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MDS Alert

TRENDS :Providers Challenge RUG-IV on Multiple Points

CMS rep addresses concerns about Rehab plus Extensive Services.

As industry experts digest the proposed overhaul of the RUG system set to roll out on Oct. 1, 2010, their concerns are starting to surface, fast -- and sometimes furiously.

One top complaint has to do with the fact that Rehab plus Extensive Services no longer includes IV meds and/or IV fluids. Instead, rehab residents would only go into Rehab plus Extensive Services if they were on a vent, received trach care, or were on isolation for an active infectious disease.

The services would have to be provided in the SNF.

"How many people on vents or in full isolation get rehab therapy?" challenges consultant **Joy Morrow, RN, PhD.** "And to say you don't need any more staff resources to do IVs and IV feedings is craziness," adds Morrow, with Hansen Hunter & Co. in Beaverton, Colo. "I'm shocked by it," said a SNF provider calling into the May 28 SNF/LTC Open Door Forum to vent about the revamped Rehab Plus Extensive Services. "I can't believe," the caller said, that if I have two patients receiving therapy, and one has a wound vac and two IVs running at different times every six hours, that you don't believe that requires more nursing resource time than the patient who just goes to therapy and gets a couple of Percocets. Why would a SNF even do IV therapy in the building then, she asked, given the extra resources and different staffing pattern required to provide the service?

CMS weighs in: In responding to the irate caller, CMS' **Sheila Lambowitz** noted that STRIVE data picked up on issues related to the topic. For one, the RUGs were picking up people who had IV meds or IV fluids in the hospital that weren't even continued in the facility, she said. However, even in cases where the SNF was providing that therapy, "the nursing resources required for those services were not at the level of extensive care," Lambowitz pointed out. "So [the IV meds and fluids] are classified where they belong appropriately for the medical treatment," Lambowitz reassured the caller.

At the same time, the rehab therapy categories include some people who may be getting some of the medical services, such as IV meds or IV fluids, Lambowitz added. "And to an extent, the cost of those is built into the therapy rate," she said.

"The model we proposed reflects the data we found when we went in and looked at services provided in over 200 nursing homes," Lambowitz concluded.

STRIVE Under the Microscope Providers and industry pundits are, however, challenging the accuracy of the STRIVE data driving the RUG changes. "The STRIVE data aren't representative of SNFs nationwide," says **Laurence Lane,** VP of government relations for Genesis Healthcare Corporation in Kennett Square, Pa. "The stratification of SNFs in the sample isn't representative, and the time frame for collecting the data isn't representative," says Lane.

There are also flaws in capturing the STRIVE therapy information, he adds. "CMS acknowledges that two different approaches were used and that there are significant differences in the resulting data," says Lane.

Another problem: CMS is requesting comments on the proposed rule that includes RUG-IV and the new MDS 3.0, observes **Sandra Fitzler, RN,** senior director of clinical services for the American Health Care Association. And the RAI User's Manual isn't due out until October 2009. "As a result, we are commenting on MDS and RUGs without the benefit of seeing the rationale supporting MDS data elements and parameters for accurate coding."

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