

HealthSystems



HealthSystems  
OF MISSISSIPPI

# Quality Review Process Manual

**Effective 01/01/09**

HealthSystems of Mississippi  
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Of Mississippi

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## ***I. Introduction***

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform certification and quality of care review services rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Our review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers in successfully navigating through HSM's review requirements and process.

## ***II. Getting Started – Helpful Tips***

Providers must read and be familiar with the DOM's policies and procedures located at:  
<http://www.medicaid.ms.gov/manual.aspx>.

### **III. Information You Need to Know**

HSM has a dedicated Quality Review fax number to assist you with your needs. Quality reviews are submitted by fax or mail. In addition, if assistance is needed from a live person, please contact our helpline. Phone numbers and hours of operation are listed in the following table.

| <b>Purpose</b>                                                                                                                                                                                                                                                                     | <b>Description</b>                                                                                                   | <b>Hours of Operation and Number(s)</b>                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Submission of: <ul style="list-style-type: none"> <li>• Quality sample charts.</li> <li>• Responses to quality letters.</li> <li>• Request for quality rereview.</li> <li>• Quality corrective action plans.</li> <li>• Other correspondence related to quality review.</li> </ul> | Appropriate number to use to submit documents or correspondence related to quality screening or quality review.      | Fax: 24 hours, 7-days a week.<br><br>1- 888-204-0506<br><br>Faxes received after 5:00 p.m. are considered received the next business day.<br><br>Mail:<br>175 East Capitol Street<br>Suite 250, Lockbox 13<br>Jackson, MS 39201 |
| Helpline                                                                                                                                                                                                                                                                           | Used by providers for questions regarding the certification and/or quality review process and to request assistance. | <b>Web Helpline: <a href="http://www.hsom.org">www.hsom.org</a> click on "Reports and Communications" link.</b><br><br>8:00 a.m. – 5:00 p.m. (business days)<br>Local: 601-360-4949<br>Toll Free: 1-866-740-2221                |
| Hot Line                                                                                                                                                                                                                                                                           | Used by beneficiaries and providers to report quality concerns and/or complaints.                                    | Hours of availability:<br>8:00 a.m. – 5:00 p.m. (business days)<br>Toll Free: 1-888-204-0221                                                                                                                                    |

#### **Electronic Helpline Inquiries**

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries and to check the status of reviews at any time. Immediate access to a provider-specific reporting module that can provide real-time status of reviews previously submitted to HSM is available to providers who are enrolled to use the system 24 hours a day 7 days a week.

#### **Obtaining Your Logon**

Contact HSM's Education Department to request enrollment and training for beginning users.

In addition to internet access, minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers
- Color monitor
- 28.8K modem connection or higher (phone line quality will determine speed of connection)
- Internet Explorer Version 4.0 or higher

## ***IV. Quality Review Program***

### **A. Overview**

The objectives of quality review are:

- To determine whether care provided to Medicaid beneficiaries meet professionally recognized standards of healthcare.
- To identify potential quality of care concerns that may place the beneficiary at risk so that appropriate action(s) aimed at positively impacting patient care and/or safety can be initiated while the patient is still in treatment.
- To identify potential quality of care issues or patterns that do not place the beneficiary at immediate risk, but may warrant post-discharge review that may lead to opportunities for systemic quality improvement.
- To work with providers and practitioners to promote patient safety and improve care delivery through peer-to-peer discussions, consultation and quality improvement plans.

HSM assesses quality of care during:

- Quality Screening – Screening performed during admission, continued stay and retrospective short stay review.
- Retrospective Quality Review - Review of the entire medical record which occurs after discharge of the patient.
- 5% Quality Sample review – A random 5% retrospective sample of records selected from completed certification reviews (excluding retrospective reviews) and home health claims for services provided to beneficiaries 21 years and older.

HSM also performs the following activities on acute inpatient hospitalizations and home health records selected for the 5% percent quality sample:

- Apply medical necessity criteria to assess the appropriateness of services and level of care.
- Validate whether the information submitted by the provider during certification review is substantiated within the medical record.
- Assess compliance with DOM policy.

Instances of medically unnecessary utilization and non-compliance with DOM policy identified during the 5% quality sample are documented. Any provider identified as having an aberrant practice pattern maybe subject to intensified review.

HSM performs analyses on data obtained during quality review on a quarterly basis for the identification of potential provider-specific aberrant quality of care and/or utilization of service patterns.

Quality issues may be assigned a category of concern level indicating that care could have been better or where generally accepted guidelines or usual practices were not followed. HSM performs quarterly analyses of data for the identification of potential provider-specific aberrant quality of care and/or utilization of services patterns. Immediate action is taken when a serious quality concern is identified. Refer to the Quality Review for Retrospective Review Certification and 5% Quality Sample section of this manual for additional information.

The following table displays HSM's quality screening review conducted by care setting and review type.

| Care Setting                                                         | Quality Screening                 | Retrospective Quality Review | 5% Quality Sample                             | 5% Quality Sample – Additional Assessments           |                                                                |
|----------------------------------------------------------------------|-----------------------------------|------------------------------|-----------------------------------------------|------------------------------------------------------|----------------------------------------------------------------|
|                                                                      |                                   |                              |                                               | Medical Necessity Review, Compliance with DOM Policy | Validation of Information Provided During Certification Review |
| Inpatient acute care general and free standing psychiatric hospitals | Yes – when manual review required | Yes                          | Yes                                           | Yes                                                  | Yes                                                            |
| Maternity Reports                                                    |                                   |                              | Yes                                           | Yes                                                  | Yes                                                            |
| Outpatient physical, occupational, and speech therapy                | Yes                               | Yes                          | Yes                                           |                                                      | Yes                                                            |
| Home health                                                          | Yes                               | Yes                          | Yes<br>(Includes services for age ≥ 21 years) | Yes                                                  | Yes                                                            |
| Hospital outpatient mental health                                    | Yes                               | Yes                          | Yes                                           |                                                      | Yes                                                            |
| Private duty nursing                                                 | Yes                               | Yes                          | Yes                                           |                                                      | Yes                                                            |
| Psychiatric residential treatment facility                           | Yes                               | Yes                          | Yes                                           |                                                      | Yes                                                            |
| MYPAC Waiver                                                         | Yes                               | Yes                          | Yes                                           |                                                      | Yes                                                            |
| Durable medical equipment                                            |                                   |                              | Yes                                           |                                                      | Yes                                                            |

The processes for quality screening, quality review during retrospective chart review, and the 5% quality sample review are described in subsequent sections of this manual.

