Codify
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MDS Alert

Medicare: Win The Payment Battle: Keep These 4 MDS Sections On Your Radar Screen

Here's a quick trick to improve ADL coding, what you don't want to miss in Section P - and other hot tips.

If you want your SNF to get its fair share of Medicare reimbursement - and stay out of hot water with auditors - you have to mind your P's, and well, not Q's, but definitely Sections G, E and B.

Section G1 (activities of daily living) tops the list of payment drivers where inaccuracies will undercut the RUGs. And MDS expert **Jane Belt, MSN, RN,** still sees costly undercoding in column A of Section G1 (activities of daily living self-performance) due to a persistent "language barrier" among nurses doing the MDS.

The problem: "The ADL assessment and scoring aren't in a language taught in nursing school where the definition of 'limited assistance' might be to help someone put on his socks and shoes - whereas 'extensive assistance' would be to do much more than that," counsels Belt, a consultant with **Plante & Moran Swartz Group** in Dublin, OH.

Yet when coding a resident's ADL performance on the MDS in Section G1 (column A), the definition of limited versus extensive assistance has to do with whether the caregiver provides any weight-bearing assistance.

Ask this question: To differentiate between non-weight-bearing assistance (limited assistance on the MDS) and weight-bearing assistance (extensive assistance), **Peggy Voitik, RN, LNHA,** a consultant with **VP Circle of Quality** in Minonk, IL, teaches CNAs and nurses to ask themselves: Whose muscles did you use in performing the activity? "If you just directed or guided the person's limb (but he used his own muscle power) to get the limb into the sleeve or the fork to mouth, then you didn't provide weight-bearing support," says Voitik. And that's "limited assistance" in MDS speak.

But if you had to use your muscles to support/move the resident's limb into a sleeve or to get the utensil to his mouth, as examples, you have provided "weight-bearing" assistance. The difference can be a difficult one to grasp at first: "When nurses talk about weight bearing, they think of how you stand on your feet," Voitik says.

Coding tip: Ask the med nurses if they had to hold a resident's head to administer medication and fluid, advises **Leah Klusch, RN,** executive director of **The Alliance Training Center** in Alliance, OH. "That counts as weight-bearing assistance."

Don't Let the Minutes Slip By

Section P (therapy minutes and treatments, including restorative nursing) drives the rehab RUGs. "Thus, someone should check therapy minutes on a regular basis for math errors," advises **Diane Brown,** CEO of **Brown LTC Consultants** in Needham, MA.

Also ask nurses how much bedside time they are spending providing respiratory therapy (RT) treatments, which count in coding RT in Section P, advises **Marilyn Mines, RN,** consultant with **FR&R Healthcare Consulting** in Deerfield, IL.

Mines has found instances where nurses spend a considerable amount of time each day assisting residents with their nebulizer treatments, as an example. "Yet no one is capturing that time on the MDS, so the facility is missing out on potential Medicare payment - and Medicaid dollars in some states," Mines says.

Capture the Mood

Depression is a third-level split for the Clinically Complex RUGs, which means the facility gets extra payment to treat the condition. To qualify, the resident has to have three or more depression/sad mood indicators coded in E1a through E1p (see Coding Quizer).

If a social worker fills out Section E, make sure she has the full picture of the resident's mood during all shifts of the 30-day look-back period. **Tip:** Keep mood/behavior tracking sheets at the nursing station, in the therapy department and in activities to assess residents in a variety of settings, advises Klusch.

Check for Impaired Cognition

Impaired cognition can make a difference between a Medicare resident going into SE2 versus SE3 in Extensive Services, says Belt.

For the resident to be considered cognitively impaired, one of the following conditions must exist:

B1 Coma and not awake (N1 a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA = 4 or 8) and B4 blank or unknown;

B4 Severely impaired cognitive skills (B4 = 3);

B2a, B4, C4 have been assessed with none being blank or unknown.

AND

Two or more of the following impairment indicators are present:

B2a = 1 (short-term memory problem)

B4 > 0 (cognitive skills problem)

C4 > 0 (problem being understood);

AND one or more of these severe impairment indicators are present:

B4 >= 2 (severe cognitive skills problem)

C4 >= 2 (severe problem being understood).

Assessment/coding tip: Don't assume a resident coded at C4 as a "3" (rarely/never understood) is necessarily severely impaired at B4 (cognitive skills for daily decision-making). The RAI user's manual advises staff to do a thorough assessment as to the cause of severe impairment in making self understood - for example, the resident might speak a different language or have a profound hearing or a vision impairment.

For more tips on how to code Section P, see MDS Coding: To Code Or Not To Code Chemo: Make The Right Choice Every Time.