Overview

Residential Care Services (RCS) is responsible for monitoring the accuracy of the Minimum Data Set (MDS) data used to establish resident classification and payment of Medicaid rates. Within RCS, the Case Mix Accuracy Review (CMAR) unit is responsible to carry out a review process that is thorough and efficient in detecting errors in resident assessment data submitted for payment and resident care plans. The CMAR process is a method of assuring nursing facility payments or reimbursements are correctly matched to resident care needs. The MDS 3.0 resident assessment data forms the basis for the Patient Driven Payment Model (PDPM) and/or other case mix model classification systems, which are factored into the payment rate. The case mix accuracy review process determines whether the MDS 3.0 data is accurate.

Selection of a stratified sample of resident assessment data at each licensed and certified nursing home (NH) and desk audits accomplish RCS's monitoring responsibilities. The purpose of the accuracy review is to ensure that nursing facilities are submitting timely and accurate data of the resident's current functional status, clinical complexity, and co-morbidities. This data results in the correct PDPM nursing category and/or other case-mix models. This review process serves to ensure the accuracy and efficacy of the MDS through problem identification and root cause identification.

Relevant Code of Federal Regulations (CFR), Revised Codes of Washington (RCW) and Washington Administrative Codes (WAC) include:

- 42 C.F.R. § 483.20: Resident Assessment
- Chapter 74.46 RCW: Nursing Facility Medicaid Payment System
- Chapter 388-96 WAC Nursing Facility Medicaid Payment System
- Chapter 388-97 WAC Nursing Homes (NH)

These procedures are in addition to DSHS Administrative Policies, as they are specific to RCS. These procedures will be reviewed for compliance and accuracy at least every five years.

Contacts

- Case Mix Accuracy Review Program Manager
- CMAR Program Nurse
- MDS Automation Coordinator
- RCS Policy Unit General Contact (**internal** RCS use)
- RCSPolicy@dshs.wa.gov (**external** RCS use)
- RCS Quality Improvement Unit General Contact

Table of Contents

Part I: General Guidelines

A. Visit Preparation
B. Visit Process
C. Post Visit Process
D. Sanctions and Addressing Inaccuracies
E. Quality Assurance Review
F. Initial Review of a New Facility

Part II: Informal Appeals Process

Part III: Appendices

A. CMAR Error Rates
B. Glossary of Terms
C. Acronym List
D. Change Log

Part I: General Guidelines

Purpose

Objectives of the CMAR Process

To provide each Nursing Facility (NF)/Skilled Nursing Facility (SNF) with:

A. Ongoing education and technical information regarding inaccuracies found during the on-site review that:
   1. placed the resident into the specific classification category.
   2. impact the resident's care plan.

B. A clinical validation review to ensure an accurate Medicaid Rate is paid to all facilities.

Facilities Reviewed During a CMAR Visit

A. All Medicaid-certified NFs or dually certified SNFs in Washington State that are paid using the PDPM nursing category and/or other case mix model system must have a periodic review by RCS to determine accuracy of the MDS 3.0 resident assessments and resident care plans.

B. Each Medicaid-certified facility will have a case-mix accuracy review conducted every 9 to 15 months or more often when:
   1. CMAR nurse's review of past CMAR visit indicates high percentage of MDS inaccuracies,
   2. CMAR Manager's discretion requests a visit, and
   3. Collaboration with RCS Nursing Home Field Offices request a visit.

Unannounced Visits

Facilities are expected to create and implement systems that accurately assess residents at all times throughout the year. CMAR staff must conduct reviews that are unannounced and irregular/unexpected. The unannounced periodic CMAR visit serves to validate assessment processes are occurring on a routine basis.

MDS Data Transmitted to Internet Quality Improvement Evaluation System (IQIES) and Case Mix Assignment and/or Patient-Driven Payment Model (PDPM) Scoring

A. Assessments done through the Resident Assessment Instrument (RAI) process are transmitted to the MDS database (IQIES Assessment Submission and Processing) system according to Federal and State scheduling requirements. That data is run through a software instrument called a "Grouper," which analyzes the MDS coding responses and places each resident assessment into five PDPM categories, physical therapy, occupational therapy, speech therapy, nursing, and non-therapy ancillary.

B. Each group has an assigned case mix weight, and those weights contribute to the facility average case mix index, which provides the basis for the nursing portion of the daily Medicaid payment. Subsets of MDS items are utilized and provide the basis for the grouper algorithm logic to place the resident's assessment into PDPM categories. It is paramount that those items affecting group determinations be accurate and verifiable. Medicaid rates are set on a semi-annual schedule by the Nursing home rates division, based on MDS data.

Reports

A. Certification and Survey Provider Enhanced Reports (CASPER) provide summary information derived directly from the facility's MDS data that facilities may utilize for oversight of their MDS processes.
B. Default Reports:
    1. Default Reports catalogue the number of defaults (missing assessments or information) in a reporting period. The department sends Default Reports to facilities, which provides an opportunity to correct errors before payment is finalized by the Nursing home rates division. Default reports are monitored by the MDS Automation Coordinator.
    2. Default Reports Identify:
        a. 2506_CMUntimelyAssessmentDefaultSummary is the number of defaults during a designated time period for each facility.
        b. 2503_CMStayPeriodExceptionResidents Names of residents whose assessments were found to be in default status.
        c. Other Default Reports list submitted assessments, Payor, Days of Stay, Dates of Stay period, PDPM grouping, and specific information pertaining to Case Mix calculation.

