



# Rehabilitation Best Practice Documentation

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# Reason for Admission to Inpatient Rehab

Best practice documentation requires the specific condition for which the rehabilitation service is being performed.

If the condition for which the rehabilitation service is no longer present, the appropriate reason for aftercare should be documented.

- Examples include but are not limited to:
  - ❑ Rehab following a CVA – the specific deficit (i.e. hemiplegia)
  - ❑ Aftercare following (specified) joint replacement
  - ❑ Rehabilitation for Fracture (specify fracture)
  - ❑ Debility/ADL/Mobility issues – identify the underlying condition causing the debility
  - ❑ Convalescence/strengthening following surgery – identify the surgery performed and link the reason for Rehab and the deficit to the surgical procedure



# CVA Deficits

- Specify deficit (s)
  - Cognitive deficits
  - Aphasia
  - Dysphasia
  - Dysarthria
  - Fluency disorder
  - Other speech and language deficit
  - Monoplegia
  - Hemiplegia or hemiparesis
  - Other paralytic syndrome (specify)
  - Apraxia
  - Dysphagia
  - Facial weakness
  - Ataxia
  - Other – specify
- Specify type of CVA:
  - Infarction
  - Nontraumatic Intracerebral hemorrhage
  - Nontraumatic subarachnoid hemorrhage
- For monoplegia, hemiplegia, and other paralytic syndromes, document side affected as:
  - Dominant - right, left or bilateral
  - Nondominant – right, left or bilateral



# Fractures

**Best practice documentation for fracture diagnoses has many new key components to accurately reflect the severity of your patients injury.**

- Type
  - Traumatic
  - Pathologic
- Location
  - Left, right , bilateral
  - Specific bone
  - Specific portion of the bone
- Acuity
  - Open
  - Closed
  - Displaced
  - Non-displaced
- Healing status for subsequent encounters
  - With routine healing
  - With delayed healing
  - With non-union
  - With malunion
- Etiology
  - Place and Cause of Injury/Fracture
  - Underlying pathological cause
- Associated complications, such as:
  - Nerve injuries
  - DVT/PE
  - Acute blood loss/blood vessel injury
  - Hardware/Device related



# Secondary Diagnoses

During the Rehab encounter patients may be treated or managed for additional diagnoses. Any diagnosis treated and/or managed should be documented to the appropriate specificity supported. The following are frequent diagnoses encountered with documentation specificity needs identified:

- DVT
  - Specify vein affected and laterality
  - Specify if this is related to a recent surgery
- Infections
  - Document organism associated to the infection (E. Coli UTI)
- Postop Hematoma
  - Specify exact site of the hematoma
  - Specify tissue type involved:
    - Skin, subcu, muscle
  - Specify the procedure this is related to
- Malnutrition
  - Specify severity:
    - Mild , moderate or severe
    - Refer to Dietitian Malnutrition Progress note for severity and clinical criteria
- Skin Ulcers
  - Specify underlying cause (Pressure, Diabetes, PVD, etc.)
  - Specify site and laterality
  - Specify depth of tissue involvement
- Deficits
  - Link to the underlying cause



# Rehab Documentation Examples

## Insufficient Documentation

- Quadripareisis secondary to spinal cord injury post-cervical decompression and fusion.
- Admitted for Rehab s/p CVA with residual right hemiparesis

## Best Practice Documentation

- Quadripareisis secondary to **spinal cord injury at C4-C5 and C6-C7 with anterior cord syndrome**, post-cervical decompression and fusion.
- Admitted for Rehab s/p acute left pons **infarct with residual increased right hemiparesis**. Patient is right hand dominant.



# Intraoperative and Postoperative Complications

The terms “Post Op” and “Status Post” are considered vague and require further clarification to determine if in fact the condition is a complication. The key elements needed for best practice documentation include:

- The affected body system
- The specific condition
  - Acute blood loss anemia
  - Accidental laceration (of specified organ)
  - Hematoma
  - Ileus
- Whether the condition is a/an
  - Complication of care or due to the procedure
  - Expected procedural outcome
- When did the complication occur
  - Intraoperatively
  - Postoperatively



# Post-op Complications Documentation Example

## Insufficient Documentation

- Patient VQ scan positive for pulmonary embolism. Ultrasound positive for DVT of the right femoral vein. History of TKR two weeks ago.

