Documenting in the Inpatient Unit

Every contact that the Inpatient Nurse or Inpatient CNA makes with a patient in the inpatient unit has to be recorded and the total number of billable contacts must show on the claim form to Medicare.

Definition of Billable Contact (CR 5567 updated 4/29/08)

Hospices are required to count all visits by their nurses, social workers, home health aides, and physicians providing care regardless of the location of the patient or the level of care provided, if the visit is necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care. To constitute a visit (billable contact), the discipline must have provided care to the beneficiary. Services provided by a social worker to the beneficiary's family also constitute a visit. For example, phone calls, documentation in the medical/clinical record, interdisciplinary group meetings, obtaining physician orders, rounds in a facility or any other activity that is not related to the provision of items or services to a beneficiary, do not count towards a visit to be placed on the claim.

Set Up

Set up the Visit Types that your Inpatient Staff will be using. Your mumms Liaison will assist. Note: you will probably need to set up Visit Types that will be used exclusively in the IPU because of the way the charges will be calculated (via "billable contacts") which may be different than staff making home visits.

Rate seen on the claim form will be calculated based on the "billable contacts". These can be calculated by hourly rate x Total Time spent w/ patient (program adds up all "durations" in "billable contacts").

Beginning of Shift

- Log into HBC; click on Open All Icon from top Tool Bar. Enter starting time of the shift and a visit type.
- Choose patients that are assigned to you or that you will be caring for. A "Team" of inpatients can be set up in PIM as a quick-selector.
- Click on Open in the top right-hand corner.
- Once patients' charts are opened, they will be listed (in yellow); choose one patient and open the appropriate form.
- In the right-hand pane "Care Plan Notes," click on the down arrow. Choose "Open Visits" and hit enter. Now you can move quickly between all open charts.

Billable Contacts Documentation

- Each time you enter the patient's room and make a "billable contact" (see definition above), you will click the next available "billable contact" number.
- On the text line, enter the duration of the contact**.** In the text box, document briefly what was done in the contact.
- Enter the details of the contact in the appropriate section of the Visit Record.
- The total number of billable contacts is recorded by the program for reporting and billing purposes.
- DURATION MUST BE NUMBER OF MINUTES ONLY (such as "6", NOT "6 min").

Example:

The nurse assessed the patient's pain and then gave a dose of MSIR. The nurse would then click (Under Billable Contacts) "contact 1, Assessment, 10:00 am, pain"; then "contact 2, Intervention, 10:10, gave MSIR", as the nurse probably had to come out of the room, go to the nurse's station/med cart and get the medication and then go back to the pt's room. Under "Pain" in the body of the Visit Record Form, the nurse would document more thoroughly the patient's s/s of pain and the dose of the medication given. (NOTE: the details may be documented in the "Billable Contacts" section w/ permission of Administration.)

End of the Shift

- Ensure that the Visit Record Form is complete (all required questions) for all patients.
- Close each chart individually to ensure documentation is complete.
- Note whether team has been notified or not.