New medication management guidelines focus on long-term care

Guidelines published in the *Journal of Gerontological Nursing* update the 2004 version to focus specifically on older populations

For the past several years, medication management has been emphasized across the entire spectrum of healthcare, and many have made strong efforts to improve patient outcomes by focusing on how medications are being prescribed.

Often, the patient population that is most affected by these initiatives consists of older patients, who are usually on multiple drugs to treat many different illnesses. Long-term care residents in particular can be on nine or more medications.

In November 2013, the *Journal of Gerontological Nursing* published updated guidelines for medication management, which focused specifically on the risk factors found among long-term care residents. The new guidelines serve as an update to the previous guidelines, which were published in 2004.

A lot has changed in the theory and practice of medication management since the original guidelines were published, says Brenda Bergman-Evans, PhD, APRN-NP, APRM-CNS, chief nurse of the Executive Advance Practice, and project director for the Enhanced Care and Coordination Project at Alegent Creighton Health in Omaha, Neb. More evidence-based practices have been published, and many facilities have changed the medication management practices in order to improve care. However, these updated guidelines have been designed specifically for long-term care facilities that care for an older adult population.
“The original guideline was really across the continuum of care for older adults, so it was a fairly generic,” Bergman-Evans says. “The work I’ve done since that time, I began working with nurse practitioners and created a nursing home network, and I have been a lot more involved with long-term care and skilled care and really recognized the need for a more specific guideline looking at long-term skilled care population.”

The guideline is broken up into four “outcomes”:

- **Outcome 1: Maintain functional status**
- **Outcome 2: Decrease polypharmacy**
- **Outcome 3: Avoid adverse drug reactions**
- **Outcome 4: Decrease inappropriate prescribing**

Although the guidelines are geared toward NPs, the information is useful for physicians, pharmacists, nurses, and other clinical staff members working in a long-term care facility, Bergman-Evans says. Reviewing the guidelines and then applying them to your own facility can help reduce unnecessary prescription medications and potentially improve the quality of life for residents.

**Utilizing the 60-day review**

CMS requires healthcare providers to conduct periodic reviews of long-term care residents. Residents must be seen at least once every 30 days for the first 90 days, and then once every 60 days thereafter.

Bergman-Evans argues that long-term care facilities need to be more diligent in thoroughly addressing medication concerns during these reviews, particularly for residents that are there for extended periods of time.

“The thing I think is quite different [from the original guidelines] is really looking at how you use the 60-day review to really use medication management as the guiding principle for how you’re going to care for the patient,” she says. “You have to look at the medication and administration records, but you should really be looking at it for changes you can make to those medications.”
Bergman-Evans believes that many facilities struggle to complete this review effectively. Those that have found success have used the review to their advantage by focusing specifically on eliminating unnecessary medications.

“You have to do [the 60-day review] anyway, so why don’t you look at how we can decrease medicines that people don’t need or make sure what they are on is what they need to be on,” she says.

**Reducing unnecessary medications**

According to a 2010 study published in the *Journal of the American Medical Directors Association*, nearly half the residents in a Honolulu long-term care facility were on nine or more medications. However, after geriatric medicine fellows and faculty reviewed each patient’s medication list, consulted the Beer Criteria and Epocrates drug-drug interaction program, and provided recommended medication changes to primary care physicians, the mean number of medications per patient decreased significantly in a number of categories, including the total number, scheduled, pro re nata, high risk, contraindicated, and those with potential drug-drug interactions.

National estimates published in 2005 showed long-term care residents received between seven and eight medications each month, and approximately one-third were receiving more than nine. One reason that older patients are on so many medications is because providers are unwilling to discontinue a medication, even one that’s not achieving its intended result, if it doesn’t have any adverse side effects.

“Sometimes the medicine doesn’t do any good, but it doesn’t hurt them,” Bergman-Evans says. “You aren’t having side effects, so clinicians are reluctant to take patients off. And one of the things we’re really looking at is the reason they are put on it originally still there?”