A. Visit Preparation

Overview

According to Chapter 388-96-905 WAC, each Washington state Medicaid-certified facility will have a case mix accuracy review conducted on a periodic basis. A hybrid off-site record review with on-site observation and interview meets the requirements of a periodic full review. During times of Natural disaster, pandemic or other events making on-site visits ill-advised, a modified Case Mix Accuracy Review (CMAR) will be conducted through off-site record review and interview.

Procedure

1. Scheduling Visits
   a. The CMAR Program Manager will:
      1) Maintain spreadsheets that show assigned facilities for each CMAR Nurse that includes facility specific information, date(s) of the last review, MDS inaccuracies and PDPM category error rates.
      2) Collaborate with the CMAR Nurse to prepare a schedule on a quarterly basis. This schedule ensures each facility is reviewed once every 9 to 15 months.
   b. The CMAR Nurse will:
      1) Schedule visits within the 9 – 15-month timeframe so that annual visits are staggered (not the same month/week every year) and facilities with higher error rates or inaccuracies are visited more frequently.
      2) Enter scheduled visits onto their personal Outlook calendar a minimum of 6 weeks in advance. The CMAR nurse will maintain the Outlook calendar to accurately reflect schedule changes.
      3) Make Outlook calendar shareable with CMAR Program Manager and other CMAR nurses so planned visits can be viewed by all.
2. Visit Planning and Preparation.
   The CMAR nurse will:
   a. Download CMAR visit forms and worksheets from the shared drive and label using the naming convention guideline.

      Note: CMAR Unit has a naming convention document that can be provided by the Unit Manager.

   b. Review and Analyze facility information for trends:
      1) Results of past CMAR visits and any survey citations or complaint investigations related to resident assessment for significant changes or trends in the past 12 months.
      2) CASPER report facility quality measures. This information is used by the CMAR Nurse to identify any areas of concern that may need additional focused attention during the MDS review.

c. Open the CMAR application.
   1) Download Facility data.
   2) Download the "RUG Categories Summary Report" and/or other case mix model reports for sample residents.
      a) Date range 60-70 days from date of review
      b) Identify how many residents are in each PDPM Nursing category.

d. Select a Stratified Sample. Stratified Sample means selecting sample residents from each available PDPM Nursing Category.
   1) MDS Assessment Reference Date (ARD) dates must be within 8 weeks of the CMAR visit (no older than 70 days from date of review).
   2) Discharged residents may be included in the sample if current residents are not available for sample selection.
      a) Review of Aspen Central Office (ACO) MDS data will show if a resident is still in-house or discharged.
      b) For an off-site entrance, sample selection can wait until census list is obtained.
   3) Select sample residents:
      a) Where areas of concern (related to facility trends) may exist.
      b) Who are in groupings that have demonstrated a high degree of coding errors.
      c) Residents who have changed PDPM Nursing Category classification in the last 70 days.
      d) A balance of residents from each PDPM Nursing Category.
   4) Download and save an Item Category Report for each Sample resident.
      a) For off-site entrance and/or onsite entrance, refer to the census list prior to sample selection. There is no need to select or print additional reports.
      b) Sample size can be anticipated based on the facility capacity and sample size of the previous year. The final sample size will be determined using the facility census on the first day of the CMAR visit. The sample is approximately 20% of the facility census (see chart below) up to a total sample of 24. If the sample size needs to be modified, consult with the Program Manager, and note the reason on your visit plan.

CMAR Sample Size				
Resident Census	**Sample Size**		**Resident Census**	**Sample Size**
1-5	All		71-75	15
6-19	6		76-80	16
20-35	7		81-85	17
36-40	8		86-90	18
41-45	9		91-95	19
46-50	10		96-100	20
51-55	11		101-105	21
56-60	12		106-110	22
61-65	13		111-115	23
66-70	14		116-299	24

B. Visit Process

Procedure

1. Entrance/Initiation of Visit
   a. Off-Site CMAR Visit Process – Initiation of CMAR Visit
      1) Prepare and send entrance email to the administrator using Modified CMAR Visit Notice. Attach the following document:
         a) Modified CMAR Visit Entrance Conference Worksheet.
         b) Send email using read receipt format.
   b. Call the nursing home and advise the administrator or designee of the initiation of the CMAR visit.
      1) Verify email address and administrator information sent in step 1.
      2) Refer to "Information Needed from the Facility Immediately Upon Initiation of CMAR Visit" outlined on the Modified CMAR Visit Entrance conference Worksheet and request:
         a) Census number
         b) An alphabetical list of all residents, room numbers and payer source. Note any resident out of the facility
         c) Specific information related to concerns affecting resident care. For example:
            - A list of residents who are confirmed or suspected cases of COVID-19
            - Number of current staff who have confirmed or suspected cases of COVID-19 & date last worked in building
         d) Name and contact information for the Minimum Data Set Nurse(s)
         e) List of key personnel, location, and phone numbers including Rehabilitation & Restorative
      3) Request from the facility off-site access to their electronic medical records
         a) Refer to the Entrance Conference Worksheet
         b) If offsite review of Electronic Medical Record is not possible, discuss the best options to get needed medical record information, such as fax, secure website, encrypted email, etc.
2. Review Process Overview
   a. The CMAR evaluation verifies that the MDS accurately represents the resident's clinical and functional status during the assessment reference period, and is consistent with MDS 3.0 items, definitions, time frames and RAI Manual clarifications.
   b. Although the entire assessment must be accurate, as stated in federal regulations (42 CFR § 483.20), Case-Mix reimbursement items are the focus of this review. A secondary and important part of the review includes a subset of MDS items that support care planning. Information from the entire record may be considered in verification of the assessment.
   c. One MDS 3.0 assessment must be reviewed for each resident in the sample. The review is documented on Case Mix Category and resident's Nursing Functional Abilities Worksheets for each resident.

