

Quality Assurance and Utilization Review: Quality Re-review Process

Objective:

To provide any provider or physician who receives a Notice of Quality/Utilization Issue letter, and disagrees with the determination of a confirmed issue(s), the opportunity to request and receive a re-review of the determination.

Performed By:

Quality Review Nurse (QRN), The Medical Director (MD), Associate Medical Director (AMD), or Physician Advisor (PA)

Policy:

Any provider 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 additional information which might resolve the issue(s).

The request must be in writing and contain the reason the provider or physician disagrees with HSM's determination, including any additional information, which might assist the Physician Advisor in resolving the issue(s). The written request must be faxed or sent by mail, within thirty (30) calendar days from the date of the Notice of Quality/Utilization Issue letter. HSM has developed a Re-review Request form for providers and physicians to use for this purpose.

HSM will conduct the re-review for all timely requests and will make a decision to perform re-review on a case-by-case basis for untimely requests. Re-reviews will be performed whether or not additional information is supplied.

HSM will ensure that the Physician Advisor (PA) performing the re-review is a Mississippi licensed, actively practicing physician (i.e., same specialty as the attending physician), and not the same PA as the one who performed the initial review.

Procedure: Quality Re-review Process

1. Once a request for re-review has been received by HSM, the case file (including review documentation, and all forms and letters), the request, and any additional information supplied is provided to a Physician Advisor. The provider/physician requesting the re-review is sent a Letter of Acknowledgment to notify them the re-review process has been started. If a request for re-review is received after the allotted thirty (30) calendar day timeframe, the provider/physician is sent an Untimely Request Letter to notify them the request was not received in time to initiate a re-review.
2. The Physician Advisor uses his/her clinical knowledge and experience, and any current local and national standards of practice, to make a determination as to whether the confirmed quality/utilization issue(s) described in the Notice of Quality/Utilization Issue remains confirmed or is resolved based on all information available at the time of re-review. Review determinations are completed within thirty (30) calendar days of the request for re-review.
3. If the Physician Advisor determines that the issue(s) is resolved, he/she documents the rationale for resolving the issue and returns the case to a QRN who updates the re-review results, drafts the verbiage for the Notice of Re-review Determination letter based on the physician's documentation, and generates the letter.
4. The Notice of Re-review Determination contains a brief case summary, description of the issue(s), and the rationale for resolving the issue(s).

5. If the Physician Advisor determines that the issue(s) remains confirmed, he/she documents the following information:
 - description of the quality/utilization issue
 - why it is still a confirmed problem
 - who was responsible for the issue/source of problem (i.e., provider and/or physician)
 - the severity level assigned
 - what the appropriate action should have been
 - any appropriate intervention the provider/physician might initiate to remedy the problem
6. The Physician Advisor 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.
7. The case is returned to a QRN who updates the re-review results into the data system, drafts the verbiage for the Notice of Re-review Determination letter based on the Physician Advisor's documentation, and generates the letter.
8. The Notice of Re-review Determination letter contains a brief case summary, and the following information for each confirmed issue:
 - description of the quality/utilization issue
 - why it is still a confirmed problem
 - who was responsible for the issue/source of problem (i.e., provider and/or physician)
 - the severity level assigned
 - what the appropriate action should have been
 - any appropriate intervention the provider/physician might initiate to remedy the problem
9. The data system generates the Notice of Re-review Determination 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 of the letter sent to the appropriate provider. The Division of Medicaid (DOM) receives a report of all confirmed quality issues.
10. Notice of Re-review Determination letters are sent within ten (10) business days from the re-review completion date.
11. Once letters are generated and sent, this activity is complete and the medical record is sent to medical records for filing.