

SNF Nursing and Therapy Collaboration

OPTIMIZING COMPLIANCE, REIMBURSEMENT, AND DOCUMENTATION



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Kate Brewer, PT, MBA, GCS, RAC-CT Theresa A. Lang, RN, BSN, WCC



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Introduction to Documentation and Long-Term Care

Documentation Defined

Why do we document? The common answers are to prove we did something or to protect our professional decisions. The real reason for documentation is to promote quality and coordination of care. In the end, the documentation that is produced may be used for accreditation and licensing, performance improvement, peer review, reimbursement, and legal protection. There are many organizations that set standards or have requirements related to documentation, including:

- Centers for Medicare & Medicaid Services (CMS)/federal certification
- State survey agencies—licensure
- Professional practice acts (state specific), such as RN, licensed practical nurse/licensed vocational nurse, physical therapist (PT), physical therapist assistant (PTA), occupational therapist (OT), occupational therapist assistant, speech-language pathologist (SLP)
- Accreditation organizations (i.e., The Joint Commission)
- Professional associations: American Nurses Association, American Medical Directors Association, American Physical Therapy Association, The American Occupational Therapy Association, Inc., and American Speech-Language-Hearing Association
- American Health Information Management Association
- Insurance carriers (i.e., liability and workers' compensations)

1

CHAPTER 1

- Payers (e.g., Medicare, Medicaid, Medicare Advantage [Medicare C], insurance,
 Veterans Affairs [VA])
- Medicare A/B Medicare Administrative Contractor (MAC) (also known as fiscal intermediaries)

In the clinical setting (long-term care [LTC]), clinical documentation is done by inclusion and/or exception. Documentation by inclusion is done on an ongoing, regular basis and makes note of all assessment findings, interventions, and resident outcomes. Documentation by exception makes note of negative findings and is completed when assessment findings, interventions, or resident outcomes vary from the established assessment norms or standards of care. Charting by exception replaces the long-held belief of "if it was not charted, then it was not done" with a new premise, "all standards have been met with a normal or expected response unless documented otherwise."

Documentation by inclusion in the skilled nursing facility (SNF) includes weekly/monthly summaries, routine vital signs, weights, target behavior monitoring, etc.

Documentation by exception in the SNF could include falls, skin tears, pressure ulcers, pain, change in mood/behavior, weight loss, change in vital signs, change in cognitive status, etc.

An excellent reference for LTC facilities is the American Health Information Management Association's tool, LTC Health Information Practice & Documentation Guidelines, which can be found at www.ahima.org/resources/infocenter/ltc/guidelines.aspx.

The C's of documentation

When discussing documentation, there are a number of factors, all beginning with "C," that help describe the basics of documentation. The medical record is an accounting of the resident and is never used to document staff or departmental relationships. The factors are:

- *Clinical note*: Is the *content* and intent of the documentation *clear*?
- Does the note show *compliance* with the *care plan*, including *continuity* and *consistency*?
- How does the clinical note show *cooperation* and *collaboration*?

- Is there *congruence* or *contradiction* within the documentation?
- Does the note identify *change*?
- Are resident comments identified as comments?
- Complaints, conflicts, and confrontations need to be documented, although the medical record may not be the most appropriate place to document such events. Every organization may have its own policy and procedures related to these topics. Some organizations may not include these in the medical record. If included in the medical record, include only data necessary to describe the physical and psychological status of the resident.
- Does the note include *closure* (the signature and qualifications of the person making the entry)?

Tips for accurate documentation

- Document concisely and factually, using precise language
- Start each entry with the date and time
- Do not offer your opinions; rather, discuss observations (e.g., resident slept poorly versus resident up walking in hall six times between 3 a.m. and 5 a.m.)
- Do not repeat information that is stated elsewhere in the health record, such as on a flow sheet

Only issues related to resident care are recorded in the health record. Professional practice issues are not documented in the health record. For example, if Digoxin is given 2 hours late, chart the time the Digoxin was given, do not chart, "Mary forgot to give Mr. C. his Digoxin; therefore, I am giving it 2 hours late" or "Nursing not applying splint as recommended by OT. Reeducated staff."

The medical record is not an area to accuse or record frustrations that can occur due to lack of follow through. This puts the facility at an increased level of risk for survey problems. Instead, if there are issues with carryover or compliance that need to be addressed, it is best to go through the proper channels. The first step is to address it with your specific supervisor, be it the director of nursing or the rehab director. Then it can be addressed in the proper internal manner to get the best outcome for the patient. Caregivers

are often passionate patient care advocates but do need to understand the internal way to correct observed breakdowns in care appropriately.

Document only what you observe with all your senses

Do not document what others have reported unless you have seen, felt, smelled, or heard it.

If necessary to document someone else's observation, identify them as such: "CNA reported resident had two watery green stools this a.m."

Be specific and avoid being general or vague

Subjective opinions leave the nurse open to questions about his or her credibility and consistency in charting. Subjective charting should be limited to the resident's experience and response to treatment. If subjective information is shared by the resident, such as they are experiencing an increase in pain, that is important subjective information and should be included in the medical record, as it would influence the treatment plan and be important for the care of the resident. It is helpful to convert the pain to an objective measure. However, subjective comments that are not relevant to the care of the resident, like "Pt. commented that they did not like breakfast," is not necessary for the medical record. If there is a concern about their satisfaction with the food, that can be addressed with dietary or by other internal means. Putting in subjective comments without follow-up can create possible survey problems.

Tone of charting can lead to conclusions of 'resident abuse'

When a nurse's documentation criticizes preceding shifts or the nurse uses the chart as a medium for making disparaging comments regarding the facility and its policies, the resident will suffer.

