Codify
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MDS Alert

Medicare: Leaving These Key RUG Drivers Behind Could Put Your SNF in a Fiscal or Survey Bind

Most SNFs home in on the IV fluids and IV meds in the hospital lookback. But failing to capture less commonly known RUG criteria could put your facility on the low road for reimbursement and/or MDS accuracy.

Key example: "Oxygen is something people don't always capture from the hospital lookback," notes **Jane Belt, MS, GCNS-BC, RAC-MT**, consulting manager with Plante & Moran Clinical Group in Columbus, Ohio. But if you have the hospital documentation, you can code it, Belt says.

Capturing oxygen could qualify the resident for Clinically Complex, which will affect the Extensive count for a resident in Extensive Services (see p. 15 for details).

Remember: To code oxygen, the person would have had to receive it only once during the 14-day lookback -- but not as part of a surgical or diagnostic procedure, says **Christine Twombly, RNC,** chief clinical consultant for Reingruber & Co. in St. Petersburg, Fla.

Smart strategy: Doing a good preadmission screening can identify the details that can make a "big difference" in the Extensive count, says **Jennifer Gross, BSN, RN, RAC-CT**, a healthcare specialist with PointRight Inc. in Lexington, Mass.

For example, whoever does the screening could see if the resident spiked a fever even once in the hospital lookback, she says. Setting the ARD to capture the fever combined with weight loss, dehydration, vomiting, pneumonia or tube feeding could affect the Extensive count by qualifying the person for Special Care.

Before you code: To determine whether an elevated temp meets the RAI User's Manual definition of a fever, which is 2.4 degrees above the patient's baseline, you have to establish the baseline, says Twombly.

Facilities usually do this by monitoring the resident's vitals each shift for the first several days after admission to the SNF, she adds. (The RAI User's Manual says you can establish the baseline before the ARD.)

Documentation tip: To substantiate the fever, "you could use the hospital graphic sheets or whatever the hospital uses to document vital signs," Twombly says.

Also check for the following MDS items:

• **Diabetes and order changes.** A resident with a diagnosis of diabetes mellitus and daily insulin injections with two or more days of order changes in the nursing facility may go in Clinically Complex, which will affect the Extensive count. So "you might flex your ARD a little to capture a second order change if it makes a difference to your RUG placement," Gross says.

• **A diagnosis of aphasia.** Tube feeding that meets the fluid/caloric requirements spelled out in the RAI User's Manual plus a diagnosis of aphasia in Section I can put someone in Special Care, says Gross. Yet people often miss the aphasia diagnosis, she observes.

For purposes of checking aphasia in Section I, the RAI User's Manual defines the condition as "a speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language. Include aphasia due to CVA."

"If the physician diagnoses and documents aphasia, the MDS nurse can code it in Section I," says **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

Capture This Rx in Section M

Gross has found instances where a resident with Stage 2 pressure ulcers didn't have two or more treatments coded in Section M5c, which meant the person didn't go in Special Care.

"Those treatments include turning/repositioning," she says. And "some facilities feel they can't code [the latter] even though they are providing that care because they don't have supportive documentation." In Gross' view, however, "that can be a motivator to formalize a turning/ repositioning program." Otherwise, the facility may not get reimbursed appropriately for pressure-ulcer related care, she adds.

Coding requirements: "Item M5c asks you to indicate whether there has been a continuous, consistent program for changing the resident's position and realigning the body during the seven-day look back period," states a DAVE2 tip sheet.

A program is "a specific approach that is organized, planned, documented, monitored and evaluated."

Also: The nursing facility has to individualize the turning/repositioning program based on a specific assessment of the resident's needs, according to the DAVE2 tip sheet.

Resource: For more details about coding a turning/repositioning program at M5c, review the tip sheet at www.qtso.com/download/mds/CMS_MDS_TIP_Sheets.zip.

Double Check These Items for Cognitively Impaired Residents

If you fail to capture a resident's short-term memory problem at B2a, impairment in cognitive skills for daily decision-making at B4, and/or difficulty in making himself understood (C4), he might not receive a score of 3 on the Cognitive Performance Scale (CPS), which will affect the Extensive count if he classifies in Extensive Services (see "RUG Calculation" below).

Resource: For more information, see "Follow The Logic " Here's How the RUG Grouper Calculates the CPS Score," in the July 2006 MDS Alert, which is available in the Online Subscription System. If you haven't already signed up for this free service, call 1-800-508-2582 for instructions or e-mail the editor at KarenL@Eliresearch.com. You can also view a handy chart online at http://interrai.org/applications/cps_diagram.pdf.

Editor's note: Capturing commonly overlooked ADL help can have a big impact on RUG placement. For more information, see the next MDS Alert.