Codify
BY AAPC

MDS Alert

MDS Management - Make Sure All Is Well With Your MDS: Give Diagnosis Coding A Check-Up

This 4-part test will show if you're up to speed on Section I.

Section I provides a paint-by-number diagnostic picture of the resident -- one that should never leave surveyors shaking their heads in dismay at its lack of resemblance to the care plan and MAR.

Picture this: "Consider what Section I would look like if it were blown up on a poster board in front of a jury in a malpractice case, because that happens," cautions **Leah Klusch**, **RN, BSN**, founder and executive director of **The Alliance Training Center** in Alliance, OH. "The diagnosis list should reflect the patient's condition and care plan in a holistic way," she emphasizes.

To make sure Section I reflects the resident, his care plan and medication administration record (MAR), ask these four questions:

1. Do you only code conditions diagnosed by the physician? The April 2004 Resident Assessment Instrument (RAI) user's manual added the reminder, "a physician diagnosis is required to code the MDS," under process instructions for completing Section I. The instructions also direct the facility to confirm diagnoses with the physician (such as clinically valid statements by a resident about a condition he has).

"Usually the physician will do a history and physical and write the current problem list or active diagnoses for the resident," notes **Cheryl Field, MSN, RN, CRRN**, a consultant with **LTCQ Inc.** in Lexington, MA. "The issue occurs when you have a pending new diagnosis -- for example, when [the physician] is working the resident up for a new problem or proposed diagnosis, or the family says the resident has been schizophrenic for 20 years but it's not written anywhere," she notes.

In such a case, ask the physician to give you a verbal order to add the diagnosis to the master problem list and elsewhere in the medical record, Field suggests. The physician can sign off on the telephone verbal orders based on facility policy, she adds. "Additionally, the physician can add the diagnosis on the routine visits, if they are timely."

2. Do you weed out outdated diagnoses each time you do the MDS? The instructions to Section I caution against coding "inactive diagnoses" or those that don't relate to the resident's current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring or risk of death.

Tip: Survey consultant **Beth Klitch** in Columbus, OH advises coding a diagnosis of hip fracture within the past six months for internal consistency purposes (e.g., you are required to code this condition within the past 180 days in Section J4).

Watch for diagnoses that get carried forward from one MDS assessment to the next via the software, cautions **Nancy Augustine, RN, MSN**, also a consultant with LTCQ Inc. "And take a careful look at why acute conditions, such as UTI, septicemia and pneumonia are still being coded from one assessment to the next, if that's the case," she adds.

Don't make this mistake: MDS nurse **Holly Sox** observes that some regulatory agencies and facilities appear to have had a misconception that the disease diagnoses recorded in Section I have to be written or rewritten during the assessment period in order to code them. That's not so, says Sox, MDS manager for **J. F. Hawkins Nursing Home** in Newberry, SC.

3. Do the conditions coded meet the definitions provided in the RAI user's manual? Physicians, nurses and MDS staff

CPT® 2023 American Medical Association. All rights reserved.

should know the hybrid definitions/requirements for coding certain diagnoses and conditions on the MDS, says Klusch. For example, the April 2004 RAI manual update says you shouldn't code quadriparesis at I1z. **Tip**:Don't code pneumonia as a respiratory infection at I2f (pneumonia goes at I2e).

Clear up UTI coding: Urinary tract infection includes chronic and acute symptomatic infection(s) in the last 30 days. Check the resident as having a UTI only if you have current supporting documentation and "significant laboratory findings" in the clinical record, advises the Resident Assessment Instrument user's manual.

For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at item I2j -- as long as you are awaiting results of the urine culture. If the facility later determines that the resident did not have a UTI, staff should complete a correction to remove the diagnosis from the MDS record, the RAI manual instructs. (For a comprehensive review of UTI diagnosis, care and coding, see the March 2004 MDS Alert.)

Real-life example: In one facility, a surgeon was ordering routine urinalyses on all residents before cataract surgery. In many cases, the urine culture would come back positive and the patient would end up on an antibiotic. "But it turns out that the surgeon wasn't ordering the urinalyses to look for infection - he was looking for protein spilling in the urine," said **John Reitan, PharmD**, speaking at the June 2004 **National Association of Directors of Nursing Administration in Long Term Care** conference in Orlando, FL. Yet all those patients were getting diagnosed and treated (and coded on the MDS) as having UTIs when they simply had asymptomatic bacteriuria.

4. Do the conditions coded drive the care plan and medications/treatments being provided to the resident? Klusch advises facilities to do a careful review of diagnoses at admission to make sure they have all the current diagnoses and to track diagnoses from the acute care to the post-acute setting. You want to see how the diagnoses interrelate, as well, she adds. "For example, someone may have had a stroke -- and that's the primary focus of care for the SNF stay -- but that person also has osteoarthritis and pain in one hip which may impact rehabilitation therapy or require pain medication," Klusch observes. "Or the person may have compromised renal function, which will necessitate interventions and be a consideration in selection of medications," she adds.

Mix 'n Match: Klusch suggests looking at your diagnoses/problem list and ask if you're managing all of the problems on there. For example, if the person is borderline diabetic, what interventions has the clinician ordered to address those? Does the nurse need to discuss that with the physician, nurse practitioner or physician assistant?

Staff should also go through the interventions (pain medications and Coumadin are prime examples) and look for the corresponding diagnosis. Is the physician ordering Tylenol or other pain medication for joint pain and stiffness but there's no documented diagnosis of arthritis in the chart? Why is the patient receiving a blood thinner?

Take credit for this: In some cases, items that the facility is actually dealing with -- such as a resident's allergy to a food or drug -- aren't recorded in Section I, notes Klusch. "So the chart may have a sticker on it alerting staff not to give the patient a food or drug (thus preventing an allergic reaction) but you can't tell that by looking at the MDS," she cautions.

CPT® 2023 American Medical Association. All rights reserved.