MDS Alert

MDS Coding: Watch Out For These Payment Drivers In June RAI Manual Update

Coding gets trickier with latest revisions.

The June 15 RAI manual update may have clouded - or even darkened - the road to RUG payment for certain services. For example, at first glance, the June revisions might appear to allow facilities to code at K5a fluids used to reconstitute IV medications. IV fluid coded at K5a counts toward Extensive Services.

But a closer look at the language in the June revision casts some doubt on whether you should code such fluids if they aren't administered for nutrition or hydration purposes. (In any case, don't code IV fluids administered solely as flushes or IV push meds at K5a. You code IV meds at P1ac.)

"CMS bolded 'nutrition and hydration' at K5a in describing IV fluids to code, which includes fluids used to reconstitute IV medications," observes **Rena Shephard, RN, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego. "Thus, CMS seems to be making the point that we should include these fluids if given for that purpose," she adds.

If the resident has a diagnosis or documentation indicating dehydration - or he's at significant risk for the condition based on medical record documentation - you could code IV piggybacks or fluids used to reconstitute IV meds, says Shephard.

To play it safe in coding fluids at K5a, "you really need a physician statement to indicate that the fluids are being given for nutrition or hydration" - or have an active diagnosis of dehydration in the medical record applying to the MDS lookback, adds **Cathy Sorgee, RN**, a consultant with **The Broussard Group** in Lake Charles, LA.

Clinical tip: Even if you don't code the IV fluids on the MDS, make sure to record them for patients on intake and output (I&O). For example, "100 ccs three times a day for purposes of administering medications adds up - especially for someone on fluid restriction," cautions **Ron Orth, NHA, RN, RAC-C**, president of **Clinical Reimbursement Solutions LLC** in Milwaukee.

Update Clamps Down on IVs

You can no longer code IVs in K5a that are part of a routine "diagnostic procedure," according to the June update, observes **Rita Roedel, RN, MN**, a consultant with **BDO/Heritage Healthcare Group** in Milwaukee. That means that if a resident received an MRI or other imaging study with IV contrast, the facility could not code the IV in K5a, says Roedel.

The update also forbids facilities from coding IV medication (which would include IV contrast material) or other treatments in P1a provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period (CMS added the italic language).

Section T ClarificationCreates Quandary

The June update directs providers to code at T1c (projected days of therapy) the actual number of days of therapy ordered by the physician (in cases where the physician orders a limited number of days of therapy). For example, if the physician orders two weeks of therapy five days a week, then you'd code 10 at T1c, says Shephard.

Say the physician orders a week of therapy, five days a week, for a short-stay patient in a transitional care unit, Shephard postulates. In such a case, you'd code "5" at T1c.

But given the way the RUG grouper works, the resident wouldn't RUG into any skilled rehab category, because you must have at last 240 minutes projected and eight days of therapy to even go into medium rehab, Shephard points out. "That could be a physician education issue [in terms of writing orders] or an area for further CMS clarification," she adds.