Consider blood pressure medication, for example. Typically patients are put on this medication and informed that they will have to take it for the rest of their life. However, if a resident on this medication has lost 50 pounds or switched to a low-sodium diet in the nursing home, it may no longer be effective. Additionally, older patients that are admitted to the hospital are put on a sliding scale of insulin if their blood sugar is high, but once they arrive at the long-term care facility, that may no longer be necessary.

Not only will the guideline changes benefit the residents, they will also impact the nursing staff, who often struggle to hand out all appropriate medications to all their residents within one hour of the assigned administration time. Although physicians do the prescribing, medication management requires a multidisciplinary approach from all clinical team members in order to help inform physicians’ prescribing practices.

“You really want everyone heading in that same direction, and when the nurses can see that they have more time to do their work because they aren’t giving so many medications, that’s when you really start to get buy-in,” Bergman-Evans says.

**Pay attention to high risk drugs**

The purpose of medication management is to prevent adverse events. Drugs such as insulin, Coumadin®, and

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**Conquer no-pay bills, exhaust billing, and ensure proper reimbursement under RUG-IV**

The Complete Guide to Long-Term Care Medicare Billing, written by Frosini Rubertino, RN, CRNAC, C-NE, CDONA/LTC, provides easy-to-understand guidance to help long-term care facilities correctly file Medicare Part A and Part B claims. It breaks down the often misunderstood consolidated billing process, clarifies the appropriate use of beneficiary notices, and offers practical solutions for billing under RUG-IV.

When you purchase this book, you will also receive on-line access to a number of valuable tools, which you can download straight to your desktop, then customize to fit your specific needs. Among the tools available include:

- RUG-IV classification chart (shows the breakdown of RUG-IV classification)
- RUG spider chart
- RUG grouper criteria chart
- ADL calculation chart
- UB-04 top sections that reveal code changes

digoxin have been shown to be particularly problematic among geriatric patients, who are often sensitive to these medications. Adverse events related to inappropriate prescribing often result in rehospitalization, an issue that CMS and other regulatory agencies have been heavily targeting.

A study published in the *Journal of Clinical Pharmacy and Therapeutics* found that prescription of potentially inappropriate medications is as high as 40% among nursing home residents in the United States and Europe. To avoid inappropriate prescribing and the adverse events that can arise from medication mismanagement, the updated guidelines recommend using the most recent Beers Criteria. Last updated in 2012, the Beers Criteria categorizes 53 medications or medication classes into three sections:

1. Potentially inappropriate for use in older adults
2. Potentially inappropriate for older adults due to drug-disease or drug-syndrome interactions that may exacerbate the disease or syndrome
3. Potentially inappropriate medications to be used with caution in older adults

CMS requires a drug regimen review at least once a month, in which a licensed pharmacist reviews the drugs that each resident is prescribed and reports their recommendations to the primary care provider. As part of the updated guidelines, pharmacists, nurse practitioners (NP), and primary care physicians need to take a more proactive approach to this drug regimen review in order to eliminate unnecessary or harmful prescriptions when the resident is admitted and when the NP does 30- and 60-day reviews.

“One of the things that is unique about our plan is we have 25% time of a consulting pharmacist and we’re looking at how doing things proactively—looking at insulin and all of those things proactively—rather than just looking at the list to see if they are in compliance,” says Bergman-Evans. “I think we’ll have more information going forward and that’s a huge piece of this.”

**OIG recommends new quality measure for LTC hospitalization rates**

High rehospitalization data from 2011 indicates nursing homes require additional monitoring, including a new quality measure from CMS.

It’s no secret that long-term care (LTC) facilities have been under increasing pressure to decrease readmissions, but the Office of the Inspector General (OIG) may have just turned that pressure up another notch. Readmissions have been a key focus area across all spectrums of healthcare for the past several years. The passage of the Affordable Care Act brought with it the Hospital Readmissions Reduction Program, allowing CMS to reduce payments to hospitals with high readmission rates, which in turn put pressure on LTC facilities to reduce readmissions so that hospitals would consider them viable business partners.

