#212
How to Submit a Successful Informal Dispute Resolution (IDR)

Wisconsin Health Care Association
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Purpose
To provide facilities, under certain circumstances, an additional opportunity to informally dispute cited deficiencies through a process that is independent from the State survey agency or, in the case of Federal surveys, the CMS Regional Office

Objectives
• Identify the key regulatory differences between an IDR and an IIDR
• Identify the key components of preparing a complete organized case for review
• Understand the process for MPRO reviewers that utilize making a recommendation to a state agency
Informal Dispute Resolution Process

• The IDR process provides nursing homes a single, informal opportunity to dispute survey findings subsequent to the receipt of the official statement of deficiencies (aka SOD or 2567)
• Federal certification regulations 42 CFR §488.31, requires that CMS and the state offer facility representatives an informal opportunity, at their request to dispute survey findings subsequent to the receipt of the official statement of deficiencies (SOD or 2567)
• If successful, the finding should be removed or modified and a revised 2567 will be issued

What Is It?

• The IDR Process may address:
  o Scope and severity of non-substandard quality of care or IJ deficiencies
  o Remedies
  o Requirements of the Survey Process
  o Inconsistency of the survey teams in citations
  o Inadequacy or inaccuracy of the IDR process
• Details found in the SOM Chapter 7
• CMS is the ultimate authority for the survey findings and imposition of CMPs

What is the IDR Process?

• Every state handles the IDR process differently
• Panel of experts, 3-7 person committee or panel that may include representatives from the agency, a trade association, a nursing home administrator, and/or DON
• Designated individual from the state agency
• Choice of state agency or independent MPRO facility will pay MPRO for IDR review
Eligibility for IDR

<table>
<thead>
<tr>
<th>Situation</th>
<th>Eligibility for Informal Dispute Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuation of some deficiency at revisit</td>
<td>Yes</td>
</tr>
<tr>
<td>New deficiency (i.e., new or changed facts, new tag at revisit or as a result of an informal dispute resolution)</td>
<td>Yes</td>
</tr>
<tr>
<td>New existence of deficiency (i.e., new facts, same tag at revisit or as a result of an informal dispute resolution)</td>
<td>Yes</td>
</tr>
<tr>
<td>Different tag for some facts at revisit or as a result of an informal dispute resolution</td>
<td>No, unless the new tag constitutes substandard quality of care</td>
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Required Elements of an IDR

• Upon receipt of the 2567 facilities must be offered an informal opportunity to dispute deficiencies with the entity that conducted the survey.
• Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process including the:
  o Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care of immediate jeopardy.
  o Remedies enforced by the enforcing agency.
  o Alleged failure of the survey team to comply with a requirement of the survey process.
  o Alleged inconsistency of the survey team in citing deficiencies among facilities.
  o Alleged inadequacy or inaccuracy of the informal dispute resolution process.

Notification

Notification process should inform the facility:
• That it may request the opportunity for informal dispute resolution, and that if it requests the opportunity, the request must be submitted in writing along with an explanation of the specific deficiencies that are being disputed. The request must be made within the same 10 calendar day period the facility has for submitting an acceptable plan of correction to the surveying entity;
• Of the name, address, and telephone number of the person the facility must contact to request informal dispute resolution;
• How informal dispute resolution may be accomplished in that State, e.g., by telephone, in writing, or in a face-to-face meeting;
• Of the name and/or the position title of the person who will be conducting the informal dispute resolution, if known.
Two Different Surveys That can be Appealed:

1. State and/or Federal Survey (happens every 9-15 months)
2. Complaint Surveys

2567 Statement of Deficiencies

- State and Federal
- Enforcement
  - Deficiencies
  - Consequences
  - Remedies
- Plan of Correction
- Dispute and Appeal
  - Opportunity to defend practices
  - Offer evidence that may have been missed

New Survey Process

- Reform of Regulations – 11/28/17
- Renumbering of F-Tags
- Interpretive Guidance
- Responding During Survey
  - Communicate often to ensure surveyors have everything they need and have requested
  - Help locate information
  - Make copies – keep copies
- Immediate Action (Investigate and Document)
New Survey Process

- Once the surveyors it is more difficult to eliminate deficiency or decrease scope and/or severity
- If brought to supervisor desk for clarification, they tend to lean toward higher scope and/or severity

