ILLINOIS DEPARTMENT OF Healthcare and Family Services

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July 30, 2008

# INFORMATIONAL NOTICE

TO: Nursing Facility Providers

RE: Review and Appeal Process for Minimum Data Set (MDS) Based Reimbursement

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This notice announces implementation of the review and appeal process for the Minimum Data Set (MDS) based reimbursement system in accordance with the requirements of 89 Ill. Adm. Code Part 147, as adopted January 1, 2008 and May 29, 2008, and provides nursing facility providers with an overview of the review and appeal process.

**Starting August 1, 2008**, Department of Healthcare and Family Services (HFS) Bureau of Long Term Care (BLTC) staff will conduct unannounced reviews of nursing facilities to validate resident MDS information. Results of these reviews **may impact** nursing facility rates. Reviews will seek to validate MDS information submitted six months prior to the quarter in which the review occurs. For example, reviews occurring during August and September 2008 (3rd quarter) will seek to validate MDS information submitted previously during January through March 2008 (1st quarter). In general, the table below delineates this further:

| Department Review Quarter | MDS Information Submission Dates (1) |
|---|---|
| | |
| 1st quarter (January through March) | July – September (3rd quarter prior year) |
| 2nd quarter (April through June) | October – December (4th quarter prior year) |
| 3rd quarter (July through September) | January-March (1st quarter prior year) |
| 4th quarter (October through December) | April – June (2nd quarter prior year) |

(1) MDS Information Submission date occurs six months (2 quarters) prior to the review quarter.

To assist nursing facilities in preparing for these reviews, HFS has developed a "List of Required Documentation" (attached) that delineates possible sources of documentation that a facility may utilize to assist BLTC staff in validating the MDS. Document form and format is at the facility's discretion. Additionally, HFS **strongly encourages** facility staff to review the Resident Assessment Instrument (RAI) Manual located on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov and to familiarize themselves with the documentation requirements found at 89 Ill. Adm. Code 147.200.

## Review Process

The original sample population of residents reviewed is defined as 20%, or no less than 10, of the eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period.

Pursuant to 89 Ill. Adm. Code 147.200(a)(1), the review team will request in writing the current charts of individual residents needed to begin the review process. Current charts and completed MDSs for the previous 15 months must be provided to the review team within an hour after this request. Additional documentation regarding reimbursement areas for the identified Assessment Reference Date (ARD) timeframe shall be provided to the review team within four hours after the initial request.

**Entrance:**

The review team from HFS will conduct an entrance conference with the facility at the beginning of every validation review. Facility staff will be provided with the "List of Required Documentation" and will be asked to discuss their process for documentation and coding as well as the location of various documents and records which may be utilized by the team during the validation review. Facility staff must ensure that all necessary records, binders and paperwork are available for review.

**Validation Review:**

A record review is conducted by BLTC staff in order to validate the MDS data submitted by the facility. At the entrance conference, facility staff is encouraged to provide the team with information regarding their coding and documentation processes, as well as to communicate any information that could assist the review team in understanding facility policy, practice and process. The facility may also provide the review team with sample documentation for any specific MDS area for the purpose of identifying documentation that may assist the team in validating an area.

Throughout the validation review, the HFS team may make additional verbal or written requests for documentation regarding a resident and an identified MDS area. If the facility believes they have already provided this information, they are encouraged to identify this information to the review team. As part of the validation review, the team may conduct observation and/or interviews on a routine or as needed basis. If the team believes that an expanded sample is warranted, they will inform the facility.

**Exit:**

Prior to the conclusion of the record review, the team leader will schedule a time to meet with the facility for the exit discussion. To ensure that the review team has all required information necessary to validate any area of MDS coding, the "Documentation Reconciliation List" (attached) identifying the information needed will be given to the facility periodically through the review up to the time of exit.

Facility staff should review the list, copy and attach any information they believe validates the area of MDS coding in question, and document the content and date of the information provided. The HFS team leader and facility staff must sign this Document Reconciliation List to indicate provision of the information by the facility and receipt of the information by the review team.

