

Welcome to the Eighth Issue of the QualityWISE Newsletter

This month's edition of the *QualityWISE Newsletter* focuses on various aspects of the audit process, including what auditors look for in documentation and the importance of accurate documenting and coding of unattended/supervised modalities.

Medical Necessity – What Auditors Look for in Documentation

Audits are required to ensure that our therapists have the tools, training and education they need to clearly and accurately document the therapy that is required by our patients. Numerous internal and external audits focus on ensuring our documentation is consistent and comprehensive.

The information below is to serve as a quick reference for all therapists to support skilled therapy documentation:

Evaluation

Tell the story/paint a picture of the patient's functional status needs with comprehensive, discipline-specific documentation that leaves no question in the mind of the reader as to why your services are medically necessary to improve the quality of life for the patients you serve.

- Choose **ICD-10 Medical and Tx Dx's** that mutually support a comprehensive assessment with a functional deficit section to contrast PLOF and current level, underlying impairments with specialized tests, measurements and goals to address the identified deficits/impairments.

- **Reason for Referral** details the reason(s) that led to the need for skilled rehab, inclusive of status post-hospitalization, new admit, recent decline/improvement from baseline function, current medical status or co-morbidities impacting rehab and related to functional impairments, and barriers with statement of risk(s) without skilled rehab intervention.
- **Therapy Necessity** justifies why skilled rehab is reasonable and necessary with documented issues/problems to be addressed, interventions with rationale and how these skilled services will improve function necessary for the return to PLOF, prior living setting and improvement in quality of life.
- Include **Functional Deficits**, both prior and current level (ADLs, bed mobility, transfers, gait, swallowing, communication, cognition, etc.) that have an impact on rehab and relate to established goals.
- Include **Underlying Impairments** (strength, balance, pain, vision, motor control, tone, ROM, sensation, coordination, cognition, recall, articulation, comprehension, expression, etc.) to be addressed in the plan of care related to the goals that impact the patient's ability to perform a task at his/her highest level of function possible.
- Appropriate **Standardized Tests** need to be initiated at the beginning of treatment and throughout the plan of care as appropriate, to objectify, strengthen and help justify your therapeutic rehab interventions.
- **Goals** relate to functional deficits and underlying impairments and are objective, measurable, functional and patient-focused. Goals should support the rehab treatment diagnosis with time frames to achieve.
- **Treatment Plan** includes intensity, frequency, duration (no ranges) with procedures, treatments and modalities that are consistent with the PLOF, objective findings and goals with anticipated treatment time.

QualityWISE NEWSLETTER

WELL INFORMED | INNOVATIVE | SECURE | ETHICAL

OCTOBER 2016

Progress Notes

Progress Notes document the following:

- **Significant changes** in the patient's condition (precautions and medical status) with resultant modifications to the goals and POC
- **Clinical rationale** and **patient response to therapeutic interventions** performed
- **Results of formal/informal assessments and tests** administered, and updates to previous standardized assessments and tests and how they affect function
- Address **barriers** to progress and modify goals and approaches accordingly.
- Provide a **clinical summary of progress or lack of** to include: objective, measurable, comparative data of functional status, and communication to supervisor, other disciplines, and caregivers
- **Patient/caregiver education** to include who was trained, what was trained and outcome of training
- **Types of services delivered**, such as:
 - o Concurrent treatment and co-treatment – state rationale, patient response and goals to be addressed
 - o Group therapy – state type of group, number of participants, purpose and patient response
 - o Modalities – state type of modality, indication, parameters and treatment setting, pad/treatment area, skin condition pre- and post-treatment and patient response
- **Specific interventions**, not just the task
- **Progressive programs** that require the skills of the therapist for ongoing assessment, modification and goal revisions
- **Trials of variety of approaches and effectiveness** with the patient
- Progress towards goals and updates to the treatment approach
- Avoid duplication of services and report on sub-components of the function or task

Points to Consider and Questions to Ask Prior to Discharge

- Were the patient's interests considered?
- Were safety strategies addressed and implemented?
- Were all functional treatment areas addressed?
- Were significant barriers or lack of progress addressed from week to week?
- Was there consultation with other rehab team members or medical staff on resolution of barriers interfering with treatment or, if needed, was follow-up consultation impacting treatment considered?
- Was the patient's care discussed routinely with the patient and family?
- Was the patient's care discussed with the physician?
- Are the patient's functional capabilities sustainable in the discharge/transitional level of care environment?
- Were recommendations provided for a restorative/maintenance plan of care adequately documented with outcome of teaching and training provided?
- Were the patient's training needs fully assessed and met for a successful return to the discharge setting?
- Does the primary caregiver at home have a comprehensive understanding of the patient's ongoing clinical needs?
- Does the patient understand the signs and symptoms of a recurrence or complication from his/her medical problem?
- Has social services met the patient's equipment needs for the home?

Continued on next page 

Don't forget to complete your General Compliance Training and/or CIA-required training by December 31, 2016

OCTOBER 2016

Discharge Summary

The Discharge Summary documents the following:

- Clear reason for discharge from therapy services and includes transitioning to the discharge location
- Summary of the patient's functional status and changes in status from evaluation to discharge
- Addresses whether goals were met or not and why
- Summary of skilled therapy services provided with rationale and patient response
- Patient/caregiver education and outcome
- Update of standardized tests and measurements with scores and analysis
- Recommendations for follow-up, such as functional maintenance program, home exercise program, support, adaptive equipment, home health services, caregiver provision, etc.

Remember to always keep the following in mind: "If you didn't document it clearly and objectively, you didn't do it!" If you have any questions or concerns about the items listed here, please contact your PD/ADO and they can schedule a call for you with a member of our audit team.

Unattended/Supervised Modalities: Tips for Accurate Documenting and Coding

An unattended/supervised modality is the application of a modality that does not always require direct one-on-one patient contact by the therapist/assistant throughout its duration, such as electrical stimulation and diathermy. Patients receiving unattended modalities should always be within the line-of-sight of the treating therapist/assistant to ensure patient safety and optimum therapeutic outcome.

Documenting an unattended modality involves a comprehensive daily note that captures the skilled and non-skilled therapy time provided to the patient. Medicare Part A requires us to differentiate the time because only the skilled treatment time may be recorded on the MDS. Remember: Skilled therapy services require the skills, knowledge and judgment of a qualified therapist/assistant and our documentation must reflect this. A **recent issue of Fast Fact Friday** provided specific examples of skilled therapy time/minutes, as well as documentation examples of an unsupervised modality treatment. For more information on these topics, please **review the September 16 issue**.*

Additionally, it is imperative that therapists/assistants select the CPT code that matches the clinical treatment being provided. This process is the same regardless of payer source. Last month, the CPT codes with definitions for all the unattended/supervised electrical stimulation and diathermy codes were covered in an **issue of Fast Fact Friday**. For more information about the codes and definitions, please **review the September 9 issue**.*

**Please note the Fast Fact Friday issues are hosted on Knect, so you will need to be connected to the Kindred network to access these links.*

Remember, every issue of the *QualityWISE Newsletter* is archived at <http://www.rehabcare.com/employees/qualitywise/>, along with helpful FAQs. If you have any questions or concerns related to quality, compliance or the CIA, you can email RehabCareQualityWISE@rehabcare.com or contact Kindred's Compliance Department at compliance@kindred.com. And you can always contact the Compliance Hotline at 800.359.7412 to report suspected violations of any federal healthcare program requirements or Kindred's policies and procedures.

Thank you for everything you do to ensure exceptional outcomes for our patients and partners.