Eli's Rehab Report

SNFs: Avoid This Trap: A Mismatch Between the MDS and Therapy Eval

Get nursing and therapy on the same page with takeaways from this case study.

With the Recovery Audit Contractors (RACs) and other auditors on the loose, the last thing you want to do is ontribute to a case where a Part A resident's Minimum Data Set (MDS), therapy, and nursing documentation show major inconsistencies. That very scenario, which cost one SNF its payment, offers some key take-away points for all facilities trying to keep their payment and compliance on track.

What happened: A resident went on Part A following a three-day hospitalization for pneumonia and an exacerbation of chronic obstructive pulmonary disease. Based on the therapy evaluation, the resident was receiving occupational therapy primarily due to hand contractures and speech therapy for dysphagia, reports **Marilyn Mines, RN, RACCT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill., who reviewed the case for the facility.

The fiscal intermediary's medical reviewer requested the admission assessment, which the team completed with an assessment reference date during the same timeline as the therapy evaluations. Thus, "one would have expected" the MDS and evaluations to be consistent, says Mines. But they proved to be anything but.

The MDS appeared at odds with therapy in the following key areas:

• Section G4 (functional limitation in range of motion). The occupational therapy (OT) evaluation said the resident had hand contractures, but the MDS did not indicate any problem with range of motion at G4, Mines observes.

• Section J2 (pain). The OT evaluation indicated that the resident had pain, which was part of the problem affecting her ability to use her hand. "Therapy was rating the resident's pain as 6/10, and the assessment reference date was on or about the same date as the [therapy] evaluation.

Yet the MDS did not indicate any pain," Mines notes.

• Section K1 (oral problems). While a speechlanguage pathologist had been seeing the resident for dysphagia, the MDS didn't indicate that he had any problem with swallowing or chewing.

• Section G1 (activities of daily living). Section G1 showed the resident as an extensive to total assist in every activity of daily living (ADL). And G9 (change in ADL function) indicated no change in the resident's normal function, Mines says.

Scout Out the Documentation Problems The nursing documentation and MDS indicated that the patient was more independent than did the therapy documentation. Usually, the opposite is true, Mines points out.

"In therapy, the person usually has 100 percent of the therapist's attention, who is coaxing the person to be more independent." The clinical record documentation did not explain the conflict between the nurses' and therapists' observations.

The discrepancies between the MDS and therapy would lead a reviewer to question whether the care plan is on the mark, Mines cautions.

Example: If the resident has dysphagia, the care plan should have included related interventions, such as observation during mealtime and perhaps thickened liquids, observes **Gail Robison, RN, RAC-CT,** a consultant with Boyer and Associates Inc. in Brookfield, Wis.

Dig Deeper to See What's Going On

If the MDS, which is supposed to "paint a picture," and the therapy evaluation and therapy documentation don't match without an explanation as to why, "the facility has a problem," says Mines.

In such a case, "you have to ask who's missing the boat? Is it the MDS nurse or is therapy looking to add people to its census? These are the questions that the RACs are going to be asking," Mines cautions. To figure out what's going on in this particular case, Mines suggests the staff could ask these questions:

1. Do the CNAs know how to complete the ADL tracking form accurately, if the facility uses one?

2. Is the nursing staff identifying pain? "Are they documenting what they see without communicating with other disciplines, such as therapy and activities?" Mines asks.

Tip: The therapist should document the patient's pain levels before, during, and post-therapy sessions, especially if pain management is part of their plan of care, advises **Shehla Rooney, PT,** a consultant in Cookeville, Tenn. But due to lack of specific documentation guidelines requiring therapists to do detailed daily notes on Medicare Part A patients, often you won't find the pain assessment -- or it may be summarized in a weekly note format, she says.

"That is why it is so important for the MDS coordinator to ask not only therapists, but also nurse assistants ... if the patient has had complaints or indicators of pain in the last week," Rooney advises.

3. Are the interdisciplinary team members working in tandem? Mines finds that "the concept of the interdisciplinary team has lost its definition" in some of the medical review cases she has been examining.

"The assessment and documentation has to be coordinated," she emphasizes. "That is not to say that one department should be telling the other what to chart. Rather, the information should not appear to be about two different residents," Mines says.