

## MDS Alert

### Medicare Payment: Will Your Skilled Care Documentation Fly With The FI?

5 essential tips prevent payment recoupments or worse.

Coding the MDS accurately so a resident RUGs into the right group doesn't mean you're home-free. The medical record has to prove the resident requires and receives skilled care, which is where your documentation skills enter the fiscal picture.

The bottom line: A nurse should write at least a daily note that includes information that will pass muster with a medical reviewer. In a nutshell, the note should substantiate the reason the person is on a skilled level of care and the facility is receiving Medicare payment for skilled care, says **Joy Morrow, RN, PhD**, a consultant with **Hansen, Hunter & Co.**, Beaverton, OR.

Follow these five key strategies for documenting so that you give a clear picture of a resident's needs and care.

1. Keep your note on point. Document to "address deficits and speak to the reason the person needs an RN watching over him," says Morrow. Otherwise, the resident could be in another care setting, she points out.

Keep in mind, however, that documentation "is for more than reimbursement -- it's also about risk management," says **Donna Senft, PT, JD**, with **Ober/Kaler** in Baltimore. So "even on days when everything seems fine, a note is critical to show that you have assessed the key issues related to the resident's care," she says.

Save time: Don't include unnecessary phrases such as "cooperative with care," "no complaints," "visiting with another patient," advises Morrow. "The skilled care documentation is not a report card for that kind of thing."

Good idea: Write a note explaining the rationale for why the facility skilled a resident -- or not, advises **Diane Atchinson, RN-C, MSN, ANP**, owner and president of **DPA Associates** in Kansas City, MO.

2. Don't skip the daily nursing documentation for rehab patients. Even if the resident is skilled based on therapy, include a daily nursing note addressing the resident's functional level, ADL requirements and response to therapy, advises **Ron Orth, RN, NHA, RAC-CT**, president of **Clinical Reimbursement Solutions LLC** in Milwaukee. Documenting that information will "help support the need for skilled therapy," he adds. (For expert tips on how nursing and therapy can work together to document a rehab patient's care and progress, see the next MDS Alert.)

3. Speak to the skilled nursing care that the resident requires and receives, and his progress. The note should speak to specific skilled nursing services the facility is providing, emphasizes Morrow. "That can be skilled observation" where the nurse records her findings, such as an "assessment of lung sounds and respiratory status for a resident who was in the hospital for pneumonia."

The nursing notes should also refer "fairly frequently" to the reason the "resident was in the hospital even if that's not the most critical issue at the moment," Morrow adds.

Remember: Even though a resident is in a clinical RUG presumed to be skilled, you still have to provide and document daily skilled nursing care, emphasizes Orth.

Example: Say a resident RUGs into Special Care due to a Stage 4 pressure ulcer and two or more skin treatments coded in Section M. Documentation should include daily wound assessment and treatments, says Orth. "Document the wound size, depth, color, drainage, odor, etc.," and any fever or signs of infection, he adds.

"If you use a [wound] dressing that doesn't require changing daily, skilled nursing services would also include how the team is addressing any comorbidities, such as nutritional depletion," says Orth. "You'd look at -- and document -- your assessment and interventions related to issues that affect wound healing." (For tips on how to document skilled care for a resident in one of the lower 18 RUGs, see the next MDS Alert.)

4. Document the changes in care the team makes as the result of the nursing observation and assessment. Examples include titrating pain medicine or oxygen or reporting changes to the physician, who changes orders, says Senft. "You may not be changing the overall care plan but you are modifying how you deliver that care."

For example, "if the person has too much pain for a wound dressing change, you change the timing or dose of the pain medication -- or change interventions to help motivate a depressed person to participate in his care," advises Senft.

Watch for this: "When you get to the point that you're no longer doing anything that requires licensed nurse assessment and clinical judgment to modify care, you have to ask if the person needs skilled [nursing] services any more," adds Senft.

5. Use strategies and tools to help staff consistently document skilled care in the right way. For example, to remind nurses to document skilled care correctly, **Holbrook on the Hill** uses a brightly colored piece of paper that goes in the front of the chart. It says, "This resident is being skilled because \_\_\_ and this is what we should focus on \_\_\_," advises **Donna Gay, RN**, director of nursing for the facility in Buckhannon, WV.

Superior Woods Health Care Center uses a form "that is primarily a check-off sheet with room for a narrative note," says **Sheryle Thomas, RN, RAC-C**, MDS coordinator for the facility in Ypsilanti, MI. "For Medicare Part A-stay residents, a nurse charts once every 24 hours. We assign the nurses on various shifts to do that for certain residents," she adds.

Cover the bases: "Even though Medicare requires only daily documentation, some facilities document for all three shifts," reports **Roberta Reed, RN, MSN**, clinical care manager at **Legacy Health Services**, which operates nursing homes in Ohio. "That strategy avoids problems if you have a nurse on one shift who is poor at documentation -- or a situation where a nurse doesn't have time to document because she's putting out fires for the entire shift."