Team Documentation

• The goals of the team documentation are:
  ▪ Tell the story of the patient's stay
  ▪ Communicate why you made the treatment decisions for care rendered
  ▪ Indicate how the patient progressed
  ▪ Present the barriers to discharge or safety concerns throughout the stay
  ▪ Let the service provider treating the patient next know what to expect
Team Documentation

- **Proving necessity of the skilled service:**
  - Reviewers look for evidence that the patient requires continued skilled services. This is shown through the treatment/progress notes.
    - Write progress notes that clearly explain the skilled services delivered in each treatment session.

Team Documentation

- **Team has an ongoing opportunity to document medical necessity. This is achieved by documenting:**
  - That services needed are of such a complex nature that they require a licensed clinician
  - Services are consistent with diagnosis, need, and medical condition
  - Services are consistent with the treatment plan
  - Services are reasonable and necessary
  - Patient is making progress towards reasonable goals
Plan of Care

- **How do you develop a plan of care?**
  - Physician plan drives the plan of care for clinicians
  - All clinicians document consistent findings
  - Goals are clear, measurable, functional

- **How do you document the plan of care?**
  - All clinicians document on their evaluations
  - Everyone is aware of the team goals and supports them through treatment

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**Establishing barriers:**

- Plan of care should answer these questions:
  - Why does the patient need an inpatient rehabilitation stay?
  - What difference will inpatient rehabilitation make in this patient’s quality of life?

- Problem list:
  - List the problems requiring post-acute services
  - Indicate which professionals will work on reducing the barriers
  - Set goals for how much progress will be made
  - Indicate time frame for resolving the barriers
Plan of Care

• Goal setting:
  ▪ Team goals (long-term)
    • Represent what it will take for the patient to reach their discharge goal
    • Will require care or carry-over from the team to achieve
    • Nursing goals tend to be task driven and prevention related
  ▪ Discipline-specific goals (short-term)
    • Should link to long-term team goals
    • Must be objective
    • Divide into processes for nursing

Examples of incremental short-term goals:
  ▪ Skin integrity
    • Create positioning schedule or plan
    • Implement schedule or plan
    • Educate patient on positioning and maintaining skin integrity
    • Monitor for breakdown and compliance
    • Outcome: Maintain skin integrity
  ▪ Medication management
    • Establish medication schedule
    • Education patient on medications, risks and side effects, dosage and schedule
    • Observe medication administration, identification of medications, side effects, dosage, schedule
    • Outcome: Maintain overall health or be free of infections
• **Examples of incremental short-term goals:**
  - Bowel program:
    - Initiate bowel management program
    - Educate patient on program and schedule
    - Advance as appropriate
    - Outcome: Regular elimination
  - Pain management program:
    - Determine ideal pain level
    - Establish medication schedule
    - Educate on alternative pain relief techniques
    - Educate on pain reduction strategies
    - Advance to self-management of pain control
    - Outcome: Patient will be free from pain

• **Continuity**
  - Plan of care should be the guiding force for treatment decisions throughout the stay
    - Update weekly at team
    - Ensure that team is on target with established goals
    - Reorient team to long-term goals if treatment plan seems to be taking a different course
    - Adjust plan of care goals as necessary
Nursing Notes

• Nursing progress summaries:
  ▪ Summarize the week’s progress prior to or as a part of the team conference note
  ▪ Include reasons for progress or lack thereof
  ▪ State focus for the next week
  ▪ Ensure that these summaries and focus goals coincide with the plan of care

Nursing Notes

• Ongoing documentation of skilled services:
  ▪ Use skilled terminology and objective measurements in documentation to show functional progress and improved safety as a result of the delivery of skilled intervention.
    ▪ Examples include:
      ▫ Assessment of performance
      ▫ Adaptation of the task or environment
      ▫ Training in the use of adaptive equipment
      ▫ Use of specialized treatment techniques
      ▫ Adjusting the treatment program as the patient’s condition changes
      ▫ Providing analysis of performance and skilled feedback on performance
• **Ongoing documentation of skilled services:**
  - Document that the patient is able to follow directions, retains the skills learned, and shows carryover of the learned skills into other functional areas.
  - Justify the need to continue treatment based on progress, treatment goals, and functional level needed at discharge.
  - Explain any setback or lack of progress while supporting that the patient retains good potential to achieve the set goals.

