MDS Audit

Resident Name:_____ Date of Admit: _____ ARD:_____ Audit Date:_____

Hospital Packet:

MAR from last 7 days of hospital stay: Reviewed ☐ Requested ☐
IV Fluids received: Dates/mL:_____ Total:_____
Fluids were for hydration: YES ☐ NO ☐
ARD date needed to capture hydration:_____

HYDRATION HINTS: Fluids must be for hydration. Do not include fluids used to dilute or reconstitute IV medications. Look for key words, "gentle hydration" and ask for clarification if necessary. Common diagnoses include CHF, acute kidney injury, chronic kidney failure, electrolyte imbalances, dehydration and diabetes.

Diagnosis List:

Diagnoses captured from hospital packet: YES ☐ NO ☐
Malnutrition, Risk of Malnutrition, or Morbid Obesity: BMI_____
Diagnoses from radiology reports:_____
Dysphasia, aphasia, apraxia, and dysphagia are coded to I69 codes for patients with a cerebrovascular disease or recent stroke: YES ☐ NO ☐
Section I coding is accurate: YES ☐ NO ☐
Query the physician:_____

DIAGNOSIS DISCOVERY: Using clinical knowledge, clues in the medical record, and the ICD-10 guidelines to query the physician leads to more accurate coding. Pay special attention to CT scans, MRI reports, low BMI for indications of malnutrition or risk of malnutrition, BMI >40 for Morbid Obesity. COPD with home oxygen use may indicate chronic respiratory failure.

REMEMBER, "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis." - CMS ICD-10-CM Official Guidelines for Coding and Reporting FY 2021

Primary Diagnosis:

Primary Diagnosis PDPM category: _____
Is this diagnosis the most accurate reason for skilled care? YES ☐ NO ☐
For IPA, did the Primary Diagnosis change? YES ☐ NO ☐

PICKING THE PRIMARY: The Primary Diagnosis is the **primary** reason why the patient came to the SNF for care. It does not have to be the discharge diagnosis from the hospital. It could be an underlying chronic condition, such as Parkinson's disease, that hinders, extends, or complicates the recovery from the conditions that brought the patient to the hospital.

Interviews:

Section B: Is the resident comatose? YES ☐ NO ☐
Section B: Is the resident seldom or never understood? YES ☐ NO ☐
Were pain, BIMS, and PHQ-9 interviews were conducted? YES ☐ NO ☐
Are staff interviews supported in the medical record? YES ☐ NO ☐
Are interviews signed within the ARD lookback period? YES ☐ NO ☐

INTERVIEW INSIGHTS: Unless the patient is coded "comatose" in B0100 or "rarely/never understood" in B0700, C0100, D0100 and J0100 must be coded, "**yes**." **ALL** interviews must be **attempted** unless the resident is coded "comatose" or "rarely/never understood." Record the answers given or "no response" from the attempt, then code the staff interview.

The RAI User's Manual instructs, **"**Encourage staff to report symptom frequency, **even if the staff believes the symptom to be unrelated to depression."** The PHQ-9 is asking whether an indicator is present, not what the interviewer or staff believes to be the underlying cause of the indicator. The patient may feel tired because they are up and down several times per night to use the toilet. Appetite may be poor because the patient is taking antibiotics for an infection. The patient with advanced dementia may show little interest in activities or require frequent redirection because they cannot focus on a task or activity. Those indicators should be coded as present in a staff interview, regardless of whether staff believes the patient is depressed.

