Codify by AAPC

MDS Alert

Diagnosis Coding: Give Section I And The Resident's Care Plan A Checkup By Answering These 3 Critical Questions

If this section is ailing, your facility may be flailing.

Getting Section I of the MDS right requires a careful eye for detail and the ability to see how the diagnoses fit in the bigger RAI picture.

This quick checklist of questions will help ensure Section I keeps your SNF fiscally fit and in top shape for medical reviewers, surveyors or plaintiff attorneys.

1. Have you coded all of a resident's active diagnoses that meet the RAI manual definition as such? The RAI user's manual says to "code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death."

Section I can end up littered with outdated diagnoses if you aren't careful, creating a "garbage in, garbage out" syndrome. For example, some facilities lift diagnoses from the discharge summary form from the hospital to code Section I, which may include inactive diagnoses, says **Gail Robison, RN, RAC-C**, a consultant with **Boyer and Associates** in Brookfield, WI.

LTCQ Inc. sometimes finds inactive diagnoses automatically carried from one MDS to the next, cautions **Susan LaBelle, MSN, RN**, a consultant with LTCQ in Lexington, MA.

The solution: Ask the team to review Section I to see if they are aware of an active diagnosis that isn't coded in the section. Review each diagnosis in Section I to see if it is still active and meets the RAI definition for coding it as such there. **Remember:** You need physician documentation in the clinical record to code a diagnosis in Section I.

Watch out for this: Failure to capture hemiparesis in someone who's had a stroke is an omission that Robison sometimes finds. If the person had a stroke and still has hemiparesis affecting his ADL functioning, check that diagnosis in Section I1, she says.

2. Does the physician-documented diagnosis fit what you've checked in I1 or I2? Patricia Boyer, MSM, RN, NHA, principal of **Boyer and Associates,** sometimes sees the MDS team code a condition similar to the physician-documented diagnosis -- for example, cataract when the person really has a diagnosis of macular degeneration.

If a diagnosis doesn't fit, don't code it in I1 or I2. You can clarify the diagnosis with the physician and get an ICD-9-CM code to use in I3, if necessary (see the article on p. 67).

3. Does Section I jibe with other symptoms and interventions coded on the MDS, as well as the medical record documentation and care plan? Do a quick "big picture" review to connect the dots between arthritis, for example, and any related problems, such as impaired ADL functioning or pain, and see if the care plan addresses those issues.

Important: If you've coded a diagnosis normally associated with pain, such as hip fracture, arthritis or cancer, does the resident have pain coded in Section J? That's important to look for because there's currently no RAP for pain, observes **Joan Brundick, RN**, state RAI coordinator for Missouri. Also look for documentation of ongoing pain assessment and whether the treatment regimen meets the resident's goals for pain relief.

More examples of quality checks: If the person had an eye disease coded, such as macular degeneration, look at how you coded Section D for vision and the care plan, advises Brundick.

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If a resident has a diagnosis of schizophrenia checked in Section I1, does he have an antipsychotic med coded in Section O4? Does he have hallucinations checked in Section J or behavioral symptoms in E4? If so, perhaps the person's medication and assessment and/or care plan interventions need revisiting.

If the person has Parkinson's disease, does he have falls coded in Section J? Has the interdisciplinary care team investigated whether the two are related?

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