Avoid bias

Describe observations and behavior of the resident rather than "labeling" a resident. Be descriptive as to what you are observing. Avoid comments like "confused, combative, difficult, etc.," as these terms do not describe what "behavior" is occurring. For example, the word "manipulative" does not describe the behavior. When trying to avoid bias, ask yourself whether the terms you are using are considered a behavior. To some professionals they are, but to others they are not.

Inaccuracies can result in inappropriate care decisions and resident injury. If the accuracy of a nurse's charting is questioned in a court of law, questions might be raised about the credibility of both the documentation and the nurse.

Charting in a rapidly changing situation

This is easier said than done. Write down even the briefest of notes in any situation, especially in an emergency, in order to preserve the accuracy and credibility of the record. Charting varies, but most facilities mandate minimum charting of every 1 to 2 hours and more frequently depending on the environment. When you are able to chart, indicate the chronological nature of the events that occurred. In a crisis, it is easy to forget what happened first. The use of an electronic medical record will document the entry at the time the entry is made, not the time the event occurs.

From a rehab perspective, charting at the point of service is essential. Documenting the treatment and the patient's response is critical to ensuring information is accurate. It is important to note that straight "documentation" time is not billable from a rehab perspective, but there are opportunities during the course of treatment where the resident needs to recover from physical activity under the skilled monitoring of therapy for respirations, response to activity, and medical status condition where documentation could be performed simultaneously. If the resident is not engaged in treatment or recovering from an activity and is just "staring" at the therapist as he or she documents, that time is not billable, as it does not require the skills of a therapist.

Electronic Charting

As more organizations move to electronic health records, there are basic rules that apply:

- Never reveal or allow anyone else access to your personal identification number or password, as these are, in fact, electronic signatures
- Inform your immediate supervisor if there is suspicion that an assigned personal identification code is being used by someone else
- Log off when not using the system or when leaving the terminal
- Maintain confidentiality of all information, including all print copies of information
- Shred any discarded print information containing resident identification

- Locate printers in secure areas, away from public access
- Retrieve printed information immediately
- Protect resident information displayed on monitors
- Use only systems with secured access to resident information
- Only access resident information that is required to provide nursing care for that resident; accessing
 resident information for purposes other than providing nursing care is a breach of confidentiality

The Resident Assessment Instrument (RAI) User's Manual, Version 1.10, Chapter 1, page 1-8, states:

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

Documentation and the MDS

There are many areas of the MDS where the MDS can be a source document, meaning that there does not need to be duplicative entries in the clinical records. An example is a resident interview (BIMS, Preferences, Pain, and PHQ-9°). Although there are other areas of the MDS where the data are found, the MDS itself is a compilation of data found in the medical record, such as therapy minutes and days MDS item O0400, or restorative nursing O0500. In these situations, the MDS is used as a tool to gather and summarize the data for the purpose of setting reimbursement levels. This documentation becomes documentation by inclusion.

MDS 3.0 and the interdisciplinary team collaboration

CMS does not specify process or assign specific disciplines to complete specific MDS items; this is a decision left to the individual provider. As such, although nursing homes have flexibility in completion of

the RAI, some aspects of the process are dictated by regulation. Federal regulations at 42 CFR 483.20 (b) (1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status, (2) an RN conducts or coordinates each assessment with the appropriate participation of health professionals, and (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Specific state professional practice acts may limit who can complete portions of the MDS 3.0, the CAAs, and the care plan.

However, nursing homes are left to determine (1) who should participate in the assessment process, (2) how the assessment process is completed, and (3) how the assessment information is documented while remaining in compliance with the requirements of the federal regulations and the instructions contained within this manual.

There are some items that lend themselves to being completed by a particular person or discipline, whereas others are not as definitive. In this book, we are addressing the restorative process. The restorative process is not only the job of the therapists; nursing also plays a significant role in the rehab process. At times, the rehab process may rely heavily on social services to work with the resident and/or families to provide encouragement or to identify that the reality of the rehab process may not be discharge; therefore, discharge planning goals may need to be altered.

"Interdisciplinary" refers to an approach to resident care that involves the input of different disciplines (e.g., nursing, social services, medical services, and physical therapy) to ensure the best possible outcome for a resident. An interdisciplinary approach provides a holistic view of the patient, because each discipline has something unique to contribute to the plan of care. By definition, all work that is not interdisciplinary is considered intradisciplinary.

The common place to identify interdisciplinary versus intradisciplinary documentation is in the care plan. An intradisciplinary care plan will include related factors identified as separate problems (e.g., nutritional deficit, swallowing alteration, failure to follow SLP food texture recommendations). An interdisciplinary care plan would have one problem statement: Potential for nutritional deficit and aspiration due to swallowing alteration secondary to status post (SP) CVA; resident and family are noncompliant with texture recommendation of SLP.

"Collaboration" is the act of working together toward a unified goal. The process is used when the PT establishes a plan of care for a hip fracture rehab resident. Upon evaluation, communication is provided

to the nursing staff to identify the limitation on the nursing unit as well as to identify the activities the resident should be doing independently or with nursing assistance.

In the same manner, it is important not to delegate portions of the MDS to members of the interdisciplinary team that may not record the most accurate picture of the resident. Many times, facilities look to therapy to delegate completion of sections of the MDS other than Section O. A section that is often attempted to be delegated to therapy is Section G, Functional Status. Although therapy often has a lot of information about these activities, patients tend to perform at their best while in therapy sessions; with encouragement, skilled facilitation, and cueing, the resident can often be at his or her best. This status is often different from the level of assistance the resident is able to perform these activities around the clock. Their transfer status during therapy at 9:30 a.m. is most often better than at 2:15 a.m., when they wake during the night and have to use the bathroom. Nursing has the best first-hand information of what level of assistance the resident needs around the clock and is most often the best resource for the Section G information.

