PA/UR BOOT CAMP 2014

Using the 5 Ws for Documenting for Inpatient Certification

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The Challenge

- Increased Audit Scrutiny
- Surviving Audit Scrutiny
- Understanding the environment
- Developing Meaningful tools

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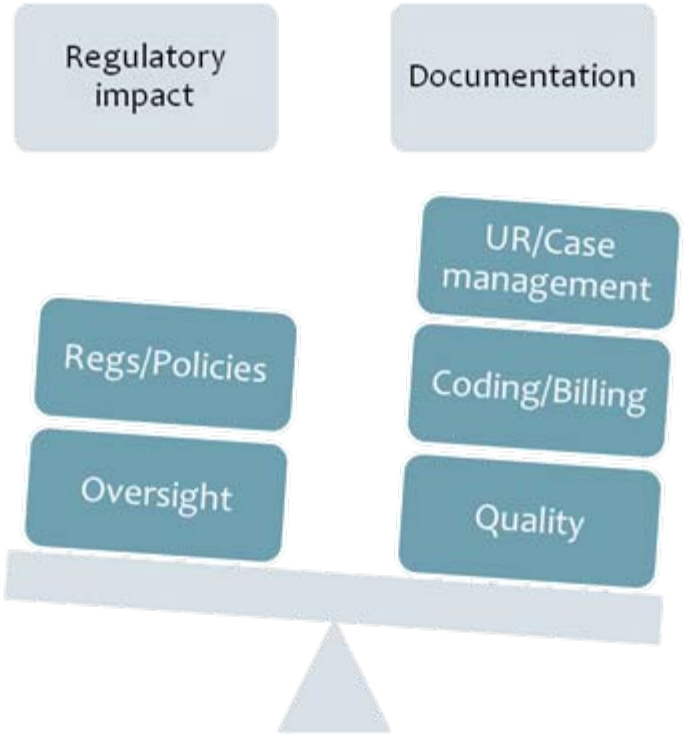
Where is the burden?



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Past Documentation Challenge

Ms. Smith presented with ANGINA following a 2 Day history of chest pain. She has had CONGESTIVE HEART FAILURE for 5 years. Will admit the patient.

Will perform HEART CATHETERIZATTION with possible percutaneous coronary intervention [PCI] or coronary artery bypass graft surgery [CABG]. Will discharge patient following procedure dependent on findings with possible home health follow-up if needed.

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Current Documentation Challenge

* The 2 Midnight Presumption and Assumption
* The Certification for Inpatient Admission

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The Inpatient Certification

* **CMS Guidance:**
* *The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient service(s) were reasonable and necessary. The following guidance applies to all inpatient hospital and critical access hospital (CAH) services unless otherwise specified. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B and 42 CFR 412.3.*

Components:

* Content
* Timing
* Authorization to sign Certification
* Format
* Methodology for certification

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Components

- **Order**
- **The Reason for the inpatient stay is usually covered in the ED Discharge, History and Physical or initial progress notes. This should be written clearly and concisely.**
  - **Patient is being admitted for inpatient stay because of (1) *diagnosis (symptomatology)* (2) *treatment needs* (3) *chronic conditions/complications.***
- **The time of hospitalization whether expected or completed.**
  - **Patient is expected to require at least 2 midnights of hospitalization**
  - **Or, is receiving an Inpatient Only Procedure.**
- **The Plan of Care or Course of Treatment is usually spelled out in ED Discharge, History and Physical or initial progress notes.**
- **Can be done at admission or discharge with exception of order that should be given at admission (stay up to date on FAQs here).**

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Components

* **Remember Certification has to be dated and documented in the medical record PRIOR to discharge. Keep in mind a dictated discharge summary most likely *WILL NOT BE AVAILABLE.***
* ***Dictations will most likely need to be submitted for review during probe and educate***
* **Can be noted throughout the medical record or hospital stay**
* **Can be completed as a form but *not necessary***