Daily Check In & Exit

- Check in daily during survey to obtain information and the pulse of the survey and the team
- Ask to meet with survey lead before formal exit so there are no surprises in front of residents and staff members

Surveyors Exit – Now

- What?
  - Start on POC immediately, don’t wait for 2567
  - Review Appendix PP, P, and Q for enforcement guidelines
    - What should we do?
    - Where did the deficiency come from?
  - To offer more documentation/information
    - Call team lead, then supervisor
    - Provide written proof ASAP of your position
After 2567 Arrives

- Review SOD thoroughly and include the IDT with SOM in hand for reference
- Copy previous submission and submit, things DO get lost
- Organize & highlight your documents as proof of care and services

Scope and Severity

10 Days to Appeal

Add a disclaimer to your POC

F000:
- This plan of correction constitutes our written allegation of compliance for the deficiencies cited.
- Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements.
Remedies by Category

Category 1
- Directed Plan of Correction
- State Monitoring
- Directed In-Service Training

Category 2
- Denial of Payment – New Admissions
- Denial of Payment – All Individuals
- Imposed by CMS
- CMPs
  - $50 - $3,000/day
  - $1,000 - $10,000/instance

Category 3
- Temporary Management
- Termination of Certification
- Optional CMPs
  - $3,050-$10,000/day
  - $1,000-$10,000/instance
Appeal Issues

• Scope and Severity Matter in Appeals
• If you know there is obvious deficient practice and it will not be eliminated, ask for a decrease in scope and severity
• More successful

Plans of Correction

• EPOC
• Required
  o What do you do? We follow our policy
  o How did we correct for cited residents?
  o How do we identify other residents who may be affected?
  o How do we prevent recurrence?
  o How will we monitor for compliance?
  o Who is responsible?
  o Date of Correction?

Types of Appeals

• IDR – Informal Dispute Resolution
• IIDR – Independent Informal Dispute Resolution
• *****Must choose one or the other
• Formal Federal Appeal
• Facility State Complaint Division
  o Reconsideration & Appeal Hearings
  o ***Separate from IIDR & Federal Appeal
  o IDR for Complaint = Request for Reconsideration
### How Do I Prepare?

1. Review the citation
2. Review written documentation from state and/or federal surveyors
3. Review medical record of cited resident(s)
4. Organize records in a fashion all can read, find, and understand (Exhibit A, B, C, D, etc.)
5. Request clinician or practitioner involvement
6. Request to meet in person, not always granted but priceless if approved
7. Prepare staff and leaders for informal appeal

### IDR

**Informal Dispute Resolution**

You may submit an informal appeal for deficiencies or correction orders that result from:

- State standard survey
- Federal survey
- Complaint investigation
- Follow-up survey or revisit
- VA Investigation

### IDR Process

- **Timing**
  - Within 10 days after 2567 is received
- **Appeal to health department**
  - Online, in writing, by telephone, or in person
  - Identify which tags are being appealed and why
- **POC due within 10 days**
- **Who hears the appeal?**
  - Another unit supervisor
IDR Process

- Decision Process
  - Recommendations come from health department
  - Commissioner upholds or changes recommendation(s)
  - CMS has final decision

What is an IIDR?

- Independent Informal Dispute Resolution
  - Reviewed by an Administrative Law Judge (ALJ)
  - Can be used to dispute any deficiency issued during standard survey or complaint
  - More formal – typically legal counsel is involved

IIDR Process

- Appeal within 10 days of receiving the 2567
- Appeal in writing or online
  - What tags are you appealing and why?
- The 2567 is still due within 10 days even if you are appealing
  - Disclaimer is important to defend your practice

Comment
Who Hears Appeal?

