MDS Alert

RAI Compliance: Keep These Red Herrings Out Of Your MDS Net

5 practices that can artificially inflate your QIs/QMs.

When faced with outlier QM or QI scores, you have to rule out the MDS as the underlying cause - just like you'd check the accuracy of a thermometer or blood pressure machine if a lot of your residents suddenly developed unexplained fevers or hypertension.

Check out the following key reasons for false quality concerns that can get surveyors looking for clinical shortfalls where none exists:

1. Reliance on inaccurate or outdated information. "Some facilities assume that because they have an excellent MDS nurse that the MDS cannot be the underlying reason for the outlier," cautions **Steven Littlehale**, chief clinical officer with **LTCQ Inc.** in Lexington, MA. "But we've all attended MDS presentations that disseminated misinformation," he notes. Or a facility might be using an outdated Resident Assessment Instrument user's manual.

For example, a fiscal intermediary tagged one facility for an audit because its dehydration QI was way up. "The FI felt the facility was inflating its coding of dehydration to get extra RUG payment, which is really an outlandish idea because the payment for that is fairly negligible and surveyors view dehydration as a sentinel event on the QIs," Littlehale notes.

It turns out the MDS coordinator didn't realize that the December 2002 RAI manual reduced the threshold for coding dehydration in Section J to 1,500 cc of fluid intake. "So she was still coding residents who weren't taking in 2,500 cc of fluid a day," Littlehale reports. "The facility also found that a non-clinical person was carrying forward old diagnoses of dehydration from one assessment to the next using the software program. And that was also triggering the QI and causing a problem with Medicare claims," Littlehale relates.

2. Inaccurate ADL scores categorizing residents as low risk for pressure ulcers. If a resident flags as low-risk for pressure ulcers, take another look at his ADL scoring, advises **Christine Twombly, RNC**, chief clinical consultant with **Reingruber & Company** in St. Petersburg, FL. "The ADL scores may be higher than what staff are recording, which means the resident isn't really low-risk at all," Twombly points out.

3. An early assessment reference date for pain or delirium QMs. The assessment reference date (ARD) for the MDS can affect quality measures, notes **Jacqueline Vance**, director of clinical affairs for the **American Medical Directors Association**. For example, if MDS staff consistently set the 14-day MDS ARD very early in the assessment window for post-acute rehab patients before you can get their pain under control, the facility will have higher pain scores on the quality measures. The same may be true for residents with some residual delirium from their surgery, pain medications or acute illness, says **Pam Manion**, a nursing consultant with the **Quality Improvement Program for Missouri's Long-Term Care Facilities**. "Given a few more days, the resident's delirium may resolve," she notes.

4. Coding conditions and events that didn't occur within the assessment window. "Check the assessment window and specific directions for coding each section or item," counsels **Pam Campbell**, MDS operations director for **LTC Solutions Inc.** in Camdenton, MO. MDS staff sometimes make this error when they see a clinical issue driving a care plan, such as a past fecal impaction or dehydration. So they continue to code the clinical condition or event on the current MDS, even though it didn't occur during the lookback.

5. Data entry errors. Pay careful attention to the qualifications and training of personnel assigned to do data entry for the MDS, as these individuals can input errors, suggests **Howard Sollins**, an attorney with **Ober/Kaler** in Baltimore, MD.

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