But a recent report from the OIG, released in November 2013, indicates that nursing home resident hospitalization rates need further monitoring. In its report, the OIG found that nursing homes transferred 25% of their Medicare residents to hospitals in fiscal year (FY) 2011, which translated to more than $14 billion in Medicare spending. The OIG issued the following recommendations to CMS:

1. Develop a quality measure that describes nursing home resident hospitalization rates
2. Instruct state survey agencies to review the proposed quality measure as part of the survey and certification process

“The harm that residents experience during hospitalizations can include disruption of their care plans, disorientation, stress, and iatrogenic illness (e.g., adverse events),” the report states. “The Centers for Medicare
& Medicaid Services (CMS), in its 2012 Nursing Home Action Plan, suggests that negative outcomes associated with hospitalizations are further complicated because health care providers often do not communicate critical information when transferring the residents. Financial costs associated with hospitalizations of nursing home residents include, but are not limited to, Medicare reimbursements for hospital stays, physician services during these stays, and applicable copayments.”

CMS concurred with the OIG’s recommendations, and although the industry is likely still a long way from seeing an official quality measure related to hospitalization, these recommendations indicate that at some point, nursing home rehospitalization rates will be monitored with specific and standardized metrics.

Summarizing the report

Of the 24.8% of residents that were hospitalized in fiscal year 2011, 67.8% were only hospitalized once, according to the report. However, 20% were transferred twice, 7.2% were transferred three times, and 5% were transferred four or more times. These hospitalizations cost Medicare $14.3 billion in FY 2011, which made up 11.4% of Medicare Part A spending that year. Perhaps more interesting is that Medicare spent an average of $11,255 on each

Five target areas to reduce rehospitalizations

From February 2013 through June 2013, PPS Alert launched a series of articles that looked at specific areas in which LTC facilities could reduce rehospitalizations. Subscribers can go into the archives at www.hcpro.com/publication-newsletter-60-2013-department-long-term-care.html to review each of the five articles that focus on different aspects of reducing readmissions. Below is a summary of each one:

- **Mastering the admissions process** (February 2013): This first step dictates the course of the resident’s stay at your facility. SNFs should focus on appropriate documentation in order to establish a baseline for that individual. Additionally, nurses need the training and education to appropriately identify health issues that may be manifest into health risks or complications later on.

- **Getting to the root of the problem** (March 2013): SNFs can break readmissions data into specific categories including payer source, high risk diagnosis, days of the week, specific shifts, or specific clinicians or physicians, which can help identify particular weaknesses in your care processes. Facilities should ignore preconceived notions about why they think readmissions are occurring, and focus on what the data is telling them.

- **Nursing practices and systems of care** (April 2013): INTERACT is the primary system available to nursing homes for improving communication among clinicians, and is also key in helping CNAs recognize potential health issues. However, a supportive environment is crucial to implementing the INTERACT program and requires ongoing training to identify appropriate in-house interventions. The CNA’s ability to identify small changes in a resident’s health can have a huge impact on readmission rates.

- **Improving your systems and processes** (May 2013): Making systematic changes to care planning, discharge planning, or the admissions process will eventually give way to a culture change in which early recognition of possible readmissions becomes second nature for clinicians and there is an organized and defined process for taking action.

  The Green House Project has been a leader in making a radical redesign of LTC facilities so that residents have their own bedroom and bathroom, and CNAs are tasked with more responsibilities and fewer patients.

- **Tracking and auditing your data** (June 2013): Performing ongoing monitoring of readmissions data is imperative to maintaining an effective program. Utilizing your facility’s QAPI program to take a deeper dive into potentially troublesome issues can identify what is working and what needs more attention when it comes to re-admissions. Performing quarterly audits and setting up meetings with admitting hospitals can also help identify any additional issues.
hospitalization of a nursing home resident, 33% above
the average cost of a hospitalized patient.