• Administrative Law Judge (ALJ)
  o Department of Health and provider present their cases
  o Submission in writing ahead of time is required
  o Exhibits, witnesses, opening and closing arguments
    are a part of process

Decision Process

• Administrative Law Judge (ALJ) makes recommendations within ten days
• Commissioner upholds or changes the ALJ recommendations
• CMS always has final decision

Formal Federal Appeal

• Timing – within 60 days after receipt of the 2567
  o If facility waives right to appeal within 60 days of CMS letter date (separate from 2567), CMPs may be reduced by up to 35%
  o Provider can still request IDR or IIDR
  o POC due within 10 days
  o Appeal to CMS
  o Federal law judge hears appeal
  o Decision is ALJ recommendation and then provider reimbursement review board makes final decision
**Complaint Division Appeals**

- Any complaint deficiency is subject to IDR or IIDR federal appeal process for F or K Tag cites
- For complaint division determination of maltreatment, neglect, abuse, or exploitation
  - Request within 15 days of report results
  - Appeal to division director
  - Director or Assistant Division Director/Manager of the health complaint division
  - Director makes decision to uphold or rescind findings or report after final hearing

**Not Satisfied with Decision?**

- Request a Fair Hearing
- Request within 30 days after
  - Receipt of decision of reconsideration
  - Denial of reconsideration request
  - Facility complaint division fails to act within 15 days
- Request to Commissioner of Human Services
  - Written request for hearing

**Who Hears the Appeal?**

- Department of Human Services Judge hears the appeal
- Decision Process
  - Determination is based on preponderance of evidence
  - Human Services Judge makes recommendation to health commissioner to either uphold or rescind findings or reconsideration hearing
Example

- New Resident in past 8 hours
- Morbidly Obese
- Staff member double padded resident for night shift
- Resident put call bell on to be changed
- Staff member told resident they don’t change people at night
- At 6am new CNA arrived
- Resident was tearful explaining how night staff member did not change her
- Facility cited with a G

Citation

Psychosocial Severity Guide

Severity Levels

The following are examples of severity levels of negative psychosocial outcomes that could have developed, continued, or worsened as a result of a facility’s noncompliance. This Guide is only to be used once the survey team has determined noncompliance of a regulatory requirement. The survey team must have established a connection between the noncompliance and a negative psychosocial outcome to the resident as evidenced by observations, record review, and/or interviews with residents, their representatives, and/or staff.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate Jeopardy is a situation in which the facility’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Examples of negative psychosocial outcomes as a result of the facility’s noncompliance at severity level four include, but are not limited to:
### Level 4

Suicidal ideation/thoughts and preoccupation (with a plan) or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself.

Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., banging head against wall).

Sustained and intense crying, moaning, screaming, or combative behavior.

Expressions of intense fear/anxiety that are likely to cause serious injury, harm, or death to self or others.

Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, or death to self or others.

Extreme changes in social patterns, such as sustained isolation from staff, friends, and family for a prolonged period of time.

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### Level 3

Severity Level 3 Considerations: Actual Harm that is not Imminent Jeopardy

Severity Level 3 indicates a less severe level of risk compared to Level 4, and can indicate but may not be limited to clinical significance. Declines in the resident’s ability to maintain and to perform at a higher potential for self-harm.

Significant decline in former social patterns that does not return to a level of imminent jeopardy.

Perceived depressed mood that may be manifested by verbal and unverbal behaviors such as:

- Social withdrawal, apathy, immobility, anxiety, hopelessness, tearfulness, crying, or increasing
- Loss of interest or ability to experience or feel pleasure nearly every day for much of the day
- Psychomotor agitation (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects), accompanied by a behavioral or affective expression
- Psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering)

- Verbal agitation (e.g., repeated requests for help, groaning, sighing, or other repeated vocalizations), accompanied by sad facial expression
- Expressions of feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick or needing care)
- Markedly diminished ability to think or concentrate
- Recurrent thoughts of death (not just fear of dying) or statements without an intent to act (e.g., “I would be better off if I was dead” or “I might as well be dead”), or any similarly serious thoughts

### Level 3

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- Expressions of anger at an intense and sustained level that has caused or is likely to cause serious injury, harm, or death to self or others.

- Extreme changes in social patterns, such as sustained isolation from staff, friends, and family for a prolonged period of time.
Level 3

- Chronic or recurrent fear or anxiety that has compromised the resident’s well-being and that may be manifested as avoidance of the fear-producing situation(s) or person(s); preoccupation with fear; assistance to care and/or social interaction; moderate aggressive or agitation behaviors related to fear; sleeplessness due to fear; and/or verbal expressions of fear. Expressions of fear/intimacy are not to the level of panic and immobilization (as in Level 4).

