

5% Quarterly Quality Sample – Inpatient Acute Care

Objective:

To ensure that care provided to Medicaid beneficiaries meets professionally recognized standards of care, and to validate the information provided during precertification, concurrent, and telephonic retrospective certification with the documentation in the medical record.

Performed By:

Initial review by Quality Review Nurses (QRN) who are registered nurses. Physician level review by the Medical Director (MD), Associate Medical Director (AMD), or Physician Advisor (PA).

Policy:

On a quarterly basis, HSM will select a five percent (5%) sample of all inpatient acute care and reported maternity admissions for delivery and Medicaid cases previously certified for admission and concurrent stay. HSM will review the medical record to identify quality/utilization concerns/issues and to validate the information provided during precertification and concurrent certification.

This 5% sample will be a random retrospective sample selected from HSM's data base, excluding cases with confirmed problems identified during the precertification, concurrent and telephonic retrospective certification process. Once the sample is selected, monthly letters which include a medical record inventory sheet/checklist will be sent to applicable providers requesting medical records for review. Providers have a maximum of twenty (20) calendar days to provide the medical records to HSM from the date of the HSM request. HSM will make two attempts to obtain copies of records: 1) the initial request for records, and 2) one additional request (second request), if record copies have not been received.

If the facility does not provide the copies of medical records as requested, HSM's Quality Review Staff (Quality Manager and Quality Review Nurses) will provide a list of the providers and their records not received to the Division of Medicaid for further intervention.

Procedure: 5% Quarterly Sample

1. For all cases selected for this 5% sample, the Quality Review Nurse (QRN) verifies that the information provided during precertification and concurrent certification is substantiated by the documentation in the medical record.
2. Profiling for patterns of providing unsubstantiated information during precertification and/or concurrent certification, by provider and/or physician offices, will be performed and interventions initiated to remedy the pattern.
3. In addition, the QRN applies the appropriate quality screens to all selected cases. The *Quality Assurance/Utilization Review Section* of this manual contains a copy of the quality screens to be used.

4. In applying the quality screens, the QRN uses his/her clinical knowledge and experience to determine if a potential quality/utilization issue(s) exists. If one or more screens are failed, the case is referred for physician review. If no screens are failed, this activity is complete.
5. For all screen failures, the QRN notes each screen failure(s), describes each identified issue, and poses his/her questions to the Physician Advisor.
6. The QRN refers the case to the Medical Director (MD), Associate Medical Director (AMD), or a Physician Advisor (PA) to determine if the identified issue(s) is confirmed or resolved.
7. 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.
8. If the issue(s) is resolved, the MD, AMD, or PA documents his/her rationale for resolving the issue. This activity is then complete.
9. 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., facility and/or physician)
 - what the appropriate action should have been
 - the assigned severity level
10. 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

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.
11. The case is returned to the 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 using documentation provided by the MD, AMD, or PA.
12. 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
13. The data system generates the Notice of Quality/Utilization Issue letter. For provider issues, the letter is addressed to the administrator or designee. For physician issues, the letter is addressed to the physician, with a copy to the appropriate provider in order for the provider and

the 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.

14. Notice of Quality/Utilization Issue letters are sent within ten (10) business days from the date the issue is confirmed.
15. Once letters are generated and sent, this activity is complete.
16. 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.