# MDS Alert

## QUALITY OF CARE: Enlist the MDS in the Battle Against the Bugs and F Tags

Make sure you know how to code UTI and other infections.

With swine flu and a growing number of infectious threats on the loose, you definitely need to get the MDS on your side.

One aspect of infection surveillance should involve the MDS, advises **Kristin Lueschow, RN, RRT, WCC,** a consultant with Boyer & Associates in Brookfield, Wis.

You don't want to be caught with MDSs showing that several people were coded as having pneumonia or another infectious disease weeks before -- "and the facility didn't respond," cautions Lueschow.

To augment its infection control program, the facility could use the MDS to help with "case-finding" and as an internal quality tool, agrees **James Marx, RN, MS, CIC,** principal of BroadStreet Solutions in San Diego. For example, you can use software-generated data from the MDS to flag infections coded in Section I2.

The facility should, however, probably use the MDS more to focus on tracking infections in its Part A SNF population where the staff does more frequent MDS assessments, adds Lueschow.

Follow the Instructions for Coding Infections in I2

To avoid over- or undercoding infections, the MDS team has to follow the RAI User's Manual instructions. For one, you need a physician diagnosis in the medical record to code the diagnosis in Section I. The lookback for I2 is seven days except for urinary tract infection (UTI), which has a 30-day lookback period.

Code an infection in I2 only if it "has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death," instructs the RAI User's Manual. "If the clinical record provides more detailed information for a more definitive diagnosis, check the box in I2 and enter the more detailed information(with ICD-9-CM code) under I3," according to the manual.

As one example, you might include an ICD-9 code for a specific antibiotic-resistant microorganism (I2a), such as Methicillin Resistant Staphylococcus Aureus (MRSA).

On the quarterly MDS assessment, you are supposed to put an ICD-9-CM diagnosis in I3 for anything new within the last 90 days, notes Lueschow. But only code "those diseases diagnosed in the last 90 days that have a relationship to current ADL status, mood or behavior status, medical treatments, nursing monitoring, or risk of death," states the RAI User's Manual. (I3 has a seven-day look back except for all quarterly assessment forms which require a 90-day look back.)

Tip: Don't simply assume that the resident's infection has resolved and leave it off the MDS, cautions **Charlotte Lefert, RHIA,** coding strategy facilitator for the LTC Community of Practice for the American Health Information Management Association. Instead, get the physician involved in determining and documenting that it has resolved, she suggests.

Follow the RAI Manual Definitions of Infections in I2

Code that the person has tuberculosis, for example, if he has active TB or has converted to PPD-positive tuberculin status and is currently receiving drug treatment for TB, according to the RAI User's Manual.

As for coding MRSA at I2a: If the resident had MRSA colonization rather than an active MRSA infection, you wouldn't code it, says **Ron Orth, RN, NHA, CPC, RAC-MT,** president of Clinical Reimbursement Solutions LLC in Milwaukee.

Tip: Whether the facility should code HIV on the MDS is up to the individual state, says **Joan Brundick, RN,** state RAI coordinator for Missouri. Thus, the facility MDS staff should check with their state RAI coordinator, she suggests.

Focus Closely on UTI

How you code UTI drives the UTI QI/QM, which is the only one that exists for an infection. To code a UTI on the MDS, "the resident has to have symptoms of UTI during the lookback period of 30 days," reminds **Rena Shephard, MHA, RN, RACMT, C-NE,** president of RRS Healthcare Consulting Services in San Diego, and founding chair and executive editor for the American Association of Nurse Assessment Coordinators. In addition, the medical record has to have a physician diagnosis of UTI and significant lab findings for the condition.

Based on an RAI manual clarification, the physician determines what constitutes "significant laboratory findings," which doesn't have toinclude urine culture, says Shephard. "For example, the physician could decide on the basis of an elevated white count and symptoms that the resident is having a UTI."

Forget the "yeah, buts": People will say, 'Yeah, but what if the [resident] doesn't have symptoms but is on antibiotics?'" Shephard notes. "It doesn't matter whether the person is on antibiotics -- it matters whether the person has symptoms during the 30-day lookback, significant lab findings, and a physician diagnosis documented in the medical record," Shephard emphasizes.

Quality assurance tip: In addition to focusing on coding UTI accurately on the MDS, facilities can do a QA review to identify physicians ordering antibiotics inappropriately for asymptomatic bacteriuria. The medical director could track such cases and present the results in "bar graph format" to the ordering physicians, suggests **Daniel Haimowitz, MD, CMD,** an internist and nursing home medical director in Levittown, Pa. That's what some of his colleagues are planning on doing in the state of Pennsylvania, Haimowitz tells Eli. "Physicians are more likely to change treatment habits when presented with solid data."

Editor's note: See the related article on UTIs at the bottom of page 125 of this issue.