**B. HSM Staff Functions**

Request for certification review and records submitted for the 5% quality sample are processed by HSM intake staff. The intake staff is experienced and work collaboratively with clinical staff to provide quality services to our customers. Clinical staff is composed of registered nurses, physicians and physician consultants. These highly qualified professionals make the certification and quality review determinations. The following table describes staff functions for the quality review process.

| Staff                                        | Functions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Non-clinical Support Staff<br>(Intake Staff) | <ul style="list-style-type: none"> <li>• Screen records for completeness.</li> <li>• May request additional non-clinical information.</li> <li>• Support all review functions.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| First Level Reviewers<br>(Registered Nurses) | <ul style="list-style-type: none"> <li>• Apply Category of Concern quality triggers and quality screens. <i>See Attachments A and B.</i></li> <li>• Apply DOM approved medical necessity criteria, when applicable.</li> <li>• Apply DOM policy.</li> <li>• Use medical record to validate information submitted by providers during certification review.</li> <li>• May request additional information.</li> <li>• Refer potential quality and utilization issues for physician determination.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Second Level Reviewers<br>(Physicians)       | <ul style="list-style-type: none"> <li>• Make determinations regarding utilization and quality of care concerns that are:               <ul style="list-style-type: none"> <li>- Based on documentation that supports medical necessity and appropriateness of setting.</li> <li>- Patient-centered and takes into consideration the unique factors associated with each patient care episode.</li> <li>- Sensitive to the local healthcare delivery system infrastructure</li> <li>- Based on his or her clinical experience, judgment and generally accepted standards of healthcare.</li> </ul> </li> <li>• Participate in the quality intervention committee and:               <ul style="list-style-type: none"> <li>- Identify patterns and trends.</li> <li>- Implement interventions to prevent aberrant patterns from recurring.</li> <li>- Monitor the effectiveness of interventions.</li> </ul> </li> <li>• May contact the provider for additional information.</li> </ul> |

**C. Quality Screening**

Along with the determination of medical necessity and appropriateness of care, quality screening takes place during admission, continued stay, post discharge continued stay and short stay retrospective review.

*Quality Review Triggers*

HSM's medical director, in conjunction with HSM's clinical and professional staff and physician reviewers select the quality review triggers that are applied by nurse reviewers during the review process. Quality review triggers may include generic quality indicators, patient safety, and disease-specific triggers.

*Quality Screening Process*

The quality screening process is described in the following steps.

- The provider submits a review request to HSM.
- Nurse reviewers apply DOM approved quality of care triggers for the appropriate care setting. Additional clinical information is requested if necessary to complete the quality of care review. HSM provides verbal and written notification of the need for additional information along with the timeframes for submission for the particular care setting.
- If a quality screen is triggered the nurse will take one of three actions based upon the specific indicator. The nurse will:
  - Refer the case to a physician reviewer for a potential quality concern.
  - Request that the hospital submit a medical record for quality review as part of the 5% quarterly sample so that a complete quality review may be performed.
  - Identify the case for track and trend analysis of aberrant patterns of care.
- If a case is referred to a physician reviewer (PR), the physician assesses all available clinical information. The PR applies clinical knowledge and professionally recognized standards of care to render a quality determination.

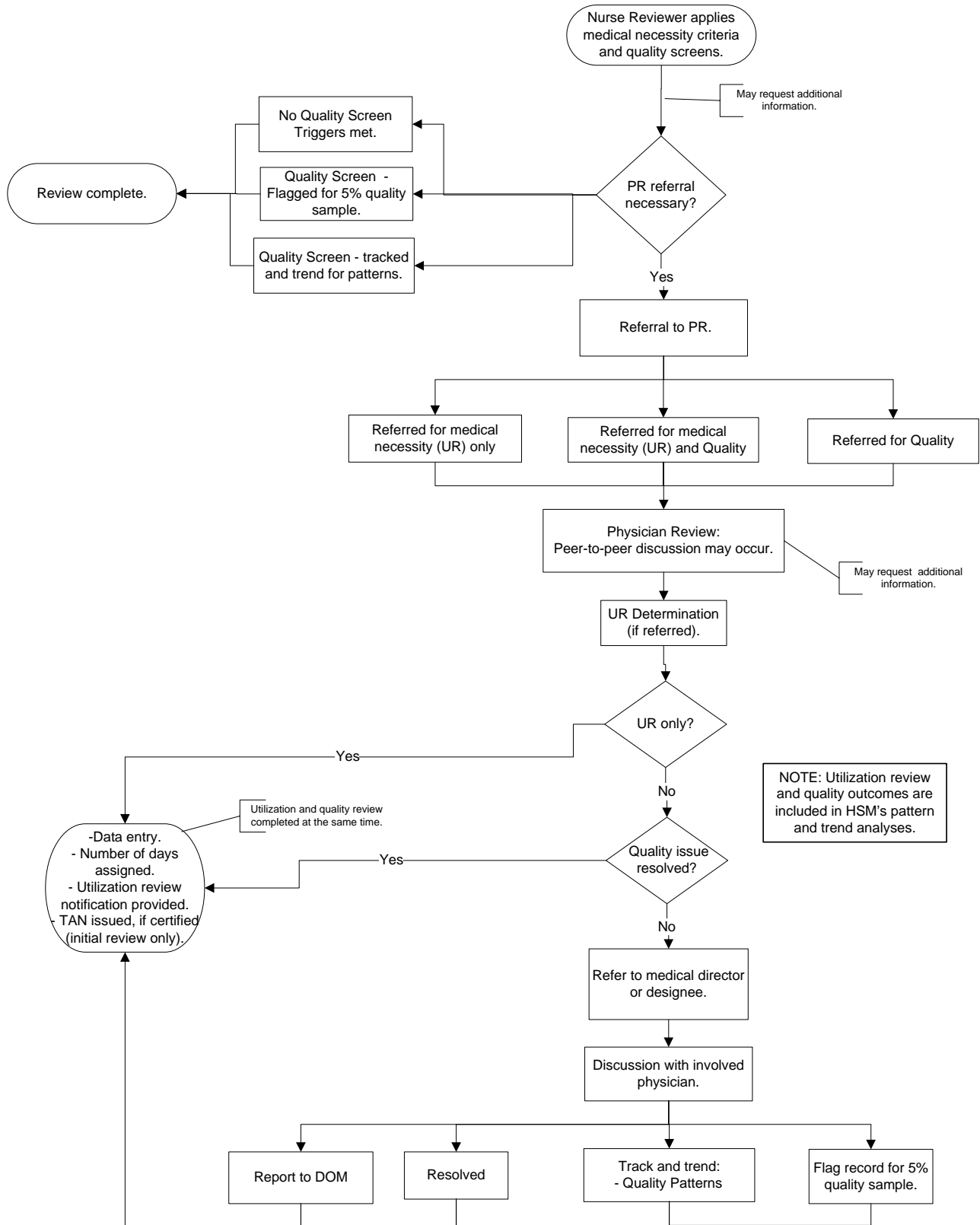
| If the PR determines that there is ... | Then the PR...                                                            | And then ...                                                                                                                                                                                                                                |
|----------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| no quality of care concern             | documents his or her findings.                                            | the case is closed.                                                                                                                                                                                                                         |
| a quality of care concern              | Attempts to contact the attending physician for peer-to-peer consultation | <ul style="list-style-type: none"> <li>• resolves the concern, documents his or her findings, and closes the case.</li> </ul> OR <ul style="list-style-type: none"> <li>• refers the case to HSM's medical director or designee.</li> </ul> |

