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MDS Alert

Payment Compliance: Restorative, Rehab Or Both? This Decision-Making Tree Will Help Keep You Worry Free

5 quick questions will put your care and payment on the right track.

You may get kudos from surveyors for detecting a resident's decline in time to turn it around. But getting rehab on the case when restorative could have done the job will land your facility in hot water with auditors.

Watch out: "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 "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.

Answering these key questions when deciding whether to provide rehab can help your facility feel confident it made the right decision.

1. How significant is the decline and does it require skilled therapy services to turn it around? Suppose a patient is now ambulating 50 feet when he could previously ambulate 150 feet, says **Shehla Rooney**, a physical therapist and president of Premier Therapy Solutions in Cookeville, Tenn. The patient may benefit from restorative interventions to improve his walking distance and endurance, which aren't skilled therapy services, she notes.

Yet if a patient's ambulation has decreased because he now drags his right foot, leans to the side, or can't grip the walker, as examples, the patient may require the therapist's skills in order to regain function, Rooney adds.

2. What are the goals for intervention? In order to provide 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? Neimann thinks of restorative when a resident isn't medically stable enough to progress in therapy. For example, restorative can help the person maintain range of motion and so forth, she says. If the person 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.

Has the person declined due to an acute illness or pulmonary or cardiac issue? You 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.

Also do a pharmacy review as part of evaluating decline (see the article on the next page).

4. Is the patient a candidate for both rehab and restorative? 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."

Practice makes more perfect: "If a person is getting speech language pathology therapy 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**, an SLP and VP of clinical services for Nyman Associates Inc. in Ft. Washington, Pa.

Getting paid: "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.

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

If the team does decide to provide rehab therapy, make sure you ask this final pivotal question:

5. Does the therapist's documentation support skilled services? Senft finds that therapy documentation tends to include objective data about the resident and functional outcomes. But it "often lacks information about the skilled therapy interventions that allowed the [resident] to achieve the objectives," cautions Senft. And that can be a problem when reviewers try to connect the dots without having it spelled out.

Don't do this: You tend to see documentation, especially from physical therapists, that reads: "Patient ambulated 50 feet," and the next entry: "Patient ambulated 75 feet, etc.," Franko cautioned. The problem is that "to Medicare, that constitutes repetition and doesn't need the skills of a therapist."

Instead: Document determinations about the patient's gait disturbance and other problems requiring skilled intervention, Franko suggests. "The therapist has to establish and document the person's weight-bearing status, balance, and ability to weight shift, etc.," she says.

"The therapist identifies and documents, for example, that in the swing-through phase, the patient is getting a hip hike rather than a swing-through -- or has a flat-foot weight bearing stance instead of a heel-toe push off," Franko says.

In terms of intervention, a nursing aide could make the statement that a "patient ambulated 100 feet with minimal assistance using rolling walker," Rooney observes. By contrast, she says, documentation that shows a level of complexity specific to a skilled professional might include:

"Patient performed gait training with rolling walker for 100 feet with minimal assistance for weight shifting to facilitate right lower extremity clearance during swing phase.