Functional Impairment – Clinical Protocol

Assessment and Recognition

1. Upon admission to the facility, at any time a significant change of condition occurs, and at least quarterly during a resident's stay, the physician and staff will assess the resident's physical condition and functional status.

    a. The physician will help identify individuals who have had a recent history of functional decline and those who are at risk for additional functional decline.

2. The staff will identify individuals with a significant decline in function, including ability to perform activities of daily living (ADLs).

Cause Identification

1. As appropriate, the physician and other staff will identify and evaluate the individual's co-morbidities, conditions causing functional decline, symptoms, risks, impairments, and disabilities, and investigate their causes (for example, muscle weakness or pain due to adverse drug reactions, recent complications while hospitalized, and sedation or confusion due to fluid/electrolyte imbalance).

    a. The physician should order additional diagnostic and laboratory tests, consultations and professional evaluations that are appropriate for the resident's conditions.

2. The physician and staff will review the results and implications of these evaluations and use them to guide subsequent care planning.

    a. The physician will help identify and explain medical causes of functional decline and/or why functional decline might be medically unavoidable.

3. A physician, nurse or therapist may initiate screening for the potential to benefit from rehabilitative services such as physical and occupational therapy.
4. Following the screening, the therapist will document whether the resident may benefit from a more detailed rehabilitation evaluation or from unskilled therapy (e.g., restorative nursing services that can be provided by caregivers or exercises with which family members can assist).
5. If a potential to benefit from skilled rehabilitation therapies is identified, the attending physician will order a relevant therapy evaluation (for example, by a physical or occupational therapist).

    a. The reason for ordering the evaluation should be documented.

Treatment/ Management

1. The physician will manage medical causes of impaired function; for example, conditions or medications causing lethargy, confusion, pain, or weakness.
2. In conjunction with the physician, family and resident staff will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcomes efficiently using available resources.

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Treatment/ Management (continued)

3. Based on a review of available information (including results of the evaluation), the physician will determine if a resident meets the criteria for skilled therapy services.

    a. The physician and staff will discuss whether and how therapies could enhance the resident's quality of life and help to attain the resident's functional goals.
    b. For rehabilitation services to be reimbursable under Medicare (among other criteria), the individual must have a potential to benefit, the treatment must be appropriate, the resident must be able to tolerate the treatment, and the most cost-effective therapies should be used.

4. The physician and staff will consider possible risks related to exercise or activity, and any relevant precautions.
5. The physician will order therapy services based on the above considerations and the therapist's recommendations.

Monitoring and Follow-Up

1. The physician will subsequently help the staff determine whether therapy services should continue, based on the resident's progress relative to his/her care goals (e.g., functional stabilization or improvement) and conditions that were previously identified as affecting his/her function.
2. The physician will order any skilled therapy services discontinued when they no longer meet the criteria for medical necessity.