Codify
BY AAPC

Long-Term Care Survey Alert

Quality of Care: Top 7 Ways Physicians Can Get Your Facility In Trouble With Surveyors

Protect yourself by helping docs get with the OBRA program.

You might think of the physician as being like the pied piper in directing resident care -- and if he isn't in tune with OBRA, your nursing facility will be paying a different piper in survey fines.

"A big problem in the survey process is that surveyors second-guess physicians'plans of care, which the facility is required to implement," says attorney **JenniferGimlerBrady** with **Potter Anderson & Corroon** in Wilmington, DE. "Then the surveyors tag the facility, but they don't go to the medical boards when they claim that the physician-ordered directives don't meet OBRA standards or the medical standard of care," she adds.

So what's a nursing home to do if it's caught between a regulatory rock and a physician who takes a hard line against practicing by the OBRA rules? The key is knowing where physicians are most likely to saddle your facility with F tags, and then implementing preemptive strategies to head off resident care and related survey problems.

Problem 1: The physician doesn't understand quality indicators, including sentinel events, and how they drive the survey. The physician may not understand that a high QI score isn't good -- or that surveyors have "zero tolerance" for the three sentinel events (fecal impaction, dehydration or pressure ulcers in low-risk patients). In that regard, geriatric practitioner **Malcom Fraser, MD**, finds it works well to explain to physicians that a QI is like a golf score: "The higher your score, the worse you are doing," he says.

Solutions: To educate attending physicians about QIs, Fraser advises getting the medical director involved. "Offer evening or early morning meetings for physicians that include some business and reimbursement issues in addition to OBRA-related requirements" -- for example, billing and coding tips so physicians can get paid fairly for what they do, suggests Fraser who is president of **Bay Geriatrics** in St. Petersburg, FL.

Tip: To prevent fecal impaction (a sentinel event) caused by opioids or medications with an anticholinergic effect, ask the physician to prescribe a stool softener or other medication for constipation, Fraser suggests.

Problem 2: The physician fails to recognize and/or respond to **medication-related falls and delirium.** In general, facilities and physicians frequently don't think about medications causing or contributing to falls and delirium and other common problems, says **Thomas Clark,** a pharmacist and spokesperson for the **American Society of Consultant Pharmacists**.

Solutions: Provide the consultant pharmacist with a list of residents who've had falls and/or changes in mental status -- especially those with fairly abrupt cognitive changes, Clark suggests. That way the pharmacist reviewing a big stack of charts can more readily make recommendations to the physician about drug regimen changes or monitoring.

Develop a policy where a resident's fall triggers an automatic review of his medications and a physical therapy screening, advises Fraser.

Clinical gem: Anormal X-ray does not exclude a fracture after a fall. "Consider an MRI or CT scan if the patient's pain or reduced function persists even though his X-ray is normal," Fraser advised attendees of his presentation on "The Dirty Dozen" clinical and liability problems involving physicians and nurses in long-term care at the fall 2003 **American Association of Nurse Assessment Coordinators'** conference in Las Vegas.

CPT® 2023 American Medical Association. All rights reserved.

Problem 3: The physician diagnoses dehydration when the resident doesn't have the condition. Nevertheless, surveyors read the diagnosis in the medical record and think "sentinel event," which can point the survey in a direction in which no facility wants to go.

Physicians may make a false diagnosis of dehydration when they don't have the full picture of what's going on with a resident.

Rule of thumb: "In caring for geriatric patients, physicians must be careful to treat the patient -- not the lab work," Fraser cautions. For example, clinicians should view a resident's elevated sodium, BUN or creatinine values within the context of his baseline lab results, clinical condition and fluid intake and output.

Solutions: Facilities can help physicians in that regard by providing baseline lab results and pertinent and accurate information about a patient's hydration status. "The move toward electronic records that the physician can access online will help in such situations," Fraser says.

Devise physician fax forms for various conditions that list pertinent data that the physician can use to make treatment decisions (see example of dehydration physician fax form). But make sure the font size is readable, Fraser cautions.

Problem 4: The physician orders outdated wound care modalities resulting in poorly healing wounds (and F314 tags). For example, long-term care consultant **Virginia Downing, RN**, still sees some physicians ordering povidone iodine or hydrogen peroxide to treat wounds. But current government standards say these should not be used, cautions Downing, principal of **Lifestyles LLC** in Anthony, KS.

