Codify
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MDS Alert

MDS Accuracy: Ready, Set … Attest To MDS Accuracy With Confidence

These 6 strategies will keep you and your facility in the clear.

They say you should always consider the fine print before signing on the bottom line. That's particularly good advice when it comes to signing the attestation at AA9.

Signing the attestation has "profound implications for the individual [signing it] as well as the facility or organization," says **Marie Infante,** a nurse attorney with **Mintz, Levin, Cohen, Ferris, Glovsky and Popeo** in Washington, DC. "Title 18 of the United States Code (18 USC sec 1035) ... makes it a federal crime to [provide] or use a materially false statement or representation in connection with a healthcare program payment or certification," Infante emphasizes.

"The attestation language is there to remind people how significant their information is for the assessment," advises **Sheryl Rosenfield, RN,** a consultant with **Zimmet Healthcare Services Group** in Morganville, NJ. The MDS is "as significant for care concerns as it for reimbursement," adds Rosenfield.

Follow These Steps

You can manage the attestation in a way that helps you and the facility rest easy and avoid compliance woes. Here's how.

1. If you didn't complete a section or item, don't sign the attestation for that section or item. People "continue to be confused" about who should sign the attestation statement, says **Marilyn Mines, RN, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. But the RAI manual states that the "primary responsibility for accuracy lies with the person selecting the MDS response," says Mines. This means that the person(s) coding the MDS must sign at AA9, indicating her name, title, the section or item completed and the date completed.

Yet in some facilities, one nurse "signs the whole attestation form, when you know she didn't put everything" on the MDS, says consultant **Leah Klusch, RN, BSN,** executive director of **The Alliance Training Center** in Alliance, OH.

What if the nurse is putting everything on the form? Mines notes that "a one-person signature [at AA9] could cause a survey to question whether the MDS was completed properly."

The MDS "assessment is supposed to be an interdisciplinary tool," Mines says. And "one person completing it may indicate that the assessment could not be accurate, depending upon the information in the clinical record to support" the MDS coding decisions, Mines adds.

Remember: If the RN assessment coordinator works on the face sheet, she must sign at ADa. Others who are responsible for completing any part of the background (face sheet) information at admission must also sign the attestation at ADb-g, indicating the section they completed and the date they completed it.

2. Code conditions and events on the MDS as the RAI manual defines them, advised Klusch in a presentation, "Legal Implications of MDS Scoring." For example, the RAI manual has specific definitions for numerous RUG drivers and items that trigger quality measures/indicators, such as falls.

3. Collect data only during the specified assessment window for each section. "One way you can get into trouble is to sign the attestation and collect information for the MDS outside the assessment window," says **Janet**

Feldkamp, a nurse attorney in Columbus, OH.

4. Assess the resident during the lookback even if you rely on second-hand information to arrive at a coding decision. "Too many facilities rely on the medical record documentation and interviews with staff to complete ADLs or other sections," cautions **Patricia Boyer, RN, NHA,** with **Boyer & Associates** in Brookfield, WI.

5. Ensure the clinical record includes documentation to support the MDS coding. "The DAVE 2 teams are doing on-site reviews where they pull residents' clinical records and use that information to do an MDS," reports **Rena Shephard, RN, MHA, FACDONA,** principal of **RRS Healthcare Consulting** in San Diego. The reviewers then compare what they have constructed to the actual MDS and calculate a discrepancy rate. Also, CMS has instructed FIs to make their payment decisions based on the documentation supporting the MDS and lookback periods for the MDSs for the claim period billed, she adds. "If that doesn't tell us how critical it is to have documentation to support every code on the MDS -- then I don't know what does," Shephard says.

6. Develop interdisciplinary and QA processes to validate and detect potentially inaccurate information before coding the MDS. If the CNAs' flow sheets are off the mark, the team should be able to detect that if it has a "solid QA and interdisciplinary process" where team members regularly communicate about the resident, says Feldkamp.

Example: The team at **Tallwoods Care Center** receives a weekly report from rehab on a resident's progress in rehab therapy. And if nursing has documented the resident as being more independent in ADLs than his performance level in therapy, the team will address that possible discrepancy, says **Clare Polatschek, RN, MA,** the MDS coordinator for the Bayville, NJ facility. "Usually people strive to do their best in therapy, whereas nursing has to support the person more after his therapy session," she notes.