

## Quality Review Activities

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving outpatient physical, and occupational therapy, and speech-language pathology services. Quality of care review will be conducted during precertification, concurrent, and retrospective review as well as through a randomly selected 5% Quality Sample of cases certified by HSM.

### Objectives of Quality Review

- Ensure care provided to Medicaid beneficiaries meets professionally recognized standards of care
- Ensure that information provided to HSM during certification is substantiated by the complete medical record during sample review
- Notify healthcare providers of confirmed quality issues identified during the review process
- Provide a mechanism for providers to request a re-review of confirmed quality issues
- Work with healthcare providers to remedy identified patterns of quality/utilization problems through education and other interventions.
- Report suspected fraud and/or abuse to DOM

### Quality Review Program Components

- Quality Screening Process
- 5% Random Quality Sample
- Quality Re-review Process
- Quality Intervention Process
- Criteria for Quality Intervention Committee (QIC) Review
- Quality Screens/Indicators

**Note:** A flow chart of the quality review process is included for your reference.

### Quality Review Staff

Quality review will be performed during the certification process by registered nurses, physical and occupational therapists, speech language pathologists, and physicians. Registered Nurses (RNs) perform quality review for the 5% Quality Sample.

HSM's Quality Intervention Committee (QIC) uses an established process as a means to analyze, identify, and remedy the causes of the confirmed quality issues. The QIC reviews providers with identified patterns of quality and utilization problems through profiling and analysis of confirmed quality issues. This committee works collaboratively with healthcare providers to remedy aberrant practices through education and other interventions to improve patient safety and quality of care.

Staff	Functions
Registered Nurses for utilization  Therapists	<ul style="list-style-type: none"> <li>➤ Apply quality screens</li> <li>➤ Refer failed quality screens to physicians for review</li> <li>➤ If resolved, will document physician's finding</li> <li>➤ Report suspected fraud and/or abuse to DOM</li> </ul>
Registered Nurses for 5% Sample	<ul style="list-style-type: none"> <li>➤ Apply quality screens</li> <li>➤ Determine if information submitted to HSM during the certification process is substantiated by the medical record (5% sample)</li> <li>➤ Refer failed quality screens to physicians for review</li> <li>➤ If a quality issue is confirmed, the physician's findings are documented and a provider notice is generated</li> <li>➤ Process requests for quality re-review and refer to physicians</li> <li>➤ Report suspected fraud and/or abuse to DOM</li> </ul>
Physician Reviewers	<ul style="list-style-type: none"> <li>➤ Apply quality screens</li> <li>➤ Determine if potential quality issue(s) is resolved or confirmed</li> <li>➤ If confirmed, will document source of problem, severity level, appropriate action that should have been taken, and rationale for determination</li> <li>➤ Review the request for quality re-review and resolve or reconfirm issues</li> <li>➤ Report suspected fraud and/or abuse to DOM</li> </ul>
Quality Intervention Committee	<ul style="list-style-type: none"> <li>➤ Review medical records for a particular provider identified through the established profiling system</li> <li>➤ Make recommendations for specific interventions</li> <li>➤ Communicate recommended interventions to providers via certified restricted delivery mail</li> <li>➤ Monitor effectiveness of interventions</li> <li>➤ Communicate intervention activities to DOM</li> </ul>

### Overview of the Quality Screening Process

HSM applies quality screens/indicators to all certification review requests submitted by outpatient therapy providers.

- Quality screens are failed; the review is referred to the physician reviewer.
- The physician reviewer makes a determination to confirm or resolve the potential quality issue(s).
- The physician reviewer also applies the quality screens during review to identify any other existing quality issues.
- The physician reviewer documents the rationale for the determination and, if confirmed, documents the source of problem, severity level, and the appropriate actions that should have been taken.

- If any issue is confirmed, a quality/utilization issue letter of notification is sent to the identified source of problem.
- Quality/Utilization Issue Notices contain the following information:
  - Brief case summary
  - Description of the quality issue(s)
  - Source of problem (SOP)
  - Severity level
  - Appropriate action that should have been taken
  - Process for requesting a re-review and timeframes for doing so

### **Overview of the 5% Quality Sample Process**

HSM issues written requests on the first business day of each month to those providers selected for the random 5% sample review .

