

Home Health Services: Quality Re-review Process

Objective:

To provide any home health agency or physician who receives a **Notice of Quality/Utilization Issue** letter the opportunity to request and receive a re-review of a confirmed issue, if there is disagreement with the determination made by HSM.

Performed By:

Medical Director (MD), Associate Medical Director (AMD), or peer Physician Advisors (PA). Quality Review Nurses (QRNs) assist in processing these cases.

Policy:

Any home health agency (HHA) or physician who 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 HHA or physician disagrees with HSM's determination. 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 provided a Re-review Request form for agencies/physicians to use to request re-review. Along with the completed request, agencies should include any additional information which might assist the physician advisor in resolving the issue.

HSM will conduct re-review for all timely requests and will make a decision to 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 PA performing the re-review is a Mississippi licensed, actively practicing peer physician (i.e., same specialty) to the attending physician.

Procedure: Quality Re-review Process

1. Once a request for re-review has been received by HSM, the case file, the request, and any additional information supplied is provided to a peer PA. The agency/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 agency/physician is sent an Untimely Request Letter to notify them the request was not received in time to initiate a re-review.
2. The peer PA uses clinical knowledge, and experience, and any current local and national standards of practice, to make a determination as to whether the confirmed quality issue (as described on the Notice remains confirmed or is resolved. This decision should consider 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 peer PA determines that the issue is resolved, the case is returned to a Quality Review Nurse (QRN) who drafts the **Notice of Re-review Determination** letter, and generates the letter. This letter contains a brief case summary, description of the issue, and the rationale for resolving the issue.

4. If the peer PA determines that the issue remains confirmed, the following information is documented:
 - description of the quality issue
 - why it is still a confirmed problem
 - who was responsible for the issue/source of problem (i.e., home health agency or physician)
 - the severity level assigned
 - what the appropriate action should have been
 - any appropriate intervention the HHA/physician might initiate to remedy the problem
5. The peer 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.
6. The case is returned to a QRN who drafts the **Notice of Re-review Determination** letter, and generates the letter.
7. The **Notice of Re-review Determination** letter contains a brief case summary, and the following information for each confirmed issue:
 - description of the quality issue
 - why it is still a confirmed problem
 - who was responsible for the issue/source of problem (i.e., facility or physician)
 - the severity level assigned
 - what the appropriate action should have been
 - any appropriate intervention the HHA/physician might initiate to remedy the problem
8. The system generates the **Notice of Re-review Determination** 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. The Division of Medicaid (DOM) receives a report of all confirmed quality issues.
9. **Notice of Re-review Determination** letters are sent within ten (10) calendar days from the re-review completion date.
10. Once letters are generated and sent, this activity is complete.