



The information provided in this course is to be used for educational purposes only. It is not intended as a substitute for professional healthcare. Contact Hours: 1.25 NAB Approval 20260213-1.25-A109213-DL 02.14.2025-02.014.2026, 1.0 Nursing Approval 02.14.2025-02.14.2026

Nursing Documentation: If It's Not Charted, It Didn't Happen

DISCLOSURE

Select Rehabilitation provides educational activities that are free from bias. The information provided in this course is to be used for educational purposes only. It is not intended as a substitute for professional healthcare. Neither the planners of this course nor the author has a relevant financial relationship with ineligible companies to disclose. This course is not co-provided. Select Rehabilitation has not received commercial support for this course. Trade names, when used, are intended as an example, not an endorsement of a specific product or company. Accreditation does not imply endorsement by Select Rehabilitation of any commercial products or services mentioned in conjunction with this activity. This educational session is non-clinical and no financial, mitigation or disclosure required.

HOW TO RECEIVE COURSE CREDIT

View the entire course including any applicable handouts/resources. Complete a post-test assessment. You must score 80% or better on the post-test and complete the course evaluation to earn a certificate of completion for this activity. If required, Select Rehabilitation will report attendance to CE Broker.

ABOUT THE COURSE AUTHOR

Neely Tolbert Sullivan MPT, CLT-LANA, CDT, has worked with diverse client populations ranging from pediatric to geriatric in a variety of clinical settings. These experiences have allowed her to treat and develop effective client care programs. She has served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and worked closely with interdisciplinary teams to ensure that all clients have the opportunity to attain their highest level of function and quality of life. She has most recently been responsible for the identification, implementation and evaluation of clinical programs in long-term care settings.

Neely currently provides educational support to 16,000+ therapists nationwide as the Director of Wellness and Education Specialist for Select Rehabilitation. Neely has lectured nationally and at the state level on a variety of clinical and regulatory topics. She has authored publications focusing on evidence-based practice and clinical care. Neely conducts audits, quality improvement planning, and clinical training to Select Rehabilitation employees and customers monthly. She is a member of the APTA including the Clinical Electrophysiology and Wound Management section and Geriatric section.

POST-TEST

1. For a facility to obtain and maintain Medicare certification the facility must:
 - a) Document on a client's progress and condition twice a day
 - b) Maintain clinical records on each resident in accordance with accepted professional standards and practices
 - c) Verify how well nursing staff complies with documentation requirements
 - d) Verify how well therapy staff complies with documentation requirements

2. For a client residing in a skilled nursing facility, the clinical record must contain:
 - a) Detailed descriptions of changes in condition including what events may have precipitated the change
 - b) A toll-free telephone number to collect, maintain, and continually update information on Medicare documentation
 - c) Evidence of nurse aide competency evaluation programs
 - d) Evidence of state survey agency certifications
3. Skilled documentation must:
 - a) Include data from accredited and non-accredited surveys
 - b) Substantiate daily skilled care was delivered
 - c) Provide evidence of an audit of the medical record
 - d) Include a list of covered items or services
4. An example of a teaching and training nursing skill that may be captured in the medical record includes:
 - a) Leading a client through repetitive and routine exercises
 - b) A list of CPT descriptors
 - c) Teaching a newly diagnosed diabetic to administer insulin injections
 - d) The ongoing implementation of a maintenance program
5. The accuracy of ICD-10-CM coding is paramount to ensure that:
 - a) Medically unnecessary diagnostic tests are performed
 - b) ICD-10 replaces Current Procedural Terminology (CPT)
 - c) The clinician can code the condition to a low degree of certainty
 - d) The principal and supporting diagnosis codes are correct on the UB-04 claim

The post-test and corresponding course evaluation can be accessed at:

https://www.surveymonkey.com/r/Not_Charted_On_Demand

Or by using the following QR Code:



If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.

Any questions or issues related to this course should be directed to Dr. Kathleen Weissberg, National Director of Education for Select Rehabilitation at kweissberg@selectrehab.com

If accessibility of learning is required, please contact Kathleen Weissberg at kweissberg@selectrehab.com for appropriate accommodations.