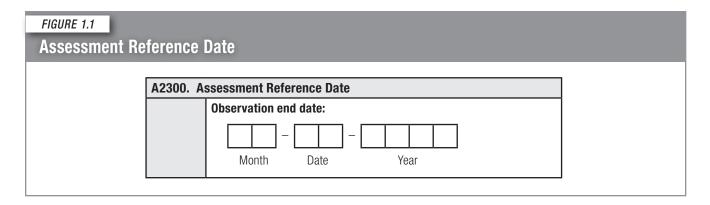
The MDS 3.0 Collaboration

There are many areas of the MDS that lend themselves to a collaborative interdisciplinary approach.

Assessment reference date selection

The assessment reference date (ARD), item A2300 (Figure 1.1), is key to the MDS process as well as reimbursement. ARD selection is best accomplished by a collaborative effort between the MDS coordinator and the therapy manager. When setting the ARD, there are many factors to be considered, such as:

- Therapy tolerance and ability
- Overall goals of therapy
- Resident schedule, such as medical appointments
- Medical/acute illnesses
- Prior level of function and activity



The ARD has limited flexibility, as the ARD can be changed only if the resident is in the Medicare assessment window and grace days. Once the grace days have passed, movement of the ARD is no longer possible. With the MDS 3.0, the movement of the ARD may also impact the ability of the facility staff to conduct the resident interviews.

A0310: Reason for Assessment

With implementation of the MDS 3.0, the new End of Therapy (EOT) and Start of Therapy (SOT) assessments are critical to Medicare billing. Interdisciplinary communication is critical regarding changes to resident therapy orders as well as resident refusals. In order to conduct the EOT assessment in a timely manner, communication between the MDS coordinator and therapy manager needs to occur daily. EOT assessments can easily be missed without timely communication.

PPS Other Medicare Required	I Assessment	
Enter Code	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment	

Section G: Functional Status

When coding item G0110 of the MDS, the intent is to identify the resident's participation as well as the maximum staff assistance provided during the look-back period. This involves both the nursing as well as the rehab staff.

Section G consists of two components: resident self-performance and staff support. Each is coded separately. The key to coding G0100 of the MDS is understanding the definitions and the subparts of each task. The MDS 3.0 definitions are not the same as what may be used in everyday conversation in the SNF (e.g., transfers to and from the toilet are not considered under transfer but rather are a part of toileting).

Coding self-performance

A resident's activity of daily living (ADL) self-performance may vary from day to day, from shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours per day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well). This may also occur between nursing and therapy staff.

ADLs are a two-part evaluation (ADL self-performance and ADL support), each using its own scale, and it is recommended that the self-performance evaluation be completed for all ADL activities before beginning the ADL support evaluation.

Coding instructions for G0110, column 1, ADL self-performance (RAI User's Manual, p. G-5)

- Code 0, independent, if resident completed activity with no help or oversight every time during the 7-day look-back period.
- Code 1, supervision, if oversight, encouragement, or cueing was provided three or more times during the past 7 days.
- Code 2, limited assistance, if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance three or more times during the past 7 days.

- Code 3, extensive assistance, if the resident performed part of the activity over the past 7 days, help of the following type(s) was provided three or more times:
 - Weight-bearing support provided three or more times
 - Full staff performance of activity during part but not all of the past 7 days.
- Code 4, total dependence, if there was full staff performance of an activity with no participation by the resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- Code 7, activity occurred only once or twice, if the activity occurred, but not three times or more.
- Code 8, activity did not occur, if, over the 7-day look-back period, the ADL (or any part of the ADL) was not performed by the resident or staff at all.

Instructions for the Rule of Three: (RAI User's Manual, p. G-4)

In March 2013, CMS clarified the Rule of Three. Consider the following from CMS:

- At this point, you can't just follow the algorithm. Even after reading the full 17-page section on
 coding G0110, professionals need to understand the Rule of Three and all of the coding guidelines
 in order to code accurately. Professionals are unable to use only the algorithm without reading the
 caveats within each box.
- According to the Rule of Three, when a level is provided three or more times, that is the level at which to be coded. (For more information, see Figure 1.3 on p. 13.)

Example 1: If a resident had the following, how should he or she be coded?

- One occurrence of limited assistance (code 2)
- One occurrence of extensive assistance (code 3)
- One occurrence of total dependence (code 4)
- Three occurrences of supervision (code 1) during the look-back period

According to a CMS memo issued to state RAI coordinators in March 2013, the resident should be coded with "supervision."

Rationale for this decision: Due to the fact that the threshold of three or more times of supervision was met, and there were not three or more instances of a single higher level, the correct code in such a scenario would be "1," indicating "supervision."

When an activity occurs three times at any one given level, code that level

When an activity occurs three times at multiple levels, code the most dependent.

For example, three times extensive assistance (3) and three times limited assistance (2)—code extensive assistance (3). Exceptions are as follows:

- Total dependence (4)—activity must require full assist every time
- Activity did not occur (8)—activity must not have occurred at all

For example, the resident may be totally dependent on the nursing unit for transfers utilizing a mechanical lift and does not ambulate, although in the therapy gym, the resident is standing in the parallel bars and ambulating with assistance from the PT and PTA after transferring with a maximum assist of two from the wheelchair to a standing position. This occurred on four occasions during the look-back period. This would be coded:

- Transfers self-performance (3)
- Staff support (3)

Coding ADL support

Code the greatest degree of support even if it has only happened once. Remember that only SNF staff support can be coded. Coding of support provided by ambulance attendants, family, or hospice workers cannot be coded as ADL support.

Code 0, no set up or physical help from staff, if resident completed activity with no help or oversight.

