Ohio Administrative Code

Rule 5160-3-43.4 Nursing facilities (NFs): exception review process.

Effective: March 1, 2016

(A) The definitions of all terms not defined in this rule are the same as set forth in rules 5160-3-01 and 5160-3-43.1 of the Administrative Code.

(1) "Combination review" is a type of exception review where the Ohio department of medicaid (ODM) reviews records selected in one of the following ways:

(a) A combination of records selected pursuant to random and targeted criteria.

(b) Records initially selected for a targeted review, but insufficient records were available to meet the targeted review sample size requirements, combined with randomly selected records to complete the sample size.

(c) Records initially selected for a random review, combined with records selected for a targeted review as a result of findings of the random review.

(2) "Effective date of the rate" is either the first day of July or January for a given fiscal year.

(3) "Exception review" is a review of minimum data set (MDS) assessment data. It is conducted at selected NFs by registered nurses and other appropriate licensed or certified health professionals as determined by ODM who are employed by or under contract with ODM. The purpose of an exception review is to identify any patterns or trends related to resident assessments submitted in accordance with rule 5160-3-43.1 of the Administrative Code that could result in inaccurate case mix scores used to calculate the direct care component of the nursing facility per diem rate. Exception reviews shall be conducted in accordance with section 5165.193 of the Revised Code.

(4) "Exception review tolerance level" is the level of variance between the facility and ODM in MDS assessment item responses affecting the resource utilization groups (RUG) classification of a facility's residents. Two kinds of tolerance levels have been established for exception reviews: initial

sample tolerance level, and expanded review tolerance level.

(a) "Initial sample tolerance level" is the percentage of unverifiable records found during the initial sample of an exception review, below which no further review will be pursued for the same six month period. The initial sample tolerance level shall be less than fifteen per cent of the entire sample.

(b) "Expanded review tolerance level" is an acceptable level of variance in the calculation of a provider's quarterly facility average medicaid case mix score or an acceptable per cent of the records sampled at exception review that were unverifiable.

(5) "Random review" is a type of exception review that examines randomly selected records from any of the RUG major categories listed in paragraph (C) of rule 5160-3-43.2 of the Administrative Code.

(6) "Targeted review" is a type of exception review that targets records in restorative nursing programs, current toileting program or trial, and/or bowel toileting program, clinically complex with depression, or one or more of the RUG major categories listed in paragraph (C) of rule 5160-3-43,2 of the Administrative Code.

(7) The "variance" is the percentage difference between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider's submitted MDS records.

(a) The exception review tolerance level shall be either less than a two per cent variance between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider's submitted MDS records or less than twenty per cent of the medicaid records sampled at exception review were unverifiable.

(b) The variance calculation will not recognize modifications to MDS assessments and new assessments following an inactivation, submitted by the facility after notification of the exception review.

(8) A "verifiable MDS record" is a provider's completed MDS assessment form, based on facility

supplied MDS assessment data submitted to ODM for a resident for a specific reporting quarter, which upon examination by ODM during an exception review has been determined to accurately represent the aspects of the resident's condition that affect the correct RUG classification of that record during the specified assessment time frame.

(9) An "unverifiable MDS record" is a provider's completed MDS assessment form, based on facility supplied MDS assessment data, submitted to ODM for a resident for a specific reporting quarter which, upon examination by ODM, has been determined to inaccurately represent the aspects of the resident's condition that affect the RUG classification of that record during the specified assessment time frame. MDS coding may be deemed unsupported if inconsistencies are found in the sources of information through verification activities.

(B) All exception reviews will comply with the applicable provisions of the medicare and medicaid programs.

(C) Providers may be selected for an exception review by ODM based on any of the following:

(1) The findings of a certification survey conducted by the Ohio department of health (ODH) that may indicate that the facility is not accurately assessing residents, which may result in the resident's inaccurate classification into the RUG system.

(2) A risk analysis profile that may include, but is not limited to, one or more of the following:

(a) A change in the frequency distribution of residents who receive nursing rehabilitation/restorative care in accordance with section O of the minimum data set version 3.0 (MDS 3.0), or who meet the RUG criteria for depression in accordance with section D of the MDS 3.0.

(b) The frequency distribution of residents who receive nursing rehabilitation/restorative care in accordance with section O of the MDS 3.0, or who meet the RUG criteria for depression in accordance with section D of the MDS 3.0 exceeds statewide averages.