At the exit discussion, the team leader will briefly summarize which MDS areas may not be validated. **No final determination of results regarding the facility's rate will be provided by the onsite review team.** The facility will be given an exit letter containing a telephone number to call with questions regarding the review process. The Department will inform the facility in writing identifying any changes in reimbursement resulting from the validation review.

**Appeal Process:**

Pursuant to 89 Ill, Adm. Code 140.830, appeals must be submitted to the Department no later than 30 days after the date of the Department's notice to the facility of the rate calculation resulting from the validation review. Any revised rates potentially resulting from the validation review will not be posted to the Provider Data Base until 30 days after the date of the Department's notice in order to allow time for submission of appeals. The appeal must be submitted in writing and addressed as follows:

Chief, Bureau of Long Term Care
Department of Healthcare and Family Services
201 S. Grand Ave. East, 3rd Floor
Springfield, Illinois 62763

The appeal must contain clear and relevant supportive documentation. The facility must succinctly address point by point the area being appealed. Additional documentation not presented to the HFS team during the review, or at the time of exit, **cannot** be submitted with an appeal.

In accordance with 89 Ill. Adm. Code 140.830, the Department will rule on all appeals within 120 days after the date of appeal, except in rare instances where the Department may require additional information from the facility. In this case, the response period may be extended.

The appeal and supportive documentation will go through several stages of review within the Department to ensure fairness, objectivity and consistency within the appeal determination. The rate resulting from an appeal determination will become effective the first day of the applicable quarter

Contact the Bureau of Long Term Care at 217-524-0372 with questions relating to the processes identified above and you will be connected with the appropriate staff person handling inquiries in your area of the state.

Theresa A. Eagleson, Administrator
Division of Medical Programs

**List of Required Documentation**

The following is a sample list of documentation that can be used to validate MDS coding for the residents identified for review. Please carefully review the list of documentation to determine which areas are applicable to the residents identified. Documentation should be applicable to the identified timeframes. Because ARD timeframes vary, it is best to provide supporting documentation for 30 days prior to the ARD identified on the list of residents form. It is important to inform the teams when certain documentation is located in additional binders and/or areas, and to ensure the team has been given this information for review. It is the facility's responsibility to carefully review this list and ensure the review team is given all the documentation the facility has used to support coded specific MDS areas/items. The facility should carefully review the RAI and Rule requirements to determine what documentation is necessary.

**The following information should be provided to the review team upon request:**

1. Current list of residents in the facility with their room numbers.
2. Current list of residents identified as meeting Subpart S.
3. Current list of residents on Skills Training and the schedules for the sessions
4. Current list of residents going out to Day Training/group therapy and/or other sessions on a routine bases.
5. Current list of residents on Restorative(s) and the type of restorative they are receiving.

**The following information should be provided to the review team within an hour of the request.**

1. Current charts for identified residents.
2. Minimum Data Set (MDS) data for previous 12 months.
3. Current care plans, and Resident Assessment Protocols (RAPs), if applicable, for the identified residents.

**The following information applies to the identified ARD. This is a sample list of documentation, the actual form and format of the documentation is up to the facility**

1. Care plans and RAPs (if applicable) completed for the resident during the Assessment Reference Dates (ARD) identified.
2. All supporting documentation used for coding Activities of Daily Living (ADLs) during the ARD identified and the Subsequent MDS timeframe.
3. All documentation to support restorative programs for the resident for the past 12 months to present. This would include, but is not limited to, the restorative plan of care used during the ARD and current POC, any assessments/documentation completed that supports the resident's need for the program/deficits, and residents ability to participate in the program. In addition, documentation used to support the delivery of the program during the ARD and documentation used to support the program is ongoing. Any documentation to support the resident's progress, maintenance, and/or regression, as well as any revisions to the program. The department designated endurance assessment.
4. All documentation used to support any scheduled toileting or bladder retraining programs. Including the plan/schedule for the program, any documentation regarding the monitoring/evaluation of the program, documentation of the deficit, and documentation the plan was delivered such as CNA sheets/B+B sheets/etc.

