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Eli's Rehab Report

Long-Term Care: Restorative, Rehab, or Both? The Wrong Answer Can Cost Your SNF

4 quick questions can keep your care and payment on track.

Your skilled nursing facility may get kudos from surveyors if it detects a resident's decline in time to turn it around. But if your rehab team tackles the case when restorative care could have done the job, your facility could land in hot water with auditors.

"Facilities are getting into trouble when restorative nursing is doing the same thing as skilled therapy, which leads to denials of the Medicare stay and skilled services," says **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

And watch out: "Medicare and other third-party payers are now hiring therapists to do medical reviews whereas they used to use nurses," adds **Donna Senft,** a licensed physical therapist and attorney with the law firm of Ober/Kaler in Baltimore.

Helpful: An SNF should ask the following five questions when deciding whether to provide rehab. The answers will steer your rehab team and other SNF staff in the right direction.

1. How significant is the decline -- and does it require skilled therapy to turn it around? You might consider a resident who is currently ambulating 50 feet when he could previously ambulate 150 feet a drastic decline. But that's still not enough to justify that rehab get involved.

The patient may simply benefit from interventions to improve his walking distance and endurance, which aren't skilled therapy services, says **Shehla Rooney,** a physical therapist and president of Premier Therapy Solutions in Cookeville, Tenn.

On the other hand: If a patient's ambulation has decreased because he now drags his right foot, leans to the side, or can't grip the walker, the patient may require the therapist's skills to regain function, Rooney says.

2. What are the goals for intervention, and are they realistic? If the SNF's goal is to simply make the patient more comfortable or to provide maintenance-type therapy, that is not enough reason for rehab to get involved. On the other hand, if the goal is for a patient to measurably improve an activity of daily living, the SNF has more of a case.

Furthermore, to justify Medicare skilled rehab, the provider has to determine that the resident has the potential to improve, notes **Jody Neimann,** an occupational therapist with Jenkins Living Center in Watertown, S.D. "And to keep the person on skilled rehab, he has to show improvement."

Example: Suppose a resident has impaired cognition due to a recent stroke or traumatic brain injury. Speech therapy could help the resident with language function -- with the expectation that the resident has potential for new learning to restore cognitive abilities, says **Elisa Bovee,** an occupational therapist and consultant with Harmony Healthcare International in Topsfield, Mass.

3. What's the person's medical status and motivation? When a resident isn't medically stable enough to progress in therapy, that's an appropriate opportunity for restorative to step in, Neimann says. For example, restorative might help a medically unstable resident maintain range of motion.

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Or, if the resident is medically stable but lacks motivation to participate in rehab therapy, he might be willing to accept restorative nursing interventions. Neimann also looks at whether the person may be in the dying process, in which case the decline may be unavoidable -- thus it would be inappropriate for rehab to play a role.

Good question: Has the person declined due to an acute illness, or pulmonary or cardiac issue? The SNF might try restorative first, suggests **Pauline Franko,** a physical therapist and principal of Encompass Consulting & Education in Tamarac, Fla. Then if the patient doesn't improve after a certain time, therapy can do an evaluation and pick the person up, she adds.

4. Is the patient a candidate for both rehab and restorative? Be careful not to be too black-and-white in your rehab decisions. Suppose a resident has declined in his ability to bathe himself since the last quarterly MDS assessment. OT might evaluate the person and decide he needs skilled rehab intervention, restorative, or a combination, says **Cheryl Field, MSN, RN, CRRN,** senior healthcare specialist with PointRight Inc. in Lexington, Mass. "In some cases of ADL impairment, the nursing staff can integrate restorative techniques to help the person improve function in ADLs."

And remember, real-life practice makes perfect. "If a person is getting speech-language pathology for swallowing problems -- or OT for feeding issues -- restorative should work with the therapists to integrate the goals into actual meal situations," suggests **Robert Serianni, MS, CCC-SLP,** VP of clinical services for Nyman Associates Inc. in Ft. Washington, Pa.

Moneymaking tip: "Restorative can go in without the therapist's involvement and work with a resident," says **Katy O'Connor,** a physical therapist and consultant in Morganville, N.J. But to return the person to former functioning, therapy can pick up the person and help develop the restorative program. "That way the facility gets paid for the therapy," she adds.

Good idea: Neimann advises facilities to have the interdisciplinary team discuss each case in terms of whether to provide skilled rehab or restorative, or both, and to document its decision making.

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