3. Record Review
   The CMAR Nurse will:
   a. Look in medical/health record for documentation in support of MDS coding.
      1) Supportive documentation may be found in medical notes, nursing notes, social service notes, therapy notes, care plans, Kardex (a document system used by NHs that communicates a brief overview of each resident's individual care needs), Medication Administration Record, MDS including Care Area Assessment (CAA), orders, lab reports, History & Physical, Hospital records or other documentation.
      2) If supportive documentation is not found, provide facility staff the opportunity find or show documentation.
   b. Record visit findings on CMAR Worksheets.
      1) Supportive documentation was found and MDS coding was confirmed.
      2) Supportive was NOT found:
         a) Document findings so that during an Informal Administrative Appeal process, the CMAR Program Manager is able to determine what specific issues led to the reviewer's findings and decision making.
         b) Download or snapshot copies of care plans, doctor's notes, medical records, or other related records that supports CMAR coding or demonstrates the inaccuracy onto CMAR worksheets to support findings.
      3) The CMAR nurse will maintain records in an electronic fashion. Records may be scanned or securely emailed. The CMAR nurse will not remove hard copy paper documents from the facility.
4. Staff Interviews
   The CMAR Nurse will:
   a. Interview staff when there is missing documentation or an MDS coding inaccuracy is identified.
      1) Document discussions regarding discrepancies between documentation and MDS coding (problem identification).
      2) Interview to find out why the inaccuracy occurred (root cause identification).
   b. Document Date & Time, Name & Title of person interviewed on the appropriate worksheet.
5. Resident Observations/Interviews
   The CMAR Nurse will:
   a. Strive to gain a complete picture of sample resident's physical and mental condition and abilities, needed treatments and medications, services and interventions provided by staff and daily life activities. The goal of observation is to verify PDPM and/or other case mix model category, Activities of Daily Living (ADL) coding and items in support of care planning.
      1) Attempt to observe every sample resident. At a minimum, 75% of the sample should be observed.
      2) When it is necessary to observe a wound, pressure ulcer, gastrostomy site, or other similar situation, the CMAR Nurse will ask:
         a) Permission from the resident.

b) Ask facility staff to accompany them to view the area in question. Ask facility staff to arrange the resident's bed linen, clothing, and/or wound dressing as necessary to observe the condition.

b. Document observations on the CMAR Resident Observation Form. Note Date & Time, overall resident condition and confirm MDS coding.
   1) Diagnosis: does it drive the plan of care? Look for evidence that resident condition, equipment, and care support diagnoses coding (for some, i.e., Sepsis, this may be resolved at the time of observation, but many other diagnoses such as Parkinson's disease or Multiple Sclerosis or Chronic Obstructive Pulmonary Disease are chronic conditions and can be observed). Shortness of Breath (SOB) while flat is a significant coding item that affects the PDPM category.
   2) Pressure Ulcers: Is care identified on the care plan being implemented?
   3) Restorative: Is care identified on the care plan or documented in the record being implemented?
   4) Treatments/Cares: Oxygen, Intravenous) medications, dressing changes, tracheostomy, and/or isolation – is there evidence of treatments being implemented?
   5) ADL and mobility status: What level of assistance is provided? Presence of mobility aids.
c. Follow-up any observations with interviews of residents, family, and/or facility staff when needed.
   1) Interview to confirm MDS coding (i.e., SOB while flat)
   2) Document interviews pertaining to resident observation on the Observation document.

Note: Documentation should include the name of the staff/resident/visitor, the date and the time of the interview/observation.

Example

Room #	**OBSERVATION / INTERVIEW** Document Resident Name & any notes about what to observe followed by observation. Note Date & Time of Observation(s) and interviews (if done)

6. Data Reconciliation
   The CMAR Nurse will:
   a. Validate or identify inaccuracies in the PDPM and/or other case mix model MDS items using multiple sources (record review, observations, interviews).
   b. Confirm MDS inaccuracies with facility staff.
   c. Enter MDS item changes (MDS inaccuracies) into the CMAR application computer program. A new PDPM classification may result based on MDS item changes.

1) Enter all MDS inaccuracies in the CMAR application prior to compiling summary reports.
2) Verify if a change to the PDPM classification and/or other case-mix models has occurred.

d. Review all data for accuracy and completeness.

