MDS Alert

MEDICARE: RUG-IV Reshuffles Nursing RUG Placement -- Here's What to Expect

It definitely won't be business as usual come Oct. 1, 2010.

When RUG-IV rolls out, your SNF will have to get used to a wholenew set of RUG drivers that will take utilization in some new directions.

For one, most SNFs can expect far fewer residents to go into Extensive Services, which will be limited to residents who are in isolation for an active infectious disease during the SNF stay, or those whoreceive trach care or a vent/respirator while they are in the SNF. The final rule eliminates the hospital lookback for services now coded in P1a of the MDS 2.0, which includes all of the above except for isolation.

As for isolation, the MDS 2.0 doesn't include a question to capture that information, although the draft MDS 3.0 does, observes **Marty Pachciarz, RN, RAC-CT,** a consultant with The Polaris Group in Tampa, Fla. The item does not include standard body/fluid precautions. However, "we don't have the directions for how to complete the [isolation] item on the MDS 3.0."

The Centers for Disease Control & Prevention provides guidelines on its Web site defining when someone needs to be in isolation, observes **Rena Shephard, MHA, RN, RACMT, C-NE,** founding chair and executive editor of the American Association of Nurse Assessment Coordinators. Thus, SNFs would have to meet the standard of practice for putting a resident in isolation, Shephard concludes.

An important concession: The final rule allows SNFs to capture parenteral/IV fluids (now coded at K5a) from the hospital lookback, which will help residents go into Special Care High, observes Pachciarz. But we don't know the payment rates yet, she notes.

More changes: In the final rule,CMS put oxygen therapy alone in Clinically Complex but added oxygen with respiratory failure to Special Care Low, observes **Darlene Greenhill,** a consultant in Atlanta. CMS also completely eliminated dehydration as a RUG qualifier (the proposed rule had dehydration and fever in Special Care High). (For a few additional changes, see the last paragraph on page 40331 of the final rule at http://edocket.access.gpo.gov/2009/ pdf/E9-18662.pdf.)

As for Those Pricey IV Meds...

Under RUG-IV, IV medications provided in the SNF are a qualifier for Clinically Complex -- a demotion that will no doubt be a financial blow for higher-acuity facilities that provide IV therapy and medications in house.

"There was a lot of discussion in the final rule from commenters about the price of IV medications,"observes **Patricia Boyer, RN, MSM, NHA,** principal of Boyer and Associates in Brookfield, Wis. "CMS says it's in discussion about how to pay for non-therapy ancillaries," she notes. But unless the agency comes out with something next year, "the IV medications will be a problem."

Cautionary tale: Boyer works with a Montana transitional care unit that provides a lot of expensive IV meds. And even now, the TCU is experiencing cost pressures and looking at ways to break even. One strategy for doing that "is to keep patients in the hospital longer rather than transferring them to the TCU." Boyer predicts more of that type of decision-making will occur under RUGIV,"although there aren't that many subacute TCUs left."

A suggested solution: The National Association for the Support of Long Term Care has recommended that CMS put the

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"drugs in Part D where they belong," says **Peter Clendenin,** executive VP for the organization. Doing so would typically leave a small core of other nontherapy ancillary products, such as specialty beds, enteral feedings, and infusions, he adds.

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