

Exception Review Tips and Best Practices

- Please note that the tips contained in this document are based on previous Exception Reviews. Information needed to validate PDPM Nursing Component scores may vary depending on reviewer interpretation of the guidelines, and changes to the MDS 3.0 RAI manual.

Rules Related to Exception Reviews

Ohio Administrative Code ([OAC 5160-3-43.4](#)) Nursing Facilities: exception review process

Ohio Revised Code ([ORC 5165.193](#)) Exception review of assessment data

Exception Review Sample

Reviews may be on-site or virtual, and will be communicated to communities upon notification of the review.

Typically, 90% of the initial sample will be Medicaid residents. The other 10% of residents could be another payer source.

Documentation Principles

"The MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues that are relevant for a resident" – RAI Manual

- The MDS must be reproducible
- This can be accomplished through use of multiple tools. There is no mandated format.
- In order to validate a portion of the MDS, documentation must be part of the medical record, and signed/dated per facility policy and CMS standards. Documentation should also be completed during the assessment period, or refer to the assessment period.

Once a provider is notified that they will have an Exception Review, no additional modifications to the documentation will be considered, thus it is critical to perform internal audits routinely to ensure accuracy.

Exception Review Notification

The provider will be notified at least 2 business days in advance of the review. Notification will be by telephone, but frequently by email as well.

Ensure that anyone who answers the phone understands that a call from the Ohio Department of Medicaid or Myers and Stauffer must be communicated to the Administrator and MDS Nurse as soon as possible.

Entrance Conference

The initial sample will be provided, which will include resident names and assessment reference dates.

The following policies are frequently requested. Good practice would be to have them ready in advance of your review: protection of the electronic health record (EHR); mattress policy; master signature log.

What Type of Records are Acceptable?

Electronic or paper records are both acceptable.

Electronic signatures are acceptable.

Only information from the medical record will be accepted.

Please note that if a service was provided outside of the facility (i.e., Dialysis, Chemotherapy, Radiation), a statement that the resident left for treatment will not be enough to validate the record. Proof of treatment from the provider must be present.

Preparing for the Review

The first two records must be presented to the reviewer within 15 minutes after the entrance conference. The remaining records must be provided within 60 minutes after the entrance conference.

Failure to comply with timing guidelines could lead to expansion of the survey.

Determine which quarter will be used for the review.

Use the Ohio Department of Medicaid/Myers and Stauffer case mix report for the quarter to determine who may be in the sample, the score to validate, and the assessment reference date.

Tip: If a folder is created for each resident, either physically or electronically, the reason for inclusion in the Nursing Component category can be determined, and all supporting documentation for the score can be placed in the folder. When the sample is provided by the reviewer, the folders can be used to quickly give the information needed for the review.

Typical Information that will be Requested During the Review

Determine why each resident was categorized into their Nursing Component score.

Using the knowledge of why the resident was categorized, work to gather information that will support every part of the score.

Typically requested for each record:

- ADL supporting documentation
- Copy of section Z signatures
- The care plan related to the Nursing Component Score elements

Supporting Documentation Example for Extensive Services:

- The resident categorized as an ES1 due to isolation for COVID-19 and a Nursing Function Score of 11. The information which should be gathered includes:
 - Evidence that the resident required transmission-based precautions beyond standard precautions.
 - Evidence that the resident was in single room isolation with all services brought to them. The resident must not have been cohorted with another resident. The census alone will not validate that all services were brought to the resident.
 - Evidence of an active diagnosis of COVID-19 (i.e., symptomatic and/or have a positive test)
 - Keep in mind that the information above can be proven with use of the physician orders/MAR and proof of symptoms or a positive test. For example: a nurse signature on an order in the MAR that states, "Single room, droplet precaution isolation, with all services brought to the resident due to a diagnosis of COVID-19."
 - Evidence that the resident's self-care and mobility status (Section GG) was based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. There should be evidence that an interdisciplinary team of clinicians was involved in assessing the resident during the assessment period, and the coding represents the

- resident's usual performance. Many communities use a combination of documentation and a statement to indicate the data collection methods.
- Care Plans for: Respiratory Status, ADLs
- Section Z signatures with dates

Supporting Documentation Example for Special Care High:

- The resident categorized as an HDE2 due to Chronic Obstructive Pulmonary Disorder (COPD), shortness of breath while lying flat, a Nursing Function Score of 4, and a PHQ2-9 score of 12. The information which should be gathered includes:
 - Evidence that the COPD diagnosis was present in the last 60 days and active in the last 7 days from the ARD. This evidence should include a signature within the last 60 days by a physician or extender. Any physician or extender would be acceptable. For example, but not limited to, a nurse practitioner or physician assistant. Also, do not forget other physicians such as a dentist or podiatrist. To prove that the diagnosis was active within 7 days of the ARD, documentation of a treatment or medication related to the diagnosis would be acceptable.
 - Proof of shortness of breath while lying flat during the assessment period, or an intervention was used during the assessment period to prevent shortness of breath while lying flat.
 - Consider use of the physician orders/MAR for proof of shortness of breath. For example: a nurse signature on an order in the MAR that states, "Elevate head of bed to prevent shortness of breath while lying flat due to COPD."
 - Evidence that the resident's self-care and mobility status (Section GG) was based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. There should be evidence that an interdisciplinary team of clinicians was involved in assessing the resident during the assessment period, and the coding represents the resident's usual performance. Many communities use a combination of documentation and a statement to indicate the data collection methods.
 - Proof in the medical record that the resident PHQ2-9 interview was conducted either on the ARD or prior to the ARD within the assessment period.
 - Care Plans for: Respiratory Status, ADLs, Mood/depression
 - Section Z signatures with dates

