Alliant Health Solutions
SOURCE Documentation Best Practices

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HEALTH SOLUTIONS

Presenters

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Documentation Best Practices Training Outline

- I. Source Overview
- II. Target Population
- III. Justification of Services – Renewals
  - Case Reviews – Provide examples of complete documentation and incomplete documentation
- IV. Nurse's Role
  - Data collection at time of annual review
- V. Case Manager's Role
  - Supportive documentation in care coordination – before and after approval

SOURCE Waiver Program

- Service Options Using Resources in Community Environment (SOURCE) is an enhanced primary case management program that serves frail elderly and disabled beneficiaries.
- SOURCE works to improve the health outcomes of persons with chronic health conditions, by linking primary medical care with home and community-based services through case management agencies.

ALLIANT'S Scope of Work for SOURCE

- Initial Level of Care (LOC) admission determinations
- Second Level of Care (LOC) determinations
- Annual re-certifications

SOURCE Target Population

- Aged, blind, and disabled Georgian's who are Medicaid eligible;
- Individuals who have acquired a cognitive loss that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs);
- Individuals must meet the definition for Intermediate Nursing Home Level of Care.

SOURCE Reviews

- Alliant began SOURCE Level of Care determinations in 2012.
- Around 1,500 – 1,800 SOURCE Level of Care reviews are completed per month.
- 18,856 reviews were completed in 2016.

Complete Reviews

- Contains:
- MDS HC for current year
- Appendix I/signed
- Source C Addendum
- MD note for w/n 1 year
- Nurses Narrative
- Appendix F
- Appendix U for 6 months

Continued

- The DONR for new admissions
- Any other documents that approve your case.

Simple Error in documentation- incomplete PA files

- Contact Us states:
- Dear Provider, Technical denial given due to missing PCP notes. Please upload current PCP documents to the PA and alert me when you have done this so I can expedite the review process.
- Thank you and have a Blessed day.
- This is a recurring problem in the PA files.

Danger of inadequate documentation

- Delayed client approval-client goes without services until documentation is achieved.
- Short approval time-6 month approval given for clients already in program, requiring a new assessment and addition of the document.
- Delay of submitted PA's in the queue as presentation of documentation delays approvals in PA awaiting approval.

Why the need for a new assessment

- Because PA's are approved for 365 days, the client may have changed in the last 6 months therefore rendering the assessment lacking documentation as inadequate.
- This scenario could be avoided by planning- when client is coming forward for yearly assessment ask for MD note in advance.

Next 6 month scenario-incomplete determination

- Contact Us from Alliant nurse reads:
- 03/17/2017
  The Neurologist, __Wilson,MD, did not confirm Dementia, he asked for the lab results from the PCP and a CT Scan of the brain or an MRI of the brain, was this done?

Issue at hand PA did not contain documentation

- Source contact note received: Hello. Additional records have been successfully uploaded. Thank you.

  - Submitted on : 3/24/2017 9:40:43 AM
- 7 days later.

6 month approval

- Contact us reads:
- Dear Provider
- Approved for 6 months for the Neurologist to review all documents and make a diagnosis, the f/u Neurologist's appointment will be needed at the 6 month assessment

- - Alliant Nurse Reviewer (4/3/2017 10:12:44 AM)

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New Assessment and MD note will be required

- Increased work required by agency to get full 1 year approval.
- Agency will be required to submit a new assessment in 6 months as patient's status may have changed.

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Narcotics and Drug Issues

- Contact us from nurse reads:
- Dear Provider
- Applicant approved x6 months. Requesting drug testing/screening at reassessment. Will need to be submitted to PA. Thank you.

- - Alliant Nurse Reviewer (4/3/2017 9:55:11 AM
- Approval given per Source Specialist

Alliant Nurse Received this statement on Nurses Narrative

- During ER visit patient was drug tested and found to have amphetamines in his system.

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Alliant nurse found in documentation

- Dear Provider
- Requesting clarification:
- 1. Member had a positive drug screen in February 2017. Physician also wrote a note regarding the drug use. Has involuntary discharge been initiated? This is what SOURFE policy is. How is this being addressed?

Continued

- 2. Also on page 35 of the packet is the drug screen but it appears that the page has areas that have been scribbled out. Please forward a unaltered document.

