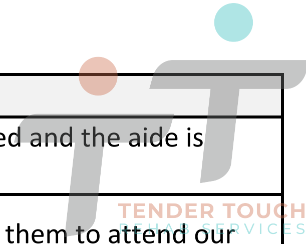
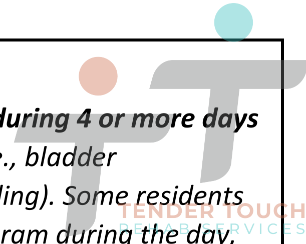
Q & A FROM REHAB DIRECTOR SEMINAR SEP 8-9, 2019



	RESTORATIVE NURSING PROGRAM	
1	Should Nursing wait for rehab to start RNP or can they initiate RNP themselves?	Nursing may initiate RNP or Rehab may initiate RNP; as long as goals are established and the aide is trained by someone in the specific procedures for that specific resident
2	What about a facility that doesn't have RNP? How can we stress the importance of RNP if facility doesn't have one?	Speak to you Regional Manager and see if we can help them start one. Encourage them to attend our seminar.
3	Does RNP need an MD order?	No. Just a careplan and outlined documentation described
4	If a patient admits Friday night ,how can you establish an RNP if the aide works Mon to Fri?	RNP requires 6 days, so an RNP aide would need to work 6 days a week. If you cannot achieve 6 days by day 8, you can consider an IPA. Bear in mind, RNP only affects the Behavioral-Cog and Physical Function RUGS
5	If the patient requires 15 min/day from 2 programs, does that mean walking needs to be 15 min on one day and ROM is 15 min on another day?	No. EACH program must be provided 15 minutes EACH day. Therefore RNP must be 30 min a day to achieve a RUG. You may provide less minutes or less days if that is clinically appropriate, but it will not capture a PDPM RUG.
6	Is the RNP form and attendance grid enough for the documentation of RNP program?	You also need a careplan, evidence of periodic evaluation by a nurse, and evidence staff was trained on the specific patient techniques
7	Could the Tender Touch aide provide RNP 3 days and facility aide provide RNP 3 days?	Some states require that RNP be provided by a CNA. As long as the program is provided 6 days/wk, is documented, follows all the regs, and is provided by the appropriate personnel, it doesn't matter if the personnel is the facility, or Tender Touch. Tender Touch may hire CNAs to assist with RNP
8	If patient is a feeder, ie total assist for feeding, then could an RNP program for feeding be set up?	ONLY if the program meets all the requirments. <u>**RAI manual O-44 states:**</u> "***O0500H, Eating / Swallowing*** *: Code activities provided to improve or maintain resid self-performance in feeding oneself food and fluids,* ***or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth."*** The instructions must be specific to the resident. For eg, aides may be instructed to provide verbal cues for chin tuck, remind patient to take small bites, guide patient in proper posture, etc
9	Will Tender Touch be completing RNP section O0500 of the MDS?	Every facility is different. RNP is still a NURSING program, but facilities may ask for our assist. Section O0500 can be added as a custom MDS worksheet to Optima if needed.
10	If the restorative aide does a group of 15 minutes, is each person coded for 15 minutes?	Yes, as long as the group didn't exceed 4 people
11	Can Rehab supervise the restorative aide?	RAI Manual O-42: "Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or <u>to supervise aides performing these maintenance services</u>. Although therapists may participate; **members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs"**
12	For ambulation RNP, do we establish the amount of assistance needed?	YES. We should establish the amount of assistance provided by the aide. The aide should follow these recommendations and not PROGRESS the amount of assistance without consulting rehab
13	Can we train nursing staff on weekend to provide RNP?	Yes! RNP needs to be six days a week



