MDS Alert

Resident Assessment: This Common ADL Coding Tendency Can Cost You Big Time

Undercoding to avoid hassles leads to payment and care plan shortfalls.

ADL undercoding not only creates a black hole in the payment arena--it can run afoul of OBRA requirements to promote the resident's highest practicable level of functioning and well-being.

Yet nurses sometimes tend to feel more comfortable with undercoding ADLs because they don't think they will be challenged if they undercode, noted **Sheryl Rosenfield, RN**, in a presentation on the MDS at the most recent annual **American Association of Homes & Services for the Aging** conference in San Antonio. "So they code a 2 [for limited assistance] instead of a 3 for extensive assistance because" then they don't have to worry about the documentation for those three or more instances of weight-bearing ADL assistance, she said.

Tip: Eating and bed mobility are the two most underscored ADLs, said Rosenfield.

Yet undercoding ADLs has "catastrophic effects" under the RUG-53 system, Rosenfield warned.

Example: A resident with an ADL index of 16 who received ultra high rehab plus extensive services (IV fluids, IV med, suctioning, trach care or a ventilator) will go into RUX. But if you undercode his ADLs so he has an ADL index of 15, he will go into a RUG that pays about $68 less (federal unadjusted rate for urban) than RUX, notes **Diane Brown**, CEO of **Brown LTC Consultants** in Newton, MA.

Sidestep Care Plan Inaccuracies

The MDS also drives the care planning process. And underscoring ADLs detracts from formulating a care plan that promotes the resident's optimal self-care abilities.

If you code a "2" for limited assistance because you know the resident is "capable of doing more," the care plan may fail to address how the staff can get the person to do more, Rosenfield cautioned.