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MDS Alert

Compliance: Don't Let Your Therapy Documentation Undercut Rehab RUG Payment

Shortfalls in documenting previous functional status can be a ticket to claims denials.

From ZPICs to MACs, auditors are targeting Part A rehab in SNFs. And if therapy documentation leaves reviewers shaking their head in confusion, your SNF could be in for payment denials or even a fraud and abuse review that the following strategies will head off at the pass.

1. Describe the resident's previous functional abilities. "The documentation should give a history of the resident's previous functional status to justify the therapy goals," advises **Sheila Capitosti**, **RNBC, NHA, MHSA,** clinical compliance director for Functional Pathways in Knoxville, Tenn.

Capitosti reports seeing instances where a therapist documents a resident as "independent at home with increased shortness of breath during ambulation." What you want to see, however, are objective measures, such as how far the person could walk previously compared to now, she says. "How did the person perform independent activities of daily living and ADLs? Look at the big picture, too. What does the person do with leisure activities, as well?"

Positive example: One therapist documented how the resident lived with her husband in a one-story home requiring her to navigate one step to get in and out of the living room, Capitosti recounts. The documentation explained how the resident "was independent with ADLs and took care of her husband with Alzheimer's disease.

She drove, cooked, cleaned, and ambulated with a quad cane but had suffered recent falls." Thus, the woman needed therapy to help regain her previous level of function where she wasn't falling when using her cane.

The therapy would not only help restore the woman to her prior level of functioning -- it would also help her continue to take care of her husband, Capitosti relates.

Tip: "The lookback period for prior level of functioning can be as far as six months and should be as detailed as possible," Capitosti stresses.

Also look for this common scenario: Suppose the therapist sets a goal for a resident in a wheelchair to become as independent as possible, says Capitosti. Yet the person was dependent on a wheelchair for mobility before hospitalization and nursing home admission, she adds. From an auditor's perspective, that goal may be appropriate. But the auditor will also want to know the resident's previous level of functioning, Capitosti stresses.

People often enter a nursing home dependent on their wheelchairs because it's easy to develop that dependency in a home setting, she points out. And "it may be very appropriate to try to make the person more independent, but the documentation has to justify why you are doing it. You have to document why the service is needed and what therapy can provide that restorative cannot."

2. Beware assessment omissions. "The documentation should also reflect a complete assessment," advises Capitosti. She recently reviewed one record where the therapist wrote that the patient was short of breath when ambulating. "The therapist did include O2 saturation [readings] and the O2 level the person required at rest and after therapy. But the therapist documented: "BP unknown." And "the auditor is going to wonder what that means -- why did the therapist not take the blood pressure?"

Focus on functional outcomes. "The therapy goals should address a functional outcome," which is what needs to be accomplished by the end of therapy, says Capitosti. Yet the documentation sometimes indicates a goal such as

"ambulate 200 feet contact guard assistance," which doesn't tell you the functional reason for the goal. "Does the person have to ambulate to get to the bathroom and become independent in toileting?"

Bottom line: "The short-term goals should address the impairment and need to be specific," she adds. For example, if the therapist is working to improve a resident's knee flexion, the documentation should indicate the person's current knee flexion and the flexion goal, as well as the functional outcome that the therapist is aiming to accomplish, Capitosti advises.

4. Differentiate how the therapist provided services. Due to the implications for RUG-IV, "therapy documentation needs to clearly identify which category the treatment minutes fall into," advises **Kate Brewer, PT, MBA, GCS, RAC-CT,** with Greenfield Rehabilitation Agency Inc. in Greenfield, Wis. The RUG grouper will only count half of concurrent minutes recorded on the MDS 3.0 toward a rehab RUG -- and "group [therapy] is limited to 25 percent of the total for the discipline," Brewer adds. "If it is not clear that the documentation is individual (vs. concurrent or group) when multiple modes are used during a session, there is a risk that the minutes could be re-assigned to another category."

5. Document the intensity of therapy required and provided to support the RUG level. Suppose the resident is in ultra high. "The documentation should demonstrate what activities were performed and why they were medically necessary," Brewer says. "If the daily documentation for a rehab medium looks similar to daily documentation for an ultra high, that could be a potential area for risk."

Editor's note: See "Make Sure Nursing Notes Address Rehab Residents' Progress, Functional Goals" below.