GUIDELINES FOR DOCUMENTATION UTILIZATION REVIEW

1. **Admission Sheet or Initial Order Sheet**
   “Reason for Admission” should be stated in terms of Severity of Illness or Intensity of Service criteria.

2. **History and Physical**
   a) Create a clear picture of why in-patient (as opposed to outpatient) treatment is required.
   b) State why the patient is being admitted now as opposed to last week or next week (this is particularly important for patients with chronic problems).
   c) Describe previous treatments and outcomes -- was the patient refractory to outpatient care?
   d) If the patient does not meet Severity of Illness or Intensity of Service criteria, document why in-patient evaluation or treatment is necessary, i.e., problems with mobility, need for continual observation, specific high risk indicators, or other extenuating circumstances (do make sure that whatever you write is verifiable).
   e) Describe signs and symptoms in detail.

3. **Progress Notes**
   a) Describe the patient’s status and progress in meaningful progress notes daily.
   b) Include a plan of care that specifically describes why the patient continues to require hospitalization in an acute care hospital. When possible project anticipated discharge date or additional days the patient will require to complete his/her care. **DO NOT** write “Plan per Dr. __________________.”
   c) Severity of Illness and Intensity of Service Criteria must be met sometime during the hospitalization for Medicare patients. Some private Review Agencies reviewing on behalf of Private Insurance companies require that Severity of Illness and Intensity of Service is substantiated for each hospital day for hospital reimbursement and in certain cases physician reimbursement. If these criteria are not addressed on the order sheet or in the History and Physical, they may be defined in a progress note.
   d) Documentation of patients or family education, contacts with outside agencies or physicians, consults for home assessment or placement, and follow-up plans, etc., are increasingly important and can be even more important if the patient requires readmission within 18 days of discharge.

4. **Quality of Care Review**
   a) All Medicare cases selected for review will be screened not only for appropriateness of admission, but also for quality of care using Health Care Financing Administration (HCFA) mandated generic quality screens.
   b) Thorough and **accurate** medical record documentation is essential for conveying the quality of medical care patients received while hospitalized.
c) Failure to clearly indicate reasons/rationale for action or inaction may at a later date raise questions as to the quality of care rendered.
d) Quality of care review has serious implications for both Provider (Hospital) and Practitioner (Physician). It is in everyone’s best interest that medical record documentation reflects accurate and comprehensive information regarding the quality of care rendered while hospitalized.

5. **Nursing Home Placement**
a) Medicare only pays if the patient is awaiting a bed in a skilled nursing facility (SNF). Chart documentation must reflect that there is an active search for SNF bed. If there is a long wait for a nursing home bed, then periodic updates are needed (every 7 days). The patient must take the first available bed within 50 miles of the patient’s home.
b) Medicare does not pay for intermediate care facilities -- either for awaiting a bed or for that level of care itself.
c) Begin placement planning as soon as there is any indication that the patient will not be able to return home. Notify both the Social Worker and the UR Coordinator.

6. **The M-01 (Discharge Information Face Sheet)**
a) The DRG is determined mainly by the Principal Diagnosis; to a lesser degree by the Principal Procedure; and by some other parameters.
b) There can only be one Principal Diagnosis, which is defined as the diagnosis after study of the condition chiefly responsible for the admission.
c) List all conditions which were treated, evaluated or for which the patient was medicated, i.e., hypertension, gout, NIIDM.
d) List all procedures done during the admission.
e) The Attending Physician should review the information on the M-01 (and the Discharge Summary) for thoroughness and accuracy and make the needed additions and corrections before signing the attestation statement.
f) Only the Attending Physician should sign the attestation statement, which is the physician’s indication that the billing information is accurate.