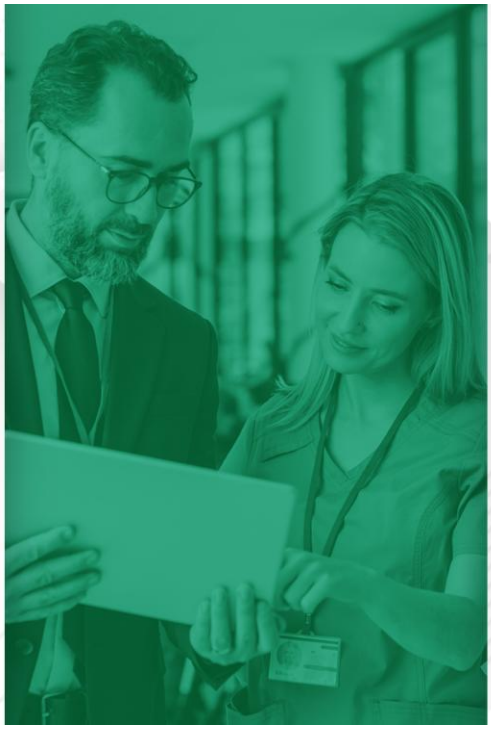
If it Wasn't Documented, It Wasn't Done: Common Documentation Issues Impacting Home Health and Hospice Agencies



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Victoria Barron is a Registered Nurse who joined Healthcare Provider Solutions in December 2021 as a Clinical Consultant. As part of the HPS clinical consulting team, Victoria provides support and solutions to home health and hospice agencies nationally to achieve regulatory compliance.

With more than 40 years of nursing and healthcare experience, the majority of Victoria's career has been in the home services arena including home health, hospice, home care, and home infusion where she has served in various roles.

Victoria is a licensed Multistate Registered Nurse and is a CHAP and ACHC Certified Home Health and Hospice Consultant.

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Learning Objectives

- Identify common documentation issues impacting home health and hospice agencies
- Discuss essential documentation that is often missing or incorrectly noted.
- Perform clinical audits and follow-up for effective quality improvement

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Documentation – the act or an instance of furnishing or authenticating with documents.

Medicolegal – of or relating to both medicine and law.

https://www.merriam-webster.com/dictionary

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Regulatory References to Written Documentation

	Home Health SOM Appendix B	Hospice SOM Appendix M	Emergency Preparedness SOM Appendix Z
"Written"	48	82	21
"In Writing"	10	6	5
"Documentation"	34	61	54
"Documented"	6	23	15
	MBPM Chapter 7	**MBPM Chapter 9**	
"Written	8	21	
"In Writing"	2	9	
"Documentation"	37	20	
"Documented"	26	5	

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Documentation Essentials for Home Health and Hospice Providers

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Documentation At Time of Admission

- Admission Documents address multiple requirements under regulation for both home health and hospice providers related to information that must be provided to patients both verbally and in writing including consent to treat, hospice election/addendum statements, patient rights, grievance process, contact information for the agency, specific policies – infection prevention and control, etc.
- All clinicians should be educated to stress the importance of the admission packet/documents to patients and caregivers.
- Establishing a practice that all clinicians review the admission packet/documents at the start of each visit and prior to leave to update the visit schedule , note communication documentation between disciplines, perform medication reviews is recommended.
- An individualized emergency plan is required to be developed as part of the comprehensive assessment for home health patients and a written plan must be provided to the patient/representative AND a copy retained by the agency. CMS does not require a specific format for the individualized emergency plan. Refer to State/Local regulation for additional emergency preparedness/plan requirements. Emergency preparedness for ALL patients is essential.

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Required to be Provided to Patients/Caregivers in Writing

- Patient Rights – confirm that patient rights provided to patients included all rights noted in the State Operations Manual that is applicable for your program.
- Infection control - Provide infection control education and document associated training – handwashing.
- Written information about the agencies policies on Advance Directives (Hospice) and identify the patient's Advance Directives for home health patients as applicable.
- Written Policies and procedures on the management of controlled drugs – must be documented in the clinical record that policy was provided and discussed. (Hospice)
- Visit Schedule - Are changes to the visit schedule documented? No specific format is required. Missed visits
- Medication List provided to patient and updated as needed.
- Individualized emergency plan as part of the initial comprehensive assessment (Home Health)

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Home Health Certification

A certification (versus recertification) is considered to be anytime that a Start of Care OASIS is completed to initiate care. In such instances, a physician must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home.