Residents were hospitalized for a variety of
conditions, but the top five included several that were
infection-based: septicemia (13.4%); pneumonia
(7%); congestive heart failure, nonhypertensive
(5.8%); urinary tract infections (5.3%); and aspiration
pneumonitis, food/vomitus (4%). Notably, Medicare
spent nearly $3 billion on septicemia or sepsis, a
potentially deadly bloodstream infection—more
spending than the next three most expensive
conditions combined.

“Some nursing homes sent residents to hospitals
far more often than other nursing homes,” Jeremy
Moore, team leader for the Office of Evaluation and
Inspections in Dallas, said in an OIG podcast following
the publication of the report. “We found that nursing
homes that sent patients to hospitals more often scored
lower on the Medicare Five-Star rating system that is
posted online at the Nursing Home Compare website.
We think this information about nursing home hospi-
talization rates will be helpful to the healthcare com-
community, patients, and families because high hospitaliza-
tion rates could signal quality of care problems with
certain nursing homes.”

Moore also said the OIG plans to dig deeper into the
data to determine how many of these hospitalizations
were avoidable; the agency is scheduled to release two
additional reports to evaluate these issues. “The first will
evaluate how many of these hospitalizations were likely
avoidable,” he said. “Figuring out which of these hospi-
tal stays could be prevented will help us pinpoint where
nursing homes need to improve. We will also release a
report about how often adverse events, such as falls and
bedsores, occur in nursing homes. Together, these re-
ports will provide a better understanding of why nursing
home residents are sent to hospitals so frequently, and
help inform policies for reducing avoidable hospitaliza-
tions and harm to these vulnerable residents.”

**Mixed reactions to a new quality measure**

Reactions to the possibility of a new quality measure
vary. On one hand, many industry experts agree that
rehospitalizations are a legitimate quality care concern.
But some also argue that punitive regulations may not
be the best approach.

“A lot of buildings put a lot into the [Five-Star Qual-
ity Rating] and what I’m afraid of is that they aren’t
going to send residents to the hospitals because they
don’t want it to take away from their stars,” says
Bonnie Foster, RN, BSN, MEd, owner and presi-
dent of Foster Consulting, Inc., in Columbia, S.C.

Foster also has concerns about how the standard will
be built and what metrics it will use. Others, like Diane
L. Brown, BA, CPRA, director of postacute educa-
tion at HCPro in Danvers, Mass., think it’s too early to
tell. Although the OIG report highlights some interest-
ing issues, for now it is simply a recommendation
to create a quality measure, and there is not enough
information coming from CMS to determine whether
doing so will be effective, she says.

“It’s a good recommendation; I don’t think you’ll find
anything in that that isn’t appropriate, but we don’t
know specifically what it’s going to look at or what the
time frame will be,” Brown says. “As far as recommend-
dations go it could be a positive thing, but it doesn’t
talk about any aspect of what that quality measure
would look like.”

Fortunately, many LTC providers have already been
working on reducing rehospitalizations. LTC facilities
often find success by incorporating rehospitalization is-
ues through the Quality Assessment and Performance
Improvement (QAPI) committee, Foster says. Devot-
ing time to this issue during QAPI meetings forces
the physician—who makes the decision to readmit the
resident—to be involved with improving that process.

“I think it’s definitely getting better,” Foster says.
“I’m seeing less pressure ulcers because they aren’t
sending them out, less weight loss, and fewer UTIs,
because in the hospital they put Foley catheters in.”

- Each facility has its own unique risks, but some
  specific issues that LTC providers can focus on to
  reduce rehospitalizations include the following:
  - Understand DNR orders. Many clinical staff mem-
    bers struggle to carry out advance directives or do-
    not-resuscitate (DNR) orders for every patient.
    “When you have a resident with end-stage cancer
    and they have a DNR, you need to be thinking about why
    you’re sending them to the hospital,” Foster says.
  - Educate family members. In some cases, rehospitali-
    zations are influenced by family members, Foster says.
    Physicians worried about malpractice lawsuits may
send a resident to the hospital because of pressure from the family. “I question a lot of buildings: Why did you send them out?” Foster says. “And the answer is usually that the family insisted. Well, you know what? Families shouldn’t be making those decisions.”