Functional Assessments:

Functional assessments for GG supported in the medical record: YES ☐ NO ☐
Significant interdisciplinary differences are reconciled: YES ☐ NO ☐
Are inconsistencies present between G and GG? YES ☐ NO ☐
If an item was not assessed, was the reason coded correctly? YES ☐ NO ☐
Are there dashes entered for any functional assessment? YES ☐ NO ☐
How many goals are coded in Section GG? _____
There is a personalized care plan for all Section GG goals: YES ☐ NO ☐
Goals are consistent with prior level of function: YES ☐ NO ☐
Section GG is signed in the MDS by day 3 of the stay: YES ☐ NO ☐

FOCUS ON FUNCTION: Dashes in the **functional** areas of Section GG can result in payment penalties, so they should be avoided. If an item was not assessed, be sure to use the appropriate code. "88" means there were medical reasons, such as weight bearing status or the patient was simply too weak to safely attempt. "10" means there was an environmental problem, such as, poor weather prevented going outside for car transfers. "09" means NOT APPLICABLE. This means **the patient did not do a particular function prior to their spell of illness/injury.** Coding only **ONE goal** is required. More than one can be coded, but a specific, personalized care plan for each goal is **required**.

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 1.800.530.4413
www.harmony-healthcare.com

ADL and Toileting Coding

Coded ADLs reflect the Rule of 3: YES ☐ NO ☐
Point of Care charting is consistent: YES ☐ NO ☐
Are there "holes" in Point of Care charting? YES ☐ NO ☐
Are toileting programs in the plan of care? YES ☐ NO ☐
Are toileting programs reviewed within the ARD lookback period? YES ☐ NO ☐
Is there a decline in continence since the last MDS? YES ☐ NO ☐
Is there a decline in self-performance of ADLs since the last MDS? YES ☐ NO ☐

Section J

Short of breath while lying flat is supported in the medical record: YES ☐ NO ☐
Short of breath while lying flat is coded in J1100c:
Fever, dehydration, vomiting, or internal bleeding coded is supported in the medical record: YES ☐ NO ☐
Is there record of any falls since last MDS assessment? YES ☐ NO ☐
Falls are accurately recorded in J1900: YES ☐ NO ☐
Did the patient have major surgery during the past 100 days or during their hospitalization? YES ☐ NO ☐
Recent surgery is accurately coded in J2000 and J2100: YES ☐ NO ☐

Section K

Difficulty swallowing is supported in the medical record: YES ☐ NO ☐
K100a, b, c, or d is coded "yes" in Section K: YES ☐ NO ☐
Height and weight are coded in K200: YES ☐ NO ☐
% of total calories by parenteral or tube feeding: _____
Average mL/day fluids by IV or tube: _____
Mechanically altered diet supported in the medical record: YES ☐ NO ☐
Mechanically altered diet is coded in K510c: YES ☐ NO ☐

Oral Status

Oral conditions coded in Section L are supported in the medical record: YES ☐ NO ☐
The plan of care reflects the needs identified in Section L YES ☐ NO ☐

Skin

Braden assessment date:_____
Clinical skin assessment date:_____
Patient is at risk for pressure injury: YES ☐ NO ☐
Number and stages of all pressure injuries present on admission: _____
Number and stages of all pressure injuries acquired in house: _____
Pressure injury treatments:_____
Number of vascular ulcers:_____ Treatments:_____
Surgical incisions: YES ☐ NO ☐ Treatments:_____
Diabetic foot ulcers: YES ☐ NO ☐ Treatments:_____
Other wound/lesion: YES ☐ NO ☐ Location:_____ Treatments:_____
Moisture associated skin damage: YES ☐ NO ☐ Treatments:_____
Pressure relieving mattress and cushion coded are supported in medical record: YES ☐ NO ☐
Creams/ointments coded are supported in medical record: YES ☐ NO ☐

Medications

Medications are coded by pharmaceutical class regardless of reason used: YES ☐ NO ☐
How many days were insulin orders changed? _____
Antipsychotics were used: YES ☐ NO ☐
Date of the last GDR for antipsychotic: _____
Date of physician statement that GDR is not clinically appropriate: _____
Date of medication regimen review: _____ Issues found YES ☐ NO ☐
Date/time physician notified of issue: _____
Date/time physician response: _____
Date/time facility staff acted on physician instructions: _____