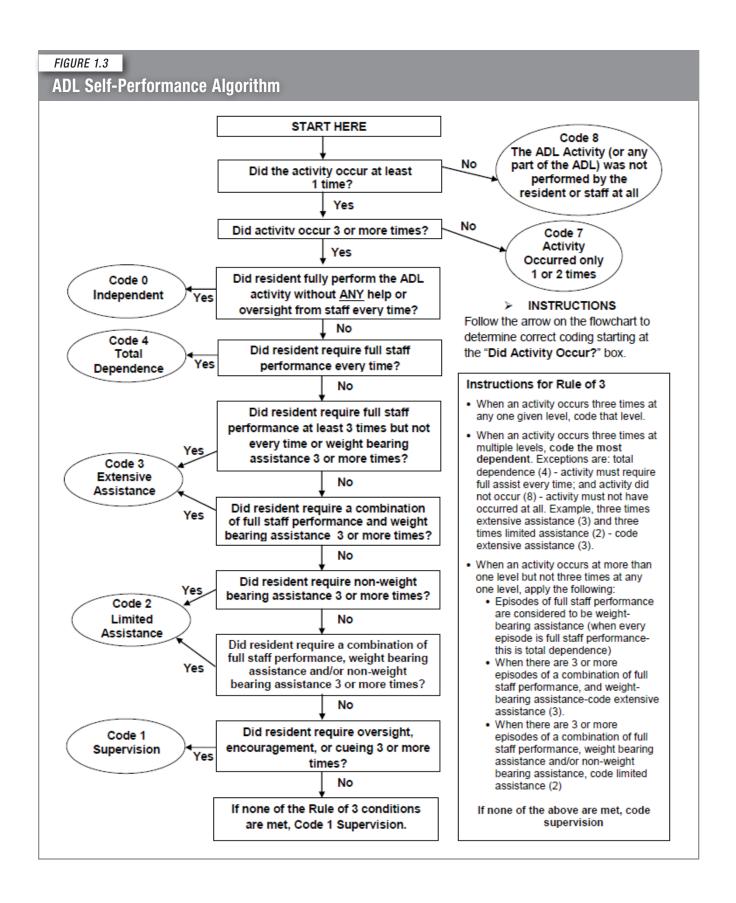


FIGURE 1.4

G0110: Activities of Daily Living (ADL) Assistance

SECTION G: FUNCTIONAL STATUS

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

G0110: Activities of Daily Living (ADL) Assistance

G0110. Activities of Daily Living (ADL) Assistance		
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding		
Instructions for Rule of 3		
 When an activity occurs three times at any one given level, code that level. When an activity occurs three times at multiple levels, code the most dependent, exceptions are to every time, and activity did not occur (8), activity must not have occurred at all. Example, three time assistance (2), code extensive assistance (3). When an activity occurs at various levels, but not three times at any given level, apply the following 	es extensive assistance (3) : j:	
 When there is a combination of full staff performance, and extensive assistance, code extensive as When there is a combination of full staff performance, weight bearing assistance and/or non-weight none of the above are met, code supervision. 		e limited assistance (2).
 ADL Self-Performance Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time 	 ADL Support Provide Code for most supposhifts; code regardles performance classified 	ort provided over all ss of resident's self-
Coding:	Coding:	
Activity Occurred 3 or More Times	0. No setup or phys	ical help from staff
Independent - no help or staff oversight at any time	Setup help only	•
Supervision - oversight, encouragement or cueing	One person phys	ical assist
Limited assistance - resident highly involved in activity; staff provide guided maneuvering	3. Two+ persons ph	
of limbs or other non-weight-bearing assistance		f did not occur during
Extensive assistance - resident involved in activity, staff provide weight-bearing support Total dependence - full staff performance every time during entire 7-day period	entire period	
Activity Occurred 2 or Fewer Times	-	_
 Activity occurred only once or twice - activity did occur but only once or twice Activity did not occur - activity (or any part of the ADL) was not performed by resident or 	1. Self-Performance	2.
staff at all over the entire 7-day period	↓ Enter Code	Support es in Boxes.↓
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)		
C. Walk in room - how resident walks between locations in his/her room		
D. Walk in corridor - how resident walks in corridor on unit		
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident		
corridor on same floor. If in wheelchair, self-sufficiency once in chair F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas		
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F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding,		
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)		
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding,		

- Code 1, set up help only, if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- Code 2, one person physical assist, if the resident was assisted by one staff person.
- Code 3, two+ person physical assist, if the resident was assisted by two or more staff persons.
- Code 8, ADL itself did not occur during the entire period, if, over the 7-day look-back period, the ADL activity was not performed by the resident or staff at all. For example, a resident is being seen by physical therapy. The resident is nonambulatory on the nursing unit and uses a sit-to-stand lift for all transfers with two nursing staff. Transfers occur three to four times per day. While in therapy, the resident is being transferred from WC to parallel bars by one therapy staff. This transfer has occurred daily for the past 3 days. The MDS would be coded as a 3 for staff support.

Resolving contradictions with Section G of the MDS

Section G of the MDS is the most common area for contradictions to be found between nursing and nursing assistants, as well as therapists. In completing the MDS 3.0, review of the documentation is only one method of collecting data for scoring a given item on the MDS 3.0. Staff and family interviews are another means of gathering data to complete the MDS. CMS does not have specific requirements on documentation to support Section G of the MDS, although your state Medicaid agency may have specific requirements.

When reviewing ADL documentation, a facility may have manual or computerized tracking for care provided. There are typically variations between shifts as well as staff regarding the documentation. When these discrepancies occur, the best solution is to interview the direct care staff involved. At that time, ask specific questions to clarify the degree of dependence or independence of the resident. If necessary, a "clarifying entry" may need to be made to clarify: "based on staff interview, the MDS is scored as a 3 for self-performance with transfer, as resident can and does participate with transfers at times but is inconsistent in performance."

