Eli's Hospice Insider

Medical Review: 8 Ways To Improve Your Documentation And Fend Off Denials -- Or Worse

Tip: Focus less on what your staff does and more on what your patient needs.

At least 10 different types of government agencies and contractors can now review your records -- will your documentation stand up to the scrutiny?

Your charts have to be strong enough to hold up to every single contractor who has jurisdiction to comb through them, emphasized **Debra Sellers**, director of home care services for **St. John's Health System** in Springfield, Mo, at the **National Association for Home Care & Hospice** annual meeting in Las Vegas. (For a list of contractors that can put your records under the microscope, see story, this page.)

Some documentation of the hospice patient's condition is "black and white, but a lot of it is interpretation," Sellers told attendees at her Oct. 4 education session, "The Devil's In the Details: Documentation for Hospice Success."

Use these tips offered by Sellers, who formerly worked for regional home health intermediary **Cahaba GBA**, to shore up your documentation and protect your claims from medical review, denials, and compliance enforcement:

1. Change your IDT meetings' perspective. Instead of reviewing the services you've already provided to the patient since the last meeting, your interdisciplinary team meetings should focus on what your patient will be needing from you in the time period until your next meeting, Sellers advised. Changing the team meeting's perspective from retrospective to prospective is often "a fundamental shift," Sellers acknowledged.

This can be a tough change for managers who want to recognize staff's hard work in cases, Sellers noted. That's a great idea, but the IDT meeting is not the place to do it, she maintained.

2. Reorganize your IDT meeting structure. Many managers like to organize their IDT meetings to review cases by case number, alphabetically, based on staff assignment, or some other grouping. Instead, consider talking about patients by diagnosis, Sellers suggested.

Organizing your discussion this way will give staff, especially those new to the field, a comparative base, Sellers offered. And that may encourage them to furnish more analytical and thorough documentation.

3. Don't be afraid to change the diagnosis. Patients at end of life often have a lot going on, Sellers pointed out. You may admit the patient under one diagnosis, but later find another diagnosis has taken the lead as the reason for the terminal illness.

While you don't want to change the diagnosis every week, you should certainly review it for accuracy periodically -- perhaps at monthly billing time, or at recerts, Sellers said. That way your documentation can more thoroughly support that diagnosis.

Bonus: Big payment changes are poised to hit the hospice industry. The **Medicare Payment Advisory Commission**, the **Centers for Medicare & Medicaid Services**, and legislators have all called for payment system changes. Don't be surprised to see the diagnosis codes you're reporting today have a big impact on how a hospice payment system is structured down the road, Sellers warned.

For example: With home health agencies, diagnosis codes now play a big part in prospective payment system case mix rates, Sellers pointed out. But the data CMS based PPS categories on came from claims submitted when diagnosis codes

had no reimbursement impact on HHAs. "What goes around comes around," she cautioned.

Hospices probably shouldn't worry about hiring certified coders quite yet, but they should take pains to be as specific as possible with the one diagnosis code allowed, Sellers suggested.

4. Shift your documentation priorities. Like in IDT meetings, staff often want to focus on the services they provided rather than the patient's condition and how her needs were met, Sellers observed.

Hospice clinicians are prone to "positive charting," where they describe what the patient still can do instead of highlighting what they can't, Sellers pointed out. "Hospice staff need a 'paradigm shift' from wanting only to chart what they are 'fixing' and ignoring the fact their patients are dying," she urged.

You need to get your staff to see the glass half empty instead of half full when it comes to documenting the patient's condition, Sellers advised. Otherwise reviewers won't understand why the patient qualifies for hospice.

5. Ban canned documentation. Especially with medical records generated electronically, do not allow your clinicians to use a template for documentation, Sellers counseled. Beware the rote plan of care, because "that's where they're going to nail you," she warned of reviewers and surveyors.

For example: Sellers once saw a patient's record that included "make sure eats appropriately" with weight-increasing interventions. But actually, the patient had gained 80 pounds and needed help to reduce or at least not gain more weight.

Even if the canned documentation doesn't include an outright incorrect statement, it still doesn't paint an accurate picture of your patient, she said.

6. Avoid language pitfalls. You can bank on trouble if your patients' charts include some red flag words. Those include "stable," or "remains hospice appropriate" without any reason why, for example.

"Stables are for horses!" Sellers joked. "Get that out of those records, it's a fast track to denial."

And beware of "continues slow decline" without any measures to support the statement, she added.

7. Include objective measures. You need to show reviewers and surveyors exactly why the patient qualifies for the hospice benefit. Part of that is including objective measures such as Karnofsky, Palliative Performance Scale (PPS) and Functional Assessment Scale (FAST) scores, Sellers advised. And don't forget weights, heights, and BMI -- not just one of those scores.

Tip: Including a comparison to a baseline or previous time period is ideal, Sellers said.

8. Put resources into training. Your staff won't magically figure out how to improve their documentation on their own -- you'll need to spend some time and money training them. In addition to the usual inservices and quality reviews, you may try doing co-visits with staff and reviewing their documentation. This has the added bonus of getting them used to someone looking over their shoulder, in case a surveyor or investigator wants to shadow them.

In extreme situations, you may even have a clinician explain her documentation to a surveyor who is questioning it, Sellers suggested. This can really show her why her documentation needs to be clear and complete.

Remember: If you tighten up your hospice's documentation practices, you shouldn't be afraid to have reviewers go over your records, Sellers suggests. "If you don't get ADRs ever, you're probably leaving money on the table," she warned. While you don't want to see an ADR every week, you shouldn't worry if you see one occasionally. Otherwise, you may be too conservative with your billing.

Note: View Sellers' slide presentation for the session at www.nahc.org/Meetings/AM/11/Handouts/705.pdf.

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