Correct ways to correct documents

- One single line with nurses or MD initials.
- Please do not obliterate writings.
- Documents that have been altered will be requested to send unaltered view or form NN from MD.

Source Policy on Narcotic use:

- Source policy for Illegal drug abuse is involuntary discharge…
- Client could become unmanageable for agency.
- Poor client outcomes.
- Illegal drug abuse is illegal!

Next Scenario: Contact us reads

- Dear Provider
- PA Approved for 6 months.
- The medical documentation submitted with this PA was inadequate. It did not contain documentation to substantiate that applicant's medical conditions are such that the functional status of this applicant rises to the level of care for nursing home placement and meets SOURCE eligibility.

Contact us continued

- Please submit an Appendix NN completed by the MD at next review. Please encourage the PCP to complete the form in its entirety. Without this information, Alliant may have to make the determination with insufficient information.
- Thank-you.
- - Alliant Nurse Reviewer (4/5/2017 7:41:56 AM)

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Appendix I reads:

management of a medical condition(s) under the direction of a licensed physician.

Etiology _____

2. Nutritional management, which may include therapeutic diets or maintenance of hydration status.

Etiology _____

K2a-d = 1 K3 1-9 = 5, 6, 7 or 8

N2d = 2 or 3

3. Maintenance and preventative skin care and treatment of skin conditions such as cuts, abrasions or healing decubiti.

Etiology _____

L1 = 2, 3, 4 or 5 L3; L4; L5 = 1

L7 = 2 or 3 N2K = 1, 2 or 3

loss addressed on MDS/care plan for continued placement.

Etiology _____

C1a-c = 1

2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/care plan for continued placement.

Etiology _____

C1 = 3, 4 or 5 or C5 = 2

3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention.

1. Transfer and locomotion performance of resident requires limited/extensive *assistance by staff* through help or one-person physical assist.

Functional Etiology of movement deficit _____

G2F 3 4 5 6 G2g 3 4 5 6

G3c 0 G3d 0

*J3a 1 2 3 4 *J3b 1 2 3 4

*If J3a-b is circled, is this compensated by walker cane, slower movements, or use of furniture? Y N If so, this is not enough for NH level.

2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals.

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Issues-Balance and Unsteady Gait

BALANCE

a. Difficult or unable to move self to standing position unassisted.	4
b. Difficult or unable to turn self around and face the opposite direction when standing	4
c. Dizziness	1
d. Unsteady gait	4

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Nurses Narrative reads

FUNCTIONAL: Member stated that she has daily pain in her leg and hip and is unable to stand or walk for any long period of time. Member stated she is out of bed 10-12 hours daily. Member stated she continues to needs assistance with ADL'S and IADL'S.

Other: Member stated during visit she is going to see the orthopedic because she has been having lots of pain in her knee which make it very difficult to get around. Member denies any skin alteration, no falls, emergency room visits and or hospitalization in the last 90 days. Member will continue to benefit from source program to remain safe in the community.

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Nurses note and Appendix I conflict

e. Walking -- How walks between locations on same floor indoors	1
f. Locomotion -- How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair	1
g. Transfer toilet -- How moves on and off toilet or commode	0
h. Toilet use -- How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET	0
i. Bed mobility -- How moves to and from lying position, turns side to side, and positions body while in bed	0
j. Eating -- How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0

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MD note : paints patient as normal.

Constitutional

The patient is not in acute distress

Neck

Neck is supple, no carotid briuts

Respiratory

The patient is relaxed and breathes without effort The lungs are clear to percussion and auscultation.

Cardiovascular

The rate is normal, the rhythm is regular, S1 and S2 are normal, there are no murmurs, no gallops, and there are no rubs. There is no pitting edema of the lower extremities. There are no bruits. The peripheral artery pulses are 2+ brisk.

Psychiatric

The patient is oriented to person, place, and time. Speech is fluent and words are clear. Thought processes are coherent, insight is good.

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6 month approvals

- Each assessment must stand on it's on.
- To prevent gaps in service DCH has allowed 6 month approvals for current members to get additional information however, this increases agency processing time.
- All clients with illegal narcotic use should be evaluated for discharge according to Source policy.

Questions and Answers

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Making Health Care Better