

MDS Alert

Check Your RUGs Before CMS Calls You On The Carpet

Don't let your software leave you taking the rap for this compliance trap.

If your MDS software allows the facility to RUG a resident into the highest-paying group for which a resident qualifies -- regardless of the group's case-mix index -- it's time for a compliance check-up.

The **Centers for Medicare & Medicaid Services** reports it has "become aware" of problems with MDS software that the agency says it believes are being caused by "well-intentioned" vendors, an agency representative warned providers during a recent SNF Open Door Forum.

Herein lies the rub (or RUG burn, in this case):

Since CMS implemented congressionally mandated add-ons to the RUG rates, the RUG with the highest case-mix score may not always be the one with the most dollars attached.

The bottom line: "Even so, the facility should still use the RUG group generated by the official RUG grouper," the CMS representative advised. "You can't just look at the RUG groups and choose," she emphasized. CMS does not plan to fix the payment issue until it implements RUGs refinements.

Good advice: "Never do an assessment backward where you decide what RUG you want first and then do the assessment accordingly," advises **Nathan Lake, RN**, a Seattle-based MDS expert and software developer. Of course, anyone who has done MDS assessments for a while can look at a resident and figure he may fall into a certain RUG. "But there are 108 PPS-driven items that you have to fill out accurately and then use the RUG that the grouper comes up with," Lake points out.

Watch Out for Section T

CMS has identified another RUGs-related problem with Section T where facilities estimate therapy minutes on the 5-day MDS. "If the admitting physician ordered therapy, the facility has to put that in Section T," the CMS representative counseled providers. "The facility cannot just ignore it."

Experts report that some facilities want residents to go into SE3 based on the hospital lookback on the 5-day MDS, so they put "0" in Section T for projected minutes, even though the physician has ordered therapy. "If the physician orders therapy, the facility has to proceed with it," cautions **Marilyn Mines, RN**, with **FR&R Healthcare Consulting** in Deerfield, IL. "And if the FI does medical review and sees the facility was actually providing therapy -- and it's not recorded on the MDS -- the FI could refer the case to the fraud and abuse division."

"It's not a good policy to engage in a pattern or practice of behavior that could be construed as intended to mislead the Medicare program," agrees **Donna Thiel**, an attorney with **Morgan Lewis & Bockius LLP** in Washington.