Codify by AAPC

MDS Alert

What Do You Think?:

Question 1: What are the requirements for documenting ADLs? My staff usually documents one time a shift, which may be any time during the 7.5 hour CNA tour of duty. I have been told that this is not enough. Is that true?

Answer 1: According to the RAI manual, you should consider each episode of any ADL when determining the appropriate coding for Section G0110 1 and 2, a-j (G-3). Because you have an algorithm that mandates how to code this section (G-6), an accurate assessment is not possible without point of contact documentation.

Question 2: Can I use the therapy evaluation to complete section G0300, Balance?

Answer 2: According to the RAI manual G-20, you should complete the assessment on G-20 – G-21 on all residents unless you have systematic documentation in the residents' clinical record that clearly "answers" the questions listed. The PT evaluation does not always specify the resident need for assistance in balance as they relate to standing, walking, turning around, moving on and off the toilet, and transferring surface to surface. Therefore, it is best to have the Interdisciplinary team document their observations routinely. If you have no documentation, the assessment mentioned above should be conducted.

Question 3: I am confused about coding in Section H0300. My CNAs do not code every time the resident is wet or dry: they merely indicate whether the resident has been incontinent during their shift. Can I indicate always incontinent if all three shifts indicate incontinent?

Answer 3: Always incontinent, according the RAI manual (H-7), means the resident never had an episode of continent voiding. Therefore, if you know that the resident was never dry and/or toileted with success, yes, always incontinent would be appropriate. However, because you should have documentation to support the MDS coding, it would be better if there was a note each shift supporting that fact, such as "no episode of continence this shift."

Question 4: What is the difference between a contracture and functional limitation in range of motion?

Answer 4: According to the RAI manual, functional limitation is defined as "limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury" (G-29). A contracture is an abnormal shortening of muscle tissue, rendering the muscle highly resistant to passive stretching. One must consider the effect of the limitation to determine whether it is a functional limitation or not. A resident with a contracture may still be able to perform certain ADLs without any problem or risk. Therefore, no limitation might be indicated even for a resident with a contracture.

Question 5: When is it appropriate to code "not rated" in H0300?

Answer 5: You can only code "9", not rated, if the resident has used an indwelling bladder catheter, a condom catheter, or an ostomy, or if there is no urine output for the entire 7-day look-back period (H-8).

Question 6: Constipation vs. Fecal impaction: What is the difference?

Answer 6: You should consider a resident as constipated when only 2 or fewer bowel movements have occurred during the 7-day look back or if the resident had difficulty passing the stool (i.e. it was very hard). It does not matter how many stools the resident had in the 7-day look-back, but rather whether the stools were hard or not. Think about how the CNAs document bowel movements. Does something have to change? Do they need more education/training?

Fecal impaction may be the result of unresolved constipation. Fecal impaction is a large mass of very dry and hard stool that is unable to be moved out of the rectum. A person may have a fecal impaction and still have watery stools excreted from the rectum. Therefore, it is vital that all bowel movements be well documented.

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Question 7: How long should a toileting program be in effect?

Answer 7: A toileting program is not appropriate for a resident who is totally incontinent or for whom a pattern cannot be established. A resident for whom a trial toileting program has been attempted resulting in an increase in the number of continent episodes, should continue on the program to either maintain the current level or to further increase the number of continent vs. incontinent episodes. The program is appropriate as long as the interventions are required to maintain or improve the residents' continence status.

Question 8: Can you give me any suggestions on how to code section H0300 for a resident who has intermittent catheterizations but is incontinent, at times, in between the catheterizations?

Answer 8: If intermittent catheterization is used to drain the bladder, code continence status based on incontinence between catheterizations (H-8). CNAs must be documenting the actual number of times the resident was incontinent between the intermittent catheterization.

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