MDS Alert

RAI Compliance: Don't Confuse Consolidated Billing With MDS Coding Rules

Excluding an excluded service on the MDS can cost you a RUG.

You want to code everything you legitimately can on the MDS, so don't omit services based on whether they are excluded from the PPS rate under consolidated billing.

For example, you code chemotherapy even though a particular agent is excluded, says **Diane Brown**, CEO of **Brown LTC Consultants** in Boston. The PPS rate also excludes dialysis for end-stage-renal patients that isn't provided by the SNF. But you would "code dialysis on the MDS regardless of the setting where it's provided," says **Nancy Augustine, MSN, RN**, with **LTCQ Inc**. in Lexington, MA.

The consequences: Fail to code chemotherapy or dialysis in Section P of the MDS, and a resident could miss out on a clinically complex RUG.

Watch out: Evaluate a drug before coding it as chemotherapy at P1aa. For example, Megace is classified by the Physician's Desk Reference as an anti-neoplastic agent. But if the resident is receiving Megace to stimulate his appetite (rather than to treat cancer), don't code the treatment as chemotherapy.

Code radiation therapy (P1ah) regardless of the site of service. For example, radiation therapy is excluded when provided in a hospital outpatient setting, but not if the resident somehow receives the service in a freestanding center.

The consequences: If you don't code radiation therapy on the MDS, a resident could miss out on a Special Care RUG category.

Tip: You can code physician visits at P7 when the resident is evaluated by a physician off-site during dialysis or radiation therapy. You should have documentation of the evaluation in the clinical record.

Know These Coding 'Don'ts'

You also need to know whether to code treatments, such as IVs and IV meds, blood transfusions, ventilators and suctioning, provided in conjunction with services excluded from consolidated billing. Knowing what not to code is important because IV fluids, IV meds, suctioning and ventilators qualify a resident for extensive services, if he has a total ADL score of at least 7. So if you capture those services inappropriately, the SNF may end up owing Medicare money. Follow these three rules:

• Don't code IV fluids (K5a) administered as a routine part of an operation or diagnostic procedure or recovery room stay or during chemotherapy or renal dialysis.

• Don't code IV meds or blood transfusions in Section P that are administered during chemo or renal dialysis.

• Don't code IV medications, blood transfusions and other treatments in Section P1a (which includes suctioning and ventilators) provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure period.

Question: What if the resident returns to the facility after chemotherapy with an IV or IV medication to treat nausea and vomiting? If the IV or IV med continues after the chemo session and becomes part of the resident's treatment when he

returns to the facility, code it on the MDS, advises Augustine.