MDS Alert

Survey Management: Get Your UTI Coding In Line With New Survey Expectations

Beware: Surveyors have their eyes on UTIs.

Coding urinary tract infection correctly has taken on new urgency. Tougher F315 guidelines have surveyors tagging facilities that over- or under-diagnose and treat this common condition.

Nail down the basics: You check I2j if the resident has had a symptomatic acute or chronic UTI in the last 30 days. To back up your coding, you need "supporting documentation" and "significant lab" findings, according to the RAI manual. For a new UTI, "a physician's working diagnosis of UTI" will suffice if urine culture results are pending, the manual adds.

Don't miss this step: If you code UTI based on a physician's working diagnosis and the urinalysis shows the resident didn't have a UTI, complete a correction to remove the diagnosis from the MDS record, advises **Nemcy Cavite Duran, RN, BSN, CRNAC**, director of MDS for **Dr. William O. Benenson Rehabilitation Pavilion** in Flushing, NY.

Use F315 Guidance

The RAI manual directions leave lots of room for interpreting what to count and code as a UTI.

Be proactive: The F315 instructions can fill in the gaps for the RAI manual as to the criteria, signs and symptoms of UTI and positive lab values signaling someone may have a UTI, says **Joan Redden, RN.** Redden is vice president of clinical risk management for **Skilled Healthcare LLC**, a nursing home management company in Foothill Ranch, CA, who has trained surveyors on the new F315 guidance.

Several test results in combination with clinical symptoms, such as fever, new or increased burning pain on urination, frequency or urgency, flank pain or suprapubic tenderness, can help to identify UTIs, according to the revised F315 guidelines. These include the following:

• the presence of pyuria (more than minimal white cells in the urine) on microscopic urinalysis;

• a positive urine dipstick test for leukocyte esterase (indicating significant pyuria) or for nitrites (indicating the presence of Enterobacteriaceae). (A negative leukocyte esterase or the absence of pyuria strongly suggests UTI isn't present, but a positive one alone doesn't prove someone has UTI.)

Read the guidelines at http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf.

Consider this standard of practice: If the resident has UTI symptoms and more than 100,000 colony forming units of a urinary pathogen from a well-collected urinary specimen, consider treating him with antibiotics, advises **Joseph Ouslander, MD**, an expert in geriatric incontinence and professor at **Emory University**

Ouslander defines a well-collected specimen as one obtained by clean catch or an "in and out" urinary catheterization.

Code Abnormal Urinalyses at P9

Don't forget to code a resident's abnormal urinalysis or "yes" at P9 (abnormal labs in the past 90 days or since admission). And look at the urine culture results for the identified microorganisms, which can give you clues as to what

might be causing a resident's UTI.

For example, "the number one cause of UTI in women is E. coli, which often signals a problem with pericare," says Redden. Providing frequent inservices for pericare can be extremely helpful, she adds. In men, the most common cause of UTI is Staphylococcus aureus, which often relates to urinary retention, says Redden.

If a male resident has recurrent UTI, check to see if he has a diagnosis of prostate hypertrophy or has been checked for the condition.

Rethink Routine Urinalysis

To steer clinicians away from diagnosing asymptomatic bacteriuria as UTI, rethink the facility's protocol for performing routine urinalyses.

For example, the facility might only do urinalysis when a person has symptoms, such as new onset of urinary frequency or complaints of burning, suggests **Kathy Hurst, RN, JD**, director of healthcare operations and human resources for **TSW Management Group**, an Anaheim Hill, CA-based nursing home management company.

The problem: Some nursing home patients who are chronically colonized with bacteria have low-grade inflammation and white blood cells in their urine without an active infection, says **Chesley Richards, MD**, a geriatric specialist in Atlanta and consultant to the **Centers for Disease Control & Prevention**.

Not only that, but 100 percent of people with indwelling catheters will have bacteria in their urine within 30 days, says **James Marx, RN, CIC**, an infection control specialist and principal of **Broad Street Solutions** in San Diego.

Tip: While greater than 100,000 colonies in a symptomatic patient indicates UTI, some residents can be asymptomatic in spite of a culture of more than 100,000 and shouldn't be treated, cautions Redden.

To reculture or not to reculture? Richards doesn't recommend reculturing patients after UTI treatment with the appropriate antibiotic (based on culture and sensitivity testing) for the correct duration of time. "If the person continues to have genitourinary symptoms after a course of antibiotics, he or she is a candidate for further investigation of the genitourinary tract," he says.