

## Correct Coding: Common coding queries and answers

### Information for assessors

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#### Skin Conditions

**Question 1:** Should the condition 'foot drop' be included when coding this item?

Answer: Yes, under 'foot problems' if it limits walking then code as such.

Related Section per assessment to			
CA	HC	CHA	LTCF
	L7	FS- L7	L7

#### Treatment and Procedures

**Question 2:** Do I need to capture the visits undertaken by a physician whilst a client is in an acute hospital setting?

Answer: NO. The intent is to capture visits to clinics/ offices by the client or visits to the clients home only.

Related Section per assessment to			
CA	HC	CHA	LTCF
	N4c	M2a	O5

**Question 3:** Who in NZ is classified as a medical provider?

Answer: The following disciplines can be included: podiatrist; Optometrist; Ophthalmologist; Nurse practitioner (autonomous practitioner); dentist; dental surgeon; Naturopathic physician; any consultant.

Do not include chiropodist; orthotist; chiropractor; optician; psychologist; osteopath (they are not trained as in USA/Canada) and clinical Nurse specialist.

Related Section per assessment to			
CA	HC	CHA	LTCF
	N4c	M2a	O5

**Question 4:** Is CPAP (Continuous Positive Air Pressure) coded under Treatments and procedures section: Ventilator or Respirator?

**Answer:** CPAP can be included under N2j as it is considered a respiratory treatment.

Related Section per assessment to			
CA	HC	CHA	LTCF
	N2j	FS: K1j	O2j

**Question 5:** What does interRAI.org consider to be the difference between an "enabler" and a "restraint"?

**Answer:** An Enabler: items which allow a person to safely move in his/her environment and which can be removed by the person.

A Restraint: items which prevents/restricts a person's movement and is unable to be removed by that person. *Irrespective* of the reason for the restraint

Related Section per assessment to			
CA	HC	CHA	LTCF
	N5	N5	O7

**Question 6:** Should we capture homemaking services the person pays privately for?

**Answer:** If the person has an identified therapeutic need for such services then, any formal care received privately or publicly funded would be captured in "Home making Services"?

The intent is to capture required services the person had to support community living.

Related Section per assessment to			
CA	HC	CHA	LTCF
	N3c	FS:N4c	

**Question 7:** What is defined as a 'scheduled toileting programme'?

**Answer:** The intent of the plan must be to improve the person's continence not just to keep them dry.

Related Section per assessment to			
CA	HC	CHA	LTCF
	N2I	FS: N3I	O2I

## Overview and Related Screens

**Question 8:** What information should be recorded in the 'Advance Directives' section?

**Answer:** FOR ALL ASSESSMENT TYPES

- Names and contact details of EPOA for welfare (and finance in ARC sector).
- Whether copies of documents are held on client/ resident clinical file. Essential for LTCF coding
- Whether directives are activated or not
- Name the person (legal name, not 'daughter'), which, in the event of the EPOA becoming active, is the identified legal appointee.

## Psychosocial Well-being

**Question 9:** If a person's social activity was scrabble, but due to relocation, they could no longer play with the initial group, is it still counted as 'participation in social activities of long standing interest' if they now play with a different set of people?

**Answer:** YES

The intent is asking about activities a person has always been interested in – can they adapt and still partake in these things as they move from community to residential living?

Related Section per assessment to			
CA	HC	CHA	LTCF
			F1a

## Medications

**Question 10:** How do I code for medications not in the medication database?

**Answer:** Enter the medication in manually e.g. Osteo 500,code as usual for dose. Enter NA for M3g drug code.

Related Section per assessment to			
CA	HC	CHA	LTCF
	M1	FS:M1	N1

**Question 11:** How do I code for medications with multiple active ingredients, e.g. Sinemet

**Answer:** (a) Select the medication as usual  
(b) manually enter the number of tablets per dose  
(c) select 'oth'

Related Section per assessment to			
CA	HC	CHA	LTCF
	M1	FS:M1	N1

**Question 12: How do I code medications delivered by patch?**

**Answer:** dose = 1  
units = 'oth'

Related Section per assessment to			
CA	HC	CHA	LTCF
	M1	FS:M1	N1

**Question 13: Where does New Zealand record herbal preparations / medicines?**

**Answer:** All prescribed, non-prescribed and over-the-counter medications should be included in medication section of the MDS - List of all medications.