## Best Practice Documentation

- **Postop pulmonary embolism and right femoral DVT most likely resulting from immobility from recent TKR.**





# Hematoma due to a Procedure

- Site of the hematoma
  - Depth
    - Skin
    - Subcutaneous tissue
    - Musculoskeletal
  
- Procedure associated with the hematoma
  - The clinical significance of the hematoma
    - considered a postoperative complication
    - or an expected outcome
    - Unrelated to the procedure
      - Due to other chronic condition
      - Due to anticoagulants



# Dementia

- Identify the type of dementia
  - Vascular dementia
    - Includes:
      - Arteriosclerotic
      - Multi-infarct
  - Dementia due to a specific disease, such as:
    - Alzheimer's Disease
      - ❖ Early Onset
      - ❖ Late Onset
    - Parkinson's Disease
    - Alcohol Dependence
    - AID's
- Document any associated Behavioral disturbance
  - Aggressive
  - Combative
  - Violent



# Skin Ulcers

## *excluding Pressure Ulcers*

**Best practice documentation requirements for skin ulcers requires a provider to capture all of the key elements in their documentation**

- Underlying Etiology
  - Diabetic
  - PAD/PVD
  - Venous stasis
- Associated Manifestations
  - Cellulitis
  - Gangrene
  - Osteomyelitis (acute, chronic)
- Depth
  - Limited to skin breakdown
  - With fat layer exposed
  - With muscle necrosis
  - With bone necrosis
- Site / Location/Laterality
- Present on Admission Status



# Pressure Ulcer

- Site/Location/Laterality
- Stage I-IV, Unstageable
- Associated Manifestations
  - Cellulitis
  - Gangrene
  - Osteomyelitis (acute/chronic)
- Present on Admission Status



# Diabetes Mellitus

To accurately capture the severity of illness and risk of mortality of your Diabetic patient you must document all of the key elements associated with the condition including:

- Type
  - Type 1
  - Type 2
  - Drug/chemical induced
  - Due to underlying condition
    - Due to genetic defects of beta-cell function
    - Due to genetic defects of insulin action
    - Post-pancreatectomy
    - Postprocedural
- Control
  - Inadequate control
  - Out of control
  - Poorly Controlled
  - Hypoglycemia
  - Hyperglycemia
  - Insulin use



# Diabetes Mellitus and Complications / Manifestations

Diabetic manifestations must be linked to the diagnosis to establish a cause and effect relationship.

## *Manifestations and Complications*

- Diabetic retinopathy
- Diabetic Osteomyelitis
- Diabetic PVD
  - With Diabetic Ulcer
- Diabetic peripheral neuropathy
  - With Diabetic Ulcer
- Diabetic nephropathy
- Diabetic gastroparesis
- Diabetic ulcer and/or gangrene
- Diabetic Hyperosmolarity
  - With or without Coma
- Hyperglycemia/hypoglycemia
  - With or without Coma
- Diabetic Ketoacidosis
  - With or without Coma



# Key Documentation Concepts

- Link reason for admission/deficit to associated surgery, injury or illness.
  - i.e., Aphasia due to CVA
- Document any associated manifestations or conditions needing treatment or management
  - i.e., malnutrition, DVT, UTI, delirium, pressure ulcers, etc.
- Document progress of patient daily
- Be as specific as possible when documenting any diagnosis



# Take the Extra Step!

## Document :

- ALL chronic conditions – present and stable but managed.
- Significance of abnormal tests (i.e.: UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out
- Establish cause-and-effect relationships (i.e. PICC line infection)
- Laterality, if applicable
- Explain the “why” and “because” to support medical necessity
- Any tobacco use, abuse, dependence, history of smoke exposure (e.g., second hand, occupational, etc.)