- Improve LPN training. State laws vary regarding LPNs’ scope of practice, but more employers need to provide training that allows the LTC facility to initiate simple interventions like IV therapy, particularly in facilities where there are only one or two RNs around the clock. Sometimes a hospital admission is necessary, but LTC providers need to ensure they can effectively perform simple interventions to avoid unnecessary hospitalizations. “Sometimes we just need to give IVs or watch them for 24 hours,” Foster says. “When they come back from the hospital it’s weight loss, it’s pneumonia, it’s dehydration, it’s pressure ulcers; they are so much worse.”

**Nurse practitioners in the SNF: What your facility should consider**

*Editor’s Note: This article was written by Janet Potter, CPA, MAS, manager of healthcare research at Frost, Ruttenberg & Rothblatt, PC, in Deerfield, IL.*

We know that nurse practitioners (NP) can be a valuable resource for staff and families, but how can their services be incorporated into the SNF setting? This article will explore the services that NPs can provide and review reimbursement possibilities for facilities to consider.

**What can a nurse practitioner bring to the SNF?**

An NP is a practitioner with at least a master’s degree level of nursing training who provides a high level of care to his or her patients. In a nursing facility setting, NPs generally provide evaluation and management (E/M) services to their residents. When a resident has a medical complaint, the NP is able to examine the resident at the facility and determine the course of action. Thanks to the NP being on-site, the facility nurse does not need to relate the condition to a physician over the phone and receive orders without a face-to-face examination, and as a result, overall patient care may be improved. In many instances, the NP can help prevent unnecessary emergency room visits by being able to see and treat the resident within the facility.

Other services the NP can provide to SNF residents include:

- Ordering of diagnostic and therapeutic tests
- Ordering or applying medical devices or supplies and other corrective measures to treat illness
- Palliative and end-of-life care
- Advanced counseling and patient education
- Prescriptive authority as allowed by state law
- Delegation of services to other clinicians

In addition to direct care duties, many SNFs use their NP to provide education for facility nurses to improve their clinical skills. The NP can develop best practices and train staff nurses to respond to changes in a resident’s status and improve their clinical and technical nursing skills. This is another way in which NPs are able to reduce unnecessary hospitalizations.

NPs often provide education and health promotion activities to residents and families, both through formal programs and informal discussions. Many SNFs use their NPs to help residents transition through the continuum of care. They provide education and training for residents planning to return home or to other residential settings, such as assisted or independent living apartments.

In some states, NPs are licensed to work independently, while in many states a written collaborative agreement (WCA) with a physician is required. The WCA is a document that spells out what services the NP can provide with and without supervision, criteria for referral, general guidance, evaluation procedures and other limitations. The WCA reflects the collaborative
effort between both the NP and the physician. State law must be consulted to determine the specific requirements for a WCA.

**Billing and reimbursement Issues**

In many states, the NP can bill the Medicaid program directly for his or her services, but the requirements for this vary greatly. If your SNF is considering contracting or hiring an NP and you wish to bill the Medicaid program, you will need to consult the Medicaid handbooks for your state. NPs are often included with physician services or with other nonphysician practitioners within the Medicaid manuals.

In addition, each managed care organization or private insurance will have different rules for the use and reimbursement of NPs with their patients. If your facility has a high managed care or private insurance utilization, you will want to contact the plans directly to determine their NP coverage and billing regulations.

An NP can enroll in the Medicare program under his or her National Provider Identifier (NPI) number and bill Medicare Part B directly. However, if the NP is employed by an SNF, all the services performed by the NP will be considered part of the SNF’s general nursing care and will not be separately billable to Medicare. Some organizations opt to form a separate nurse practitioner or physician group to obtain a Part B billing number in order to bill Medicare Part B for the NP services—this requires a separate 855B form to be completed. The usual Part B billing that a SNF does (e.g., physical therapy services) statutorily cannot include physician services.

