

Physician/Consultant Review Manual

Section II: Review Process

- **Contacting PRs for Availability to Review**

A KFMC Review Assistant will call you, or your designated contact person, prior to sending any cases.

We request that reviews be completed in 5 to 7 days.

In order to meet our rather strict review timeframes, we ask that if you are not going to be able to review cases shortly after they are received

- Return them un-reviewed
- Contact KFMC to determine if a delay would be acceptable

We want a quality product. Please devote the appropriate amount of time to ensure that the case is given a fair evaluation. If you do not have the time, do not hesitate to let us know.

- **Gross and Flagrant**

Example: A case is grossly and flagrantly unacceptable when, in the opinion of the reviewer, if uncorrected it should result in consideration of enforcement actions related to licensure. The use of licensure descriptions does not override the definitions in Part 1004 of Title 42 of the Code of Federal Regulations (CFR). The federal regulation at 42 CFR 1004.1 defines the “serious risk” situations that may involve care that was gross and flagrant. (K.A.R. 28-52-4: Possible grounds for disciplinary action by the appropriate licensing agency.)

There should be great caution in assigning this level of concern.

All gross and flagrant cases will be evaluated by the Medical Director and appropriate action will be taken as indicated.

- **The “Principal Diagnosis” and “Secondary Diagnosis”/Coding**

When cases come up for review with a question about the proper DRG assignment, we are not asking the PR to assign codes. We are (usually) asking the PR to use their medical expertise to determine the “principal diagnosis.”

The principal diagnosis is – “that condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital.” Usually, even in complex cases with multiple diagnoses, there is one condition that really required hospitalization. Likewise, it is usually possible to determine one condition that was the focus of treatment, requiring more of the physician’s management skill, hospital resources, staff time, etc. than other problems. That condition is usually the principal diagnosis.

Secondary diagnoses may be coded if they coexist at the time of admission or develop during the hospitalization. Additional conditions that affect patient care in terms of requiring:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring.

- **Physician Reviewer (PR) Tips**

- General Statement

- The PR has the responsibility to study each case in sufficient detail to arrive at a decision regarding the medical necessity and/or quality of care provided (e.g. Did the services meet professionally recognized standards of care?)
- The entire medical record should be reviewed.
- Try and put yourself in the physician's point of view.

- Each decision should be based on a clear rationale. This rationale should be based on:

- Medical knowledge,
- Experience and skills, and
- Professionally recognized standards of healthcare.

- Focus on the questions posed.

- Comments referencing situations that either do or do not meet criteria should never be used.

- Each PR review determination should have a detailed rationale that:

- Explains and supports the decisions rendered.
- Identifies the source of the concern as instructed on the Physician Reviewer Assessment Forms (PRAF) (e.g. nursing, lab, Dr. ABC, and/or Dr. XYZ).
- Can be provided as feedback/educational information to the physician or facility involved in the case

- For both resolved and confirmed concerns, offer advice to provider/practitioner to consider as an alternative approach to future care as indicated.
 - It is not acceptable to state simply “yes” or “no,” “agree with initial PR,” or “as above.”
- In the process of doing your review if additional quality of care concerns are found, list them as well.
- Your rationale will be incorporated into the response letter to the physician or facility. Please keep this in mind when formulating your response.

If you have questions or concerns about previous review comments and/or determinations, please contact KFMC.

- **Level of Care: Inpatient vs. “Observation”**

Medical care is provided at multiple levels. The highest level is acute hospital inpatient. Separate from this (and considered a lower level) is hospital outpatient or observation care and SNF (skilled nursing facility).

- **Outpatient** services furnished in a hospital, including the use of a bed and at least periodic monitoring by its nursing or other staff, that are reasonable and necessary to evaluate and treat a patient’s condition or determine the need for an inpatient admission.
- **Observation stays are:**
 - Outpatient care, although rendered in a hospital
 - Intended for short-term monitoring—generally < 48 hours

Documentation is critical. A physician’s order must specify “observation status” and must be signed and dated.

The circumstance where this is most often relevant to the KFMC physician reviewer is the brief hospital admission, where the question is:

- Was inpatient admission necessary, or could the patient have been treated at a lower level of care?