- The medical director or designee will review the available information and initiate one or more of the following actions:
  - Attempt to contact the attending physician to discuss the concern.
  - Request the record for 5% quarterly sampling selection for quality review of the medical record.
  - Records the potential quality concern for track and trending for pattern identification.

**Note:** Please refer to HSM's setting-specific provider manuals for additional information regarding request for additional information and HSM's pend process.

HSM's process for conducting quality screening is depicted in the following flow chart.

**Quality Screening Process Flow Chart**



**D. Quality Review for Retrospective Review Certifications and 5% Quality Sample***Quality Review during Retrospective Review*

Retrospective review occurs when the patient has been admitted and discharged and certification of services was not sought from HSM. Retrospective review is a full scope review which requires a copy of the beneficiary's medical record. During retrospective review, the medical necessity of the admission and continued stay/services are reviewed. In addition, HSM conducts quality of care review.

The same quality review process described below is applicable for retrospective review and review of medical records selected for the 5% quality sample, with one exception – validation of information submitted during certification review is not applicable. *Please refer to HSM's setting-specific provider manuals for additional information regarding timeframe for submission of review request and additional information regarding the retrospective review process.*

*5% Quality Sample*

Under contract with DOM, on a quarterly basis, HSM selects and performs quality of care review on a 5% sample of cases from each care setting. In addition to quality review, medical necessity criteria is applied to medical records selected from care provided in acute care inpatient hospitals and home health services.

*Quality Screens*

HSM's medical director, in conjunction with HSM's clinical and professional staff and physician reviewers select the quality screens that are applied by nurse reviewers. Quality review screens may include generic quality indicators, patient safety, and disease-specific indicators. Confirmed quality concerns are assigned to a category of concern.

The following table displays the three concern levels and actions taken by HSM. Refer to the *Quality Intervention and Improvement Process* section of this manual for additional information

| <b>Category of Concern Level</b>                                       | <b>Explanation</b>                                                                            | <b>Action</b>                                                                                                                 |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Care could reasonably have been expected to be better.                 | A confirmed quality problem with no significant adverse effect to the patient.                | Included in quarterly analysis for identification of patterns of instances of provision of less than optimal quality of care. |
| Care failed to follow generally accepted guidelines or usual practice. | A confirmed quality problem with the potential for significant adverse effect to the patient. | Quarterly analysis for pattern identification and intervention.                                                               |
| Care was grossly and flagrantly unacceptable.                          | A confirmed quality problem with significant adverse effect.                                  | Immediate intervention.                                                                                                       |

5% Sampling Quality Review Process

The quality review selection process is described in the following steps.

- HSM selects the 5% sample from HSM's review data base and from claims for the home health setting.
- Records are requested on a monthly basis. The following table displays submission timeframes and methods and timeframes.

| HSM provides the hospital with                                                                                                 | The provider submits the requested information within |
|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Record request letters</li> <li>• Medical record inventory sheet/checklist</li> </ul> | 20 calendar days of date of HSM's request letter.     |

If the records are not submitted by the 25<sup>th</sup> day, HSM will make one additional request (second request) to obtain the records. Non-compliance with requests will be tracked and patterns will be reported to the Division of Medicaid.

The quality review process is described in the following steps.

- HSM nurse reviewer verifies whether the information provided during certification review is substantiated by documentation in the beneficiary's medical record. If required, the reviewer applies medical necessity criteria and assesses compliance with DOM policy.
- Nurse reviewers also apply quality screens to medical records to determine if a potential quality or utilization issue exists. If issues are identified, the case is referred for physician review.
- The physician reviewer (PR) makes a determination as to whether a quality and/or utilization issue(s) exists. The PR may call the provider to obtain additional information about the case.

| The PR determines that       | Then the PR                         | And then                                                                                                                                                                                                                                                                                                                         |
|------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The issue(s) is resolved.    | Closes the case.                    |                                                                                                                                                                                                                                                                                                                                  |
| Care could have been better. | Confirms a potential quality issue. | Assigns the appropriate category of concern level: <ul style="list-style-type: none"> <li>• Care could reasonably have been expected to be better.</li> <li>• Care failed to follow generally accepted guidelines or usual practice.</li> <li>• Care was grossly and flagrantly unacceptable (serious quality issue).</li> </ul> |

Written notification of a potential serious quality concern, i.e. care was grossly and flagrantly unacceptable, is sent to the providers identified by the PR to be the source of concern.

| If the source of concern is the | Then written notice is sent to the               | And within 30 calendar days of HSM's notice                                                                                                             |
|---------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| Facility/servicing provider.    | Facility/servicing provider.                     | The source(s) of concern may:                                                                                                                           |
| Physician.                      | Attending physician with a copy to the facility. | <ul style="list-style-type: none"> <li>• Submit additional information by Fax or phone, and/or</li> <li>• Request a peer-to-peer discussion.</li> </ul> |

The written notification contains the following information:

- Date of notice.
- Brief statement of HSM's authority and responsibility for review.
- Description of the quality concern.
- The responsible source of concern, i.e., facility, physician, practitioner or both.
- The appropriate action that should have been taken.
- The category of concern level.
- Instructions for submission of additional information or for obtaining a peer-to-peer discussion.

