

SECTION VII

UTILIZATION MANAGEMENT REVIEW PROCESS

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A. General Background

The Utilization Management Review (UMR) Program fulfills the requirement of the Social Security Act that states monitor unnecessary utilization of services and to assure that payments are consistent with efficiency and economy. The UMR Program is headquartered in Harrisburg, Pennsylvania, in the Bureau of Long Term Care (LTC) Programs under the Division of LTC Provider Services. The UMR Area Field Offices are located throughout the Commonwealth. These offices are staffed by UMR representatives with nursing, social services and financial backgrounds. Their task is to ensure that nursing facilities enrolled in the Medical Assistance (MA) Program comply with applicable state and federal regulations.

Reorganization of the UMR process has been ongoing with numerous changes since October 1998. After a period of reviews and revisions, implementation of the new concepts started in February 2000 with the Financial component. The MDS component was implemented in July 2000 and the Preadmission Screening Review and Evaluation component in October 2000.

Prior to July 2000, UMRs were conducted annually. Currently, each nursing facility is reviewed quarterly and more frequently if needed. This increases awareness of the need and opportunities for technical assistance as well as direct contact with the nursing facility.

The UMR process includes the Financial Review, MDS Review, and the Preadmission Screening Review and Evaluation. In addition, the UMR includes evaluating the resident's continued need for nursing facility services.

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B. Explanation of Forms and Terms used in the UMR Section

Admissions Notice Packet - The packet given to all nursing facility residents upon admission regardless of payment source as required by Federal law 42 U.S.C. § 1396r(c)(1)(B) and (e)(6). It contains the "Notice of Rights of Nursing Facility Residents", "Resource Assessment Form" and "Protecting your Spouse's Resources".

Aging Report - A listing that displays the age of a nursing facility's outstanding accounts receivable balances. Balances may include overpayments and/or inaccurate accounts.

Annual Facility Baseline MDS Review - A review completed in the first quarter of the fiscal year for every nursing facility to establish a baseline for MDS activities during the following year. Includes a review of the February 1 Picture Date MA and non-MA Case Mix Index Reports, and 15 MDS Verification Profiles.

Billing Census - A monthly report that accounts for each nursing facility resident's daily payor source and status (e.g., in-house, hospitalized, therapeutic leave or discharge).

Case Mix - The mix of residents, MA and Non-MA, cared for in a nursing facility at any given time.

Case Mix Index (CMI) - A number value score that describes the relative resource use for the average resident in each of the groups under the Resource Utilization Group, Version III (RUG-III) classification system based on the assessed needs of the resident (55 Pa. Code § 1187.2). For MA, the Pennsylvania Normalized Nursing Only Case Mix Indexes detailed in the 1187 regulations are used. For Medicare, CMI sets are issued in federal regulation and available on the web site for The Centers for Medicare and Medicaid Services/MDS (www.hcfa.gov/medicaid/mds20).

Case Mix Index (CMI) Report - A report generated by the State Database after a Picture Date, detailing the residents in the facility on the Picture Date, their MA for MA Case Mix status, the most recent appropriate comprehensive assessment (MDS Section AA8a = 01, 02, 03; AA8b = 1-5, 7, 8), sequence number (MDS Section AT1), Resource Utilization Group (RUG) classification and CMI. The Nursing Home Administrator or designee signs the certification page for the report that accurately reflects the population of the nursing facility on the Picture Date.

Centers for Medicare and Medicaid Services, The (CMS) - Federal agency located in the U.S. Department of Health and Human Services that administers Medicare and Medicaid. Prior to June 14, 2001, was known as Health Care Financing Administration (HCFA).

Claim Adjustment - The method by which the nursing facility corrects an inaccurate bill paid by MA.

Corrective Action Plan - A nursing facility's response to UMR's findings.

Department of Public Welfare (Department) - The Commonwealth agency designated as the single state agency responsible for the administration of the Commonwealth's MA Program (55 Pa. Code § 1187.2).

Exceptional Admission - An applicant or resident that is identified as meeting Target criteria on the Pennsylvania Preadmission Screening Resident Review Identification Form (PA-PASRR-ID) and additional criteria that will allow the individual to enter the nursing facility without further evaluation for a specific period of time.

