MDS Alert

Payment & Compliance: 6 RUG Patterns Your Facility Should Beware

Look closely for lost dollars, compliance red flags.

Watch out: Your RUGs have quite a story to tell. And most often it's a tale of lost payment opportunities - or sometimes one of potential compliance problems - that you'll want to catch before government watchdogs settle in for story-time.

To see if your Resource Utilization Groups (RUGs) are on track for fair payment, stay on the lookout for these potentially treacherous trends:

1. You have a high number of residents with a three-day qualifying hospital stay who RUG below the skilled categories. Facilities should look at each one of these patients to find out why they aren't scoring higher, suggests **Gary Woessner**, principal of **Woessner Healthcare Consulting** in Edina, MN. "Oftentimes, you'll find that the MDS has not been scored accurately - for example, the activities of daily living weren't recorded over a 24-hour period," he says. "Or the MDS fails to capture the resident's diseases in Section I - or the resident's IV during the hospital stay." Perhaps your MDS staff didn't project therapy minutes accurately (for details on how to capture therapy minutes on the MDS, see "Don't Let Therapy Minutes Slip By The MDS").

2. A lot of days are billed at the default rate. "Default rates not only represent outliers - facilities should view them as sentinel events," suggests **Diane Atchinson, RN-CS, MSN, ANP**, president of **DPA Associates** in Kansas City, MO. If you use the default rate a lot, you probably aren't managing the MDS process like you should, Atchinson stresses to facilities. "For example, perhaps the facility isn't providing the support required to complete the MDS during the required deadlines."

Default days can also pile up when the MDS staff doesn't pull together an MDS on patients who are only in the facility for a day or two. (For details on how to avoid the default rate, see the next issue of MDS Alert.)

3. Some RUGs seem too low for certain types of patients. "Most recent stroke patients, for example, should receive or project higher than rehab medium," Woessner advises.

"These patients typically have deficits that require the skills of all three therapy disciplines - for example, stroke patients may have hemiparesis, speech, language, or swallowing problems. Such a resident would typically need more than a half hour of therapy a day five days a week, which is typical for the rehab medium category."

4. The facility is showing a very low utilization of rehab low. A benchmarking analysis may show the facility is under-utilizing the rehab low category, Woessner says. "That category was carefully designed to provide residents with an appropriate 'bridge' between intensive therapy services and no therapy," he notes. "By using this category, the facility can help residents sustain their clinical outcomes," he emphasizes.

Reminder: To qualify for rehab low, the resident must also receive restorative nursing services (15 minutes of two restorative activities over six days during the lookback). Many facilities actually provide restorative nursing care but don't take credit for it on the MDS - either because they don't track the required minutes or they haven't officially set up a program that meets the criteria spelled out by the Resident Assessment Instrument user's manual.

"Some facilities think there's some mystique surrounding restorative nursing ... where they don't know how to get started with the documentation and other requirements specified by the RAI manual so they can code it on the MDS," says **Rita Roedel, MS, RN**, a consultant with **BDO Seidman** in Milwaukee, WI. (For inside advice on how to provide and code restorative nursing, see the next issue of MDS Alert.)

5. The facility has had a noticeable RUG spike or a shift toward higher paying categories. As part of medical review, fiscal intermediaries will look for aberrant patterns in utilization to identify possible problems or targets for further review or audit, cautions attorney **Donna Thiel**, with **Morgan, Lewis & Bockius** in Washington, D.C. And a notable change in RUGs categories might trigger their interest, she adds. "So be aware of changes in your RUGs and be prepared to explain the underlying reason - for example, a different case-mix profile or more accurate MDS assessment and scoring, or a new orthopedic program in the neighborhood hospital." Perhaps the facility is admitting more recent stroke patients who fall into the higher rehab RUGs.

Tip: A critical question to ask: Can you support the therapy minutes reported on the MDS with documentation in the clinical record? "You have to determine and strictly follow Medicare medical necessity requirements," emphasizes **Carol Job, RN**, consultant with **Myers and Stauffer** in Topeka, KS. And keep in mind: Nursing has some accountability for determining medical necessity of therapy requirements. The RAI manual says the "licensed therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity ... for therapy services" (p. 3-185).