MDS Alert

MDS Accuracy: Enlist DAVE To Stave Off Payment And Survey Woes

Target these audit hotspots now.

DAVE may be gone, but its handiwork is in the hands of government auditors and surveyors targeting your assessments and claims. So don't let the program's MDS lessons go unheeded.

The **Centers for Medicare & Medicaid Services** says it will continue to analyze and utilize the data uncovered by the Data Assessment and Verification project (DAVE) about MDS inaccuracies for program integrity and training purposes, says **Rena Shephard, RN, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego. In fact, DAVE's legacy lives on in the public domain in the form of CMS webcasts and DAVE tip sheets highlighting MDS sections with the most inaccuracies. "FIs also seem to be conducting more probe reviews and identifying problems with Part A coverage - and some of those problems are tied to the MDS," Shephard notes.

In addition, numerous MDS-based case-mix states conduct MDS reviews, notes **Carol Job, RN, MS**, a consultant with **Myers and Stauffer** in Topeka, KS, which conducts Medicaid audits for several states. "And DAVE didn't uncover anything the reviewers weren't already aware of" in terms of MDS hotspots, she notes.

Scrutinize These MDS Sections

In the light of what DAVE found, target these specific MDS problems:

1. **Section G1 (activities of daily living).** Look for scores that are a "cause to pause," says **Rita Roedel, MS, RN**, a consultant with **BDO Healthcare Group** in Milwaukee. Facilities might question an instance, for example, where the resident's toileting score is less dependent than his transfer score in the late-loss ADLs, she says.

   Toileting has three components: transfer, dressing and hygiene, so you need to ask why a resident would be more independent in transferring to the toilet than in other circumstances, says Roedel.

   That could happen if the person uses a grab bar to transfer from the wheelchair to the toilet, but he requires more assistance to transfer from the bed to a chair, Roedel adds. "Or someone whom you code as 4/3 in transfer might use the bedpan during the lookback for elimination needs, and will be scored as a 4/2 for toileting," she adds.

2. **Over- or undercoding treatments at P1a.** "The RAI manual is clear that you shouldn't code IV meds, for example, and other treatments provided in conjunction with a surgical procedure (and with the recent RAI manual update, also diagnostic procedures)," says Shephard. "Yet facilities continue to code these and could end up owing Medicare money," she cautions.

   Conversely, facilities don't always make sure they get the information from the hospital to code treatments that the resident received during the lookback, cautions **Jane Belt, MS, RN, CS, CLNC**, a consultant with **Plante & Moran Clinical Group** in Columbus, OH.

3. **Inaccurate therapy minutes in Section P1b.** Use a calculator to double-check the therapy minutes reported in Section P1b.

   Also target some common reasons that facilities misreport rehab therapy minutes on the MDS, which can lead to over- or underpayments. For example, miscommunication about the assessment reference date can occur if the MDS nurse changes it and rehab doesn't get the message, cautions **Garry Woessner**, **MA, MBA, CAS,** a consultant with Stubbee &

Associates in Minnetonka, MN.

Rounding of therapy minutes can also occur where therapists are used to reporting (and rounding up or down) therapy in 15-minute increments for Part B and other payers, cautions Woessner. "For example, the therapist might round up 24 minutes to 30 minutes."

Solution: Make sure therapists know to count (using a stopwatch) the actual minutes of therapy provided to Part A-stay residents.

Tip: The less steps to a process, the more error proof it becomes. Woessner thus advises facilities to have the therapist rather than nursing input the therapy minutes on the MDS. The MDS nurse can then audit the therapy minutes to make sure they are correct.

4. **Restorative nursing at P3.** If the restorative services don't meet the criteria spelled out in five bullets in the RAI manual (p. 3-192), the facility cannot code them on the MDS, cautions Shephard. She thus advises the MDS nurse to check with the DON to see if the restorative program is meeting the requirements. For example, is the licensed nurse overseeing the program, which is a key requirement in order to code restorative on the MDS?

   "Therapy aides can be involved in providing restorative activities - and those aides can be supervised by the therapy department," Shephard notes.

   But the therapy department can't be supervising and overseeing the restorative program, says Shephard.

   If a medical reviewer finds the facility has been coding restorative on the MDS and billing Medicare or Medicaid for it - and the restorative doesn't meet the RAI manual guidelines or the state requirements for Medicaid - the payer can recoup the payment, cautions Belt.

Make Sure the MDS Jibes With Records and Resident

DAVE's key lesson: CMS expects to see supporting documentation for what the facility codes on the MDS - even though the agency has said in the past that the MDS is a source document, notes Roedel.

But MDS compliance is more than a paper exercise. The MDS must also match the resident's actual condition. For example, you don't want auditors to find a resident in a very high rehab RUG coded as having all these deficits when the patient appears much more functional than the MDS reflects, cautions **Michael Cook**, an attorney in Washington, DC.