MDS Alert

Medicare Payment: To Keep the Coffers Filled, Hone Your ARD-Setting Skills.

How would you manage these 3 scenarios?

All RUGs are not created equal in terms of providing payment that best reflects a resident's conditions and care. That's why you should carefully evaluate when to set the assessment reference date for each MDS assessment in order to capture the RUG that pays the most.

To illustrate the critical thinking required to make this vital determination, consultant **Joy Morrow, RN, PhD**, provided the following case examples in a presentation at the October 2008 American Health Care Association's annual meeting.

Example No. 1: In this scenario, which Morrow entitled "a good versus better ARD," the SNF admitted a patient with a hospital diagnosis of pneumonia and physician orders for skilled nursing, and PT and OT evaluation and treatment. Therapy evaluated the patient on day two of the SNF stay and determined that the person would probably tolerate a rehab medium level of service (150 minutes per week).

The hospital lookback included morphine administered by IV pump for pain on 1/30/08, and IV fluids for dehydration on 1/27/08.

The MDS nurse assesses the resident's ADL scores as follows:

Bed mobility 2/3
Transfers 3/2
Eating 2
Toileting 3/3 = 14 points.

The MDS nurse sets the ARD for day six to capture five days and 150 minutes of therapy provided between days two and six, and to capture the IV med given in the hospital, which was administered three days after the IV fluids.

Using day six as the ARD, the patient RUGs into RML.

A better bet: By setting day two as the ARD, the RUG will be RMX based on a section T therapy projection of 10 days with 330 minutes plus the IV fluids, according to Morrow's presentation. And the IV fluids increase the eating ADL score by one point for a total ADL score of 15 points.

Coding reminders: Coding IV fluids automatically gives a resident an eating score of three points, notes **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

The 15 ADL or above score qualifies the resident for RMX, which pays more than RML.

Example No. 2, which Morrow entitled "the art of negotiation." The SNF admitted a patient with a diagnosis of a right below the knee amputation, and physician orders for PT and OT evaluation and treatment. Therapy evaluations on day three estimated the patient could tolerate rehab very high (500 minutes of therapy per week). Therapy wants to set day eight as the ARD in order to capture that RUG level, which will put the resident in RVB.

The nurse, however, reviews the medical record and realizes that day five as the ARD (with an ADL of 15) will put the resident in RMX by capturing the IV med in the hospital, two days of 205 minutes of therapy coded in Section P, and a Section T projection of 10 days for 1,000 minutes of therapy.

A costly mistake: In the case example Morrow provided, therapy pushes for day eight, and the nurse backs down. Yet RMX pays more than RVB.

Example No. 3: The SNF admits a patient with resolving urosepsis who doesn't need rehab therapy and appears to require little ADL assistance.

The MDS nurse sets an ARD for day four, capturing IV meds and fluids in the hospital lookback, vomiting with fever, and an open lesion with treatment.

The patient's ADL scores are:
Bed mobility 0/0
Transfer 0/0
Eating 0
Toilet use 0/0 = 4 points

Add two points to the above for IV fluids for a total of 6 points, resulting in a RUG of SSA.

Upon closer examination, however, the MDS nurse finds the patient received two occasions of a one-person limited assistance for transfers three days before admission to the SNF -- and also a one-person limited assist in the SNF on the day of admission, Morrow relayed.

Coding transfers correctly as 2/2, the ADL score comes up to 8.

A big bump up: The resident now goes into SE3, which pays more than SSA. [For this resident to go into SE3, it's assumed the person has impaired cognition.

ADL lessons learned: You can capture ADLs in the hospital lookback, Morrow emphasized. Make sure to document ADLs in the facility, too. The ADL that nurses document most? "Ambulation," said Morrow. "We need to educate our staff to speak to late loss ADLs."

Also play close attention to ADL assistance on the day of admission when the resident may have required a two-person assist for transfer, as an example, from the ambulance gurney into the facility, Morrow counseled.

Editor's note: See "Nail Down ADL Assistance Provided in the Hospital," on the previous page.