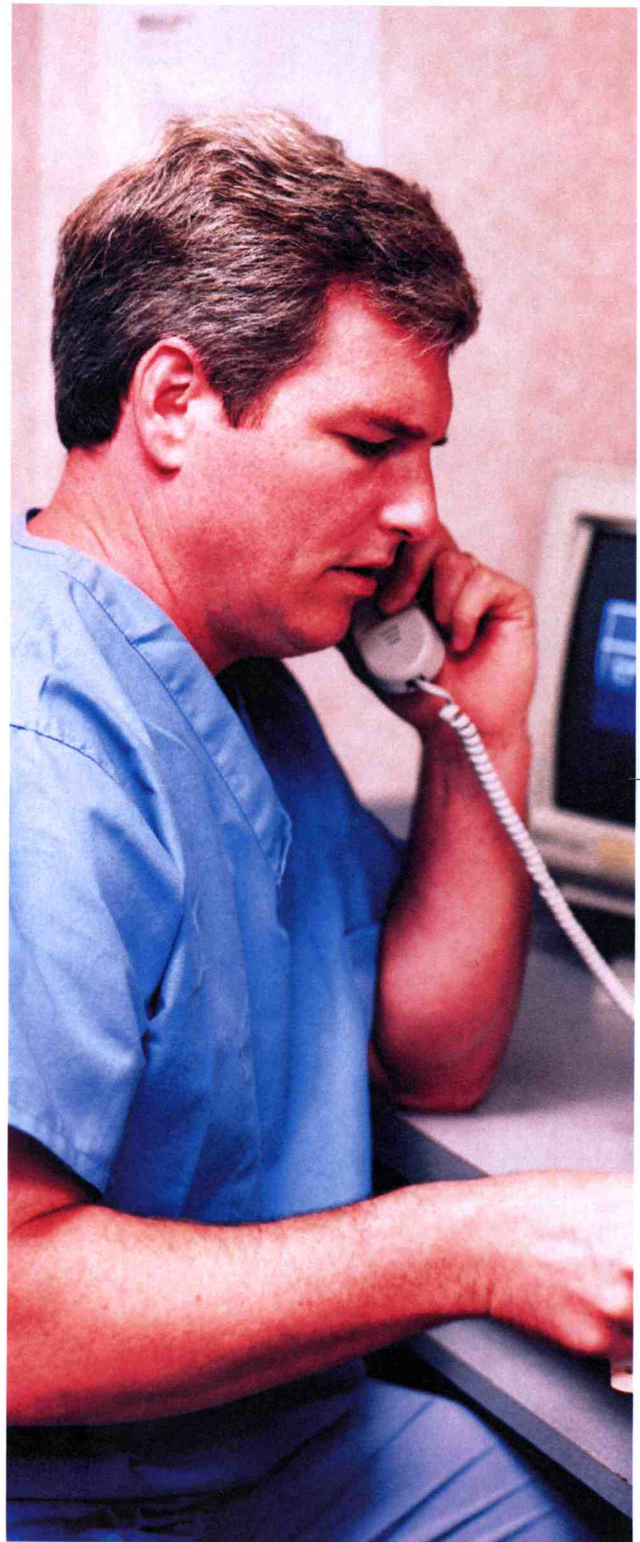
p26-31_ECPN1112_Orth.qxd 11/17/05 2:36 PM Page 26

Out from Under the RUG

Changes to the Resource Utilization Groups (RUG) payment classification system take effect in January and present a daunting challenge to long-term care facilities.

