Codify
BY AAPC

MDS Alert

Compliance Tips: 3 Ways to Stay Out of the Audit and Survey Fray

Is your facility using these simple practices?

You can head off claims denials and F tags with these documentation tactics.

1. Realize what you're up against. Judy Wilhide Brandt, RN**, R**A**C-M**T**, C-**NE**,** counsels nursing facility staff to "write like an auditor is going to read it. People can expect to have charts requested for review," stresses Brandt, of Judy Wilhide MDS Consulting Inc. in Virginia Beach, Va. "The MACs are pulling charts like crazy and aren't going to stop."

2. Perform this double-check. Have "someone who didn't do the documentation but is familiar with the resident read the chart and verify that the documentation is painting an accurate picture of the resident's condition and the treatment provided," advises **Janet Potter, CPA,** a healthcare research specialist with FR&R Healthcare Consulting Inc. in Deerfield, Ill.

3. Consolidate documentation. Barbara Frank recalls one situation "where surveyors looked in the 24-hour report initially to find something about a patient's bowel incontinence and whether the person had received assistance. The documentation wasn't there," she says. "We did find it in other documentation. But the more places you have to document something, the more inconsistent and incomplete your documentation will be," cautions Frank, co-founder of B&F Consulting Inc. in Warren, R.I. You want the "whole story in a place where it can be easily found," she adds.