If no additional information is supplied and there is no request for peer-to-peer discussion made by the source(s) of concern(s), the quality issue is confirmed and notification is sent to the cited party(ies).

If information is submitted, the case is returned to the original PR, if possible, for a second review.

| If the issue(s) is                   | then HSM sends a written notification of a | And the issue(s) is                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Resolved                             | Non-confirmed quality issue(s).            | Closed.                                                                                                                                                                                                                                                                                                                                                                                                                |
| Downgraded to a lesser concern level | Non-confirmed quality issue(s).            | Tracked by category and analyzed for patterns.                                                                                                                                                                                                                                                                                                                                                                         |
| Confirmed                            | Confirmed quality issue.                   | <ul style="list-style-type: none"> <li>• Referred to HSM's Quality Intervention Committee for determination of appropriate intervention.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Immediate request for a corrective action plan (CAP)</li> </ul> <p><b>Note:</b> Refer to the <i>Interventions and Quality Improvement Process</i> section of this manual for additional information.</p> |

The following table describes the contents of written notices.

| If the notice involves a              | The notice will contain                                                             |
|---------------------------------------|-------------------------------------------------------------------------------------|
| Non-confirmed Serious Quality Concern | The date of the notice.                                                             |
|                                       | A brief statement of HSM's authority and responsibility for review.                 |
|                                       | The description of the potential quality concern.                                   |
|                                       | The rationale for resolving the issue.                                              |
| Confirmed Serious Quality Concern     | The date of notice                                                                  |
|                                       | A brief statement of HSM's authority and responsibility for review                  |
|                                       | The description of the quality concern.                                             |
|                                       | The responsible source of concern, i.e., facility, physician, practitioner or both. |
|                                       | The appropriate action that should have been taken.                                 |
|                                       | The category of concern level.                                                      |
|                                       | The rationale for confirmation of the concern.                                      |

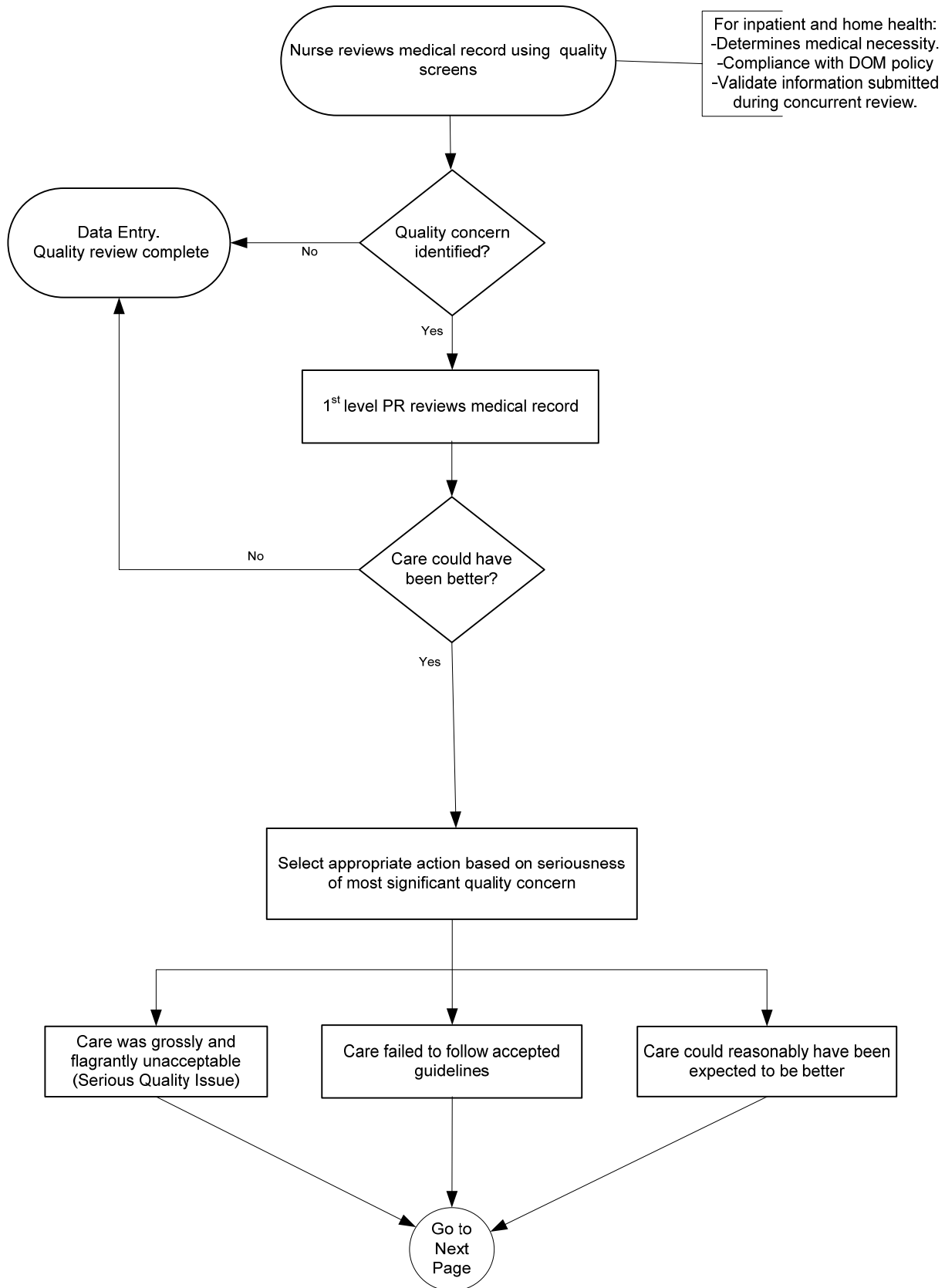
The cited party is allowed 15 calendar days to submit additional information for re-review consideration by HSM's Quality Intervention Committee.

