MDS Alert

Diagnosis Coding: Flush Out Inaccurate Dehydration Diagnoses In Section I3

Before you code, confirm a resident has true clinical dehydration.

A little diagnosis and coding checkup is sometimes all you need to make a case of dehydration disappear. And that can save your facility from having to explain a sentinel health event to surveyors.

Know the triggers: The quality indicator for dehydration gets triggered by checking J1c on the MDS - or coding an ICD-9-CM diagnosis for dehydration in Section I3. The nursing staff can code symptoms of dehydration if observed during the past seven days in Section J, but a physician-documented diagnosis is required to code in Section I3, says the MDS/OASIS coordinator for Colorado.

But that doesn't mean the MDS and nursing staff can't work with attending physicians or the medical director to make sure a resident truly has dehydration before the facility gets saddled with a sentinel event.

For example, sometimes a physician in the hospital diagnoses the resident as being dehydrated before admission or during an acute-care transfer. "Hospitals often add the diagnosis of dehydration because it's a comorbidity that impacts their DRG payment," cautions **Theresa Lang, RN, BSN, PHN, RAC-C, WCC**, a consultant with **Specialized Medical Services** in Milwaukee.

Or the nursing home resident goes to the ED where he gets an IV just in case he might need fluids, Lang notes. Then a few hours later the nurses or physician on the floor assume the person has an IV because he's dehydrated. Thus, the resident ends up with that diagnosis in his record. "Yet, in reality, the person may not be clinically dehydrated," says Lang.

But hospitals aren't the only culprits in overdiagnosing dehydration. "The condition is often inaccurately diagnosed in nursing homes, as well," cautions **Charles Crecelius, MD,** CMD, who practices in long-term care facilities in St. Louis, MO. "Or the diagnosis is left from a previous medical illness," he adds.

Develop a QA Strategy

"Given the regulatory implications of coding dehydration on the MDS, facilities would be wise to review all diagnoses of dehydration through their quality assurance process," Crecelius says.

"Or have the nursing supervisor or medical director promptly review any diagnosis of dehydration," he adds. For example, they can use the serum osmolality test, which is easy to calculate, Crecelius points out.

"If the doctor simply observed the patient looked a little dry and wrote 'dehydration' in the documentation, that's not sufficient clinical evidence to support the diagnosis," agrees **Myra Peskowitz, RN, MBA**, principal of **The Peskowitz Group** in Shelter Island Heights, NY.

Thus, education of practitioners is the key to prevent misdiagnoses of dehydration that can come back to haunt the facility, says Peskowitz.

Tip: Serum osmolality can be used to help confirm a case of true dehydration or intracellular fluid deficit.

You can get a general estimate of the serum osmolality by doubling the serum sodium level. For example, if the serum sodium were 140 mEq/L (milliequivalents per liter), the serum osmolality would be 280 mOsm/Kg. The normal range of values runs from 275-295 milliosmoles per kilogram (mOSm/kg) of water.

For a more accurate calculation of the serum osmolality, use the following formula:
(2 x serum sodium) + (BUN/2.8) + (glucose/18) = serum osmolality.

"The serum osmolality test can be measured using standard chemistries usually obtained by the nursing home," Crecelius notes. "And as the formula suggests, the BUN alone is not the best measure of dehydration, which is a common mistake."

If the dehydration diagnosis fails to reflect true clinical dehydration, the facility should work with the medical director to correct the resident's medical record, Peskowitz says.

Don't Code Outdated Diagnoses

Say a resident had a physician-documented diagnosis of dehydration at admission but his problem resolved in a few days with IV fluids and a change in medication, postulates the Colorado MDS/OASIS coordinator. In that case, "discuss with the attending physician or medical director whether he wants to maintain that diagnosis as a current one in the medical record," she advises.

But "if the resident is still receiving nursing or medical interventions to stave off dehydration, such as I&O and care plan directives to push fluids, then continue coding a physician-documented ICD-9 clinical diagnosis," adds Lang.