MDS Alert

Compliance: Make Sure These Documents Jibe for Rehab Residents

This documentation shortcut can cause ADL undercoding.

Medical reviewers will likely look at more than the SNF's therapy and nursing documentation for rehab residents -- and so should you.

A potential problem: Sometimes the therapy notes describe how a resident has steadily progressed but the MDS tells a different story, observes **Sheila Capitosti, RN-BC, NHA, MHSA ,** clinical compliance director for Functional Pathways in Knoxville, Tenn. The therapy notes show, for example, that the person has progressed from maximum to minimum assistance over a couple of MDS assessment periods. But the MDS assessments show the person's ADLs haven't changed over that timeframe, she says.

Capitosti notes that might be explained by the fact that residents tend to be a little more independent in therapy sessions where the therapist pushes them to achieve goals. By contrast, "the MDS captures the resident at his most dependent. Thus, you'd expect to see some type of discrepancy."

Time for action: "If I'm seeing contact guard assist in therapy and a 3 or 4 on the MDS for that same ADL -- that's too big of a spread," Capitosti warns. At that point, you need to start asking who's right about the person's ADL status, she stresses. "These types of discrepancies can be a red flag to auditors and place the facility at risk for scrutiny of their Medicare claims."

Tip: Use a crosswalk that translates therapy terminology, such as contact guard assistance, into related MDS terminology, Capitosti recommends (for more information on that topic, see an upcoming issue of MDS Alert).

Focus on Diagnoses Supporting Therapy

Capitosti oftentimes finds that the UB-04, MDS, and therapy log don't have the same diagnoses to support the claim. "The diagnoses need to match or correlate," she says. "If you look through the chart, often the diagnoses are there. But auditors don't want to read through charts to find them," she points out.

"That's where the triple check audit process can help where you review that before billing. Then you have time to correct things before it's too late. The triple check should include the biller, MDS person, and therapy," Capitosti says.

Tip: For a therapy resident, you shouldn't have an MDS with no diagnoses related to therapy, said **Marilyn Mines, RN, RAC-CT, BC,** in a presentation at the fall AANAC meeting in Baltimore.

Have a Proactive Plan

As part of your QA function, take a closer look when you find a significant discrepancy between the MDS and how the therapist describes the resident's progress, advises Capitosti.

Example: Consultant and physical therapist **Shehla Rooney,** has seen cases where therapists documented that a patient required higher levels of assistance than the nursing aides were reporting. In such cases, the nursing aides were routinely filling in the ADL coding when they started the shift in order to complete their documentation requirements for the day, says Rooney, principal of Premier Therapy Solutions in Cookeville, Tenn.

Also: "Facilities should be doing audits to review documentation -- particularly for those residents who are outliers [due to] higher than average RUG utilization and/or lengths of stay," Capitosi advises. Look for patterns and trends and come up with an action plan to develop educational interventions, she adds. Also track and trend the SNF's Additional

Development Requests and denials in order to develop an action plan and education to address those, Capitosti suggests.

"Facilities should also be aware of local coverage decisions and issues their MACs and the RACs are looking at when selecting their audit samples to be sure they are in compliance." (For an update on the RACs, see page 23 of this issue of MDS Alert.)