The following flowcharts illustrate full chart quality reviews conducted for all provider settings for:

- Retrospective review certifications.
- Records selected for the 5% quality sample.

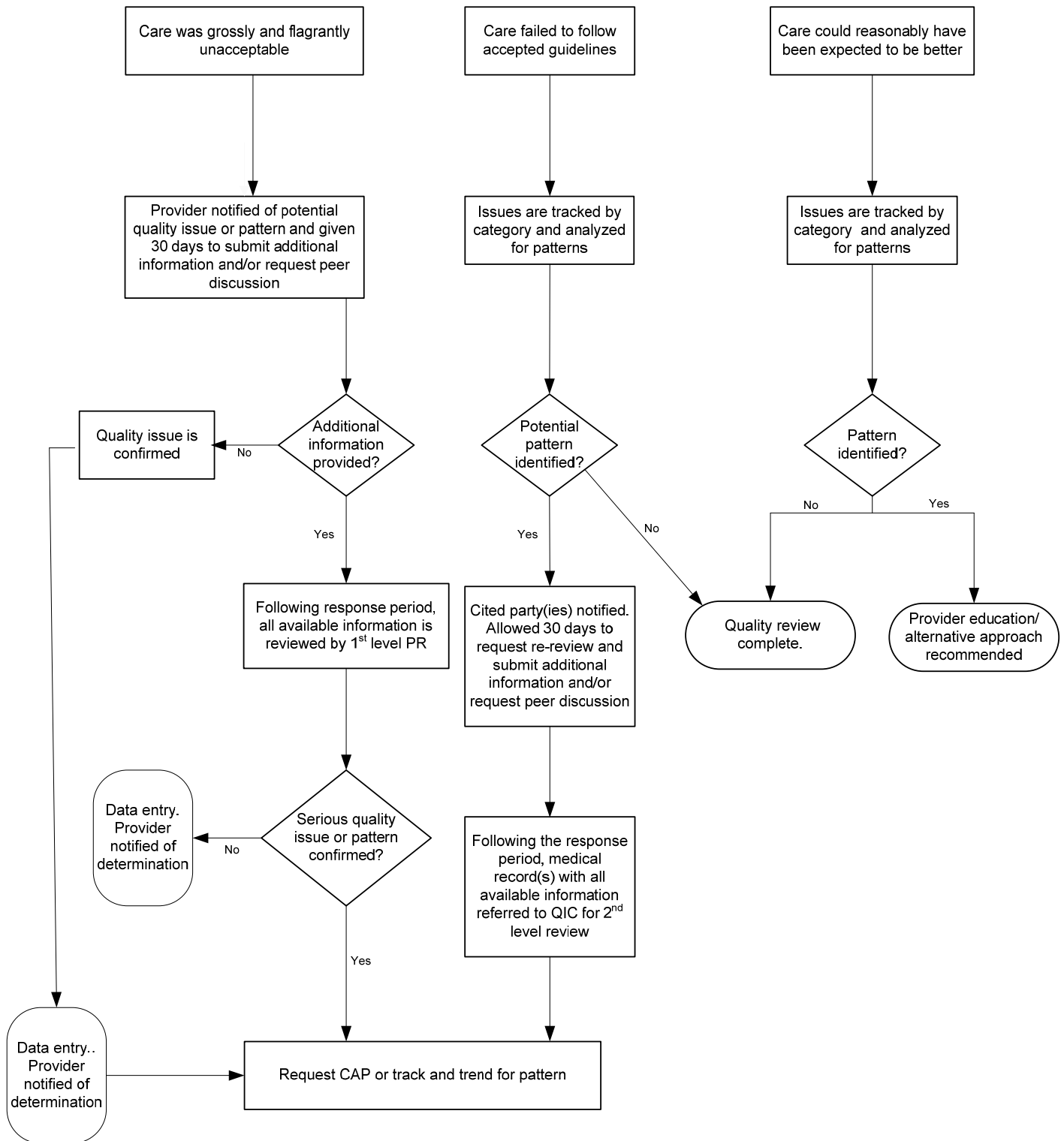
**Retrospective Review and 5% Quality Sample Process Flow Chart**

(Page 1)



**Retrospective Review and 5% Quality Sample Process Flow Chart**

(Page 2)