RONALD A. ORTH, RN, LNHA, RAC-C

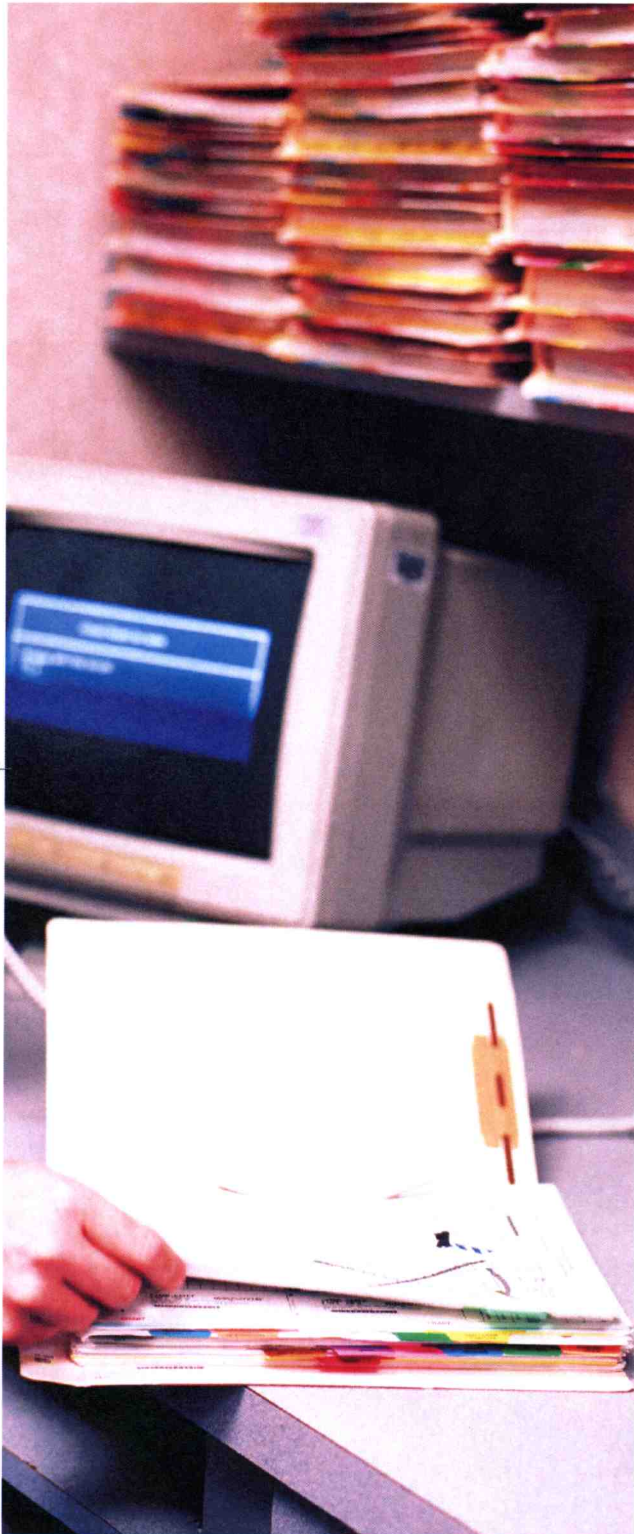


On July 28, 2005, nearly 7 years in the making, the Centers for Medicare & Medicaid Services (CMS) issued its final regulations outlining the refinements to the Prospective Payment System (PPS) Resource Utilization Groups Version III (RUG-III) payment classification system originally implemented in 1998. Success under the new payment classification system will require not only an understanding of the RUG III qualifiers but also a thorough understanding of how the RUG-III Case Mix maximization system will assign the appropriate RUG score based on Minimum Data Set (MDS) coding.

Under the RUG refinements, CMS has added a new major RUG classification and 9 new sub-RUG categories. The new RUG classification applies to the Extensive plus Rehabilitation payment group. This category combines the qualifiers for the current rehabilitation RUGs with the qualifiers for the extensive services RUGs. The intent of these new RUGs is to properly classify and reimburse for those residents who require rehabilitation services in addition to extensive nursing services. The new RUGs will become effective January 1, 2006 (see Table 1).

There are 3 essential requirements to qualify for each of the new RUG classifications: rehabilitation services, extensive services, and activities of daily living (ADL) scores. The rehabilitation requirements remain unchanged from the current rehabilitation RUG categories:

- **Rehab Ultra High:** a minimum of 720 minutes of therapy over the past 7 days delivered by a minimum of 2 therapy disciplines—one for at least 5 days and the other for at least 3 days



- **Rehab Very High:** a minimum of 500 minutes of therapy over the past 7 days delivered by at least one discipline over 5 days
- **Rehab High:** a minimum of 325 minutes of therapy over the past 7 days delivered by at least one discipline over 5 days
- **Rehab Medium:** a minimum of 150 minutes of therapy over the past 7 days provided by any combination of therapies totaling 5 days
- **Rehab Low:** a minimum of 45 minutes of therapy over a minimum of 3 days and 2 or more nursing rehabilitation services received for at least 15 minutes each over 6 days or more.

