MDS Alert

Prospective Payment System: Beware: PPS Rule Expands RUGs But Closes Assessment Windows

The time is now to comment on the proposal's payment drain.

Did you know? **The Centers for Medicare & Medicaid Services'** proposed FY 2006 PPS rule would sharply curtail your ability to capture key MDS payment drivers.

How so? The proposals, if enacted, could essentially put an end to the hospital lookback period, grace days for setting the assessment reference date, and Section T for projecting therapy, warn MDS experts.

The regulation says CMS "anticipates that it can implement the changes through an update to the MDS Manual instructions."

The goal of the proposals is to improve MDS accuracy in a way that could result in some overall savings to the Medicare program, according to CMS' **Sheila Lambowitz**, speaking at the May SNF Open Door Forum.

The proposed rule asks for comments on these three provisions aimed at changing the ability to capture RUG drivers on the MDS:

1. Allowing only special care treatments and programs (coded at MDS Section P1a) furnished to the resident since admission or re-admission to the SNF, similar to the requirement for P1b. That means you could no longer code IV meds or other treatments that occurred in the hospital and drive RUG placement.

2. Eliminating or decreasing grace days for setting the ARD, specifically for the 5-day PPS MDS assessment. The proposed rule goes on, however, to invite comments on decreasing or eliminating grace periods for all MDS PPS assessments. Grace days give SNFs flexibility for capturing a resident's highest level of services and acuity (see related story, p. 72).

3. Eliminating the projection of anticipated therapy services (Section T1) during the 5-day PPS. Getting rid of Section T1 will have a major impact on payment, claim experts.

The problem: "If the SNF can't project therapy minutes, residents won't end up in an accurate RUG category that represents how much rehab they actually receive," observes **Ron Orth**, owner and president of **Clinical Reimbursement Solutions LLC** in Milwaukee. "This proposed change also contradicts the original PPS rule's premise that some residents require a couple of days after admission to stabilize before ramping up for therapy," he adds.

Ready for More RUGs?

The proposed rule also includes RUG refinements designed to compensate SNFs that care for patients requiring rehabilitation and high-intensity medical and nursing care.

Methodology: Effective Jan. 1, 2006, CMS plans to add nine new RUGs to the existing 44 "in order to capture a subpopulation of SNF patients that require a high level of rehab, non-therapy ancillaries, and extensive nursing care," said CMS'
Sheila Lambowitz at the May 2005 SNF Open Door Forum. The proposed RUGS are:

RUX Rehabilitation Ultra High plus Extensive Services, High

RUL Rehabilitation Ultra High plus Extensive Services, Low
RVX Rehabilitation Very High plus Extensive Services, High
RVL Rehabilitation Very High plus Extensive Services, Low
RHX Rehabilitation High plus Extensive Services, High
RHL Rehabilitation High plus Extensive Services, Low
RMX Rehabilitation Medium plus Extensive Services, High
RML Rehabilitation Medium plus Extensive Services, Low
RLX Rehabilitation Low plus Extensive Services

Some RUGs a Bit More Bare

"The newly proposed RUGs would have a distributional effect depending on a facility's patient mix that will potentially favor hospital-based facilities," predicts attorney **Marie Infante** in Washington, DC. "The latter are most likely to receive [medically complex residents requiring rehab] before moving them through the post-acute cycle."

Potential Impact: The proposed RUG-53 will have a positive impact on freestanding SNFs that care for high acuity patients with both rehab and extensive care needs, adds **Diane Brown**, CEO of **Brown LTC Consultants** in Newton, MA.

On the downside, the proposal may reduce payment for wound care for patients in the Special Care category, says Brown.

"The financial impact of this reduction may be significant," Brown continues, "considering that the cost of wound care treatments (for example, wound vacs) continues to escalate - and facilities are held accountable to new survey guidelines for pressure ulcers (F314)."

The reduction in the Special Care and Clinically Complex categories occurs because the rule eliminates the add-ons and increases the base, Brown notes. She views this change as positive overall, however, "as it helps get rid of some of the payment skew" in the RUG system.

What you can do: Submit comments about the proposed rule to CMS by July 12. "The good thing about the proposed rule is that it's a draft ... and providers can still comment," says **Karen Merk, RN**, a clinical consultant with **Briggs Corporation** in Des Moines. "If providers truly want to have impact on their new payment system, they need to make their voices heard," Merk stresses.

Editor's note: Read the FY 2006 SNF PPS Notice of Proposed Rulemaking at www.cms.hhs.gov/providers/snfpps/rugrefine.asp. CMS is accepting comments until July 12 at 5 p.m. Submit electronic comments on specific issues in the regulation to www.cms.hhs.gov/regulations/comments. (Read the snail-mail and hand-delivery instructions at the above Web address.)