RUG-IV Classification: Get Paid for the Care You Provide

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The Medicare Part A skilled nursing facility prospective payment system has used the RUG-IV (Resource Utilization Group, version IV) classification system as the case-mix reimbursement vehicle for paying SNFs since Oct. 1, 2010. “However, some providers still could do better financially by paying attention to certain opportunities within the RUG-IV system,” says **Michelle Synakowski**, LNHA, RN, C-NE, RAC-MT, a policy analyst and consultant with LeadingAge New York in Latham. SNFs can step up their RUG classification game by taking these steps:

Routinely monitor temps

In the Special Care High RUG category, a fever (MDS item J1550A) plus certain characteristics results in a significant RUG score, says Synakowski. “You have fever plus pneumonia (I2000), fever plus vomiting (J1550B), fever plus weight loss (K0300 coded 1 or 2), and fever plus feeding tube (K0510B1 or K0510B2). Some of those clinical issues on their own — without a fever — will also get you a RUG score, but it won’t be as high a RUG score.” She offers two examples:

- A feeding tube by itself is a qualifier for Special Care Low; a tube feeding with a fever is Special Care High.
- Pneumonia by itself qualifies for Clinically Complex; pneumonia with a fever is Special Care High.

“Capturing a fever can make a difference of $50 to $60 a day in these scenarios,” she explains. “The problem is that facilities are not always good at routinely monitoring temperatures during the look-back period, even when patients have some of these other clinical conditions. However, you have to do it if you want to capture the fever so you can get that additional bump in the RUG score.”

Assess for shortness of breath while lying flat

On its own without any additional clinical characteristics, a diagnosis of chronic obstructive pulmonary disease (COPD) coded in I6200 does not result in a significant RUG score, with the patient most likely defaulting into the Reduced Physical Function category, points out Synakowski. “But if a patient has COPD and *also* has shortness of breath while lying flat (J1100C), he or she will

qualify for Special Care High. The reimbursement difference can be quite significant: The Special Care High payment ranges from about $350 to $480 a day, while the Reduced Physical Function payment is more in the range of $200 a day."

However, many nurses do not assess for shortness of breath while lying flat on a regular basis, says Synakowski. "Nurses are good at documenting if a patient is short of breath on exertion, or they might document that there is shortness of breath 'at rest.' However, they often do not assess for and document whether a patient is short of breath while lying flat."

It is important to do a true assessment rather than make assumptions, she adds. "For example, you can't assume that if a patient is short of breath sitting up, he or she would be short of breath lying flat. So I encourage facilities to put it on the treatment sheet and actually assess for it, especially during the look-back period."

Documenting the results of that assessment in the progress notes is also critical, says Synakowski. "If the resident meets the coding guidelines for shortness of breath while lying flat, you need to have that documentation to support the MDS coding and the resulting RUG score."

While the best practice is for the floor nurses to assess for shortness of breath while lying flat, "MDS nurses should be aware that they can interview the resident themselves and then code it if the resident says that he or she avoids lying flat because of shortness of breath — as long as they document that interview," adds **Becky LaBarge**, RN, RAC-MT, a consultant with RLL Consulting in Olathe, Kansas. "The *RAI Manual* (page J-21) clearly spells out that any evidence of shortness of breath while lying flat, including resident interviews, should be captured."

Differentiate between septicemia and UTI

Here's a common scenario: A patient arrives at the SNF from the hospital, and the hospital records indicate the patient was admitted for a urinary tract infection (UTI). "However, if you read through the patient's history, you often will find that the patient had septicemia related to a UTI, but the sepsis isn't listed as a specific diagnosis," says Synakowski.

Providers that take the time to clarify this scenario with the physician and obtain the diagnosis of septicemia when warranted could see a financial boost, she notes. “UTI (I2300) is not a RUG qualifier, so a patient without any other clinical conditions probably would default into the Reduced Physical Function category. However, septicemia (I2100) will qualify the resident for Special Care High.”

Not only is it beneficial to always clarify a septicemia diagnosis with physicians, “it’s important to educate physicians on all diagnoses that can impact RUG calculation so that you can get clearer documentation that is more useful,” suggests Synakowski.

Be more flexible scheduling PPS assessments

Many MDS coordinators have become very rigid in setting assessment reference dates (ARDs), says Synakowski. “MDS nurses often do not like to move their dates. For example, they might always use day 8 as the ARD for the 5-day PPS MDS or always use day 27 for the 30-day MDS. Being that rigid, they could miss other codable conditions or services by a day or two. If they are willing to move that ARD to another acceptable date within the ARD window, they could capture other things that are higher RUG qualifiers.”

The problem is two-fold, says Synakowski. “First, nurses often do not have a high level of comfort with moving the date because they are afraid they’ll miss something if they change the schedule. Second, many rehab departments have become very regimented about wanting ARDs to always fall on a COT [change-of-therapy OMRA] date so they then can choose to do the COT or not do the COT. Some have adopted a system of ‘If I choose this date, it makes my life easier’ as opposed to ‘If I choose this date, I get the best RUG score.’”