

Quality Assurance/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)

Quality Review Nurses (QRN)

Medical Director (MD)

Associate Medical Director (AMD)

Physician Advisor (PA)

Non-Physician Reviewers (NPR):

- Physical Therapist (PT)
- Speech Therapist (ST)
- Occupational Therapist (OT)

Policy:

HSM uses the quality screens to identify quality/utilization concern/issues for all precertification, concurrent, and retrospective certification cases for home health admissions.

Procedure: Quality Screening

1. The reviewer applies the quality screens for all review types (i.e., precertification, concurrent, and retrospective certification).
2. In applying the quality screens, the reviewer uses 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 reviewer describes each identified issue, and refers the case to the physician for review.
4. The MD, AMD, PA uses 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 Medical Director (MD), Associate Medical Director (AMD), or Physician Advisor (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 reviewer for updating of the review results into the data system. 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., agency and/or physician)
 - what the appropriate action should have been
 - the assigned severity level
8. The MD, AMD, PA use 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.
9. The case is forwarded to the Quality Review Nurse (QRN) for updating of the review results into the data system. In addition, the QRN 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 system generates the **Notice of Quality/Utilization Issue** letter. For agency issues, the letter is addressed to the agency's administrator or designee. For physician issues, the letter is addressed to the physician, with a copy of the letter sent to the appropriate agency in order for the agency 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/or agency have the right to request a re-review of any confirmed quality issue(s). Refer to the *Quality Re-review* section of this manual for additional information.