CAH Swing Bed Management

Rehab Model

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Components of a Quality SB Program

- Program implemented to meet patients' skilled needs
- Acute care management model to identify those acute care patients from your CAH who could benefit from skilled care
- Early and well-planned discharge process from acute
- Process for taking referrals from other hospitals and rapid decision making
- Pre-cert process for non original Medicare payors
- Rehab model
- Staff training specific to SB over and above acute care
- Strong nursing and therapy component
- Space and creativity (bedroom and hallway is very limiting to a strong rehab program)
- Early and well-planned goal setting and discharge planning from SB
- Care planning specific to the patient
- True interdisciplinary team approach with medical staff who understand the rehab model vs the medical model
- Ideally patient-centered care programs with set expectations and training for treatment plan and documentation such as ortho, cardiac & pulmonary rehab, pain management etc for types of patients you admit
- Clinical follow-up program w/in 24 to 72 hrs. or longer as it is for acute care discharges
- Utilization and key indicator management
- Quality program specific to SB with processes to identify opportunities for improvement
- SB PI/QI reports to hospital PI/QI department on a monthly to quarterly basis as all other departments of the hospital should

What is Rehabilitation?

- This and next slide were extracted from WHO (World Health Organization) re: Rehabilitation
- Rehabilitation is defined as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment"
- Anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age
- Rehabilitation is highly person-centered, meaning that the interventions and approach selected for each individual depends on their goals and preferences.
- Rehabilitation can be provided in many different settings, from inpatient or outpatient hospital settings, to private clinics, or community settings such as an individual's home.
- Swing Bed rehab is not simply an extension of the acute stay because the patient is not ready to go home!!! (consultant's note)

Benefits of Rehabilitation

- Rehabilitation can reduce the impact of a broad range of health conditions, including diseases (acute or chronic), illnesses or injuries.
- It can also complement other health interventions, such as medical and surgical interventions, helping to achieve the best outcome possible. For example, rehabilitation can help to reduce, manage or prevent complications associated with many health conditions, such as spinal cord injury, stroke, or a fracture.
- Rehabilitation helps to minimize or slow down the disabling effects of chronic health conditions, such as cardiovascular disease, cancer and diabetes by equipping people with self-management strategies and the assistive products they require, or by addressing pain or other complications.
- Rehabilitation is an investment, with cost benefits for both the individuals and society. It can help to avoid costly hospitalization, reduce hospital length of stay, and prevent re-admissions
- Rehabilitation enables individuals to remain independent at home and minimize the need for financial or caregiver support.

Medical & Physical Skilled Rehab Model

- Medical issues are addressed to complete the post-acute needs and allow the patient to be safely discharged to home or a lower level of care as well as prevent readmissions for those same medical issues
- Physical impairments are addressed to improve the patient's functional abilities
- Regardless of whether the patient was admitted to SB for medical issues only or functional issues or a combination of both, it is recommended that we use a Rehab Model regardless of the reason(s) for admission meaning:
  - Program philosophy (has a beginning and an end)
  - Strong emphasis on discharge plan (discharge disposition, level of assistance available, pre-admission functional status, present status, potential…)
    - Discharge plan directs the care plan
    - Prevents need for re-admission
  - Sufficient therapy staff if taking patients with CVA, Ortho and other diagnoses with high therapy requirement
  - Therapy staff to increase independence in mobility and tolerance (such as transfers, ambulation, managing COPD, CHF), ADLs, swallowing etc or to develop a nursing rehab program for those without a therapy skill need but who require repetitive exercise or process to continue improving or maintain their strength level while continuing to work with other medical or rehab skilled needs
  - Dressed in street clothes as soon as possible – all meals in chair vs bed if medically approved
  - Encourage independence (nursing not to do for the patient unless necessary)
  - Patient and family involvement on an on-going basis
  - Staff training for types of patients you are taking in
  - Documentation to support skilled needs on an IP basis

IP Therapy Rehab Model Specifics

- Functional team goals
  - Measurable
  - What specifically do you want to achieve
  - Based on pre-morbid status and the anticipated discharge plan
  - Where are they going, what will they be expected to be able to do safely
- Interdisciplinary team approach is a must!
- Gait training using indoor and outdoor terrain
- In and out of a car
- Tub transfer, safe use of tub bench – mimic tub if not available
- Use of walker while doing a functional activity such as maneuvering a tray in the cafeteria, pots and pans
- Use of chapel if church goers and post knee or hip surgery
- Use laundry basket to demonstrate do & don'ts post hip replacement
- Use of pots and pans as appropriate
- Real stairs (in or out) when available (vs just training stairs)
- Use of cafeteria if appropriate
- Games for dexterity such as dominoes, puzzles of different size vs just cone stacking
- Actual or make-shift kitchen area if space allows
- Etc….