MA for MA Case Mix - The resident is considered to be MA for MA Case Mix only if the day of care is paid 100% by MA or is paid partially by MA combined with resident pay and/or third party pay other than Medicare Part A to equal 100%. The resident must have a valid MA Recipient Number and a current MA Nursing Facility Effective Date from the "Notice to Applicant". MA for MA Case Mix is identified on the MDS Section S by a response of '1' in Section S1d.

MA Status Change Report - A computer generated report from the State Database listing MDS Tracking Forms submitted over the defined time period for selected residents. Used by the UMR Representative to assess for accurate completion of tracking forms, accurate identification of MA for MA Case Mix Status and appropriate use of Medicare benefits.

Medicare - A health insurance program for people age 65 and over, for individuals with permanent kidney failure and for certain people with disabilities that is administered by CMS under provisions of Title XVIII of the Social Security Act. This insurance for the aged and disabled is funded by the federal government and individual insurance premiums paid by the insured.

MDS Verification Profile - An electronic printout of MDS data submitted to the State Database for use by the UMR Program to verify accuracy of the MDS submission.

Minimum Data Set (MDS) - A set of forms and processes mandated by CMS to be used to assess every nursing facility resident. Version 2.0, September 2000, with the Optional RUG-III quarterly 1997 Update Correction Request form and the State-specific Section S is required in Pennsylvania. Section T is required only for Medicare

assessments (MDS Section AA8b = 1 - 5, 7, 8).

Omnibus Budget Reconciliation Act of 1987 Nursing Home Reform Act (OBRA - 87) - In 1987, Congress enacted major nursing home reform legislation that affected all nursing facilities participating in the MA Program. These provisions were addressed in the Pennsylvania Bulletin, Volume 18, Number 52, on December 24, 1988, and MA Bulletin 1181-88-08, issued December 28, 1988.

OPTIONS - A program of the Area Agency on Aging (AAA) that is responsible for providing options to individuals in the community when they require assistance with care. OPTIONS assesses the need for nursing facility services in light of the condition of the individual involved in the assessment and of the alternative available for the care of that individual in the community. OPTIONS is responsible for completion of the Preadmission Screening Review and Evaluation on Targets prior to seeking nursing facility placement. In addition, this program is responsible for evaluating nursing facility eligibility when individuals apply for MA funding.

OPTIONS Determination Report - A report completed by OPTIONS on an individual applying for MA payment for nursing facility services. OPTIONS will forward their determination to the applicant. The OPTIONS Determination Report is also known as the OPTIONS Preadmission Level II Client Determination Report.

Patient Pay Amount - The amount of money a MA resident is responsible to pay toward the cost of their nursing facility care, as determined by the County Assistance Office (CAO).

Pennsylvania Preadmission Screening Resident Review Identification Form (PA-PASRR-ID) - Screening tool by which all new admissions, regardless of payor source, are determined to meet or not meet criteria for Mental Retardation (MR), Mental Illness (MI), or Other Related Conditions (ORC), for admission to a Pennsylvania nursing facility that participates in the MA Program.

Personal Care Account - Interest bearing account(s) established by a nursing facility for the management of resident funds and used by the resident.

Picture Date - The first calendar day of the second month of each calendar quarter (55 Pa. Code § 1187.2). A "snapshot" of residents in Pennsylvania nursing facilities participating in the MA Program is taken for rate-setting purposes. For the February 1 Picture Date, assessments for both MA for MA Case Mix and non-MA residents are used. For May 1, August 1, and November 1 Picture Dates, only assessments for residents who are MA for MA Case Mix on the Picture Date are used on the CMI report.

Program Office(s) - These offices are the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS), the Pennsylvania Office of Mental Retardation (OMR), and the Pennsylvania Office of Social Programs (OSP).

Program Office Letter of Determination - Notification to the resident, resident's family, and the nursing facility of the determination for nursing facility services and specialized services for all Target residents. The letter informs all interested parties of the appeal process, if there is disagreement with the Program Office determination.

Remittance Advice - An explanation of the actions taken and the status of claims and claim adjustments processed by payor sources.

