

ADL Coding

Getting the most from those that do the most!



Learning Objectives

- Attendees will be able to identify the most common errors in ADL coding.
- Attendees will understand what drives end users to code inaccurately.
- Attendees will identify the effects of miscoding on their reimbursement.
- Attendees will identify the effects of miscoding on their quality measures.

ADL Coding Goals

- Accuracy
- Consistency



Why does ADL accuracy matter?

- Reimbursement
 - Medicare
 - Medicaid
 - Insurance
- Quality Measures
 - ADL declines
 - Mobility Decline
 - Functional Improvement

What is “accurate”?

- Compare your residents to yourself, not to other residents.
- Does anybody ever help you out of a chair or feed you a bite of food?
- Did your patient need you?
- Nurse Aide documentation is different than MDS documentation.
- Coding is interpreted on a set standard.



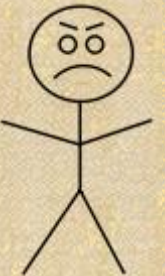
Bed Mobility, Transfer, Toilet Use

Nurse aides code the highest level of support they gave over their shift or per event coded.

- 0- Independent. NO help or oversight provide. This is someone getting ready to go home.
- 1- Supervision. Oversight or cueing provided. NO Touching!!!
- 2- Limited Assistance. Guiding. No resident weight support. NONE!!!!



- 3- Extensive Assistance. Any weight bearing support. *Most prevalent*
- 4- Total dependence. The resident did not assist in the activity over the entire time period that this entry covers.
- 8- Activity did not occur. Activity did not occur at all over the entire shift.



Eating

- 0- Independent. NO help or oversight
- 1- Supervision. Cueing and monitoring- no hands on.

- 2- Limited Assist. Handing silverware, cups. Guiding hands. NOT feeding at all!
- 3- Extensive assist. Staff fed at least one bite, but Resident also fed self at least one bite.
- 4- Total dependence. Resident did not feed self at all during event.



Are LTC residents *ever* Independent in eating?

YES!

RAI example of Independent:

- After staff deliver Mr. K.'s meal tray, he consumes all food and fluids without any cueing or physical help during the entire 7-day look-back period.
- Coding: G0110H1 would be coded 0, independent. G0110H2 would be coded 0, no setup or physical help from staff.
- Rationale: Resident is completely independent in eating during the entire 7-day look-back period.

RAI example of Supervision:

- One staff member had to verbally cue the resident to eat slowly and drink throughout each meal during the 7-day look-back period.
- Coding: G0110H1 would be coded 1, supervision. G0110H2 would be coded 0, no setup or physical help from staff.
- Rationale: Resident required staff supervision, cueing, and reminders for safe meal completion daily during the 7-day look-back period.



Interpretation

- Our coding is decoded based on these definitions.
- Misinterpretation is caused on the coding end, not the interpretation end.
- Facilities must code to the defined meanings.

Common Errors

- Bed Mobility coded total dependence.
- Transfers and Toilet Use coded as Limited Assist when weight bearing was utilized.
- Eating under coded when:
 - Reminders given
 - Handing cups
 - Feeding that first bite to an otherwise independent resident

Quality Measures Directly Impacted

- ADL decline- Long stay
- Move Independently worsened- Long Stay
- Improvement in Function- Short Stay
- Impacts due to inaccuracy can be devastating!



ADL Decline

- Target compared to prior
- Change in 2 points of one item or
- Change in 1 point of two more items
- Late loss ADLs (Self-performance)
 - Bed Mobility
 - Transfer
 - Toilet Use
 - Eating
- Exclusions (i.e., Dependent, Hospice)
- Consistency

ADL Decline		
Range		Points
0.0%	10.0%	100
10.0%	13.5%	80
13.5%	16.8%	60
16.8%	20.8%	40
20.8%	100.0%	20

Move Independently worsened

- Target to prior
- Locomotion on Unit (Self-performance) decline of 1 or more.
- Exclusions (i.e., Dependent, Hospice)
- Consistency

Mobility Decline		
Range		Points
0.0%	8.0%	100
8.0%	14.5%	80
14.5%	19.3%	60
19.3%	24.9%	40
24.9%	100.0%	20

Functional Improvement (Short Stay, all payers)

- Successful improvement is defined as a total of 1 point of improvement in combined self performance total:
 - Transfer
 - Walk in Corridor
 - Locomotion on Unit
- True barriers
 - Make gains but do not leave categories.
 - DC to hospice, another SNF, etc..
 - Short times between first and DC assessment.
- Exclusions (Hospice, independent, unplanned DC's, etc)

Functional Improvement		
Range		Points
81.7%	100.0%	100
71.0%	81.7%	80
62.9%	71.0%	60
52.0%	62.9%	40
0.0%	52.0%	20

Reimbursement

- ADLs drive all reimbursement
- ADLs are the greatest source of coding related revenue loss.
- ADLs impact every RUG category.