14	RNP programs must be at least 6 days to qualify for RNP, but you mentioned Toileting programs do not require 6 days in lookback period. Is there a minimum of daysrequired to code a toileting program?	**RAI Manual H-4**: **H0200C : Toileting Program**: "*Code 1, yes: for residents who are being managed,* ***during 4 or more days of the 7-day look-back period*** *, with some type of systematic toileting program (i.e., bladder rehabilitation /bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."* **RAI Manual H-12**: **H0500: Bowel Toileting Program** *"Code 1, yes: if the resident is currently on a toileting program targeted specifically at managing bowel continence."*
14	How do we monitor decline if RNP doesn't clarify distance or assitance levels?	RNP DOES clarify distance and assistance levels. This is logged on the attendance grid and the program guidelines and the careplan. When training the aide on the specific program techniques, the distance and amount of assist is included. The aide should follow these guidleines and not progress the patient without rehab input.
15	Who is making sure the RNP we establish is actually getting done?	Every facility will run RNP differently. Please consult with your Regional Manager.
16	What RNP goals do you recommend for a low level patient on rehab for ROM/Bed Mob, and splint.	You can choose any two programs from PASSIVE ROM, splinting, or bed mobility as appropriate
	SPEECH THERAPY	
1	What day should the SLP screen be done?	Preferably within 48 hours of admission
2	If a swallowing episode occurs on the 4th or 5th day do we re-do the screen if patient is not on an SLP program?	If a patient had a swallowing incident, they should always be referred to SLP for screen and possible intervention. SLP and Rehab Director should check if the 5 day assessment was already completed and if the swallowing incident was coded in section K. If the MDS was already submitted without section K being coded, then an IPA should be considered.
3	If we code both R13.13 - oral dysphagia in addition to the I8000 dysphagia codes on our evals, will it trigger the diagnosis exclusion error on the closeout?	You do not need two codes for dysphagia. If the patient has dysphagia due to Cerebro-vasular incident, then code dysphagia from the "I" series. If they have dysphagia from a non cerebro-vascular incident then code the R13.1 series.
4	Is it advisable to add the I8000 CVA dysphagia code to the treatment diagnosis in addition to adding it to the medical diagnosis?	The medical diagnosis should represent the medical reason you are treating the patient and the treatment diagnosis is the condition you are treating, Dysphagia secondary to CVA should be sufficent for both Medical and Treatment diagnosis.
	GROUP REHAB	
1	Can we do a 30 min group and 30 min individual treatment on the same day? Can you bill group and individual on the same day like a split session?	if that is what is clinically appropriate it is allowed.
2	Does Med B have a cap for group minutes per week or max of patients alloowed in group?	Med B has no cap on minutes per week. Regarding number of participants, the LCD says 2 or more, but we would not recommend exceeding 6, just like Med A.
3	Are the minutes divided by 4 regardless of number of patients in the group	The FULL minutes are reported on the MDS and no minutes are divided. Minutes do not affect RUG, but Group + Concurrent minutes may not exceeed 25% of total treatment time per discipline

4	Could we include Med B patients in a group	Yes as clinically appropriate; but the patient can only be billed one unit (approx $15), regardless of length of group treatment
5	If a therapist treates 6 patients in a group , that can affect their time in the facility -- what are they supposed to do.	Group should not fall on one therapist, but should be divided among staff. Staff must have schedules that are reasonable clinically, and finanically sound. If you have too much or too little staff, discuss this with your Regional Manager
6	How do you do Point of Service documentation when running groups?	The laptops on carts and the ipads are both available to assist with documentation
7	Could you do a group of 2 Med A patients and 2 Med B patients?	Yes. Different payers can be mixed, however, remember, for Med B only one unit is billed per patient regardless of length of treatment.
8	Can 2 therapists from the same discipline split a group, ie, 2 PT's each see 2 patients?	Yes but then it will be considered **2** groups, with 2 patients in each group. If all patients are doing the same thing, it is better time management if one therapist conducts the group with all 4 patients.
9	Can two therapists from DIFFERENT disciplines Co-treat a group?	**RAI O-21**: *When 2 therapists from different disciplines treat one resid at the same time w/different treatments,* ***both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed. For example, if two therapists from different disciplines were conducting a group treatment session, the group must be comprised of the allowed number of participants who were doing the same or similar activities in each discipline*** *. The decision to co-treat should be made on a case bycase basis and the need for co-treat should be well documented for each patient.Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.*
	OUTCOMES	
1	why do we need good outcomes?	To help our patients reach their highest potential and improve quality of life
	TRANSITIONAL IPA	
1	For current Med A patients that transition on Oct 1, what diagnosis is used for I0020B?	You need to sit with MDS to determine primary reason for SNF stay on every single Med A patient who crosses into October and enter that on the Transitional IPA.
2	If the current diagnosis is Return to provider, will that be a problem?	Return to provider cannot be used for the primary reason for SNF stay in I0020B. It may be used as a secondary treatment diagnosis on the eval, or may be used on the eval if rehab is not the primary reason for SNF stay. If rehab is primary, thenyou should not use it on the eval as the medical diagnosis but you could use it as treatment diagnosis. Select a non Return to Provider cocode for I0020B
3	Are we opening non-therapy cases for patients in September?	Only if they cross into October
4	If an Interrupted Stay occurs between Oct 1-7; when do we do the IPA? If we do it upon the patient's return, is it considered late?	The ARD of the Transitional IPA must be between Oct 1 and Oct 7. If the patient returns from an interrupted stay by Oct 7, you can schedule the transitional IPA either before the interrupted stay, or ON Oct 7. But you CANNOT schedule it **after** Oct 7. If you cannot gather all of the clinical items by Oct 7, and ideniofy additional items later, then consider doing another IPA later.