Therapy Services

- First must meet the Inpatient Requirement
- List is not all-inclusive
- The obvious diagnosis requiring post-rehab such as:
  - Ortho injury/surgery, Stroke, TBI, Spinal issues/injury, Muscular injury/pain etc
  - Use of orthotic or prosthetic devices
  - Any medical or physical condition that the patient could benefit from exercise to improve strength, range of motion. flexibility, balance and proprioception exercises as well as functional mobility exercises.
  - Wound debridement
  - Breathing strategies, Energy-conservation techniques and Relaxation techniques as well as self-exercion assessment for the patient needing pulmonary rehab such as CHF, COPD, pneumonia and cardiac rehab
  - Restoration of independence through functional activities regardless of the diagnosis
  - Vestibular rehab to improve balance and reduce dizziness-related problems with goals to enhance gaze & postural stability, improve vertigo and ADLs
  - Edema management – often an under-treated condition (chronic vascular insufficiency, lymphedema, lipedema, CHF edema, dependent edema)
  - Sensory processing conditions interfering with a person's daily functioning
  - SLP therapy for Resonance disorders, Receptive disorders, Expressive disorders, Cognitive-communication disorders, Aphasia and Dysarthria for stroke, TBI, aspiration pneumonia etc…. as well as eating
  - Post burn scar management, range of motion (ROM) and stretching with techniques, mobility training as needed, education re: self- management
  - Bed posture, increase level of bed mobilization, ROM program for vent patients
  - Developing a maintenance program while in SB or for home discharge

Therapy Services (cont')

- In short, PT & OT specialize in the diagnosis, treatment, and management of a variety of medical conditions and diagnoses that may require improvement in the following areas:
  - Gross and fine motor coordination
  - Balance, strength, endurance
  - Eating or feeding, ADLs
  - Cognitive processing
  - Functional mobility and Gait
  - Medical S&S management for specific diagnosis

- Treatment are based on skilled needs in following arenas:
  - Cardiovascular and post-Cardiothoracic Surgery
  - General Medicine issues
  - Orthopedic
  - Trauma
  - General surgery
  - Vascular
  - Pulmonary
  - Neuro
  - Oncology
  - Wound management
  - Edema management

What about Chronic or Terminal Condition?

- Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists.
  - For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services.

- The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition.

- In the case of a progressive degenerative disease, for example, service may be intermittently necessary to determine the need for assistive equipment and establish a program to maximize function.
  - For example: patient may have been admitted to acute and has gotten physically worst – therapy may be required to assist him in returning to his usual capacity or to determine the neem for new assistive equipment and establish a new program to maximize function

- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel without the supervision of qualified professionals.

What Are MAC's Denials Based On?

- **§ 409.44 Skilled services requirements.**
- (a) General. The Medicare Administrative Contractor's decision on whether care is reasonable and necessary is based on information provided on the forms and in the medical record concerning the unique medical condition of the individual beneficiary.
- A coverage denial is not made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care.
- A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.
- (c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

Skilled Nursing Care

- **§ 409.44 Skilled services requirements.**

- (1) Skilled nursing care consists of those services that must, under State law, be performed by a registered nurse, or practical (vocational) nurse, as defined in § 484.115 of this chapter, meet the criteria for skilled nursing services specified in § 409.32, and meet the qualifications for coverage of skilled services specified in § 409.42(c). See § 409.33(a) and (b) for a description of skilled nursing services and examples of them.

- (i) In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice.

- (ii) If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service.

- (iii) The fact that a skilled nursing service can be or is taught to the beneficiary or to the beneficiary's family or friends does not negate the skilled aspect of the service when performed by the nurse.

- (iv) If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled nursing service.

Skilled Nursing Care

- **§ 409.44 Skilled services requirements. (cont')**

- (2) The skilled nursing care must be provided on a part-time or intermittent basis.

