Survey Deficiencies and Related MDS Coding Errors

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Objectives

- Understand the RAI process of coding, assessing, and care planning in problematic MDS sections
- Understand the relationship of common coding errors and deficiencies
- Understand how proper coding improves resident care

MDS Coding

- Must be based on observations, interviews and record reviews
  - Includes information from all disciplines, including direct care staff
  - Over a 24 hour period for 7, 14 or 30 days preceding the Assessment reference date

- Information and documentation in the clinical record must support MDS coding

Section E: Moods and Behaviors

- Goal is to identify and quantify specific, observable behaviors
- **Care Issue: Significant**
- **RUG Sensitivity: Moderate**
- **Requires documentation**
- Impacts on Quality of Care & Quality of Life

E1 - Depression

E1 – Indicators of Depression, Anxiety, Sad Mood

- Read the coding options E1a-p carefully
- Ensure that information is considered from all shifts and all disciplines, 24 hours per day for the entire 30-day observation period
- Coding
  - If the indicator did not occur at all → 0
  - If neither apply, indicating that it occurred, but less often than 6 to 7 days per week, → 1
  - If it happened 6 to 7 days per week → 2

E1 - Depression

- Common Coding errors
  - Even if occurred only once in the 30-day observation period it must be coded
  - Information collected by the clinical team should be documented on the chart and MDS
  - Interpretations
    - Requests for pain medications → Repetitive health complaints?
    - Crying, tearfulness – what about crying related to a sad movie?
  - Under coding due to acceptance of behaviors and complaints and the failure to identify and formally document symptoms

E1- Depression

- Under coding Depression
  - Affects resident quality of life and activities of daily living
  - Quality Measures implications
  - Survey implications
  - Resident care implications

E2 – Mood Persistence

- Staff is responsible to assess residents
  - To overcome sad or anxious feelings, determine causes and develop interventions
- This item asks whether those interventions were successful or not
- Care plan review is required if moods are coded as 2, not easily altered
  - Even when all interventions have been attempted without success, this coding still is important because of the impact the condition may have on the resident's overall health status

E3 – Change in Mood

- A snapshot from 90 days ago (or since last assessment if less than 90 days ago) compared to the current assessment
  - Resident could have had several "ups" and "downs" in the 90 days but still be coded "no change" if the status on last assessment is the same as the current assessment
- Coding: *Intensity* is as important to assess as frequency or number of episodes

Section H: Continence

- Determines continence pattern over 14 day window
- **Care Issue: Significant**
- **RUG Sensitivity: Moderate**
  - Nursing rehabilitation/toileting schedules
  - Relates to 10 F Tags
- Any wet episodes must be coded
- Often performed but not captured due to misunderstanding of rules
- Impacts on Quality of Care & Quality of Life

Section H

- Coding is not about ability to toilet oneself; it is about control of bowel and bladder function
  - Control may include
    - A catheter or ostomy device that does not leak
    - Scheduled toileting plans
    - Continence training programs
- Coding tip: Bladder and bowel use same scale, different scale definitions
- If staff assignments change often, consider using bladder and bowel elimination flow sheet

Section H

- Encourages tracking and recording of information
  - Interview direct care staff across all shifts
  - Code for actual patterns and not ideal
- Detailed clarifications about fecal impaction and constipation
- Detailed instructions for **scheduled toileting program**
- New regulations for survey Tags F314 & F315

Section H

H1a – Bowel Continence

- 0. Continent – *Complete control*
- 1. Usually Continent – Incontinent episodes occur *less than once a week*
- 2. Occasionally Incontinent – Incontinent episodes occur *once a week*
- 3. Frequently Incontinent – Episodes occur *2 to 3 times per week*
- 4. Incontinent – Incontinent *all or almost all of the time**

*Coding tip: If incontinent episodes occur more than 3 times per week → incontinent

Section H

H1b – Bladder Continence

- 0. Continent – Complete control regardless of means of achieving control*
- 1. Usually Continent – Incontinent episodes occur ***once a week or less***
- 2. Occasionally Incontinent – Incontinent episodes occur ***2 or more time per week but not daily***
- 3. Frequently Incontinent – Incontinent episodes tend to occur ***daily but some control is present*** (e.g., on day shift)
- 4. Incontinent – Has inadequate control. Incontinent episodes occur ***multiple times daily***

