MDS Alert

MANAGEMENT: Start Thinking Through How to Make RUG-IV Work for You

Consider these key principles, including options for rehab case management.

When the new RUGs roll out, SNFs will be fielding a whole new payment landscape. And now's the time to consider a game plan to improve your chances of succeeding under the revamped system.

Experts suggest taking into account these three key principles:

Look at the Impact of Rehab Changes on Your Facility

Facilities that currently provide a lot of concurrent rehab therapy may take a hit, as they will only be able to capture half of those minutes in putting a resident in a rehab RUG, unless CMS makes changes before implementing RUG-IV.

The FY 2010 final SNF PPS rule addressing RUG-IV defines concurrent therapy as treating two residents at the same time, regardless of payer source, who are performing different activities within line of sight of the treating therapist or therapist assistant.

You break out the number of therapy minutes on the MDS 3.0 based on whether they are individual (provided one-on-one), group, or concurrent. And you record the total number of concurrent minutes provided.

The RUG grouper then divides that number of concurrent therapy minutes in two, says **Rena Shephard, MHA, RN, RAC-MT, C-NE,** founding chair and executive editor of the American Association of Nurse Assessment Coordinators, and president of RRS Healthcare Consulting Services in San Diego. The industry will take some time to figure out if having to split the minutes of concurrent therapy will "produce fallout for facilities coding concurrent minutes," says **Elisa Bovee, OTR/L,** director of education and training for Harmony Healthcare International in Topsfield, Mass. Bovee predicts, however, that facilities will "steer away" from providing the modality.

Instead, facilities that have been providing concurrent therapy may use more group therapy -- "especially facilities with an influx of admissions and not enough therapy staff to manage it," she says.

"One case management strategy -- if clinically appropriate for the patient -- is to move to more group minutes ... to meet the patient's needs and also get in all the therapy minutes.

Patients in group therapy are all performing a similar activity," counsels Bovee.

Group therapy, which has a ratio of four residents per supervising therapist or assistant, can't exceed 25 percent of the captured RUG therapy minutes, however.

Another factor that will affect SNFs providing rehab is the number of short-stay patients they have where the SNF relies on the projection to obtain a rehab RUG, says **Ron Orth, RN, NHA, CPC, RAC-MT,** president of Clinical Reimbursement Solutions LLC in Milwaukee.

The highest rehab RUG you can get based on the projection under RUG-III is rehab high, Orth notes. By contrast, RUG-IV allows the SNF to get very high or even ultra high rehab based on the number of therapy minutes actually provided, "even if the person goes back to the hospital within three days or so," says Orth. "That could actually help."

Weigh Whether Vent, Trach Care Makes Sense for Your SNF

Under RUG-IV, Extensive Services only includes residents who receive a ventilator or respirator, trach care, or isolation for an active infectious disease in the SNF.

And one option for capturing Rehab Plus Extensive Services is for a SNF to take vent patients and offer rehab to those patients, if they need it, says Orth. Doing so will require the SNF to provide adequate resources to take care of people on ventilators, he adds.

Medicare payment could dovetail with Medicaid coverage for vent patients in some cases. Shephard notes that California and some other states have Medicaid systems that cover ventilator-dependent, medically complex patients. "And since Medicaid generally won't pay until any available Medicare has been used, Medicare, if reimbursement is available, would pick up the payment for some of those patients."

But like Orth, Shephard stresses that SNFs that decide to provide ventilator care will have to ramp up their resources. "California's Medicaid program, MediCal, pays for ventilator care in the nursing home, and California has very specific regulations for such units related to staffing and other issues," she says.

Another care opportunity: If a SNF isn't taking patients with trachs, says Orth, it "could provide the staffing education to do that safely, and start taking those patients."

Beware Turning Patients Away for Cost Reasons

Atlanta consultant **Darlene Greenhill** predicts the RUG-IV will impact the preadmission screening process because SNFs will "at least initially" fear that certain residents will cost them money due to changes in RUG qualifiers. "SNF staff will have to be extremely careful, however, about saying that they don't take certain residents due to costs."

Key point: SNFs have to apply their admission criteria consistently to all residents and payer types, emphasizes **Marty Pachciarz, RN, RAC-CT,** a consultant with the Polaris Group in Tampa, Fla.