

5% Quality Sample On-site Review Policy and Procedure

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. To provide on-site review services for Mississippi Medicaid providers that meet established criteria based on the number of cases selected for the sample and on the distance in which they are geographically located from HealthSystems of Mississippi's (HSM) office.

Performed By: Quality Review Nurses (QRNs), Physician Advisors (PAs), Medical Director (MD)

Policy:

On a quarterly basis, HSM selects a five percent (5%) sample of all Medicaid cases previously certified for admission, concurrent, or telephonic retrospective stay and reviews the medical record to identify quality/utilization concerns/issues, and to validate. From the monthly cases selected, the Quality Review Nurse(s) determines which provider(s) meet the criteria to qualify for on-site review services.

HSM's schedules the on-site review at least one (1) business day in advance of the visit, unless otherwise agreed upon. The Quality Review Nurse (s) shall follow all reasonable provider procedures, including checking in with designated personnel upon arrival for an on-site review. QRN's must wear a picture identification badge with full name and HealthSystems of Mississippi's name visible at all times during the on-site review.

HSM requires the provider to provide the QRN(s) with a workspace conducive to review and prefers that includes telephone and computer access. HSM requires the provider to copy and submit to HSM, at their own expense, any medical records in which a failed quality screen is identified by the QRN during review, records that involve death of a beneficiary, or records that are not available for review during the on-site visit.

Procedure: On-site 5% Quality Sample Review Process

On-site Review Procedures

1. The 5% sample selection is based on HSM's quarterly Medicaid review volume, however, requests for medical records are issued to providers on a monthly basis so that a manageable workload is maintained for both providers and HSM quality review staff.

2. The Quality Review Nurse (QRN) prints the monthly 5% Quality Sample Review requests on the first (1st) day of each month.
3. The QRN determines which providers qualify for on-site review services each month based upon the following two (2) criterion:
 - The provider has greater than 30 (thirty) 5% Quality Sample medical records selected **and**
 - The provider is located within a 25 mile radius of the HSM office in Jackson, MS.
4. The request is sent to the provider and includes the inventory tracking sheet(s) to be attached to the complete medical record at the time of the on-site visit.
5. Once a provider is determined to meet both criteria, the QRN contacts the Director of Information Management, or designated person, of the qualifying provider to schedule the on-site review. The QRN must allow at least one (1) business day advance notice to the provider before the proposed date of the on-site review, unless otherwise agreed upon.
6. The QRN is responsible for transporting an HSM owned lap top computer to the facility. Once the QRN connects to HSMPURS, the screen saver mode should be activated. If for any reason the QRN steps away from the laptop, the QRN should select the Control, Alt, Delete buttons and select the lock computer mode to prevent unauthorized access to the system.
7. Upon arrival at the facility, the QRN(s) check in with the designated personnel and follow all reasonable facility protocol while on premises. The QRN ensures that the designated facility personnel escorts the medical records to the workspace designated for QRN review services, if the workspace is somewhere other than the medical records department.
8. The QRN(s) must wear picture identification badges at all times while on-site that bears their full name, title, and HealthSystems of Mississippi's name as well.
9. The QRN(s) conducts review of each available medical record and documents review notes on a QRN 5% Quality Sample Review Worksheet. If no quality screen failures are identified, the information provided during certification review is substantiated by the medical record, and the record does not involve death of the beneficiary, the on-site review process is complete.
10. The QRN shall request a copy of the medical record be submitted to HSM by the medical record personnel within five (5) business days of the on-site review at the provider's expense if any of the following situations are encountered during the on-site review:
 - The medical record requested for review is not available for review during the on-site visit

- The medical record involves the death of a beneficiary (regardless of whether a quality screen failure is identified or not)
- The QRN identifies one (1) or more failed quality screens in a record, or
- The information provided during certification review is not substantiated by the medical record

The QRN should instruct the medical record personnel to complete and attach a copy of the medical record inventory tracking sheet to the top of the medical record submitted to HSM for proper tracking and processing of the information and to ensure that the complete medical record has been included.

11. The QRN enters review results into the HSMPURS data base.
12. When the QRN(s) has completed review of all available records, the QRN notifies the designated medical record personnel that on-site review is complete and that the records may be returned to their designated area. The QRN must maintain possession of the medical records until the designated provider personnel has taken possession.
13. QRN staff verifies the information provided during certification review is substantiated by the medical record documentation.
14. Any observed patterns of providing unsubstantiated information during precertification concurrent, or telephonic retrospective certification, by provider and/or physician offices, is documented as a quality issue and referred for physician review and recommendation.
15. When the records are received at HSM for any of the reasons listed in procedure nine (9), they are tracked in by clerical support and then processed as follows:
 - For records that were not available during the on-site review, the QRN follows the routine 5% Quality Sample review process as outlined in the 5% Quality Sample Review Policy and Procedure in this manual.
 - For records in which review information was not substantiated by the medical record the QRN copies the QRN 5% Quality Sample Review Worksheet and the screen prints indicating appropriate documentation into HSM's database and files these in the file cabinet in the Quality Department for pattern analysis.. The complete medical record is filed in medical records area.
 - For records involving the death of a patient in which the QRN identified no failed quality screens, the QRN forwards a summary of the admission to the Medical Director (MD) for his review. The QRN maintains the complete medical record in the Quality Department until the MD has reviewed the summary and determines there are no quality issues indicating need for further review of the record or until the MD determines there are potential quality issues and requests the complete medical record for further review.

- For records involving the death of a patient in which the QRN identified one (1) or more failed quality screens, the routine process for referring a potential quality issue for physician review is followed as outline in the 5% Quality Sample Review Policy and Procedure in this manual.
16. The QRN has twenty (20) business days from the date a medical record is received to complete this level of review.
 17. For all screen failures, the QRN notes each screen failure(s), describes each identified issue, and poses his/her questions to the Physician Advisor.
 18. 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.
 19. 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. The physician reviewing the case has forty (40) business days from the date the record is received to complete this level of review.
 20. If the issue(s) is resolved, the MD, AMD, or PA documents his/her rationale for resolving the issue. This activity is then complete.
 21. 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
 22. 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.**
23. 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.
 24. 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
25. The data system generates the Notice of Quality/Utilization Issue letter. For provider issues, the letter is addressed to the provider 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.
26. Notice of Quality/Utilization Issue letters are sent within ten (10) business days from the date the issue is confirmed.
27. Once letters are generated and sent, this activity is complete.
28. 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