• **Rehabilitation nursing services are necessary 24/7**
  - Nursing plan addresses rehabilitation needs of the patient
  - Supports medical management as laid out by physician
  - Addresses education needs of the patient
    - This one is more important than ever given the emphasis on avoiding re-admissions
  - Establishes continuity of care among the team
• **Daily Documentation:**
  - Daily system assessment
  - Notes that state
    - Care rendered
    - Patient’s response to care
    - Patient's performance in areas where functional deficits exist
    - Education provided
      - Specific to disease management, prevention, caregiver awareness, medication administration, etc
    - Patient/family’s response to education

• **FIM Scoring**
  - Are you scoring daily?
  - Starting when?
  - Which items?
    - Minimum requirements (in my humble opinion):
      - Eating
      - Toileting
      - Bladder
      - Bowel
      - Bed transfers
      - Toilet transfers
Nursing Notes

• **Functional Performance Examples:**
  - Patient showed no signs or symptoms of aspiration while taking noon meds with nectar thick liquids.
  - Patient required moderate assistance while transferring to the toilet due to loss of balance.
  - Patient was reminded to keep his feet on the floor while transferring with sliding board as instructed by PT.
  - Patient experienced a bladder accident due to a urinal spill. Caregiver was needed to change the patient’s bed linens.
  - Patient required moderate assistance while bathing this morning due to increased pain. He was unable to wash lower extremities, buttocks, and perineal area.

Nursing Notes

• **Family/patient education examples:**
  - Patient has not exhibited improved performance with external cath placement. Family is discouraged, but willing to continue education in order to assist the patient at home.
  - Patient demonstrating signs of difficulty adjusting to disability. Nurse provided support group information to patient and wife.
  - Patient and family educated on blood sugar testing and monitoring. Family performed task with nurse supervising. More instruction with finger sticks is required.
  - Patient/family continue to require education regarding medication administration and signs/symptoms of disease exacerbation.
• **Showing progress:**
  - At least weekly, return to the established team goals.
  - Think of where progress has been made by stating current status compared to prior status.
  - Review previous notes to determine what burden of care was present earlier that is now resolved.
  - Consider how nursing interventions resulted in a positive outcome.

• **At least weekly, report the patient’s progress**
  - Document progress toward goals
  - Detail barriers to achievement of goals
  - Describe changes to the plan of care as appropriate
  - Describe patient’s response to treatment
  - State the justification for continued stay on the rehab unit
Therapy Notes

The Rule

• Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria
  • The patient’s condition must be sufficiently stable to allow the patient to actively participate in an intensive rehabilitation program and willing to participate in the program.
    • This does not mean the patient's medical conditions will be fully resolved. Rather, the requirement is that a patient's medical condition be such that it can be successfully managed in the IRF setting while the patient is participating in the intensive rehab therapy program.

Better outcomes for everyone.
The Rule

**Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**

- Must demonstrate that the following criteria were met at the time of admission to the IRF:
  - The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be PT or OT.

- The patient must generally require an intensive rehabilitation program: current industry standards are 3 hours of therapy per day at least 5 days per week.
  - CMS does not intend for this measure to be used as a “rule of thumb” for determining whether a particular IRF claim is reasonable and necessary.
  - In certain well-documented cases, this intensive program might instead consist of at least 15 hours of intensive rehab therapy within a 7 day consecutive period, beginning with the date of admission to the IRF.
  - CMS will provide guidance in manuals on additional instances in which they might find that the patient is receiving intensive rehab therapy services despite not receiving the generally expected intensity of therapy services for a brief period of time.
**The Rule**

**Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**

- The patient must generally require an intensive rehabilitation program: current industry standards are 3 hours of therapy per day at least 5 days per week.
  - The intensity of therapy provided must never exceed the patient's level of tolerance or compromise the patient's safety.
  - One on one (individualized) therapy is the standard of care for IRF patients. Group therapies are an adjunct. In instances in which group better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record.

Treatments must begin within 36 hours from midnight of the day of admission to the IRF.

