Codify
BY AAPC

MDS Alert

Quality Improvement: Quality Indicators Ailing? Give Them A Coding Checkup

An ''F' in assessment and coding can translate into a failing survey record.

The first step in making a quality improvement is to figure out if you have an improvement to make--and if so, whether it's in the coding or care arenas.

"As the first step in analyzing any QI, you look to see if the MDS is coded accurately," says **Ron Orth, RN, NHA**, president of **Clinical Reimbursement Solutions LLC** in Milwaukee.

MDS experts provide these five key strategies for preventing and detecting coding issues that, left undetected, can wreck your quality profile and survey.

1. Keep your dates and definitions straight when coding Section E, which drives both an incidence and prevalence-based QI/QM looking at depression. "A lot of times, people forget that you code a 30-day lookback for E1 (indicators of depression, anxiety, sad mood), but only a seven-day assessment reference period for E2 (mood persistence)," says **Cathy Sorgee, RN**, a consultant with The Broussard Group in Lake Charles, LA.

For the incidence-based measure, E2 (mood not easily altered) counts as one of the eight items in the mood scale, flagging residents who are more anxious or depressed from one assessment to the next.

In addition, residents without an antidepressant coded in 04c who had sad mood (E2 = 1 or 2) and at least two of a number of specified indicators of functional depression will trigger Q1 2.3 (prevalence of residents with symptoms of depression without antidepressant therapy). And withdrawal from activities of interest or reduced social interaction will count as a depressive symptom for the QI.

To avoid overcoding social isolation and withdrawal, look at the resident's baseline and figure out what's normal for him, advises Sorgee. "If the person has always been shy and not the type of person who socializes with groups of people, then that's normal for him--so don't code it."

2. Don't hurt your facility by overcoding pain at J2a and b. Moderate pain coded daily--or one instance of "horrible or excruciating" pain--during the seven-day lookback will trigger the pain measure. Using a pain scale of 0 to 10, mild pain would be a 1, 2 or 3; moderate pain, 4, 5 or 6; and severe or horrible pain, a 7 or greater, suggested **Regina Fink, RN, PhD, AOCN**, with the **University of Colorado** Hospital in Denver, in a **Centers for Medicare & Medicaid Services**' Webcast on Sections I, J and O.

3. Recheck pressure ulcer assessment/coding on the 5-day assessment when a short-stay resident triggers the postacute pressure ulcer QM. A short-stay resident will trigger on the pressure ulcer QM when his 5-day MDS either shows no pressure ulcer and the 14-day shows at least one of any stage ...quot; or the pressure ulcer(s) recorded on the 5-day get worse or stay the same as the ones coded on the 14-day MDS.

So revisit the resident's assessment and coding to make sure both MDSs capture the wound's true status. The RAI manual requires facilities to "downstage" an ulcer as it heals, which penalizes your RUG payment but helps avoid triggering a postacute pressure ulcer QI.

The RAI manual notes that if staff don't do a full body check, they can miss a pressure ulcer. "It's important for staff to

perform a thorough head-to-toe skin assessment on residents upon admission to the facility, as appropriate, and with all subsequent MDS assessments to identify any ulcers," says **Andrea Platt, RN,** with **Thomas Healthcare Consulting** in Indianapolis. "But the frequency of performing skin assessments is not based solely on the timeframes mandated by the MDS, but on a variety of factors including, but not limited to, the resident's clinical condition, pressure ulcer risk factors--and state regulations," Platt emphasizes.

4. Make sure staff follows RAI definitions for coding restraints. To avoid overcoding restraints, determine if a device or side rail acts as a restraint in a given situation. The RAI manual instructs facilities to assess the impact of a device on a resident in order to determine whether to code it as a restraint. For example, can the resident easily remove the device, material or equipment? The assessor should not focus on the intent or reason behind the use of the device, but on the effect the device has on the resident.

Example: To evaluate whether a side rail is acting as a restraint, assess the resident's bed mobility with and without the use of the rail, emphasizes **Cheryl Field, CRRN, MSN,** a consultant with LTCQ Inc. in Lexington, MA. Document how the side rail enhances the resident's bed mobility, if that's the case, she adds.

Check for this inconsistency: If you code the resident as using bedrails for bed mobility (G6b) and then code him as dependent for bed mobility, surveyors will look at that contradiction as a red flag. In such cases, be prepared to show surveyors you've followed the RAI user manual's restraint policy and procedure.

5. Double-check meds coded in Section O. If a resident flags on the QI for nine or more medications, recheck your count for coding Section O1 of the MDS, advises **Carla Saxton, RPh, CGP**, professional affairs manager for the **American Society of Consultant Pharmacists**.

Avoid this coding "no no." Counting combination medications as separate drugs will inflate your medication count at O1.

If the resident triggers on the QI looking at prevalence of hypnotic or anti-anxiety agent use, double check the classification of the drugs you've coded in O4b or O4d. For example, don't code an antihistamine such as Benadryl as a hypnotic even though the physician prescribes it as a sleep aid. The same principle applies to Lexapro, an SSRI antidepressant commonly used to treat anxiety disorder. Code the drug as an antidepressant--not an anti-anxiety agent.

If the resident triggers as having signs of depression without antidepressant therapy, review the medication administration record to see if you missed coding a medication classified as an antidepressant.