Nursing Documentation: If It's Not Charted, It Didn't Happen

Neely Sullivan, MPT, CLT-LANA, CDP
National Director of Wellness and Education Specialist
Select Rehabilitation
nsullivan@selectrehab.com



1

Objectives

- Describe key Medicare skilling criteria for Nursing and Therapy Services
- Identify strategies for documenting to demonstrate implementation of the critical thinking process and provision of skilled level of care
- Outline tips and strategies to promote quality analysis, staff communication/education and promote quality documentation



2

Medicare Criteria for Nursing and Therapy Services



3

Regulations

- In order for a facility to obtain and maintain Medicare certification the facility must:
 - Maintain clinical records on each resident in accordance with accepted professional standards and practices that are:
 - Complete
 - Accurate
 - Readily accessible
 - Systematically organized
- Facility determines how frequently to document on a resident's progress and condition



4

Regulations Continued

- The clinical records must contain:
 - Sufficient information to identify the resident;
 - A record of the resident's assessments;
 - The plan of care and services provided;
 - The results of any pre-admission screening conducted by the State; and
 - Progress notes
 - Supportive clinical documentation



5

Initial Admission Assessment

- Initial resident assessment data – Nursing/Therapy and other disciplines
 - Don't own what isn't yours
 - Physical assessments on admission must be thorough and timely and should identify all issues/risks present upon admission
 - Facility should be sure to obtain the necessary hospital records to support resident status on admission and to support coding of MDS for items "while not a resident"
- Collect relevant info from various sources and analyze it to assemble a complete picture of the resident
- Drives the baseline/interim admission care plan until the comprehensive admission assessment and care plan can be completed



6

Building the Care Plan

- Care plans provide:
 - Resident-centered direction to the interdisciplinary team
 - Central focus for the ongoing documentation of the resident's care, condition, needs and risk factors
- Should include:
 - Measurable objectives and time tables to meet the resident's needs



7

Skilled Care is a Process

- Assessment
- Diagnosis
- Planning
- Implementation
- Evaluation
- Documentation – If it is not documented its not done!
 - Content should be specific to the clinical reason for coverage
 - Should contain observations, assessments and actions by staff
 - Response by resident to treatment and interventions
 - Adjustments as needed for barriers to progress or newly identified problems that arise
 - Should illustrate a logical approach to problem solving



8

Strategies for Documentation that Demonstrates Skilled Services



9

Critical Thinking

- The careful, deliberate determination of what course of action is appropriate using evidenced-based interventions that are grounded in current standards of practice
- Nurses and Therapists must use critical thinking every single day of his or her practice
- The critical thinking process must be included in the documentation in order to demonstrate the skills of a nurse or therapist were reasonable and necessary for care



10

Documenting Critical Thinking

- The nurse or therapist should describe the process that defines why it was necessary for their involvement in the resident's care
 - Assessment of resident conditions, causative factors, and/or risk factors and concerns for safe function
 - Analysis of potential outcomes or consequences
 - The plan for action
 - Evaluation of the resident's response to the plan
 - Documentation should be ongoing regarding the continued deficits or problems, risk factors, concern for safe function, barriers to progress and necessary revisions to the plan in order to facilitate the best possible outcome for the resident



11

Documentation Basics

- The clinical record must contain:
 - Detailed descriptions of changes in condition including what events may have precipitated the change
 - Details of unusual occurrences
 - Evidence of physician and responsible party notification
 - Evidence of care provided and the response to treatment
 - Per Chapter 2 of RAI Manual - Develop and implement a baseline care plan within 48 hours of admission
 - Resident enters facility with a set of physician-based treatment orders
 - Review these orders and begin to assess/identify potential care issues and problems



12

What to Document?