- The request will include an inventory tracking sheet to be returned with the medical record to HSM to identify the review type being submitted
- Providers must submit copies of the complete medical record requested to HSM within twenty (20) calendar days.
- HSM will make two (2) attempts to obtain the medical record.
- HSM will notify DOM of providers who are non-compliant with submitting requested medical records
- The RN applies the quality screens to the entire medical record and verifies that the medical record substantiates the information submitted during certification review.
- If the information submitted during certification review is not substantiated by the record, it is documented and later profiled for trends or patterns reportable to DOM.
- The same process is followed as described above in quality screening if the RN identifies a failed quality screen(s).

### **Overview of Quality Re-Review Process**

Any provider who receives a quality/utilization notification letter and disagrees with the determination has the opportunity to request and receive a re-review of the determination.

- The provider must submit in writing a request, which contains the reason the provider disagrees with HSM's determination and any additional information, which might assist in resolving the issue.
- The request must be submitted within thirty (30) calendar days of HSM's notice via fax or mail.

**Note:** An HSM Quality Re-Review Request Form and instructions are included in this manual for provider use.

- HSM conducts re-reviews for all timely requests and will make a decision to perform re-review on a case-by-case basis for untimely requests.
- Re-reviews will be performed whether or not additional information is supplied.

- HSM ensures that the physician reviewer performing the re-review is a different reviewer than the initial reviewer.
- HSM will render a re-review determination within thirty (30) calendar days of receipt of the request for re-review.
- HSM issues written notice of the re-review determination to the involved provider within ten (10) business days of the determination date.
- Written notices for resolved and/or confirmed quality issues will contain the following information:
  - Brief case summary
  - Description of the quality issue(s)
  - Rationale for resolving the issue(s)
  - Rationale for reconfirming the issue(s)
  - If reconfirmed also includes:
    - Source of problem (see glossary)
    - Severity level (I, II, or III – see glossary)
    - Appropriate action that should have been taken

### **Overview of Quality Intervention and Quality Intervention Committee (QIC) Processes**

Quarterly profiles are generated and analyzed using the following criteria to determine which providers are to be reviewed at the QIC level for possible intervention.

- All Severity Level III Cases
- Frequency of occurrence – eight (8) or more issues identified for a source of problem during a quarter period
- Weighted Severity Level Scoring (WSLS) – ten (10) or more points identified for a source of problem during a quarter period.

The means of calculating the WSLS:

- |  |             |
|--|-------------|
| a. Each Severity Level I confirmed issue   | = 1 point   |
| b. Each Severity Level II confirmed issue  | = 5 points  |
| c. Each Severity Level III confirmed issue | = 25 points |

For example, for each SOP reported on a quarterly profile:

Provider (or Physician) # 000000		
3 Level I issues	X	1=3
0 Level II issues	X	5=0
0 Level III issues	X	25=0
Total WSLS for quarter:		3

**Note:** A "case" is defined as each certification period for outpatient therapy services. In the instance where a single case has multiple confirmed quality issues for a single source of problem, and they fall into more than one (1) severity level, the issue with the highest severity level is used to calculate the weighted severity level score for that source of problem.

**Example:** If Patient A's outpatient therapy services of 3/20/04 through 4/20/04 had two (2) confirmed quality problems with the same assigned source of problem, one a level II and one a level III, the level III case is used to calculate the weighted severity level score. When the case is reviewed by the QIC, the QIC will consider all confirmed issues, whether used in WSLS calculation or not, when determining the appropriate intervention.

Cases that meet the criteria for QIC review are grouped according to the source of problem. These cases are commissioned to physician reviewers for review to identify patterns and trends, review prior interventions, and make recommendations for the most appropriate intervention. Types of interventions include:

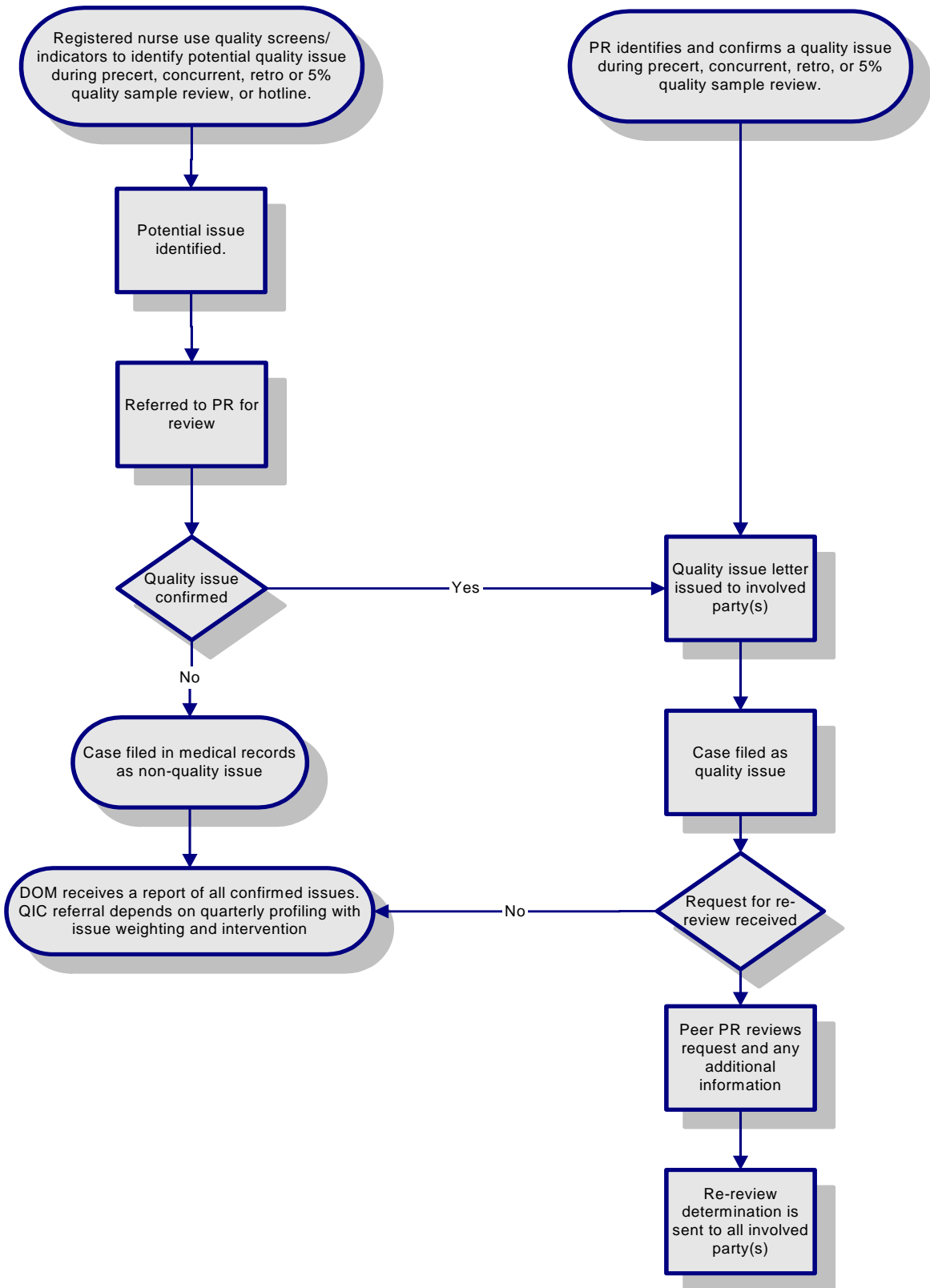
- Educational notices
- Telephonic consultation
- Requests for process improvements
- Requests for corrective action plans
- Requests for root cause analysis
- Requests for meeting at HSM with Medical Director and Quality Manager to discuss remedies for identified problem(s)
- Notification to Division of Medicaid as deemed necessary
- Focused reviews or studies

Providers should submit the requested response to HSM within the timeframe identified in the written notice. The QIC will evaluate the response for appropriateness and notify the provider if approved and/or if modifications or recommendations are made by the QIC. Because quality review is an ongoing process, HSM's QIC will continue to monitor the effectiveness of those interventions.

