HOW TO WRITE A PHYSICIAN ORDER FOR SKILLED SERVICES
In a Skilled Nursing Community

Initially, a physician must order the appropriate therapies to evaluate and treat a resident. After the initial evaluation, therapists clarify what they expect is needed to treat the resident. The attending physician reviews that and signs to make it an order, if in agreement. The therapy clarification should clearly state:

1) the specific duration of service delivery (how many weeks)
2) frequency of services (how many days each week)
3) medical reason for therapy
4) exact treatments or services to be provided.

Then, the medical record must document all skilled therapy provided along with the number of minutes the treatments were provided. There is a CMS requirement to identify group time in the minute log. Only 25% of treatment time can be group time. Failure to report treatment as group time when it was done with a group is considered Medicare fraud.

At the time of the next therapy evaluation, a new treatment order should be written specifying the new duration, frequency, medical reason and exact treatments.

For SNF Medicare A treatments, HCPCS codes are used for bookkeeping only. They are not reported to Medicare.

A correctly worded therapy clarification order reads:

Physical therapy two to three times per week for 4 weeks for “medical condition”: range of motion, stretching and strengthening; TENS and ultrasound as indicated; pain management techniques; aqua therapy; and ROM exercises.

In most Colorado SNFs the AVERAGE rehabilitation days are 26 to 28. However, the number of weeks specified should be enough to cover the recovery of the resident given their co-morbidities, motivation and status prior to illness resulting in admission.

The frequency is based on the resident’s stamina, reason for therapy, types of therapy, etc. Frequency is specific to the resident.

Each order should include the types of treatments that will be provided. If more treatments are added a new order should be written. If some treatments are ineffective or no longer appropriate, a new order should be written.

Physical therapy treatment types include but are not limited to: Gait training; ADL training; Safety training; Therapeutic activities for ____________; Therapeutic exercises to _______________; ________ strengthening and balance; Patient education; Caregiver instruction; Adaptive equipment instruction; Pain management; Biofeedback; Neurostimulation; Group therapy; Neuromuscular re-education; Aqua therapy; Massage; Joint mobilization; Posture training; ROM exercises; Transfer training; Heat or cold treatments; TENS; Whirlpool treatment; traction, etc.
Occupational therapy treatment types include but are not limited to: Therapeutic exercise to ___________; Therapeutic activities for ___________; ADL re-training; Transfer training; Home safety training; Adaptive equipment training; Assistive technology training; Caregiver training; Group therapy; Patient education; Prosthesis training and education; Functional gross motor training; Bed mobility, etc.

Speech therapy treatment types: Cognitive treatment; Safe swallow techniques; Voice training; Articulation training; Oral motor therapy; Language intervention therapy; Language disorder training; Patient education; Caregiver instruction; Assistive device training; Fine motor and Visual-motor skill training, etc.

Nursing skilled services: IV antibiotic administration and monitoring; Coumadin monitoring; Insulin monitoring and administration; pain monitoring; s/s infection in wound monitoring; behavior monitoring; tube feeding; wound dressing & changes; PICC line monitoring; monitoring medication adverse effects; tracheotomy, nephrostomy, ileostomy, colonoscopy, etc., care; incontinence care; and/or bowel/bladder re-training, etc.

From the Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services

30.2.3.2: Observation and assessment are skilled services when the likelihood of change in a patient’s condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient’s need for possible modification of treatment or initiation of additional medical procedures, until the patient’s treatment regimen is essentially stabilized. If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. “Reasonable probability” means that a potential complication or further acute episode was a likely possibility.

From 30.2.3.3: Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:
• 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 medical gases to a patient;
• Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
• Teaching patients how to care for a recent colostomy or ileostomy;
• Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
• Teaching patients how to care for and maintain central venous lines, such as PICC lines and Hickman catheters;
• Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
• Teaching patients the proper care of any specialized dressings or skin treatments.

From 30.2.4: There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:
• The primary service needed is oral medication; or
• The patient is capable of independent ambulation, dressing, feeding, and hygiene.

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From 30.3: Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- 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 patient’s progress adequately (see §30.5 for exception);
- 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; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- 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 patient’s medical record.

In each of the areas listed above the “Daily Skilled Note” must specifically state what is being addressed, how it relates to the overall care plan for the resident and the response to treatment.

Management and Evaluation of the Care Plan should address:

- What is being monitored based on the Physicians Orders?
- Resident status related to each problem.
- Interventions provided or modified in response to changes or decline.
- Interventions to prevent decline - related to managing risk and safety.
- Progress toward goals.
- Changes, physician notification, etc.

How is the resident responding to treatment and what progress is being made toward the goals as defined on the Care Plan?

Skilled Observation & Assessment

- Identify and evaluate need for modifications of treatment or initiation of additional medical procedures
- What is being monitored?
- What are the abnormal assessment results?
- How are the assessment results different from the resident’s normal condition?
- What interventions are provided or required by nursing to meet the needs of the resident, and to address the unstable medical conditions?
- When Response or status is negative, what was done?
  - Lab done - what were results, what was done?
Edema status - what was done, and did status change?
- Nebulizer treatment provided and the response to treatment?
  - How effective were the interventions (meds/treatments)?
  - Do the interventions need to be modified to meet the needs of the resident?
    - If modified, response.
  - Assessment of progress or lack of progress
  - Physician updates & changes in orders
  - The ADL status of the resident and the amount of assistance provided should be documented for: bed mobility, transfers, eating and toileting and these have a direct impact on the MDS RUG level.

Teaching and Training Activities
- What is being taught and why?
- Who is doing teaching and how being taught?
- Response to the teaching.
- Goal and progress towards goals.
- Contributing factors: cognition, ability to learn, eyesight, endurance etc.

Nurses Notes that only document the following are considered non-skilled Services:
- Routine medications
- Maintenance care of colostomy or ileostomy
- Maintain functioning indwelling catheter
- Changes of dressings for non-infected post-op or chronic conditions
- Maintenance of plaster cast
- Routine care connected to braces or similar devices
- Restorative Maintenance program treatments or deliver of care

The medical record must document all skilled services provided on a daily basis at a minimum. Billings Medicare for skilled services that are not documented will be denied and may be considered Medicare fraud.