***E. Quality Intervention and Improvement Process***

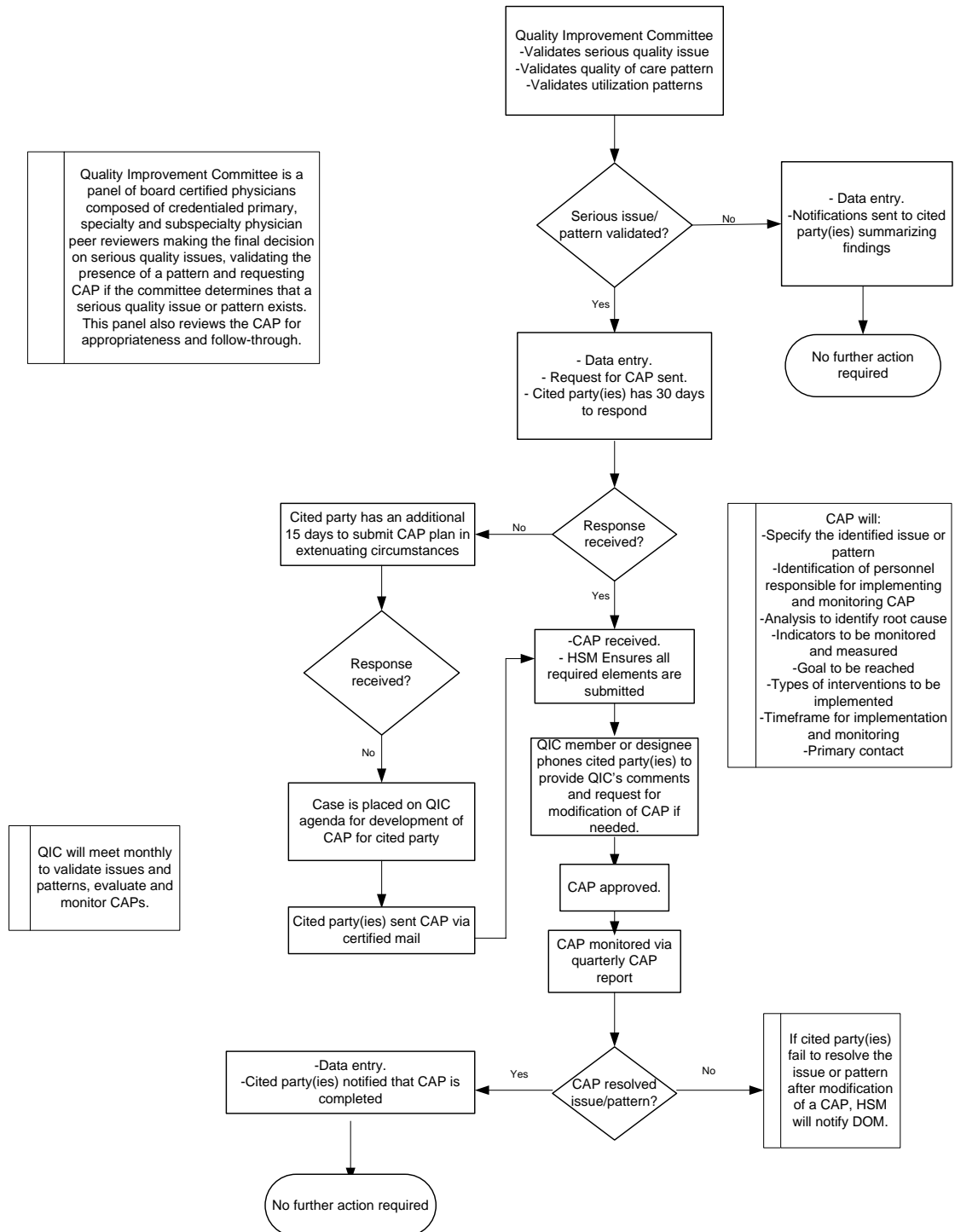
On a quarterly basis, data obtained during quality review is analyzed for the identification of potential provider-specific quality of care patterns. Category of concern and concern levels of seriousness are used in identification of patterns of care which fails to follow accepted guidelines.

If our statistical analysis suggests a pattern, the cited cases composing the potential pattern are reviewed by our Quality Intervention Committee (QIC) for validation. Prior notification will be sent to the provider.

HSM will request a corrective action plan (CAP) from the cited party when it is determined through the quality review process that a serious quality concern or a pattern of quality issue exist. The request will contain recommended actions that may be undertaken to address the issue or pattern.

The following flow chart outlines our process for requesting a CAP and the ongoing monitoring of results. The length of time required for CAP monitoring is case-specific, based on the target goals and monitoring results. Modifications to a CAP may be requested if the interventions do not appear to be resolving the quality concern or pattern.

**CAP Approval and Monitoring Process Flow Chart**



## ***V. Provider/Beneficiary Hotline***

HSM staffs a toll-free, dedicated telephone line for providers and beneficiaries to report quality of care concerns. HSM staff logs calls and resulting investigation or referral of complaint with final outcomes into our review system upon completion of the hotline process.

### ***Hotline Process***

Information gathered when the call is received is forwarded to our review manager for investigation.

For all calls not relating to a quality concern or complaint regarding access to care/services (e.g., questions regarding bills, benefits, etc.) the caller is redirected to the appropriate person or agency.

If the call involves a complaint or quality concern, the review manager requests a copy of all medical and/or any other information necessary and available to investigate. Resolution for calls relating to a quality concern or complaint related to access to care/services will be completed within the following timeframes:

- Urgent complaint (could endanger the life of a beneficiary) – begun immediately and completed within one business day.
- Non-urgent complaint (poses no immediate danger to the life of a beneficiary) – within 14 business days.

The information is to be sent to HSM within 10 days of our call requesting the information.

Once the information is received, quality review is performed as detailed in the 5% quality sample process. The caller receives a letter notifying him/her that the complaint has been handled and any problems identified would be dealt with appropriately.

Quality review outcomes for complaints are captured in the same data system; are included in profiles for aberrant patterns; and follow the same quality intervention and improvement process as issues identified through the review process.

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***VI. Utilization Analysis, Focused Studies, Outcome Reports,  
And Proposals for Improving Health Care Delivery System***

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

## **VII. CATEGORY OF CONCERN**

**INPATIENT ACUTE MEDICAL/SURGICAL CARE  
SPECIFIC SCREENS MATERNITY FOR DELIVERIES  
INPATIENT ACUTE PSYCHIATRIC CARE  
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY**

