MDS Alert

MDS Coding: Cross The T's And Dot The I's In Coding, Treating UTI

3 best practices will shore up MDS coding and care.

If your MDS team is overcoding UTI in Section I2, residents may also be receiving inappropriate antibiotic therapy. And both of those practices create problems in the survey and quality-of-care arena -- ones you can head off at the gate.

The latest coding update: The January 2008 RAI manual update says you only code an acute or chronic urinary tract infection when the person has symptoms, reminds **James Marx, RN, CIC**, president of **BroadStreet Solutions** in San Diego.

"If the patient just has a positive urinalysis or urine culture but no symptoms, then you don't code that," Marx emphasizes.

The rationale: "Asymptomatic bacteriuria in the elderly is relatively common," explains **Joan Redden**, VP of regulatory and consumer affairs for **Skilled Healthcare Inc**. in Foothill Ranch, CA.

And based on best practices and the revised F315 survey guidelines, the facility shouldn't treat someone for UTI in the absence of symptoms.

To ensure accurate MDS coding and appropriate care, consider these other key strategies:

1. Don't leap to the conclusion that a mental status change means the resident has a UTI. A change in mental status may be a significant sign of UTI, Redden acknowledges. But staff should not automatically assume that's the case without doing a thorough assessment, she says.

For example, the person may have pain due to another medical condition causing his mental status change, she says.

Medical director **Susan Levy, MD, CMD**, in Baltimore, suggests clinicians see if the resident has signs and symptoms of UTI beyond just a change in mental status. "Also, when the facility gets the urine analysis results, the staff needs to re-evaluate the resident" and see if his clinical issue has resolved without antibiotic therapy, adds Levy. "Fifty percent of residents will have a positive urine culture on any given day." And when the lab report comes back, you don't have to treat the report, she says.

2. Give physicians the information they need to decide whether to order an antibiotic. Levy believes nurses can play a pivotal role in determining whether an asymptomatic resident receives an antibiotic.

"Nurses have to really understand the issue and what's going on with the resident/patient," she says.

Otherwise, if they call a physician to report a positive culture -- and the physician doesn't remember or know the specifics about the case -- she is likely to order an antibiotic, Levy cautions.

Before you call: Investigate why the urine culture was ordered and how the resident is doing now, Levy advises. Then report that information to the physician. (See p. 70 for a suggested format for gathering information before calling the doctor about a resident's change in condition.)

3. Do a QA review of each resident who received antibiotic therapy for UTI to see if it was appropriate. The resident may have received the wrong antibiotic, or too long of a course of an antibiotic -- or a second course for asymptomatic bacteriuria.

Clinical tip: Levy's facility has educated physicians to use sulfa antibiotics as a first-line therapy for UTI versus a quinolone, such as Cipro.

Keep in mind: The revised F315 survey guidance notes that continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy. Recurrent UTIs (two or more in six months) in uncatheterized individuals, however, may warrant additional evaluation, according to the guidance.

Editor's note: See the "In the Spotlight" feature on p. 63 to find out how one nursing facility has dramatically decreased its UTI QI/QM and antibiotic usage.