2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification;

3. A plan of care has been established and is periodically reviewed by a physician;

4. The services are or were furnished while the patient is or was under the care of a physician;

5. For episodes with starts of care beginning January 1, 2011 and later, in accordance with §30.5.1.1 below, a face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type. The certifying physician must also document the date of the encounter.

The F2F encounter documentation must be obtained – verify that encounter notes are signed by the provider.

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Home Health – Sample Certification Statement

Example Certification Statement:

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with an allowed provider type on --/--/--- and the encounter was related to the primary reason for home health care.

Home Health Certification Periods are 60 days.

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Hospice Certification of Terminal Illness

- Only MDs or DOs can certify terminal illness. Ensure credentials are clearly noted on the hospice election statement to support required/not required certification by attending.
- Benefit period dates are required to be noted on each CTI.
- Patients are required to be certified terminally ill within 15 days before the start of a certification period or up to 2 days after the start of the certification period.
- Certification periods for hospice include two 90-day certification periods followed by an unlimited number of 60-day certification periods.
- A Face-to-Face encounter is required within 30 days before the start of the 3rd and all subsequent benefit periods. A Face-to-Face encounter performed on the first day of the benefit period is considered timely.
- CTI signature requirements:

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Hospice Certification of Terminal Illness

- The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers are required.
- The CTI is required included a brief narrative of patient specific objective clinical findings to support a 6 month or less prognosis.
- The physician signature is required to be immediately below the narrative statement if the narrative is included on the CTI form.
- If the narrative is an addendum to the CTI form, the physician must sign the CTI form AND immediately below the narrative on the addendum.
- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient/s record or , if applicable, his or her examination of the patient. The physician may dictate the narrative.
- No checkboxes or standard language is allowed. Must be individualized for each patient.

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Hospice F2F Encounter/Attestation Requirements

- A hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a nurse practitioner or non-certifying hospice physician performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the
- Documentation of the actual encounter is required.

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Hospice Election/Addendum Statements

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~~Model Example of~~ **Hospice Election Statement**

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ **(Patient Name)** choose to elect the Medicare hospice benefit and receive Hospice services from _____ **(Name of Hospice Agency)** to begin on _____ **(Start of Care Date).**

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

Note attending name and contact information. ONLY if chosen by the patient/representative at time of election. Include credentials.

☐ I do not wish to choose an attending physician
☐ I acknowledge that my choice for an attending physician is:
(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name:

Ensure NPI or office address are also noted.

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on what items, services, and drugs the hospice is to cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions will continue to be eligible for coverage by Medicare under separate benefits.

Last updated: March 2024

~~Model Example of~~ **Hospice Election Statement**

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- If I request this form within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If I request this form during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

Ensure the BFCC-QIO for the area that serves the patient is noted including name and phone number of address.

BFCC-QIO Name: _____

BFCC-QIO Phone Number or Website: _____

Signature of Beneficiary: _____

Signature of Beneficiary Representative (if beneficiary is unable to sign): _____

Date Signed: _____

ALL SPACES MUST BE COMPLETED AT THE TIME OF ELECTION!!!

Last updated: March 2024

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~~Model Example of~~ **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

Patient Name: _____

Ensure the DATE FURNISHED is noted on the form.

Patient MRN: _____

Hospice Agency Name: _____ **Date Furnished:** _____

Purpose of Issuing this Notification

The purpose of this addendum is to notify the requesting Medicare beneficiary (or beneficiary representative), in writing, of those conditions, items, services, and drugs not covered by the hospice because the hospice has determined they are unrelated to your terminal illness and related conditions. If you request this notification within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If you request this notification during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.

Diagnoses Related to Terminal Illness and Related Conditions

1.	5.
2.	6.
3.	7.
4.	8.

Diagnoses Unrelated to Terminal Illness and Related Conditions

1.	5.
2.	6.
3.	7.
4.	8.

Items, Services, and Drugs Determined by Hospice to be Unrelated to Your Terminal Illness and Related Conditions (these items, services, and drugs will not be covered under the hospice benefit):

Items/Services/Drugs	Reason for Non-coverage

Note: The hospice makes the decision as to whether conditions, items, services, and drugs are related for each patient. As the beneficiary (or beneficiary representative), you should share this list and clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions. The hospice should provide its reasons for non-coverage in language that you (or your representative) understand.

Right to Immediate Advocacy

As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to request for Immediate Advocacy if you (or your representative) disagree with the decision of the hospice agency on items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions.

Updated March 2024

All sections MUST be completed prior to patient or representative signature!!! A signed copy must be available to provide to medical reviewer.

