MDS Alert

Documentation ~ Don't Expect Your Coding To Stand On Its Own

The heat is on for supporting what you put on the MDS.

You've heard the expression "put your money where your mouth is." In the MDS world, you want to put your documentation where your coding is -- especially for coding decisions that drive payment. That's true more than ever before now that DAVE 2 nurse reviewers are going on-site to reconstruct MDSs from residents' medical records in randomly selected nursing facilities.

Not only that but a September 2006 **Health & Human Services Office of Inspector General** (OIG) report recounts how a SNF owed Medicare money because several of its claims lacked supporting documentation for IV therapy (read the report at http://oig.hhs.gov/oas/reports/region6/60600047.pdf).

The compliance reality: The concept of the "MDS as an original source document is gone," in the view of **Marie Infante, JD,** an attorney in private practice in Washington, DC. Some experts recommend facilities have support documentation for everything they code on the MDS. One thing is certain: You should be able to ante up clinical record documentation for the items that group a resident in a RUG for Medicare or Medicaid payment.

Target These MDS Sections

Pay close attention to documentation to support the following MDS sections, which drive payment or show the impact of a resident's rehabilitation therapy on his functional status.

Cognitive status (Section B): For cognitive status, the MDS has a seven-day lookback, advises **Roberta Reed, MSN, RN,** clinical care manager at **Legacy Health Services,** which operates nursing homes in Ohio. You need supportive documentation about how the resident performed cognitively during the seven-day lookback for the MDS, says Reed.

Communication/hearing patterns (Section C): Section C involves assessing whether a resident can make his needs known, says Reed. "If the resident is getting speech therapy, document any changes resulting from the therapy and code it in Section C."

Mood/Anxiety Indicators (Section E1): "Every time the resident has an MDS assessment, all disciplines should do some kind of assessment of the person's mood and behavior," suggests Reed. And "if the resident is in clinically complex with the depression end split, make sure you document the depression indicators in the medical records [during the 30-day lookback]."

Activities of daily living (Section G1): Data collection must include the ADL self-performance and support information, which the direct-line staff usually complete for every shift during the lookback period, says **Marilyn Mines, RN, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

Diagnoses (Section I): Code only a current diagnosis that the "team is care planning," advises Reed. The physician must document a condition before you can code it in Section I.

Watch out: If your MDS software pulls forward a pneumonia diagnosis from the 5-day to the 14-day MDS -- and the resident has finished his antibiotics and is stable -- "that can be a problem if the person RUGs into clinically complex" as a result of the diagnosis, says **Cindy Hart, LPN, CPA, CPC,** with **LW Consulting Inc**. in Jenkintown, PA.

Even if the resident RUGs into a therapy RUG, coding pneumonia in Section I is "still inaccurate if the facility isn't

addressing it any longer in the care plan," adds Hart.

Tube feedings and IV fluids (Section K): The last thing you need is for the FI to deny a 100-day SNF stay because the facility failed to document how much enteral feeding a resident received.

Remember: For purposes of skilling someone for Part A, the tubeeeding only counts if the resident receives 51 percent or more of his calories (K6a) or 26 to 50 percent of his calories (K6a) and 501 cc or more of fluid enteral intake daily (K6b) in the seven-day lookback.

"The resident should have an intake and output sheet to show the amount of enteral feedings and flushes provided," says **Debra Miller, RD, LDN,** director of dietary services for **Heritage Enterprises Inc.** in. Bloomington, IL. If the resident receives nourishment by mouth and a tube feeding, the dietitian should document what percentage of the resident's total caloric intake comes from the tube feedings.

Don't miss out: "The residents who fall through the cracks in terms of lack of documentation are often the ones receiving a combination of tube feedings and oral intake," cautions Miller.

Skin condition (Section M): Consultant **Patricia Boyer** says she often finds "no documentation in the chart at all to support coding of pressure ulcers and other wounds in Section M."

In Boyer's experience, that documentation shortfall most commonly occurs because nursing home staff become "so reliant on their wound-care consultants seeing residents with ulcers weekly that they don't chart" on the wounds. But the chart may not even have documentation from the wound-care consultant, says Boyer, principal of **Boyer and Associates** in Brookfield, WI.

This won't work either: Some facilities maintain wound-care logs on all wound-care residents, "which isn't going to work as individual documentation to support coding," adds Boyer. The revised F314 (pressure ulcers) says the facility must assess the wound daily and at dressing changes, she advises.

Editor's note: For an in-depth look at documentation requirements for Section P, which includes numerous RUG drivers, including rehabilitation therapy, see the December 2006 MDS Alert.