7. Questions the CMAR Nurse should ask themselves during the on-site review to assist with Root Cause Analysis
   a. Has there has been a significant change in significant change in case mix model groupings, have resident care needs changed?
   b. Have there been staff changes in who is performing the MDS assessments? Have there been system changes in the facility?
   c. Do the changes reflect changes in the facility accuracy in documentation and assessment since the last CMAR visit and signify the facility is more/less accurately coding and assessing residents?
8. Documentation of CMAR Findings
   The CMAR Nurse will document Findings and Conclusions on the following forms:
   a. Case Mix Item Category Report
   b. Individual Worksheets (ADL, PDPM Category Worksheet and/or other case-mix model classification worksheets).
      1) Highlight inaccurately coded MDS items, or items that should have been coded in the MDS and were not.
      2) In the grid at the bottom of the worksheet, note PDPM errors, inaccuracies, and reason for change.
         a) Highlight data supporting inaccuracies or PDM changes.
         b) **BOLD** PDPM Changes.
      3) Add name and date to worksheets.
   c. CMAR Summary forms.
      1) For both forms: **BOLD** rows where there are case mix model changes.
      2) Both summary form documents include the following information: Sample resident name; case mix model grouping compared to CMAR determination; RUG-IV error rate and total inaccuracies.
      3) In addition:
         a) CMAR Review Summary for MDS 3.0 includes: ARD, specific MDS item, error type, incorrect value, correct value, and reason for the inaccuracy and/or category change.
         b) CMAR Provider Letter includes:
            - Facility right to appeal CMAR findings through informal administrative hearing
            - Where to send the appeal request if mailed or if emailed, including a reminder that if the appeal request has any resident identifying information that the appeal request must be encrypted; and
            - The time limit of 10 calendar days for requesting the appeal, as provided under WAC 388-96-905(5)
   d. At the end of each CMAR Visit Day, the CMAR nurse will save documents onto each nurse's OneDrive.

9. Criteria for RUG and/or other case mix model Error Rate
    a. If the case mix model classification group (i.e., from Special Care Low to Clinically Complex) changes as a result of the case mix accuracy review, the CMAR nurse will:
        1) Review the case mix model to validate that all documentation for that category mix model is present in the clinical record.
        2) Complete a new worksheet for the corresponding Case Mix model value.
    b. If the clinical record does not have documentation to validate the new case mix category, then the resident will be grouped into the next corresponding case mix category group. This will count as two MDS inaccuracies and one case mix category change for the Case Mix Accuracy Review Summary Report.
    c. Any MDS item reviewed and not verified must be reported to the facility on the CMAR Review Summary for MDS 3.0. Not all of the inaccuracies result in a change up or down in a resident's case mix PDPM category.
10. Determining the Case Mix Model Error Rate – (See Table in Appendix A)
    a. Look at the far-left column and find the sample size.
    b. Move across the top row and find the number of errors (the number of PDPM Categories that changed from the information sent by the facility).
    c. Move across the column and row and find the box where they intersect. This is the error rate for the sample that was reviewed.
11. Exit Conference
    a. All CMAR visits are concluded by means of an exit conference with facility administration. The purpose of an exit conference is to provide facility staff with the review findings. Discrepancies should be resolved prior to the exit conference.
    b. The CMAR nurse should arrange the exit conference time and date as early in the process as possible to help ensure key facility staff can attend. The CMAR Nurse and any additional RCS staff involved in the CMAR review should attend the exit conference. The exit conference can be done:
        1) In person at the conclusion of the on-site visit, or
        2) Off site
            a) Via TEAMS, telephone, or other mutually accessible and agreed upon electronic media.
            b) Using secure email with read receipt,
                - The CMAR nurse will send Summary documents (Dear Administrator Letter, CMAR Summary for MDS 3.0 and Care Area Review Summary, if applicable) to the facility prior to the exit conference.
                - The facility will sign, date, and return The CMAR Dear Administrator Letter at the conclusion of the exit conference.
    c. The CMAR nurse will lead the exit conference:
        1) Make introductions
        2) Express appreciation for facility staff assistance during the visit
        3) Restate the reason the CMAR visit was conducted
        4) Explain the exit conference purpose
        5) Share findings from the CMAR Review Summary for MDS 3.0 document

a) The number of residents in the sample
b) The MDS inaccuracies identified by the reviewers
c) Changes in the resident's PDPM classification and the projected error rate caused by the MDS inaccuracies
d) The facility's coding
e) A description of the information which substantiates the MDS inaccuracies

6) Present discrepancies case mix model items in a polite, objective, and non-judgmental manner. Successful two-way communication is a key element in validation and education of facility staff.
   a) Differentiate between coding decisions based on assumptions or misinterpretations verses coding decisions based on RAI manual language, definitions and supporting nursing literature.
   b) Share root cause analysis of coding discrepancies to help the facility address system issues impacting correct MDS coding.
7) Advise the facility:
   a) Page one of the Dear Administrator Letter must be signed and filed/downloaded with the electronic CMAR summary visit papers to indicate that an exit conference was held, and that the facility received a copy of the report.
   b) MDS inaccuracies presented during the exit conference are final. After the exit conference no additional documentation will be accepted, except those submitted as part of an appeal or informal administrative hearing.
   c) The Dear Administrator Letter gives specific information on the Appeal Process and timelines for submitting an appeal request.

C. Post Visit Process

Purpose

- Care concerns and CMAR Visit Findings are summarized on the "CMAR Report to Nursing Home Field Office."
- Changes that a CMAR Nurse finds in the resident assessment during case mix accuracy review are entered into the CMAR application computer program.
- All working papers and summary reports are sent to and retained in the Department's designated secured electronic filing system. No CMAR hard copy working papers should be retained or stored at the local office level or on CMAR laptops.