In order to be a covered service under Medicare Part B, the following conditions must be met:
- The services are typically considered physician’s services
- The services are performed by someone who meets the definition of an NP
- The NP is legally authorized to perform the services in the state in which they are being provided
- The services are performed in collaboration with a physician, podiatrist, or dentist
- The services are not otherwise excluded

NPs may bill Part B under one of two methods:
1. Incident to a physician. The NP services are billed under the physician’s NPI and are paid at 100% of the physician fee schedule. However, this method requires the physician to be physically present in the same building while the procedure is taking place and, it does not allow the NP to see new residents or those with new conditions.
2. Direct to Medicare. The NP services are billed under the NP’s NPI and paid at 85% of the physician fee schedule. The physician does not have to be on-site and the NP may see new residents or those with new conditions.

Many SNFs find the first method to be far too limiting. A major advantage of having an NP on-site is so that the physician does not need to be physically in the building in order to provide high level medical care to the residents.

**Factors to consider when WCA is required**

If your SNF is located in a state which requires a written collaborative agreement (WCA), there are additional factors for your facility to consider.
- Nurse practitioners (NPs) can only prescribe drugs, perform services, and complete other tasks without supervision that are detailed in their WCA—and that are within the normal scope of the collaborating physician’s practice.
- In some states, physician involvement requires a monthly joint review of the charts of all the patients under the care of the physician with the NP. The physician must also be available for consultation and emergencies.

One potential obstacle that facilities in these states must be aware of is whether the NP is required to have a WCA with each physician in order to see the physician’s patients, or if a WCA with one physician will cover all facility residents. This issue must be addressed with the NP, the collaborating physicians, and the medical director.
Delegation of physician visits

Delegation of physician visits to an NP varies depending on whether the NP is employed by the SNF and whether services are provided in a SNF or nursing facility (NF). If the resident is covered by Medicare Part A, the SNF rules are followed. If the resident is covered by Medicaid, the NF rules apply. These rules were recently updated in the March 8, 2013 Survey and Certification Memo S&C 13-15-NH. The memo can be found at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-13-15.html.

If the NP is employed by a related organization, such as a NP group practice owned by the parent organization, the delegation rules are different. For a SNF Medicare Part A resident, it is considered the same as direct employment; however for an NF, the NP is not considered a direct employee of the SNF. When identifying potential billing opportunities for NPs, take this into consideration.

In a SNF, for Medicare Part A residents, if the NP is employed by the facility or a related entity, the NP:
1. May not perform initial comprehensive visits or sign initial orders
2. May not sign certifications or recertifications
3. May perform alternating other required visits
4. May perform other medically necessary visits and sign orders

The physician may delegate only every other “other required visit” to the NP (i.e., alternating visits).

<table>
<thead>
<tr>
<th>Sample Medicare fee schedule amounts for nurse practitioners (NPs)</th>
<th>Chicago @ 80%</th>
<th>Boston @ 80%</th>
<th>Utah @ 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304 Initial Nursing Facility visit</td>
<td>$99.90</td>
<td>$95.92</td>
<td>$89.41</td>
</tr>
<tr>
<td>99307 Nursing Facility subsequent visit level 1</td>
<td>$46.62</td>
<td>$46.06</td>
<td>$42.32</td>
</tr>
<tr>
<td>99308 Nursing Facility subsequent visit level 2</td>
<td>$72.77</td>
<td>$71.61</td>
<td>$65.78</td>
</tr>
<tr>
<td>99309 Nursing Facility subsequent visit level 3</td>
<td>$95.01</td>
<td>$93.93</td>
<td>$86.28</td>
</tr>
<tr>
<td>99316 Nursing Facility Discharge</td>
<td>$109.77</td>
<td>$107.72</td>
<td>$99.87</td>
</tr>
<tr>
<td>99212 Office or outpatient visit, established patient level 1</td>
<td>$26.80</td>
<td>$25.45</td>
<td>$24.06</td>
</tr>
<tr>
<td>99213 Office or outpatient visit, established patient level 2</td>
<td>$53.96</td>
<td>$51.76</td>
<td>$48.72</td>
</tr>
<tr>
<td>99214 Office or outpatient visit, established patient level 3</td>
<td>$82.87</td>
<td>$79.85</td>
<td>$75.04</td>
</tr>
<tr>
<td>99215 Office or outpatient visit, established patient level 4</td>
<td>$116.73</td>
<td>$112.52</td>
<td>$105.71</td>
</tr>
</tbody>
</table>
When determining the estimated number of visits, the visits which cannot be delegated must be taken into consideration.

