Codify
BY AAPC

MDS Alert

Intersectional Coding: Are You Coding UTIs Correctly?

Avoid F-tags and expand your coding to fully match your assessment.

You know that UTIs are tricky to code because the instructions in the RAI Manual are simultaneously specific and vague. Surveyors are cracking down on SNFs for not doing enough to prevent UTIs, as well as coding diagnosed UTIs incorrectly. Read on to find some tips about UTI coding basics and ways to improve your team's protocol and communication facility-wide.

Specifics: Surveyors are hot on the trail for inaccurate, incorrect, or incomplete UTI coding, giving out F315 tags (No catheter/Prevent UTI/Restore Bladder) and citing preventing UTIs as a top deficiency, as well as giving out F278 tags (MDS Accuracy) for incorrectly coding UTIs as common errors in 2015 in a nationwide survey of facilities in volunteer states, according to a CMS Fiscal Year (FY) 2015 Minimum Data Set (MDS) Focused Survey Summary, released Nov. 4, 2016.

As UTIs are so prevalent, it's especially crucial to code them properly. According to the **Centers for Disease Control and Prevention**, "The urinary tract is one of the most common sites of healthcare-associated infections, accounting for 20-30 percent of infections reported by long-term care facilities."

The process for coding UTIs is unique to other items in Section I. "UTI is the one diagnosis with special coding rules. It is the exception to every instruction in Section I for coding diagnoses. The rules for coding UTI are not in line with McGeer criteria for infection surveillance," **Judy Wilhilde Brandt, Rn, Ba, QCP, CPC, RaC-Mt, Dns-Ct,** Principal at **Wilhide Consulting**, says**.**

Assessing: Urinary Tract Infections present frequently in SNF residents, particularly in those who need assistance toileting or rely on a catheter. The symptoms range across body systems and may present differently depending on the particular resident affected.

"Using the Suspect UTI SBAR will enable nursing staff to properly assess the resident for a UTI, and report to the physician or nonphysician practitioner, who will diagnose and/or order antibiotic therapy," **Marilyn Mines, RN, BC, RaC-Ct**, senior manager at **Marcum LLP**, says. You need concrete signs and symptoms (see criteria below) to code Section I.

Coding: Once you or team members have determined that a UTI is present, make sure you're coding the situation appropriately. "Another issue that comes up is that the 30-day lookback does include prior to admission. This means that all four elements (as described below) required for coding can happen prior to admission. This will not affect the Quality Measures, however, because the UTI QM is a long-stay measure. If a UTI from the hospital is triggering your UTI QM, that means you sent them to the hospital from your facility. They had to achieve 'long-stay' status prior to it triggering," Wilhilde Brandt says.

You Know UTI Coding is Unique: Here are Your Criteria to Code

Because an active UTI presents across so many different systems, it's necessary to code across different sections of the MDS. As you can see in the RAI chart below, correctly coding UTIs involves coding many sections: Section C (C1310: Signs and symptoms of delirium), Section I (I2300 Urinary tract infection), Section H (H0600 Urinary continence), Section G (G0110 ADLs ... consider health-related quality of life), Section J (J0300 Pain presence), and Section P (P0100 Physical restraints) which could prevent a resident from toileting frequently enough, along with evaluating other extenuating circumstances like caffeine intake, fluid intake, toilet access, and the use of absorbent pads or briefs.

Here are some things to remember when coding UTIs:Section I: UTIs have a lookback of 30 days instead of seven days.

The RAI Manual states:

Code UTIs only if all the following criteria are met:

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days,

2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),

3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and

4. Current medication or treatment for a UTI in the last 30 days.

Tricky: What about a diagnosis code? "If there is a need to mark an ICD-10 code, for example, on a Medicare UB-04 if we are actively treating the infection, it would be included on the UB. However, it would be necessary to remove that code once it is no longer being treated. The MDS itself automatically pulls the ICD-10 when we code in Section I," Mines says.

Keep in mind: Coding a UTI for the MDS does not require a urinalysis. "There is no requirement for a urine culture to code UTI in Section I. The physician determines what is a relevant lab finding," Wilhilde Brandt says.

But to make sure everyone is on the same page, it's important to set facility protocol. People filling out the MDS can become confused if one physician requires a urinalysis and another doesn't. "I think it's a great idea for directors of nursing service to collaborate with the medical director to determine what 'significant lab findings' mean for his or her organization. If the medical director says, 'We follow McGeer criteria and will give no diagnosis of a UTI without a culture,' then the data for the facility will be consistent. You won't have a UTI coded on one MDS and not another, depending on who the physician is," Wilhilde Brandt says.

Clarification will come. "To code or not to code is a hot topic today. The implementation of the antibiotic steward will help clarify this problem when the facility begins to write and follow the required policies and procedures. Asymptomatic bacteria are often the basis for antibiotic use and a diagnosis of UTI. Everyone will culture something, which is why the CDC does not recommend that urinalysis and cultures be routinely done to determine the diagnosis," Mines says.

See more: https://www.cdc.gov/nhsn/pdfs/ltc/ltcf-uti-protocol_final_8-24-2012.pdf,

RAI Manual Appendix C: CAA Resources 6. Urinary Incontinence and Indwelling Catheter, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-06.pdf.