Resource Utilization Group Version III (RUG-III) - A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs (55 Pa. Code § 1187.2). Pennsylvania MA uses version 5.01, 44 group. Medicare uses version 5.12b, 44 group.

Specialized Services - Services provided by the appropriate Program Office to the Target resident above and beyond what the nursing facility can provide. The Program Office is responsible for developing, implementing, and monitoring a Specialized Services OBRA Plan of Care.

State Database - A collective term referring to two different systems: CMS MDS data collection system and the Pennsylvania Nursing Facility Information System.

Target Diagnosis - Any diagnosis that would or could identify an individual as meeting criteria for MI, MR, or ORC.

Target Resident - An individual that has a target diagnosis, screened through the PA-PASRR-ID, and meets the appropriate criteria listed on the PA-PASSR-ID.

Target Resident Reporting Form - The designated nursing facility reporting form used to notify the Department regarding the status of Target residents.

Technical Assistance - Training or other educational assistance provided by the UMR Representative to assist the nursing facility in complying with UMR requirements. The type of assistance provided is determined by the results of prior facility reviews or facility request.

Utilization Management Review (UMR) - A review conducted by the Department of Public Welfare's medical and other professional personnel to monitor the accuracy and appropriateness of payments to nursing facilities and to determine the necessity for continued stay of residents (55 Pa. Code § 1187.2).

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C. UMR and Nursing Facility

The UMR is responsible to determine nursing facility compliance with applicable state and federal regulations. In addition, UMR representatives investigate complaints brought to the attention of the Department. They refer "Quality Assurance" observations/complaints, issues relating to resident's rights and violations, and fiscal problems to the appropriate agency. They defend UMR findings, recommendations, and corrective actions at hearings.

In most instances, UMR will notify the nursing facility of upcoming reviews and the time period of records to be reviewed. The nursing facility must cooperate with reviews conducted by UMR and furnish resident records upon request. The UMR staff should be provided with a sufficient workspace with adequate ventilation, lighting and a telephone. In addition, the UMR staff may need to access a dedicated phone line.

At the beginning of each review, the UMR representatives will meet with the nursing facility staff for an Entrance Conference to explain the review process and discuss previous review findings. The review ends with an Exit Conference. During this conference, the UMR representative presents review findings and discusses corrective actions. The nursing facility is required to develop and implement a Corrective Action Plan on areas of noncompliance. UMR reviews and approves the nursing facility's Corrective Action Plan and monitors implementation. UMR provides technical assistance to the nursing facility based on review findings or at the request of the nursing facility.

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D. Types of Reviews

1. Financial Review

a. Background

This review examines the record keeping and billing practices associated with the financial management of MA accounts. The UMR Representative/Financial Representative reviews the MA billing and Personal Care Accounts of MA residents.

b. Purpose

The Financial Review ensures proper utilization of MA expenditures by reviewing billing, collections and disbursement functions for accuracy and compliance with state and federal regulations (Title XIX of the Social Security Act and the Pennsylvania Code, 55 Pa. Code, Chapters 1101 and 1187). This process identifies billing discrepancies which result in claim adjustments and/or fund recovery.

c. Responsibilities of Nursing Facilities

NOTE: The following is not inclusive of all responsibilities of nursing facilities participating in the MA program.

1. Assure that an MA applicant has been approved for nursing facility services and the OPTIONS Determination Report is available upon admission and placed in the resident's record.
2. Assure the presence of the attending physician's initial certification and continued recertification of the MA resident's need for nursing facility services.
3. Assure that all residents utilize Medicare or other insurance before payment is made by MA. MA is the payor of last resort.
4. Assure that the Department is invoiced in accordance with regulations. This includes Medicare and private insurance since MA is the payor of last resort.
5. Retain supporting documentation for all drug, insurance premiums, and Other Medical Expense deductions.
6. Complete claim adjustments and submit recovered funds promptly to the Department.
7. Notify the Department, using forms designated by the Department, when MA residents are admitted, expired, converted to MA, or no longer need the services provided by the nursing facility.
8. Assure that all MA resident records are retained for a period of at least four years.
9. Assure that the person(s) responsible for billing is promptly notified of admissions, discharges, hospitalizations, therapeutic leave and other matters that impact payment.
10. Assure that a bed is available for a resident on return from a hospitalization or a leave of absence, in accordance with regulations.
11. Notify each MA resident in writing of the services covered under MA.
12. Provide the resident with an easily understood monthly statement of itemized deductions from the Personal Care Account.

d. Functions of the UMR Program

NOTE: The following is not inclusive of all functions of the UMR Program.

