Long-Term Care Survey Alert

Steer Clear of Tricky Section I Situations

Look to state laws for directions.

Coding for Section I Active Diagnoses can lead you into a whole host of pitfalls. Here are the answers to three common Section I coding questions.

Is the Diagnosis Legit Enough for MDS Coding?

Question: We have a nurse practitioner who works with our physician. How do I know if the physician-documented diagnosis criterion is met with the nurse practitioner's notation of a diagnosis?

Answer: The answer here would depend on the state in which the facility is located, answered **Shelly Ray, RN, BSN**, with the **Centers for Medicare & Medicaid Services**' (CMS) **Center for Clinical Standards and Quality**, in the March 20 provider update video. "Your state nursing board, state nurse practice act, or state survey agency should provide you with information as to who can document diagnoses in the medical record."

And your state RAI Coordinator can further assist you in understanding the criteria and coding instructions provided in Section I, Ray said. You can find your state RAI Coordinator's contact information in Appendix B of the RAI User's Manual.

Question: If the care plan identifies a diagnosis of depression and the signed physician orders indicate she has reviewed the plan or care, does this meet the criteria of a physician-documented diagnosis, provided the physician signed the orders within 60 days of the Assessment Reference Date (ARD)?

Answer: "A signature associated with a physician review of a care plan is not an acceptable substitute for a physician-documented diagnosis, even if there are physician orders signed within 60 days of the ARD," Ray warned. The physician's orders that document a diagnosis, medication or treatment are acceptable, as well as the following sources within the medical record:

- Progress notes;
- History and physicals;
- Transfer documents;
- Discharge summaries;
- Diagnosis problem list; and
- Other sources as available.

Note: If you use a diagnosis problem list, you can enter only those diagnoses that the physician has confirmed, Ray cautioned.

Is the Diagnosis Active in the Look-Back Period?
Question: A new resident in our facility has diagnoses that include morbid obesity, Stage 3 pressure ulcer and hypoalbuminemia. She is receiving protein supplements that the physician ordered after his consultation with the facility dietitian to aid in healing the Stage 3 pressure ulcer. The resident is also receiving a weight-reduction diet per her request. After reviewing her most recent (30 days old) albumin level, the physician noted that the resident has protein malnutrition and requested that the dietitian reevaluate the resident's nutritional plan. The dietitian made adjustments to the resident's dietary approaches and continued with the protein supplements. Should we code I5600 Malnutrition?

Answer: Because you already know that the physician diagnosed the resident with protein malnutrition during the last 60 days, you must then identify whether the diagnosis is active in the seven-day look-back period, Ray instructed.

The resident is receiving additional protein to address the newly diagnosed hypoalbuminemia and will continue with protein supplements to aid in healing her Stage 3 pressure ulcer, Ray noted. Also, staff documented nutritional plan adjustments in the resident's care plan to address the diagnosis of protein malnutrition.

Bottom line: "This is all evidence of an active diagnosis for protein malnutrition in the seven-day look-back period," Ray said. Therefore, you can code the MDS for I5600 Malnutrition.