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| <b>INPATIENT ACUTE MEDICAL/SURGICAL CARE</b> |                                                                                                                                                           |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b>                   |                                                                                                                                                           |
| Q1.                                          | Apparently did not obtain pertinent history and/or findings from examination.                                                                             |
| Q2.                                          | Apparently did not make appropriate diagnosis and/or assessment.                                                                                          |
| Q3.                                          | Apparently did not establish an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care.                        |
| Q4.                                          | Apparently did not carry out an established treatment plan in a competent and/or timely manner (e.g. omissions, errors of technique, unsafe environment). |
| Q5.                                          | Apparently did not appropriately assess and/or act on changes in clinical, mental, or other status.                                                       |
| Q6.                                          | Apparently did not appropriately assess and/or act on laboratory tests or imaging study results.                                                          |
| Q7.                                          | Apparently did not establish adequate clinical justification for a procedure which carries patient risk.                                                  |
| Q8.                                          | Apparently did not perform a procedure that was indicated (other than lab or imaging).                                                                    |
| Q9.                                          | Apparently did not obtain appropriate laboratory tests and/or imaging studies.                                                                            |
| Q10.                                         | Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans.                                                    |
| Q11.                                         | Apparently did not demonstrate that patient was ready for discharge.                                                                                      |
| Q12.                                         | Apparently did not provide appropriate personnel and/or resources.                                                                                        |
| Q13.                                         | Apparently did not order appropriate specialty consultation.                                                                                              |
| Q14.                                         | Apparently the specialty consultation process was not completed in a timely manner.                                                                       |
| Q15.                                         | Apparently did not effectively coordinate across disciplines.                                                                                             |

| <b>MATERNITY ADMISSION FOR DELIVERY</b> |                                                                                                                                                                  |
|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b>              |                                                                                                                                                                  |
| M1.                                     | Is there evidence that the admission assessment for delivery was completed according to acceptable standards of practice?                                        |
| M2.                                     | Is there evidence that monitoring of maternal and fetal status was provided during labor according to acceptable standards of practice?                          |
| M3.                                     | Before induction of labor or Cesarean delivery, is there evidence provided for a non-emergency delivery of fetal maturity > 39 weeks gestation (AGOG guideline)? |
| M4.                                     | Is there evidence that Cesarean delivery was completed within standard time frames once fetal distress was identified?                                           |
| M5.                                     | Is there evidence that Vaginal Birth after Cesarean Delivery has continual monitoring of fetal heart rate and contractions during labor?                         |
| M6.                                     | Is there evidence that all complications were adequately addressed?                                                                                              |
| M7.                                     | Is there evidence that patient's pain management requests were addressed according to acceptable standards of practice?                                          |
| M8.                                     | Is there evidence of adequate staff present for delivery?                                                                                                        |
| M9.                                     | Is there evidence of appropriate monitoring and interventions for abnormalities immediately following delivery?                                                  |
| M10.                                    | Is there evidence that regular postpartum assessments were completed?                                                                                            |
| M11.                                    | Is there evidence that patient was provided adequate discharge instructions?                                                                                     |

| <b>INPATIENT ACUTE PSYCHIATRIC CARE AND PRTF</b> |                                                                                    |
|--------------------------------------------------|------------------------------------------------------------------------------------|
| <b>Category of Concern</b>                       |                                                                                    |
| 1.                                               | Lack of evidence of coordination of care with attending/consulting physician.      |
| 2.                                               | Medication management failure.                                                     |
| 3.                                               | Treatment plan does not address measurable goals.                                  |
| 4.                                               | Lack of behavioral assessment.                                                     |
| 5.                                               | Lack of security systems and processes in place.                                   |
| 6.                                               | Lack of education on medication usage or risk factors associated with medications. |
| 7.                                               | Inadequate or absence of a physical assessment process.                            |
| 8.                                               | Inadequate patient observation procedures.                                         |
| 9.                                               | Lack of communication with patient, family/caregiver.                              |

**ATTACHMENT B**

**VII. CATEGORY OF CONCERN**

**HOME HEALTH**

**PRIVATE DUTY NURSING**

**DURABLE MEDICAL EQUIPMENT**

**HOSPITAL OUTPATIENT MENTAL HEALTH**

**OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY**

**EFFECTIVE 01/01/09**

**ATTACHMENT B**

| <b>HOME HEALTH</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| H.1                        | Adequate assessment of patient before or at time of entry to determine the patient meets requisites for home care.                                                                                                                                                                                                                                                                                                                                                                                                  |
| H.2                        | Adequacy of HHA's capacity to provide the services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H.3                        | Adequate assessment of physical environment and capability of caregiver to provide care in home.                                                                                                                                                                                                                                                                                                                                                                                                                    |
| H.4                        | The plan of care (care plan) reflects measurable goals specific to the areas of care needed by the patient.                                                                                                                                                                                                                                                                                                                                                                                                         |
| H.5                        | The plan of care (care plan) was followed exactly or documentation was provided for any deviation from the plan of care.                                                                                                                                                                                                                                                                                                                                                                                            |
| H.6                        | Care plan and interventions modified appropriately according to the ongoing/periodic reassessment of patient need.                                                                                                                                                                                                                                                                                                                                                                                                  |
| H.7                        | Documentation shows patient/patient care giver participation in care planning.                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| H.8                        | The following indicators relate to the appropriate and timely intervention by the HHA for changes in the patient's medical condition which would warrant timely intervention (i.e., physician notification, possible change in treatment, etc.). Timely intervention, at a minimum, would be an attempt to notify the physician within 4 hours from the time of detection. Intervention may include change in treatment, ordering of diagnostic tests, treatment changes based on abnormal diagnostic results, etc. |
| H.8.1                      | Presence of temperature elevation (100 degrees oral, 101 rectal) or hypothermia noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H.8.2                      | Presence of BP reading < 85 or > 180 systolic or < 50 or > 110 diastolic noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                        |
| H.8.3                      | Presence of pulse < 50 or > 120 noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H.8.4                      | Presence of other significant changes in signs or symptoms noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| H.8.5                      | Presence of incident with resultant injury or untoward effect noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| H.8.6                      | Presence of a decubitus ulcer noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| H.8.7                      | Adverse drug reaction or medication error noted and acted on.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| H.8.8                      | Appropriate reporting of abuse/neglect.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| H.8.9                      | Timely reporting to the physician of family and/or patient non-compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| H.9                        | Presence of a patient education plan and evidence of patient learning.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| H.10                       | Adequate documentation of coordination of services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H.11                       | Evidence of ongoing discharge planning.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

