

### **Overview of Programs**

#### HSM's Operations:

HSM has been authorized by the Division of Medicaid to carry out the Utilization Management and Quality Improvement program for the State of Mississippi. Our offices are located in Jackson at the following address:

175 East Capitol Street, Suite 250, Lockbox 13, Jackson, MS, 39201.

HSM's business offices are open from 8:00 a.m. to 5:00 p.m., Monday through Friday. Our direct office telephone number and primary FAX number are:

Telephone: (601) 352-6353

FAX: (601) 352-6358

#### Other Important Numbers:

<b>Function</b>	<b>Description</b>	<b>Numbers</b>
Certification Review Request Submission	Appropriate numbers to use to submit IP certification requests.	Telephone: (Available 7:00 a.m. – 5:30 p.m.) 1-888-204-0502 FAX: 1-888-204-0504
Help Line	Numbers to use for questions regarding certification review decisions and other review processes.	Telephone: (Available 8 a.m. – 5 p.m.) Local: 601-360-4949 Toll Free: 1-866-740-2221
Hot Line	Number to use to report quality concerns and/or complaints	Toll Free: (Available 8 a.m.-5 p.m.) 1-888-204-0221

Please Note: For business (not certification) calls coming in after 5:00 p.m. and before 7:00 a.m., HSM's voice mail will record your message, and staff will return your call the next day. No clinical information should be left on this voicemail. Faxes received after 5:00 p.m. are considered received the next working day.

## **Summary of Review Activities**

### **General Information**

Health Systems of Mississippi conducts medical necessity review for inpatient care for Mississippi Medicaid beneficiaries.

For first level review, HSM employs only registered nurses in all of its inpatient review activities. The registered nurses (Utilization Review Coordinators) use screening criteria to determine medical necessity and appropriateness of admissions/continued stay/services. In addition, they use quality screens for review of quality of care. If a case does not meet screening criteria or a quality concern is identified by failure of one or more of the quality screens, the URCs must refer the case to a Physician Advisor. Only physicians can make adverse determinations (denials and/or confirmation of a quality issue). The URCs have access to consultation with licensed physicians.

### **Exempt Cases**

Listed below are the cases in which a certification number is not required:

1. Cases in which the physician's orders specifically state that the patient be placed on twenty-three (23) hour observation status and the patient stayed twenty-three (23) hours or less.
2. Acute care cases in which the patient has Medicare Part A and Part B coverage unless inpatient Medicare benefits are exhausted. Note: Patients with Medicare Part A and Part B do not require certification if the patient also has private insurance.
3. Patients with Medicaid only or patients with Medicaid and third party insurance are also exempt from review in the following circumstances:
  - a. admits for vaginal deliveries who stay two (2) days or less. (*See reporting of maternity admissions below*)
  - b. admits for Cesarean section who stay four (4) days or less. (*See reporting of maternity admissions below*)

### **Reporting of Maternity Admissions for Delivery (Effective 07/01/05)**

Vaginal deliveries with stays of two (2) days or less or Cesarean Section deliveries with stays of four (4) days or less must be reported to HSM. Please refer to the *Maternity Admission for Delivery Reporting* policy and procedure in this manual for additional information.

### **Newborn Admissions**

Providers should seek Medicaid certification by HSM when a newborn:

- is admitted to any setting other than a "well baby nursery" (*i.e., NICU/PICU, Intermediate, etc.*) regardless of the mother's length of stay.
- stays longer than the mother. (*The mother's discharge date should be used as the certification admit date.*)
- transfers from a well baby setting to a more acute setting. (*The infant's transfer date should be used as the certification admit date.*)
- is admitted to any setting other than a "well baby nursery" and is born to a mother who has Medicare A and B coverage.

It is also important to note that:

- infants must be admitted or transferred to a NICU/PICU, Intermediate, etc., setting in order to require separate certification from HSM. (Changing the infant’s status or level of care without physically transferring the infant to a more acute setting does not require HSM certification.)
- any newborn with a well baby status who is discharged with the mother is exempt from review.
- it is necessary to provide HSM with the name of the infant. “Baby Boy” or “Baby Girl” is not acceptable.