Therapy evaluations constitute the beginning of the required therapy services and are included in the total/daily/weekly provision of therapies used to determine the intensity of therapy services.
The Rule

- Exceptions Policy: if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in therapy for a period not to exceed 3 consecutive days (e.g. extensive diagnostic tests off premises, prolonged IV infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's IRF medical record.
  - If appropriately documented in the patient's IRF medical record, such a break in service will not affect the determination of the medical necessity of the IRF admission.
  - Medicare contractors may approve brief exceptions to the intensity requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent pre-admission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

Better outcomes for everyone.

The Interpretation

- CMS Q&As:
  - "Therapy time" is time spent directly with the patient.
  - Breaks in therapy for up to 3 days should be explained in the record.
  - "Missed" time can be made up on another day.
    - For example, if a patient receives his or her intensive rehabilitation therapy program Monday through Thursday, but then refuses to participate in the last 30 minutes on Friday, the additional 30 minutes of "missed" therapy time can be made up on either Saturday or Sunday. In no case can the "missed" therapy time be made up in a different week; it must be made up within the same week (7 consecutive day period starting with the day of admission) that the "missed" time occurred. The reasons for the "missed" therapy time on Friday must be well documented in the patient's medical record at the IRF, and repeated refusals by the patient to participate in the intensive rehabilitation therapy program should prompt the interdisciplinary team to investigate further and consider discharging the patient to a more appropriate setting.

Better outcomes for everyone.
**The Interpretation**

**CMS Q&As:**
- Not providing weekend therapy jeopardizes your ability to provide intensive therapy services and puts you at risk for denial of the claim.
- The same rules apply for therapist illness and inclement weather.
- Time spent in family conferences cannot be counted toward the 3-hour rule.
- It is not acceptable to round the number of therapy minutes.
- Day of admission is DAY 1.
- There is no such thing as Medicare holiday.

**Therapy Documentation**

**Subjective - Statement provided by the patient about:**
- Rating of pain
- Patient’s goal
- Complaints or comments about tolerance of prior session
- Missed time and reason for variance
- Attempts to meet missed minutes
• **Objective - Actual treatment performed:**
  - Exercises
  - Activities
  - Modalities
  - Measurements
  - Standardized test results
  - Balance assessments
  - Communication with other team members
  - Education

• **Assessment - Skilled summary of the session:**
  - Clinical diagnoses
  - Review of the patient’s performance
  - Progress with interventions
  - Barriers to progress
  - Therapist’s conclusion of the patient’s performance
  - Appropriateness for continued care
  - Response to education and ongoing needs
• **Plan - Recommendations for following sessions:**
  - Hand-off communication of treatment strategies to next therapist
  - Changes in established treatment plan and goals
  - Changes in repetitions, weight, exercises
  - Alterations to frequency, duration
  - Addition of modalities
  - Educational needs and plans
  - Plan for making up missed minutes

**IRF-PAI Therapy Information**

• Reminder: Therapy minutes provided in week 1 and week 2 of the rehab stay should be reported
  - O0401A. Physical Therapy
    - a. Total minutes of individual therapy
    - b. Total minutes of concurrent therapy
    - c. Total minutes of group therapy
    - d. Total minutes of co-treatment therapy
  - O0401B. Occupational Therapy
    - a. Total minutes of individual therapy
    - b. Total minutes of concurrent therapy
    - c. Total minutes of group therapy
    - d. Total minutes of co-treatment therapy
  - O0401C. Speech-Language Pathology
    - a. Total minutes of individual therapy
    - b. Total minutes of concurrent therapy
    - c. Total minutes of group therapy
    - d. Total minutes of co-treatment therapy
**Definitions: Modes of Therapy**

- **Individual Therapy**
  - The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) to one patient at a time (this is sometimes referred to as "one-on-one" therapy).

- **Concurrent Therapy**
  - The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2 patients at the same time who are performing different activities.

- **Group Therapy**
  - The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2-6 patients at the same time who are performing the same or similar activities.

- **Co-Treatment Therapy**
  - The provision of therapy services by more than one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed therapist) from different therapy disciplines to 1 patient at the same time.
**Managing the data:**
- Where does the information come from?
- Who is validating the minutes?
- Is there consistency between the daily notes and the IRF-PAI total minutes?

Questions?
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