**ATTACHMENT B**

| <b>PRIVATE DUTY NURSING</b> |                                                                                                                                                                                    |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b>  |                                                                                                                                                                                    |
| P.1                         | Apparently did not appropriately assess and/or act on changes in clinical, mental, or other status.                                                                                |
| P.2                         | Suspected abuse and/or neglect not appropriately reported.                                                                                                                         |
| P.3                         | Adequate assessment of physical environment and capability of caregiver to provide care in home.                                                                                   |
| P.4                         | Adequacy of the Private Duty Nursing Agency to provide appropriate personnel (LPN or RN) and the ability to staff for the certified hours.                                         |
| P.5                         | Apparently the plan of care was not followed exactly or no documentation was provided for any deviations from the plan of care.                                                    |
| P.6                         | The timely signed plan of care (care plan) reflects measurable goals specific to the areas of care needed by the patient and/or submission of the plan of care in a timely manner. |
| P.7                         | The Private Duty Nursing Agency will provide the appropriate resources to carry out the established treatment plan.                                                                |

**ATTACHMENT B**

| <b>DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS AND SUPPLIES</b> |                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b>                                            |                                                                                                                                                                                                                                                                                                                                     |
| D.1                                                                   | Specific provider documentation, as outlined in the respective criteria set, must be maintained as required by DOM.                                                                                                                                                                                                                 |
| D.2                                                                   | The delivery date for requested DME, Orthotics and Prosthetics or Medical Supplies corresponds with certification dates of service.                                                                                                                                                                                                 |
| D.3                                                                   | DME, Orthotics and Prosthetics and Medical Supplies delivered for patient use must meet physician specifications.                                                                                                                                                                                                                   |
| D.4                                                                   | For all Medical Supplies delivered, provider documentation must include: <ul style="list-style-type: none"> <li>A. A direct patient request,</li> <li>B. The patient's need continues to exist</li> </ul>                                                                                                                           |
| D.5                                                                   | Certification requests for the provision of DME, Orthotics and Medical Supplies must contain verification of: <ul style="list-style-type: none"> <li>A. The illness or condition requiring services,</li> <li>B. The date of the delivery, and</li> <li>C. The name of the discharging hospital, if applicable.</li> </ul>          |
| D.6                                                                   | The patient-provider relationship is maintained until the patient requests discontinuance of service or the physician validates no further medical need exist.                                                                                                                                                                      |
| D.7                                                                   | The DME Provider must document that: <ul style="list-style-type: none"> <li>A. The DME was properly prepared for patient use (set-up), and</li> <li>B. The patient was educated in the proper use and maintenance of equipment by appropriate provider staff.</li> </ul>                                                            |
| D.8                                                                   | For Orthotics and Prosthetics the DME provider must documentation that: <ul style="list-style-type: none"> <li>A. The Orthotic / Prosthetic was properly fitted / adjusted</li> <li>B. The patient was educated, by the appropriate provider staff, in the proper use, care and maintenance of the Orthotic / Prosthetic</li> </ul> |
| D.9                                                                   | The DME provider ensures equipment is maintained in a safe working condition.                                                                                                                                                                                                                                                       |

**ATTACHMENT B**

| <b>HOSPITAL OUTPATIENT MENTAL HEALTH</b> |                                                                                                                    |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b>               |                                                                                                                    |
| MH.1                                     | Lack of evidence of coordination of care with other health care service provider(s).                               |
| MH.2                                     | Failure to appropriately adjust medications-Physician.                                                             |
| MH.3                                     | Failure to appropriately refer for medication evaluation or medication adjustment(s).                              |
| MH.4                                     | Treatment plan does not address measurable goals.                                                                  |
| MH.5                                     | Lack of plan of care within four (4) sessions/visits.                                                              |
| MH.6                                     | Lack of evidence of a safety plan that has been developed and discussed with the patient or with family/caregiver. |
| MH.7                                     | Lack of education on medication usage or risk factors associated with medications.                                 |
| MH.8                                     | Lack of evidence that progress notes correspond with the treatment plan, treatment goals and objectives.           |

**ATTACHMENT B**

| <b>OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Concern</b>                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 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.                                                                                                                                                                                                                                                                                                                                          |
| 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.                                                                                                                                                                                                                                                                                                                                                    |
| OP. 3.                                                      | Standardized test measurements are administered at the beginning of treatment and re-measured at appropriate intervals during course of treatment.                                                                                                                                                                                                                                                                                                                                                                  |
| OP. 4.                                                      | Treatment plan was followed as ordered for course of therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| OP. 5.                                                      | Therapist documents patient and/or parent (caregiver) education.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| OP. 6.                                                      | Home Exercise Program (HEP) includes: <ul style="list-style-type: none"> <li>• Home program that models the therapy</li> <li>• Documentation of instruction and verbalization of understanding</li> </ul>                                                                                                                                                                                                                                                                                                           |
| OP. 7.                                                      | Orthotics and Prosthetics (O&P) ordered has: <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> |
| OP. 8.                                                      | Discharge plan is documented.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

## ***VI. Form and Instructions***

- Quality Re-Review Request Form
- Quality Re-Review Request Form Instructions



## Instructions for Completing the HealthSystems of Mississippi Medicaid Quality Re-review Request Form

### Section I Beneficiary Information

1. **Beneficiary Medicaid #** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth.
4. **Sex** - Indicate the sex of the patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered

### Section II Provider Information

1. **Provider's Name** - Enter the name of the billing provider that will render the treatment.
2. **Provider's MS Medicaid Number** - Enter the provider's Mississippi Medicaid provider number.
3. **Physician's/Treating Clinician's Name** - Enter the name of the physician or (treating) clinician rendering the service.
4. **MS Medicaid #** - Enter the physician's/treating clinician's Mississippi Medicaid provider number.
5. **Physician Tel #** - Enter the telephone number of the physician/treating clinician including area code.

### Section III Requester's Information

1. **Requested By** - Indicate whether the physician/treating clinician or facility made the request.
2. **Requester Name** - Enter the name of the individual requesting the review
3. **Requester Tel #** - Enter the telephone number of the requester including area and extension.

### Section IV Request and Notification Dates

1. **Request Date** - Record the date of the request.
2. **Admission/ Service Start Date** - Enter the date the patient was admitted or the service start date (for non-inpatient care settings)
3. **Date of Quality Issue Notification** - Enter the date denial letter was issued.

### Section IV Rationale/Medical Reason For Disagreement

1. **Rationale for Request** - Enter the medical basis/rationale for disagreement.
2. **Additional information submitted** - Indicate whether additional information was submitted with the request.