MDS Alert

MEDICARE :CMS Rolls Out New RUGs With Significant Changes

Extensive Services to include only vents, trachs, isolation for active infection.

The proposed SNF PPS update unveils the long-awaited RUG-IV system, which significantly changes the payment landscape. Of course, the final rule may differ from the proposed rule to some extent, but one thing is apparent: SNFs are going to have to learn a system where familiar rules no longer apply.

That's going to be a big challenge, experts say: "The SNF rule has the feel of the level of changes in the 1998 rule implementing PPS," observes **Peter Clendenin,** executive VP of the National Association for the Support of Long-Term Care.

AWhole New Ballgame With More RUG Scores

The RUG-IV system, which incorporates the Staff Time and Resource Intensity Verification (STRIVE) findings, has 66 RUGs, compared to the 53 RUGs in place now (for a look at the new RUGs, see p. 76).

Rehab plus Extensive Services, rehab, Extensive Services, Special Care, and Clinically Complex are still in the RUG line up. But Special Care now has a low and high, says **Ron Orth, RN, NHA, CPC, RACMT,** president of Clinical Reimbursement Solutions LLC in Milwaukee (see p. 83). The proposed RUG-IV system combines the RUGIII impaired cognition and behavioral categories into Behavioral Symptoms and Cognitive Performance.

Extensive Services no longer includes IV fluids or IV medications. IV/parenteral is now in Special Care High, and IV meds has been moved to Clinically Complex.

Under the proposed rule, only a ventilator or respirator, tracheostomy care and isolation for an active infectious disease counts toward Extensive Services when provided in the SNF. "Under the proposal, SNFs would not be able to count anything preadmission in Section O of the MDS 3.0," says Orth. It's uncertain if this will apply to other sections as well, such as IV fluids in Section K, he adds.

CMS Revamps ADL Index and ADL Split

Proposed ADL changes will affect RUG categories in terms of the ADL point ranges. Instead of the ADL index going from 4 to 18, as it does under RUG-III, it will go from 0 to 16, which is a "huge change," notes **Peter Arbuthnot,** a regulatory analyst with American HealthTech in Jackson, Miss.

To compute the RUG-IV ADL Index, CMS proposes adding the component ADL scores, which would include both self-performance and support, for bed mobility, transfer, eating and toileting. As for calculating individual late-loss ADLs, it looks like CMS is reverting back to the old way of scoring ADLs with a few additional changes in coding, says Orth (see p. 78).

The proposed RUG-IV scheme changes the ADL calculation for eating, which would include support provided as well as self-performance.

Under RUG-III, a resident who had IV/parenteral or tube feeding automatically got the highest ADL score of 3, but CMS eliminated that in the proposed rule, observes **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Consulting Inc. in Deerfield, Ill. Now the highest level is 4 based solely on Section G coding.Artificial feeding mechanisms (IV/parenteral, tube feeding) are not included in the ADL calculation, according to the proposed rule.

Rule Makes 2 Therapy Changes

The proposal seeks to eliminate the therapy projection now in Section T of the MDS 2.0. CMS is proposing a person be assigned a RUG score based on how much therapy he received while in the SNF only for a few days, says Orth.

SNFs would be required to do an Other Medicare Required Assessment (OMRA) not only when therapy ends, but also when therapy starts. This would allow CMS to more accurately account for how much therapy the resident actually received so the RUG classification is more accurate, says **Roberta Reed, MSN,RN,** a consultant with Plante & Moran Clinical Group in Cleveland, Ohio.

Concurrent Therapy a Focus

The rule also hones in on concurrent rehab therapy, which CMS defines as a professional therapist treating multiple patients at the same time while the patient performs different activities. CMS notes that Medicare currently has no restrictions on the amount of concurrent rehab that a SNF can code on the MDS. But STRIVE data show that approximately two-thirds of all Part A therapy provided in a SNF is now being delivered on a concurrent basis rather than individually, the rule pointed out.

The data also showed that under RUG-III, patients treated concurrently typically go in higher therapy groups than appropriate "based on the therapy resources actually used to provide care for those patients." CMS thus proposes that each therapy discipline allocate concurrent therapy minutes before reporting total therapy minutes on the MDS 3.0. CMS is soliciting comments as to whether therapy data need to be reported separately by therapy mode (individual, concurrent, group) on the MDS 3.0 or whether it will be sufficient to document that information in the medical record.

Not all bad: CMS concedes that concurrent therapy can be a legitimate modality when used properly based on individual care needs as determined by the professional therapist's clinical judgment. But, CMS warns, concurrent therapy should be an adjunct to individual therapy, and an exception rather than the standard of care.

Prediction: Concurrent therapy could end up being something that the SNF can count but only a portion of it, says **Pauline Franko, PT, MCSP,** president and owner of Encompass Consulting & Education LLC in Tamarac, Fla. "For example, currently, group therapy can only contribute 25 percent to the RUG levels," she notes.

Editor's note: See the article on concurrent therapy on p. 75.