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MDS Alert

MDS 3.0: Show Physicians the Benefits of Participating in the MDS 3.0

A medical director highlights where physician input can improve the RAI process.

The MDS 3.0 provides a new opportunity to get physicians more on board with assessment and care planning, which can be a win-win for residents and the facility.

Key point: The MDS is a screening instrument and not intended to include all factors necessary for care planning and evaluation, stressed **Leonard Gelman, MD, CMD,** in a presentation on the MDS 3.0 at the March 2010 American Medical Directors Association annual conference. And the RAI process can benefit from physician input in a number of ways to take care planning to another level, he told conferees.

2 key examples: The MDS may indicate that the resident has certain medical conditions, but you may need additional assessment, Gelman noted. "This is where the physician comes in," he said, noting he's seen care plans be "very incomplete" in addressing some of the medical issues, such as unstable diabetes or orthostatic hypotension. "We need to work together to do that ... ."

The physician can also make efforts to provide important information in the initial history and physical (H&P). That "initial H&P is a key document," Gelman counseled. In fact, "much of what goes into the MDS comes from that initial ... H&P. "This also goes back to the issues ... with transitions of care" where you need "to get the proper information, the history [and] what's going on with the patient."

Tip: The medical director should evaluate some of the assessments coming out of the MDS system, suggested Gelman. The medical director should also potentially review the integration of consultant and ancillary service data into the assessment and care plan, he added.

3 More Ways Physicians Can Improve MDS A ssessment

1. Ensure physician documentation supports the MDS.

There shouldn't be anything on the MDS that the physician hasn't noted in "some way, shape, or form" -- even if it's in the initial H&P or in the annual assessment, etc., Gelman emphasized. "If the physician doesn't have a note to corroborate what the staff is finding, I find that problematic, because then is the physician really assessing what's going on with the patient? Probably not."

Tip: Given that staff is "much more familiar with the MDS" than the physicians, "they could better identify when an assessment doesn't correspond to physician documentation," opines **Daniel Haimowitz, MD, CMD,** in Levittown, Pa.

2. Do hands-on evaluations of cognitively impaired residents who show nonverbal pain indicators.

"Nonverbal descriptors are very explicit" on the MDS 3.0, Gelman pointed out. And physicians should be prepared to get questions from nurses: Is this person having a lot of pain? The physician needs to do a hands-on assessment in such cases to find out, for example, if the patient has a tender, warm, or reddened joint, he said. The good news is that the physician can bill for a visit for that. "If the staff thinks the patient is in pain -- that's a reason to go see the patient," Gelman stressed.

Tip: Responding to a question from a conferee, Gelman noted that physicians can't bill for an extra visit to review the MDS. But reviewing the MDS "can be construed" as part of the evaluation of the patient during mandatory physician visits, he said. When a patient has had a new care plan done since his last visit to the patient, Gelman always makes a comment in the medical record about that and notes any major changes. Physicians should document that information at

the mandatory visit and in between, if something significant occurs, he urged.

3. Help ensure accurate diagnosis of depression. Even though we know that depression is perhaps under-diagnosed, there is also some research to say that it is perhaps overdiagnosed, Gelman cautioned. "And we have to think about that." Thus, physicians should be prepared to assess mood-related symptoms, such as problems with sleeping, he said.

The goal: You want to stop the evaluation for depression at "the right point so you don't go down the chain" unnecessarily where staff is saying the person is depressed and asking the doctor to do something about it, such as get a psych consult.