of current medications and dietary instructions, and
- o Services and treatments to be administered by the facility and personnel acting on behalf of the facility;

The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, if it meets all the requirements of the summary.

CE Pathway CMS-20072 doesn't offer any additional guidance. The resident's medical record must reflect that the written Baseline Care Plan Summary was provided to the resident. Without such documentation, it wasn't done! How your facility does that should be provided for in a policy/procedure. I recommend that the date and time as well as who the summary was provided to is, at a minimum, recorded by the nurse. When I designed the Baseline Care Plan Summary form for Briggs customers, I provided an area for signatures, including dates and times on the actual summary that is 2 parts – a copy for the resident/resident representative as well as a copy for the medical record.



ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received this summary of my Baseline Care Plan and my care has been explained to me. I understand that I may ask questions at any time and request changes as I feel are necessary.

Resident:_____ Date:___/___/___ Time:_____

Resident Representative:_____ Date:___/___/___ Time:_____

Facility Representative/Title:_____ Date:___/___/___ Time:_____

ORIGINAL - Resident/Resident Representative **COPY** - Retain in Resident Medical Record

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

Form 802P 10/17 © BRIGGS, Des Moines, IA (800) 247-2343 Unauthorized copying or use violates copyright law. www.Briggs-Healthcare.com PRINTED IN U.S.A. BRIGGS Healthcare **BASELINE CARE PLAN SUMMARY**

This leaves no doubt in the reviewer's mind as to compliance with F655.

21. **Should resident social history and pyscho-social assessment only be done by a licensed person or can an unlicensed person complete them?**

    I cannot locate a specific requirement for a social history in Appendix PP. F745 says "The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." That said, a social history would be in order to assess the resident's needs. F850 specifies that the regulations do not require a Social Worker when a facility has equal to or less than 120 beds."

22. **For Section I8000, do we have to put any diagnosis that was checked above into this section? What about for Claims? etc.**

    The checkboxes in I0100 through I6500 on the MDS 3.0 Item Set are general diagnoses. If there is a more specific active diagnosis code beyond the general checked above, add that to one of the 10 items in I8000. Specific diagnosis codes belong on the actual claim.

23. For the care plan meeting, does it have to be an RN or can it be an LVN who attends the meeting?

Here's what F657 currently says (Appendix PP) …RN with responsibility for the resident is part of the IDT that prepares the comprehensive care plan:

F657
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

24. Regarding the quarterly progress note, our computer software requires review and signature that CCP has been reviewed. There is no assessment piece required. Would we be out of compliance?

F657 requires the comprehensive care plan to be "Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments." With the RAI process, (see slide #45), the quarterly MDS is completed to be in compliance with OBRA requirements. The QR is completed then staff evaluate the effectiveness of care planning by reviewing and recording a progress note based on the goals established by the IDT which includes the resident. If your software doesn't provide and/or your current policy does not provide for compliance with F657, please take another look at this requirement and step up your procedure!

25. Regarding the pneumonia/immunization, do we need to have a new consent to immunize signed each year?

Pneumonia vaccinations are not given each year – hopefully influenza vaccinations are! Check out the requirements and guidance in F883 which speaks to receiving education regarding the benefits and potential side effects of influenza and pneumococcal immunizations. F883 also speaks to minimal documentation that the resident or resident's representative was provided such education and whether the immunization was provided. Some providers do not use a written consent. I believe that a written consent meets the CMS requirements at F883 and provides the needed documentation. Going through the consent form with the resident or resident's representative is a great educational opportunity for the nurse and promotes discussion. Signing for or declining the vaccination is documented clearly within the consent form itself.

26. For morbid obesity, does the MD have to document words or if BMI meets criteria is that sufficient?

Ideally the physician should document morbid obesity but the NTA point can be awarded if the physician documents obesity and the BMI ≥ 40. Record the Z code for the elevated BMI as well if a dx of morbid obesity is not specified.

27. What are the involuntary discharge requirements?

Documentation is specified beneath F622 in Appendix PP (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf) beginning on page 167:

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

28. Where do we find a link to Critical Elements Pathways?

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html is the website where the CE Pathways are found. Scroll down the page to Downloads and select Survey Resources. That goes to a .zip file. Open that and select LTC Survey Pathways. There you'll find all the CE Pathways – both in Word as well as PDF.

29. Can you provide examples of how good, not-so-good or great documentation is helpful when working with the nurses?

That would make a great future webinar wouldn't it and it could be quite lengthy! We've all seen not-so-good documentation, particularly in retrospect when auditing or when surveyors question our documentation; some of us have seen it when a lawsuit has been filed and we're trying to piece together what happened with that resident's care, often months or years after the fact. The trick is to stop and think about what you're charting and who you're charting it on. Don't chart things like resident resting well or slept all night. Be very specific and thoughtful about your observations/assessments and chart those. If a resident makes a statement regarding his/her care or symptoms, capture that statement in quotation marks in the medical record. If a resident had pain earlier in your shift, go back to see if your interventions reduced/eliminated the pain and chart that. What was the level of pain experienced before your intervention(s)? After those interventions? Review your documentation to ensure it is complete. Would someone else clearly see what you observed, what you did and how the resident responded? If not, your documentation doesn't pass muster. If you're making a late entry, make sure your documentation reflects that – don't sneak something in. It will bite you down the road if you're sneaky.

Great documentation, as I've said before, paints a picture or tells the story of the resident's stay in your facility. What the resident looked like upon admission, your assessment and identification of needs, your interventions to meet those needs, the success of those interventions and the resident's response to care and services. Great documentation is a hallmark of a competent clinician. We owe it to ourselves and those we care for to record accurately, completely and as often as needed. In God we trust, all others must document!

30. Do you have any suggestions for any auditing tools?

The Critical Element Pathways (CMS) are great auditing tools (see my answer and link in question #28). The state and Federal surveyors are using them to audit you/your processes – use them to audit yourself as well.

If you're a member of AAPACN (AANAC or AADNS), there are some excellent audit tools online on those websites.