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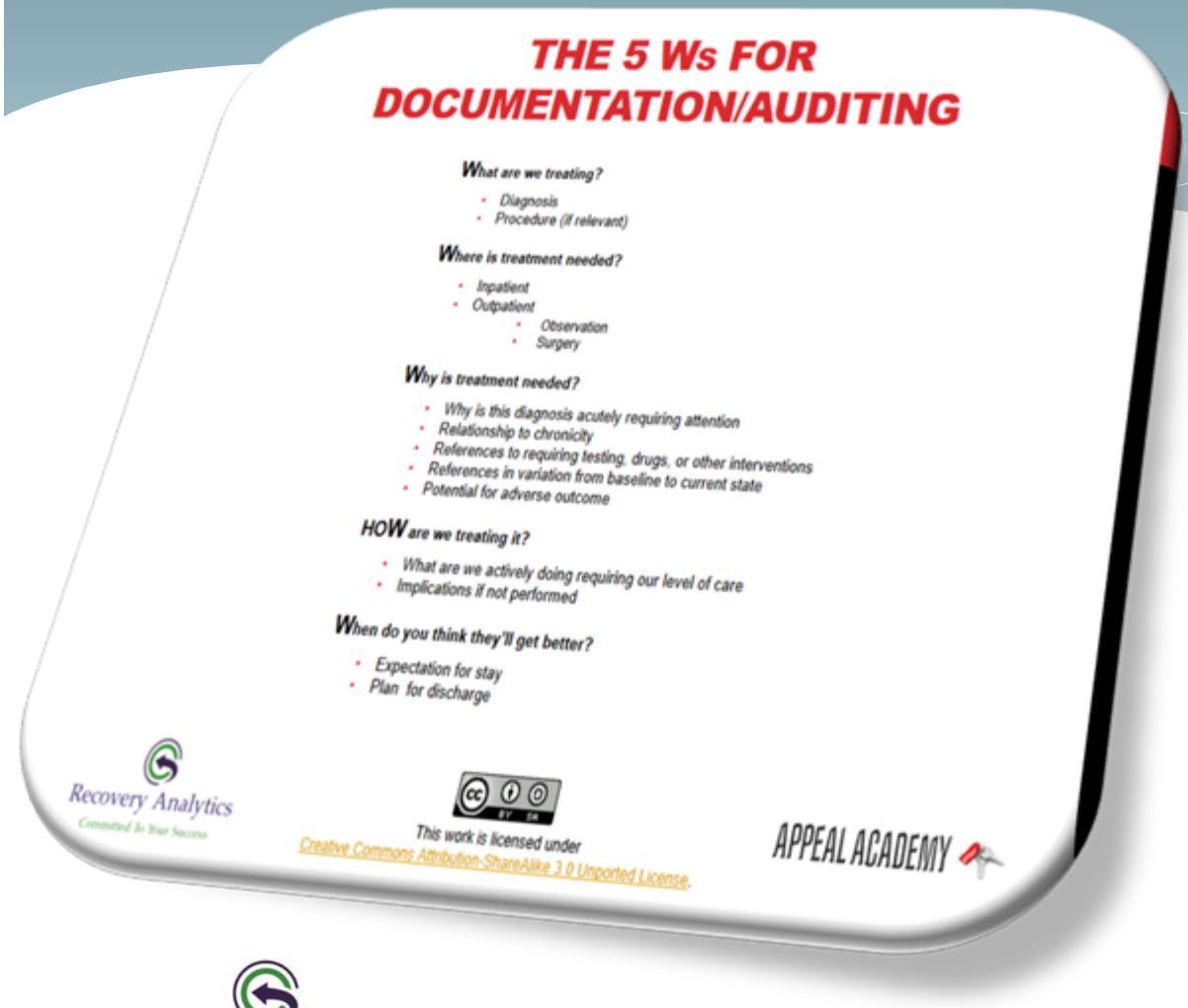
Meeting the Challenge…



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APPEAL ACADEMY

The 5Ws for Documentation/Auditing

* What are we treating?
  * Diagnosis
  * Procedure (if relevant)
* Where is treatment needed?
  * Inpatient
  * Outpatient
    * Observation
    * Surgery
* Why is treatment needed?
  * Why is this diagnosis acutely requiring attention
  * Relationship to chronicity
  * References to requiring testing, drugs, or other intervention
  * References in variation from baseline to current state
  * Potential for adverse outcome
* HOW are we treating it?
  * What are we actively doing requiring our level of care
  * Implications if not performed
* When do you think they'll get better?
  * Expectation for stay
  * Plan for discharge

