

Overview of Nursing Facility Utilization Review

Legal Authority

The Inspector General (IG) nursing facility utilization review function operates under guidelines and regulations contained in:

Texas Administrative Code (TAC)

- TAC, Title 1, Part 15, Chapter 371, Subchapter C, Sections 371.212 - 371.216
- TAC, Title 40, Part 1, Chapter 19

Code of Federal Regulations (CFR)

- CFR, Title 42, Part 483, Subpart B

United States Code (USC)

- USC, Title 42, Chapter 7, Subchapter XIX, Rules 1396a and 1396r

Overview

The IG Utilization Review Unit performs retrospective onsite utilization reviews of nursing facility records to evaluate whether facilities correctly assessed and documented residents' needs; Medicaid reimbursements were appropriate for the level of care provided; and care provided was medically necessary. IG selects facilities to review and the records it reviews at a selected nursing facility, based on an assessment of risk.

Risk Assessment

TAC requires the IG Utilization Review Unit to conduct unannounced onsite Minimum Data Set (MDS) utilization reviews of each nursing facility in Texas at least once every 15 months. At the beginning of fiscal year 2016, there were approximately 1,135 nursing facilities in Texas. IG has 67 nurse reviewer positions responsible for performing onsite utilization reviews of nursing facilities and utilization reviews of thousands of inpatient hospital claims. Due to the high volume of claims subject to review and limited staff resources, IG is unable to review all nursing facilities every 15 months. Instead, the Utilization Review Unit uses a risk-based methodology to select a sample of nursing facilities for review each fiscal year.

Selection of Nursing Facilities for Review

The number of nursing facilities selected for review each fiscal year is dependent on the availability of resources, historical outcomes, and other factors such as legislative mandates. With consideration of these factors, IG plans to review 235 nursing facilities across 5 regions during fiscal year 2016.

The Utilization Review Unit begins selecting nursing facilities for review by determining the number of nursing facilities participating in the Medicaid program and analyzing vendor billing reports to identify the population of nursing facilities available for review. Excluded are nursing facilities that, during the previous fiscal year, closed, did not have any billings, or were classified as a veterans' home or children's facility. Consideration of risk factors within several groups forms the basis for selection of nursing facilities for review. IG selects nursing facilities for review from each of these groups.

No Reviews

Nursing facilities that have not received a Minimum Data Set (MDS 3.0) utilization review.

High Risk

Nursing facilities with claims in the following high-risk categories.

Error Rate

- Nursing facilities with error rates greater than 5 percent are listed in rank order, with the highest error rate representing the highest risk facility.

High Dollar RUGS

- Nursing facilities with claims in each of three high-dollar Resource Utilization Group (RUG) categories (rehabilitation, extensive services, and special care services) are listed in rank order by amount of dollars claimed in each category, with the most dollars in each category representing the highest risk facility.

Billing Variances

- Nursing facilities are ranked for each of the following:
 - Total dollars paid in fiscal years 2013, 2014, and 2015
 - Variance between total dollars billed in fiscal year 2013 and fiscal year 2014
 - Variance between total dollars billed in fiscal year 2014 and fiscal year 2015
- The three billing rankings are averaged, resulting in an overall rank order.

Low Risk

Nursing facilities whose claims do not indicate high risk.

Referrals from IG Medicaid Provider Integrity

Nursing facilities referred for review by the IG Medicaid Provider Integrity (MPI) Unit. These reviews focus on specific items, such as high-dollar RUGs.

Selection of Claims for Nursing Facilities Selected for Review

Once a nursing facility is selected for review, the Utilization Review Unit uses a proprietary application to generate a statistically valid random sample of MDS 3.0 assessments stratified by RUGs within specified date ranges. Depending on timeframes and resources, the Utilization

Review Unit will either use the system-generated sample or create an ad-hoc sample based on a more limited date range or sample size.

Utilization Review Process

Nursing facilities conduct a comprehensive assessment of a resident's needs, using an MDS Resident Assessment Instrument specified by the Department of Aging and Disability Services (DADS). Requirements for completing the MDS assessment are included in the MDS 3.0 manual posted on the federal Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) website.