To review sample 2013 fees for NPs, see the table on p. 9. This table provides fees within the regions of Chicago, Boston, and Utah, and will allow facilities to gain a general understanding of fees in these or similar areas.

Benefits to the campus

Many SNFs quickly determine that as a pure revenue source, a NP isn’t feasible. However, there are many other advantages of having an NP on campus. Some include:

- More referrals
- A better marketing position
- More flexibility in scheduling physician visits
- Better care for residents
- Physician-level care on-site
- Providing care for residents in other parts of the campus
- Decreased hospital readmission rates through improved care management
- Opportunities with managed care and accountable care organizations

Improved care for the residents can be seen through quicker exams, diagnosis and prescribing of necessary drugs or treatments. In addition, an NP can work to establish protocols for the management of chronic conditions such as diabetes, hypertension, and congestive heart failure. By working closely with the residents and the facility staff, the NP can promote improved self-management and provide education and coaching to residents, caregivers, and family members.

In a campus setting, the program doesn’t have to stop when the residents return to their independent or assisted living apartments; the NP can continue to provide services and coordinate care. In addition to improving the health of the residents, increased control of chronic conditions will lead to fewer rehospitalizations.

There are many factors to consider before adding an NP to your organization. Having the medical director and top organizational management members on board with the decision will be key.

If your facility is considering hiring or has recently hired an NP, you will want to introduce the NP to the primary physicians of the current residents. Consider including the organization’s marketing team in the plans; events such as “Meet the Nurse Practitioner” can increase the excitement of the campus and the community. In addition, be sure that all the local hospitals and discharge planners are aware of the new addition to the staff.

PPS Q&A

Ensure your documentation is ready for the transition to ICD-10

Editor’s note: On February 5, 2014, HCPro will be hosting a webcast entitled “ICD-10 Coding and Documentation for Long-Term Care.” During the 90-minute webinar, Karen Fabrizio, RHIA CHTS-CP, CPRA, AHIMA-Approved ICD-10-CM/PCS trainer, will identify common documentation pitfalls and review ways that SNFs can prepare their documentation and policies for the transition to ICD-10 on October 1, 2014. Fabrizio is medical record administrator and HIPAA privacy and security officer at Van Duyn Home and Hospital, a 513-bed SNF in Syracuse, N.Y.

PPS Alert recently caught up with Fabrizio to discuss some of the issues surrounding ICD-10 coding and documentation. For more information as well as pricing details, visit http://hcmarketplace.com/coding-and-documentation-for-longterm-care.

Q: To start, what are the important takeaways of this webcast? How will this be beneficial to SNFs?
A: My underlying objective is to really identify how important documentation is for accurate and thorough coding and to identify areas that
facilities can take a look at across all disciplines. The identification of a diagnosis is a physician’s responsibility; however, when you get some of the specificity sometimes from different disciplines, for example a physician may not pick up on the dominate side or the non-dominant side for a stroke, but a physical therapist or an occupational therapist definitely will be focused on that. So it’s looking at documentation on an interdisciplinary standpoint.

So far I’ve highlighted 10 diagnoses that are pretty common. I’ll be talking about the pitfalls of bad documentation and things to consider for providing good documentation.

The second takeaway is I feel very strongly that facilities need to have a coding policy so that if you have multiple people coding or multiple people interpreting codes, they all come up with the same interpretation.