Reimbursement

- 1 instance of weight bearing assist
 - 1 bite of food fed
 - 1 drink placed in a hand
 - 1 straw brought to the lips
 - 1 instance of another care giver support
 - 1 over coded total dependence
- Each one of these inaccurately reported events can represent:
 - \$3,000 in one patients Medicare/Managed care payments.
 - \$9,000 in quarterly Medicaid rates

Other Impacts of ADL coding

- PBJ staffing requirements
- Covariates and exclusions in Quality Measures
 - Short Stay Improved Mobility
 - Short Stay Pressure Ulcers
 - LS Pressure Ulcers
 - LS decline in Locomotion
- Covariates in Quality Reporting Program
 - Short Stay Pressure Ulcer
- Accuracy assigns covariates appropriately.

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- Hurrying.
- Getting used to coding a resident and never changing it.
- The names!
 - “Limited means a little”
 - “Extensive means a lot”
- “Because the Nurse Aides don’t care.”
 - Ok, But if that’s true, then, why?
 - Have we caused it? Worked to prevent it?

What do we do to get accuracy?

- Problem- Hurrying.
 - Free up some time. Only have your aides document on what you actually need.
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- Problem- Getting used to coding a resident and never changing it.
 - Discuss changes, especially planned discharges. Make sure the aides know if patients are supposed to be doing more on their own r/t pending discharge home.

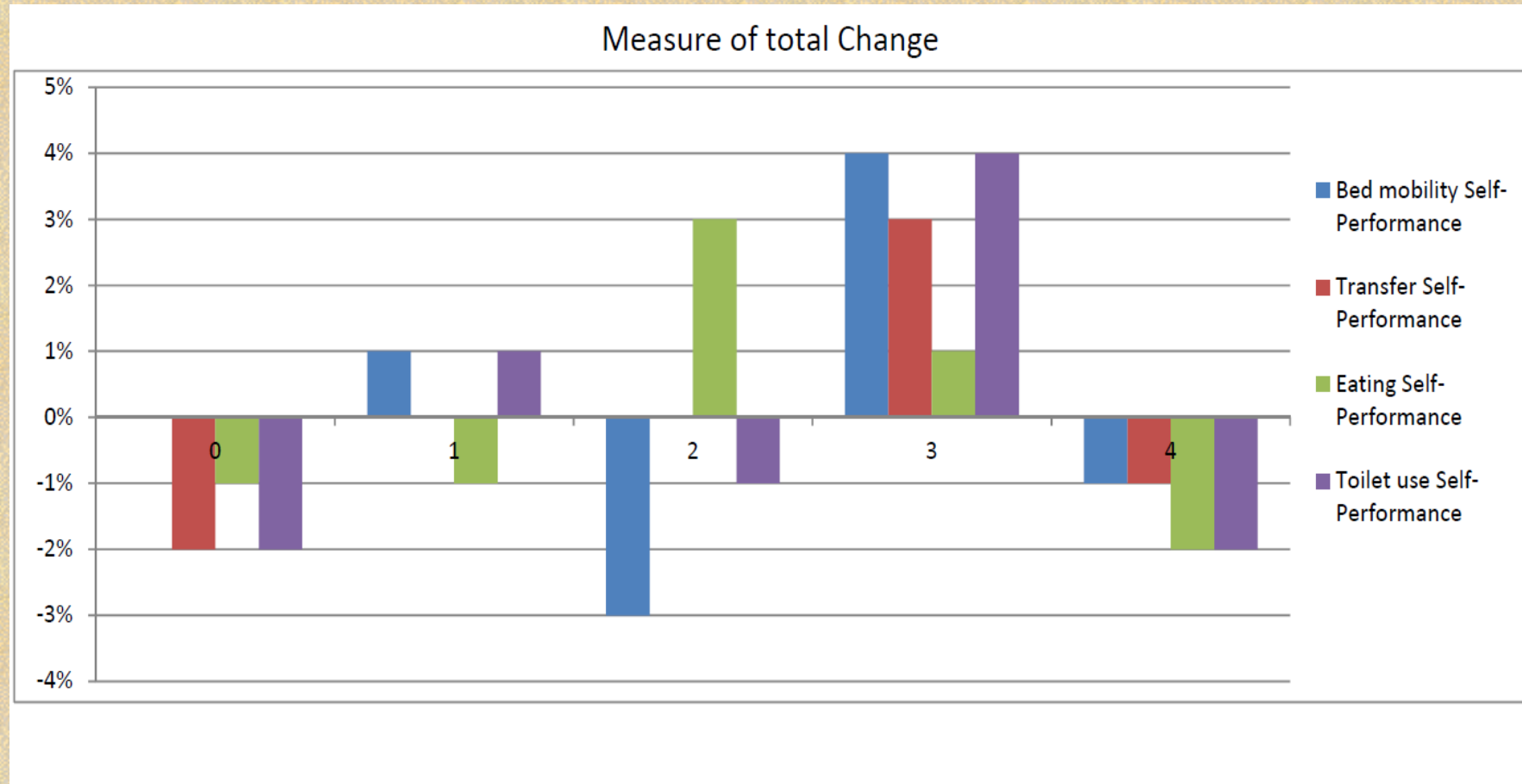
What do we do to get accuracy?

