MDS Alert

MDS Coding: Root Out ADL Inaccuracies

Dig your facility out of a payment black hole.

The minute someone talks about improving ADL accuracy, you may think "Oh no, not this again." But getting back to basics for ADLs can erase payment and care plan headaches.

The fiscal reality: The ADLs alone constitute about 25 to 35 percent of the Medicare rate, "so if a facility is thinking about improving a process--that's the one to improve," says **Diane Brown, CEO** of **Brown LTC Consultants** in Boston.

These field-tested strategies will help staff finally "get" how the MDS instrument assesses a resident's ADL status and ensure they report the right information.

1. Teach staff to always look for and document the resident at his "worst" for coding ADLs. "MDS uses a dependence model for coding ADLs," emphasizes Brown.

Key learning point: At admission "some residents initially act like they just arrived at a Four-star hotel and aren't as independent as they can be," says Brown. "So if the person required a two-person assist by nursing staff from the ambulance stretcher to the bed, then capture that if it occurred in the seven-day window. Or if the person needs a two-person assist to lift her up in the bed when the head of the bed is elevated 30 degrees, then you count that."

2. Capture the frequency of a resident's ADL performance and support provided 24/7 during the lookback. Sometimes CNAs simply document the "worst" or most dependent ADL performance for a shift without indicating how many times it occurred, notes **Marilyn Mines, RN, BC, RAC-C,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. "Unless the person who analyzes the data knows how often the resident required more help, the MDS may continue to be under-coded," she says.

Also, don't just focus on what the resident does during the day shift, advises **Karen Merk, RN**, a clinical consultant with **Briggs Corp.** in Des Moines, IA. Saying that may sound like beating a dead horse. But Merk still sees facilities fail to capture what the resident does in the evening and night when "the person may require two people to move him up in bed or get out of bed."

Warning: Omitting that one instance of a two-person assist can cost you a RUG.

3. Teach staff to do all of column A (self-performance) first. If staff do all of column A first and then go back to do column B, they don't mix up the definitions for each scale, says Brown. Self-performance (column A) measures what the resident actually did in each ADL category over the seven-day lookback. Column B (ADL support provided) measures the highest level of support that staff provided to the resident in the last seven days--even if that support occurred only once.

4. Break down the more complex ADLs to assess for self-performance. For example, toilet use has several components, including transfer, says Brown. The RAI manual says toilet use includes how the resident "uses the toilet room, commode bedpan or urinal, transfers on/off the toilet, cleanses, changes [his or her] pad, manages an ostomy or catheter and adjusts clothes." And if the person who has crippled hands from arthritis can do everything but her hygiene after toileting, then she's not independent in toileting, says Brown.

Bed mobility includes how the resident moves to and from a lying position; turns side to side; and positions the body while in bed or in a recliner or other type of furniture the person sleeps in rather than a bed.

Focus On What Counts as Extensive Assistance (Column A)

Ensuring you capture "extensive assistance" requires careful assessment and documentation 24/7 during the lookback. And you have to know what counts as extensive assistance.

The bottom line: Capture at least three instances of extensive assistance if the resident required and received them, says Brown. "That's weight-bearing support three or more times." Weight-bearing means the caregiver used her own muscles in bearing the resident's weight to help him with an ADL. Thus, if the CNA lifts a person's arm rather than simply guiding it as part of feeding, you'd count that as one instance of extensive assistance.

Know What Else Counts as Extensive Services

In addition, staff may overlook other scenarios that will count as extensive assistance. For example, if the resident required "total" care most of the time during the lookback but started doing more for himself, you can count that as extensive assistance, says Brown. The RAI manual also illustrates how performing an entire subtask for a resident counts as extensive assistance--if it occurs three or more times in the seven-day lookback, says **Rena Shephard, RN, MHA**, president of **RRS Healthcare Consulting** in San Diego. Examples include "shaving a resident who is otherwise independent in hygiene--or doing a female resident's hair because it's long and the resident can't brush and fix it like she wants," says Shephard.

"Performing all of a subtask of toileting such as all of the hygiene each time a resident toilets (because the resident has restricted range of motion or crippled hands) would count as extensive assistance if it occurred three or more times in the lookback," says Shephard. "If it occurred only two times, then it'd be limited assistance."

Tip: If the resident is totally independent in dressing himself but the CNAs have to apply his TED hose daily, you'd code dressing 3-2, advises Mines.

Read "Empower CNAs To Assess And Report Accurate ADLs" in the June 2006 MDS Alert.