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To: All Medicaid-Enrolled Nursing Facilities

**Subject: Minimum Data Set Audit and Rate Calculation
 Process**

Overview

The purpose of this bulletin is to address the Minimum Data Set (MDS) audit and rate calculation process for nursing facilities enrolled in the Indiana Health Coverage Programs. This provider bulletin will summarize the complete MDS audit process, how the finalized MDS audit results will impact Medicaid case mix rate setting, and the application of corrective remedies for nursing facilities with excessive levels of MDS records that do not comply with the MDS supportive documentation guidelines.¹

The Indiana Office of Medicaid Policy and Planning (OMPP) has adopted final rules² that provide for periodic audits of the MDS assessments completed by Indiana nursing facilities and transmitted to the State. The OMPP has contracted with EDS to perform these audits. The OMPP has collaborated with its contractors and the case mix work group, which includes nursing facility provider representatives, to develop a comprehensive MDS audit process that is now fully field-tested. All aspects of this audit process began on October 1, 1999. It is the OMPP's objective that all nursing facilities shall have an MDS audit completed at least once every 15 months in order to verify appropriate Medicaid reimbursement and accurate data reporting.

¹ The MDS supportive documentation guidelines have been developed as a collaborative effort between the OMPP, its contractors and the nursing facility industry. The current version of the Supportive Documentation Guidelines was published in Provider Bulletin BT199932 on October 1, 1999, and may be updated by the OMPP as needed. See also *405 IAC 1-15-4*.

² See *405 IAC 1-15-5*.

MDS Audit Process

EDS will periodically conduct audits of MDS supportive documentation using audit parameters established in the case mix rules. EDS will, at a minimum, audit a sample of the facility's most recently transmitted MDS records from each of the seven RUG-III categories in which the facility has residents. EDS will then determine whether any records in the sample are inaccurate or untimely. If the percent of inaccurate or untimely MDS records in the sample exceeds 50 percent, then EDS will expand the scope of the audit to include the latest MDS assessment of all facility residents.³

At the end of the MDS field audit, EDS auditors will conduct an exit conference with appropriate facility staff and review the preliminary results of the audit and other comments and recommendations on the facility's clinical documentation systems. Within 10 business days following the exit conference, EDS will issue preliminary MDS audit findings to the facility in writing. The facility will then have an opportunity to review the written preliminary audit findings. If the facility disagrees with the findings, the facility may submit an informal written reconsideration request to EDS within 15 business days. The informal reconsideration request must include specific audit issues that the facility believes were misinterpreted or misapplied during the audit. It should be noted that MDS supporting documentation that is provided after the audit exit conference shall not be considered in the reconsideration process.⁴ EDS will then review the facility request, and within 10 business days will communicate to the facility in writing the final MDS audit findings, along with a response to the issues raised. The MDS audit shall be concluded once EDS communicates the final MDS audit findings to the facility.

Each facility will be asked to submit a Validation Improvement Plan (VIP) to EDS for review if the percent of assessments for all residents considered to be inaccurate or untimely exceeds the 50 percent threshold. The VIP must be submitted within 15 business days following EDS' request, and must outline the facility remedy, completion date, and responsible party that will implement to ensure future compliance with the supportive documentation guidelines. The VIP will be required when the scope of the MDS audit is expanded to

³ See 405 IAC 1-14.6-4(k). The threshold percent used in the MDS audit process to determine whether the scope of the MDS audit is expanded to include all facility residents beginning October 1, 1999, is 50 percent. On January 1, 2001, this percentage is reduced to 35 percent, and is further reduced to 20 percent on April 1, 2002.

⁴ See 405 IAC 1-15-5(c).

all residents, and the inaccurate or untimely threshold for all residents is still exceeded.⁵

Following the conclusion of the informal reconsideration process, EDS will communicate the final MDS audit findings to the facility, the OMPP, and Myers and Stauffer for use in the case mix rate setting process. The information will include MDS audit workpapers that provide, in detail, the adjustments to MDS data the provider has previously transmitted to the State.

Application of Recalculated Case Mix Indices and Medicaid Rates

Upon receipt of the final MDS audit findings from EDS, Myers and Stauffer will incorporate those findings into the calculation of the facility's time-weighted case mix index (CMI) used for Medicaid rate setting purposes. Because of the one-quarter lag between the MDS A3a assessment reference date and the impacted Medicaid rate effective date, the MDS audit will be concluded for some MDS records in sufficient time for the audit findings to be incorporated into the facility's initial quarterly case mix rate setting affected by the audit. However, depending on the relationship between the assessment key dates and audit completion, there will also be circumstances when the application of MDS audit findings for some MDS records could result in retroactive rate adjustments.