Procedure

1. Finalization of CMAR Visit - Reports and Working Papers
   a. Document Quality of Care problems, PDPM, or case-mix model changes and MDS inaccuracies on the "CMAR Report to Nursing Home Field Office." E-mail report to the Field Manager (FM) who has oversight of the facility.
      1) For significant care concerns, call to discuss with the CMAR Program Manager and FM for review and possible action.
      2) For > 30 % PDPM Category Changes - note this in the email to the FM and note possible Focus visit with timeframes (see 'Sanctions and Addressing Inaccuracies' for details.
   b. Review appropriate folder for completeness and add signed Dear Administrator Letter once received following the exit.
      1) Open the CMAR folder within Q: drive and find the Visit folder for the appropriate year.
      2) Within the Year folder find the correct alphabetical folder by facility name and open that folder.
      3) Save /drag your facility folder with working papers into the visit folder and ensure it is saved.
2. Finalization of CMAR Visit - Computer Process
   a. Once all MDS item changes are entered into the CMAR application program:
      1) Establish internet access.
      2) Upload facility data to enable transmission back to the RCS database.
         a) Under administrative Tab – Manage Facilities.
         b) Move Facility Name from "Selected" to "Available" Facilities.
      3) Uploaded Information is accessed by Aging and Long-Term Support Administration (ALTSA) rates division for use in calculating facility payment. Changes may result in a change in the resident's case-mix grouping and case-mix weight, which in turn may change the:
         a) Facility's average case-mix index, and
         b) Medicaid average case mix index. These values are used to set the facility's rate.
   b. Transfer any electronic records used during the CMAR Visit from the laptop to the Q: drive as directed by the CMAR Program Manager. Review and remove all facility specific data related to the CMAR visit from desktop.

D. Sanctions and Addressing Inaccuracies

Purpose

The CMAR review reinforces the integrity of the case-mix PDPM system. CMAR error rates reflect MDS coding inaccuracy. PDPM Category error rates greater than the designated threshold may result in sanctions.

Procedure

1. Phase 1 Sanction
   For case-mix model error rate greater than 30%, the facility is considered to be in Phase I sanction. The CMAR nurse must:
   a. Notify the CMAR Program Manager of the error rate.
   b. Complete a return focused visit within 12 weeks.

11. Return Focused Visit
    a. The Return Focused Visit will address potential assessment system problems that may have contributed to the high error rate. From the previous CMAR Visit:
       1) Review prior CMAR Report to FM for Root Cause Analysis.
       2) Identify Case-Mix model categories with the highest error rates.
    b. The CMAR Nurse will review the areas which had the most MDS inaccuracies.
       1) Focused Review of Case-Mix model Categories:
          Review the PDPM and/or other case-mix model categories that had high errors as a basis for sample selection.
    c. The sample size will be from five to seven residents based on the facility's census.

Residents	Sample Size
1 – 75	5
76 – 110	6
111 – 299	7

    d. Focus visit forms and format will follow the same secure electronic format as the original case mix visit.
       1) PDPM Category Case-Mix Category Worksheets.
          a) Document findings on electronic PDPM Category Worksheets.
          b) Collect data and documentation or download onto worksheets to support inaccuracies or findings.
          c) Complete the standard summary documents:
             - CMAR REVIEW SUMMARY FOR MDS 3.0 report. The facility signs page 1.
             - Dear Administrator Letter.
             - The facility receives a copy of the signed reports.

e. Following standard CMAR process:
   1) Conduct an entrance and exit conference.
   2) Assist the facility to identify systems issues / root cause analysis for errors.
   3) Enter and upload inaccuracy data in the CMAR application program.

f. At the conclusion of the focused visit, the CMAR Nurse will:
   1) Notify the CMAR Program Manager of Focus visit completion and of the findings.
   2) Save the file of worksheets and reports in the CMAR shared drive. The focus visit will be filed in the same file as the original visit that had greater than 30% error rate.

> Example: If Facility X had a 35% error rate in December 2023 and the focus visit was done in March 2024, the Focus Visit would be filed under 2023 with the original visit.

12. Phase 2 Sanction
    a. Any facility in Phase I sanctions with an error rate greater than 30% at the next periodic CMAR visit (within the next 9 to 15 months), will move into the second phase of sanction activity (Phase 2), which includes the following:
       1) The CMAR Nurse will complete another Return Focused Visit in accordance with the same procedures under subsection 1 of this section.
       2) The CMAR Program Manager, after consultation with the FM, may request the CMAR Nurse make a report to Complaint Resolution Unit for investigation of MDS inaccuracy. The report will include the specifics of the allegation.

E. Quality Assurance (QA) Review

Procedure

1. Performance Metrics:
   a. Documentation Standard for Working Papers Met:
      1) Legible documentation on CMAR Worksheet(s) with supporting reason for error or inaccuracy determination.
      2) Interview: Date/Time/Name/Title of person interviewed documenting coding reason or support for facility coding or response to inaccuracy found by CMAR Nurse.
      3) Observation: Date/Time/Object or Person Observed supporting facility MDS coding or miscoding. Minimum 75% of Sample Observed.
      4) Save working papers to Q: drive subfolder for CMAR Visits within five working days (WD) of exit.
      5) Upload data to CMAR application within five WD of exit.
   b. Process Standard for CMAR Visit Met
      1) Preparation and Stratified Sample Selection.
      2) Notification of unannounced visit & clear explanation of visit purpose and parameters.
      3) Receipt of Written CMAR report & appeal rights.
      4) Exit meeting with review of CMAR report.
   c. Timeliness of CMAR Visits: 9–15-month Timeframe
2. CMAR program data will be reviewed, analyzed, and reported monthly by the FM
   a. CMAR monthly report will include census, Sample Size, End Date(s), # days in facility, CMAR Nurse, MDS Inaccuracies, RUG Error %
   b. CMAR Program Card Metrics:
      1) State law requires periodic CMAR review and WA State's SOP specifies states that each nursing home that receives Medicaid funding must have a case mix accuracy review every 9 to 15 months.
         a) # NH reviewed/month; # NH reviewed <9 months
         b) # NH Reviewed > 15 months
         c) CMS requires that the RAI Coordinator provide two to three trainings per year
         d) Number of trainings scheduled for Federal Fiscal Year (FFY)
         e) Number of trainings completed for FFY to date

F. Initial Review of a New Facility

Purpose

To conduct an initial CMAR visit in new SNFs/NFs to ensure that the facility is completing and submitting MDS assessments accurately.