- Assessment information
 - A collection of objective data and details about resident's current condition
- Action
 - What did the nurse or therapist do with the findings?
- Response
 - How did the resident react?
 - What did you communicate to others about the resident's condition?
- Evaluation
 - Was the action taken effective?
 - Does the plan need to be re-evaluated?
 - What else does the clinician "anticipate" they will have to:
 - Observe, assess, manage, evaluate



13

How to Document

- Always follow facility policy
- Document events in chronological order
- Document the facts
- Do not chart in advance or prior to providing care/treatment
- Make sure documentation is in keeping with acceptable standards of practice
- Document only what **you** are qualified to do
- Date and time all entries using AM/PM unless military time is used
- Sign all of your entries with your credentials
- Avoid using abbreviations or only used acceptable abbreviations approved by your facility
- Avoid "red flag" language/statements such as "by mistake" or "accidentally"



14

How to Document - Continued

- Documentation should include correct anatomical terms
- Know your medical terminology; Superior, inferior, anterior, posterior, medial, lateral, proximal, distal
- ICD-10 is very specific; documentation must support accuracy and specificity in order to avoid questions about claims
- Keep your documentation concise, objective and professional



15

Principles of Determining Skilled

- The service must inherently complex
- Nature of the services requires the skill of licensed personnel
- Skilled service provided directly or under supervision of a licensed nurse or therapist
- Diagnosis and prognosis DO NOT determine what is skilled care



16

Practical Matter

- Considering economy and efficiency, skilled services can only be provided in a SNF
 - Contributing reasons for a skilled SNF stay:
 - Intensity of therapy provided
 - Medical complexity
 - Less than 24hour/day care would impose safety risks and/or adverse impact on resident's medical condition
- The documentation provided by the licensed personnel should support that SNF care was reasonable and necessary by illustrating the above bullet points



17

Reasonable and Necessary

- Skilled care may be necessary to either:
 - Improve a resident's current condition, or;
 - Prevent/slow further deterioration of the resident's condition
- Skilled documentation must:
 - Substantiate daily skilled care was delivered
 - Record treatments, therapy and resident's response to same
 - Communicate between the disciplines and serve to facilitate continuity of care



18

Medical Records as a Communication Tool

- The medical record is expected to provide a record of communication:
 - Among all members of the care team regarding the:
 - Development of the POC
 - Course of care and treatment
 - Outcomes of the:
 - Skilled observations
 - Assessments and/or treatments
 - Training



19

Medical Necessity

- The resident's medical record must document as appropriate:
 - The history and physical exam
 - The skilled services provided
 - The resident's response to the skilled services
 - Plans for future care
 - Detailed rationale explaining the continued need for skilled care
 - Complexity of the services to be performed
 - Any other pertinent characteristics of the resident



20

Maintain Objectivity

- Documentation should be objective
 - Staff should avoid using terms such as:
 - Normal
 - Good
 - Resident had a good night/day
 - Appears
 - Seems
 - Generalized weakness
 - Voiced no complaints
 - Think of documenting in terms of head to toe
 - Include objective observations and subjective statements
 - Consider and document about risks and concerns for safety



21

Documenting Response to Treatment

- The following terms do not adequately describe the reaction of the resident to his/her skilled care:
 - Tolerated treatment well
 - Continue with POC
 - Remains stable
 - This documentation is vague and does not adequately paint the picture of a complex resident
 - Does not address the next steps for course of treatment



22

Facts and Details

- Documenting "Condition improved" or "wound appears to be healing" is not detailed enough to describe the resident's current condition
 - State the facts
 - Provide comparison over time
 - Give exact measurements and provide your observations in support of your clinical opinion
 - Indicate "As evidenced by"
 - These are the details that support your statement "wound appears to be healing" or "condition improved"
 - Document the continued risks and concerns
 - Document what you are planning next and why
 - Incorporate considerations for all things that contribute to goal achievement



23

Examples of Nursing Documentation

- Left lateral calf wound healing as evidenced by decrease in size and amount of drainage from last week. Wound measures 0.2 cm x 0.5 cm. No drainage observed on dressing or in wound bed at time of scheduled dressing change. Oral intake has been optimal with resident consuming at least 75% at every meal in the last week.
- Resident's condition is improving since admission as evidenced by resident is now able to ambulate entire distance from room to dining room for meals without requiring a rest break and without evidence or complaints of shortness of breath.