<b>Quality of Care Review and Intervention Timeframes</b>	
<b>Activity</b>	<b>Timeframe</b>
5% Sample – outpatient therapy providers submit medical records for cases selected for review.	Within 20 days of notification.
Initial screening of cases for quality or utilization concerns by quality review nurse.	Completed within 20 days of receipt of the medical record.
PR review to determine if a confirmed problem exists.	Within 40 days of receipt of the medical record.
Send Notice of Quality/Utilization Issue to involved party.	Within 10 calendar days of the PR's determination.
Re-review process – Involved party requests review of the determination.	Within 30 days of the date of the Notice of Quality/Utilization Issue
Re-review of cases by a PR.	Completed within 30 days of request
Send Notice of Re-review Determination to involved party.	Within 10 calendar days of the PR's determination
For quality concerns identified by RNs during precertification or concurrent review, which would impede the authorization process, HSM reviewers flag the case for immediate review by medical director or PR designee.	When a concern is identified
Medical director or PR phones involved party to discuss concern and make a determination as to the existence of a problem and regarding authorization of services.	Determination made within 24 hours of receipt of complete information
Verbal and written notification of the authorization and quality problem provided to appropriate parties.	Within 24 hours of receipt of complete information for certification. Within 10 days of confirmation of the issue by the PR
If additional information is required to make a determination, the Medical Director will make the request to the appropriate party	Provider or facility has 24 hours to provide this information
PR reviews additional information and makes a determination regarding authorization and existence of problem	Within 24 hours of receipt of complete information
Hotline provided for beneficiaries and providers.	Monday through Friday, from 8 a.m. to 5 p.m.
Complaint or concern regarding quality or utilization of care received – request all medical information.	Information to be sent within 10 days of request
Case given to quality review nurse to review as outlined in the 5% sample.	See 5% quality sample review process

<b>Quality of Care Review and Intervention Timeframes</b>	
<b>Activity</b>	<b>Timeframe</b>
Generate profiles for each prescribing provider, each facility, and statewide to include Quality review results and other review results for most recent quarter and cumulative results up to the previous four monitoring quarters.	Every quarter
Quality Intervention Committee meets to make determinations regarding who requires intervention and the appropriate interventions.	Meets monthly, but may teleconference more often if necessary
Once determination made, the quality manager and staff generate letters to all involved parties outlining the QIC's request for action plans.	Within 15 working days of the QIC's determination
Involved parties submit corrective action plan to HSM.	Within 30 days of the notification
The QIC reviews the action plans received for feedback and approval. Send notice of acceptance outlining recommended changes.	Within 15 working days of approval by the QIC
Quality manager performs follow-up monitoring to determine effectiveness of interventions in remedying aberrant practices.	As often as necessary but at least quarterly
If interventions are ineffective, QIC makes determinations to modify the intervention and/or submit a written case summary to DOM of the practices including the quality problem, interventions and current practices.	As necessary

**Quality Review Process**



<b>OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY QUALITY OF CARE SCREEN</b>	
<b>INDICATOR</b>	<b>APPLICATION OF SCREEN</b>
<p>OP. 1. There is documentation of adequate assessment of a patient before or at time of admission to determine if the patient meets prerequisites for outpatient therapy services.</p> <p>Choices:                      T1: Pertinent history                      T1: Evaluation incomplete/inadequate                      T1: Unsigned MD orders                      T1: Prior therapy history                      T1: Reassessment not performed appropriately                      T1: Social history                      T1: Clinical status &amp; impairment                      T1: Other assessment</p>	<ul style="list-style-type: none"> <li>• Review of required comprehensive evaluation</li> <li>• Documentation of assessment of rehabilitation potential to include physical limitations</li> <li>• Description of cognitive functioning and motivation for treatment</li> <li>• Appropriateness of outpatient setting-document if setting is different than in evaluation report</li> <li>• Documentation of current status of receptive/expressive language, articulation, voice fluency, oral-motor abilities, feeding/swallowing skills, hearing ability, fine motor skills and vision.</li> <li>• Documentation of cognitive/orientation skills as applicable.</li> <li>• Documentation of patient’s communication needs and motivation for treatment</li> <li>• Documentation of physician order on CMN form for consultation of PT/OT/SLP for evaluation.</li> </ul>
<p>OP. 2. The treatment plan is appropriate for the diagnosis. Outcome based, measurable goals specific to therapy required by the patient are included in treatment plan.</p> <p>Choices:                      T2: POC untimely                      T2: Unsigned POC/MD                      T2: No clinical update                      T2: Other tx plan/dx                      T2: ST goals                      T2: LT goals                      T2: Updated goals                      T2: Other goals</p>	<ul style="list-style-type: none"> <li>• The length of the individual therapeutic service is reasonable to complete the goals of the therapy for the diagnosis.</li> <li>• This screen fails if:                             <ol style="list-style-type: none"> <li>1. The therapist provides services that are contraindicated or not indicated for the diagnosis without supporting documentation.</li> <li>2. The therapist does not provide indicated services for the diagnosis.</li> </ol> </li> <li>• Goals must be measurable.</li> <li>• Goals must be reasonably achievable for course of treatment.</li> <li>• Documentation of problems encountered or changes in treatment plan or goals</li> </ul>

