MDS Alert

DAVE Program: Doctor Section I With The Right Diagnosis Coding Cures

7 ways to keep DAVE off your case.

The "I's" have it as far as DAVE is concerned in winning the vote for one of the most problematic MDS sections. And that means your facility might be due for a diagnosis coding checkup.

Section I (diagnoses) rang up second place on the **Centers for Medicare & Medicaid Services'** Data Assessment Verification project's (aka DAVE) top five hit list targeted for education and review, which includes Sections P, I, O, J and G.

"Section I is important because it not only captures residents' health status and diagnoses but impacts the RAPs, RUGs, quality indicators and quality measures," emphasized **Michelle Dougherty, RHIA, CHP**, HIM practice management manager with the **American Health Information Management Association**. Dougherty presented Oct. 29 in the second of a series of CMS-sponsored Webcasts targeting MDS coding problems unveiled by the DAVE prenational or pilot phase. (CMS will analyze DAVE findings resulting from offsite and onsite MDS reviews conducted this year.)

View the Oct. 29 Webcast on Sections I, J, and 0 at www.cms.internetstreaming.com.

Keep DAVE at Bay

Give your facility a clean bill of health in Section I by targeting these specific hot spots and coding nuances.

1. Code only "active" diagnoses and infections. To qualify as "active," the diagnosis has to affect the resident's current functional, cognitive and/or mood/behavior status, medical treatment, nursing monitoring and risk of death. Generally, these are conditions that drive the resident's care plan.

Example: Don't code a diagnosis of hypertension if it has no impact on the resident's functional status or plan of care. "If the facility is administering a medication for hypertension that's working, then you would code hypertension as an active diagnosis," said **Mary Pratt, RN, MSN,** acting director of CMS' **Division of Ambulatory & Post Acute Care.**

But what if the resident had episodes of elevated blood pressure in years past and has a diagnosis of hypertension for that reason?

"Don't code hypertension if he receives no medications for the condition and it doesn't affect his plan of care or ADL status," advised Pratt (given the resident's blood pressure isn't currently elevated, of course).

2. Know the RAI manual definitions for diagnoses in Section I1 and I2. Check the descriptions for various diseases and infections to see if the resident's diagnosis fits.

For example, if the resident has a physician-documented diagnosis of chronic bronchitis, check COPD based on directions in the RAI manual.

3. Follow the rules for coding ICD-9 codes in I3. "The intent of I3 is for providers to list current conditions that do not appear in I1 or I2 and/or to provide more specific diagnosis codes for disease states or conditions that do appear in I1 or I2," **Lynda Dilts-Benson, RN, RNAC, CCM, CRRN**, a consultant with **Reingruber & Co.** in St. Petersburg, FL tells **Eli.** "In both cases, you would only include those diagnoses that are being actively addressed in your plan of care," she emphasizes.

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Example: Say a resident has diabetes mellitus with renal manifestations. Check diabetes and, if you have room in I3, report the more specific diagnosis code to reflect the diabetic complication, advised Dougherty.

Beware: Failing to prioritize the diagnoses in I3 and code them correctly can have a negative effect on billing, says **Diane Brown, CEO** of **Brown LTC Consultants** in Boston.

"Or a surveyor could look at the MDS and conclude that a resident taking an antipsychotic doesn't have a diagnosis to warrant the medication," Brown adds.

4. Check more than one box to reflect diagnostic statements that can't be captured otherwise. Say the resident has a diagnosis of CVA with hemiplegia.. Then check I1t for CVA and 11v for hemiplegia. Or if a resident has diabetes mellitus and diabetic retinopathy, check both of those boxes in Section I1.

If the relevant diagnosis does not fit the RAI manual definition for a checkbox, code it in I3 using a specific ICD-9 diagnosis.

5. Code allergies documented in the resident's medical record. DAVE reviewers found a high rate of coding omissions of item I1nn for residents who had allergies, including food, drug, environmental or animal allergies.

To code an allergy, the resident does not have to demonstrate an allergic reaction in the seven-day lookback, said Dougherty. "Mark that item if the resident is susceptible to allergic reactions."

See the RAI manual definition of allergy, p. 3-130 at www.cms.hhs.gov/quality/mds20/raich3.pdf.

6. Don't let your MDS software do the talking if it's wrong. "If your computer system populates Section I, make sure the diagnoses are [active] and updated with the new ICD-9 codes," advised Dougherty.

Facilities must also update their ICD-9-CM codes by Oct. 1 each year as CMS no longer provides a 90-day grace period, cautions **Kim Allen**, national director of client services for **Keane Care**, an MDS software provider in Bellevue, WA. If your facility doesn't receive annual updates of new and deleted codes from your software vendor, make sure to manually update them each Oct. 1, advises Allen.

7. Double-check UTI coding. DAVE reviewers found a high level of miscoding at I2j. The assessment reference period (30 days) was the most common cause of the coding confusion, as other infections in Section I2 have a seven-day lookback.

Check I2j for UTI if the resident has symptoms of the condition and the treating clinician has ordered a urine culture and she documents the working diagnosis of UTI in the medical record.

"But if the urine culture comes back negative, the facility must follow the MDS correction process to remove the UTI diagnosis," said Dougherty.

Remember: Only code UTI if the resident has symptoms of the condition, emphasized Webcast presenter **Rena Shephard, RN, FACDONA, MHA.** "The symptoms could be obvious physical ones such as burning on urination, frequency or urgency," she said. "Or cognitively impaired residents may display agitated or other behaviors recognized as signs of potential infection."

Coming your way: Look for revised survey guidance for urinary incontinence by spring 2005, which will increase the focus on this prevalent clinical issue.

"Providers will be (and currently are) expected to pick up very quickly on a change in the resident's continence pattern - and the first thing you want to exclude is UTI," says **Cheryl Field, RN, MSN,** with **LTCQ Inc.** in Lexington, MA.

Read about what DAVE will be up to in 2005 in MDS & BILLING NEWS TO USE in this issue.

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