MDS Alert

DIAGNOSIS CODING: Before You Code Section I: Perform These 2 Double Checks

These steps taken in time can head off care, compliance woes.

Incorrectly identifying and coding ailments in Section I can leave your facility ailing in the care planning, survey and payment realms.

A two-fold goal: You want to make sure the resident has an accurate diagnosis list so the care plan meets his needs. And follow the RAI manual rules for coding or checking diagnoses in Section I of the MDS.

These two simple strategies will help you meet both of those objectives.

1. Involve the resident/family in developing the resident's diagnosis list. "Diagnoses can travel with the resident from year to year and place to place, resulting in some of them being very outdated," says **Lynn Peterson, RN,** quality regulatory consultant for **Health Dimensions Group** in Minneapolis. Yet the RAI rules for completing Section I "force the facility to review whether the diagnoses are current and part of the treatment plan," she notes.

Real-world practice: The interdisciplinary team at **SunBridge Pinelodge Care and Rehabilitation** meets with the resident/family at admission and asks them about the resident's diagnoses and history, according to **Norma Todd, RN,** director of nursing for the facility in Beckley, WV. "If you don't do that," she cautions, "you can miss certain diagnoses -- for example, a resident with a history of diabetes mellitus who isn't on dietary restrictions or medication to treat the diabetes. When we uncover information such as that, we notify the physician, who then confirms the diagnosis and documents it in the medical record."

Failing to ask the resident or surrogate about his history and condition can also result in inaccurate diagnoses and a care plan that's off the mark.

Example: A rehab patient with a documented diagnosis of diabetes mellitus asked physical therapist **Shehla Rooney** why she was assessing her lower-extremity sensation as part of a therapy evaluation. When Rooney explained that the assessment would help ensure good diabetic foot care, the patient said she didn't have diabetes. Turns out "the diagnosis of diabetes mellitus was an error in the hospital history and physical" that the facility had added to the patient's diagnosis list, says Rooney, owner of **Premier Therapy Solutions** in Cookeville, TN.

2. Make sure you have a physician-documented diagnosis for conditions such as pneumonia or aphasia. In that regard, an abnormal chest x-ray does not a pneumonia diagnosis make. "Sometimes people code pneumonia because the resident has had a chest x-ray showing he has an infiltrate," says **Roberta Reed, MSN, RN,** in Columbus, OH. But the physician hasn't really documented pneumonia, she notes.

Beware: A diagnosis of pneumonia coded in Section I2 alone can RUG a resident into clinically complex. So you want to make sure medical reviewers don't find you've improperly checked that condition on the MDS.

In addition, aphasia has to be diagnosed by a physician. So if you are in a state where a speech therapist can diagnose, the physician needs to co-sign the diagnosis, emphasizes Reed.

A physician can mention the diagnosis in the progress note or within an order, says **Julie Thurn-Favilla, MSN, RN,** corporate director of clinical services for **Augustana Care** in Minneapolis, which owns several facilities in Minnesota.

"For example, if the speech therapist is going to be following and treating the resident for aphasia, the physician could indicate that's the case, which would suffice as physician documentation of the diagnosis," says Thurn-Favilla.

Good question: Does a physician extender's documentation of a diagnosis meet the RAI requirement for coding it on the MDS? "The RAI manual says a physician must document a diagnosis before you code it on the MDS," says Thurn-Favilla. "The physician extender notes and orders are usually co-signed by the physician at some point," she notes. But the "**Centers for Medicare & Medicaid Services** hasn't really clarified officially that a nurse practitioner or physician assistant can document diagnoses," she adds. Thus, without a physician co-signature, the diagnosis wouldn't "technically" be valid for coding the MDS, says Thurn-Favilla, although she doesn't know that's been an issue.