MDS Alert

Clip 'N Save: Know MDS Requirements For Coding UTI

The MDS coding instructions for UTI may be a bit vague, but they do set some parameters for what you shouldn't code in Section I.

Urinary tract infection includes chronic and acute symptomatic infection(s) in the last 30 days. Check the resident as having a UTI only if you have current supporting documentation and "significant laboratory findings" in the clinical record, advises the Resident Assessment Instrument user's manual.

For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j - as long as you are awaiting results of the urine culture. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if the facility later determines that the resident did not have a UTI, staff should complete a correction to remove the diagnosis from the MDS record.

A physician often prescribes empiric antimicrobial therapy for a suspected infection prior to receiving the culture results, the RAI manual notes. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine "the appropriateness and continuation of antimicrobial therapy."

Source: The revised December 2002 Resident Assessment Instrument user's manual, page 3-136 (www.cms.hhs.gov/medicaid/mds20/man-form.asp).