An easy way to double-check that the functional status is consistent between therapy and nursing is during the Medicare meeting. Therapy should be giving a brief functional overview and nursing should be aware of how their documentation is reflecting patient status, identifying whether there are inconsistencies. If

these are discovered, the group needs to determine why or how the patient is doing better for the other discipline and find a way to agree for accuracy.

Section 0: Special Treatments, Procedures, and Programs

Therapists are typically responsible for the collection of O0400 therapy minutes by mode (individual, concurrent, group) and treatment days for the MDS. The process of how these data are collected and entered on the MDS varies greatly by facility based on automation or lack of automation.

Therapy minutes and days are critical to the calculation of the resource utilization group IV (RUG-IV) score for Medicare payment purposes. Many states use RUG-III or RUG-IV data for calculation for Medicaid purposes. When calculating the RUG score that involves therapy minutes, the following applies:

- Add the individual minutes (O0400A1)
- One-half of the concurrent minutes (O0400A2)
- One-fourth of the group minutes (O0400A3) (Note: limitation on group therapy below)
- Record as total minutes

When the 25% group therapy limitation applies (i.e., for Medicare Part A residents), calculate the adjusted total minutes as follows:

- If group minutes (O0400A3) divided by total minutes is greater than 0.25, add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0, divide by 3.0, and record as adjusted minutes.
- Individual minutes—Enter the total number of minutes of therapy that were provided on an individual basis in the past 7 days. Enter 0 if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- Concurrent minutes—Enter the total number of minutes of therapy that were provided on a concurrent basis in the past 7 days. Enter 0 if none were provided. Concurrent therapy is defined as the treatment of two residents at the same time when the residents are not performing the same or

similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.

- Group minutes—Enter the total number of minutes of therapy that were provided in a group in the past 7 days. Enter 0 if none were provided. Group therapy is defined for Part A as the treatment of two to four residents, regardless of payer source, who are performing similar activities and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
- Days—Enter the number of days therapy services were provided in the past 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine whether the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. Enter 0 if therapy was provided but for less than 15 minutes every day for the past 7 days. If the total number of minutes (individual plus concurrent plus group) during the past 7 days is 0, skip this item and leave blank.
- Therapy start date—Record the date the most recent therapy regimen (since the most recent entry) started. This is the date the initial therapy evaluation is conducted regardless of whether treatment was rendered or not.
- Therapy end date—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

O0500, Restorative nursing, is typically collected by the nursing assistants/restorative aides providing the treatment and coded on the MDS by the MDS coordinator.

esident	Identifier Date			
Section O	Special Treatments, Procedures, and Programs			
00400. Therapie	A. Speech-Language Pathology and Audiology Services			
Enter Number of Minutes 1. Individual minutes - record the total number of minutes this therapy was administered to the rein the last 7 days				
Enter Number of Minutes	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days			
Enter Number of Minutes	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days			
	If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date			
Enter Number of Minutes	3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days			
Enter Number of Days	4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days			
	 5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing 			
	Month Day Year Month Day Year			
	B. Occupational Therapy			
Enter Number of Minutes Enter Number of Minutes	Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the resident			
Enter Number of Minutes	 concurrently with one other resident in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days 			
	If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date			
Enter Number of Minutes	3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days			
Enter Number of Days	4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days			
	5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing			
	Month Day Year Month Day Year			
O0400 continu	ued on next page			

sident	Identifier Date			
Section O	Special Treatments, Procedures, and Programs			
00400. Therapies - (Continued			
_	C. Physical Therapy			
nter Number of Minutes	 Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days 			
nter Number of Minutes	Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days			
nter Number of Minutes	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days			
	If the sum of individual, concurrent, and group minutes is zero, → skip to 00400C5, Therapy start date			
nter Number of Minutes	3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days			
inter Number of Days	4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days			
	5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing			
	Month Day Year Month Day Year			
D	D. Respiratory Therapy			
inter Number of Minutes	 Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy 			
	2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days			
Inter Number of Minutes	Psychological Therapy (by any licensed mental health professional) Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days.			
	If zero, → skip to O0400F, Recreational Therapy			
inter Number of Days	2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days			
_	Recreational Therapy (includes recreational and music therapy)			
inter Number of Minutes	 Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy 			
inter Number of Days	 Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days 			
20420 Distinct Cale	endar Days of Therapy			
Inter Number of Days	- · · · · · · · · · · · · · · · · · · ·			
	Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.			
	of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99			
Therapy	evious rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End o			
1. Yes	P Sup to 00500, Restorative Nursing Programs			

Section I: Active Diagnoses

Coding of diagnosis continues to be an ongoing challenge in SNFs. The Cooperating Parties (American Hospital Association [AHA], American Health Information Management Association [AHIMA], CMS, and NCHS) and the Editorial Advisory Board for Coding Clinic for the ICD-9-CM releases the ICD-9-CM Official Guidelines for Coding and Reporting annually, most recently updated in October 2012. This document can be found at www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm. During the fourth quarter of 2012, Coding Clinics reissued the Coding Clinic, which specifically addresses ICD-9-CM coding in SNFs originally issued in 1999. The Coding Clinics are available from the American Hospital Association.

Coding Clinics are a set rules that have been developed by the Cooperating Parties to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. The instructions and conventions of the classification take precedence over the official guidelines. Adherence to Coding Clinics and the Official Guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The diagnosis codes (Volumes I and II) have been adopted under HIPAA for all healthcare settings. Volume III procedure codes are not used in SNFs.

The MDS 3.0 gives additional instruction to the coding of diagnosis on the MDS 3.0. The *Official Guidelines for Coding and Reporting* must be followed in addition to meeting the criteria of the *RAI User's Manual* in relation to active versus inactive diagnosis.

The MDS 3.0 identifies that only active physician documentation (in the past 60 days) can be coded on the MDS. The discharge summary and the resident's history and physical identify many diagnoses present on admission that are being treated medically. These documents are usually not specific to the treating diagnosis used in therapy to describe the symptoms that they are treating.