Section H

Coding may not be intuitive - think resource utilization

- Incontinent resident with indwelling catheter → continent
- Continent resident with leaking catheter → incontinent
- Incontinent resident with condom catheter that keeps falling off → incontinent
- Would be incontinent except staff toilets according to resident pattern (staff is "trained" rather than resident) → continent

Section H

H3 – Appliances and Programs

- Definitions are important
  - H3a - Any scheduled toileting plan
    - Must be
      - Scheduled – Specific routine time, not necessarily by the clock, that is communicated to resident and staff
      - Toileting – voiding in an appropriate receptacle
        - Changing wet pads and linens does not qualify
      - Program – specific approach that is organized, planned, documented, monitored, and evaluated
    - Includes verbal prompted voiding and habit training

Section I: Disease and Diagnosis

- Purpose: To documents the presence of diseases and diagnosis that have a relationship to the residents' current ADL status, mood or behavior status, medical treatments, nurse monitoring, or risk of death
- **RUG Sensitivity: High**
- **Care Issue: Moderate to Significant**
- Payment, care & survey implications

Section I

- This section must accurately reflect the resident's current status; if it doesn't, care planning and reimbursement can be adversely impacted
- Physician diagnosis is required before it can be coded in Section I
- For Medicare Part A reimbursement, diagnoses that justify the resident's coverage should appear on the MDS, the medical record face sheet, and the UB-04 claim form
- For rehab therapy, the diagnoses the therapists use for treating a resident should appear on all three as well

Section I

I2 – Infections - (7-day look back except UTI)

- Check item only if the infection has a relationship during the observation period to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death
  - Exception: UTIs resolved in the last 30 days are included as well as current UTIs

Section I

I2 – Infections

- Specific issues: UTI
  - Requirements for coding
    - Symptomatic during the observation period
    - Significant laboratory findings
    - Physician diagnosis
    - Current supporting documentation of all of the above
  - Once a urine culture has been done, a physician's working diagnosis can be coded at I2j as long as it appears in the clinical record. Confirming the diagnosis requires culture results and clinical assessment
    - If labs indicate that UTI was not present, complete a correction to remove the diagnosis from the MDS

Section J1: Health Conditions

- Identifies specific problems or symptoms affecting health and/or functional status
- **Care Issues: Moderate**
- **RUG Sensitivity:**
- Impacts on Quality of Care & Quality of Life
- Impacts special care & clinically complex RUG payment

Coding of Pain

- "If the resident states he or she has pain, take his or her word for it.
- Pain is a subjective experience."

- **<u>Use a standard pain scale for all pain assessments</u>**

Pain Definition per RAI

- Any type of physical pain or discomfort in any part of the body
- May be localized to one area, or may be more generalized
- May be acute or chronic
- May be continuous or intermittent
- May occur only at rest or only with movement

Coding Confusion

- Be Objective
  - Either pain occurred or it didn't
    - It doesn't matter for coding purposes whether the resident received pain medication or not
      - The only thing that matters is whether the resident had pain
    - It is not appropriate to attempt to estimate what the pain level would have been without pain medication

Assessing the Resident

- Observe the resident for indications of pain
  - Verbal indicators such as moaning, crying
  - Facial expressions such as wincing, frowning, appearing tense
  - Body posture such as not wanting to move, protecting one area of the body
  - Onset or increase in restlessness, agitation, or behavior problems

Section J

J2 – Pain Symptoms

2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)* a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (*skip to J4*) 1. Pain less than daily 2. Pain daily		b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	

Coding Instructions for Pain

- Record
  - The frequency with which resident complains/expresses or shows evidence of pain (J2a)
  - The intensity of signs and symptoms of pain (J2b)
- Code for the highest level of pain present in the last 7 days
- If resident has had no pain during the observation period, J2a = 0
- Constant pain management may be difficult to attain, however Include residents on pain management programs even if pain level is tolerable by the resident- **It's still pain**

Determining Level of Pain

- Set up facility parameters with your pain scale to determine if the pain is mild, moderate or severe
- Example: Scale of 1-10
- 1-3 is Mild
- 4-7 is Moderate
- 8-10 is Excruciating

J3 – Pain Site

- Pain is sometimes difficult to localize: Use acute observational skills combined with effective interview techniques and thorough physical assessment, including vital signs
- Check all that apply in the last 7 days

Care Planning Pain

- Accurate assessment of location, characteristics, factors that cause or increase pain and that reduce pain will guide facility to development of effective care plan

- Documentation and demonstration of thorough, accurate assessment; prompt, consistent, appropriate intervention; and routine reevaluation for effectiveness of interventions and care plan adjustments as indicated is essential

Managing the Pain

- While medications are often the most common intervention of pain management, consider other options such as hot packs, cold packs, exercises, topical applications, repositioning, etc.