**Precertification**

Providers are required to request precertification on all planned and elective admissions prior to the proposed admission date for all inpatient, non-emergency medical/surgical admissions, inpatient acute psychiatric admissions, swing-bed admissions, transplants, pre-transplant, and Psychiatric Residential Treatment Facility (PRTF) admissions. Urgent and emergent admissions are required to be precertified on HSM’s next working day. Please read the policies and procedures sections of this manual for more details on this process.

The table below outlines the options for submission of certification requests for the various types of review settings:

Request Options	Review Setting
Mail	Inpatient Non-Emergency Medical/Surgical, Inpatient Acute Psychiatric, Swing-Bed, Inpatient Transplant, Pre-Transplant, Psychiatric Residential Treatment Facilities
Telephone	Inpatient Non-Emergency Medical/Surgical, Urgent/Emergent Inpatient Medical/Surgical, Inpatient Acute Psychiatric, Swing-Bed, Inpatient Transplant, Maternity Admission Reporting
Fax	Inpatient Non-Emergency Medical/Surgical, Urgent/Emergent Inpatient Medical/Surgical, Inpatient Acute Psychiatric, Swing-Bed, Inpatient Transplant, Pre-Transplant, Psychiatric Residential Treatment Facilities, Maternity Admission Reporting
Web	Inpatient Non-Emergency Medical Surgical, Urgent/Emergent Inpatient Medical/Surgical, Inpatient Psychiatric, Maternity Admission Reporting

The table below outlines the required timeframes for submission of precertification requests:

Review Setting	Required Timeframe
Inpatient Non-Emergency Medical/Surgical, Inpatient Non-Emergency Psychiatric, Inpatient Transplant, Pre-Transplant, Swing-Bed	Prior to the admission
Urgent/Emergent Acute Care admissions to Medical/Surgical, Psychiatric, Transplant *	HSM’s next business day*
Psychiatric Residential Treatment Facility	Three (3) business days prior to the planned admission
Maternity Admission for Delivery Reporting	Within fifteen (15) days post discharge

- **For urgent admissions**, providers are required to request certification review at the earliest opportunity. When conditions permit, certification review should be initiated prior to admission. Otherwise, certification should be requested no later than HSM's next working day.
- An example of an **urgent admission** is as follows: The beneficiary was seen by the physician on the day of admission and the physician identified an urgent problem that required immediate inpatient intervention to prevent an emergency condition.
- **For emergent admissions**, the provider is required to notify HSM for post-admission certification within one working day of the admission (i.e., if the admission happened on a Friday [after noon], Saturday, or Sunday, the certification should be requested on the following Monday. If that Monday is a holiday, the certification should be requested on Tuesday). For emergent admissions that fall on holidays, the certification should be requested the next working day.
- An emergent admission is defined as follows:  
**Emergency Medical Admission:** The admission to an inpatient hospital setting results from the sudden onset of a medical condition or injury requiring acute care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient hospital care could result in:
  - ⇒ Permanently placing the patient's health in jeopardy
  - ⇒ Serious impairment to bodily function, or
  - ⇒ Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences

Please read the policies and procedures section of this manual for more details on this process.

**Concurrent Certification**

HSM performs concurrent certification review of inpatient medical/surgical (including transplants), acute psychiatric, swing-bed, and Psychiatric Residential Treatment Facility (PRTF) continued stays. HSM will provide all acute care facilities with a daily list of beneficiaries whose certification expires within forty-eight (48) hours. Psychiatric Residential Treatment Facilities and will receive notification of beneficiaries whose certification expires within five (5) business days. HSM will forward a copy of this list to the beneficiary's attending physician if requested.