In scoring the MDS review, the therapy evaluation/plan of care, the therapist will include medical and treating diagnoses on these documents. Treating diagnoses are commonly symptoms versus medical diagnoses. Frequently, diagnoses may be found within physician progress notes or new orders, including telephone orders.

For example, the therapist is not treating the cerebrovascular accident (CVA), but rather, he or she is treating the balance, gait disturbance, aphasia, and dysphasia that are a result of the CVA. These are diagnoses that can be scored on the MDS 3.0 as reimbursement, which requires that the plan of care be signed by the physician.

Many times, the therapy treating diagnoses are found as symptoms in the ICD-9-CM codes.

It is important to ensure that, if therapy is treating certain conditions, a diagnosis is identified and made/ confirmed by a physician/approved NPP. If speech therapy is providing interventions for dysphagia and swallowing problems, there should be a corresponding diagnosis present in the medical record to support these services.

Be sure to include these medical and treating diagnoses in I8000 of the MDS if not already selected in Section I.

Section I coding tips

In the ideal setting, every time a new problem/diagnosis is identified, the nurse on duty would add it to the cumulative diagnosis list. Knowing that this is not a reality in all settings, an alternative is to:

- Thoroughly review the medical record at least quarterly to identify new problems or conditions. Update the cumulative diagnosis list as well as Section I of the MDS 3.0 at that time. There are many formats to maintaining a cumulative diagnosis list. The following are some items that are key and that facilities will find helpful:
 - Date of the diagnosis
 - Date of resolution of the diagnosis
 - Source of the diagnosis (hospital record, progress note, consult report, etc.)
 - Identification of the diagnosis as current, history, or resolved

Common errors in coding Section I of the MDS:

- Only the hospital discharge diagnosis list is coded
- Acute/self limiting diagnoses that are active problems are not coded
- Acute problems are not removed from subsequent MDSs if resolved

Resident Falls

The definition of falls in the RAI 3.0 User's Manual, Version 1.10, states:

Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.

Falls include any fall, no matter whether it occurred at home, while out in the community, or in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him- or herself or had not been intercepted by another person—this is still considered a fall.

Communication between nursing and therapy is critical to capturing fall status on the MDS 3.0. Intercepted falls are frequently undercoded on the MDS 3.0, because those intercepted falls that occur during a therapy treatment session may not be reported to nursing or specifically documented in therapy documentation.

When documenting a fall, organizations may have specific forms that need to be completed or the documentation may be done completely as a narrative. The following are considerations when documenting a fall.

Include the following:

- The patient's condition when you found him or her; you wouldn't assume he'd fallen. For example, the resident was found on the floor next to the bed, with his or her head resting on the bed.
 - Identify any safety devices being utilized at the time (e.g., pressure pad on chair)
 - Any direct quotes from the resident, including complaints or denials of pain (e.g., "I was reaching for my Kleenex box and I slid out of bed")
 - What the resident says he or she was doing (valid or not) (e.g., "I was looking for my mother; I just saw her coming out of the bathroom")
 - Your physical assessment findings (e.g., position of the resident, any signs/symptoms of injury, range of motion, pain, etc.)

- Safety initiatives taken to prevent harm or further harm to the patient (e.g., efforts taken to contact the physician to evaluate the patient)
- The time the physician was called
- Time contact with physician was actually made
- Any diagnostic studies performed as a result of the fall and the results of the studies
- Contact made with the patient's family and what was said to them

If, upon completion of the MDS, it is identified that a fall occurred, it is important to identify the reason for the fall and see whether it can be corrected with environmental adaptation. Referral for a screen for therapy is an important step if a pattern is identified or the skills of a therapist are needed to help identify intervention to give the patients their best outcomes.

Section J: Health Conditions

Although the MDS 3.0 assesses pain via the resident interview process, clinical assessment (nursing and therapy) is critical to resident outcomes. Residents need to be continually reassured that pain does not need to be tolerated and that short-term pain medication use does not lead to dependency.

Because the presence of pain and how it is being addressed influences payment with the MDS 3.0, it is important to have a mechanism of communication between therapy and nursing so that this information is communicated accurately and timely. Pain is often a common occurrence during the rehabilitative process. If a patient is voicing pain during therapy treatment, the therapist should be documenting the report and trying to get an associated objective measurement for the pain and have a response. The response could be a variety of things, including notifying nursing for delivery of as-needed pain-relieving medication, scheduling therapy around medication administration, providing modality intervention for pain relief (ultrasound, electrical stimulation, etc.), or allowing the patient to rest and modifying the treatment interventions to not aggravate the pain response. If pain is being voiced by the patient during therapy, therapy needs to communicate this to nursing so it can be dealt with.

Coordination between therapy and nursing is critical for pain relief for many of the short-term rehabilitation residents being cared for in SNFs today. Pain relief begins with a therapy schedule so that nursing is

able to premedicate residents prior to the start of therapy. Pain during therapy limits the progress of the resident and does not need to be present.

For example, a patient with a joint replacement may have scheduled pain medication that is delivered at 8:00 a.m. and 1:00 p.m. during the day. Scheduling occupational therapy at 8:45 and physical therapy at 1:45 would be in the patient's best interest to allow them to participate in therapy with the least amount of pain with the help of medication.

