Codify
BY AAPC

MDS Alert

MDS Coding: Cover These Bases In Coding A Resident On Palliative Care

Otherwise, you could end up with a losing survey or QIs/QMs out of bounds.

The MDS may not have a place to indicate a resident is receiving palliative care, but don't let that shortcoming trip you up in presenting an accurate picture of the person for care planning, quality outcomes reporting--and surveyors.

In fact, the **Centers for Medicare & Medicaid Services** is considering looking at outcomes for end-of-life care for its pay-for-performance demonstration for nursing facilities. The agency is eyeing issues such as advance care planning, use of enteral nutrition, hospice and hospitalization at end-of-life, according to a presentation by CMS' **Mary Pratt** at the recent annual fall NASPAC conference in Washington, DC.

Take a Close Look at Sections A9, A10

Start by paying close attention to how you code A9 (responsibility/ legal guardian) and A10 (advance directives) for all residents at admission or as their condition changes (to refer to those sections, see the Clip 'N' Save later in this issue). Surveyors will zero in on these sections if a resident's family complains to the state or a plaintiff's attorney that their resident didn't want certain treatments or life-saving efforts or vice versa, cautions **Nathan Lake, RN**, an MDS expert and software developer in Seattle.

If the resident has a responsible family member involved in his care (and no guardian or durable POA, as an example), make sure to check that at A9e, advises **Reta Underwood**, a survey consultant in Buckner, KY.
For residents on palliative care, **Schervier Nursing Care Center** indicates in Section A10 (advance directives) if the person has a "do not resuscitate order" and the designated treatment restrictions outlined on a palliative care order sheet that the team develops with the resident or his designated representative.

Check End-Stage Disease at J5c

You should check J5c (physician-certified life expectancy of six months or less) to accurately reflect the resident's condition, if he has such a prognosis. For one, the physician must certify in writing that the resident is in the end stages of terminal illness for the person's advance directive to be activated, says Underwood.

The physician must also explain in documentation how the resident's specific condition relates to his advance directive (e.g., for withholding parenteral nutrition), Underwood says.

"Some states have a separate form you fill out to indicate the person is end-stage for purposes of activating the advance directive," adds **Steven Littlehale, RN, MSN,** chief clinical officer with **LTCQ Inc**. in Lexington, MA.

Checking J5c to reflect end-stage disease will exclude the resident from certain quality measure calculations, adds Littlehale, "so don't take [the item] lightly".

Overcome this objection: Some facilities don't code J5c because they interpret the requirement to mean that a physician has to sign a note saying positively the person is going to die in six months. "But the physician can document that the resident's prognosis or life expectancy of six months or less is a greater possibility than not," says Littlehale. "That will suffice for checking item J5c."

Check These Additional Items

• **Hospice (P1ao).** Check this item if a certified hospice meeting the RAI manual definition is in place (e.g., one certified by the state or Medicare as a hospice). "Some facilities have a hospice-type or palliative program, but they cannot check P1ao if the program doesn't meet the specified requirements," says Underwood.

• **Comatose state at B1.** "Check the resident as comatose, if that's the case," says Underwood. To code B1, the clinical record must include a documented neurological diagnosis of coma or persistent vegetative status. "As the resident's disease process progresses, the MDS should reflect how dependent the person is," she adds. "And a comatose status supports total care requirements." (A comatose state will exclude the resident from a number of QIs/QMs, including ADL decline and low-risk incontinence, so make sure to code the resident's comatose state.)

• **Pain in Section J.** "Pain management is a major issue in palliative care, so review Section J2" to see if the resident's pain goals are being met, advises Underwood.

• **Diagnoses in Section I.** "You need a very specific ICD-9-CM code or codes in Section I3 to explain the reason for the end-stage condition," advises Underwood.

• **Weights in Section K**. "If the nursing staff isn't weighing the person [receiving palliative care], the MDS nurse at Schervier puts a 'no information code' in Section K of the MDS," says **Mary Ann Sero, RN**, MDS coordinator for Schervier.

"Then we explain to state inspectors or surveyors that the person is on palliative care," Sero adds. "Since there's no place to check palliative care on the MDS, we rely on documentation and the order sheet for survey purposes," she adds.

Editor's note: See the January 2006 MDS Alert for an "In the Spotlight" focus on Schervier Nursing Care Center's state-of-the-art palliative care program, and an article on LTCQ Inc.'s research on MDS items reflecting quality outcomes at the end of life.