The Medical Director's Role in the State Survey and Dispute Resolution

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An American Medical Directors Association (AMDA) policy on the role of the medical director, based on a position statement approved by the association in 2003, indicates that the medical director should review, respond to, and participate in federal, state, local, and other external surveys and inspections.1 Anecdotal discussions at annual AMDA symposia and state chapter meetings suggest that a number of medical directors take an active role when inspectors from the state survey agency are on site in the nursing facility by making themselves available to the survey team in person, by telephone, or both. By being available, the medical director may be able to address a surveyor’s concern about an avoidable or unavoidable condition, a potentially inappropriate medication order, or the etiology of a wound. Allaying a surveyor’s concern may decrease the risk of the nursing facility receiving a citation or limit its scope and severity.

Becoming involved in the survey process can be time consuming and frustrating for medical directors, however. Another AMDA position paper suggests that the citation of deficiencies is often arbitrary and that the adversarial atmosphere created by this punitive approach does little to enhance resident safety or quality of care.2,3 Statistical validity also comes into question with some citations. In a case report describing a state survey’s citation of a nursing facility for med-pass errors, Woolley4 points out that in situations where error rates are low, large numbers of observations of an activity must be made to reach acceptable validity of estimates for the true error rate.

Whether involved in the survey process or not, most medical directors have experienced the angst of having their facilities receive deficiencies on a state survey. What can a facility’s administrative and clinical staff members do if they receive a citation with which they disagree? How should the medical director be involved?

One option to challenging deficiencies is the Informal Dispute Resolution (IDR) process. IDR has been available to nursing facilities since 1995 and is a less expensive, less time-consuming alternative to the more formal appeals process adjudicated before an administrative law judge. The purpose of this informal process is to give providers one opportunity to refute cited deficiencies after any survey. Facilities may not use IDR to delay the formal imposition of remedies or to challenge any other aspect of the survey process. The procedures and time lines for IDR are described on the Centers for Medicare and Medicaid Services (CMS) Web site.5 Filing an IDR does not preclude a subsequent appeal by the facility to an administrative law judge.

In the July 2012 issue of the Journal of the American Medical Directors Association, Mukamel and colleagues6 reported on the frequency with which facilities file IDRs and factors involved in the decision to initiate the IDR process. Using CMS data, the researchers analyzed 94,188 annual and complaint surveys and 9388 IDRs from 15,916 Medicaid- and Medicare-certified nursing homes nationally between 2005 and 2008. They found that 10% of surveys prompted an IDR. Not unexpectedly, substantial variation is seen from state to state over the entire study period. Multivariate analysis suggests that nursing homes’ decisions to request an IDR depend on their assessment of the probability of success and assessment of the benefits of the submission. For example, the probability of IDR submission increased with the number of deficiencies the facility received and increased even further with increasing severity of the deficiencies.6 IDR submission was less likely in states with more stringent quality regulations and when deficiencies were associated with a complaint survey.6

The article by Mukamel and colleagues6 provides important national data for medical directors interested in helping their facilities appeal deficiencies that are considered to be unjustified. The findings suggest that the medical director can help facility administrative staff decide whether to submit an IDR regarding a clinical issue based on the nature of the citation, available evidence from the medical literature, and other considerations.

To best carry out the responsibilities of the medical director as described in current AMDA policy,1 the medical director should be involved in quality improvement activities on an ongoing basis and be available either in person or by telephone whenever a team from a state survey agency is in the facility. If the facility is cited for a deficiency in a clinical area in spite of the medical director’s involvement in the survey process, the medical director can provide guidance about whether to submit an IDR and help craft the document by providing evidence-based rationale for the clinical decision making and outcomes that prompted the citation. The work required on the part of the medical director to carry out these tasks should be appropriately compensated by tracking the time involved and submitting an invoice to the facility at a fair market value rate. Better still, the medical director should list these tasks in the contract or memorandum of understanding with the nursing facility.

As long as the survey process continues to be adversarial and punitive, informal dispute resolution is an important option for nursing facilities that are cited for deficiencies that are considered unjustified. The medical director can be an effective partner for the
facility in the decision to submit an IDR and in crafting the document. It may be a long while before the survey process takes on the educational and facilitative approach proposed in the AMDA position paper.2

References