Benefits of Nursing and Therapy Collaboration

The struggle to develop a strong relationship between nursing and therapy is not one that is isolated. Regardless of whether your therapy services are contracted to an outside agency, in-house, or contracted with an owned subsidiary company, there is often a struggle to communicate and collaborate together. There can be a multitude of factors that contribute to this disconnect. Some of them are:

- Practice patterns: Nursing is an around-the-clock responsibility and is staffed that way. They have primary responsibility for the patient and, therefore, deliver their care 24/7, whenever resident need indicates. On the other hand, therapy services are given in a session or visit format: We interact with the resident for a set interval of time, a certain number of days per week. Because of this, therapy has a limited exposure to resident performance and may have a different perception of status.
- Perception: Because the professions of nursing and therapy focus on different aspects of the patient's status (i.e., medical versus functional), we often perceive things differently. For example, therapy may see someone as functionally unsafe with ambulation activities because of the decreased response to balance challenges and safety concerns, but nursing may not perceive the same deficits or level of risk. Nursing may see that the patient does not appear to have any instability in their medical status but may not notice that they are not achieving good clearance during the swing phase of gait on the left side, which may put the patient at increased risk for falls because of the sensation loss from the sustained CVA.
- Language: Therapy and nursing by training use different terms to describe levels of assist. Therapy usually uses terms such as "minimal," "moderate," and "maximum," and nursing usually uses terms like "limited" and "extensive assist." This can set up a conflict of documentation and perception of resident status in the medical record and in communication.

MDS Terminology vs. Therapy Terminology

MDS SCORE	MDS TERMINOLOGY	THERAPY TERMINOLOGY	THERAPY DEFINITION
0	Independent	Independent	No physical or cognitive assistance required.
1	Supervision	Supervision/ Stand By Assistance	Therapist is needed for supervision for safety and performance specifics.
2	Limited Assistance	Contact Guard	Therapist is in contact with patient via gait belt, just in case physical assistance is needed.
3	Extensive Assistance	Minimal Assistance	Therapist provides 25% of physical output needed for task; patient does 75% of work.
3	Extensive Assistance	Moderate Assistance	Therapist provides 50% of physical output needed for task, patient does 50% of work.
3	Extensive Assistance	Maximum Assistance	Therapist provides 75% of physical output needed for task, patient does 25% of work.
4	Total Dependence	Dependent/ Total Assistance	Therapist provides 100% of physical output needed for task, patient does 0%.

- Location of departments: Therapy services are most often in a separate department, commonly in basements and away from the general resident room activity. Often, this physical separation can be challenging to keep the teams coordinated. To overcome this environmental challenge, therapy staff can make an extra effort to work with patients on the "unit" at times so that they can be visible to the nursing staff and interact. In addition, participating in care conferences and the morning report can serve to bridge the communication gap. Many sites have turned to e-mail or software programs such as "electronic whiteboards" where the members of the team can informally communicate in a HIPAA-protected way to coordinate patient care.
- Time constraints: Both nursing and therapy staff are busy. Everyone is focused on giving care, responding to resident needs and requests, and documenting. Neither nursing nor therapy has free

time, so sometimes communication and collaboration can suffer as a result. To this end, both nursing and therapy need to make a concerted effort to have their conversations be short and pertinent. Avoid "chit-chat" during busy times and keep communication relevant to patient care. Although it is valuable to develop personal relationships between nursing and therapy, try to do this during breaks or lunch, when the pressure is temporarily alleviated.

- Scheduling challenges: Therapy often sees patients at scheduled treatment times, which can be cumbersome to work around from a nursing perspective. The conflicts that arise can strain the relationship between nursing and therapy. Using a schedule works best when everyone agrees they are accountable to the schedule. The following are common ways a facility has problems "sticking to the schedule":
 - Therapy not providing treatment at their scheduled time
 - Therapy trying to see the patient when they are not scheduled
 - Nursing not having the patient ready for therapy
 - Nursing scheduled other activities or nursing procedures during a scheduled therapy session

This disregard for the schedule often means "tense" situations between therapy and nursing and also frustration on behalf of the patient, because what they are expecting is not happening.

There are undoubtedly many more reasons collaboration can be challenging in long-term care. However, it is time to shift to why collaboration between therapy and nursing is so important.

Optimize Care and Resident Outcomes

When therapy and nursing work together and collaborate, there are usually many positive results. The first benefit that it creates is that care is optimized and the resident usually achieves a positive outcome. When we think of optimal resident care, we think of the resident receiving all the services and care that are necessary for him or her to achieve his or her fullest potential. This is not only to benefit the patient's medical and functional status but is also important to provide excellent customer service. The resident will have a positive impression that the facility is all on the same page and focused on his or her individual recovery.

Interdisciplinary collaboration is essential to generate successful outcomes for patients. However, effective collaboration requires that disciplines have a thorough understanding of team members' respective roles, use their team members' expertise effectively, and have a willingness to work together to solve problems and integrate interventions (Touchard & Berthelot, 1999). Another study, performed at Gold Coast Hospital, identified that an intense nursing-therapy collaborative effort resulted in an overall reduced incidence of falls and related injuries (Brandis, 1999).

It is clear to most that the resident benefits when therapy and nursing collaborate and work together. In longterm care, the success of this relationship becomes clearer under MDS 3.0. We can see a successful resident outcome when a resident recovers medically and physically from his or her illness or injury and returns to his or her place of previous residence. The RAI User's Manual acknowledges this importance by stating (p. 1-4):

The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being.

Improved reimbursement

Nursing and therapy collaboration can be fully realized in financial terms as well. The MDS 3.0 document is developed as a care plan tool for the long-term care resident, but it is also used to determine payment. When the tool is completed and fully captures the care provided to the resident, the payment should be reflected accordingly. The RAI User's Manual explains this as follows (p. 6-2):

The MDS assessment data is used to calculate the RUG-IV classification necessary for payment. The MDS contains extensive information on the resident's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-IV groups that form a hierarchy from the greatest to the least resources used. Residents with more specialized nursing requirements, licensed therapies, greater ADL dependency, or other conditions will

be assigned to higher groups in the RUG-IV hierarchy. Providing care to these residents is more costly and is reimbursed at a higher level.

Therefore, a facility should expect to receive more reimbursement if it is accurately giving the resident all the necessary services and capturing those on the MDS tool.