The MDS assessment establishes a RUG classification, which determines the amount the Texas Medicaid program pays a nursing facility for care provided to a resident. Utilization review staff review a sample of MDS assessments to evaluate whether the Medicaid reimbursement was appropriate for the level of care provided.

Utilization Review Unit staff hold an onsite exit conference with the nursing facility to discuss the results of the review and provide written notification of the MDS findings. A telephone exit conference generally occurs within 10 days of the onsite review, where utilization review staff provide the facility with an estimated RUG adjustment dollar amount and respond to facility questions.

Utilization Review Unit staff process RUG reclassifications identified during the onsite utilization review, except for instances where the nursing facility requests reconsideration, and will recover any overpayment amounts associated with an MDS assessment claim. After the exit conference, the Utilization Review Unit provides a final notification letter to the nursing facility with the facility's error rate. When a nursing facility has an error rate greater than 25 percent, or is suspected of a significant program violation, the Utilization Review Unit refers the facility to the IG Medicaid Provider Integrity Unit for investigation.

Reconsideration and Appeals Process

If the nursing facility disagrees with any review findings, it may request a reconsideration review by IG. The request must be submitted in a letter, and must describe in detail the reason a reconsideration review is requested for each specified assessment error. An MDS assessment error that is not identified in the request will not be reconsidered.

Utilization Review Unit staff who did not participate in the onsite review perform the reconsideration review. The reconsideration consists of reviewing documentation from the onsite review and any additional documentation provided by the facility with its reconsideration request. After the reconsideration review is complete, Utilization Review Unit staff provide a written decision to the requestor.

If the nursing facility disagrees with the results of the reconsideration review, it may request a formal appeal from the DADS Appeals Division. The nursing facility must have requested a reconsideration review in order to request a formal appeal. The DADS Appeals Division handles

the appeals and the State Office of Administrative Hearings (SOAH) conducts formal hearings. After a formal hearing, the SOAH Administrative Law Judge provides a written proposal for decision. If the appeal finds that IG correctly identified a RUG as an error, the Utilization Review Unit directs the Texas Medicaid and Healthcare Partnership to correct the error and work with DADS Claims Management staff to implement the appellate decision.

Results

In fiscal year 2015, the Utilization Review Unit reviewed 22,640 MDS forms submitted by 569 nursing facilities, and identified overpayments of \$5,314,624.00 and underpayments of \$145,813.07. Appeal settlements during fiscal year 2015 for MDS 2.0 and MDS 3.0 reviews totaled \$1,261,587.17. There were 263 outstanding appeals (MDS 2.0 and MDS 3.0) as of December 3, 2015.

Nursing Facility Assessment Error Trends

Reviews of MDS 2.0 assessments, performed from November 2010 to May 2013, identified an average error rate of 4.63 percent. The Utilization Review Unit is currently performing reviews of MDS 3.0 assessments, after previously conducting MDS 3.0 reviews in fiscal years 2014 and 2015. Average error rates for those reviews were 5.40 percent and 4.87 percent, respectively, with nursing facility error rates ranging from 0.0 percent to 34.74 percent.

Listed below are the 10 most frequently identified errors from fiscal year 2015, and the percentage of total errors each error category represented.

Error Categories	Percent
Unsigned MDS forms	23.63%
Lack of, incomplete, or conflicting documentation in the records	15.19%
Missing MDS or Long Term Care Medicaid Information forms and/or records	13.92%
Signatures did not match Long Term Care Medicaid Information	12.24%
No documented training or training out of date	6.33%
Medical records not systematically organized or readily accessible	5.91%
Brief Interview for Mental Status/Resident Mood Interview not within Assessment Reference Date/look-back period	5.49%
Restorative Nursing - lack of plans, goals not measureable, missing documentation	4.64%
Altered documentation	2.11%
No physician visits or visit outside of Assessment Reference Date, or no diagnosis	1.69%

Stakeholder Meetings and Training

IG holds quarterly stakeholder meetings with nursing facility representatives.