It is the responsibility of the facility/physician office to ensure that concurrent review is requested in accordance with program requirements:

Review Setting	Required Timeframe
Medical/Surgical, Psychiatric, Swing-Bed, Transplant	On or prior to the last day certified
Psychiatric Residential Treatment Facility	Seven (7) business days prior to the last day certified

The following options are available for submission of concurrent review requests:

Request Options	Review Setting
Mail	Inpatient Medical/Surgical, Inpatient Acute Psychiatric, Swing-Bed, Inpatient Transplant, Psychiatric Residential Treatment Facilities
Telephone	Inpatient Medical/Surgical, Inpatient Acute Psychiatric, Swing-Bed, Inpatient Transplant
Fax	Inpatient Medical/Surgical, Inpatient Acute Psychiatric, Swing-Bed, Inpatient Transplant, Psychiatric Residential Treatment Facilities
Web	Inpatient Medical Surgical, Inpatient Psychiatric, Inpatient Transplant

Please read the policies and procedures section of this manual for more details on this process. It is the policy of HSM not to reverse previously certified review determinations regardless of whether information is received that was not available at the time of the original review.

### **Retrospective Certification**

Retrospective certification review is initiated when a facility/physician notifies HSM that 1) the beneficiary received a service and was discharged without precertification or certification, or 2) the beneficiary's Medicaid eligibility was not established at the time the service was rendered.

For this review, a complete copy of the medical record (or record parts) must be submitted to HSM along with completed request forms provided by HSM. For stays of eight (8) days or less, facilities may request retrospective review by telephone or via the web as outlined in the policy and procedure section of this manual. Under HSM's current Mississippi Division of Medicaid (DOM) contract, HSM nor DOM reimburse providers for costs associated with the duplication of medical records to be submitted for retrospective review.

Please read the policies and procedures section of this manual for more details on this process.

**NOTE:** Psychiatric Residential Treatment Facilities (PRTFs) must continue to submit a copy of the complete medical record along with the HSM Retrospective Certification Request Form.

### **Pended Cases**

HSM will provide verbal and written notice to the attending physician or facility/nursing agency when additional information is required to complete certification review. Timeframes for submission of the information are detailed in HSM policies and procedures included in this manual and are dependent upon the type of review (precertification, concurrent, etc.). If the requested information is not received in the allotted timeframe, HSM will stop (suspend) review of the case and notify the attending physician or facility/nursing agency that further review of the case is not possible. Review will resume once HSM receives the requested information. In certain circumstances (precertification review where the proposed admission date has passed) a new certification request must be submitted.

### **Electronic Submission**

Providers may choose to electronically submit review requests for certification of inpatient admissions, post-admissions, concurrent, and retrospective reviews (eight days or less) via HSM's web site. Additional information, requested by HSM, may be submitted electronically if the initial review was submitted via the web.

HSM's web-based review system includes a provider-specific reporting module that can provide real-time status of reviews previously submitted to HSM. This feature can be accessed without utilizing the review submission option.

Providers must contact HSM's Data department for a provider-specific password and an electronic review User's Guide before submitting a review.

Providers are required to have Internet access for personnel submitting certification requests or accessing provider reports electronically. The minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers
- Color monitor
- 28.8K modem connection or higher (phone line quality will determine speed of connection)
- Internet Explorer Version 4.0 or higher

HSM ensures that all electronic submissions are secured and maintains a current understanding of HIPPA security regulations.

### **Psychiatric Residential Treatment Facilities – Monthly Census Report**

Psychiatric Residential Treatment Facilities (PRTFs) must submit a monthly census report to HSM indicating the current patients, new admits (including date) and discharges (including date). The report for the preceding month should be submitted no later than the last day of the month. See the policy and procedure section of this manual for required information.

### **Provider Certification Non-compliance Policy**

HSM will monitor and track the number of times a facility requests a late certification either for precertification, concurrent or retrospective certification on an ongoing basis. On a quarterly basis, HSM will generate a profile identifying the number of times a facility requests non-compliant certifications. Interventions will be initiated for those facilities meeting thresholds as defined in our policy.

Providers and/or physician offices are required to request precertification on all planned and elective admissions prior to the proposed date of admission to any setting. For urgent admissions, providers are required to request certification at the earliest opportunity. When conditions permit, certification review should be initiated prior to admission. Otherwise, certification should be requested no later than HSM's next working day.