Procedure

1. Each facility will have an unannounced CMAR visit after the first full quarter of MDS submissions has occurred. The sample size will be 50% of the normal CMAR sample size, except in facilities with 20 or fewer residents. In those cases, the sample size will be no less than five residents.
2. The CMAR Nurse will follow all of the regular CMAR processes under sections in Part I: A through F of this chapter.
3. Findings from the review will be finalized for upload to the database to be used for rate setting purposes.
   a. Depending on the issues identified during the review or error rate over 30%, the CMAR Nurse will confer with the Program manager.
   b. A follow-up visit, with a focus on the areas of concern identified during the initial review, may be conducted.
4. The first periodic CMAR review should occur 9 to 15 months after the date of certification for Medicaid.

Part II: Informal Appeals Process

Purpose

NFs are provided an opportunity to appeal the CMAR findings. The purpose of the informal hearing is to give the provider one opportunity to present documentation and information that might warrant modification or deletion of resident-specific accuracy findings resulting from the case mix accuracy review.

Procedure

1. The facility may request an appeal within 10 calendar days from the end of the CMAR visit. The facility may request the appeal be conducted via any of the following formats:
   a. Web-based conference (i.e., Teams);
   b. Telephone conference;
   c. Desk record review; or
   d. Any combination of these.
2. The CMAR Program Manager will:
   a. Contact the provider within 10 WD of the provider request to schedule an informal hearing for a mutually agreeable date and to confirm the appeal format.
   b. Review any documentation and/or information submitted with the appeal request.
      1) Supporting documentation or other information from the facility must be submitted to the CMAR Program manager on or before the informal administrative hearing date.
      2) Additional information may be requested by the CMAR Program Manager at any time prior to the final informal hearing decisions being issued.
3. Not be involved in preliminary decisions related to the case mix findings prior to the informal hearing.

The Informal Case Mix Accuracy Review Hearing

1. Hearings will occur in person or virtually. Facility will indicate their preference, and a mutually agreed date and time will be set. The meeting should last no longer than one hour.
2. The hearing will focus only on clinical issues of resident need and assessment.
3. At the conclusion of the informal hearing, the CMAR Program Manager will:
   a. Review the issues.
   b. Request any additional documentation needed to make an appeal decision.
   c. Remind the facility when and how the decisions will be made.

Decision Making/Results

1. The CMAR Program Manager has 10 WD after the informal hearing or receiving any additional information, whichever is later, to make a decision, and notify the provider of the results.
2. The determination will either uphold the facility coding of the MDS or support the CMAR findings of an MDS item inaccuracy.
   a. If the hearing upholds the facility's MDS coding, the Case Mix Accuracy Review Program Manager will revise the Case Mix Accuracy Review forms, the summary report, and the Quality Assurance Nurse Program (QAN) database to reflect the changes.
   b. If the Case Mix Accuracy Review Nurse's findings are supported, the Case Mix Accuracy Review forms, the summary report, and the data in the QAN database will remain unchanged.
3. Hearing Results represent the final agency decision by the department.
   a. The results of the informal hearing will be sent to the provider in writing.
   b. If the provider is dissatisfied with the final agency decision, a petition for judicial review may be requested under the state's Administrative Procedure Act (Chapter 34.05 RCW).
   c. The CMAR nurse will be notified of the Hearing Results verbally by the Program Manager.
      1) Including rationale for removing CMAR findings from final report.
      2) Examples of overturned CMAR nurse findings will be used for CMAR unit QA purposes only.
   d. Results of the appeal determination will be entered into the database used for rate setting.
   e. A copy of the results, along with all materials used in the informal administrative hearing, will be retained per DSHS record retention schedule.

