# MDS Alert

## MDS Coding: Don't End Up High And Dry By Miscoding Signs

**Follow CMS' Webcast tips to improve accuracy of Section J1c.**

Over code dehydration and you'll have surveyors up in arms, but miss the subtle signs of the condition and a resident could go downhill fast.

Recognizing signs of dehydration can be difficult in frail, chronically ill elders, emphasized **Michelle McDonald, RN, MPH**, a DAVE clinical consultant presenting during a **Centers for Medicare & Medicaid Services** Webcast on MDS coding accuracy focusing, in part, on Section J.

And coding J1c (dehydrated: output exceeds intake) is a problematic section to say the least, said McDonald. Yet accuracy is essential because this item will trigger the quality indicator for dehydration, which surveyors view as a sentinel health event (see the next article for a related story).

Check J1c if at least two of the following three indicators are present:

1. Resident usually takes in less than 1,500 ml of fluid daily (water or liquids in beverages and high-fluid- content foods, such as soups and gelatin). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice guidelines, states the RAI manual.

"While 1,500 ml per day is the recommended amount, a registered dietitian or physician should determine the resident's fluid needs based on his or her size and health status," said McDonald. "The general rule of thumb is 30 ml/kg per day. Record this information in the clinical record."

2. The resident has clinical signs of dehydration. The RAI manual list includes dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, and abnormal lab values (elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, BUN, urine specific gravity).

"The signs of dehydration are nonspecific and present in many other situations, as well," said McDonald. "However, if these signs are present, consider a diagnosis of dehydration."

**These abnormal labs do not a diagnosis make:** Intravascular depletion evidenced by an elevated BUN, hematocrit or sodium is not true dehydration. "And to rely on these lab values to diagnose dehydration is misleading," McDonald emphasized. "That's not to say that residents who have these abnormal lab values aren't without issues," she added. "But to diagnose and treat residents for dehydration based on these labs alone is insufficient and unreliable."

The total serum osmolality gives a more accurate diagnosis of true dehydration, according to McDonald. Nursing home staff or their labs can calculate serum osmolality using a straightforward formula, according to McDonald.

3. Intake exceeds output (e.g., loss from diarrhea, vomiting or fever that exceeds fluid replacement).

**Tip:** Double check the seven-day lookback for J1c. Facilities sometimes code dehydration unnecessarily when they code outside the assessment window, cautions **Myra Peskowitz, RN, MBA,** with **The Peskowitz Group in Shelter Island Heights, NY.**