As has been the practice since the time-weighted guidelines were implemented on January 1, 1999, the MDS A3a assessment reference date generally determines the calendar quarter during which each MDS assessment applies for case mix rate setting purposes.⁶

Beginning October 1, 1999, an audited MDS record will not be considered as inaccurate in accordance with *405 IAC 1-14.6-2(r)* unless the audited MDS values result in a different RUG-III classification group for that MDS assessment record. The audit findings for all MDS records that are audited on or after October 1, 1999, and determined to be inaccurate, shall be incorporated into the

⁵ See *405 IAC 1-14.6-4(k)* for an explanation of when the scope of the MDS audit is expanded to include all facility residents.

⁶ The time-weighted guidelines are followed for purposes of calculating the number of calendar days each MDS record remains effective. The time-weighted guidelines have been published by the OMPP to all Medicaid certified nursing facilities in a memorandum dated July 1, 1999, and may be updated by the OMPP as needed. See also *405 IAC 1-14.6-9(e)*.

MDS database used by Myers and Stauffer to classify each resident. This process will reclassify each resident into one of the 44 RUG-III groups. Once each resident is reclassified, the CMI's for Medicaid residents and all residents are established pursuant to 405 IAC 1-14.6-7(e), which are then used for case mix rate setting purposes.

Once a case mix rate is established that includes the MDS audit findings, in addition to questioning rate setting issues, the facility can request a formal rate reconsideration raising MDS audit issues with which they disagree.⁷ The formal reconsideration request for rate setting and MDS audit issues should be sent to Myers and Stauffer within 45 days after release of the Medicaid rate by Myers and Stauffer. Myers and Stauffer will then coordinate the MDS audit issues with EDS and issue a written response to all issues raised within 45 days after receipt of the formal rate reconsideration request. If the formal reconsideration results in a recalculation of the previously established Medicaid rate due to MDS audit or rate setting issues, Myers and Stauffer will reissue the Medicaid rate following the completion of the reconsideration process. Revised MDS audit workpapers will be provided in order to document any changes in MDS audit findings that result from the reconsideration process. If the facility disagrees with any determination resulting from the formal reconsideration process, the facility may then appeal that determination pursuant to *Indiana Code 4-21.5-3-7* and *405 IAC 1-1.5*.

Application of Corrective Remedies

As provided in OMPP's case mix rules, after the conclusion of the audit, the percent of audited MDS records that are determined to be either inaccurate or untimely will be computed. For facility MDS audits begun by EDS on or after October 1, 1999, a corrective remedy will apply if the number of inaccurate or untimely MDS records exceeds the 50 percent threshold.⁸ The corrective remedy will be applied when the scope of the MDS audit was expanded to include all residents.⁹ MDS audits that are begun prior to October 1, 1999, will not result in the application of any corrective remedies.

⁷ See *405 IAC 1-14.6-22(c)*

⁸ See *405 IAC 1-14.6-4(k)(6)*. Beginning October 1, 1999, the threshold percentage for determining whether a corrective remedy shall be applied is 50 percent; beginning January 1, 2001, the threshold percentage is reduced to 35 percent; and beginning April 1, 2002, the threshold percentage is further reduced to 20 percent.

⁹ See *405 IAC 1-14.6-4(k)(2)* for an explanation of when the scope of the MDS audit is expanded to include all residents.

The corrective remedy will be applied by reducing the administrative component portion of the Medicaid rate by five percent.¹⁰ The corrective remedy will take effect beginning on the calendar quarter following the completion of the MDS audit, and shall remain in effect for one quarter. For example, if an MDS audit beginning October 4, 1999, is concluded on November 30, 1999, and the audit finds that 51 percent of the audited MDS records are inaccurate, then a corrective remedy will be applied beginning January 1, 2000. The corrective remedy will remain in effect for one calendar quarter. Alternatively, if that same MDS audit was concluded with the same results on January 10, 2000, then a corrective remedy will be applied for the Medicaid rate quarter beginning April 1, 2000. Any reimbursement lost due to the corrective remedy is not recoverable by the facility.

Additional Information

If you have any questions about the MDS audit process, please contact the EDS Long Term Care Unit at (317) 488-5099.

¹⁰ See 405 IAC 1-14.6-4(k)(6). Beginning October 1, 1999, the corrective remedy percentage that will be applied to reduce the administrative rate component is five percent; beginning January 1, 2001, the corrective remedy percentage is increased to 10 percent; and beginning April 1, 2002, the corrective remedy percentage is further increased to 15 percent.