1. Verify resident's MA eligibility and patient pay amount.
2. Determine if the nursing facility has billed MA for the correct dates of service, hospital days and coinsurance days, and that MA is the payor of last resort.
3. Verify deductions from the gross patient pay by reviewing supporting documentation for all deductions.
4. Verify resident eligibility for MA covered services provided.
5. Review if Medicare and/or other insurance coverage is applied for and used as appropriate.
6. Review the Aging Report (Accounts Receivable) to determine if MA resident accounts have a credit balance.
7. Review the MA Status Change Report and Billing Census to verify that the Billing Census coincides with the information the nursing facility submitted to the State Database.
8. Process claim adjustments and/or recover funds when incorrect payment is made by MA.
9. Review the nursing facility's management of Personal Care Accounts. Verify the resident is not improperly billed for MA covered services. When necessary, initiate referral to the

appropriate agency.

10. Report suspected fraud to the appropriate agency.
11. Act as a channel for information exchange between the state and county offices and the nursing facility.

2. Minimum Data Set Review

a. Background

In 1989, the Centers for Medicaid and Medicare Services (CMS), formerly Health Care Financing Administration (HCFA), funded a study that resulted in the development of the Resource Utilization Group (RUG), Version III, Classification System. This system classifies residents by the resources they use in the facility.

The classification system is dependent on a resident assessment process which accurately measures the functional level, conditions present and services required by the resident. The Long Term Care Resident Assessment Instrument has been used in Pennsylvania since 1990. Using selected items from the MDS and RUG-III, Version 5.01, each resident is placed in a RUG category.

In Pennsylvania, resident classification is a step in the Case Mix Payment System. "Case Mix" refers to the mix of residents cared for in a nursing facility at any given time. The CMI is a number value score that describes the relative resource use for the average resident in each of the groups under the RUG-III classification system based on the assessed needs of the resident (55 Pa. Code § 1187.2). The Pennsylvania Normalized Nursing Only Case Mix Indexes with Index Maximization are used in this system.

A Case Mix Payment System systematically links the amount paid to the facility for the types of residents served. The more extensive the services and the greater the need, the higher the CMI incorporated in the payment rate. Pennsylvania's reimbursement system is based on a single facility rate established annually and adjusted quarterly by the CMI.

In 1996, the UMR initiated reviews of the resident's MDS to verify the accuracy of the RUG element responses submitted to the State Database by MA participating nursing facilities. Beginning July 2000, the MDS process expanded to include technical assistance dictated by review outcomes and/or facility request. The UMR Representatives will assist the nursing facility in achieving compliance with applicable regulations through more frequent contacts and reviews.

b. Purpose

To assure the nursing facility's clinical records are current, accurate and in sufficient detail to support the MDS data submitted to the State Database.

c. Responsibilities of Nursing Facilities

NOTE: The following is not inclusive of all responsibilities of nursing facilities participating in the MA Program.

1. Assure that the MDS data for each resident accurately describes the resident's condition as documented in the resident's record.
2. Assure that the MA for MA Case Mix Status is accurately reported.
3. Assure that the CMI Report submitted to the state is accurate for the Picture Date.

d. Functions of the UMR Program

NOTE: The following is not inclusive of all functions of the UMR Program.

1. Complete an Annual Baseline MDS Review in the first fiscal quarter (July, August, and September) to establish a basis to monitor progress in future reviews.

2. Review the MDS Verification Profiles to verify that the nursing facility submitted the data accurately to the State Database.
3. Verify that supporting documentation is present and timely for the MDS items selected for review.
4. Review the CMI Report to verify that the MA for MA Case Mix Status of all residents is reported correctly for the Picture Date.
5. Conduct a follow-up review in the third fiscal quarter (January, February, and March).