The qualifiers for the extensive services component of the new RUG classifications also remain unchanged from the qualifiers for the current Extensive Services category. Unlike the Extensive Services category, the new Extensive plus Rehabilitation category does not consider the extensive services count in determining the appropriate RUG. There are currently 5 qualifiers for the Extensive Services category:

- K5a: Parenteral/intravenous (IV) fluid (past 7 days)
- P1ac: IV Medications (past 14 days)
- P1ai: Suctioning (past 14 days)
- P1aj: Tracheostomy care (past 14 days)
- P1al: Ventilator/respirator (past 14 days)

The third and final component of the new RUG classifications is the ADL score. Similar to the current Extensive Services and Special Care RUG classifications, an ADL score of 7 or greater is required. Let us review a case example comparing how the RUGs will be determined for one resident.

CASE STUDY 1

Resident A receives a total of 175 minutes of therapy over 5 days, provided by 2 different therapy disciplines. The resident has received IV medications in the past 14 days and has an ADL score of 10.

- Current system RUG score = RMB
- New RUG refinement system score = RML

The PPS reimbursement system uses an index-maximizing approach to assign the appropriate RUG to each MDS. Under an index-maximization system, the RUG grouper analyzes the MDS data elements that are used in determining a RUG and determines all the RUG classifications for which the particular MDS qualifies. Once these are determined, the RUG grouper software will always assign the RUG score that is assigned the higher case mix index (CMI).

The Centers for Medicare & Medicaid Services has assigned a case mix index (CMI) to each of the 53 RUG categories. The agency uses a simplified system in which the RUGs are assigned a CMI value of 1–53. Under an index-maximization system, there is a direct correlation

p26-31_ECPN1112_Orth.qxd 11/17/05 2:36 PM Page 28

Table 1. New Extensive Plus Rehabilitation Resource Utilization Groups (RUG) Categories

	Current Rehabilitation Groups	New Combined Extensive Plus Rehabilitation Groups
Rehab Ultra	• RUC-ADL (16–18) • RUB-ADL (9–15) • RUA-ADL (4–8)	• RUX-ADL (16–18) • RUL-ADL (7–15)
Rehab Very High	• RVC-ADL (16–18) • RVB-ADL (9–15) • RVA-ADL (4–8)	• RVX-ADL (16–18) • RVL-ADL (7–15)
Rehab High	• RHC-ADL (13–18) • RHB-ADL (8–12) • RHA-ADL (4–7)	• RHX-ADL (13–18) • RHL-ADL (7–12)
Rehab Medium	• RMC-ADL (15–18) • RMB-ADL (8–14) • RMA-ADL (4–7)	• RMX-ADL (15–18) • RML-ADL (7–14)
Rehab Low	• RLB-ADL (14–18) • RLA-ADL (4–13)	• RLX-ADL (7–18)

between the CMI and the amount of reimbursement; the higher the case mix, the higher the reimbursement rate for each RUG, with "1" corresponding to the RUG with the lowest reimbursement and "53" corresponding to the RUG with the highest reimbursement.

The CMI sets used in the PPS system vary depending on the Urban or Rural classification of the facility (see Table 2).

The reimbursement rates for each of the RUG categories are based on 4 components: a nursing component, a therapy component, a non- case mix therapy component, and a non- case mix component. Once the rates are determined, the CMI score is applied in descending order according to payment rate.

Remember that the RUG grouper will automatically assign the RUG score with the highest CMI and a review of the case mix indices assigned to each of the 53 RUGs may present a few surprises. One will notice that the CMI score for the RML and RMX categories is higher than the CMI for the RHX and RHL categories. Those categories also have a higher reimbursement rate, which correlates appropriately with the higher CMI.

The increased payment rate for the RMX and RML RUG categories is a result of a higher nursing component of the overall rate. Since a resident who qualifies for a RH level of care would also qualify for a RM level of care, the RUG grouper will automatically assign the RUG with the higher CMI assignment. For this reason, there is the potential that a resident would never be assigned a RHL or RHX category, yet the facility would still benefit from the higher payment of the RML and RMX categories. An example of this anomaly follows.

A resident with 550 minutes of therapy over 5 days, an IV medication over the past 14 days, and an ADL score of 15 would qualify for a RVL level of care. In addition, this resident would qualify for a RMX level of care. Since the RMX has a CMI of 47 compared to an RVL CMI of 46, the resident would automatically be assigned the RMX RUG, holding to a true index-maximization system and a higher correlating reimbursement rate.

Success under the RUG refinement will require several key considerations, including:

1. Selection of the Assessment Reference Date (ARD)
2. Accurate ADL scoring
3. Review of pre-admission (hospital) documentation/information
4. Good therapy planning
5. Consistent and frequent communication between members of the therapy staff and MDS coordinator.

