MDS Alert

Section H: Abolish Incontinence Assessment, Coding Woes Before You Face a Surveyor

Cover these bases under revised F315 guidelines.

Urinary incontinence will always be the hot seat, so make sure you're staying a step ahead of surveyors.

You can't track what you don't code accurately, so make sure you know what counts as urinary incontinence in Section H. The RAI manual states that if the resident's skin gets wet with urine - "or whatever is next to his skin (pad, brief, underwear) gets wet"- you code that as an incontinence episode.

Coding incontinence at H1b (on a scale of 0 to 4) depends on the frequency of episodes that meet the RAI definition of incontinence during the 14-day look-back, including the assessment reference date (ARD).

Don't miss this red flag: A facility with a low prevalence of incontinence compared to state averages or its peer facilities might be undercoding Section H due to lack of understanding of the RAI manual definition, experts say.

Follow These Key Strategies

To make sure your continence assessment and care is on track - and the MDS and support documentation proves that it is - follow these seven steps.

1. Determine the type and causes of the resident's urinary incontinence. The clinical staff have to figure out why the resident is incontinent and go to the care plan phase from there.

2. Code the type of incontinence and review related diagnoses in Section I. Carefully review the patient's medical record and problem list for diagnoses that could explain the person's incontinence.

Look for these conditions: Parkinson's disease, multiple sclerosis, cerebral vascular accident, arthritis, pain, depression, poor eyesight, UTI, prostate enlargement, cognitive impairment, diabetes insipidus, constipation and behavioral symptoms can cause or aggravate UI.

Tip: Don't forget to identify and address risk factors for continent residents so you can prevent incontinence.

Diagnosis coding tip: You may record ICD-9-CM codes in Section I3 to explain the resident's type of incontinence, as follows:

Urge incontinence: 788.31

Stress incontinence (female): 625.6

Urge and stress incontinence: 788.33

3. Take a look at why a resident coded as continent in H1 is coded as wearing absorbent pads in H3. Surveyors will home in on that potential discrepancy, so make sure it's not a coding error. For example, some continent residents choose to wear pads out of fear of having a toileting accident. In that case, document and care plan the resident's preferences.

4. To address functional incontinence, look at more than toileting scores in Section G. The resident's ability to transfer (coded at G1b) is primary to his ability to toilet. Also look at scoring at G1c (walk in room. You should also focus

on how well the resident can manage his personal hygiene, including washing his hands after toileting, which is an infection control issue.

Watch out for this: You can run into instances where a resident is actually continent but doesn't do a good job cleaning herself after using the toilet. As a result, the resident may have some wetness or soiling of the underwear - and end up coded as incontinent.

5. Look for medications that could be causing or aggravating the resident's incontinence. For example, in Section O4, look for psychoactive medications or a diuretic. Nursing staff can work with the prescribing clinician and consulting pharmacist to eliminate certain medications and see if they improve the resident's incontinence. Also figure out how to time administration of a resident's diuretic to help him avoid toileting accidents.

6. Take credit where credit's due in section H3. Code any scheduled toileting program or bladder retraining program at H3a and b, if you're providing the service and it meets the RAI definition. You not only want to take credit for the scheduled program for survey purposes, but checking either H3a or b will count as one restorative nursing modality for Medicare or in MDS-based Medicaid case-mix states.

The RAI manual defines a "program" as a "specific approach that is organized, planned, documented, monitored and evaluated." A toileting program can include taking residents to the toilet or providing a bedpan at a scheduled time - or verbally prompting them to void.

7. Document incontinence as an unavoidable outcome, where appropriate. Some residents are going to have a certain level of urinary incontinence that can't be improved with medical interventions, such as medication or surgery. In such cases, document that you have carefully assessed the person clinically and have appropriate interventions in place, such as an individualized toileting plan, preventive skin care - and measures to promote dignity and quality of life.