5. Any certified nursing assistant (CNA) tracking logs during the ARD identified and the most recent ARD timeframe (i.e., ADL tracking, B+B logs, Behavior tracking, etc) that were used to support MDS coding.
6. Any documentation to support the order for and the delivery of care and treatments as applicable. This may include the treatment/care for such services as: catheter care, pressure ulcer prevention interventions, wound/skin care, IV therapy, injections, oxygen, chemotherapy, dialysis, and the delivery of medications.
7. Nursing notes, treatment sheets, physician order sheet (POS), medication administration record (MAR), and progress notes for the resident during the ARD identified and the subsequent ARD timeframe.
8. Any wound/ulcer care sheets, risk assessments, and treatment sheets for the resident during the ARD identified and/or any documentation to show area has healed.
9. Any pain assessments and documentation regarding the treatment of pain for the resident during the ARD identified.
10. Any social service notes, nursing notes, and monthly documentation regarding discharge planning for the residents. Any discharge records or transfer records.
11. Any dietary notes for the residents during the ARD identified. This may include dietary assessments/recommendations, dietary notes, I + 0 sheets, and/or monitoring of weights. Also include any documentation regarding tube feedings. This may also include physician's orders and/or documentation to support the use of diets and/or nutritional interventions.
12. Any documentation to support the occurrence of behaviors and/or any interventions used for the group therapy/behavioral symptom evaluation program being implemented. The care plan related to the above. Information identifying the group therapy being implemented and who is conducting the therapy. Additional information may include: Psychosocial notes, Social Service notes, behavior charting, program attendance sheets for psychosocial, documentation regarding programs for the resident during the ARD identified and for the subsequent ARD timeframe.
13. Any documentation regarding psychotropic medication use or reduction for the resident.
14. Any Subpart S documentation and/or assessments on the resident. Includes attendance records for skills Training during the ARD identified and the most current ARD and any documentation of Close or Constant Observation, and/or PAS screens completed.
15. Department of Public Health certification for any Alzheimer's units. Any documentation to support the delivery of activities on the unit and resident's involvement. Any documentation to support resident's cognitive status.
16. Activity charting, attendance records, and initial assessment for any identified residents residing in an Alzheimer's unit during the ARD identified.
17. Any documentation to support the delivery of any respiratory services such as trach care, suctioning, and/or ventilator care or weaning. This may include: respiratory therapy assessments, flow sheets, and notes for the resident during the ARD identified and the most recent ARD timeframe.
18. Any labs/x-rays/treatments or other interventions done to support the coding of infectious diseases.
19. Any hospital, outpatient, hospice or ER reports during the ARD. In addition, any consultation reports used to support coding
20. Any MD documentation to support diagnosis. Any documentation to support conditions/symptoms occurring during ARD.

List of Required Documentation

21. Additional Information requested:

All documentation that is to be considered for validation must be provided to the team prior to exit.
July 10th, 2008

This information was given to the facility for their review.

_____ _____
HFS Signature Date

I have received this form/information.

_____ _____
Facility Signature Date

# DOCUMENTATION RECONCILIATION LIST

| Resident Name<br>ARD | MDS Area | Facility Response<br>Identify information copied and attached or identify information is not available |
|---|---|---|
| **Example:** Mr Smith<br>1/15/08 | #1 - Section G1<br>#2 - Section P1ae<br>#3 - P1ac | # 1 ADL tracking dated 1/7/08 - 1/15/08<br># 2 Nursing note from 1/1/08 - 1/30/08<br># 2 MD Progress note dated 1/10/08<br># 2 POS dated 1/10/08<br># 3 No information available |
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| Resident Name<br>ARD | MDS Area | Facility Response<br>Identify information copied and attached or identify information is not available |
|---|---|---|
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HFS Staff Signature _____ Date given to NF _____

Facility Staff Signature _____ Date given to BLTC _____