

MDS Alert

Quality Assurance: If Physicians Fail To Provide Supportive Documentation, Your SNF Will Be Ailing

Are your physicians covering these 3 essential bases?

Getting attending physicians to provide the right documentation pays off for everyone, especially residents, not to mention the facility's quality of care and bottom line.

Check out these three key areas where physician documentation plays a pivotal role in supporting the MDS and Medicare, quality of care, and risk management.

1. Documenting diagnoses for coding in Section I. If the physician hasn't documented a diagnosis in the medical record, you can't code it in Section I. And if the physician isn't documenting and updating diagnoses, Section I won't reflect the resident's actual condition and care needs -- and the RUGs may fall short.

Most facilities have a cumulative diagnostic list that the physician should review with some regularity, advises **Gail Robison, RN, RAC-C**, a consultant with **Boyer and Associates** in Brookfield, WI. "The goal is to make sure that the physician identifies the status post or historical diagnoses as health issues resolve."

To support Part A skilled care, the physician should document diagnoses that are the focus of care for nursing or therapy, advises **Christine Twombly, RNAC**, a consultant with **Reingruber & Co.** in St. Petersburg, FL. "In the admission note, it's helpful for the physician to write why the resident is being skilled, which helps support the Medicare reason for skilled care."

Example: If speech-language pathology is involved in the resident's care, Section I (and other sections) should include the condition for which the resident is receiving treatment (aphasia, dysphasia, dysphagia), says **Evonne Fillinger, RN, RAC-CT, WCC**, a consultant with **Boyer and Associates**. "If the person is receiving speech therapy, there has to be a reason coded on the MDS."

Section I also formulates the resident's care plan when you code the correct diagnoses, Robison says.

Remember: The RAI manual instructions for Section I say to "code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death."

The physician should also document a diagnosis as the rationale for ordering a medication or treatment. For example, an antidepressant is usually for depression, but the physician may order it for other conditions, says **Susan LaBelle, RN, MSN**, senior consultant with **LTCQ Inc.** in Lexington, MA. The physician should clarify this in the resident's chart, she says.

Documenting accurate diagnoses will improve accuracy of the QI/QMs. For example, certain ICD-9-CM diagnoses of malnutrition recorded in I3 on the MDS will exclude a resident with a pressure ulcer from the low-risk pressure ulcer QI/QM, a sentinel event (review the ICD-9 codes at http://www.qtso.com/download/mds/qiqm_rpt/Appendix_A_Technical_Specs.pdf).

But unless the physician documents malnutrition in the medical record, the MDS team can't capture that information on the MDS, noted medical director **Cornelius Foley, CMD**, in a presentation at the March 2007 **American Medical Directors Association's** annual meeting. Thus, the physician has to document the diagnosis in the chart, he emphasized.

2. Documenting end stage disease. Without physician documentation that the resident has end-stage disease with a life expectancy of six months or less, the MDS team can't check J5c, which excludes the resident from a number of QIs/QMs and publicly reported quality measures. Also, to initiate hospice services, the resident has to have a life expectancy of six months or less, LaBelle notes. In such a case, the MDS should have end-stage disease coded at J5c, which requires physician documentation.

3. Documenting an examination of the resident during physician visits. For coding physician visits at P7, the RAI manual says to record the number of days during the last 14-day period (or since admission if less than 14 days) that a physician has examined the resident. "This can be a partial or full exam at the facility or in the physician's office," says **Rena Shephard, RN, RAC-MT, MHA, FACDONA**, president of **RRS Healthcare Consulting** in San Diego.

If the physician or physician extender didn't do a full or partial exam or didn't document it, even if it did occur, the FI could deny a claim if the person's RUG level is based on physician visits and order changes, Shephard cautions.

Editors' note: For strategies to help support physicians to provide supportive documentation for the MDS and Medicare, see the article below.