July 19 & 20, 2023

MDS Coding: Understanding and Making the Appropriate Choice

OSDH Quality Improvement and Evaluation Service

(QIES Help Desk)

OKLAHOMA
State Department of Health

Objectives

- Discuss accurately coding schizophrenia
- Overview of CMS guidance in QSO-23-05-NH
- Review impact on Nursing Home Compare and Five-Star Rating System

Inaccurate MDS Coding: Schizophrenia

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Background

- CMS issued updated guidance in QSO-23-05-NH related to facilities inaccurately coding a schizophrenia diagnosis.
- Erroneously coding a diagnosis leads to:
  - Improper Care
  - Unnecessary antipsychotic medications
  - Misleads the public

CMS Findings

- CMS identified facilities with patterns of erroneous coding of schizophrenia
  - ❖ Absence of comprehensive psychiatric evaluations
  - ❖ Lack of documentation reflecting behaviors related to schizophrenia
  - ❖ Sporadic behaviors noted in medical record related to dementia

MDS Section I Diagnosis Requirements

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MDS Diagnosis Requirements

- There are two look-back periods in Section I when determining if a diagnosis may be added for the resident.
  - Step 1: Diagnosis identification is to determine if there is a physician documented diagnosis in the last 60-days.
  - Step 2: Diagnosis status is determining if the diagnosis is Active or Inactive in the 7-day look-back period (except for UTI).

Step 1: Diagnosis Identification

Identify Diagnosis

- Requires a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.

- Medical record sources for physician diagnoses include:
  - Progress notes, the most recent history and physical,
  - Transfer documents, Discharge summaries,
  - Diagnosis/Problem list (physician must confirm the diagnosis), and
  - Other resources as available

Active Diagnosis: I6000 Schizophrenia (e.g., schizoaffective and schizophreniform disorders)

- Errata Document July 15, 2022 added a supporting example to the RAI Manual on page I-16:

  The resident was admitted *without* a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a ***detailed evaluation by an appropriate practitioner*** of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

  Coding: Schizophrenia item (I6000), would **not** be checked**.**

  Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.

I6000: Schizophrenia Diagnosis

- Clarification on Errata guidance:
  - Is there diagnostic information (i.e., comprehensive evaluation, any behaviors/symptoms, reports of past history from family) relevant to the diagnosis being assigned?
  - Review the medical record for the physician-documentation that s*upports* a diagnosis,(any diagnosis, not just schizophrenia), rather than questioning the physician's decision to assign a particular diagnosis.
  - Do not code a diagnosis on the MDS if supporting documentation is not available in the medical record.

Step 2: Active Diagnosis

- Active diagnoses have a direct relationship, or impact, on the resident, and the resident's care plan, in the 7-day look-back period.
- After receiving documentation from the physician, do not include the following if not applicable in the 7-day look-back window:
  - Diagnosis or condition that has been resolved, Or
  - Does not affect the resident's current status, Or
  - Does not drive the resident's care plan
- Consider if a Significant Change in Status Assessment (SCSA) is needed.

Step 2: Active Diagnosis continued

- Listing a diagnosis in the resident's medical record is not sufficient.
- Only physicians, and physician extenders, may diagnosis.
- Monitoring a medication's effect on the resident's condition (therapeutic efficacy) *would* indicate an active diagnosis (e.g., insulin or coumadin).

CMS Audit and Five-Star Ratings

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Quality Measure

Long-Stay quality measure

- Percent of Residents Who Received an Antipsychotic Medication
- N0410A Antipsychotic: Code based on the number of days the resident received this medication.
  - 7-Day Look-Back OR
  - Since Admission/Entry or Reentry if less than 7 days
  - Based on pharmacological classification, not how med is used

- Excludes residents with a diagnosis of:
- Schizophrenia; Huntington's Disease; or Tourette Syndrome

Audit Process

If selected for an audit:

- Facility will receive a letter explaining the purpose of the audit
- What the audit process will be
- Instructions for providing supporting documentation
- Facilities will have the ability to ask questions
- At the conclusion of the audit, the facility may discuss results with CMS

Audit Process

- Facilities will have the opportunity to forego the audit by admitting errors in coding schizophrenia and committing to correcting the issue.
- If admitted prior to the start of the audit, CMS will consider a lesser action related to the star ratings, such as suppression of the QM rather than downgrading.
- CMS will continue to monitor each audited facility and a follow-up audit may be conducted.

Adjusting Five-Star Ratings

- Antipsychotic quality measure is reported on Nursing Home Care Compare and in the Five-Star rating calculation.
- CMS will adjust a facility's Five-Star ratings if audit reveals inaccurate coding.
- Aligns with efforts to bring down the inappropriate use of antipsychotic medications.

Correction Process

- Coordinate with your psychiatric provider and medical directors
- Refer to the SOM Appendix PP (F-tags 658, 740, and 758) and
- MDS RAI Manual guidance in Section I
- For assistance in reducing antipsychotic medications, contact one of the Telligen QIN/QIO facilitators:
  - Morgan Satterlee, LPN (msatterlee@telligen.com);
  - Tamara Carter, RN (tcarter@telligen.com)
  - Micki Reyman, MS, RN (mreyman@telligen.com) or 405-509-0720

Summary

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Summary

- Discussed inaccurate coding of schizophrenia diagnosis
- Steps to accurately code a diagnosis on the MDS
- Reviewed CMS audit process and impact on Five-Star Ratings

Questions/Contact

Diane Henry, RN

Program Manager

Wanda Roberts, BSN

Automation Coordinator

Holly Murphy, BSN

RN Consultant

Quality Improvement and Evaluation Service (QIES)

405.426.8160

MDShelp@health.ok.gov