OFFICE OF INSPECTOR GENERAL
UTILIZATION REVIEW PROCESS FOR NURSING FACILITIES

The following provides general guidance and information regarding the utilization review process for nursing facilities. The information provided is not for the purpose of legal advice and is not intended to be exhaustive, comprehensive, or to identify all applicable state and federal laws and regulations. Nursing facilities remain responsible for and must comply with all applicable requirements of state and federal laws and regulations.

FEDERAL REQUIREMENTS
The Social Security Act\(^1\) is a federal law that regulates nursing facilities that participate in the Medicare and/or Medicaid programs\(^2\) and requires a Medicaid program to have processes in place to safeguard against unnecessary utilization of care and services. Federal law also requires states to ensure that nursing facilities meet the Medicaid requirements and contains requirements on quality of care, resident assessment, and care planning, including the mandatory use of the Resident Assessment Instrument (RAI) to assist in assessment and care planning.\(^3\) A nursing facility is required to conduct a comprehensive assessment of each resident’s functional capacity.\(^4\) Nursing facilities must comply with the federal requirements to receive payment under the Medicare or Medicaid programs.\(^5\)

STATE REQUIREMENTS
Texas Department of Aging and Disability Services
The Texas Department of Aging and Disability Services (DADS) is the state agency that licenses long-term care/nursing facilities. DADS also certifies nursing facilities for participation in the Medicaid program.\(^6\) A nursing facility must make a comprehensive assessment of a resident’s needs, using the RAI specified by the State.\(^7\) Assessments are conducted using an Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS). Requirements for completing the MDS are derived from the RAI. MDS assessments establish a Resource Utilization Group (RUG) which determines the rate at which the Texas Medicaid program pays a nursing facility for care provided to the resident.\(^8\)

\(^1\) 42 USC § 1396a (State plans for medical assistance).
\(^2\) 42 USC § 1396r (Requirements for nursing facilities).
\(^3\) See 42 CFR, Part 483 (The Omnibus Budget Reconciliation Act of 1987).
\(^4\) 42 USC § 1396r; 42 CFR § 483.20(b) (Resident Assessment).
\(^5\) 42 CFR Part 483, Subpart B (Requirements for Long Term Care Facilities).
\(^7\) 42 CFR § 483.20(b).
\(^8\) 1 TAC § 371.214(l).
Office of Inspector General

The Office of Inspector General (OIG) is a division of the Texas Health and Human Services Commission and is responsible for the prevention and investigation of fraud, waste, and abuse in Texas health and human services programs. OIG has authority to “audit the use and effectiveness of state or federal funds” and has adopted rules regarding utilization review of nursing facilities.

In addition, licensure and training requirements of the Registered Nurse Assessment Coordinator (RNAC) must be current. When a form is submitted for Medicaid reimbursement, the license on the Long-term Care Medicaid Information form is matched with the completed RUG-III training license submitted to Texas Medicaid claims administrator. When utilization review identifies a delinquent registered nurse (RN) license or untrained RNAC, the MDS form(s) may be invalidated resulting in monetary recoupment. OIG may invalidate an MDS form when the facility has not implemented and maintained an information technology policy that addresses the security of electronic health records and electronic signatures.

Onsite Review

The onsite review begins when an OIG nurse reviewer (reviewer) arrives at the facility unannounced and presents an entrance letter to the nursing facility (facility). The letter will inform the facility of the purpose of the visit and the requirement that the facility must provide access to requested clinical records and resources within two hours of the reviewer’s entrance to the facility. In order to conduct the onsite review, the reviewer will need a private room to review records, access to electronic or paper clinical records which does not interfere with facility work flow, and an identified staff member to assist with the review.