- (3) The skilled nursing services must be reasonable and necessary for the treatment of the illness or injury.
  - (i) To be considered reasonable and necessary, the services must be consistent with the nature and severity of the beneficiary's illness or injury, his or her particular medical needs, and accepted standards of medical and nursing practice.
  - (ii) The skilled nursing care provided to the beneficiary must be reasonable within the context of the beneficiary's condition.
  - (iii) The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.

Skilled Therapy Services

- PT, SLP, and OT therapy services must satisfy the following to be covered
  - Services must relate directly and specifically to a treatment regimen (established by the physician or allowed practitioner) after any needed consultation with the qualified therapist, that is designed to treat the beneficiary's illness or injury.
  - Services related to activities for the general physical welfare of beneficiaries (for example, exercises to promote overall fitness) do not constitute PT, OT or SLP services for Medicare purposes.
- To be covered by Medicare, all of the requirements apply as follows:
  - (i) The patient's plan of care must describe a course of therapy treatment and therapy goals which are consistent with the evaluation of the patient's function, and both must be included in the clinical record. The therapy goals must be established by a qualified therapist in conjunction with the physician or allowed practitioner
  - (ii) The patient's clinical record must include documentation describing how the course of therapy treatment for the patient's illness or injury is in accordance with accepted professional standards of clinical practice
  - (iii) Therapy treatment goals described in the plan of care must be measurable and must pertain directly to the patient's illness or injury, and the patient's resultant impairments.

Skilled Therapy Services

- (iv) The patient's clinical record must demonstrate that the method used to assess a patient's function included objective measurements of function in accordance with accepted professional standards of clinical practice enabling comparison of successive measurements to determine the effectiveness of therapy goals.

- Such objective measurements would be made by the qualified therapist using measurements which assess activities of daily living that may include but are not limited to eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, or using assistive devices, and mental and cognitive factors.

- (2) PT, OT, SLP services must be reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:
  - (i) The services must be considered under accepted standards of professional clinical practice, to be a specific, safe, and effective treatment for the beneficiary's condition. Each of the following requirements must also be met:
  - (A) The patient's function must be initially assessed and periodically reassessed by a qualified therapist, of the corresponding discipline for the type of therapy being provided, using a method which would include objective measurement as described in § 409.44(c)(1)(iv). If more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must perform the assessment and periodic reassessments. The measurement results and corresponding effectiveness of the therapy, or lack thereof, must be documented in the clinical record.

Skilled Therapy Services

- (B) At least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient in accordance with § 409.44(c)(2)(i)(A). Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the needed therapy service and functionally reassess the patient in accordance with § 409.44(c)(2)(i)(A) at least every 30 calendar days.
  - Consultant's note: 30 days is not the standard practice for SB and SNFs
  - Best practice calls for a weekly reassessment

- (C) As specified in paragraphs (c)(2)(i)(A) and (B) of this section, therapy visits for the therapy discipline(s) not in compliance with these policies will not be covered until the following conditions are met:
  - (1) The qualified therapist has completed the reassessment and objective measurement of the effectiveness of the therapy as it relates to the therapy goals. As long as paragraphs (c)(2)(i)(C)(2) and (c)(2)(i)(C)(3) of this section are met, therapy coverage resumes with the completed reassessment therapy visit.
  - (2) The qualified therapist has determined if goals have been achieved or require updating.
  - (3) The qualified therapist has documented measurement results and corresponding therapy effectiveness in the clinical record in accordance with paragraph (c)(2)(i)(F) of this section.

Skilled Therapy Services

- (D) If the criteria for maintenance therapy, described at § 409.44(c)(2)(iii)(B) and (C) of this section are not met, the following criteria must also be met for subsequent therapy visits to be covered:
  - (1) If the objective measurements of the reassessment do not reveal progress toward goals, the qualified therapist together with the physician or allowed practitioner must determine whether the therapy is still effective or should be discontinued.
  - (2) If therapy is to be continued in accordance with § 409.44(c)(2)(iv)(B)(1) of this section, the clinical record must document with a clinically supportable statement why there is an expectation that the goals are attainable in a reasonable and generally predictable period of time
- (E) Clinical notes written by therapy assistants may supplement the clinical record, and if included, must include the date written, the signature, professional designation, and objective measurements or description of changes in status (if any) relative to each goal being addressed by treatment. Assistants may not make clinical judgments about why progress was or was not made but must report the progress or the effectiveness of the therapy (or lack thereof) objectively.