The interesting challenge of MDS 3.0 is from the reimbursement perspective. Most SNFs provide the care the resident needs at the appropriate time but struggle with communicating and recording this on the MDS in order to trigger a higher case mix level and corresponding reimbursement. This resource is designed to help highlight where collaboration and communication are key to ensuring that those opportunities are documented and identified so the business can receive the payment that it deserves.

Survey Success

The annual survey is an extremely stressful time for all staff. The best preparation for a survey is to be prepared at all times. Every day should be considered a survey day. When facilities change practices because surveyors "are in the building," stress increases as staff act in a manner that is not the "norm," resulting in errors and possible survey deficiencies. Keys to survey success include:

- Communication among staff: Remember to let all staff members, including therapy and consultants who may not be in the facility daily, know that the survey process is occurring. Include your therapy manager in morning meetings and daily exit conferences, as well as the survey exit conference.
- Communication with surveyors: Do not answer a question that you are not 100% sure of the answer. It is okay to say, "I do not remember that specific situation. Can I review my documentation regarding that situation?" It is also acceptable to say, "I do not know the answer but I know who would" and assist the surveyor to find the appropriate staff member. If a surveyor asks, "Are all residents turned and positioned every 2 hours?" do not respond for all staff. Instead, indicate that, "I can only speak for the care I provide the residents assigned to my care. I turn and reposition residents under my care based on their care plans." If you do not understand the question being asked, do not answer. Ask for clarification: "That is an abbreviation I am not familiar with. Does it have another name or can you tell me the content you are looking for?"
- Stick to the facts: When responding to questions from a surveyor, ensure that the answers you give are factual in response to their question and do not include any personal opinions as to the

performance of others. As commonsensical as it sounds, staff members need to be reminded to keep their answers to the point and resist the urge to comment on facility-specific internal matters.

- Keep the routine: Do not cancel staff meetings, in-services, and resident activities during the survey process. Continue the routine; it will be less disruptive to all.
- Do not add staff members: For example, during the entrance conference, the facility has given the survey team a copy of staffing for a two-week period. Sudden increases in the number of staff members will be noticed. Also, pulling additional staff into the dining room who normally do not work there will likely result in errors or staff saying, "The only time we see them is when you are here."
- Educate: Provide all staff, residents, and families education on the survey process at least annually. Include the following topics in your training:
 - Survey process
 - Communication with surveyors
 - Right to request a witness to conversations
 - Resident right to refuse observation by a surveyor

Keep in mind the following tips:

- Do not argue with a surveyor.
- Do not make excuses.
- Do not get defensive or take the findings personally. Instead, address the issues that are cited.
- Do not wait until you are in the survey window to make sure you are "survey ready." Compliance should be a year-round activity, so when the survey team does arrive, everyone is aware that it is business as usual.
- Do not compromise on issues of professional practice, ethics, or quality care.

- Do not alter a medical record. Medical records are legal documents. Changing or falsifying a medical record can result in citations or fines that can lead to termination or removal from the ability to participate in a Medicare program or to imprisonment.
- Do not attempt to recreate missing documentation.
- Do not sign your name to something that you are unsure is accurate.

In addition, it is important for all members of the team to understand how to conduct themselves during a survey process. Although the department head or manager may understand how to be professional when approached by a surveyor, it is rare that the surveyor only talks with the manager. In-service and train all staff members on how to respond and conduct themselves regardless of whether surveyors are present.

Positive Working Environment

Reimbursement, regulations, and resident need aside, the real value of good communication and collaboration between nursing and therapy is a positive work environment. Webster's dictionary defines collaboration as "to work jointly with others or together, especially in an intellectual endeavor." When nursing and therapy work together and collaborate, it creates a working environment where people are focused on the resident. It eliminates petty arguments and other distracting behaviors and keeps all members of the team focused on the resident.

There are seven keys to helping facilitate a healthy workplace relationship between therapy and nursing.

- Have a positive attitude: Avoid negative thoughts and verbalizing criticisms of another's performance. Be less judgmental and more accepting of others.
- Do not jump to conclusions: Gather as much information as possible before forming an opinion. Reacting defensively to situations without knowing the whole story can cause misunderstandings and negative feelings. Stating these judgments out loud can involve others into the situation, creating more negativity.
- Improve your communication skills: Listen carefully and focus on what the speaker is saying. This will allow you to respond appropriately. Use a communication technique called active listening. This involves waiting until the other person is finished speaking and repeating it back to them to ensure there is no misinterpretation.

- Resolve conflicts early on: When a negative situation does arise, don't dwell on it. Be to the point, but polite. Develop a course of action to address the problem or situation. Then work with your coworker toward resolving the problem before bringing it to your supervisor. Do not avoid the situation. This delay will often result in the issue growing into more than it needs to be.
- Set boundaries: It is important to set boundaries to ensure that work friendships do not interfere with your duties. Avoid having discussions about work and work-related issues on personal time.
- Treat ALL coworkers with respect: Do this by actively listening and responding at the right time. Always be polite. Allow those around you to be open and honest, and you should do the same.
- Understand and accept personal or cultural differences: Try looking at things from your coworkers' perspective. Even if you don't always see things the same, be understanding and respectful (Stanford Chinese Institute of Engineers, 1999).

Benefits of Collaboration

The many benefits of collaboration between nursing and therapy far outweigh the effort needed to achieve it. The first step is to have both nursing and therapy invested and on board. It takes only a few people to poison a department and a facility dynamic. Management needs to be vigilant in its coaching to ensure team members are treating one another appropriately and disciplining and removing those who are barriers to the process. When all the ingredients are in place, everyone wins: residents, staff, and the business alike.

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SNF Nursing and Therapy Collaboration

OPTIMIZING COMPLIANCE, REIMBURSEMENT, AND DOCUMENTATION

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