3. Preadmission Screening Review and Evaluation

a. Background

In 1987, Congress enacted major nursing home reform legislation that affected all nursing facilities participating in the MA Program as part of the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA '87). These provisions were addressed in the Pennsylvania Bulletin (Volume 18, Number 52, issued December 24, 1988) and the MA Bulletin (Number 1181-88-08, issued December 28, 1988).

One of the requirements of OBRA '87 was for each state to implement a preadmission screening program by January 1, 1989. The screening program applies to all individuals who seek admission to an MA certified nursing facility, regardless of receiving or applying for MA. The purpose of screening, based on the criteria established by CMS, formerly HCFA, is to determine whether individuals who are mentally ill, mentally retarded or have other related conditions require nursing facility services and if they require specialized services to treat their conditions.

The Pennsylvania Preadmission Screening Resident Review Identification form (PA-PASRR-ID) must be completed on all individuals, regardless of payment status, seeking admission to a nursing facility. It is important that the PA-PASRR-ID be completed before admission and not later than the day of admission. If the applicant is unable to answer the questions, anyone who is knowledgeable about the applicant's medical condition and history (e.g., family members, legal representative, or member of health care team) can complete the form. NURSING FACILITIES are responsible for the accuracy of information reported on this form. Nursing facilities are not required to complete a new PA-PASRR-ID for residents readmitted from an acute care hospital unless there is a Change in Condition that affects their Target Status. The most recently revised PA-PASRR-ID was issued July 1, 1999.

Federal regulations require that residents of nursing facilities, regardless of payment source, be provided certain information. This information is distributed through the Admissions Notice Packet.

b. Purpose

To assure that the nursing facility completes the preadmission screening on all individuals regardless of payor status. To assure the nursing facility has informed the resident and family (or responsible party) of their rights and financial options while the individual is residing in a nursing facility.

c. Responsibilities of Nursing Facilities

NOTE: The following is not inclusive of all responsibilities of nursing facilities participating in the MA Program.

1. Assure that an MA applicant has been approved for nursing facility services and the OPTIONS Determination Report is available upon admission and placed in the resident's record.
2. Assure that all residents before admission (not later than the day of admission) possess a current, complete, and accurate PA-PASRR-ID.
3. If the individual is identified prior to admission as a Target on the PA-PASRR-ID, refer the individual to OPTIONS for further evaluation and final determination by the Program Office. The nursing facility must not admit the individual without a Program Office Letter of Determination from the appropriate Program Office.

4. Complete a new PA-PASRR-ID on all residents who have a Change in Condition or diagnosis that affects their Target Status. This change must be reported to the Department accurately and timely.
5. Assure that a copy of the PA-PASRR-ID accompanies the resident when transferring to another nursing facility. If the resident is a Target, also forward a copy of the Program Office Letter of Determination.
6. Report the status of Targets to the Department accurately and timely for:
 - New Admission.
 - Exceptional Admission.
 - Transfer.
 - Change in Condition.
 - Discharge.
 - Expired.
 - Unreported.
7. Assure that a Program Office Letter of Determination(s) is on the record of each Target resident.
8. Assure that the resident receives specialized services when the Program Office determines that a Target resident would benefit from them.
9. Provide an Admissions Notice Packet to all residents upon admission, regardless of payor source. Retain signed receipts (first page of packet) in a folder until the UMR Representative reviews them.

d. Functions of the UMR Program

NOTE: The following is not inclusive of all functions of the UMR Program.

1. Review the PA-PASRR-ID on all selected records for timeliness, correctness, and completeness.
2. Review the Target Resident Reporting form for accuracy.
3. Assure that all Target resident records have a Program Office Letter of Determination from the appropriate Program Office.
4. Perform Resident Reviews.
5. Make recommendations to the Program Office(s) regarding the need for nursing facility and specialized services for Target residents.
6. Notify the Program Offices of deaths, discharges and transfers of Target residents.
7. Assure that all new residents admitted since the last review have received the Admissions Notice Packet.

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E. Technical Assistance

Technical assistance is training or other educational assistance that the UMR representative provides to the nursing facility. It may be provided based upon the results of UMR findings or be requested by the nursing facility. The goal is to help the nursing facility achieve compliance with applicable regulations. Technical assistance may be provided at a time other than during the review.