24

Skilled Nursing Services

- Chapter 8, Section 30 of the Medicare Benefit Policy Manual
 - Management and Evaluation of the Care Plan
 - Observation and Assessment of Patient Condition
 - Teaching and Training Activities
 - Direct Skilled Nursing Services
 - Must be delivered on a DAILY basis 7 days per week



25

Direct Skilled Nursing Services

- Intravenous or Intramuscular injections and intravenous feedings
- Enteral feeding that comprises at least 26% of daily calorie requirements and provides at least 501 milliliters of fluid daily
- Naso-pharyngeal and tracheotomy aspiration
- Insertion, sterile irrigation and replacement of suprapubic catheters
- Application of dressings involving prescription medications and aseptic technique
- Treatment of pressure ulcers, Stage III or worse or a widespread skin disorder
- Heat treatments which have been specifically ordered by a physician as part of active treatment AND which require observation by skilled nursing personnel to evaluate the resident's progress



26

Direct Skilled Nursing Services

- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel such as the institution and supervision of bowel and bladder training
- Initial phases of a regimen involving administration of medical gasses such as bronchodilator therapy
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the resident's medical record



27

Non-Skilled Supportive or Personal Care Services

- Administration of routine oral medications, eye drops, and ointments
- General maintenance care of colostomy and ileostomy;
- Routine services to maintain satisfactory functioning of indwelling bladder catheters
- Changes of dressings for uninfected post-operative or chronic conditions
- Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems
- Routine care of the incontinent patient, including use of diapers and protective sheets



28

Non-Skilled Services

- General maintenance care in connection with a plaster cast
 - Skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or requires adjustment of traction
- Routine care in connection with braces and similar devices
- Use of heat as a palliative and comfort measure
- Routine administration of medical gases after a regimen of therapy has been established
- Assistance in dressing, eating, and going to the toilet
- Periodic turning and positioning in bed; and
- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance



29

Indirect Skilled Nursing Services

- Management and Evaluation of the Care Plan
- Skilled Observation and Assessment of Patient Condition
- Teaching and Training Activities



30

Management and Evaluation of Care Plan

- Development of the care plan
- Management of the care plan
 - Changes in resident condition
 - Changes in the care plan interventions
- Evaluation of the care plan.....based on the:
 - Physician's orders
 - Supporting documentation



31

Management and Evaluation of Care Plan

- Develop the initial baseline care plan
 - Within 24-48 hours of admission
- Implement plan of care
 - Physician's orders
 - Nursing measures
- Evaluate plan of care
 - Is it working?
 - Have there been changes in resident condition?
 - How have you adjusted the plan of care and rationale behind changes?
- Changes implemented to plan of care
 - Have new problems, concerns or risk factors been identified?



32

Management and Evaluation of the Care Plan

- Remember the plan of care was created to meet the resident's skilled needs by –
 - Promoting recovery
 - Meeting medical needs
 - Providing medical safety
- The care plan must reflect frequent adjustments with weekly evaluation of goals documented



33

Example:

- 84 year old resident with history of diabetes and angina pectoris is recovering from an open reduction of the neck of the femur post fall and the resident needs:
 - Careful skin care
 - Appropriate oral medications
 - Diabetic diet
 - Therapy services to regain PLOF
 - Observations for signs of deterioration or complications resulting from age, multiple comorbidities, risk factors, and restricted mobility



34

Plan of Care

- The entire team is responsible for the plan of care
 - Develop measurable goals
 - Individualized resident specific interventions
 - Frequent evaluation of care plan is necessary
 - Frequent changes of the care plan is necessary
 - When care is stable, it no longer is reflective of a skilled need



35

What to Document?

- Based on the resident's medical and functional status:
 - What types of ongoing evaluation/assessments and interventions will Nursing and/or Therapy provide based on:
 - Medical symptoms/condition (not diagnosis) and the clinician's concerns related to the symptoms that have the potential for serious complications
 - Document observed declines/ongoing status, physical/functional or mental, or other high-risk behaviors that could complicate the recovery of the medically at-risk resident
 - Presence of a treatment plan that requires daily or more frequent intervention which requires the skills of a professional to evaluate the effectiveness of the interventions on a daily basis
 - What goals are reasonable and necessary for this resident?
 - What interventions are necessary to help achieve the goals for this resident?
 - What barriers are complicating recovery?