Section J

J4 – Accidents

- Intent: To determine resident's risk of future falls or injuries
- Addresses falls and fractures
  - Fractures from any cause are to be coded in J4c and J4d (not just fractures from falls)

When is a Fall a Fall?

- An episode where a resident lost his/her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall.

- The presence or absence of an injury is not a factor in the definition of a fall. A fall without injury is still a fall.

When is a Fall a Fall?

- When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there. Unless otherwise proven that the resident determined to be on the floor, it is a fall! The clinical team is responsible to implement interventions to prevent future falls.
- The distance to the next lower surface is not a factor in determining whether a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, this is a fall.

Better Coding = Accurate MDS

QIs/QMs

- **1.1 Incidence of new fractures (Source: QI01)**
  Residents who have a hip fracture or other fracture that are new since the last assessment. The denominator includes all residents with a valid target assessment and a valid prior assessment who did not have fractures on the prior assessment (J4c[t-1] is not checked and J4d[t-1] is not checked).
- **1.2 Prevalence of falls (Source: QI02)**
  Residents who had falls within the past 30 days on the most recent assessment. The denominator includes all residents with a valid target assessment.

QIs/QMs

- **2.1 Residents who have become more depressed or anxious (QM CMOD03)**

  Residents whose Mood Scale scores are greater on target assessment relative to prior assessment. The denominator includes all residents with a valid target assessment and a valid prior assessment.

QIs/QMs

- **2.2 Prevalence of behavioral symptoms affecting others (Source: QI03)**

  Residents with behavioral symptoms affecting others on target assessment. The overall denominator includes all residents with a valid target assessment with only the first 2 exclusions applied. Behavioral symptoms are defined as verbal abuse, physical abuse, or socially inappropriate/disruptive behavior.

QIs/QMs

- **2.2-HI High Risk –** Presence of cognitive impairment on the target assessment OR psychotic disorders on the target assessment or on the most recent full assessment OR Manic Depressive on the target assessment or most recent full assessment. The denominator for high risk includes all residents with a valid target assessment who are defined as high risk, with all 3 exclusions applied.
- **2.2-LO Low Risk –** All other residents that are not high risk. The denominator for low risk includes all residents with a valid target assessment who are defined as low risk, with all 3 exclusions applied.

QIs/QMs

- **2.3 Prevalence of symptoms of depression without antidepressant therapy (Source: QI05)**

  Residents with symptoms of depression (sad mood and at least two of other symptoms of functional depression) and no antidepressant therapy on the target assessment. The denominator includes all residents with a valid target assessment.

- **3.1 Use of 9 or more different medications (Source: QI06)**

  Residents who received 9 or more different medications on target assessment: O1 (number of medications) >= 9. The denominator includes all residents with a valid target assessment.

QIs/QMs

- **5.1 Low-risk residents who lost control of their bowels or bladder (Source: QM CCNT06 - QI Replaced: QI08 Low Risk)**

  Residents who were frequently incontinent or fully incontinent on the target assessment (H1 a = 3 or 4, or H1 b = 3 or 4). The denominator includes all residents with a valid target assessment and not qualifying as high risk.

QIs/QMs

- **8.1 Residents who have moderate to severe pain (Source: QM CPAI0X)**

  Residents with moderate pain at least daily (J2a=2 AND J2b=2) OR horrible/excruciating pain at any frequency (J2b=3) on the target assessment. The denominator includes all residents with a valid target assessment.

QIs/QMs

- **13.2 Short-stay residents who had moderate to severe pain (Source: QM PAC-PAI0X)**

  Short-stay residents at SNF PPS 14-day assessment with moderate pain at least daily (J2a = 2 and J2b = 2) OR horrible/excruciating pain at any frequency (J2b = 3). The denominator includes all patients with valid SNF PPS 14-day assessment (AA8b = 7).
- **13.3 Short-stay residents with pressure ulcers (Source: QM PAC-PRU0X)** Short-stay residents at SNF PPS 14-day assessment who satisfy either of the following conditions:

In closing

- Items discussed today not only effect the survey outcomes, they are essential components of human beings
- The clinical team is responsible to accurately assess, evaluate, implement individualized approaches to care
- The clinical team must insure that all residents receive on a daily basis care that helps them to achieve optimal functioning and of the highest practicable level