The case has already failed a screening using the Milliman Guidelines© (or else it would just have been approved and you would never have seen it). So the question for you is:

- In your medical opinion, was the acute inpatient level of care necessary, or could the case have been handled appropriately at a lower level?

Frequently, the answer we get is “Yes, they needed to be observed overnight.” But, as I think you can now appreciate that really doesn’t answer the question. The answer should be one of the following:

1. The patient needed acute inpatient care.
2. The patient did not really need inpatient, they could/should have been treated as an outpatient or observation.
3. They did not need to be in the hospital at all.

• **Beneficiary Complaint Cases**

KFMC reviews cases for a variety of reasons. Mechanisms that can lead to a case being reviewed include when a Medicare beneficiary (or their designee) files a complaint about care rendered. We refer to these as “beneficiary complaint cases.” Many of our beneficiary complaint reviews are handled by a small core group of internist reviewers. However, in order to match the specialty of the involved practitioner we may also send a beneficiary complaint for specialist review, so most reviewers could get this type of case at some point.

Beneficiary complaint cases, which frequently involve settings other than a hospital, are usually multi-faceted, and may not center on strictly medical issues.

When we send you a beneficiary complaint case, we will include a green folder, which contains the written complaint, along with various consent and authorization forms. Please take your time. Read the correspondence from the complainant so you’ll know how to focus your review. Beneficiary complaint cases require us to document considerably more than other cases.

The focus is on “opportunities for improvement” and working with providers and practitioners. As you review these cases, please keep in mind the following:

- We want to respond meaningfully to the complainant.
- Your comments will be included in our final report to the complainant.
- Include comments that may help the complainant understand what happened and why, etc.
- Any insight you may have as to what went wrong and how it could be done better in the future is valuable.

We ask that you complete the PRAF, as are used in all other types of cases. In addition, in beneficiary complaint cases, when the PR does not identify any quality of care concerns, Medicare offers an option for Alternative Dispute Resolution (ADR). Therefore, we will include an ADR form, which provides you with guidance in recommending ADR, and we will ask your opinion as to whether the case under review is suitable for ADR.

Please keep in mind that the complainant has the option to remain anonymous, and therefore KFMC is required to maintain confidentiality throughout the review process.

KFMC recognizes the additional burden to physician reviewers and will pay a higher fee for physician review of these types of cases.

- **Expedited Appeal Reviews (Immediate Telephone Reviews)**

The QIO is responsible for receiving and responding to expedited appeals seven days a week. The QIO receives expedited appeal requests from Medicare beneficiaries who are given notification that discharge is pending. If a beneficiary or their representative disagrees with the discharge plan the beneficiary contacts the QIO and requests an appeal.

Expedited Reviews are conducted in the following settings:

- Skilled Nursing Facilities
- Home Health Agencies
- Hospice Facilities
- Swing Bed Facilities
- Inpatient Acute Hospitals

The provider and attending physician will be notified of the appeal request and will request documentation needed for the expedited review. A Review Coordinator (RC) will examine medical and other records that pertain to the services in dispute, will solicit views of the beneficiary who requested the appeal, and will provide an opportunity for the provider/physician to explain why they believe discharge is appropriate.

All cases must be referred to a PR for discharge review. In general, these reviews are done over the phone. Information can be faxed to the PR if needed. **The PR must make a decision on the day he/she is contacted by the RC.**

The RC will provide a case summary, identify content from the medical record, and share the views of the beneficiary, provider, and the attending with the PR. The PR must determine whether skilled or acute care services continue to be medically necessary beyond the proposed discharge date. Determinations should be based on medical necessity and Medicare coverage guidelines.

The PR should use his/her medical training, experience, judgment, and knowledge of the Medicare coverage guidelines to determine if discharge is appropriate and provide rationale to explain the decision.

- **Re-Review (3rd Physician Reviewer) Tips**

Re-reviews are a very important part of the KFMC review process. Generally, this is the third time a chart is reviewed. This review can involve quality of care concerns and/or utilization of care concerns.

The re-review occurs because the involved facility and/or practitioner(s) continue to contest the previous PR determinations by submitting additional information and requesting a re-review. The 3rd level PR cannot be a physician who was originally involved in the 1st or 2nd level review, and should be a specialist in the type of services under review.

This is a complicated review because the reviewing Physician has to evaluate the entire process as it has evolved.