36

Painting the Picture of Skilled Care

- Use critical thinking skills and reflect this in your documentation
- Document accurately and professionally
- Initiate/evaluate and modify the care plan as needed
- Take credit for care you are providing
- Documentation should explain why it takes a licensed professional to care for this individual



37

Observation and Assessment of Resident Condition

- This consists of skilled services when the likelihood of a change in the resident's condition requires skilled nursing to identify and evaluate the need for possible modification or treatment or initiation of additional medical procedures, until the resident's condition is essentially stabilized
- The key to skilling for Observation and Assessment is the relationship of the observation and assessment to the stability of the treatment plan
- Nursing care plan that describes the resident's condition, specific or potential problems and planned interventions on a daily or more frequent basis
- Indication of daily or more frequent monitoring on vital signs, lung or bowel sounds, skin condition, nutritional/hydration status, mental status, mobility provided that the monitoring is related to the instability or probable change in condition



38

Documenting Reasonable Probability

- If a resident is admitted for skilled observation, but does not develop a further acute episode or complication the, the skilled observation services are still covered so long as there was "reasonable probability" for such a complication or a further acute episode
- "Reasonable probability" means that a potential complication or further acute episode was a likely possibility



39

Termination of Skilled Observation and Assessment

- The need for skilled observation and assessment may end when:
 - The resident's condition has stabilized
 - The resident recovers from the acute condition
 - The treatment plan is well established and risks to resident are minimized



40

Example of Skilled Observation and Assessment

- A resident with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medications, such as Digoxin and Lasix
- Essentially nursing would be observing and assessing stability of their cardiac and respiratory status and response to the plan of treatment



41

Example of Skilled Observation and Assessment - Cardiac

- Documentation for cardiac assessment should include:
 - Pulse rate, rhythm
 - Presence of peripheral edema
 - Monitoring of daily weights/signs of rapid weight gain
 - Medications – new, adjustments in doses, resident's response
 - Lung sounds
 - Presence of cyanosis, dyspnea, coughing, pulmonary congestion
 - Presence of diaphoresis



42

Example of Skilled Observation and Assessment - Respiratory

- Documentation of respiratory assessment should include:
 - Dyspnea, cyanosis
 - Lung sounds
 - Productive cough, sputum production and characteristics if cough/sputum present
 - Respiration rate and depth
 - Presence of chest pain
 - Utilization of supplemental oxygen, mode, liters
 - Vital signs including oxygen saturation
 - Sternal retraction, distended neck veins
 - Results labs or chest x-rays



43

Painting the Picture of Care

- Example Nursing Doc:
 - 1/1/24 - 4:50PM - Temp 100.2, P-76 - irregular, R-32 with dyspnea observed, Resident on O2 at 2lpm via nasal cannula continuous; pulse ox 89%, BP-178/88, Lung sounds with scattered rhonchi bilaterally, dry non-productive cough, 2+ pitting edema present bilateral ankles and feet; Educated resident on importance of keeping feet elevated when sitting in chair while assisting resident to place feet on stool. Resident states she feels nauseated and that her chest hurts when she takes a deep breath in; Dr. Fixall notified of assessment findings and he gave new orders to hold Digoxin, obtain STAT digoxin level, STAT CXR. Notify MD with results and any new changes in condition; MD to examine resident in the AM; Family notified of residents current condition and changes in treatment plan.



44

Subsequent Documentation

- 1/1/24 5pm - Nurse spoke with CNA who indicated resident required Max Assist x 1 with dressing, toileting and transfers today and resident declined to eat lunch or dinner. Resident appeared slightly short of breath during ADLs.
- 1/2/24 - 1:28AM - CXR results received showing moderate CHF present; Digoxin level is elevated at 3.2, Dr. Fixall notified of test results, new order to hold Digoxin until further notice; Administer Lasix 40mg IV now.
- 1/2/24 - 1:36am After establishing peripheral IV IV Lasix 40mg administered as ordered



45

Skilled or Not?

