Codify
BY AAPC

MDS Alert

MDS Compliance: Don't Let Resident Status Changes Put You On The Fast Track For Payment Denials And F Tags

If the MDS shows the resident has improved or gone downhill, follow these steps.

Your answers to those little questions asking if the resident's status has changed may mean that surveyors and medical reviewers will be asking your facility some tough questions of their own.

So whether the resident has improved or gone downhill, the facility had better have the documentation to show it's on top of the change with appropriate billing and careplanning.

Specifically, you code a "0" if the resident remained the same, a "1" if he improved or a "2" if he deteriorated over the last 90 days or since the last assessment in these areas:

1. Cognitive status (section B),
2. Communication/Hearing (Section C),
3. Mood and behavioral symptoms (Section E),
4. Activities of daily living (Section G), and
5. Continence status (Section H).

Further, section Q2 (discharge planning) documents that the resident's overall self-sufficiency has stayed the same, improved or deteriorated compared to his status 90 days ago or since the last assessment if less than 90 days.

By eyeballing whether the resident's ADLs, cognitive status, mood and behaviors, etc., have changed, you can get a quick picture of the resident's progress - and determine whether it jibes with the services you are providing and expected clinical outcomes.

Prepare for Payment Audits

For example, if the resident improved, the FI might wonder why the facility continues to skill the person - especially in the case of certain post-acute conditions, notes **Beth Klitch**, principal of **Survey Solutions** in Columbus, OH. An auditor might reason, for example: Hey, this is a 30-day assessment on a hip fracture patient and we know those patients don't usually remain in the SNF that long. And the MDS says he's improved? What's the deal?

That means you must be prepared to explain to the FI why you kept the patient on skilled coverage if the claim gets flagged for review. "The hip fracture resident in a rehab RUG may also have a skilled daily nursing due to a medical condition, such as complications of congestive heart failure or diabetes," suggests **Jan Zacny**, managing consultant, **BKD LLP** in Springfield, MO. If that's the case, you'll have to do an OMRA (Other Medicare Required Assessment) after all therapy ends to continue billing for the clinical services, she adds.

If the resident continues to receive therapy even though he's improved, make sure the therapy documentation explains what the resident is working on. "For example, if the resident is going to be discharged home, the therapist may be helping him with stair climbing," an ADL skill that isn't captured on Section G, offers **Marilyn Mines**, a consultant with

FR&R Healthcare Consulting in Deerfield, IL.

MDS Coding Tip: "Code Section J-5 correctly to reflect the stability of conditions, such as a flare-up of a medical condition that could have required continuing skilled intervention even though the person did become more self-sufficient and improved in ADL functioning or other areas," Zacny advises.

Don't Miss an SCSA

If you coded the resident as improving or deteriorating in two or more sections, should the MDS in question be a significant change in status assessment (SCSA)? If you miss doing an SCSA when required, the resident's care plan might not be up to date - and you may have missed out on higher reimbursement.

Two or more changes are usually required for staff to consider performing an SCSA, according to Mines. The RAI manual says you don't have to do an SCSA if:

6. the change is due to a short term acute illness;
7. the cause of a decline is easily identified and reversible with an interdisciplinary care plan;
8. the decline is part of the cyclical pattern that the resident displays;
9. the resident is making progress and the condition is not stable; or
10. the facility is involved in discharge planning for the resident.

"Page 2-11 of the RAI user's manual also provides a very clear explanation that an SCSA is not always necessary for a terminally ill resident," Mines adds.

End-stage disease coded at J5c will help explain to surveyors why the staff chose not to do an SCSA on a resident who continues to deteriorate - and you should carefully document that rationale in the clinical record, says **Gene Larrabee**, principal of **Primus Care** in Valparaiso, IN. Yet, to code end-stage disease at J5c, you have to get the physician to certify in writing that the resident has a life expectancy of six months or less.

MDS Correction Tip: The facility may complete a correction MDS if it finds a major error that was not corrected on a subsequent assessment. "If you note a significant change in status when completing a quarterly assessment, code the assessment as an SCSA and complete a comprehensive assessment," Mines says. (See page 2-7 of the RAI manual.) "But you can't complete an SCSA retroactively without going through the correction process as described in Chapter 5 of the RAI manual," she cautions.

Check Your Care Plans

Surveyors may also question why a resident's condition has unexpectedly remained the same or worsened. If that happens, you can bet they will be eyeing the care plan to see what the facility is doing to turn things around - or at least to help the resident adapt to the change in function.

Say Section C7 indicates the resident's ability to express, understand or hear information has taken a turn for the worse. Surveyors might expect to see a speech and language pathologist and audiology evaluation and implementation of any recommendations, such as therapy or a hearing aid.

"The care plan should also include individualized interventions to address the communication or hearing problem," says Angela Lobreto, a certified nursing rehabilitation specialist in Benbrook, TX. Examples include a picture board where the resident can point to a glass of water or a toilet. "If the resident can read, you can use an erasable message board to communicate," she says.

Assessment Tip: Check to see if a decline in one MDS section might be tied to other functional losses. For example, the resident who is losing his ability to hear may show cognitive decline or behavioral symptoms. Or a resident in pain may show a decline in ADL function.