Related Section per assessment to			
CA	HC	CHA	LTCF
	M1	FS:M1	N1

## Mood and Behaviour

**Question 14: Should persons who are taking anti depressants/ anti anxiety medication etc (as in E1a; E1e; E1g; E1K) be coded '1' "*present but not in the last 3 days*"?**

**Answer:** Present but not exhibited in the last 3 days indicates that an intervention (could be medications, alternative therapies) is in place but it is being closely monitored by client/family as there is continued concern that symptoms/issue may return.

Timeframe is not taken into consideration with this code meaning that the intervention could have been in place for 6 months - year or more but continues to be a concern for client/family.

Related Section per assessment to			
CA	HC	CHA	LTCF
	E1	E1	E1

**Question 15: How can we differentiate between 'sad, depressed, hopeless' when coding this item?**

**Answer:** This is a broad question and from a coding point of view the 3 mean the same thing. There is no need to spend time to differentiate. In other words sad is the same as being hopeless in this context. Designed to account for subjectivity.

Related Section per assessment to			
CA	HC	CHA	LTCF
D3	E2c	E2c	E2c

**Question 16:** If the person withdraws from activities of interest but the reason is out of their control (for instance, the person breaks a hip and cannot attend her daily swim class) should this item be coded as 0, not exhibited in last 3 days?

**Answer:** NO. The intent of this item is to assess possible anhedonia. A separate item is available in many instruments for coding changes in preferred activities and whether the person is distressed by any changes.

Related Section per assessment to			
CA	HC	CHA	LTCF
	E1i	E1i	E1i

## Identification Information

**Question 17:** How do I code for a person whilst an inpatient in the acute hospital setting?

**Answer:** If this is a current client who is now in hospital and you use the HC / LTCF to assess the client prior to returning home/ ARC facility, then 'return assessment' is appropriate.

Related Section per assessment to			
CA	HC	CHA	LTCF
	A8	A8	A8

**Question 18:** How do I code for 'time since last hospital, stay' if the facility was a hospice?

**Answer:** Only discharges from a hospice that resides *within* a hospital setting are included when coding this item.

Related Section per assessment to			
CA	HC	CHA	LTCF
D16	A14	A14	A11

**Question 19:** How is 'first assessment' defined?

**Answer:** It is only to be used the **first** time a person is assessed using that particular assessment tool, e.g. HC /LTCF/.

**Note:** CHA is not considered to be the same as HC.

Related Section per assessment to			
CA	HC	CHA	LTCF

## Disease Diagnosis

**Question 20:** How should I code for the main diagnosis PLUS additional presenting paresis e.g. CVA with hemiparesis; MND with quadriplegia?

**Answer:** Code for both the main disease process, e.g. MND (I2) and the resultant paralysis e.g. quadriplegia ( I1i) as one affects function and the other on the person's medical treatments

Related Section per assessment to			
CA	HC	CHA	LTCF
D6	I1	I1	I1

**Question 21:** Do I code for Coronary heart disease (I1k) if a person has ISD/CAD/Angina?

**Answer:** **I1m (CHF)**- Pump insufficiency, characterised by water retention

**I1k (CHD)**- Structural condition in which one or more coronary arteries is narrowed by plaque or vascular spasm.

\*Arrhythmia (electrical) & PVD not captured here– add to **I2** if required.

Related Section per assessment to			
CA	HC	CHA	LTCF
	I1 & I2	I1 & I2	I1 & I2

## Intake and Initial History

**Question 22:** What time frame is to be considered for “residence”? Should a person live in one of the options for over 6 months?

**Answer:** Code all *residential* settings resided in, other than your DHB/ facility.

\*Remember this section is coded at first assessment only.

Related Section per assessment to			
CA	HC	CHA	LTCF
	B4	B4	B8

**Question 23:** How should an Australian of Aboriginal descent be coded for this item?

**Answer:** Code '61'= Other' then make a note to state: Aboriginal descent.

Related Section per assessment to			
CA	HC	CHA	LTCF
A7	B2	B2	B3

**Question 24:** How should an Australian of European descent be coded for this item?

**Answer:** Code '12= Other European' and add a note: ' Australian of European descent'.

Related Section per assessment to			
CA	HC	CHA	LTCF
A7	B2	B2	B3

**Question 25:** How should Primary Language be coded when a person is able to speak two languages and uses the 'non-native' language most often?

