MDS Alert

Management: 4 Ways To Make Physicians Key Players In The MDS Process

MDS education, QA, documentation triggers and promoting a 'win win' mentality are on the list.

Looking to assist physicians to boost their MDS know-how and support the assessment and its related functions? Below, experts highlight some innovative strategies to achieve that goal.

Strategy No. 1: Find a way to teach attending physicians the basics. Medical director **Matthew Wayne, MD, CMD**, from Cleveland, doesn't think physicians in nursing homes need to have a detailed understanding of the MDS. "But they need to understand how the information drives QIs/QMs, risk assessment and payment." That's why **Cornelius J. Foley, CMD,** asks attendings in his facility to complete an MDS on a resident whom they have gotten to know the first week or two after admission. The approach helps the physician better understand the assessment tool and how it's used, Foley relayed in a presentation at the March 2007 **American Medical Directors Association's** meeting.

Strategy No. 2: **Develop documentation formats that trigger busy physicians to document diagnoses, risk factors and physician visits.** "Physicians are very busy, and if you ask them to document too much, they aren't going to do it," observes **Kathy Hurst, RN, JD**, director of healthcare operations for **TSW Management Group Inc.**, in Anaheim, CA, which manages several nursing facilities in California. As a solution to that problem, TSW is developing a progress note with triggers designed to help the physician remember to document needed information. For example, the progress note may have a question asking if there are any new diagnoses, says Hurst, and if yes, which ones? Are there subtractions to the diagnosis list? If yes, which ones?

"The progress note, which is in draft form, would also include a trigger for the physician to document the basics of the physical exam ...," Hurst adds.

Tip: Foley noted that some people recommend listing risk factors for pressure ulcers in the format for the history and physical and 30-day progress note. That way, you can cue the physician to identify whether the risk factors exist or not, he said.

Strategy No. 3: Let physicians know that what's good for the facility is good for them, too. Consultant **Christine Twombly, RN,** reports working with doctors who had her review their SNF documentation and found, in some cases, that they could have billed higher codes based on whether the patient had a significant change or other factors. "So educating physicians how to document their visit in terms of the services provided is a 'win win' situation for the physician and the facility," Twombly says. The physician can achieve fairer reimbursement and not only support the MDS and medical necessity for Medicare, but also help support why the resident is taking certain medications, which can avoid F329 tags for unnecessary meds, she says.

Strategy No. 5: When in doubt, shout. All facilities should have a systematic way to clarify diagnoses with physicians, Twombly says. For example, the MDS nurse should never try to make a diagnosis "fit" Section I1 or I2. That might happen if "the doctor writes schizoaffective disorder and there's no checkbox for that, so the nurse checks schizophrenia," says **Nathan Lake, RN, BSN, MSHA**, an MDS software and long-term care expert in Seattle.

Instead: In that kind of situation, the nurse should go back to the doctor to clarify the diagnosis or ask for an ICD-9-CM code for the condition to put in I3, Lake advises.

"In the isolated cases where an attending writes a diagnosis that doesn't fit clinical standards for making the diagnosis -- or doesn't meet the RAI manual definition -- the nurse or medical director can clarify with the physician," Lake says. "If it's a pattern, the QA process may identify it, and the medical director can address the pattern with the attending."

Example: Consultant **Patricia Boyer, RN, NHA**, heard of one nursing home physician who never liked to commit to a firm diagnosis. So he'd write, for example, "possible pneumonia." But you can't code possible diagnoses on the MDS, says Boyer, principal with **Boyer and Associates** in Brookfield, WI.