Skilled Therapy Services

- (F) Documentation by a qualified therapist must include the following:
  - (1) The therapist's assessment of the effectiveness of the therapy as it relates to the therapy goals;
  - (2) Plans for continuing or discontinuing treatment with reference to evaluation results and or treatment plan revisions;
  - (3) Changes to therapy goals or an updated plan of care that is sent to the physician or allowed practitioner for signature or discharge;

- (4) Documentation of objective evidence or a clinically supportable statement of expectation that the patient can continue to progress toward the treatment goals and is responding to therapy in a reasonable and generally predictable period of time; or in the case of maintenance therapy, the patient is responding to therapy and can meet the goals in a predictable period of time.

Skilled Therapy Services

❑ Services which would qualify as skilled rehabilitation services.

- (1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;
- (2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified PT or OT to ensure the safety of the patient and the effectiveness of the treatment;
- (3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality
- (4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);
- (5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.
- (6) Ultrasound, short-wave, and microwave therapy treatment
- (7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool
- Services of a speech pathologist or audiologist when necessary for the restoration of function in speech, swallowing or hearing.

Skilled Therapy Services - Examples

❑ *Rehab Skilled Care*

- **EXAMPLE 1:**
- An 80-year-old, previously ambulatory, post-surgical patient has been bed-bound for 1 week, and, as a result, had developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema.
- To the extent that the patient requires a brief period of daily skilled physical therapy to restore lost functions, those services are reasonable and necessary and must be documented in the medical record (see §30.2.2.1).

Skilled Therapy Services - Examples

❑ *Rehab Skilled Care*

- **EXAMPLE 2:**
- A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary and must be documented in the medical record (see §30.2.2.1).

Skilled Therapy Services - Examples

❑ *Rehab Skilled Care*

- **EXAMPLE 3:**
- An elderly gentleman who was living at home under the care of his spouse for ADLs was admitted to the hospital with medically complex issues and after 3 weeks, the patient is medically stable, but he is now very weak and dependent with most of his care. He is referred to SB & SNF to eventually become a LTC resident. Both the patient & spouse do not want him to go to LTC and want to be admitted to your SB program to regain his strength and return to being partial assist with ADL.
- If the patient has a reasonable potential for achieving that level of assistance only in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary and must be documented in the medical record

When is Therapy Not a Skilled Need?

- Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services.
- If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative or does not legitimately require the services of a qualified professional for management of a maintenance program as described below, the services will no longer be considered reasonable and necessary.
- Services that are not reasonable or necessary should be excluded from coverage.
- If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary.
- When there is lack of improvement as evidenced within expected time frame and options for treatment are exhausted
- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered.

When is Therapy Not Skilled

❑ *Rehab Skilled Care*

- Physical therapy services are not reasonable and necessary and would not be covered if the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results.

- Some SNF inpatients do not require skilled physical therapy services but do require services, which are routine in nature. When services can be safely and effectively performed by supportive personnel, such as aides or nursing personnel, without the supervision of a physical therapist, they do not constitute skilled physical therapy**.** Additionally, services involving activities for the general good and welfare of the patient (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

When is Therapy Not Skilled

❑ Gait Training

- Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality often require the skills of a qualified physical therapist.

- Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy.

- In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must exist to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

When is Therapy Not Skilled

❑ Example

- Mrs. D. was admitted for observation and management of her cardiac arrythmia and debility. Prior to her acute episode, she was independent walking with her quad cane. She was admitted to SB and set up on telemetry for continued cardiac observation and to notify the provider if arrythmias returned. PT identified decreased strength and difficulty with her balance for which they wrote a treatment plan that included strengthening exercise and gait training.
- Within 4 days she was able to ambulate with supervision using her quad cane but required continued activity to fully regain her strength. Gait training was no longer a skilled need so nursing initiated a walking schedule using her quad cane under supervision. The plan is now for her to continue getting stronger for a few days until her daughter is able to move with her mom for a week or so until she feels safe to live alone.
- Together, Mrs. D. and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D. with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she walks with her quad cane. She was discharged on day 6 with no episode of arrythmia, feeling like she regained her strength and independence in walking with her quad cane. In this case, therapy was skilled for 4 days only.

