

Home Health Services: 5% Quarterly Quality Sample

Objective:

To ensure that home health care services provided to Medicaid beneficiaries meet professionally recognized standards of care, and to validate the information provided during precertification and concurrent certification with the documentation in the medical record.

Performed By:

Quality Review Nurses (QRN)
Medical Director (MD)
Associate Medical Director (AMD)
Physician Advisors (PA)

Policy:

On a quarterly basis, HealthSystems of Mississippi (HSM) will select a five percent (5%) sample of all Medicaid cases previously certified for home health services to identify quality issues and to validate the information provided during precertification and concurrent certification.

The 5% sample will be a random sample selected from HSM's data base, excluding cases with confirmed problems identified during the precertification and concurrent certification process. Once the sample is selected, monthly letters which include a medical record inventory sheet will be sent to the applicable home health agencies requesting copies of medical records for review. Home Health Agencies (HHAs) have a maximum of twenty (20) calendar days to provide the medical records to HSM from the date of the request. HSM will make two attempts to obtain copies of the records: 1) the initial request for records, and 2) one additional request (second request) ten (10) calendar days prior to the due date, if record copies have not been received.

If an agency 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 agencies and the records not received to the Division of Medicaid for further intervention.

Procedure: 5% Quarterly Quality 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 certification will be performed and interventions initiated to remedy the pattern.
3. In addition, the QRN applies the 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 these indicators, the QRN uses clinical knowledge and experience to determine if a potential quality issue exists. If one or more indicators are failed, the case is referred for physician review. If no screens are failed, this activity is complete.

5. For all failed indicators, the QRN notes each screen failure(s), describes each identified issue, and poses his/her questions to the Physician Advisor (PA).
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 is confirmed or resolved.
7. The MD, AMD, or PA uses his/her clinical knowledge, experience, and any current local and national standards of practice to make a determination as to whether a quality/utilization issue is confirmed or resolved.
8. If the issue is resolved, the MD, AMD, or PA documents his/her rationale for resolving the issue on the review documentation, and 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., Home Health Agency 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 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, admission to hospital, or patient management which results in anatomical or physiological impairment, disability, or death.
11. The case is returned to the QRN for drafting of the **Notice of Quality Issue** letter. This 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
12. The system generates the **Notice of Quality 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 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.

13. **Notice of Quality/Utilization Issue** letters are sent within ten (10) business days from the date the issue is confirmed.
14. Once letters are generated and sent, this activity is complete.
15. The physician and/or HHA may request a re-review of any confirmed quality issue(s). Refer to the *Quality Re-review* Process section of this manual for additional information.