- On-going, persistent feeling and/or expression of determination or intolerance that persists regardless of the precipitating, diminishing event(s) or situation(s) has ceased. These feelings do not result in a life-threatening consequence.

- Sustained distress (e.g., agitation indicative of mild stimulation) manifested by agitation, restlessness, repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something.

- Anger that has caused aggression that could lead to injuring self or others. Verbal aggression can be manifested by threatening, swearing, or swearing; physical aggression can be manifested by self-directed responses or hitting, shoving, biting, and scratching others.

Level 2

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy

Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or loss of the potential to compromise the resident’s ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of facility’s noncompliance at severity level two include but are not limited to:

- Interpersonal sadness, reflected in facial expression and/ or demeanor, dampness, crying, or verbal/ vocal agitation (e.g., reported requests for help, moaning, and/ or crying).

- Feelings and/or complaints of discomfort or mechanic pain. The resident may be irritable and/ or express discomfort.

- Fear that may be manifested as expressions or signs of anxious behavioral (e.g., verbal expressions of fear, anxiety, pulling away from a feared object or situation) and has the potential to be compounded by the resident’s well-being.

- Feeling of shame or embarrassment without a loss of interest in the environment and the self.

- Complaints of boredom and/ or reports that there is nothing to do, accompanied by expressions of mental or physical restlessness (e.g., verbal or physical aggression).

- Verbal or nonverbal expressions of anger that did not lead to harm to self or others.
Level 1

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm

Severity Level 1 is not an opinion because any facility practice that results in a reduction of psychosocial well-being diminishes the resident’s quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the deficiencies, the following ones may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome. Areas where the survey team may see these include psychosocial outcomes where citing a particular deficiency includes, but are not limited to:

451.10 Resident Rights
F357. Request, Dignity Right to Have Personal Property;
F374. Reasonable Accommodations of Needs/Preferences;

451.12 Freedom from Abuse, Neglect, and Exploitation
F600 Free from Abuse and Neglect;
F602 Free from Inappropriate/Exploitation;

IDR Response

According to 400.100 Pub. 500 Title 42 Provider Certification, Audit Program, Memory Care: Security Guards -

It is understandable that level 1 is not an option due to the nature of the constant. The following considerations, which is usually how it's articulated properly, the findings are not consistent with the examples given for consideration:

- Actual harm: the noncompliance that results in a negative outcome that has compromised the resident’s ability to maintain their individual identity, mental, and psychosocial well-being. As an extreme, it means the resident’s perception of their needs, self-care, and personal care. This does not include all the practices that only could cause or has caused limited consequences to the resident.

- There is no evidence to suggest that the resident experienced actual harm. The resident was in the following less than 24 hours and was not able to completely achieve the resident's needs, or possible. The caring resident did not follow the facility protocol and the caring assistant was discharged from employment upon notification of the resident.

The considerations for actual harm are not consistent with the regulatory patient:

- There is no evidence that the resident was in an environment of neglect as part of the staff member. There was evidence of no following the protocol and poor resident services.
- There is no evidence of significant decline in former senior patient.
- There is no evidence of a resident deceased event.
- There is no evidence of expressions of persistent pain or physical distress.
- There is no evidence of anger or assessment finding that has compromised the resident.

In reviewing the Level 2 Considerations: No actual harm with potential for minimal harm that is not immediately previously is apparent that the considerations are somewhat consistent with the findings in the 206.7

- There is evidence that the resident had intermittent sadness. It is documented that the resident was truthful during their interview with the surveyors but not at any other time.
- There is evidence of feelings and/or complaints of discomfort but not pain.
- There is evidence of fluctuation in the verbal expression of the resident over time during the surveying the nurse assistant failed to contact the resident about the needing intervention assistance.
- There is evidence of the resident being afraid to say something to the nursing assistant about her discomfort.

IDR Response

- There is no evidence of ongoing, persistent feeling and/or expression of dehumanization or belittling that persists.
- There is no evidence of apathy and social disengagement.
- There is no evidence of sustained distress.
- There is no evidence of anger that has caused aggression that could lead to trusting well or better.

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Questions?

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Resources/References

https://www.maximus.com/appeals/appeals-inquiries
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/downloads/LawsAndRegulations/Nursing-Homes.html

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