- Problem: The misleading names!
 - “Limited means a little”
 - “Extensive means a lot”
- TRUTH:
- Limited means contact with no lifting.
 - Extensive means any weight
 - Educate! Make sure that they understand the interpretation of what they are recording.
 - Stop them in the hall and ask them to tell you what the definitions mean. Encourage them to ask questions
 - Let them know what their documentation means to staffing

What do we do to get accuracy?

- Apathy?
- Read their documentation.
- Comment on it.
- Ask them about it.
- Make sure that they know that their documentation really matters.
- Thank them for it.
- Give badges to good coders as coding mentors.

Monitor to measure success

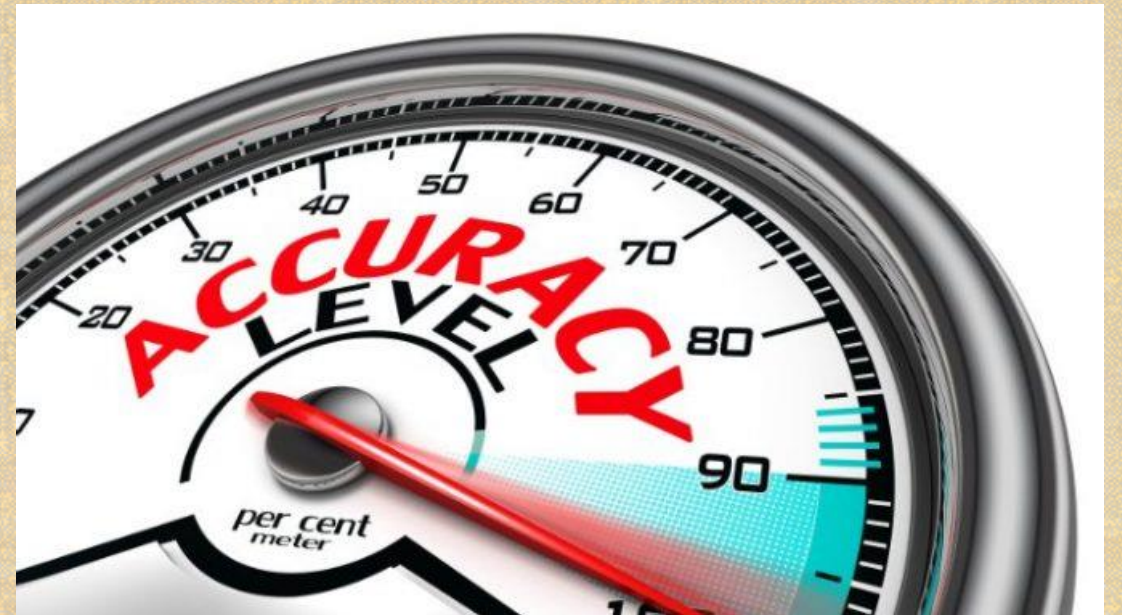


Final thoughts

- Set coding edits in EHR if applicable.
- Make sure they are doing it right, so they can code it right!
 - Discharge plans
 - Rounds in pairs
- Provide engaging education that allows beliefs to be challenged.
- Watch out for the mad wood peckers working those kiosks!
- Set a repeating schedule of training and evaluations.
- Different voices- same message.
- Make them want to.
- Motivation starts with an expectation of results.
- Set a goal and a fun reward.
- The first step to success is getting started.
- Measure coding before and after training events to validate effectiveness.

Next Steps

- Evaluate
- Schedule education event
- Measure coding prior
- Educate
- Measure coding after
- Evaluate for ongoing opportunities of improvement
- Repeat.



Questions?

- mikenicodemus@nicodemus5star.com
- For information on ADL Training for your facility,
- <https://www.nicodemus5star.com/services/>