Eli's Rehab Report

Skilled Nursing Facilities: Stop Nursing Documentation From Torpedoing Rehab RUGs

4 ways for nursing and therapists to stay on the same page.

If nursing and therapy documentation don't jibe in describing a rehab resident and his care, beware. Your facility may find itself targeted by medical reviewers aiming to reject Part A claims.

The good news: These documentation tactics will ensure your notes support medical-necessity requirements for skilled rehab.

1. Include the 'Rest of the Story'

One big killer for therapy is when nursing writes about a therapy patient, "Patient ambulating ad lib about room," but the note leaves out the fact that the resident ambulates because he lacks safety awareness or he's hanging onto furniture and at serious risk for falling. Without that information, a medical reviewer reading the note about the resident's "ad lib" performance may surmise the resident doesn't need skilled therapy.

Don't forget ADLs: The nursing notes also have to support the ADL scores on the MDS, which also dictate RUG placement. It's not enough just to say the person is a one-person assist. The notes need to spell out how much assistance the resident requires.

Target this common omission: The documentation should show that the resident required skilled therapy in an inpatient setting; otherwise, he could have received it in an outpatient or home health setting, says **Donna Senft, JD, PT,** a practicing attorney at the Baltimore law firm **Ober/Kaler.** "Nursing documentation can help" in that regard by "addressing the resident's functional limitations outside of therapy," Senft says.

To help support that the resident needs inpatient skilled therapy, nursing can address that the resident is medically unstable and requires 24/7 supervision.

2. Describe What the Resident Is Incorporating From Therapy

If occupational therapy is saying the person can now wash himself with setup help, do the nursing notes document how the person is progressing in that regard? Perhaps he has progressed from limited assistance on the MDS to requiring only supervision.

3. Address Differing Perceptions

You expect to see some discrepancy between nursing and therapy documentation because their reimbursement focus is different. For example, the Medicare SNF PPS requires nurses to document and code the MDS for the resident's most dependent ADL performance and highest level of support.

By contrast, therapists document a resident's improvement to justify continuing skilled therapy. But if you see that a resident isn't demonstrating the skills that therapy says he can do, dig deeper to find the root cause. The problem may be a lack of communication between rehab and nursing.

Example: If the staff is using a Hoyer lift to transfer the resident the entire time he's in therapy to work on transfer

skills, that's a problem. Maybe nursing staff are using the lift because they feel that the resident and/or staff aren't safe transferring the person without it.

That's where the therapist can help educate the staff on safe transfer techniques. The therapist can count that [education] toward therapy minutes under Part A (and for Part B, too).

Tips: Make sure to document the training in the nursing notes, Senft says. And include care plan interventions that encourage the resident to practice his newfound skills. Suppose the discharge plan calls for the patient to go home soon. The nursing staff can tell the patient that he needs to practice bathing on his own before going home.

4. Don't Mix Terminology

Mixing MDS and therapy terms is a surefire strategy for confusing a medical reviewer, experts say. That's because therapy terminology is a totally different language for nurses. And it won't sync with MDS definitions for activities of daily living coded in Section G1.

Example: A PT is working on bed mobility for a resident who had a hip fracture. And the patient can move up and down in bed, roll side to side and sit up on the side of the bed in preparation for getting out. But the nurses have to provide weight-bearing assistance to position the resident's weaker leg in bed.

If a caregiver provides that level of assistance three times in the lookback, you'd code bed mobility (Column A) as extensive assistance. Yet using therapy language, a physical therapist might say the resident needs only minimum assistance with bed mobility, which is lifting the leg into the bed.