Part III: Appendices

A. CMAR Error Rates

# OF ERRORS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SAMPLE SIZE																
1-4	100 %	100 %	100 %	100 %												
5	20.0 %	40.0 %	60.0 %	80.0 %	100 %											
6	16.7 %	33.3 %	50.0 %	66.7 %	83.3 %	100 %										
7	14.3 %	28.6 %	42.9 %	57.1 %	71.4 %	85.7 %	100 %									
8	12.5 %	25.0 %	37.5 %	50.0 %	62.5 %	75.0 %	87.5 %	100 %								
9	11.1 %	22.2 %	33.3 %	44.4 %	55.6 %	66.7 %	77.8 %	88.9 %	100 %							
10	10.0 %	20.0 %	30.0 %	40.0 %	50.0 %	60.0 %	70.0 %	80.0 %	90.0 %	100 %						
11	9.1 %	18.2 %	27.3 %	36.4 %	45.5 %	54.5 %	63.6 %	72.7 %	81.8 %	90.9 %	100 %					
12	8.3 %	16.7 %	25.0 %	33.3 %	41.7 %	50.0 %	58.3 %	66.7 %	75.0 %	83.3 %	91.7 %	100 %				
13	7.7 %	15.4 %	23.1 %	30.8 %	38.5 %	46.2 %	53.8 %	61.5 %	69.2 %	76.9 %	84.6 %	92.3 %	100 %			
14	7.1 %	14.3 %	21.4 %	28.6 %	35.7 %	42.9 %	50.0 %	57.1 %	64.3 %	71.4 %	78.6 %	85.7 %	92.9 %	100 %		
15	6.7 %	13.3 %	20.0 %	26.7 %	33.3 %	40.0 %	46.7 %	53.3 %	60.0 %	66.7 %	73.3 %	80.0 %	86.7 %	93.3 %	100 %	
16	6.3 %	12.5 %	18.8 %	25.0 %	31.3 %	37.5 %	43.8 %	50.0 %	56.3 %	62.5 %	68.8 %	75.0 %	81.3 %	87.5 %	93.8 %	100.0%
17	5.9 %	11.8 %	17.6 %	23.5 %	29.4 %	35.3 %	41.2 %	47.1 %	52.9 %	58.8 %	64.7 %	70.6 %	76.5 %	82.4 %	88.2 %	94.1 %
18	5.6 %	11.1 %	16.7 %	22.2 %	27.8 %	33.3 %	38.9 %	44.4 %	50.0 %	55.6 %	61.1 %	66.7 %	72.2 %	77.8 %	83.3 %	88.9 %
19	5.3 %	10.5 %	15.8 %	21.1 %	26.3 %	31.6 %	36.8 %	42.1 %	47.4 %	52.6 %	57.9 %	63.2 %	68.4 %	73.7 %	78.9 %	84.2 %
20	5.0 %	10.0 %	15.0 %	20.0 %	25.0 %	30.0 %	35.0 %	40.0 %	45.0 %	50.0 %	55.0 %	60.0 %	65.0 %	70.0 %	75.0 %	80.0 %
21	4.8 %	9.5 %	14.3 %	19.0 %	23.8 %	28.6 %	33.3 %	38.1 %	42.9 %	47.6 %	52.4 %	57.1 %	61.9 %	66.7 %	71.4 %	76.2 %
22	4.5 %	9.1 %	13.6 %	18.2 %	22.7 %	27.3 %	31.8 %	36.4 %	40.9 %	45.5 %	50.0 %	54.5 %	59.1 %	63.6 %	68.2 %	72.7 %
23	4.3 %	8.7 %	13.0 %	17.4 %	21.7 %	26.1 %	30.4 %	34.8 %	39.1 %	43.5 %	47.8 %	52.2 %	56.5 %	60.9 %	65.2 %	69.6 %
24	4.2 %	8.3 %	12.5 %	16.7 %	20.8 %	25.0 %	29.2 %	33.3 %	37.5 %	41.7 %	45.8 %	50.0 %	54.2 %	58.3 %	62.5 %	66.7 %
25	4.0 %	8.0 %	12.0 %	16.0 %	20.0 %	24.0 %	28.0 %	32.0 %	36.0 %	40.0 %	44.0 %	48.0 %	52.0 %	56.0 %	60.0 %	64.0 %
26	3.8 %	7.7 %	11.5 %	15.4 %	19.2 %	23.1 %	26.9 %	30.8 %	34.6 %	38.5 %	42.3 %	46.2 %	50.0 %	53.8 %	57.7 %	61.5 %
27	3.7 %	7.4 %	11.1 %	14.8 %	18.5 %	22.2 %	25.9 %	29.6 %	33.3 %	37.0 %	40.7 %	44.4 %	48.1 %	51.9 %	55.6 %	59.3 %
28	3.6 %	7.1 %	10.7 %	14.3 %	17.9 %	21.4 %	25.0 %	28.6 %	32.1 %	35.7 %	39.3 %	42.9 %	46.4 %	50.0 %	53.6 %	57.1 %
29	3.4 %	6.9 %	10.3 %	13.8 %	17.2 %	20.7 %	24.1 %	27.6 %	31.0 %	34.5 %	37.9 %	41.4 %	44.8 %	48.3 %	51.7 %	55.2 %
30	3.3 %	6.7 %	10.0 %	13.3 %	16.7 %	20.0 %	23.3 %	26.7 %	30.0 %	33.3 %	36.7 %	40.0 %	43.3 %	46.7 %	50.0 %	53.3 %

Section Overview Table of Contents

B. Glossary of Terms

Activities of daily living (ADL) [CMAR] – Those activities needed on a regular basis for self-care, such as: bathing, dressing, mobility, toileting, eating, transferring, or other related activities. This includes the "late-loss" ADLs (eating, toileting, bed mobility, and transferring), which are used to classify a resident into a RUG-IV group and/or other case-mix models.

Administrative sanctions – restrictions or obligations imposed by DSHS/RCS for violation of a set of internal regulations. "CARE Area Review" formerly known as QAN protocols (is a quality review instrument used to determine if a facility is in regulatory compliance with an identified care area). The original QAN protocols (last used 2012) were revised and refocused to align with CMS' Critical Element Pathways.

Administrator – Includes the various titles of the responsible person(s) for the entity. This list includes but is not limited to superintendent, director, provider, program manager, individual or entity representative, resident manager, administrator, or executive director. Please refer to the WAC relevant to the setting type for more information.

Agency – State agency.

Aspen (Automated Survey Process Environment) – a suite of software applications designed to help State Agencies collect and manage healthcare provider data.

Aspen Central Office (ACO) – refers to Centers for Medicaid and Medicare Services (CMS).

