QIO - Minimum Data Set Validation Review Process

Purpose:

The Minimum Data Set (MDS) is a standardized, core set of screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare and Medicaid. The MDS contains items that measure physical, psychological, and psycho-social functioning. The items in the MDS give a multidimensional view of the patient's functional capacities and provide a standardized communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. The MDS plays a key role in the Medicare and Medicaid reimbursement system and monitoring the quality of care provided to nursing facility (NF) residents.

As part of the MDS validation review process, qualified and trained professionals from QIO Services conduct a review of the following key components:

- Resource Utilization Group (RUG) classification: MDS validation verifies the correct RUG classification of the resident by reviewing the coding accuracy of the MDS. The validation process identifies MDS items coded in error or omitted MDS items.
- Resident Assessment Instrument (RAI) is a federally mandated standardized approach for interdisciplinary assessing, planning, and providing individualized care.
- Case mix index (CMI) is a numerical weight assignment based on the RUGs within a NF population. Validation of the MDS ensures the RUGs assigned and the resulting CMI and NF reimbursement is correct.

The QIO provides recommendations to improve documentation when inconsistencies are identified between the medical record documentation and MDS validation.

The QIO provides education to help reduce future errors and increase the accuracy of MDS coding. This occurs during the exit interview between the review coordinator (RC) and the NF staff, i.e., director of nursing (DON), assistant director of nursing (ADON), MDS coordinator, and/or administrator.

Identification of Roles:

RC – performs annual MDS validation reviews on a 25 percent random sample (or minimum of 5 records available) of Medicaid residents in 25 percent of Iowa NFs. Communicates MDS validation review outcomes and quality assurance (QA) tasks to the NF.

Program specialist (PS) – updates the MDS tracking tool with batches of NFs to be reviewed. Provides RC with sample of NF residents and collects the outcome data of MDS validation and quality assurance reviews for reporting.

Manager – provides a quarterly report of MDS validation review activity and findings.

Performance Standards:

QIO Services must conduct annual MDS validation reviews on a minimum of 25 percent of Medicaid-eligible residents (or a minimum of 5 records) in 25 percent of the current Iowa certified nursing facilities. Each Medicaid certified NF is reviewed at least once every 4 years. The review will ensure a minimum inter-rater reliability of 95 percent.

Path of Business Procedures:

MDS Review Scheduling and Record Selection

The MDS validation review may be conducted remotely as a desk review or onsite, if deemed necessary, based on the complexity and professional opinion of the reviewer.

MDS assessment records from the specified timeframe are obtained by the QIO from Quality Improvement and Evaluation System (QIES) for the MDS validation review process. The RUG grouper abstracts information from 109 MDS fields to assign a RUG category. These fields are reviewed to validate the accuracy of the predefined RUG. When possible, a sample shall include representative from each RUG category.

Step 1: PS will pull all residents from each facility in the sample and and upload the data to the MDS validation tracking system.

Step 2: Manager and technical staff assign the NFs to RCs.

Step 3: RC calls the NF and requests the name of a contact who can serve as a resource during the review process.

Step 4: RC explains the review process to the NF contact and selects the names of the residents to be reviewed for MDS validation.

Step 5: RC will use RUG III classification scheme that identifies a resident in one of the RUGs III 34-Grouper.

MDS Validation Review Process

See Attachment 1.

Validation of the sampling is performed to ensure consistency and accuracy of the MDS which results in the most accurate CMI and reimbursement to the NF.

Step 1: After the residents have been selected, the RC requests documentation from the resident's medical record and/or remote access to facility's EHR for the MDS validation review. Thinned records or documentation maintained outside the medical record may be requested to support the MDS coding.

Step 2: In addition to the MDS validation process review, a NF QA review is completed on the same sample. Attachment 2 details the NF QA questions researched from medical record review. HHS may choose a different category of concern for the NF QA process at any time.

Step 3: RC will use the documentation provided by the NF to validate MDS coding, such as restorative documentation, nurse aide documentation, tracking tools, interdisciplinary summaries, and physician documentation. A copy of the PASRR will be requested for the selected residents.

Step 4: RC will complete the MDS validation tracking system using data from the resident's documentation and conversations with facility employees.

Step 5: If documentation cannot be located to support MDS coding, RC will discuss this with the NF contact person and additional information will be requested.

Step 6: If documentation for the MDS field does not substantiate MDS coding or conflicting documentation is identified, a checkmark is entered to the MDS findings column, and a brief explanation for the discrepancy is added to the comments section.

Step 7: The RC organizes the data to be discussed during the exit conference after performing MDS validation on all required records.

Step 8: RC contacts the NF when the validation review has been completed to schedule an exit conference. The NF will be advised to invite any facility staff who are interested in attending the exit conference, such as the DON, ADON, MDS coordinator, and/or administrator.

Step 9: RC creates the exit conference report that includes the MDS validation report letter, identified inconsistencies, and the NF QA report.

Step 10: During the exit conference, RC will discuss findings and provide recommendations to improve inconsistencies identified between the medical review and the MDS validation. RC provides education to help reduce future errors and increase the accuracy of MDS coding and answers questions from NF staff.

Step 11: Information given during the exit conference is provided to the NF staff for educational purposes. RC will suggest the NF follow the RAI manual guidelines in Chapter 5 to correct any inconsistencies identified.

Step 12: RC will obtain the names of all NF staff attending exit conference and inform that a MDS validation report letter, identified inconsistencies, and the NF QA report will be emailed to the NF administrative staff within 10 calendar days from the exit conference.

Step 13: Any facility noted to have greater than a 25 percent error rate in their MDS validation will be notified of the error rate by the RC during the exit conference and the RC must repeat a MDS validation review in 6 months with the NF.

Step 14: If the facility staff have specific RAI questions that the RC cannot answer, they are referred to the RAI coordinator at the Department of Inspection and Appeals.

Step 15 Any MDS automation questions are referred to an MDS automation education specialist.

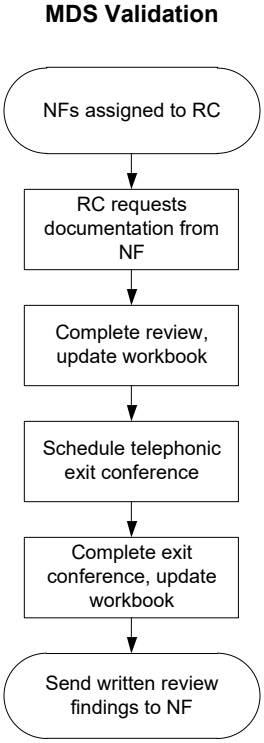
Step 16: Manager submits activities and findings from the MDS tracking system for inclusion in the QIO monthly report to HHS.

Forms/Reports:

NA

Attachments:

Attachment 1: MDS Validation flowchart



Attachment 2: Nursing Facility Quality Tool

MEDICAL SERVICE - NURSING FACILITY QUALITY TOOL

Key
A1. Was a PASRR completed prior to or on the day of admission if admitted after 2012?
A2. If not, how long was facility out of compliance?
B1. Is the PASRR currently up to date?
B2. If not, how long is the facility out of compliance?
C1. Is PASRR level II care plan up to date? Does the PASRR level II care plan identify the following criteria?
C2. Who provides services?
C3. Start of services?
C4. Frequency of services?
C5. Duration of services?

Care Plan
D1. Behaviors are identified on the care plan, if applicable
D2. High risk of skin breakdown is identified on the care plan, if applicable
D3. High risk for falls is identified on the care plan, if applicable