

Home Health Services: Provider/Beneficiary Hot-line

Objective:

To provide beneficiaries and providers with an avenue to report quality concerns and/or complaints and have them investigated by HSM.

Performed By:

Hot-line Operator (HLO)
Quality Review Nurse (QRN)
Medical Director (MD)
Associate Medical Directors (AMD)
Physician Advisors (PA)

Policy:

HSM provides a hot-line through which beneficiaries and providers can report quality concerns and/or complaints. This hot-line can be accessed from the hours of 8:00 a.m. through 5:00 p.m., Monday through Friday. A complaint/quality concern may be initiated by:

- the beneficiary
- the beneficiary's designated representative
- a representative of a home health agency who provides care to a beneficiary
- a physician who provides care to a beneficiary

Timeframes for complaint resolution are as follows:

- urgent complaint – those which may endanger the life of a patient, etc.: immediately, but not more than one (1) business day.
- normal complaint – those that do not pose any immediate danger to the life of a patient: within fourteen (14) business days.

This hot-line is manned by a nurse who will assure that HSM obtains the information needed for each quality concern and complaint, logs all concerns/complaints, and starts the quality review or complaint process.

The Quality Review staff is responsible for profiling complaints regarding access to care/services on a quarterly basis to identify patterns. When patterns are identified, DOM will be notified so that appropriate intervention may be initiated to remedy the pattern.

For quality issues identified through the hot-line, the QRN screens the case, using the HSM quality screens and processes the case as outlined in the Quality Screening Policy and Procedure in this manual.

Procedure: Hot-line

1. All calls to the hot-line are logged and the following information recorded:
 - beneficiary's name/Medicaid number
 - caller: beneficiary, beneficiary's designated legal representative, provider, physician
 - date and time of call
 - nature of call: complaint, quality concern, question regarding benefits, request for information, etc.

2. Calls not relating to a quality concern or complaint (i.e., questions regarding bills, benefits, etc.) are directed to the appropriate person or agency.
3. All calls relating to a quality concern or complaint about access to care/services will be forwarded to the QRN for resolution within the following timeframes:
 - urgent complaint – those which may endanger the life of a patient, etc.: immediately, but not more than one (1) business day.
 - normal complaint – those that do not pose any immediate danger to the life of a patient: within fourteen (14) business days.
4. If the call is regarding a complaint or quality concern, the Quality Review Nurse (QRN) completes the “Summary of Complaint” form which contains the following information:
 - beneficiary demographics (age, sex, home address, Medicaid number, etc.)
 - date complaint received
 - name/provider number of the source of the complaint or concern (agency, physician, etc.)
 - dates of the care/service in question
 - nature of the complaint (i.e., quality concern, denied access to care/services, etc.)
 - a summary of the complaint
5. The QRN generates and sends an **Acknowledgment to Complainant** letter to the caller acknowledging that HSM received the complaint, that review would be based on documented medical information received by HSM, and that appropriate action would be taken if indicated. This notification is sent within ten (10) business days of the date of the call.
6. If the call is regarding a complaint regarding access to care/services, etc., the QRN enters the information contained in the **Summary of Complaint** form into a data system to record the nature of the complaint for later profiling for patterns.
7. On a quarterly basis, the Quality Manager (QM) ensures that profiles are generated to identify patterns of problems and actions taken as outlined in the *Quality Intervention Process Policy and Procedure* section of this manual. HSM will provide DOM with copies of these profiles.
8. If a pattern is identified, HSM will identify and initiate appropriate intervention to remedy the problem. Interventions may include written notification to the agency/physician, educational efforts, and development of an improvement plan by the agency/physician, a penalty imposed by DOM, etc.
9. If the call is regarding a quality concern, the QRN generates and sends a **Request for Information** letter, to the agency/physician requesting a copy of the complete medical record, or all information available at the time the questionable occurrence took place. The agency/physician has ten (10) business days to submit the requested information.

10. If the information is not submitted within the ten (10) business days, the QRN will make a final attempt to obtain the information by calling the agency and allowing a five (5) business day extension.
11. If the information is not received within the extension period, the QRN sends written notification to the agency stating that the information necessary to determine if a quality issue exists was not provided. The case is closed, and HSM will report the non-compliance to DOM.
12. Once the information is received, the QRN begins the quality review process.
13. In applying the quality screens, the QRN uses clinical knowledge and experience to determine if a potential quality issue exists. If one or more screens are failed, the case is referred for physician review. If there are no failures, this activity is complete.
14. For all failed screens, the QRN poses his/her questions to the Physician Advisor (PA).
15. The QRN refers the case to the Medical Director (MD), Associate Medical Director (AMD), or a PA to determine if the identified issue is confirmed or resolved.
16. The MD, AMD, or PA uses clinical knowledge, experience, and any current local and national standards of practice to make a determination as to whether a quality issue is confirmed or resolved.
17. If the issue is resolved, the MD, AMD, or PA returns the case to the QRN and this activity is complete.
18. For each issue confirmed, the MD, AMD, or PA documents the following information:
 - description of the quality 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
19. 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.

20. The case is returned to the QRN for drafting of the **Notice of Quality/Utilization Issue** letter.
21. 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
22. 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 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.
23. Once letters are generated and sent, this activity is complete.
24. 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.