

Quality Assurance and Utilization Review: Quality Screening

Objective:

To ensure that care proposed to be provided and/or provided to Medicaid beneficiaries meets professionally recognized standards of care.

Performed By:

Utilization Review Coordinators (URC) and Quality Review Nurses (QRN) who are registered nurses. Physician level review by the Medical Director (MD), Associate Medical Directors (AMD), or Physician Advisors (PA)

Policy:

HSM utilizes the quality screens to identify quality/utilization concerns/issues for all precertification, concurrent, and retrospective certification cases for the inpatient acute care review setting.

Procedure: Quality Screening

1. The URC applies the applicable quality screens to the appropriate setting (i.e., inpatient acute care, acute psychiatric, swing bed, maternity admissions for delivery, and Psychiatric Residential Treatment Facilities as well as for the review type (i.e., precertification, concurrent, and retrospective certification).
2. In applying the quality screens, the URC uses his/her clinical knowledge and experience to determine if a potential quality/utilization issue exists. If one or more screens are failed, the case is referred for physician review. If no screens are failed, this activity is complete.
3. For all screen failures, the URC describes each identified issue, and refers the case to the Medical Director (MD), Associate Medical Director (AMD), or Physician Advisor (PA) to determine if the identified issue(s) is confirmed or resolved.
4. The MD, AMD, or PA uses his/her clinical knowledge and experience, and any current local and national standards of practice to make a determination as to whether a quality/utilization issue(s) is confirmed or resolved.
5. The MD, AMD, or PA will attempt to call the attending physician if a quality concern/issue is identified during the precertification and concurrent certification process. In this way, any additional information provided by the attending physician is considered prior to making a determination of a confirmed issue(s).
6. If the issue(s) is resolved, the MD, AMD, or PA documents the rationale for resolving the issue and the case is returned to the URC for updating of the review results. This activity is then complete.
7. For each issue confirmed, the MD, AMD, or PA documents the following information:
 - his/her description of the quality/utilization issue
 - who was responsible for the issue/source of problem (i.e., provider and/or physician)
 - what the appropriate action should have been
 - the assigned severity level

8. The MD, AMD, or PA uses the following severity levels and definitions for each confirmed quality/utilization issue:
 - **Severity Level 1** - A confirmed quality problem with minimal potential for significant adverse effect to the patient
 - **Severity Level 2** - A confirmed quality problem with the potential for significant adverse effect to the patient
 - **Severity Level 3** - A confirmed quality problem with significant adverse effect to the patient

NOTE: Significant adverse effect is defined as unnecessarily prolonged treatment, complications, or readmissions, or patient management, which results in anatomical or physiological impairment, disability, or death.
9. The case is forwarded to the Quality Review Nurse (QRN) for updating of the review results into the data system. In addition, he/she drafts the verbiage for the Notice of Quality/Utilization Issue letter based on the documentation provided by the MD, AMD, or PA.
10. The Notice of Quality/Utilization Issue letter contains a brief case summary, how a re-review can be requested, and the following information for each confirmed issue:
 - description of the confirmed issue
 - who was responsible for the issue (i.e., source of problem)
 - what the appropriate action should have been
 - assigned severity level and definition
11. The data system generates the Notice of Quality/Utilization Issue letter. For facility issues, the letter is addressed to the administrator or designee. For physician issues, the letter is addressed to the physician, with a copy of the letter sent to the appropriate provider in order for the provider and physician to have the opportunity to provide a joint response to the Notice. The Division of Medicaid (DOM) receives a report of all confirmed quality issues.
12. Notice of Quality/Utilization Issue letters are sent within ten (10) business days from the date the issue is confirmed.
13. Once letters are generated and sent, then this activity is complete and the medical record is sent to medical records for filing.
14. The physician and the provider have the right to request a quality re-review. Refer to the *Quality Assurance and Utilization Review – Quality Re-review Policy and Procedure* section of this manual for additional information.