MDS Alert

Reimbursement: Slick Up Your ADL Coding With These Quick Audit Strategies

Get the payment you're due and head off medical review.

Spotting inaccurate ADL coding doesn't have to take much time if you know a few inside tricks.

Start by learning the "ABCs" of your rehab RUGs--literally. Do a RUG profile to see how your rehab RUGs break out, which will give you a "big picture" of your rehab residents' ADL scores.

"Rehab RUGs ending in A and B will be the ones with lower ADL scores," explains **Bet Ellis, RN**, a consultant with **LarsonAllen Healthcare Group** in Charlotte, NC.

See how the RUGs stack up: Compare your facility's RUG distribution to the state and national averages posted on the **Centers for Medicare & Medicaid Services** Web site (www.cms.hhs.gov/apps/mds), suggests **Marc Zimmet, MBA, CPA**, principal of **Zimmet Healthcare Services Group LLC** in Morganville, NJ. "If the building has far fewer rehab RUGs ending in C's and far more A's than the national or state average," your building is probably downcoding ADLs, says Zimmet.

Also compare the RUG breakdown in house over time, suggests Zimmet. If the facility's RUG pattern has been drifting toward more rehab RUGs ending in one letter, figure out if your case-mix--or inaccurate ADL coding--is driving the change.

Develop Preemptive Strategies

Checking your RUG distribution can give you a snapshot of your rehab residents' ADL scores. But you also want to implement systems to catch ADL inaccuracies before they skew your RUG payment.

The best time to do that, of course, is during the lookback for G1. For example, at **Sunshine Terrace**, CNAs use a kiosk system to enter information for Section G1, reports **Inne Taylor, RN,** MDS coordinator for the facility in Logan, UT. (The facility uses QuickCARE MDS software.) The floor nurse double- checks the CNAs' ADL data and asks them for further clarification, if needed, Taylor says.

Before you hit "send": Always revisit ADL scores on the "cusp" where one point in either direction would put the person in a different RUG, suggests **Nathan Lake, RN**, an MDS expert in Seattle. That's important to do because "if you accidentally upcode where the person goes into a higher paying RUG, you can get in trouble and owe Medicare (or Medicaid) money," he says. "And if you accidentally undercode by a point so the resident misses out on a higher paying RUG, you are losing money," cautions Lake.

Definitely do this: Double check ADL scores any time a person doesn't go into rehab plus extensive services because his RUG score is less than seven, suggests Ellis. "Staff can do that when they see the preliminary RUG score calculated by the MDS software," she says.

Look for that one point that can make a difference: To see if you may have missed three or more instances of weight-bearing assistance to code extensive assistance, "compare the person's ability to toilet with his transfer skills," suggests Ellis. "You'd expect toileting and transfer to mirror each other since transfer is one component of the toileting ADL. Also look at bed mobility to see what type of assistance the person typically requires."

If a resident has a wheelchair, keep in mind that "locking and unlocking [the brakes] for the person will count as set-up help, which is coded as a 1--not a 0 as ADL support provided in Column B," advises Ellis. "The same is true if the resident requires you to raise the side rails for bed mobility--count that as set-up help."

"One instance of a two-person support [in Column B] can change your ADL score and make a difference whether the person goes in one RUG or another," says **Jan Zacny, RN**, a consultant with **BKD Southern Missouri** in Springfield, MO.

Appoint A Roving Chart Auditor

In the compliance world, it's not just what you code on the MDS: You need back-up documentation to support your coding in case medical reviewers, DAVE 2 or surveyors have any questions.

Proactive strategy: Perform some type of "quick and dirty" chart audits at least weekly, suggests **Rena Shephard, RN, MHA**, **FACDONA,** president of **RRS Healthcare Consulting** in San Diego.

Rotate sections of the facility so that you audit all units at least monthly, she adds.

The nurse can review a chart a day to see how the documentation depicts the resident during the MDS lookback periods. "Then the nurse can check that against the ADL coding on the MDS to identify problems and training needs."

The audit should include a review of whether the medical record documentation supports what's coded on the MDS, advises Shephard. "The facility can train a nurse [to perform the audits] who doesn't do the MDS except to provide assessment information to assess/code ADLs," she adds. That person "becomes the number two ADL expert in the facility." That way, the facility has a back-up, which is an additional perk.