Nursing Rehab/Restorative

- Consists of: ambulation, AROM, PROM, splint/brace assistance, bed mobility, transfer, dressing/grooming, eating/swallowing, amputation/prosthesis care

- Technique - Activities provided by restorative staff
  - Range of Motion (Passive) document provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the patient's needs, planned, monitored, evaluated and documented in the patient's medical record

  - Range of Motion (Active) document exercises performed by the patient, with cueing, supervision, or physical assist by staff that are individualized to the patient's needs, planned, monitored and evaluated. Include active ROM and active-assisted ROM

  - Splint or Brace Assistance – document provision of
    - (1) verbal and physical guidance and direction that teaches the patient how to apply, manipulate, and care for a brace or splint; or
    - (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record

Nursing Rehab/Restorative

- Training and Skill Practice
- Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse
  - Bed Mobility - activities provided to improve or maintain the patient's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record
  - Transfer - activities provided to improve or maintain the patient's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record
  - Walking - activities provided to improve or maintain the patient's self-performance in walking, with or without assistive devices. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record

Nursing Rehab/Restorative

- Dressing and/or Grooming - activities provided to improve or maintain the patient's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record

- Eating and/or Swallowing - activities provided to improve or maintain the patient's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the patient's ability to ingest nutrition and hydration by mouth. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record

- Amputation/ Prosthesis - activities provided to improve or maintain the patient's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record

- Communication - activities provided to improve or maintain the patient's self-performance in functional communication skills or assisting the patient in using residual communication skills and adaptive devices. These activities are individualized to the patient's needs, planned, monitored, evaluated, and documented in the patient's medical record.

Nursing Rehab/Restorative

- **Coding Tips and Special Populations**
  - For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the patient's available range of motion. The patient provides no assistance
  - For range of motion (active): any participation by the patient in the ROM activity should be coded here
  - For both active and passive range of motion: movement by a patient that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored evaluated, and documented in the patient's medical record. Range of motion should be delivered by staff who are trained in the procedures
  - For splint or brace assistance: assess the patient's skin and circulation under the device, and reposition the limb in correct alignment

Nursing Rehab/Restorative

- Coding Tips and Special Populations
  - The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met:
    - ordered by a physician,
    - nursing staff have been trained in technique (e.g., properly aligning patient's limb in device, adjusting available range of motion), and
    - monitoring of the device. Nursing staff should document the application of the device and the effects on the patient
  - Remember that persons with dementia learn skills best through repetition that occurs multiple times per day
  - Remember that is it very appropriate and expected to offer nursing rehab/restorative services while the patient is still receiving therapy skilled needs

Nursing Rehab/Restorative - Examples

- Mr. V. was admitted post pneumonia to receive IV antibiotic. He has moderate to severe loss of cognitive decision-making skills and memory. The plan is for Mr V to return home at discharge. He had been sick for 1 week at home before his admission and now lacking adequate strength for ambulation and ADLs.
- PT and OT were asked to assess him to identify if he had skilled needs.
- PT did not find any skilled needs (walk **has not been** impaired by neurological, muscular, or skeletal abnormality) so they recommended OOB at least 3 times/day and ambulation x ___ feet x 3/day to regain strength
- OT did identify lost range of motion in his right arm, wrist, and hand due to a CVA experienced several years ago.
- To avoid further ROM loss and contractures to his right arm, the OT fabricated a right resting hand splint and instructions for its application and removal/ He/she also developed instructions for providing PROM exercise to his right arm, wrist, and hand three times per day. Nursing have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises
- OT also identified the need to cue for ADL activities and reviewed with nursing how to guide him with ADLs
- These plans are documented in Mr. V.'s care plan. Nursing follows the rehab plan, documents participation, tolerance and outcome.
- Skill needs are IV antibiotic, PT & OT to develop a restorative program followed by short-term nursing rehab/restorative services

Nursing Rehab/Restorative - Examples

- Mrs. R. was admitted to SB for an eviscerated wound management post abdominal surgery. Within a few weeks Mr. R c/o right shoulder pain. ROM has decreased slightly over the past week. Upon examination and X-ray, her physician diagnosed her with right shoulder impingement syndrome.
- Mrs. R. was given exercises to perform on a daily basis to help improve her right shoulder ROM. After initial training in these exercises by the therapist, Mrs. R. and the nursing staff were provided with instructions on how to cue and sometimes actively assist Mrs. R. when she cannot make the full ROM required by the exercises on her own. Her exercises are to be performed for 15 minutes, two times per day at change of shift in the morning and afternoon. This information is documented in Mrs. R.'s medical record. The nursing staff cued and sometimes actively assisted Mrs. R. two times daily over the past 7 days.
- Skilled needs are wound management, physical rehab to the shoulder which was then turned to nursing for rehab/restorative based on a written maintenance program.

