Codify
BY AAPC

Eli's Rehab Report

SNFs: Use MDS to Put Documentation, Rehab Outcomes On Track

Find missed care opportunities, unexpected decline, inconsistencies.

Try targeting specific sections on the MDS to answer that question for you. You'll see how well your facility 1) is promoting optimal rehab outcomes and 2) has documented reasons for both resident decline and any inconsistencies between rehab and nursing observations.

Let Section G1 Be Your Starting Point

Begin by pinpointing the MDS sections relevant to rehab. If you're not sure where to start, try section G1. This one has an obvious relationship to therapy because it relates to ADLs and mobility. If you notice that the Part A-stay rehab resident has had an ADL decline from one Medicare assessment to the next, then the team needs to figure out why.

Your backup: Ideally the resident's medical record, including progress notes, care plans, weekly assessments, validation reports, etc., offers good insight into this question. That's why it's so important to explain the reason for decline in the resident's medical record. Anyone reviewing the MDS will have a clear understanding as to why the resident hasn't progressed.

Helpful: Pauline Franko, PT, MCSP, president of **Encompass Consulting and Education** in Tamarac, Fla., highlights several clinical reasons that can explain a decline in therapy:

- Worsening of foot ulcers or decubiti, which affects ambulation and transfer status;
- Unstable cardiovascular functioning;
- Pneumonia or other acute infections;
- Pain or delirium;
- Reactions to a new medication;
- Cancer. The person with cancer may do well in therapy for a few days, but weakness and fatigue may prevent her from performing at her maximum potential.
- Abnormal labs. For example, a resident may have received a blood transfusion for anemia, or his electrolytes were off, Franko says.

Bottom line: "In all cases, nursing and therapy documentation should show how the medical condition or other issue impacted the person's participation in therapy," Franko says.

The care plan should also show how the care team addressed the issues that affected the resident's therapy.

Good idea: Also look at the timeframe covered by MDS assessments showing a decline. For example, suppose three assessments in a row the 5-day, 14-day and 30-day show that a resident on very high rehab hasn't improved, Franko says. That sounds like a long time. But "if you look more closely, you may see the overlap in assessment reference dates can result in those assessments really only covering a three-week window."

So it's even more important to have supportive documentation of what's going on with the resident in terms of his response to therapy during that period.

Key In to Any Discrepancies

The nursing documentation should also explain discrepancies between a resident's ADL help requirements in therapy and his ADL scoring in Section G1. A resident may be coded as requiring extensive assistance in dressing because the CNAs have to lift his arm and put it through the sleeve each time but the OT working with the resident may document

that level of help as minimal assist if that's all the OT is doing to assist the resident, Franko says.

Another thought: Section G4 looks at functional limitations in range of motion, so it's possible that a resident could have some mild range-of-motion limitation that therapy is treating even though he has no functional deficit in ADLs. But make sure that's really the case.

Suppose an OT is working on range of motion in a resident's shoulders and documents that the resident requires a certain amount of assistance to put on his shirt. If the MDS team coded 0 at G4 for no limitation in function or loss of voluntary movement, then the MDS doesn't match the therapy documentation.

Lesson learned: It's a good idea not to code G4 before consulting with the therapist and checking their notes.

Additional Sections You Should Target

Clearly, section G1 is a therapy biggie, but the following sections should also be on your radar:

- **Section B (cognitive patterns):** If speech-language pathology or occupational therapy is working with the resident on memory, problem-solving and cognitive deficits, look for improvements on subsequent assessments.
- **Section E (mood and behavior patterns):** If PT is helping the resident improve her mobility and gait; you may see an improvement in the patient's mood as she becomes more independent. On the other hand, worsening depression or anxiety could explain a resident's lack of progress in rehab therapy.
- **Section H (continence):** If OT is working on toileting and transfers, you might expect to see the person's continence status improving if the incontinence was due to a toilet transfer issue.
- **Section J2 (pain):** Persistent pain in spite of treatment may be interfering with therapy. Or, if rehab therapy is addressing pain issues, you may see a decrease in pain symptoms coded in Section J2.
- **Section K (oral/nutritional status):** If speech-language pathology is addressing a resident's dysphagia, then "swallowing problem" should be coded in Section K1b. You may also see a decrease in weight loss (Section K3) as the speech language pathologist addresses diet modifications, positioning issues, and safe swallowing strategies.
- **Section P3 (restorative nursing):** There's underuse of rehab low or rehab low plus extensive services, which includes restorative nursing. Using that RUG category, the person has time to practice skills so he maintains them and doesn't end up entering the system again.