For instance, there is a code for history of falls. It’s important for the facility to determine when they are going to use it. You certainly don’t want to use history of falls for someone who has only fallen once and broken their leg. But if someone has fallen frequently, whether or not there is injury, that’s a code that is going to be important for facilities to consider how they are going to use it.

Unfortunately the whole coding system is new, so there are not a lot of guidelines in terms of “you need to have fallen three times in six months to be able to use that code.” I think we’ll start to see that develop, but that doesn’t mean a facility can’t make that interpretation now.

For example, in my facility that I worked at previously, we had an interpretation that if someone had fallen three times within six months, we would code that as a history of falls, and if someone had fallen once previously with a significant injury, we would use that code as well. So, my plan is to identify areas that we should seriously think about how we’re coding it and when we should consider using a specific code.

Starting that in-depth training. But if you don’t use it you lose it; it’s a corny phrase, but you don’t want to learn how to do ICD-10 and then not do anything with it.

So I think the facilities should identify a group of people to be part of their stakeholder task force. They need to have their implementation and transition team and have at least one individual become comfortable with the classification system, and that person can go back and lead discussions—not necessarily be the chief decision maker, but lead discussions to say “Chapter-by-chapter, how are we going to address the endocrine? How are we going to address the neurological system? Do we want to use external cause codes? I think you need someone with that knowledge. It’s unfortunate though, because I don’t know if a lot of facilities really have the resources to do that.

Q: Can you walk our readers through some examples of coding issues that facilities might run into?
A: Sure. So a doctor commonly says that a patient has diabetes. If he doesn’t identify Type 1 or Type 2 diabetes, the coding guidelines say we have to assume that it’s Type 2. The problem you run into is that Type 1 diabetes is generally maintained on insulin and affects other systems. So if we don’t have good documentation by applying the rules, I would have to code diabetes as Type 2 diabetes, and that might not represent the patient at all.

The other spinoff of that is we really need to identify whether a person is maintained on insulin and whether it’s to control a Type 1 or Type 2 diabetes, or if it’s a short-term use just to bring things back around. When a person is coming in from home and we have our intake people writing down their list of meds, and they add insulin, and I see a person that is Type 2 diabetes and on insulin, I have to ask whether or not that is just a short-term use of insulin to supplement their diabetes or if this person really does have Type 1 diabetes.

In long-term care it does not directly impact our reimbursement because we are reimbursed by the RUGs. However, with the nation moving towards quality improvement surveys and Medicare making sure skilled services are appropriate and medically necessary, our coding that we do in long-term care is greatly affected.
by the coding they do in acute care prior, and can affect our discharges to a home health service.

Q: What are facilities still unprepared for regarding the transition to ICD-10?
A: I don’t think a lot of facilities are aware of how long it’s going to take to do the coding. We’ve jumped to one more code that requires us to be more specific and I have heard that a patient record could take up to twice as long to code under ICD-10, just because it is more specific and you’re learning a new system. For example, I know in ICD-9 UTI is 599.0. In ICD-10 I know it starts with an “N” and maybe has a “39,” but then it’s getting into all the specifics. Part of it is that transition of it, but you’re getting into more specificity.

I think historically, long-term care facilities have utilized generic codes and maybe have used cheat sheets to be able to quickly assign codes and that’s going to be very difficult to do with ICD-10.

Q: Anything else that facilities should be thinking about?
A: The other big thing is that this really needs to be multidisciplinary. Very few facilities have the resources of an educated or credentialed health information manager, but they are fortunate to have individuals with other backgrounds who may be comfortable with coding. But you have to include everyone in this process. When you’re working on that coding policy, pull the physical therapist in who knows about the modalities, and the MDS nurses, and the billing person, and the nurse practitioners, and physician’s assistant. It has to be all-inclusive or as inclusive as possible because it will affect everything. If I have a physician order entry system and I enter in an inappropriate diagnosis code on October 2, and my pharmacy can’t recognize that diagnosis, I have to be comfortable knowing that med is still being processed and it isn’t going to stop patient care.