- Observation and Assessment by a nurse is NOT considered reasonable and necessary to the treatment of illness or injury when these characteristics are part of a longstanding pattern of the resident's "waxing and waning" condition which by themselves do not require skilled services and there is no attempt to CHANGE the treatment to RESOLVE them



46

Teaching and Training Activities

- Those that require skilled nursing personnel
- Teaching a resident how to manage their treatment regime
- Nurses are teachers, all the time, no matter who the resident is



47

Teaching and Training Activities

- Teaching self-administration of injectable medications or a complex range of medications
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot care precautions
- Teaching self-administration of nebulizers/inhalers to a resident



48

Teaching and Training Activities

- Gait training and prosthesis care for a resident who has had a recent leg amputation
- Teaching a resident how to care for a recent colostomy or ileostomy
- Teaching how to perform self-catheterization
- Teaching how to self-administer tube-feedings
- Teaching how to care for and maintain central venous or peripheral intravenous lines
- Teaching the use and care of braces, splints and orthotics and any associated skin care
- Teaching the proper care of any specialized dressings or skin treatments



49

Teaching and Training Activities and Documentation

- Type of instruction or teaching activity provided
- Identify who was taught – Resident or Caregiver
- Assess readiness to learn
- Response to instructions
- Identify any barriers to learning and describe work arounds
- Return demonstration/retention of materials taught
- Teaching aides utilized



50

Skilled Teaching and Training Scenario

- Resident has had a CVA with swallowing difficulties and left-sided paralysis. His wife has arranged for home care for 8 hours per day with herself/family doing the remainder of care. Therapy has established a transfer program using a mechanical lift as well as an orthotic wearing schedule for left arm/hand and foot. A bolus tube feeding schedule has been developed for this resident.



51

Skilled Teaching and Training Documentation Example

- Wife was instructed in tube feeding formula and potential side effects by dietician. Nursing demonstrated how to check placement of gastric tube prior to administration of feeding and how to check for residual. Wife instructed in use of stethoscope today. Wife voices concerns about "I am not sure I am listening to the right thing." Nursing will continue with additional demonstration and skill practice this evening using the teaching stethoscope so nurse can verify the wife's observation. Will progress to the mechanics of administering the bolus feeding as wife demonstrates comfort with current information.



52

Trends

- There are millions of dollars denied every year and this number will continue to grow
 - Why? Because we all too often do not adequately capture the care provided to the residents
 - We fall short of capturing the necessary details of the care in the clinical record
 - Results in a negative outcome for the facility as the facility received reduced or no payment for care provided
 - Results in more scrutiny which increases the burden on facility staff responding to these medical reviews



53

Denials

- Denials due to:
 - Conflicting information in the clinical record between Nursing, Therapy and the MDS
 - Lack of documentation
 - The medical complexity of the resident's condition that necessitate the skills of nursing or therapy are not adequately captured in the clinical records
 - Fraud, Waste and Abuse



54

Supportive Therapy Documentation

- Documentation that the skills therapy interventions are required
 - What services does therapy provide that restorative nursing cannot address?
 - Assessment and changes to the treatment regime
 - Medical complexity



55

Example: Skilled Gait Training

- PT performed gait training with client to normalize gait pattern, training in correct sequencing of gait using verbal and tactile cues with AD to increase safety, gait training w/ emphasis on stair climbing activating gluteal musculature and safety training w/ larger steps (using metronome) and changing directions.



56

Recommendations

- Educate staff on skilled documentation
- Explain WHY and WHAT the ramifications can be
- Review documentation on a regular basis providing re-education as needed
- Have an effective new-hire training in place to teach staff at the start of employment
- Have an effective Triple Check process in place



57

Documentation Risk Areas Under PDPM



58

Accuracy of the MDS

- With the implementation of PDPM came the need for increased MDS accuracy and supportive documentation
- Issues tied to reimbursement must be validated in the documentation
 - Section GG – Function Score affecting PT, OT, Nursing Components
 - Section K – Swallowing Disorder and Mechanically Altered Diet affecting SLP Component
 - Sections I and J – SNF Admitting Diagnosis and Surgical Procedures affecting PT, OT, and SLP Components



59

How do we Tell Our Client's Story?

- Collaboration and communication are imperative
 - Pre-admission process: Communication with the referral source is necessary to understand the reasoning behind referral to the SNF
 - Determination of primary diagnosis: Teams will have to determine the primary diagnosis they will be treating together.
 - Describing all comorbidities and services: Teams must determine an approach to understanding the comorbidities and services that determine case mix.
 - Pre-bill Claim Review: Members of the IDT should review claims, validate the information, and ensure that supporting documentation is in the medical record.



