MDS Alert

Medicare Payment: Missing RUG Drivers Can Turn Your Facility Into A Fiscal Wreck

Are these MDS omissions taking a toll on your bottom line?

Omit a single clinical condition from the MDS, and you may bump a resident into a lower-paying RUG. For example, SE3 pays about $1,500 more a month than SE2.

Of course, no one expects you to remember all of the 108 items that drive RUG classification. But you can keep your eye out for common conditions that place a resident in either the special care or clinically complex categories.

The resident who falls into extensive services and also qualifies for either special care or clinically complex will receive a point in the extensive services count, which can affect his placement into SE2 or SE3, says **Diane Brown,** CEO of **Brown LTC Consultants** in Needham, MA.

Target Pneumonia and Fever

Overlooking a diagnosis of pneumonia will cost your facility big time. Forget to check pneumonia at I2e and your resident may not RUG into clinically complex, even though the nursing staff is providing daily skilled monitoring of his respiratory status. (The clinically complex RUG is also assigned based on the ADL score and presence or absence of depression.)

A fever and diagnosis of pneumonia qualify a resident for special care if he has an ADL score of at least 7.

A resident in extensive services who has cognitive impairment (score on MDS 2.0 cognitive performance scale >= 3) and a diagnosis of pneumonia and fever coded on the MDS will RUG into SE3, if he received IV fluids and IV meds in the lookback.

The problem: Staff will usually capture pneumonia in Section I on the MDS if the patient comes in with the condition as a primary diagnosis, says **Maureen Wern**, CEO of **Wern and Associates** in Warren, OH. But in her experience, staff doesn't necessarily code pneumonia again when the patient has a change in condition. "And they don't record a fever because there's no documentation form for that."

Solution: Check or code a physician-documented diagnosis on the MDS if it affects the resident's current ADL status, mood, behavior, medical treatment, nursing monitoring or risk of death, etc. To capture fever (J1h) in the seven-day lookback, staff has to obtain the resident's baseline temperature to determine if he has an actual fever based on the coding rules (2.4 degrees above the resident's baseline), says **Cathy Sorgee**, RN, a consultant with **The Broussard Group** in Lake Charles, LA. "The nursing staff also has to document how they took the temperature (orally, axillary or rectally)," she adds.

A combination of fever (J1h) plus dehydration (J1c) or vomiting (J1o) or weight loss (K3a) will also RUG a resident into special care if he has the requisite ADL index.

Extend the ARD until midnight: If you complete the assessment before midnight of the assessment reference date, you may miss an instance of a resident having vomiting and fever or an ADL change on the night shift, cautions Sorgee.

Check for Tube Feedings With Fever or Aphasia

Someone with a fever and a tube feeding or a tube feeding and aphasia will go into special care if the person has an

ADL index of 7 or higher.

Know the definition of aphasia: The RAI manual defines aphasia coded at I1r 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." Facilities sometimes miss coding aphasia on the MDS, says **Pauline Franko, PT, MCSP**, a physical therapist and Medicare consultant in Ft. Lauderdale, FL.

"The resident's problem [with aphasia] may actually be documented in Section C where you assess a resident's ability to understand and communicate," she says. But to code aphasia, the physician must document the diagnosis in the resident's medical record. Residents with Parkinson's and Alzheimer's disease may have difficulty expressing their thoughts, which meets the RAI definition of aphasia, reminds **Marilyn Mines, RN, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. The resident with aphasia may benefit from a speech therapy evaluation and therapy, notes Franko.

Problems with medical review: The tube feeding only counts if the resident receives 51 percent or more of his calories (K6a) OR 26 to 50 percent of his calories (K6a) and 501 cc or more of fluid enteral intake daily (K6b) in the seven-day lookback. And some facilities don't ensure the resident receives that threshold amount, if he needs it, says Wern. "Or they fail to document that the resident is receiving the required amount," she notes, which can lead to problems if the fiscal intermediary reviews the medical records.

Solution: To capture tube feedings on the MDS, "the facility needs someone in dietary to track the resident's intake," suggests Wern. Obtain information from the registered dietitian to determine the amount of free fluid in the enteral feeding formula, adds Mines. "Include that as well as the fluid used to flush the tube and administer meds as part of the total cc of fluid intake for the daily calculation," Mines advises.

Tip: Pay special attention to missing RUG drivers on the 14-day MDS, suggests **Bet Ellis, RN**, a consultant with **LarsonAllen** in Charlotte, NC. Ellis often sees facilities miss conditions on the 14-day MDS, such as early-stage pressure ulcers or fever. That's especially true "if the team did the RAPs on the 5-day rather than the 14-day assessment," she adds.