(c) A sudden or drastic change in the quarterly facility average total case mix score or the quarterly facility average medicaid case mix score.

(d) A change in the frequency distribution of coded responses to a MDS item.

(3) Prior resident assessment performance of the provider, may include, but is not limited to, ongoing problems with assessment submission deadlines, error rates, incorrect assessment dates, and apparent unchanged assessment practice(s) following a previous exception review.

(D) Exception reviews shall be conducted at the facility by registered nurses and other licensed or certified health professionals as determined by ODM who are under contract with or employed by ODM. When a team of reviewers conducts an on-site exception review, the team shall be led by a registered nurse. Persons conducting exception reviews on behalf of ODM shall meet the following conditions:

(1) During the period of their professional employment or contract with ODM, whichever is applicable, reviewers must neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a NF for which they conduct an exception review. Employment of a member of a reviewer's family by a provider at which the reviewer does not conduct an exception review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the provider on the part of the reviewer.

(2) Reviewers shall not conduct an exception review at any facility where a member of their family is a current resident.

(3) Reviewers shall not conduct an exception review at any facility that has been a client of the reviewer within the past twenty-four months.

(4) Reviewers shall not conduct an exception review at any facility that has been an employer of the reviewer within the past twenty-four months.

(E) Prior notice: ODM shall notify the provider by telephone at least two working days prior to the review.

(F) Providers selected for exception reviews must provide reviewers with reasonable access to

residents, professional and nonlicensed direct care staff, the facility assessors, and completed resident assessment instruments and supporting documentation regarding the residents' care needs and treatments. Providers must also provide ODM with sufficient information to be able to contact the resident's attending or consulting physicians, other professionals from all disciplines who have observed, evaluated, or treated the resident, such as contracted therapists, and the resident's family or significant others. These sources of information may help to validate information provided on the resident assessment instrument submitted to ODM. Verification activities may include reviewing resident assessment forms and supporting documentation, conducting interviews with staff knowledgeable about the resident during the observation period for the MDS, and observing residents.

(G) An exception review shall be conducted of a random, targeted, or a combination of random and targeted samples of completed resident assessment instruments. The initial sample size shall be greater than or equal to the minimum sample size. The expanded sample size is based on the initial sample findings. Sample sizes are available on the ODM website at http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/LongTermCare Facilities.aspx.

(H) Results from review of the initial sample shall be used to decide if further action by ODM is warranted. If the initial sample is to be expanded for further review, ODM reviewers shall hold a conference with facility representatives advising them of the next steps of the review and discussing the initial sample findings. If the sample of reviewed records exceeds the initial sample tolerance level described in paragraph (A)(4)(a) of this rule, ODM may subsequently expand the exception review process as follows:

(1) If the initial sample was a targeted review, the expanded sample size shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size.

(2) If the initial sample was a random review that became a targeted review, the expanded sample shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size.

(3) If the initial sample was a random review, the expanded sample size shall be at least the applicable minimum sample size.

(4) If the initial sample was a combination review, the expanded sample size shall be at least the applicable minimum sample size. The expanded sample may consist of the remaining records in the targeted and random categories.

(5) If the expanded review tolerance level is exceeded, ODM may subsequently expand the sample size for the same reporting quarter up to and including one hundred per cent of the records and continue the review process.

(I) At the conclusion of the on-site portion of the exception review process, reviewers shall hold an exit conference with facility representatives. Reviewers will share preliminary findings and/or concerns about verification or failure to verify RUG classification for reviewed records. Reviewers will give provider representatives one written preliminary copy of the exception review findings indicating whether the facility was under or over the established tolerance levels.

(J) All exception reviews shall include a final written summary of the exception review findings, including the final facility tolerance level calculations as well as the revised quarterly facility average total case mix score and the revised quarterly facility average medicaid case mix score. ODM shall mail a copy of the final written summary to the provider.

(K) All exception review reports shall be retained by ODM for at least six years.

(L) If the expanded review tolerance level is exceeded, ODM shall use the exception review findings to calculate or recalculate resident case mix scores, quarterly facility average total case mix scores, quarterly and semiannual facility average medicaid case mix scores, and annual facility average case mix scores. Calculations or recalculations shall apply only to records actually reviewed by ODM and shall not be based on extrapolations to unreviewed records of findings from reviewed records. For example, ODM shall recalculate the quarterly facility average total case mix score and quarterly facility average medicaid case mix score by replacing resident case mix scores of reviewed records and not changing the resident case mix scores of unreviewed records.

