MDS Alert

MDS Coding: Fine-Tune Continence Coding Before Surveyors Tune In To You

These 6 patterns of errors will put your QIs in the toilet.

Section H has taken on new urgency, with revised survey guidance in the works that could leave your facility holding F315 tags - unless you know the coding and care planning ropes.

The dilemma: Overcode a resident's urinary incontinence and you'll trigger the facility's quality indicators unnecessarily. But under- code, and your care plans will be off the mark - and surveyors will be all over your case.

Sidestep both of these scenarios by avoiding these six common assessment and MDS coding mistakes:

1. Not taking credit for a scheduled toileting program at H3. Consultant **B.J. Collard** sees facilities fail to code a toileting plan even though it's clearly based on assessment and goals, as required by the RAI user's manual. The most common reason: "Staff dismisses 'just taking someone to the bathroom' as qualifying as a scheduled toileting program," she says. "But then the facility's QI (incontinence without a toileting plan) looks like a lot of incontinent people aren't being toileted," warns Collard, president of **Consulting and Teaching Service** (CTS) in Denver.

"A facility will always have some residents who refuse to be toileted, so that QI isn't going to be '0,'" she adds, "but you don't want it to be artificially high due to undercoding on the MDS."

Tip: Check your QI reports to detect residents coded as incontinent without a toileting plan and figure out why, advises **Bet Ellis, RN,** consultant with **Larson Allen Health Care Group** in Charlotte, NC.

"Is the person bedbound or refusing to toilet? If so, document the reason why there's no toileting plan," Ellis advises.

2. Undercoding residents who have mild to moderate stress incontinence. Staff may code a resident as continent or usually continent if she wears a daily pad because she leaks a little urine when she coughs, stands up, bends over, exercises, etc. But if the person has episodes of mild stress incontinence daily that require a pad to manage, she'd qualify more as a "3" (frequently incontinent) than occasionally incontinent ("2") or usually continent ("1"), based on RAI user's manual definitions (see Clip 'N Save: Section H).

If you don't code the stress incontinence, surveyors can detect the omission when they see you've checked the resident as wearing pads or briefs (H3g). "They will ask why the resident is wearing absorbent products if she's coded as completely continent," Collard says.

A worse scenario: The facility doesn't code the incontinence or the pads, and a surveyor observes the resident has a supply at her bedside or observes the caregiver helping the resident change pads. In that case, the double-coding omission looks as if you're trying to avoid triggering the QI (prevalence of incontinence).

3. Taking the rap with surveyors because you didn't use the RAP to make your case. "Use your RAP modules to explain a resident's status," Collard suggests.

Say a resident wears an ultra absorbent pad 24/7, but she stays completely dry except for occasional episodes of urge incontinence. In such a case, the nurse might write in the RAP summary: "Even though this person wears a pad every day, she still meets the criteria for occasional incontinence because her continence pattern is unpredictable (urge

incontinence episodes) and she prefers to wear a pad as protection," advises Collard.

Talk about frustrating: "You may actually have decreased a resident's number of incontinence episodes from four to two per day, but that resident will still flag on the QI for incontinence," says **Lynn Gerard, RN,** director of **Guardian Angels Care Center** in Elk River, MN.

In such a case, "document that information in the summary of your bowel and bladder assessments, as well as the care plan and evaluation," Gerard advises.

"Also have the physician document that, due to xyz reasons, it hasn't been possible to totally eliminate the resident's incontinence, but there has been a reduction," Gerard adds. "Then give surveyors a heads up on what's going on."

4. Coding a resident with an indwelling catheter as incontinent when he's completely dry. "If the catheter is leaking, then you'd code the resident as incontinent," says Collard. In such a case, "the nurses should do an assessment to determine why the catheter is leaking - for example, the bulb may not be in the right size or fully inflated, etc."

Under revised upcoming survey guidance, expect surveyors to question use of indwelling catheters, warns **Diane Newman, MSN, RN,C, CRNP, FAAN,** co-director of **Penn Center for Continence and Pelvic Health, University of Pennsylvania Medical Center** in Philadelphia.

Providers should use indwelling catheters for a handful of medically necessary reasons only, Newman says. That short list includes:

1. a stage 3 or 4 pressure ulcer affected by the incontinence;
2. a dying patient who doesn't want to be changed (due to pain and comfort issues);
3. someone who is incontinent and on strict I&O for a medical condition; or
4. management of urinary retention "if you can show that you've tried straight 'in and out' catheterization that has failed for some reason," Newman says.

5. Failing to get a true picture of the resident's incontinence over the 14-day lookback. The MDS nurse has to talk to enough caregivers, the resident and family to code the resident's actual continence status during the assessment window, advises Collard. Flow records can help, if they are accurate.

Real-world practice tips: At Guardian Angels, the nurse manager does the coding for Section H, says Gerard. "We capture episodes of incontinence through a bladder diary and also use a tracking form going through the assessment reference date for the MDS assessment, including the quarterly, annual and significant change assessments," she relays. "The staff tracks a resident's incontinence episodes for each shift," Gerard adds.

Also look for factors that may have made the resident's incontinence scores worse than they would have normally been (which you can document in the medical record and consider during care planning).

For example, "if you choose an ARD where the resident was in the hospital for many days during the lookback, your final assessment for Section H will be atypical," says **Jennifer Gross, RN,** consultant with **LTCQ Inc.** in Lexington, MA.

"That's because hospitals don't often provide care that enables self-functioning in that area of care," Gross observes.

In addition, "indwelling catheters, restraints, bedrails, and medications all increase the likelihood that a bowel and bladder assessment will not capture 'usual' functioning," Gross adds.

6. Ignoring H4, which assesses change in continence from the previous quarterly or most recent assessment (if less than 90 days). "This item can also provide a 'snapshot' comparison of the present assessment to the previous function in the community," says Gross.

Thus, paying attention to H4 can help staff detect and reconcile possible exaggerated incontinence present at admission, she adds.

If you code the resident's continence at H4 as having deteriorated, make sure to assess and address the underlying causes in the care plan, if you haven't already.