~~Model Example of~~ **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**

Please visit this website to find the BFCC-QIO for your area: https://qioprogram.org/locate-your-qio or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: The 'date furnished' is defined as when the beneficiary (or representative) receives an addendum within 3 or 5 days from their request and not the date of the signature.

Signing this notification (or its updates) is only acknowledgement of receipt of this notification (or its updates) and does not constitute your agreement with the hospice's determinations.

Signature of Beneficiary: _____

Signature of Beneficiary Representative (if beneficiary is unable to sign): _____

Date Signed: _____

Ensure the Medical Record Number is included on the form!

Updated March 2024

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Plan of Care

Both home health and hospice agencies are required to develop and update an individualized Plan of Care for each patient.

- Updates can occur in the form of:
  - Recertifications (both home health and hospice)
  - Must occur at all OASIS timepoints (home health)
  - Starting 10/1/25, may occur as a result of symptoms identified during Hope Admission or HUV Visits or SFV visits. (hospice)
  - May be documented as verbal orders,
  - IDG documentation if signed by the hospice physician (hospice)
  - Therapy evaluations/reevaluations (home health)
  - and should occur as frequently as needed based on updates to the comprehensive assessment.

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Home Health Plan of Care Required Elements

1. All pertinent diagnoses
2. The patient's mental, psychosocial, and cognitive status
3. The types of services, supplies, and equipment required
4. The frequency and duration of visits to be made
5. Prognosis
6. Rehabilitation potential
7. Functional limitations
8. Activities permitted
9. Nutritional requirements
10. All medications and treatments
11. Safety measures to protect against injury
12. A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.
13. Patient and caregiver education and training to facilitate timely discharge
14. Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient
15. Information related to any advanced directives
16. Any additional items the HHA or physician *or allowed practitioner* may choose to include.

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Hospice Plan of Care Required Elements

The hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

- Interventions to manage pain and symptoms
- A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
- Measurable outcomes anticipated from implementing and coordinating the Plan of Care
- Drugs and Treatments necessary to meet the needs of the patient.
- Medical supplies and appliances necessary to meet the needs of the patient.
- The IDG's documentation of the patient/representative's level of understanding, involvement and agreement with he POC.

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Visit Documentation

- Each visit note documentation should include clear documentation to support the care that was provided during the visit, that follows physician orders and includes documentation of collaboration as indicated and reflects the ongoing plan for the patient.
- Verbal or written orders should be obtained and written for any changes to the plan of care and documented timely.
- Checkbox documentation only should not occur as it may not support medical necessity, skilled care provided or eligibility for services.
- Visit documentation should include a narrative statement specifying the care and services provided during the visit.
- Documentation lacking specificity of teaching and noting education on a large volume of information during 1 visit may not accurately reflect the interventions provided.
- Documentation of education should reflect the patient/caregiver comprehension, understanding and need for continued education as appropriate.
- Documentation of education provided to patient with cognitive impairment.

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Problems/Interventions/Goals

- Must reflect the problems based on the initial and comprehensive assessments.
- Are interventions and goals updated/documented on an ongoing basis?
- Are new problems added as identified?
- Are resolved problems discontinued as applicable?
- Does documentation accurately reflect progress to goals? Goals should be measurable.
- Are high risk medications noted, fall risk, infection risk, bleeding precautions?

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Wound Documentation

- The order/intervention should include the wound number, location and type of wounds (wound etiology such as surgical wound, pressure ulcer, stasis ulcer, trauma, etc., Wound etiology must be confirmed with the physician) and measurements. (Ensure accuracy – laterality is frequently noted incorrectly).
- Size of the wound Length x width x depth listed in centimeters. Ex: 0.3cm x 2.0cm x 3.0cm
- Length: Measure top to bottom or head to toe or 12:00 to 6:00
- Width: Measures side to side or hip to hip or 3:00 to 9:00
- Depth: Deepest point of the visible wound bed
- Description of the wound: Surrounding tissue, wound bed, Undermining, rolled edges, inflammation, warmth, redness, odor, drainage, color, amount, necrotic tissue, slough, etc.
- Wound photos - A picture speaks 1000 words – (Ensure photo consent is obtained).

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Wound Documentation (cont.)

- Wound order documentation should follow the agency policy.
- Wounds should be measured at least weekly or more frequently according to agency policy. We have seen denial for wounds not being measured or description/assessment of the wound weekly.
- Wound care requires Intervention & goals for healing
- What discipline is performing.
- Removal of the old dressing/treatment;
- Is the wound care is to be performed per sterile or clean technique?
- Cleansing of the wound & Drying: with what? NS and gauze pad? How is it dried? Gauze pads? How is the medication applied or treatment applied? What is covering the wound? How is it secured?