Case mix accuracy review (CMAR) – the RCS unit that conducts the periodic nursing facility on-site accuracy review for MDS assessments of nursing facility residents. These reviews are for the purpose of verifying the accuracy of facility case mix data used to establish and update Medicaid payment rates and for other purposes, the department may deem appropriate.

Default – as used in the Washington State Medicaid Payment system, is actually referred to as 'default case' in RCW 74.46.020 (14).

Default case – no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

Department – This term refers to the Washington state Department of Social and Health Services (DSHS).

Electronic medical record (EMR) or **Electronic health record (EHR)** – a digital version of a chart with resident medical/health information stored in a computer.

Error – a change up or down in a resident's RUG-IV grouping and/or other case-mix models.

Health Insurance Prospective Payment System (HIPPS) – rate codes represent specific sets of patient characteristics (or case-mix groups) health insurers use to make payment determinations under several prospective payment systems. HIPPS codes are alpha-numeric codes of five digits. Which positions of the code carry the case mix group information may also vary by payment systems. The first position of the code represents both the Physical and Occupational Therapy case-mix group. The second position represents the Speech-Language Pathology case-mix group. The third position represents the nursing case-mix group. The fourth position represents the Non-Therapy Ancillary case-mix group. This leaves the fifth position to represent the AI (Assessment Indicator) code.

Internet Quality Improvement Evaluation System (IQIES) – the federal umbrella administrative and computer system that encompasses the MDS and Swing Bed-MDS system, other systems for survey and certification, and home health providers.

Minimum Data Set (**MDS)** – a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.

Modified off-site visit [CMAR] – means conducting the facility CMAR visit off-site, or partially off-site, including electronic health record (EHR) review, interviews, entrance, and exit. The Modified off-site visit is done during times of Natural disaster, pandemic or other events that make on-site visits untenable.

Nursing facility (NF) – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under section 1919(a) of the federal Social Security Act. All beds in a nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.

Nursing home (NH) – A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

Patient Driven Payment Model (PDPM) – means a case mix classification system for Prospective Pay System (PPS) residents. PDPM consists of five case-mix adjusted components, all based on data-driven, patient characteristics. Each component utilizes different criteria as the basis for patient classification. The five components are: Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP), Nursing, and Non-Therapy Ancillary (NTA).

Periodic CMAR review – the regular on-site review conducted every 9 to 15 months by the CMAR unit.

Quality Assurance Nurse (QAN) program – an electronic data base developed specifically for Aging and Long-Term Support Administration (ALTSA) to facilitate CMAR work. The program downloads MDS data directly from ACO. It also includes quality assurance protocol templates.

Resident Assessment Instrument (RAI) – an assessment tool, which consists of three basic components: the MDS Version 3.0, the Care Area Assessment process, and the RAI utilization guidelines.

Resource Utilization Group (RUG) – a category-based group model classification system in which nursing facility residents classify into RUG-IV and/or other case mix models rate groups based on their attributes as a recipient of NF services using a RUG or category worksheet. Residents in each group utilize similar quantities and patterns of resource. Assignment of a resident to a RUG-IV or other case mix model group is based on certain item responses on the MDS 3.0. WA State uses the RUG-IV 57 group model. Medicare Part A uses the 66-group model.

RUG Categories Summary Report – a report pulled from the QAN program that lists the number of residents in each RUG category for a specific facility during set date parameters.

RUG Item Category Report – a report pulled from the QAN program that identifies facility values for a sub-set of MDS items for a set of specific residents.

Stratified sample – means selecting sample residents for the CMAR visit from each available RUG Category.
Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

C. Acronym List

ACO	Aspen Central Office
ADL	Activities of Daily Living
ALTSA	Aging and Long-Term Support Administration (now HCLA)
ARD	Assessment Reference Date
ASPEN	Automated Survey Processing Environment System
CAA	Care Area Assessment
CASPER	Certification and Survey Provider Enhanced Reports
CFR	Code of Federal Regulations
CMAR	Case Mix Accuracy Review
CMS	Centers for Medicare and Medicaid Services
COVID	Coronavirus Disease
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
FFY	Federal Fiscal Year
FV	Facility Value
HCLA	Home and Community Living Administration
IQIES	Internet Quality Improvement Evaluation System
MDS	Minimum Data Set
NF	Nursing Facility
NH	Nursing Homes
PDF	Portable Document Format
PDPM	Patient-Driven Payment Model
QA	Quality Assurance
QAN	Quality Assurance Nurse Program
QM	Quality Measures
RAI	Resident Assessment Instrument
RCS	Residential Care Services
RCW	Revised Code of Washington
RUG	Resource Utilization Group
SNF	Skilled Nursing Facility
SOB	Shortness of Breath
SOP	Standard Operating Procedures
WAC	Washington Administrative Code
WD	Working Day

D. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
06/18/2025	I.C. Care Area Review	Section Removed	No longer a CMAR function	N/A
01/17/2025	Entire Chapter	Formatting updates	Comply with new DSHS branding	N/A
09/08/2023	Full Chapter	Updates to requirements, transition to new format	Updated Expectations	R23-076
08/12/2020	Full Chapter	Clarified Purpose of CMAR process to include items affecting care plan Modified CMAR visit process to include off-site record review	Align SOP with full extent of CMAR work Response to COVID-19	CMAR Unit staff involved in developing and clarification of SOP MB R20-089 MB R20-093 Unit Manager direction; Off-site modified CMAR visit pilot with opportunity to improve process & SOP (PDCA)
09/20/2019	Full Chapter	Establishment of chapter	Establishment of chapter	MB R19-068

Table of Contents