Solutions: Get a certified wound care nurse or consultant with wound care expertise on board to work collaboratively with the physician. "That person can interface with the physicians and be the 'bad guy'in letting them know if a prescribed treatment might be considered substandard care and also pose a litigation risk to them," says **Peggy Dotson, RN**, principal of **Healthcare Reimbursement & Strategy** in Yardley, PA.

"If you're not seeing progress in wound healing or cannot determine if it's healing within two weeks, alert the physician to change the approach," Dotson adds.

Provide the physician and interdisciplinary staff with copies of the **Agency for Healthcare Research & Quality's** pressure ulcer treatment guidelines. You can download the guidelines at www.ahrq.gov/clinic/cpgonline.htm.

Problem 5: The physician documents in a way that sets the facility up for trouble with surveyors or auditors. Aprime example occurs when the doctor's progress notes don't jibe with how the MDS describes the patient, Fraser told AANAC conference-goers.

Solution: Assign an RNAC to serve as a liaison to work with that particular physician to address and reconcile any inconsistencies.

Problem 6: The physician doesn't visit the resident frequently enough to address his care needs. An educational session on Medicare reimbursement may cure this problem, as some physicians still believe they can visit the resident only once a month under Medicare guidelines, which used to be true in the bad old days.

"Today Medicare recognizes that medically necessary visits to these patients saves the system money," says **Dennis Stone, MD, CMD, MBA**, a former medical director and chief medical officer of **HealthEssentials Solutions Inc.** in Louisville, KY. "So Medicare carriers will generally pay for medically necessary visits as long the physician has the documentation," he says.

"The **American Medical Directors Association** did a white paper that basically says 'medical necessity'is defined as anything the physician or practitioner can validate is appropriate to maintain the patient's health," Stone adds.

Nurse practitioners and physician assistants can also help facilities respond more quickly to changes in resident status, as well as improving the overall quality of care in a facility, notes **Howard Sollins**, an attorney with **Ober/Kaler** in

CPT® 2023 American Medical Association. All rights reserved.

Baltimore.

"Some nursing staff may be uncertain or uncomfortable making judgments about when to contact a physician about [a resident], but they may more readily consult with an NP who is in the building more frequently," Sollins adds. An NP or PA can assess a resident and write an immediate medical order to address an acute clinical issue, if necessary. And they can provide a more in-depth assessment and specific recommendations in securing a physician order, Sollins notes.

Problem 7: The physician isn't accountable for care that doesn't meet OBRA or other established standards of care. "You want a medical director who can write orders in the chart and who is empowered to discipline attending physicians," if needed, says **Scott Rifkin, CMD, MD**, with **Rifkin Medical Services** in Owings Mills, MD. Facilities should also have protocols that direct nursing staff when to call the medical director and how to respond to a lack of responsiveness on the doctor's part, he adds.

A Tale from the Trenches

Rifkin supervised an attending physician in a nursing facility recently who started a patient on prednisone for a rash that wasn't healing three weeks later. "The consulting pharmacist had even come in and said the medication wasn't helping the rash," Rifkin says. "The nurses called the doctor who got irritated and said to just stop the prednisone, which you can't safely do (the drug needs to be tapered)," he says. The nurses told the doctor the drug needed to be tapered, but the physician got annoyed and told them to just discontinue it. So Rifkin called the doctor and told him to either taper the dosage or he would write the order to do so -- and reassign the patient to another attending.

Remember: OBRA isn't the only game in town in terms of meeting the standard of medical and nursing care. "There are instances where OBRA requirements don't dictate what's considered to be good medical practice," says Fraser. "For example, the OBRA guidelines don't say you have to monitor a patient taking an atypical psychotic medication for hyperglycemia, but failure to do so is probably the most rapidly expanding area of litigation against physicians in long-term care settings," he notes.

All patients taking an atypical antipsychotic medication should have an up-front blood sugar and additional monitoring depending on the patient's clinical condition and risk status, according to Fraser.

Editor's Note: Take the self test to find out how "physician friendly" your facility is.

CPT® 2023 American Medical Association. All rights reserved.