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CMS Surveys: Documentation Essentials – CMS F658

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As revised CMS guidance takes hold in skilled nursing facilities, a heightened focus on diagnosis underlying the use of psychotropic medications is essential to compliance. A diagnosis of schizophrenia or other mental disorder will receive scrutiny. Documentation about a diagnosis must include defined elements.

"The new survey process raises the bar on documentation and resident-centered care in a way that will catch facilities relying on outdated systems or shortcuts," one expert told McKnight's Long-Term Care News. "It's an opportunity to improve, but it's also a real compliance risk if providers aren't prepared."

Here are some documentation essentials related to diagnosis, drawn from CMS guidance:

A diagnosis must be supported with a documentation consistent with accepted standards. Tag F658, which addresses professional standards, explains that a practitioner must use evidence-based criteria and professional standards, such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). They must support a diagnosis with documentation in the resident's medical record. Noncompliance could be cited if:

- A diagnosis does not adhere to accepted standards of quality
- Accepted standards of quality dictate that the service or care should not have been provided
- Accepted standards of quality dictate that the service or care should have been provided—and wasn't.

Avoid "insufficient documentation": What is considered "insufficient documentation" to support a diagnosis behind an order for psychotropic medications? Some examples are:

- Naming schizophrenia or another diagnosis as an indication in medication orders without supporting documentation
- Adding a diagnosis such as schizophrenia to the medical record without documentation supporting the diagnosis
- Carrying forward a diagnosis from a transfer summary, such as "history of schizophrenia". In this situation, the facility must provide evidence that a practitioner conducted a comprehensive evaluation after admission.
- A note of schizophrenia or another diagnosis in the medical record by a nurse without supporting documentation by the practitioner.

Meet ALL criteria for a diagnosis. Explains CMS, the medical record must include documentation of ALL of these items. (If not, this would constitute insufficient documentation.)

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- Documentation (e.g., nurses' notes) indicating the resident has had symptoms, disturbances, or behaviors consistent with those listed in the DSM criteria, and for the period of time in accordance with the DSM criteria.
- Documentation from the diagnosing practitioner indicating that the diagnosis was given based on a comprehensive assessment, such as notes from a practitioner's visit.
- Documentation from the diagnosing practitioner demonstrating that other causes of the symptoms, disturbances, or behaviors have been ruled out, e.g., medications or other medical conditions.
- Documentation regarding the effect the disturbance is having on the resident's function, such as interpersonal relationships, or self-care, in comparison to their level of function prior to the onset of disturbance.

Prepare for recommended probes. CMS recommends these probes for surveyors:

- Does the documentation show how the physician arrived at the diagnosis based on the DSM criteria? For example, for a new diagnosis of schizophrenia, the medical record must contain notes of symptoms or behaviors consistent with the symptoms from criterion A, and for the period of time in criterion C as listed in the DSM.
- Is there documentation of a physician's visit assessing the resident and concluding a diagnosis of schizophrenia?

Non-compliance with F658 can trigger other citations. If the resident is receiving an antipsychotic medication and experiencing negative side effects, surveyors are also advised to evaluate compliance with F605. Here's an example: A resident receiving antipsychotic medication withdraws from social activities and spends their day isolated in their room. In this case, CMS states, "A lack of documentation to support a practitioner's diagnosis of schizoaffective disorder and the use of an antipsychotic medication without an adequate clinical indication represents Immediate Jeopardy at F658 and F605."

A surveyor could also examine these tags, says CMS:

- F641: to determine if the facility completed an assessment which accurately reflects the resident's status.
- F644: to determine if the facility made a referral to the state designated authority when a newly evident or possible serious mental disorder was identified (PASARR).
- F841: to evaluate the medical director's oversight of medical care.

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Individual practitioners' status is at stake. CMS guidance advises surveyors to look for patterns. If non-compliance causes actual harm to one or more residents, or if "the surveyor identifies a pattern (e.g., three or more) by the same practitioner prescribing antipsychotic medication for any new diagnosis (such as schizophrenia) with lack of supporting documentation, the survey team should discuss their findings with their state survey agency for consideration to refer the individual to the State Medical Board or Board of Nursing."

If it isn't documented, it didn't happen. With the revised CMS guidance, complete and accurate documentation is more important than ever. For a resident on psychotropic drugs, documentation must address adequate indications for use and a program of gradual dose reduction, too.

"The medical record needs to show how clinicians arrived at the current treatment plan. This must include diagnoses, assessments, medications, side effects, behaviors, and nonpharmacological interventions. For survey purposes, if it isn't documented, it didn't happen. Documentation should also include recommendations to monitor for side effects and behaviors," says GuideStar Eldercare's Compliance Q&A.

Concerned about compliance? GuideStar's ground-breaking clinical protocols for dementia and behavioral care are built to meet—and exceed—CMS standards. We're here to help.

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