Nursing Rehab/Restorative - Examples

- Mrs. P. was admitted to the SB program following repair to a fractured hip. On admission she had difficulty moving herself in bed and required total assistance for transfers out of bed plus is non-weight-bearing. Her suture is infected and needs further management. The plan is for her to learn to transfer safely and return home with her husband until the orthopedic surgeon states she is ready for weight-bearing. PT worked with her for AROM, upper extremity exercise, bed mobility and transfer with trapeze, bed rails and transfer board. After 4 days she no longer requires skilled PT but must remain in SB for at least another 4-5 days for medical management. PT wrote recommendations for nursing to offer continued ROM, upper extremity exercise to maintain strength, and use of the new bed mobility and transfer skills she learned.
- The plan was documented in Mrs. K.'s medical record and communicated to all staff at the change of shift. The patient's nurse documented in the nurse's notes that in the 5 days Mrs. K. has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, her endurance and strength have improved, and she requires only minimal assistance for transferring.
- Skills were PT and wound management for the 1st 4 days then wound management and nursing restorative care for the last 4 days.

Nursing Rehab/Restorative - Examples

- Mr. A who lived alone was referred to your SB program after a long-term acute hospital stay. He is dependent with all care and all agree (therapy, nursing, providers from the referring hospital) that he needs to be admitted to a SNF to set up a plan of care and eventually be living in LTC but the patient refuses hence why he was referred to you.

- Should this patient be admitted to SB?
- Probably not based on the information available. Yes the patient requires a custodial care program with a short SNF stay to assess him and develop a care plan but will not meet skilled care at the Medicare level for more than a few days.

- Would be best to go to the NH directly where he will be in Medicare SNF until the 1st MDS (5 days) then to LTC where he will be under a restorative program which applies to Medicaid SNF.

- In our Medicare SB program, we require Medical Skilled Needs or Physical Rehab Skilled Needs or a combination of both. Important to remember that remaining medically skilled but no longer physical rehab skilled needs for all of the therapy treatment plan items or part is where nursing rehab/restorative care comes in.

Respiratory Therapy

- **MDS 3.0 Definition:** "Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.

- Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse.
  - A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws"

- Must be required 7 days per week to be considered a skill need

- A physician order for all respiratory therapy intervention/service must be recorded in the patient's medical record but may be by protocol

- The order must clearly indicate the evaluation or treatment to be performed, the specific modality and duration of all aspects of the treatment, including frequency of monitoring.

- Documentation by the physician must indicate the cardiopulmonary diagnosis supporting the medical necessity of the service.

Respiratory Therapy

- Nursing may provide and put a charge in for RT treatment but:
  1) Must have documented competencies in personnel file
  2) Must document assessment and treatment (recommend using the RT forms)
  3) Must have yearly competency update which may be an inservice
  4) Some state surveyors reportedly only allow patient's nurse to administer RT treatment to their assigned patients

- To be considered a Medicare skilled need;
  - Documentation must be present in the respiratory services records to show:
    - the plan of treatment and progress toward measurable goals
    - that the care rendered was appropriately delivered by a qualified practitioner
    - documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the Intermediary upon request.

Nursing & Therapy Collaboration

- Nursing has around the clock responsibilities and therapy is intermittent
  - Nursing can bring that "24 hr picture" and are more medical in nature and therapy brings skilled therapy assessments and are more functional in nature
  - Example:
    - Therapist may see someone as functionally unsafe with ambulation activities because of the decreased response to balance challenges but nursing may not perceive the same deficit or level of risk.
    - Nursing may not notice that the patient is not achieving good clearance during the swing phase of the gait on the left side which may put the patient at risk for falls because of the sensation loss from the sustained CVA

- Language used by either disciplines may set up a conflict of documentation hence why we must adopt Medicare's language in coding activities

- Ideally, therapy would notify day nurses of any observations to be made or specific methods of transfer etc which they would pass on to other shifts to ensure consistency


Q&A


THANK
YOU!


Be
Safe