**Answer:** For primary language, ask the person what their 'preferred' language is. Code the language that is spoken in the home

Related Section per assessment to			
CA	HC	CHA	LTCF
A9	B3	B3	B4

**Question 26:** How do you code for primary language when the person has no oral language? The person has been exposed to English and responds using Bliss symbols

**Answer:** Code the language that is spoken in the home; this is the language to which the person is exposed and will understand at some level. If appropriate, code that an interpreter is needed

Related Section per assessment to			
CA	HC	CHA	LTCF
A9	B3	B3	B4

**Question 27:** Do I code item B9 'yes' for every adult that has a history of depression?

**Answer:** NO

A diagnosis of depression is not enough to code 'yes.' All elements in the diagnosis must be present.

Multiple components (in the User manual definition) are considered for the question, not just one.

**Rationale:** Lots of people can have depression yet still function with major life activities, have treatment that does not include hospitalization or have significant disruption to their normal living situation.

Related Section per assessment to			
CA	HC	CHA	LTCF
			B9

## Functional Status

**Question 28:** Would you code a person as independent in shopping if they went online, purchased items, paid for goods and put shopping away when it was delivered?

**Answer:** NO. This is primarily a physical activity.

If a person has completed their shopping 'online' then *performance* is '8'. *Capacity* is where to code what the client's "presumed ability" is.

The intent of the item is to capture in store shopping activities. Activities before or after in store shopping are not to be included in the coding

Related Section per assessment to			
CA	HC	CHA	LTCF
	G1g	G1g	

**Question 29:** how is the use of blister packs captured for this item?

**Answer:** A. Performance - if a blister pack is always used then item is coded *at least '4'* = extensive assistance. Need to also check -if there are no further prompts/ assistance to open pack etc.

B. Capacity - if a person is able to use bottles / understands dosage & time of taking meds then capacity is 'independent' but prefers for convenience to use blister packs.

\*getting the script is not considered a sub-task for this item as this involves transport/ phone use etc.

Related Section per assessment to			
CA	HC	CHA	LTCF
	G1d	G1d	

**Question 30:** What is the starting position for bed mobility?

**Answer:** Bed mobility begins when the person is fully on the bed other sleeping surface (including the person's legs).

If the person can move from a lying position into a sitting position then this is coded as bed mobility.

Related Section per assessment to			
CA	HC	CHA	LTCF
	G2i	G2i	G1i

**Question 31:** Can a person be coded for bed mobility if they sleep in a chair?

**Answer:** YES: Bed mobility is relevant when the person is fully lying on the bed or other sleeping surface (including the person's leg).

Related Section per assessment to			
CA	HC	CHA	LTCF
	G2i	G2i	G1i



**Question 32: What are the guidelines for coding 'Set up ' help only?**

**Answer:** It is that activity which the caregiver/someone else completes to enable the person to complete the task independently

e.g. 1. if the person was given the phone on the table beside them before the caregiver left, but the person was able to select number dial and speak/receive incoming calls then they have been 'set up' to facilitate the task of making phone calls.

2. If a person has the walker placed within reach every time they wanted to walk, then this is set up help.

NB: If they have been provided with a frame/ raised toilet seat/grab rail one month ago. They continue to use this item(s) alone then they are **independent** and not 'set up' in the last 3 days.

Related Section per assessment to			
CA	HC	CHA	LTCF
	G1 & G2	G1 & G2	G1

## Health Conditions

**Question 33: " Present, not in last 3 days" – what does this mean?**

**Answer:** This indicates that an intervention (medications, alternative therapies) is in place and effectively managing the symptom. It remains a concern and it is being actively monitored by person//family/ medical team as there is continued concern that symptoms/issue may return.

Timeframe is not taken into consideration with this code meaning that the intervention could have been in place for 6 months - year or more but continues to be a concern for client/family.

Related Section per assessment to			
CA	HC	CHA	LTCF
	Section E & J3	Section E & J3	Section E & J3

## Environmental Assessment

**Question 34: What items / purchases can be considered for this item?**

**Answer:** If the person did without any of the items listed (food, shelter, clothing, medications home heating or cooling, needed health care) due to financial constraints, this is considered a Trade Off. Do not consider the reasonableness of such decisions here.

Related Section per assessment to			
CA	HC	CHA	LTCF
	Q4	Q4	