OIG conducts an onsite review of a statistically valid random sample of MDS forms submitted by the facility for reimbursement. This sample is based on a population of paid claims along with the related RUG classifications and assessment claim forms. OIG reviews residents’ clinical records to validate the coding of the MDS assessment. Coded items on the MDS assessment submitted for Medicaid reimbursement must be supported by documentation in the resident’s clinical record. Inconsistent and unsupported findings will not be validated by OIG and may result in an adjustment in the RUG-III classification. Lack of documentation to validate the items claimed on the MDS assessment may be the basis for an error and a RUG reclassification.

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9 Tex. Gov’t Code § 531.102(h)(4).
11 1 TAC § 371.214(n)(2).
12 See 1 TAC §§ 371.214(l) and (m).
13 1 TAC § 371.212(a)(3).
14 1 TAC § 371.212(a)(2).
15 1 TAC § 371.214(n)(2)|D|ii).
During the review, when the reviewer identifies an item coded on the assessment that cannot be substantiated or does not accurately reflect the resident’s status during the applicable look back period, the reviewer will notify facility staff and may request supporting documentation. The facility must provide the requested supporting documentation during the onsite review period and prior to the onsite exit conference. Any requested documentation not provided prior to the exit conference but known to exist, e.g., stored offsite, will be identified as “Awaiting Documentation” at the onsite exit conference.

The facility may deliver additional documentation to regional offices by close of business the following day. Any documentation provided after the onsite exit conference must be accompanied by a notarized Fact and Records Affidavit.

On-Site and Telephone Exit Conferences
After the onsite review, the reviewer conducts an onsite exit conference, which consists of meeting with facility staff to discuss and provide written notification of the results and findings of the onsite review. This written notification is the Preliminary Statement of Findings. Nursing facility representatives participating in the onsite exit conference and reviewers in attendance will be required to sign the Preliminary Statement of Findings.

The reviewer subsequently will schedule a telephone exit conference with facility staff. The conference will usually occur within 5-10 days of the onsite review and after data from the review can be processed. At this telephone exit conference, the reviewer will provide the facility with an estimated RUG adjustment dollar amount and respond to facility questions.

Reconsideration Review
If a facility disagrees with the RUG determination or assessment of errors, the facility may submit a request for reconsideration to OIG. (A facility must request a Reconsideration Review in order to have the right to request a formal appeal.) The reconsideration request must be postmarked on or before the 15th calendar day after the date of the exit conference. OIG will conduct a reconsideration review upon receipt of a written request that includes the following:

- A letter which identifies each assessment error to be reconsidered, describing in detail the reason a reconsideration review is requested for each specified assessment error;
- Copy(ies) of the MDS form(s) to support the RUG(s) claimed;
- Copy(ies) of each signed affidavit executed during the onsite review for which reconsideration is requested;
- Copy of the List of Reviewed Assessments with the RUG change form(s) indicated either by circling or highlighting the items that are being requested for reconsideration; and

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16 1 TAC § 371.214(n)(2)(D)(i).
17 1 TAC § 371.214(n)(3).
18 1 TAC § 371.214(n)(3)(B)(iii).
19 1 TAC § 371.214(q)(2)(A) (if deadline falls on a Sunday or national holiday, request must be postmarked on following business day).
• Copy of the Preliminary Statement of Findings.\(^{20}\)

If these requirements are not met, the reconsideration request will not be granted.\(^{21}\)

A facility may submit additional clinical records along with a timely request for reconsideration review. These additional records must be accompanied by a notarized Fact and Records Affidavit that properly authenticates the documents as true and correct duplicates of business records. This Fact Affidavit must specify:

• Why the records were not produced during the onsite review;
• When the records were obtained;
• Where the records were located;
• Who located the records; and
• The circumstances under which the records were obtained.\(^{22}\)

The OIG reconsideration review is performed by an RN who was not a part of the onsite review. The reconsideration consists of a review of documentation from the onsite review and any additional documentation provided by the facility with the reconsideration request. The weight to be given any supplemental documentation is within the discretion of the OIG reconsideration reviewer.\(^{23}\)

Once the reconsideration review is complete, OIG will prepare a written decision for the requestor. After the reconsideration, any net overpayments from the reconsideration RUG changes will be recouped from the facility and will be reflected in the facility’s Remittance and Status Report. The facility will be reimbursed for any underpayments identified.

