

## ***Quality Assurance and Utilization Review: 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:***

The Hot-line Operator (HLO) receives the initial calls, logs and forwards them to the Quality Review Nurse (QRN). QRN's (registered nurses) are responsible for investigating all quality concerns regarding care/services provided and complaints (i.e., complaints regarding access to care/services). The Medical Director (MD), Associate Medical Director (AMD), or Physician Advisor (PA) will make determinations regarding the confirmation of a quality concern.

### ***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:

- a beneficiary
- a beneficiary's designated representative
- a health care provider who provides care to a beneficiary
- a physician who provides care to a beneficiary

Timeframes for complaint resolution as determined by the QRN 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 Help Line Coordinators and the calls are routed to a nurse who will obtain the information needed for each quality concern and complaint, log all concerns/complaints, and start the 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 concerns identified through the hot-line, the QRN screens the case, using the HSM quality screens, and processes the case as outlined in the *Quality/Utilization Review* section of this manual.

**Procedure: Hot-line Process**

1. All calls to the hot-line are logged. The Help Line Coordinator (HLC) maintains the log and records the following information:
  - beneficiary's name/Medicaid number
  - caller: beneficiary, beneficiary's designated representative, provider
  - date and time of call
  - nature of call: complaint, quality concern, questions regarding benefits, requests for information, etc.
2. For all calls not relating to a quality concern or complaint about access to care/services (i.e., questions regarding bills, benefits, etc.), the HLC directs the caller 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 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 (provider, physician, etc.)
  - admission/discharge dates of the stay/services 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 complainant (caller) acknowledging that HSM received the complaint and that review would be based on documented medical information we receive, and that actions would be taken if necessary. 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 into a data system, which will record and track the nature of the complaint to profile for patterns.
7. On a quarterly basis, the Quality Manager (QM) generates profiles by provider/physician and by nature of the complaint to identify patterns of problems. HSM will provide DOM with copies of these profiles.

8. If a pattern(s) is identified, HSM will notify DOM and will work with DOM to identify and initiate an appropriate intervention to remedy the problem. Interventions will include written notification to the provider/physician and may also include educational efforts, development of a corrective action plan by the provider/physician, and/or a penalty applied by DOM, etc.
9. If the call is regarding a quality concern, the QRN generates and sends a Request for Information letter to the provider/physician requesting a copy of the complete medical record, or all information available at the time the questionable occurrence took place. The provider/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 provider/physician and allowing an extension of five (5) business days. If the information is not received within the extension period, the QRN sends written notification to the provider/physician stating that the review could not be performed as the information necessary to determine if a quality/utilization issue exists was not provided. The case is closed, and HSM will report the non-compliance to DOM.
11. Once the information is received, the QRN reviews for initial quality screening.
12. In applying the quality screens, the QRN uses his/her clinical knowledge and experience to determine if a potential quality/utilization issue(s) exists. If one or more screens are failed, the case is referred for physician review. If no screens are failed, this activity is complete.
13. For all screen failures, the QRN describes each identified issue, and poses his/her questions to the Physician Advisor. 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(s) is confirmed or resolved.
14. The MD, AMD or PA uses his/her 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. 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 QRN for updating of the review results.
15. 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., provider and/or physician)
  - what the appropriate action should have been
  - the assigned severity level

16. The MD, AMD, or PA 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

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.

17. The case is returned to the QRN for updating of the review results into the data system. In addition, he/she drafts the verbiage for the Notice of Quality/Utilization Issue letter using documentation provided by the MD, AMD or PA.

18. 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

19. The data system generates the Notice of Quality/Utilization Issue 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 in order for the provider 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.

20. Once the letters are generated and sent, this activity is complete.

21. The physician and provider have the right to request a re-review of the confirmed issue(s). Refer to the *Quality Assurance/Utilization Review- Quality Re-review Policy* and Procedure section of this manual for additional information.