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MDS Alert

MDS Coding: 5 Ways To Keep Your ADLs On The Money And Off The F Tags

Catch little errors before they cost you a RUG or a clean survey.

Inaccurate ADL scoring takes you out of the game for fair payment--and drives your quality indicators/ measures out of bounds. But using winning strategies can turn around even serious MDS coding shortfalls.

The bottom line: An ADL index score that's off the mark by a single point can cost your facility about $20 to $50 a day for a Part A stay resident, says **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL (see the chart in the following article).

In the survey realm, a pattern of under- or overcoding ADLs skews your quality indicators/measures to the point that surveyors will be looking at you askew.

For example, undercoding a resident's self-performance in bed mobility or transfer can trigger a sentinel event by mistakenly classifying the person as low risk for a pressure ulcer (for more information, see the story later in this issue).

The good news: You can get a solid grip on your ADL assessment and scoring. Check out these five field-tested strategies:

1. Review the resident's ADL index once you complete the MDS and enter it into the computer. Double-check scores on the cusp between one RUG and the next. Say the RUGs category is Special Care (SSA) with an ADL index of 14. Check the assessment data for the late-loss ADLs (bed mobility, transfer, eating, toileting) to be sure that you didn't miss a resident's need for more help, advises Mines. If you did, the ADL index may go up to 15--a higher reimbursable category in Special Care, Mines notes.

2. Conduct a focused audit of the four late-loss ADLs that drive payment. "If the auditor finds a problem with those ADLs, you can expand the audit to see if all of the ADLs have inaccuracy issues," says **Rena Shephard, RN, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego.

Conduct focused audits once a week or every other week until the MDS team feels confident the coding is on target--and then cut back to monthly audits, Shephard advises.

If the MDS nurse is doing G1 coding, she shouldn't audit her own work. But the facility can train someone to do the audits, says Shephard. "For example, a floor nurse or someone with good critical thinking skills can learn to do the audits."

3. Make sure nursing and therapy speak the same ADL language. "Otherwise you're comparing apples and oranges," cautions Shephard.

The problem: The MDS has larger, more inclusive categories for people with a greater range of ADL deficits than the Functional Independence Measure (FIM) language that therapists use, observes **Patrick Van Beveren PT, DPT, MA, OCS, CSCS,** in Syracuse, NY.

Example: Extensive Assistance on the MDS indicates the caregiver provided weight-bearing support (using his or her own muscles to help the resident perform an ADL), Van Beveren points out.

"That [category] correlates on the FIM to anything from a hand-hold assist to help a patient maintain her balance to maximum assistance where the patient requires assistance with up to 75 percent of the task," Van Beveren says.

Solution: "Therapists and the MDS nurses should discuss exactly what kind of support the patient required from the therapist to perform an ADL," Van Beveren suggests.

4. Keep communication simple when asking CNAs about ADL self-performance. To differentiate between supervision and limited assistance and extensive assistance for coding the resident's self-performance, ask CNAs about activities they perform every day.

Example: Say the MDS nurses are assessing how Mr. Jones functions with his bed mobility.

"The CNAs may say, 'Mr. Jones can move around in bed by himself,'" says MDS coordinator **Maureen Woods, RN**, who works at **Baldomero Lopez State Veterans' Nursing Home** in Land O' Lakes, FL. But then Woods and the MDS team asks the CNAs: "Can Mr. Jones sit up by himself?" If the CNAs say no, then they use MDS terminology and ask: "Do you cue him, guide him or do you use your own muscles to help him sit up?"

5. Provide frontline staff regular access to effective ADL coding resources. For example, **Little Flower Manor** has an electronic documentation system that allows CNAs or nurses coding ADLs to watch a video with a vignette explaining what constitutes various levels of ADL assistance. "That really helps," says **Lisa Marcincavage, CRNAC**, who is an MDS coordinator for the Wilkes-Barre, PA facility.

Licensed nurses who really know how to do a professional ADL assessment can serve as a role model by documenting their hands-on evaluations each shift during the lookback, suggests **Myra Peskowitz,** president of **Peskowitz Group** in Shelter Heights, NY.

That assessment and documentation can serve as a teaching tool for the CNAs to follow, she adds.