Supporting Documentation Example for Special Care Low:

- The resident categorized as an LBC1 due to a diagnosis of pneumonia, a fever at 102 degrees, and a Nursing Function Score of 12. The information which should be gathered includes:
 - Evidence that the pneumonia diagnosis was present in the last 60 days and active in the last 7 days from the ARD. This evidence should include a signature within the last 60 days by a physician or extender. Any physician or extender would be acceptable. For example, but not limited to, a nurse practitioner or physician assistant. Also, do not forget other physicians such as a dentist or podiatrist. To prove that the diagnosis was active within 7 days of the ARD, documentation of a treatment or medication related to the diagnosis would be acceptable.
 - Proof of a temperature at least 2.4 degrees from the resident's baseline, within 7 days of the ARD.
 - Evidence that the resident's self-care and mobility status (Section GG) was based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. There should be evidence that an interdisciplinary team of clinicians was involved in assessing the resident during the assessment period, and the coding represents the resident's usual performance. Many communities use a combination of documentation and a statement to indicate the data collection methods.

- Care Plans for: Respiratory Status, ADLs
- Section Z signatures with dates

Supporting Documentation Example for Clinically Complex:

- The resident categorized as a CBC2 due to a diagnosis of hemiplegia, Nursing Function Score of 14, and a PHQ2-9 score of 10. The information which should be gathered includes:
 - Evidence that the hemiplegia diagnosis was present in the last 60 days and active in the last 7 days from the ARD. This evidence should include a signature within the last 60 days by a physician or extender. Any physician or extender would be acceptable. For example, but not limited to, a nurse practitioner or physician assistant. Also, do not forget other physicians such as a dentist or podiatrist. To prove that the diagnosis was active within 7 days of the ARD, documentation of a treatment or medication related to the diagnosis would be acceptable; however, hemiplegia doesn't usually use a medication or treatment. Consider how the hemiplegia affects the resident's daily function and consider using the physician orders to support this. For example: a nurse signature on an order in the MAR that states, "Provide additional ADL assistance to the resident's affected side due to hemiplegia." Please note that care plans alone will typically not support that the diagnosis was active.
 - Evidence that the resident's self-care and mobility status (Section GG) was based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. There should be evidence that an interdisciplinary team of clinicians was involved in assessing the resident during the assessment period, and the coding represents the resident's usual performance. Many communities use a combination of documentation and a statement to indicate the data collection methods.
 - Proof in the medical record that the resident PHQ2-9 interview was conducted either on the ARD or prior to the ARD within the assessment period.
 - Care Plans for: Hemiplegia, ADLs, Mood/depression
 - Section Z signatures with dates

Supporting Documentation Example for Behavioral Cognitive Symptoms:

- The resident categorized as a BAB2 due to a resident BIMS score of 5, wandering, 2 Restorative programs, and a Nursing Function Score of 14. The information which should be gathered includes:
 - Proof in the medical record that the resident BIMS interview was conducted either on the ARD or prior to the ARD within the assessment period.
 - Documentation of the resident wandering within the assessment reference period. Please note that the care plan alone will not support that the resident actively wandered during the assessment period.
 - Evidence that the resident's self-care and mobility status (Section GG) was based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. There should be evidence that an interdisciplinary team of clinicians was involved in assessing the resident during the assessment period, and the coding represents the resident's usual performance. Many communities use a combination of documentation and a statement to indicate the data collection methods.
 - Proof in the medical record that the resident received 2 Restorative programs for at least 15 minutes per day for 6 days of the assessment period. This documentation must include at a minimum:
 - Proof of an individualized assessment
 - Proof that the programs were provided for at least 15 minutes per day.
 - Proof that the programs are care planned.
 - Proof that the programs have been periodically (at least each quarter) evaluated

- Be prepared to show proof that the direct care team has been trained on the services provided.
- Be prepared to show proof that the programs were coordinated by an LPN or RN.
- Care Plans for: Cognition, Wandering, Restorative, ADLs
- Section Z signatures with dates

Supporting Documentation Example for Reduced Physical Function:

- The resident categorized as a PDE1 due to a Nursing Function Score of 5. The information which should be gathered includes:
 - Evidence that the resident's self-care and mobility status (Section GG) was based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. There should be evidence that an interdisciplinary team of clinicians was involved in assessing the resident during the assessment period, and the coding represents the resident's usual performance. Many communities use a combination of documentation and a statement to indicate the data collection methods.
 - Care Plans for: ADLs
 - Section Z signatures with dates

Following the Review

An exit conference will be conducted, and a summary of findings will be provided after the exit.

Need Help?

Please contact Tammy Cassidy at tcassidy@ohca.org with questions.