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MDS Alert

MDS Compliance: 5 Red Flags That Could Hang Your Facility Out To Dry With FIs

Learn how to view the MDS through an auditor's eyes.

If your facility opened the door to a surprise visit from medical reviewers - or Medicaid Fraud Unit auditors - would your MDS patterns provide a clear map to payment recoupments - or worse?

If you exhibit any of these five patterns, see if your facility has a rationale for providing care and coding the MDS as it's doing - or if you need to shore up supportive documentation for items that drive case-mix payment:

1. Most of the residents are in restorative nursing programs (which affects case-mix payment), but the facility doesn't appear to have enough staffing hours to have provided all of the restorative services coded in Section P3.

Documentation tip: If you're providing a lot of restorative care, "use good tracking tools to record the times actually provided rather than just automatically checking off 30 minutes of two restorative services per day," advises **William Gillick,** a nursing home operations consultant in East Amherst, NY.

"And make sure to document the resident's response to the restorative nursing program on a regular basis," Gillick adds - for example, is he meeting the established goals in maintaining or improving his functioning?

2. Lack of supporting documentation for activities of daily living that references the observation period for the MDS. That particular documentation omission is one of the most common seen by **Patrice Nicholson, RN, CRNAC,** a consultant with **Myers & Stauffer** in Indianapolis, which does Medicaid audits in nursing homes on a contract basis for states.

Solution: "The MDS nurse should interview staff and the resident to uncover instances where a two-person assist, for example, may not be coded on the flow sheets or documented in the record," advises **Susan Battaglia, RN,** a consultant with **MG Healthcare Solutions** in Orchard Park, NY.

Bed mobility is a common example. "CNAs tend to think of bed mobility as turning from side to side, so they forget that one instance where they had to call a second caregiver to help move a resident up in bed," Battaglia adds.

What if the MDS nurse discovers information that differs from what's recorded on the ADL flow sheet or in the medical record?

"The person should make a notation [to that effect] in the chart," advises Battaglia. "Also continue to educate staff to report and document their actual level of ADL support provided and the resident's self-performance - especially when it's outside the resident's usual ADL requirements," she adds.

3. Lack of specific examples in the medical record to support coding in Sections E and cognitive impairment items (Sections B and C4). "These sections affect Medicaid payment in RUG-based states," says Nicholson, and they can also impact Medicare payment.

Tip: Behavior/mood flow sheets can work - if they require the CNAs to actually document specifically how the resident demonstrated the mood or behavior, Nicholson says.

For example, if the CNAs check off verbal abuse on a flow sheet that's used to code E4, what did the resident say or exactly how was he verbally abusive and to whom? "This type of specific documentation also helps with care planning," Nicholson notes.

4. Excessive respiratory therapy services provided by nursing on virtually all residents (e.g., turning, coughing and deep breathing), which results in an increased RUG classification. Nicholson characterizes the "TCDB" as "what used to be viewed as good old-fashioned nursing care for patients postoperatively or those with respiratory issues or immobility. Yet some facilities are providing [these services] to people who are walking and talking and have cognitive impairment as their primary problem," she cautions.

Solution: "Look closely for any service that your facility offers routinely to all residents (and gets RUG credit for)," advises **Ari Markenson, JD,** with **Epstein Becker & Green PC** in New York City. "Validate that the facility can justify the medical necessity of the service in each case."

5. Overcoding physician orders in Section P8. Over coding can occur if the MDS coordinator misinterprets the MDS coding requirements and counts four order changes in one day as four days of orders, says Nicholson. But a pattern that looks as if the physician purposefully unbundled or spaced out orders over several days to optimize payment can move the facility into fraud territory.

Know the rules: Section P8 requires you to code the number of days the physician (or authorized assistant or practitioner) changed the resident's orders within the last 14 days (or since admission if less than 14 days) but not order renewals without change.

If the facility is coding physician order changes over several days during the lookback, determine why. "Take a close look at the resident's clinical status and progress notes," suggests Battaglia.

"Normally, the resident would have to be very unstable clinically to justify repeated changes in orders," she adds. "Even if the physician ordered pain or antipsychotic medication to be titrated, usually the order will be complete enough to cover various contingencies, unless the patient had a reaction to the medication, for example, and the nursing staff had to call the physician for intervention."