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Wound Documentation

- Dressing/treatment ordered and what discipline, EX SN to perform 3 times per week on M, W, F. Caregiver to provide wound care on non nursing visit days. Or no willing and able caregiver. Reasons patient cannot perform with specific details to support.
- Frequency of dressing/treatment.
- Ability to teach patient or caregiver to perform wound care or reasons why the patient or caregiver cannot be taught and the days. Documentation in the record that the patient or caregiver has been observed providing the wound care correctly.
- Signs and symptoms to report.
- Any other treatments such as wraps or supportive devices: When they are to be applied, removed such as TED hose, don in the am prior to getting out of bed, take off at night.
- For Home Health, document the reason a patient/caregiver is unable to provide the specific care. No willing able caregiver, legal blindness, severe RA both hands, as examples.

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Wound Documentation Issues

- Documentation lacks specificity of the wound care provided.
- Documentation does not include a full assessment of the wound.
- Laterality, location is not noted.
- Wound care provided does not align with current orders.
- Wound care products not noted on the medication list/profile.

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Examples of Poor/Weak/Missing Documentation – Home Health

- Patient entering 3rd certification period with ordered frequency for SN 1w4. Plan of Care includes 72 nursing interventions – copied and pasted from 1st and 2nd certification periods.
- Visit documentation not addressed problems and lacks evidence of interventions provided or progress to goals.
- Visit documentation does not support skilled care was provided.
- Teaching, training documentation is generalized, lacks specificity or is repetitive. Education continues into subsequent certification periods with previous documentation supporting understanding and compliance by patient/caregiver.
- The plan for next visit lacks specificity.
- Medication profile does not align with current orders. DC dates lacking, dosage change not updated on medication profile. PRN entries lack a reason for the order.

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Examples of Poor/Weak/Missing Documentation – Hospice

- Visit notes include checkbox assessment only.
- Narrative notes lack documentation to support a 6 month or less prognosis.
- Narratives are repetitive and appear to be copied and pasted.
- No weights documented.
- Documentation not supporting change, decline.
- Visit documentation not addressed problems and lacks evidence of interventions provided or progress to goals.
- Medication profile does not align with current orders. DC dates lacking, dosage change not updated on medication profile. PRN entries lack a reason for the order.

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Talk to Text

- Extreme caution must be used when utilizing any dictation tools.
- Incomprehensible language, obvious spelling errors may not relate the necessary information to support the patient condition, care provided.
- Documents should be proofread for clarity, errors and corrections made.
- Remember – clinical records including consent forms, election statements, visit notes, etc. are legal documents and may be used for medical review to support payment or denial of claims or in a court of law.

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QAPI

- QAPI Program must be documented.
- Performance Improvement Projects must be in writing and should be based on most prevalent issues/concerns identified through record review, adverse events reports, infections, falls, as examples.
- Audits - Clinical record reviews – must be documented and follow agency policy regarding frequency.
- Peer audits
- Focus Audits should be performed when issues are identified.
- Corrections based on audit findings may prevent survey deficiencies if clearly documented.

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Hospice IDG/IDT Meetings

- Documentation must support participation by all required members: Hospice physician, hospice RN, Social Worker, Chaplain/Spiritual Care.
- Signatures of participants are not required.
- Must occur AT LEAST every 15 days.
- IDG/IDT documentation should reflect address the patient's current condition, any changes needed, such as medication orders, increased frequencies, change in bereavement needs, etc.

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Communication/Coordination Notes

- All EMRs include a method to document communication or coordination notes. This function is often underutilized.

When should communication/coordination notes be used?

- Reporting of signs/symptoms to physician/other providers or members of the IDG/IDT.
- Contact with patient/caregiver regarding patient's current status, updates to the care plan, etc.
- Communication with facility staff.
- Communication with other providers – at time of resumption of care (home health) discharge/transfer.
- Consider other communication tools – texting apps (HIPAA compliant). Is crucial information being communicated OUTSIDE of the EMR?

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Aide Care Plans and Documentation

- Should be written and include specific instructions.
- Must include specific task assignments – no PRN or as needed.
- Should include instruction to notify the hospice RN of any changes in condition, changes to the plan of care, fall risk, bleeding precautions.
- Do aide visit notes support completion of all assigned tasks only?