For emergent admissions, the provider is required to notify HSM for post-admission certification within one working day of the admission (i.e., if the admission happened on a Friday, Saturday, or Sunday, the certification should be requested on the following Monday. If that Monday is a holiday, the certification should be requested on Tuesday). For emergent admissions that fall on holidays, the certification should be requested the next working day.

The facility/physician must note the circumstances, which caused the admission to be an urgent/emergent admission on the Admission Review Form or relate these circumstances to the nurse reviewer during telephonic review or via the web.

Late requests for certification are considered non-compliant except in the following instances:

- the beneficiary's Medicaid eligibility was not established at the time the service was rendered (i.e., a late certification because of retroactive eligibility would not be counted as non-compliant), OR
- the admission occurred in an urgent or emergent situation as documented in patient review information submitted.

Please read the policies and procedures section of this manual for more details on this process.

### **Quality Assurance/Utilization Review Activities**

#### **Quality of Care Screening**

Registered Nurses use quality screens during the review process to determine if services/care provided meet professionally recognized standards of healthcare. These screens are applied to all cases reviewed. If one or more screens are failed, the case is referred to a Physician Advisor for review. The quality screens are included in this manual.

**Five-percent Quarterly Sample**

On a quarterly basis, HSM will 1) select a five percent (5%) sample of all Medicaid cases certified for admission and concurrent stay and 2) review the medical record, to identify quality/utilization concerns/issues, and to validate the information provided during precertification and concurrent certification. Results of this review will be profiled to identify patterns of problems by the facility/physician. If these patterns are confirmed by HSM's Quality Intervention Committee, HSM will work with those facilities/physicians to plan, implement, and monitor improvement efforts aimed at resolving the issue. Please read the policies and procedures sections of this manual for more details on this process.

**Quality Intervention Process**

Quarterly, HSM will generate profiles identifying, by physician and by provider, the number of confirmed quality problems, the severity level of those problems, and the frequency of confirmed problems. The data compiled in these profiles include confirmed quality problems from the five-percent quarterly sample, from precertification/continued stay reviews, retrospective reviews, and from the beneficiary/provider hot-line. The purpose of the quarterly profiles is to identify potential patterns of problems by physicians and/or providers.

**Submission of Records and Additional Information**

HSM may request that facilities submit copies of complete medical records (i.e., for the quarterly 5% sample). HSM will send a letter to each facility, which includes a list of the records to be sent to our office. Included with this letter will be an inventory sheet for each case selected for review and listed in the letter. This inventory sheet is to be attached to the copy of the appropriate medical record. Under the current Mississippi Division of Medicaid contract, neither HSM nor DOM reimburses providers for the cost associated with duplication of medical records for the 5% Quality Sample activity.

Facilities will have a maximum of twenty (20) calendar days from HSM's request date to submit the records to HSM at the following address:

HealthSystems of Mississippi  
ATTN: Five-Percent Quarterly Sample  
175 E. Capitol Street, Suite 250, Lock Box 13  
Jackson, MS 39201

### **Denials/Reconsiderations and Quality Re-Reviews**

If a Notice of Adverse Determination letter is issued denying the admission, services, or days of stay, the beneficiary/representative, facility, or physician has the right to request a reconsideration of any denial decision. The request for a reconsideration may be submitted to HSM by telephone, FAX or mail within thirty (30) calendar days of the date on the denial notice for non-expedited reconsiderations or within three (3) business days of the denial notice for expedited reconsiderations. Refer to the *Reconsideration* Policy and Procedure section of this manual for additional information.

Any facility or physician who receives a Notice of Quality/Utilization Issue letter and disagrees with the determination of a confirmed issue may request a re-review of that determination and supply any information, which might resolve the issue. The request must be in writing and contain the reason the facility or physician disagrees with HSM's determination. The written request may be faxed or sent by mail, within thirty (30) calendar days from the date of the Notice of Quality/Utilization Issue letter.

HSM has Reconsideration and Quality Re-review Request forms for facilities and physicians to use for these purposes.

### **Mississippi Medicaid Disclaimer Statement**

HealthSystems of Mississippi's certification determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid Program.