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5	If we notice MDS checked "no swallowing disorder" on MDS, but patient has a swallowing disorder, should we change the MDS?	All patients must be re-screened for the transitional IPA before oct 7. SLP should re-screen all patients and if a swallowing disorder was identified in the last 7 days, it should be coded on the tranistional IPA.
6	If patient currently has R13.13 diagnosis coded, should we change that rolling intoOctober ?	All patients must be re-screened for the transitional IPA before Oct 7. SLP should re-screen all patients. If the patient has dysphagia secondary to a cerbrovascular incident, then the appropriate ICD10 code should be entered on the transitional IPA.
7	For the GG that we will do for the IPAs come Oct 1st, will it be the status of the pt at that time and not upon the original admission?	the status of GG for the transitional IPA is based upon ARD date plus two days back. ARD must be between Oct 1-7. So whatever ARD is used the status is that date plus two days back
8	Do we have to establish new goals for the GG too?	New Goals do NOT have to be established for an IPA.
9	Do we have to redo all GG items for the IPA?	No Only the items that affect PDPM socres. 3 self care items (GG0130A-C) and 7 mobility items (GG0170B-F,J,K)
10	Does the new status on the IPA count towards QRP?	No. QRP only looks at GG status from admission to discharge
	Regular IPA	
1	Can we open an IPA on every resident just in case they need one, so all dept get skilled documentation in and generate a RUG then strike it if its not needed?	Yes and no. An IPA is indiated if you identify a patient change. If a change is in fact idendified, then an estimated IPA shuold be opened to see how the NEW RUGS compare to the old RUGS. If the IPA is warranted, it should be done, and if not, it can be discarded. . But you should only open the IPA if you have a reason to do so. Opening IPAs on everyone would cause alot of unnecessary work
	DIAGNOSES	
1	If we have all the diagnoses listed on the eval and MD signs it, is that enough to have the primary diagnosis.	If rehab is the primary reason for SNF stay, then the diagnosis in I0020B should be listed as at least one of the MEDICAL diagnoses on your eval
2	Can MDS fill out the MD diagnosis checklist and MD just sign it ?	NO! The Physician or physician extender is the only one who can diagnose; and only the MD can complete the SNF cert.
3	Does MD diagnosis checklist have to be signed by attending physician or can it be signed by physiatrist	The goal is to have the diagnosis checklist attached to the MD H&P which should be done by the MD signing the SNF cert. If additional diagnosesor comorbidities are identified later, they can be added by MD.
4	Toxic encephelopathy and metabolic encephalopathy both trigger acute neuro. Which do we choose?	You need to query the MD which the patient actually had. You can only choose one diagnosis for I0020B.
5	If patient has a fracture entered into I0020B but it comes up medical management, what should you do?	Look at CMS'Clinical Category mapping for a more specific diagnosis and query the MD to confirm it it approrpirate for the patient. Look for codes in the same family as the code you initially chose (ie, same prefix, above and below the code)
	QUALITY MEASURES	
1	What are CASPER REPORTS?	CASPER stands for Certification and Survey Provider Enhanced Reporting system. It is the system where you can print the Quality Measure and QRP reports and the VBP reports

2	Where can I get CASPER reports? How often?	Usually MDS or Administrator has access. You should get QM and QRP reports at least monthly to quarterly. For the SNF QRP Review & Correct Report, if you are making corrections, corrections are updated every Monday, so during that time, you may want to print it weekly
3	How can I use CASPER reports to work on clinical program development?	The CASPER reports have quality measure reports which display the specific names of the patients who trigger for each quality measure. Make a list of the patients who trigger for rehab related measures and screen those patients monthly - quarterly
4	If a patient triggers on CASPER Report, how do I tell when they triggered?	The reporting period of the report is listed on the report. You can adjust these days for the time period you wish to print. The patient will display based on the last MDS in the system for that time period
5	Our facility says we should not "walk patients in corridor" How do we address QM of Improved Fxn?	Speak to your Regional Manager to help you address this issue
	ARD	
1	Should we always wait until day 8 to complete initial assessment, even if using day 1?	There is no harm in leaving it open. Even if you provide IV meds on day one, you may also identify additional items such as swallowing disorder later and both can be captured in the 7 day lookback. On the other hand, if you can capture a service such as IV fluid provided in the hospital five days ago, then you may want to use an earlier ARD. Remember, you can change the ARD until day8. Once you have passed day 8, you can no longer change the set ARD.
2	Is the Medicare week being impacted by PDPM?	Do not confuse Medicare week with therapy frequency. If therapy frequency is ordered 5x/wk, then it is 5x/wk from the day of therapy evaluation and rolling continuously from that day. Each discipline may have a different rolling week
	DEPRESSION	
1	If patient has signs and symptoms of depression, will they have to have a psych consult.	PDPM does not change the clinical care needed. If the patient triggers for depression, a careplan is required along with appropriate intervention

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