The ARD establishes the assessment period to be used when completing the MDS. It is the services the resident receives or clinical conditions presented by the resident that will be reflected on the MDS, resulting in the RUG assignment. Selecting the wrong ARD may result in a significant loss of reimbursement.

CASE STUDY 2

A resident admitted to the facility, and the MDS coordinator is preparing to complete the 5-day PPS Medicare assessment. The MDS coordinator, in collaboration with the therapy staff, is trying to determine the best ARD to use.

- **Day 1 ARD:** The resident would qualify for an SE3 RUG score based on current clinical criteria and extensive services count. Therapy services have yet to be initi-

ated; the resident qualifies for SE3 with a CMI of 40.

- **Day 3:** The resident would continue to qualify for Extensive services but at an SE2 level. The resident has also received 150 minutes of therapy and has an ADL score of 15. The resident would qualify for both an SE 2 (40) and a RMX (47).
- **Day 8:** The resident would no longer qualify for extensive services. He or she has received 500 minutes of therapy and has an ADL score of 15. The resident would qualify for RVC (45).

Based on these 3 ARD options, the facility would benefit the most financially by choosing Day 3, even though the resident received a higher number of therapy minutes on Day 8, since the CMI assigned to the RMX is higher than the other potential RUGs due to the addition of the Extensive services qualifier.

Another key consideration to optimize your reimbursement is to ensure that ADL coding on the MDS is accurate and best reflects the functional level of the resident. As is the case now, it is imperative for facility staff to understand the terminology used by the MDS to measure a resident's level of independence or dependence in completing ADL tasks.

The 9 new RUG categories require an ADL score of 7 or higher in order to qualify. Inaccurate coding of the ADLs in Section G of the MDS may result in a significant loss of reimbursement to the facility.

CASE STUDY 3

Resident A received 250 minutes of therapy services, has received an IV medication in the past 14 days, and, based on MDS coding, has an ADL score of 6.

- RUG = RMA

Resident B also received 250 minutes of therapy services, has received an IV medication in the past 14 days, and, based on MDS coding, has an ADL score of 8.

- RUG = RML

The facility would receive $293.11/day in reimbursement for resident A compared to $381.17 for resident B, a difference of $88.06/day based on ADL coding alone. (The rates are based on federal urban unadjusted rates.)

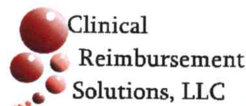
Communication between the MDS coordinator and therapy staff is required to ensure the most desirable ARD is used to capture the most appropriate RUG for each MDS completed. In addition, appropriate planning of therapy services, based on resident evaluation, will also play a major factor in the RUG outcome.

The implementation of the RUG refinements also means the elimination of the RUG add-ons that were implemented with the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000. The add-ons that will be eliminated include the 6.7% increase to the rehab RUG categories and the 20% increase to 12 of the nursing RUG categories (CA1–SE3). To help offset the elimination of these add-ons, CMS has increased the nursing CMIs of the federal rates by approximately 8.65%, which the agency says represents an approximate 3% increase in the nursing component rate. A 3.1% market basket (ie, inflationary) adjustment has also been made.

EASING THE TRANSITION

Billing for the new RUGs may also present challenges to facilities, particularly during the transition period. The new RUG rates are effective January 1, 2006. The Centers for Medicare & Medicaid Services has issued a transition plan to assist facilities in ensuring appropriate billing of RUGs between 2005 and 2006. The agency has calculated that MDS assessments completed between November 22, 2005 and January 13, 2006 have the potential to be billed under both the current 44 RUG system and the upcoming 53 RUG system. The RUG billed in December 2005 may not be the same RUG billed in January 2006, even though the RUG was derived from the same MDS.

To assist facilities in identifying RUG changes between the 2 systems, CMS will be reporting both RUG scores on MDS Final Validation (feedback) reports that facilities receive after a MDS submission. For those assessments with an ARD of November 22, 2005 thru January 13, 2006, the



LTC reimbursement systems today are complex and challenging requiring strong clinical systems and processes.

Clinical Reimbursement Solutions, LLC can assist you in meeting these demands and in understanding the changing regulatory environment.

Clinical Reimbursement Solutions, LLC offers affordable consulting services to assist you in in the following:

RAI Education
PPS Education and Training
PPS/Medicaid RUG Reviews
Medicare Compliance Reviews
Consolidated Billing Training and Reviews
Medicare Claims Appeals Management
Customized educational programs

Visit us at www.clinicalreimbursement.com
or call 1-888-225-7147

"Keeping you Informed, Compliant and Successful"

Circle Reader Service Card No. 8