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MDS 3.0 and RUG-IV

One of the primary reasons that the implementation date for the MDS 3.0 system was again delayed from October 1, 2009 to **October 10, 2010** was to coordinate the MDS 3.0 with the **RUG-III Medicare Prospective Payment System (PPS).** The current RUG-III (Resource Utilization Groups) categories are based on MDS 2.0. As a result of the expected changes under MDS 3.0, the Centers for Medicare and Medicaid Services **(CMS) has released a proposed RUG-IV based on the MDS 3.0.**

Consistent with current CMS efforts to reduce Medicare funding, **the proposed RUG-IV system will most likely result in additional cuts in Medicare revenue.** Along with eliminating the rehab adjustment add-ons mentioned in the May 8, 2009 newsletter, the proposed rule, published in the May 12, 2009 *Federal Register*, eliminates and constricts some of the services covered under RUG-III. The proposed rule cites the recently completed **Staff Time and Resource Intensive Verification (STRIVE) study,** designed to analyze the actual amount of nursing and therapy staff time required to care for residents in order to determine the rates under PPS. According to the CMS explanation, the STRIVE study *"shows that the RUG-III model is still effective in determining relative nursing resource use generally across a broad range of conditions - **however, we have found that the resource times associated with specific conditions or service categories, such as diabetes and IV fluids or medications, have changed significantly."*** As a result of the STRIVE study and other cost and clinical data, CMS is proposing significant changes to RUG-IV once the MDS 3.0 is implemented:

Dividing Up Concurrent Therapy
Concurrent therapy is a therapy treatment approach in which one therapist treats **multiple patients at the same time with patients performing <u>different</u> activities.** Therapy time is counted as if it were individual therapy for each participating resident. For example, if a therapist is concurrently treating three residents over an hour's time, 60 minutes would be allotted to each of the three residents. According to CMS, about two-thirds of all Part A therapy is provided on a concurrent basis.

Under RUG-IV, CMS is proposing to have therapists allocate separately to each patient based on the therapist's clinical judgment of how much of the therapist's time was actually provided to each patient during a concurrent therapy session. **Rather than each patient recording 60 minutes in a 60-minute session, the therapist would divide the session minutes by each patient** participating (i.e., 30 minutes, 20 minutes and 10 minutes among three patients, even though all three were in the therapy room for 60 minutes). This would not be true for group therapy, in which all individuals in the group **perform the same activities** with one treating therapist.

Hospital Services Not Counted
Currently, MDS 2.0 services listed in P1a, Special Care Treatments, such as IV medications, suctioning, traecheostomy care, ventilator/respirator, respiratory therapy, radiation, oxygen, transfusions, chemotherapy and dialysis provided in the hospital prior to admission are counted in RUGs-III categories when they fall into the look-back period, even if the same services are

not continued in the SNF. **Under RUG-IV those Special Care Treatments provided in the hospital but not in the SNF will not be captured for the RUG calculation.**

Revised Extensive Services Category
Under RUG-IV the Extensive Services category would only include tracheostomy care, ventilator or respirator, and adds isolation for active infectious disease, but **drops suctioning completely as a covered service and moves IV medications and IV feedings to lower categories.**

Revised Special Care Categories
RUG-IV divides Special Care into two new categories of **Special Care High** and **Special Care Low,** and adds the presence of **depression** as an additional end split along with ADL levels. RUG-IV **Special Care High** takes quadriplegia, fever and respiratory therapy from the RUG-III Special Care category; includes Parenteral/IV feeding from the RUG-III Extensive category; moves up comatose, septicemia and diabetes from the RUG-III Clinically Complex category; and adds COPD with shortness of breath when lying flat. RUV-IV **Special Care Low** has CP, MS, Parkinson's, pressure ulcers, and feeding tube from the old Special Care category and brings up foot infections, radiation, oxygen and dialysis from the RUG-III Clinically Complex category.

Revised Clinically Complex Category
Aside from a number of RUG-III Clinically Complex conditions moved up to RUG-IV Special Care High and Special Care Low, the RUG-IV Clinically Complex Category keeps pneumonia, hemiplegia, burns, chemotherapy, and transfusions from RUG-III, and adds IV Meds from RUG-III Extensive and wounds from RUG-III Special Care. **Internal bleeding, dehydration, and extra physician visits/order changes will no longer be covered in any category.**

Behavior/Cognition/Physical Function
The two RUG-III categories of Impaired Cognition and Behavior Problems have been combined into one RUG-IV **Behavioral Symptoms and Cognitive Performance**, with the same requirements. **Reduced Physical Function** stayed the same.

Changed ADL Scoring
ADL Scoring will continue to be based on the four late-loss ADLs of bed mobility, transfer, toileting and eating, but the scoring will change from 1 to 5 to 0 (independent/supervision) to 4 (totally dependent) in all four categories including eating. Consequently the RUG-IV Index Range will be from 0 to 16 rather than the current RUG-III 4 to18. **Parenteral/IV and feeding tube items have been eliminated in determining the eating assistance score**.

Section T Dropped
Under MDS 2.0 and RUG-III, providers were allowed to project the amount of therapy that would be needed through day 15 on the five-day assessment to determine a RUG category. **Under RUG IV, Section T is eliminated** and the following provision would be implemented for short-stay residents:

"Short-stay patients – For residents discharged prior to day 14 who have completed only one to four days of therapy, the RUG level will be assigned by calculating the average daily number of therapy minutes for each of the days therapy was actually delivered. A non-therapy RUG also will be calculated for the days that therapy was not provided. ***The provider will bill the non-therapy RUG for the days therapy was not provided and will also bill the therapy RUG for the days therapy was provided."***

OMRA and Therapy
Under the new RUG-IV, providers would file an **OMRA (Other Medicare Required Assessment)** with one to three days **at the end of therapy**. Payment for a therapy RUG would start the first day of therapy and end on the last day of therapy. For the rest of the skilled stay

during that assessment period, the non-therapy RUG would be billed for the days after therapy ended. However, unlike the proposed short-stay requirement, a resident stays on the therapy RUG during **the whole therapy period from the first to the last day of therapy, even on the days that no therapy was provided.**

14-Day Submission Requirement
Under MDS 2.0 facilities are required to submit MDS data within 31 days of completion of the assessment on at least a monthly basis. **The proposed change under MDS 3.0 would require providers to submit data within 14 days after completion of the assessment**.

CMS published no RUG-IV rates by category, but CMS stated it expects that the transfer from RUG-III to RUG-IV to be essentially budget neutral (at least for them). Given the extensive changes proposed, it is hard to imagine anyone accurately predicting at this time what the financial impact will be, either on the system or on individual providers. RUG-IV is still in the proposal stage and has not been finalized, but it gives a good indication of what CMS intends to do with the PPS system under MDS 3.0.