<b>OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY QUALITY OF CARE SCREEN</b>	
<b>INDICATOR</b>	<b>APPLICATION OF SCREEN</b>
<p>OP. 3. Standardized test measurements are administered at the beginning of treatment and re-measured at appropriate intervals during course of treatment.</p> <p>Choices:  T3: Hearing  T3: Development  T3: Muscle  T3: Motor  T3: Functional  T3: Standardized  T3: Oral assessment  T3: ROM  T3: Endurance  T3: Criterion  T3: Other measure</p>	<p>Examples/accepted measurements:</p> <ul style="list-style-type: none"> <li>• Muscle testing</li> <li>• Range of motion</li> <li>• Wee FIM or FIM (Functional Independence Measure)</li> <li>• Developmental tests</li> <li>• Motor test such as Bruinicks test of motor proficiency</li> <li>• Endurance levels</li> <li>• Criterion referenced assessments</li> <li>• Standardized assessments</li> <li>• Modified barium swallow studies as ordered by MD</li> </ul>
<p>OP. 4. Treatment plan was followed as ordered for course of therapy.</p> <p>Choices:  T4: Failure to follow POC orders  T4: Missed visits  T4: No therapists notes  T4: Clinical change  T4: Precautions taken  T4: Other tx plan/followed</p>	<ul style="list-style-type: none"> <li>• Documentation of therapy must be exactly as ordered in physician's treatment plan prescribing: <ul style="list-style-type: none"> <li>○ type,</li> <li>○ amount,</li> <li>○ frequency and duration of therapy,</li> <li>○ diagnosis and anticipated goals, and</li> <li>○ the reason treatment is not indicated.</li> </ul> </li> <li>• Treatment verified by therapist signature and date.</li> <li>• Any change in treatment requires physician's order.</li> <li>• Plan of Care approved by physician before therapy begins and signed within fourteen (14) days.</li> <li>• Patient's response to treatment is documented.</li> </ul>
<p>OP. 5. Therapist documents patient and/or parent (caregiver) education.</p> <p>Choices:  T5: No ed pt/CG documentation  T5: No ed pt/CG feedback  T5: Other education</p>	<ul style="list-style-type: none"> <li>• Evidence of patient teaching including case conferences.</li> <li>• Documentation of patient/parent/caregiver response to teaching (i.e. return demonstration).</li> </ul>
<p>OP. 6. Home Exercise Program (HEP) includes:</p>	<ul style="list-style-type: none"> <li>• Return demonstration of home program by patient/caregiver</li> </ul>

<b>OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY QUALITY OF CARE SCREEN</b>	
<b>INDICATOR</b>	<b>APPLICATION OF SCREEN</b>
<ul style="list-style-type: none"> <li>• Home program that models the therapy</li> <li>• Documentation of instruction and verbalization of understanding</li> </ul> <p>Choices: T6: No POC with a defined home program T6: Lack home program update T6: Other tx plan</p>	<ul style="list-style-type: none"> <li>• Determine if there is a need for increased education or change in program through discussion on follow through at home.</li> </ul>
<p>OP. 7. Orthotics and Prosthetics (O&amp;P) ordered has:</p> <ul style="list-style-type: none"> <li>• Documentation of reason O&amp;P needed by the patient.</li> <li>• Treating therapist experienced and knowledgeable of O&amp;P.</li> <li>• Physician order for such O&amp;P.</li> <li>• Caregiver/patient trained in proper use of O&amp;P.</li> <li>• Augmentative communication assessment performed.</li> <li>• Documentation of justification by diagnosis of need for custom fabrication of O&amp;P /supplies</li> </ul> <p>Choices: T7: Documentation of need for O&amp;P T7: Education of proper use/care T7: F/U as appropriate T7: No patient/CG feedback T7: Other O&amp;P</p>	<p>Example:</p> <ul style="list-style-type: none"> <li>• Splint/braces should have documentation of: need for use, instruction of proper use and care, plan for follow up</li> <li>• Assessment performed by speech/language pathologist with input of either OT or PT to address motor issues.</li> </ul>
<p>OP. 8. Discharge plan is documented.</p> <p>Choices: T8: DS complete T8: Unsigned DS T8: DS untimely T8: Progress to discharge T8: Other dsch plan</p>	<ul style="list-style-type: none"> <li>• Therapist documents discharge plans beginning with initial treatment.</li> <li>• Therapist documents progress towards discharge.</li> </ul>