(M) ODM shall use the quarterly facility average total case mix score, quarterly and semiannual facility average medicaid case mix scores, and annual facility average case mix score based on

exception review findings that exceed the exception review tolerance level to calculate or recalculate the facility's rate for direct care costs for the appropriate six month period(s). However, scores recalculated based on exception review findings shall not be used to override any assignment of a quarterly facility average total case mix score, quarterly facility average medicaid case mix score, or a peer group cost per case mix unit made in accordance with rule 5160-3-43.3 of the Administrative Code as a result of the facility's failure to submit, or submission of incomplete or inaccurate resident assessment information, unless the recalculation results in a lower quarterly facility average total case mix score, or lower quarterly or semiannual facility average medicaid case mix score, or lower peer group cost per case mix unit than the one to be assigned.

(1) If the exception review of a specific reporting quarter is conducted before the effective date of the rate for the corresponding six month period, and the review results in findings that exceed the tolerance level, ODM shall use the recalculated quarterly facility average total case mix score and quarterly facility average medicaid case mix score to calculate the facility's semiannual facility average medicaid case mix score for the facility's direct care rate for that six month period. Calculated rates based on exception review findings may result in a rate increase or rate decrease compared to the rate based on the facility's submission of assessment information.

(2) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a lower rate than it was entitled to receive, ODM shall increase the direct care rate prospectively for the remainder of the six month period, beginning one month after the first day of the month after the exception review is completed.

(3) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a higher rate than it was entitled to receive, ODM shall reduce the direct care rate and apply it to the six month periods when the provider received the incorrect rate to determine the amount of the overpayment. Overpayments are payable in accordance with rule 5160-3-22 of the Administrative Code.

(N) Except for additional information submitted to ODM as part of the processes set forth in paragraphs (O) and (P) of this rule, the ODM exception review determination for any resident case

mix score shall be considered final. A provider may submit corrections for individual records in accordance with rule 5160-3-43.1 of the Administrative Code; however, the exception review determination for any resident assessment case mix score will be used to establish the quarterly facility average total case mix score, quarterly and semiannual facility average medicaid case mix scores, and annual facility average case mix score.

(O) A provider may seek reconsideration of any prospective direct care rate that was established by recalculating the direct care rate as a result of an exception review of resident assessment information conducted before the effective date of the rate.

(1) A reconsideration of a prospective direct care rate on the basis of a dispute with ODM exception review findings shall be submitted by the provider to ODM in accordance with the following:

(a) The request shall be submitted no later than thirty days after receipt of the exception review finding.

(b) The request shall be in writing, and shall be addressed to "Ohio Department of Medicaid, Bureau of Long Term Care Services and Supports, P.O. Box 182709, 5th Floor, Columbus, Ohio, 43218".

(c) The request shall indicate that it is a request for rate reconsideration due to a dispute with exception review findings.

(d) The request shall include a detailed explanation of the items on the resident assessment records under dispute as well as copies of relevant supporting documentation from specific individual records. The request shall also include the provider's proposed resolution.

(2) ODM shall respond in writing within sixty days of receiving each written request for a rate reconsideration related to disputed exception review findings. If ODM requests additional information to determine if the rate adjustment is warranted, the provider shall respond in writing and shall provide additional supporting documentation no more than thirty days after the receipt of the request for additional information. ODM shall respond in writing within sixty days of receiving the additional information.

(3) If the rate is increased pursuant to a rate reconsideration due to disputed exception review findings, the rate adjustment shall be implemented retroactively to the initial service date for which the rate is effective.

(4) When calculating the annual facility average and semiannual facility average medicaid case mix scores in accordance with rule 5160-3-43.3 of the Administrative Code, ODM shall use any resident case mix scores adjusted as a result of a rate reconsideration determination in lieu of the resident case mix scores from the exception review findings.

(P) The findings of an exception review conducted after the effective date of the rate may be appealed under Chapter 119. of the Revised Code. ODM shall not withhold from the facility's current payments any amounts ODM claims to be due from the facility as a result of the exception review findings while the provider is pursuing administrative or judicial remedies in good faith.