North Carolina Division of Medical Assistance
MDS Validation Review Protocol
September 2017

Policy Decisions for MDS Validation Reviews

- Delinquent MDS assessment definition
  - Any assessment with an Assessment Reference Date (ARD) greater than 121 days from the previous ARD will be deemed delinquent and assigned a RUG code of BC1 and the lowest Case Mix Index (CMI)
- MDS validation review documentation guidelines
  - Guidelines that define the supporting documentation necessary to verify a RUG MDS item
- Unsupported MDS assessment definition
  - When the MDS validation review results in a new RUG classification
- Frequency of MDS validation reviews
  - Each Medicare/Medicaid facility annually with these exceptions:
    - Waiver facilities
    - State operated facilities
    - Facilities with two or fewer Medicaid residents
- Sample payer source selection
  - The primary and expanded assessment samples will be selected to include 90% Medicaid and 10% non-Medicaid
- Primary sample size is the greater of:
  - 20% of the residents listed on the point in time Final CMI report utilized for the review
  - 10 assessments
- Expanded sample size (required if primary sample results in greater than unsupported threshold) is the greater of:
  - 10% of the remaining residents listed on the point in time Final CMI report utilized for the review
  - 10 assessments
- Threshold defines when expanded review is required
  - Greater than 25% unsupported
- Late-loss Activities of Daily Living (ADL) documentation to reflect the 7-day/24 hours a day observation period while in the facility
- Follow-up review process
  - The DMA reserves the right to conduct a follow-up review as needed but not earlier than 120 days following the exit date of the prior review

Pre-Review Protocol

- Facility notification will occur no less than three (3) business days prior to the scheduled on-site review
  - Notification by telephone
  - Confirmation by fax or email

On-site Review Protocol

- Entrance conference
  - Facility Administrator or designee, MDS coordinator, Medical Records and any other staff of facility choice
  - Private area to be provided free of any audio or video taping or surveillance
  - Electronic records access must be provided if applicable
  - Facility designee to complete Facility Information Form
  - Review process is explained
  - Facility to identify liaison to assist with record retrieval

On-site Review Protocol (continued)

- First resident request list provided
- Facility Administrator or designee and all other staff in attendance sign the entrance conference form
- Time allowed for questions

- Review process
  - Facility liaison will provide medical records for resident list
  - A limited number of resident charts will be requested at one time to minimize chart removal from the resident chart location
  - The liaison will be asked to assist in locating any documentation the reviewers are unable to locate in the medical record
  - Once records are brought to the review area, the record cannot leave the room until review of that record has been completed
- Exit conference
  - Exit conference provided following the completion of the review
  - Facility Administrator or designee may invite any staff deemed appropriate to attend the exit conference
  - Preliminary findings will be reported including the number of assessments reviewed sorted by RUG-III category and percent unsupported
  - No supporting documentation may be submitted after the close of the exit conference
  - Facility designee and all other staff in attendance sign the exit conference form
  - Time allowed for questions

Post-Review Protocol

- The post review summary letter will be mailed per USPS no later than 10 business days following the exit conference date
  - If review results are greater than 25 percent unsupported
    - New RUG classification is assigned based on review
    - New facility average CMI is calculated
    - Post review PIT report reflecting new average CMI is included with the summary letter
- Reconsideration process
  - Within 15 business days of receipt of the summary letter the facility may submit a written request for a Reconsideration Review
  - DMA facility services manager will assign a staff member to re-examine the original review results
  - DMA facility services manager will render a decision within 20 business days of receipt of the request
  - If the facility disagrees with the DMA decision, the facility can request a second reconsideration within 10 calendar days of receipt of the first reconsideration decision
  - DMA facility services manager will render a decision within 30 calendar days of receipt of the request
  - The second reconsideration decision by DMA concludes the reconsideration process

Corrective Remedy

- Re-classify all unsupported assessments for facilities exceeding the state threshold and recalculate the direct care rate with retrospective rate adjustment
  - Adjustment to impact one quarter