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MDS Alert

REIMBURSEMENT: Nurses Providing Respiratory Therapy? Don't Lose Out on Available Reimbursement

You can capture RT if you meet the RAI User's Manual guidelines.

Your MDS team wouldn't dream of not coding rehab therapy in Section P1b, but does it always code respiratory therapy in that section, as well? If not, your facility may be providing free services -- and your MDSs won't reflect what you're doing for certain residents.

Nail down the Medicare payment: A resident can qualify for Special Care if he receives 15 minutes of respiratory therapy a day during the seven-day lookback and has an ADL score of at least 7, notes **Patricia Boyer, MSM, RN, NHA**, president of Boyer & Associates LLC in Brookfield, Wisc.

If the resident is in Extensive Services, providing the requisite amount of RT qualifies the person for Special Care, which will add a point to the Extensive Count, notes **Nemcy Cavite Duran, RN, BSN, CRNAC**,director of MDS at Dr. William O.Benenson Rehabilitation Pavilion, and a private consultant in Flushing, N.Y. And that can make a difference, for example, in whether someone goes into SE3 versus SE2.

Not just a Medicare issue: Capturing RT can also lead to better payment in MDS-driven Medicaid case-mix systems, experts point out.

Use This 3-Point Checklist

Of course, providing RT is one thing, whereas being able to legitimately code it in Section P1b is another. These key strategies can help you keep your RT services in compliance with the standard of care and payment requirements.

1. Know what counts as RT in Section P1b. And that includes "coughing and deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist)," according to the RAI User's Manual. Remember: You can only capture actual time spent with the resident. (Don't include handheld medication dispensers.)

The RAI manual notes that a trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act. So verify what RT services LPNs and RNs can provide under the nurse practice act, suggests **Ron Orth, RN, NHA, CPC, RAC-MT**, president of Clinical Reimbursement Solutions LLC in Milwaukee.

Critical: Keep in mind that in some states, LPNs may not be able to assess. For RT, this would only be an issue if you include the time that the LPN spends doing an assessment such as listening to lung sounds,advises **Amy Snetsky, RN, BSN, RAC-CT**, a consultant with the Polaris Group in Beaverton, Ore. And an LPN would be able to document the effect of a respiratory therapy treatment without assessing in most cases, Snetsky adds.

2. Provide and document training. The facility should offer inservices for nursing staff on how to do a proper respiratory assessment and deliver certain RT treatments, such as nebulizer treatments, Orth suggests. Also include information on signs and symptoms to watch out for related to the treatments.

Hold onto these: Keep a record of the inservices, along with a copy of the presentations and learning objectives, suggests Orth. The nursing facility should also have some way to validate that the licensed nurse can properly administer RT treatments. For example, as part of training, the nurse could take a competency test, Orth adds.

Real-world example: Dr.William O. Benenson Rehab Pavilion has a respiratory and ventilator unit staffed with RNs who

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provide certain RT services. An outside agency provides the training and certifies the nurses to do RT, reports Duran. The facility is also considering having trained nurses provide RT services, such as nebulizer treatments, on the regular floors. The RT on staff will provide the training for the floor nurses, says Duran.

3. Document the RT minutes and patient response to Rx. The documentation should include the results of the treatment, says **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services, FR&R Healthcare Consulting in Deerfield, Ill. To capture RT minutes, Duran advocates using flow sheets.

Auditors will want to know how you quantified the RT minutes -- just as you have to do with restorative nursing, she says. And remember: In capturing RT minutes, you'd need a clinical reason to be at the bedside for a patient who receives an RT treatment and can administer it independently, Duran notes.

But beware this ommission:

Sometimes nurses fail to capture the time they spend at the bedside helping residents with inhalation therapy because they don't realize how the minutes add up, observes Mines. A resident coded as having short-term and long-term care memory loss in Section B probably needs the nurse to stay for several minutes during the treatments to remind him to keep his mask on during the therapy, she points out. And even five minutes per three or four treatments comes to 15 or more minutes a day.

Also watch out for this: Nurses are so used to providing RT in nursing homes that the facility may fail to capture RT services provided by a respiratory therapist on staff, notes **Nathan Lake, RN, BSN, MSHA**, an MDS expert in Seattle.

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