MDS Alert

Medicare and Medicaid: Keep Your RUGs Out Of A Rut

These 4 RUG profiles can dig a facility into a payment deficit.

Keeping an eye on RUG patterns can root out problems before they become entrenched - or unravel the mystery of recurring revenue shortfalls.

As the person on the frontlines, watch for these four potential signs the RUGs need straightening out - either in aggregate or in an individual case.

1. RUGs show marked and unexpected improvement from one Medicare or Medicaid assessment to the next. That improvement may actually signal that the subsequent RUG doesn't reflect the resident's services and diagnoses, says **Diane Atchinson, RN, MSN,** principal of **DPA Associates** in Kansas City, MO. "If the MDS nurse, for example, codes hemiplegia [in Section I] on one assessment but omits that diagnosis on the next one - there goes the RUG," she cautions.

Tip: Use the previous MDS as a worksheet when completing the current assessment. "By crossing out what you change, you can easily see if the resident got better or worse," Atchinson advises. "Then figure out if the information is accurate. If so, you may realize you need to do a Significant Change in Status Assessment," she adds.

Or you may see you coded six days of restorative last time but the resident only received five days this time because he was sick or out of the building. In that case, adjust the assessment reference date, advises Atchinson. "By doing the quarterly a bit earlier or later, you can capture the service," she adds.

Failing to capture the service can lower a facility's case-mix score in some Medicaid states. While a couple of states calculate individual resident's RUG scores, most states use an averaging process to adjust a facility's case-mix quarterly or every six months, said **Joe Lubarsky, CPA, BBA**, with **BDO Seidman LLP** in Wisconsin in a presentation on RUGs at the March 2005 **American Association of Nurse Assessment Coordinators** annual conference in Chicago.

Restore restorative: If you see a pattern of all PB1s or PC1s, etc. in the lower 18 RUGs, and your facility is providing restorative care that meets the RAI manual requirements, you aren't coding two programs in Section P3, cautions Atchinson.

2. RUGs fail to capture depression. If your facility has all CC1s and CB1s, etc., but few, if any CC2s or CB2s, you're probably not capturing three or more mood issues in E1, says Atchinson.

Solution: When completing Section E1, make sure you've coded all the indicators of depression/sad mood occurring during the 30-day lookback. "An indicator has to occur only once in the lookback" to code it, **Rena Shephard, MHA, RN, FACDONA, RAC-C,** reminded MDS nurses during a presentation at the March 2005 AANAC conference.

Make sure staff don't get focused on looking for just one or two indicators. "Sometimes facilities don't document indicators that occur later in the lookback," says Shephard.

Audit idea: Select several MDSs that generated a CA1, CB1 or CC1 and check the medical record documentation to see if the facility missed one or more signs of a sad or depressed mood that could have been coded in Section E1.

3. Too many R's. If the RUGs are top heavy on rehab (mostly or all R's), encourage your facility to figure out why. Rehab may end up eating the facility's case-mix pie for a number of reasons. For one, therapy is easier to document and

capture than skilled nursing, because you just add up the therapy minutes, says **Rita Roedel, RN, MS,** a consultant with **BDO/Heritage Healthcare Group** in Milwaukee.

One potential problem: Rehab staff often focus on their own plan of care and discharge the person from the program and Part A coverage once the resident achieves therapy goals, notes **Celia Strow, RN, MPS, CNHA, FACHCA, CEO** of **MyZiva** in Lake Success, NY.

Solutions: Do team-based assessments rather than siloing them, advises **Clint Maun, CSP**, in a presentation, "Leadership in Lean Times," at the March AANAC conference. "Don't let therapy decide how long the resident will be in the building. Therapy shouldn't be using words like 'discharge,'" he says.

Strow agrees: "All clinical staff should review the resident's condition to make sure he or she receives needed care and proper reimbursement - either a continuation on Medicare A or Part B," if needed.

Tip: If your building has proportionately low numbers of residents RUGing into extensive services, give your preadmission screening process a checkup. "See if you're capturing hospital services that would qualify the resident for SE3," suggests Roedel.

4. Rehab RUG category bulge. If the facility has all residents in the same one or two rehab RUGs, take a close look at what's going on. Maybe the case-mix is truly that homogenous - or maybe the facility has a "one-size-fits-all" approach to providing rehabilitation therapy. Perhaps the SNF isn't meeting residents' true needs for rehabilitation. For example, Atchinson encountered a SNF that had only one resident in ultra-high and all the rest in high or medium. "Yet this is a hospital-based SNF, so you'd think they'd be providing ultra or very high," she points out.