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Signatures

- (SOM Appendix B) In the absence of a state requirement, the HHA should establish a timeframe for physician *or allowed practitioner* authentication, i.e. for obtaining a physician *or allowed practitioner* signature for verbal/telephone orders received. The signature may be written or in electronic form following the requirements of the particular system. A method must be established to identify the signer.
- SOM Appendix M Review all entries, including physician (written and verbal) orders to determine whether they are legible, clear, complete, and authenticated and dated in accordance with hospice policy and currently accepted standards of practice.

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Signatures

- Handwritten - A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation. NOTE: Stamped signatures are not typically acceptable. CMS permits use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.
- Electronic - Providers using electronic systems shall recognize there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods. (Electronic Signature Policy)

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Signatures

- Signature Logs - Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.
- Signature Attestation Statement

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General Signature Attestation Statement Examples

- CMS does not specify a specific format for GENERAL attestations.

  Example of a GENERAL attestation statement : "I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

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Signature Logs

Signature Log

A signature log lists the typed or printed name of the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. The provider should also list his/her credentials in the log.

Example

Name and Credentials	Signature	Initials
Victor Frankenstein, D.O.	Dr. Victor Frankenstein	VF
Doogie Howser, M.D.	Doogie	DH
Dr. John Doolittle		

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Amendments, Corrections and Delayed Entries in Medical Documentation

All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided may not be properly documented. In this scenario, the documentation may need to be amended, corrected, or entered after rendering the service. The date and author of any amendment, correction or delayed entry should be identifiable, and the change/addenda should be clearly and permanently denoted.

If the MACs, CERT, SMRC or RACs identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the UPIC and may consider referring to the RO and State Agency.

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Error Correction

- Follow agency policy when correcting identified documentation errors.
- Ensure corrections are clearly noted, signed and dated accurately to reflect when the correction occurred.
- Be transparent when noting corrections. Some errors CANNOT be corrected after the fact. Example: Consent form/election statement not accurately completed. These forms cannot be

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CMS: EHR Guidance - Program Integrity Issues

Copy and Paste/Populating via Default

- Can lead to redundant and inaccurate information. Can lead to authorship integrity issues since documentation cannot be tracked to the original source.
- Cloned documentation lacks the patient-specific information necessary to support services rendered to each patient and can affect quality of care.
- False impression of services provided to the patient.
- Coding from old or outdated information that may lead to “upcoding.
- Populating via default may encourage overdocumentation to meet reimbursement requirements, even when services are not medically necessary or are never delivered.
- Editing existing material is less accurate than writing new material.
- Can cause upcoding (higher level of service than provided).

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CMS: EHR Guidance - Program Integrity Issues

Templates

- Documenting accurately can be problematic if the structure of the note is not a good clinical fit and does not reflect the patient's condition and services. (CTI statements, attestation statements, brief narrative statement).
- Ensure all forms are the most current form per CMS regulation. Forms/documents should be updated according to recommendations from CMS and/or your MAC.

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CMS Best Practices for EMR Documentation

- Ensure providers recognize each encounter as a standalone record and ensure the documentation for the encounter reflects the level of service actually delivered and meets payer requirements for billing and reimbursement.
- Validate each entry not solely authored by the user in a manner similar to bibliographic notations and include the name, date, time, and source of the data. System software design that routinely provides validation can satisfy this need.
- Do not allow cut and paste, as it removes original source information.
- Double-check edited default text to ensure it accurately represents the services provided.
- Limit which users can populate by default selectively and what information they can populate by default.

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CMS Best Practices for EMR Documentation (cont.)

- Ensure understanding of the necessity to review and edit all defaulted data to ensure only patient-specific data is recorded for that visit, while removing all other irrelevant data pulled in by the default template.
- Retain all signatures when there are multiple authors or contributors to a document, so that each individual's contribution is unambiguously identified.
- Disable automated change of note author. Restrict ability to disable audit log to a limited set of users.
- Use the audit log functionality of the EMR to identify and trend use of health records.
- Set policies and procedures to ensure providers or a thirdparty review, edit and approve dictated information in a timely manner.

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CMS Best Practices for EMR Documentation (cont.)

- Ensure your agency has a policy on copy and pasting to avoid inaccurate, fraudulent or unmanageable documentation.
- Perform clinical audits to ensure copied/pasted documentation is not occurring.
- Set parameters in your EMR to prohibit copy and paste.
- Educate clinicians and provided additional training if documentation issues are identified.

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References/Resources

- State Operations Manual – Appendix M Guidance to Surveyors :Hospice (Rev. 222; Issued: 06/07/24) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
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Thank You for Participating!
Have any questions?
Scan the QR Code to schedule a call!
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