MDS Alert

Resident Assessment: Are Systemic ADL In accuracies Undermining Your Facility's Fiscal Status?

Use this checklist to find out for sure.

ADL scores are the biggest driver of RUG payment, so you want to make sure inaccuracies don't head your facility into the red. "Incorrect assessment in section G can result in a lower nursing category allocation, e.g., a rehab RUG coded B or A when it should be C or B, cautions **Pauline Watts**, PT, co-founder of **Encompass Education Inc.** in Palm Harbor, FL. The following checklist of questions will help you get to the root of problems in assessment and coding Section G that can whittle away your facility's fair share of reimbursement.

Is the MDS capturing the facility's standing care policies designed for resident and caregiver safety? For example, many facilities have a policy requiring two caregivers to use a mechanical lift when moving certain residents -or ask that two or more caregivers transfer residents of a certain size or those with certain conditions, such as end-stage osteoporosis. And coding that two-person assist could increase Medicare reimbursement under the PPS or Medicaid RUG-based systems.

So do a quick MDS audit to detect whether Section G reflects the level of assistance with transfer that you know certain residents require. If not, figure out why and correct the underlying issue.

Does the ADL score reflect the highest level of caregiver assistance provided during the lookback? You code for the highest level of assistance provided, not the average level or the least. Take bed mobility, for example. Staff might be tempted to think a bed-bound resident who can turn from side to side in bed doesn't require assistance with this late-loss ADL. But if that resident requires two caregivers to help him scoot up in bed or to a sitting position, then you code a two-person assist, says **Jan Stewart**, a nurse consultant with **QUnique Corporation** in Carroll Valley, PA.

Tip: In column A (self-performance) code the highest support provided three times or more -- in other words, three strikes and you code, says **Cheryl Field**, a nurse consultant with **LTCQ Inc.** in Lexington, MA. But in column B, code the highest intensity of support provided, even if it happened only one time during the lookback. "So if the resident fell on the floor once during the lookback, and two caregivers had to lift him back to bed, you'd code that two-person assist in column B," Field directs

Are staff using the actual RAI definitions for assessing ADLs? "CNAs should know and use the definitions for coding ADLs from the Resident Assessment Instrument user's manual," says **Gail Polanski**, president of **MG Healthcare Solutions** in Buffalo, NY.

That knowledge is especially critical when a facility moves to new ADL flow sheets or a computerized system where CNAs enter a numeric code. In such a case, "make sure staff knows that if they arbitrarily use a code, they can affect the facility's payment and even flag a resident on a QI report," cautions **Denise O'Donnell**, the DON at **Pine Run Health Center** in Doylestown, PA.

Do evening and night staff tend to defer to the ADL assessment performed by therapy or day shift staff? "Sometimes the occupational therapy staff do the ADL assessments in the morning when the resident is in his/her best form," notes **Beth Klitch**, president of **Survey Solutions** in Columbus, OH. "And the evening and night staff don't like to challenge the assessment of the therapy staff or someone on the day shift. Or they don't have time to challenge that assessment - or don't know to."

Are rehab staff primarily responsible for completing Section G? "If the rehab staff are coding Section G, make

sure they thoroughly understand the MDS coding and descriptors and don't relate it to rehab coding," advises Watts. "The rehab staff should work with nursing staff to obtain the correct data."

Do staff accidentally or intentionally carry forward ADL coding from one shift or flow sheet to the next?
Mistakes on flow sheets can wreak havoc if staff carry them forward from one shift to the next.

And "copycat" charting, where CNAs take shortcuts by purposefully record what the last shift wrote on the ADL or other flow sheet, not only undermines MDS accuracy and RUGs classification, but surveyors can view it as a form of falsification, cautions Klitch. To stop this practice, charge nurses should audit flow sheets each shift to look for duplications from the previous shift, Klitch suggests."Education also stops copycat charting."