If a facility does not request reconsideration, the RUG changes and associated per diem rate from the onsite review remains in effect and becomes final. OIG will submit the RUG changes from the onsite review to DADS for adjustment. The facility’s Remittance and Status Report will reflect the RUG changes.

**RUG Changes and Error Rate**

An assessment error is a RUG reclassification and may result in an overpayment or underpayment of an MDS assessment claim.\(^{24}\) OIG will recover from the facility any overpayment associated with an MDS assessment claim. The facility will be reimbursed for any underpayments identified.\(^{25}\) To calculate overpayments, OIG may extrapolate to the population and the extrapolation will be applied only to the RUG classifications found in error.\(^{26}\) When the adjustments are finalized, the OIG will provide a final notification which includes the facility’s actual error rate.

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\(^{20}\) 1 TAC § 371.214(q).

\(^{21}\) 1 TAC § 371.214(q)(2)(B).

\(^{22}\) 1 TAC § 371.214(q)(4).

\(^{23}\) Id.

\(^{24}\) 1 TAC § 371.214(r)(2).

\(^{25}\) 1 TAC § 371.214(r)(2)(C)(i).

\(^{26}\) 1 TAC § 371.214(r)(2)(C)(ii).
If a facility requests a reconsideration review, the assessment error rate will be based on the results of the reconsideration review. If the facility does not timely request reconsideration, the assessment error rate will be based on the results of the onsite review. If a facility has an error rate greater than 25% or is suspected of a program violation, the facility will be referred to the OIG Medicaid Program Integrity (MPI) Division for investigation.

### Appeals Process

If the facility disagrees with the results of the reconsideration review, the facility may request a formal appeal to HHSC Appeals Division. (Since the appeal is based on the results of the reconsideration review, an appeal will only be granted if the facility requested a reconsideration review.) The RUG changes and associated per diem rate from the reconsideration determination remain in effect during the appeal.

A request for an appeal must be in writing and addressed to:

Director, Appeals Division (MC W-613)  
Texas Health and Human Services Commission  
P. O. Box 149030  
Austin, TX 78714-9030.

The HHSC Appeals Division will docket the request, and DADS will be informed that an appeal has been requested. At that time, DADS will assign an attorney to handle the case and will contact and communicate with the facility, the relevant party (or parties) to the contract, or the representing attorney, if applicable. The hearing will be conducted by State Office of Administrative Hearings (SOAH). After a formal hearing, a proposal for decision (PFD) will be provided in writing by the SOAH Administrative Law Judge and sent to the facility or its attorney and DADS’ Legal Counsel. If the appeal establishes that a RUG was changed incorrectly, OIG will direct the Texas Medicaid claims administrator to correct the error and will work with DADS’ claims management to implement the appellate decision.

### Waiver of Extrapolation

The Inspector General (IG) may waive the calculation of an overpayment by extrapolation. The IG has the sole discretion to evaluate and determine whether a waiver is warranted. The decision may be based on a number of factors, including the facility's error rate or the actual RUG dollar

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27 1 TAC § 371.214(r)(2)(D).  
28 1 TAC § 371.214(r)(2)(C)(iii).  
29 Hearings will be conducted as outlined in 1 TAC Chapter 357 (http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=1&pt=15&ch=357).  
30 1 TAC § 371.214(q)(6).  
31 1 TAC § 371.214(q)(5).  
32 1 TAC § 371.216(a).  
33 1 TAC § 371.216(c).
amount, and the IG’s decision on the request for waiver is not subject to administrative or judicial review.\textsuperscript{34}

Other Resources

DADS’ website for MDS information: http://www.dads.state.tx.us/providers/MDS/index.cfm


\textsuperscript{34} 1 TAC § 371.216(d).