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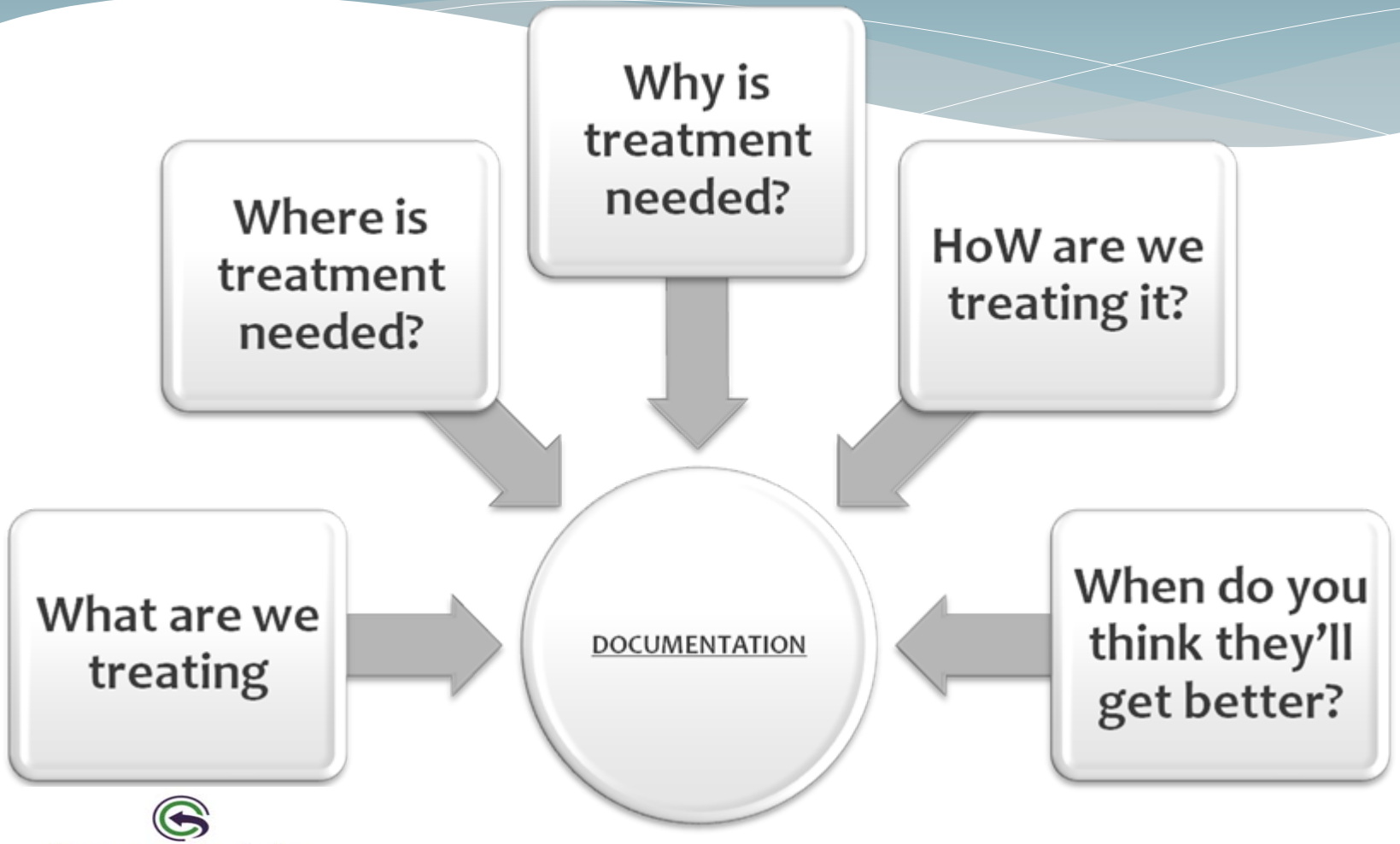
The 5 Ws for Documentation/Auditing



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What are we treating?

* Diagnosis
* Procedure (if relevant)

Ms. Smith presented with ANGINA following a 2 Day history of chest pain.

She has had CONGESTIVE HEART FAILURE for 5 years.

Will perform HEART CATHETERIZATTION with possible percutaneous coronary intervention [PCI] or coronary artery bypass graft surgery [CABG]

Where is treatment needed?

* Inpatient
* Outpatient
  * Observation
  * Surgery

Patient will be placed in observation for further evaluation and management.

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Why is treatment needed?

- Why is this diagnosis acutely requiring attention
- Relationship to chronicity
- References to requiring testing, drugs, or other interventions
- References in variation from baseline to current state
- Potential for adverse outcome

- Patient has possible unstable angina. Concern for patient risk due to MI 5 years ago. Her CHF is acute diastolic requiring Lasix 80 mg every 12 hours then 40 mg. Ms. Smith has 3+ pedal edema which is more significant than witnessed on previous admission. Reversal of CHF is needed to diminish cardiac stress in the presence of CHF.

Why is treatment needed?

- Why is this diagnosis acutely requiring attention
- Relationship to chronicity
- References to requiring testing, drugs, or other interventions
- References in variation from baseline to current state
- Potential for adverse outcome

- Patient has a TIMI risk score of 4.
- Patient of advanced age with frailty.
- With underlying cardiac disease, age, arrhythmia noted on EKG, and high risk TIMI score, there is concern for risk to the patient.

HoW are we treating it?

* Echo with Cardiac enzymes will be performed with beta blocker to prevent arrhythmia and further ischemia, and nitro given.

When do you think they'll get better?

- Expectation for stay
- Plan for discharge

* Patient is being placed in observation will re-evaluation following 1 midnight of tests and possible need for further intervention/disease management/risk assessment.
* Cath shows 50% stenosis of RCA.
* Patient can be discharged home with home health with Lovenox. (can be stated at discharge).

Prior to 2nd Midnight

* Ms Smith is still noted to have difficulty breathing with inability to ambulate to restroom without increased respirations. Patient noted to have 4+ pedal edema even with aggressive diuresis; repeat chest x-ray and urinalysis will be performed for suspicion of infection.
* Ms, Smith will be admitted to the hospital as an inpatient with evaluation in the a.m. for continued stay.

Thank You!!!

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References

* *42 CFR Part 424 subpart B and 42 CFR 412.3.*
* *Sharon Easterling's 5Ws for Documentation and Auditing*

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