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MDS Alert

Rehabilitation Therapy: Sharpen Therapy Documentation Skills to Support Skilled Rehab

MDS 3.0 RAI manual focuses on difference between non-skilled and skilled rehab.

Documenting to clearly differentiate between skilled and non-skilled therapy will take on new urgency when the MDS 3.0 goes live.

For one, the RAI User's Manual for MDS 3.0 (Chapter 3, Section O) addresses instances where residents refuse to participate in therapy, says **Elisa Bovee, OT R/L,** director of education and training for Harmony Healthcare International in Topsfield, Mass.

The manual states: "When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes."

In Bovee's view, that directive means "therapists will have to weed out whether the patient really refused [therapy] or was resistant and the therapist came up with an alternative plan to engage the patient in skilled therapy."

Example: "Suppose Mr. Jones says he doesn't want to go to the gym, but asks the therapist for assistance" with going to the bathroom, Bovee says. While helping Mr. Jones with toileting, the therapist works on his transfer skills and balance, environmental barriers, and educates him on these issues. "A newbie therapist might reason that all he or she did was help the person to the bathroom" and not count the time spent providing the skilled therapy, says Bovee.

Bovee believes CMS may clarify whether the therapist's efforts to educate and motivate a resident who refuses therapy will count as skilled services.

Atlanta consultant **Darlene Greenhill** believes, however, that CMS has addressed the issue as it has "because time spent investigating the cause of the resident's refusal or trying to persuade the resident to participate does not meet the definition of a skilled service in CMS Pub 100-2, Chapter 8, Section 30.4" (www.cms.gov/manuals/Downloads/bp102c08.pdf). Also, the PPS final rule for FY 2011 published last year seems to repeatedly emphasize "therapy actually received," Greenhill points out.

The interdisciplinary team should address the reason for the resident's refusal, if it persists. That's because "the cause of the resident's refusal likely impacts other areas of the resident's health," says Greenhill. "For example, if the resident is refusingtherapy due to pain, this could also affect his ADL status, nutrition, sleep, mood, and participation in activities."

Be Prepared to S upport Why a Modality I s S killed

Chapter 3, Section O, also notes that "in some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time." And you can only record the skilled portion on the MDS.

Example from manual: "A resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS."

"In other instances," the manual states, "some modalities only meet the requirements of skilled therapy incertain situations." Application of a hot pack, for example, often doesn't constitute a skilled intervention, the manual points out. "However, when the resident's condition is complicated," requiring the therapist's "skills, knowledge, and judgment" for

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treatment, then you can record the minutes associated with the skilled therapy time on the MDS, the manual instructs.

Key: Documentation in such cases has to explain "any complicating factors" that require the therapist's knowledge, skill, and judgment, says **Shehla Rooney,** a physical therapist and principal of Premier Therapy Solutions in Cookeville, Tenn.

When might providing a hot pack constitute a skilled therapy service? Examples might include scenarios where a patient had a diagnosis of an "extreme skin condition such as herpes zoster, or a cardiovascular or respiratory condition," says Bovee.

In those cases a thermal modality, such as a hot pack, would require the therapist to assess and monitor the patient. Based on the patient's clinical status, the therapist would decide whether to provide the modality that day to alleviate pain or limitation in order to continue with the plan of care, Bovee counsels.

What to document: Bovee notes that the therapist might document in such a case that the "patient is at high risk for exacerbation of ABC diagnosis with utilization of hot packs. Patient had significant complaints of shoulder pain prior to initiation of therapy session. Therapist consulted with nursing and physician prior to application of hot pack. Therapist monitored hot pack and patient during therapy session, approximately every 120 seconds. Patient's breathing not affected; skin continued to be within normal limits. Patient tolerated this modality and reported reduction in pain to 3 out of 10 (was 9 out of 10 at outset of hot pack application).

Patient was able to increase active ROM to x degrees as the result of the heat modality. Therapist does not recommend patient receive this modality outside of skilled level of care due to patient's significant risk factors."

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