MDS Alert

Risk Management: Get In The Coding Flow For Dehydration

Nail down how the dehydration QI/QM really works.

Yes, dehydration is a sentinel event that will have surveyors poring over your care plans with citations on their minds. But knowing how to code dehydration on the MDS -- and which assessments are excluded from the dehydration QI/QM -- helps you avoid survey and compliance surprises.

Coding J1c (dehydrated;output exceeds input) will trigger the dehydration QI/QM on the target assessment, as will an ICD-9 code of dehydration in I3. And two scenarios can cause staff to overcode dehydration, which will unnecessarily trigger the dehydration QI/QM.

Scenario No. 1: The staff continues to code a dehydration diagnosis in Section I even though it's no longer a current, active diagnosis. "You code the diagnosis in Section I if it is an active problem," says **Christine Twombly, RN**, chief clinical consultant, **Reingruber & Company** in St. Petersburg, FL. "Care planning for someone who is at risk for the condition isn't the same thing as care planning for someone who has the condition."

Double-check dehydration on subsequent assessments: Usually, you'd expect to see dehydration resolved by the next assessment so that it's not coded in Section I, says **Joan Brundick, RN, BSN**, Missouri state RAI coordinator.

Scenario No. 2: Staff codes dehydration at J1c outside the seven-day lookback, says **Marilyn Mines, RN, BC, RAC-C**, director of clinical services for **FR&R Healthcare Services** in Deerfield, IL.

Know Which Assessments Trigger the QI/QM

Many people believe coding dehydration on a Medicare-only or OBRA-required admission assessment will trigger the dehydration QI/QM. But you can code dehydration on a 5-day PPS-only and a 14-day PPS combined with the admission assessment, and the dehydration won't show up on the QI/QM, advises Twombly.

Not only that, but the **Centers for Medicare & Medicaid Services** recently released a new DAVE 2 tip sheet emphasizing that you should only code IV fluids for nutrition or hydration (see p. 93 for details). And facilities "miss the boat" if they don't identify the resident at admission who has had dehydration or a risk of dehydration, which helps support coding IV fluids in the hospital lookback, advises **Gail Robison, RN, RAC-C,** a consultant with **Boyer & Associates** in Brookfield, WI.

Evaluate Sig Changes Carefully

Dehydration coded on a significant change in status assessment (SCSA) will trigger the dehydration QI/QM. That's true whether the sig change is combined with a Medicare assessment or not. Thus, "nursing home residents who return from the hospital and have a significant change assessment completed on return may flag this QI" if the person has dehydration coded on the assessment, says Twombly.

But evaluate carefully whether you need to do a sig change assessment for a particular resident.

"Many times you will expect to see a person who went to the hospital have a significant change," says Brundick. But there are exceptions. Say a person was hospitalized for flu and the staff expects he will return to his baseline within 14 days. "You possibly wouldn't do a significant change in that case," she says.

Document unavoidable dehydration: Document carefully how you're complying with resident/family wishes or advance

directives to refuse adequate hydration. "If the resident is in the dying process and the family has refused IV therapy or to send him to the hospital for hydration, dehydration would be unavoidable," notes **Joan Buck**, a registered dietitian at **Heritage Enterprises** in Bloomington, IL.

Editor's note: Read "Achieve Fair Payment, Capture Dehydration, Fever, IVs" in the next MDS Alert.