60

Importance of Accurate ICD-10 Coding

Accuracy is critical to ensure:

- Medical records reflect resident
- MDS is accurate
- Quality Measure exclusions are identified
- Diagnosis codes are correct on the UB-04



61

Determining Primary Diagnosis



- PDPM requires facilities to code the diagnosis that corresponds to the primary reason for care
- CMS recognizes that in many cases, the primary reason for SNF care may not be the same as the primary reason for the prior inpatient stay



62

Keys to Success



- Ensure staff have sufficient ICD-10-CM training to properly assign diagnoses codes
- Ensure your facility is receiving appropriate medical records to accurately assign diagnosis codes to the fullest specificity
- Make ICD-10 coding a priority for review at Triple Check
- Decide the Primary Diagnosis as a TEAM



63

Importance of Clinical Documentation

- Under PDPM, accurate ICD-10-CM code assignment drives reimbursement for the entire Med A stay
- Must have the complete picture via medical records in order to capture accurate code assignment

PT	OT	SLP	Nursing	NTA
<ul style="list-style-type: none"> Primary reason for SNF care Functional status on admission 	<ul style="list-style-type: none"> Primary reason for SNF care Functional status on admission 	<ul style="list-style-type: none"> Primary reason for SNF care Cognitive status Swallowing disorder or mechanically altered diet present Additional SLP related comorbidities 	<ul style="list-style-type: none"> Clinical information related to SNF stay Functional status Extension services Depression Restorative Nursing 	<ul style="list-style-type: none"> Comorbidities Extensive Services

Select

64

Preparation is Key



- Ensure your facility is receiving appropriate medical records to accurately assign diagnosis codes to the fullest specificity
- Practice coding on tough areas such as fractures
- Ensure that the proper Primary ICD-10 CM is assigned
- ICD-10 CM codes to support Comorbidities

Select

65

Section GG: Functional Status

- Points are assigned based on performance of each item
- "Resident refused," "Not applicable," "Not attempted due to medical condition or safety concerns" "not attempted due to environmental limitations" are grouped with "dependent"
- Additional response level to reflect residents who skip the walking assessment due to their inability to walk
- Multiple items are averaged together

Select

66

Section GG: Coding Tips and Definitions

- Residents should be allowed to perform activities as independently as possible, as long as they are safe
- Activities may be completed with or without assistive device(s)
 - Assistive device should not affect coding
- Code based on “usual performance”
- Not the most independent or dependent



67

Section GG: Coding Tips and Definitions

- If a helper is required (i.e., resident is unsafe), only consider staff assistance when scoring
- A “helper” is facility staff who are direct employees and facility-contracted employees



68

Section GG: Coding Tips and Definitions



- Residents with cognitive impairments may need physical or verbal assistance
- Code based on the resident's need for assistance to perform the activity



69

Section GG: Activity Not Attempted

- 07, 09, 88, 10 should not be used if you did not directly assess the item during your evaluation
 - All attempts should be made to obtain the information from other sources
- 09 should be a rare score for eating, toileting, and bed mobility items
- Do not score dashes



70

Documentation to Support Discharge Planning

- Social Determinants of Health (SDOH) should be included in coding and documentation
- MDS SDOH Elements
 - Ethnicity
 - Race
 - Transportation
 - Health literacy
 - Preferred language
 - Isolation
- Incorporate at the beginning of POC.



71

Nursing Documentation & PDPM

- Visit Selectrehab.com
- Click on *PDPM* at the top of the page then click on *PDPM Resource Center*
- Resources include topics:
 - Section GG
 - Strategies for Success
 - How it Works
 - Depression & Cognition
 - Impact of ICD 10 CM and Coding Sections I&J
 - Harnessing Technology
 - Nursing Documentation
 - We are all in this Together



72

Thank You!

Neely Sullivan, MPT, CLT-LANA,
CDP
Education Specialist
Select Rehabilitation
nsullivan@selectrehab.com

Select