The PR should:

- Be meticulous in evaluating the additional information provided.
- Focus on the questions listed on the Physician Reviewer Assessment Form.
- Contact KFMC if you have questions or concerns.

The emphasis should be that if the first two levels of review have persistently documented a deficiency in either quality of care or utilization of care then it should take a significant **revelation** by the involved parties in order for the PR to resolve the concern(s). There must be a clearly documented new finding that would result in an overturn of the initial reviews.

It is quite possible that the involved facility/practitioner(s) may indicate that they have made changes in their system to address the concerns posed to them. This is appreciated by KFMC, and the PR is encouraged to recognize the efforts of the involved parties; however, just because the involved parties have subsequently recognized and addressed the problem does not necessarily resolve the concern.

It should be stated that it is not the position of KFMC that re-reviews should not result in a favorable determination. There should, however, be very clear and obvious reasons for concerns to be resolved at this level.

- **Criteria is Only a Guideline**

Summary:

KFMC non-physician reviewers currently use Milliman Care Guidelines[®]. If a case fails Milliman Care Guidelines[®], the review coordinator (RC) refers the case to a physician reviewer. As a PR, KFMC is asking for your medical expertise to the question asked.

Please do not say the case failed the guideline/criteria but instead explain your reasoning/rationale for your determination.

Case Review:

When you receive a review, the screening criteria used by KFMC that resulted in the case being referred for physician review may be included with the case.

KFMC sends copies of applicable screening criteria, including the bibliography used in developing those criteria, along with cases you review. This should help you to understand the logic behind the referral.

However, in order to do this, we need your help. The following limitations apply:

- KFMC uses the Milliman Care Guidelines[®] to screen cases for inpatient admission necessity and quality of care. These are a copyrighted commercially available product. You should not further disclose them without written permission from the publisher. They should be returned with the case materials.
- We would appreciate feedback on the criteria. We are required to reassess the screening criteria regularly, and we would like to include you in that process. When you identify a possible improvement that could be made, we would appreciate a brief note alerting us to the issue. We will collect these over time, and periodically assess them to determine if there are any recurring issues or changes that should be made. For example, we can use your feedback to alert the publisher of changes in technology that result in a different approach to a case, or advances in diagnostics that are routinely applied and should be considered in utilization or quality reviews.
- Using the criteria itself as justification for your decision does not represent a sufficient rationale. A decision rationale should use facts and circumstances particular to the case under review, point out any pre-existing medical problems or other circumstances that change the approach to that particular patient's care, and tell us why the screening criteria does or does not apply.

Case Examples:

1. Inpatient admission necessity review:

- Inadequate rationale: "The admission was not medically necessary because it failed Criteria #43."
- Adequate rationale: "The admission was not medically necessary. The patient's oxygen saturation was normal, and there were no extenuating circumstances that made outpatient treatment more risky for the patient. No intravenous medications were required in this case. The standard practice for this case would be outpatient treatment with close office follow-up."

OR

"This admission was medically necessary as acute care and intravenous antibiotics were required. Care could not have been safely provided at a lower level."

2. Quality review:

- Inadequate rationale: Criteria #42 requires aspirin for myocardial infarctions, which was not given. This is a quality concern.

- Adequate rationale: This patient had a myocardial infarction and did not receive aspirin on arrival to the hospital, although it was prescribed on discharge. No contraindication to aspirin was noted in the record, nor could I infer one from the clinical situation. Aspirin for heart attack is the accepted standard of care, and is a key quality measure for heart care. This is a quality concern.

Final Note:

We are not asking you whether the case met criteria but we are asking for your medical judgment, based on your training and experience.

- PR Completion of Forms

Below is an excellent example of PR completion of both the PRAF case summary and the Response Determination Category (RDC) forms.

— **The PR will:**

- **Assign a Category of Concern for each of the concerns (e.g. A01; C05; D03, as listed on the back of the Case Summary form).**
- **Identify the Concern Source for each of the concerns (e.g. P1, F2, as listed on the back of the Case Summary form).**
- **Provide the name of the involved physician(s) as a Concern Source (e.g. Dr. Jacob Jones).**
- **Clearly explain the reason(s) for the outcome of the Review Coordinator's (RC) question(s) OR provides excellent rationale to explain and support the review determination(s).**

RC Case Summary: 81 yr old male admitted 06/12/07. CABG 4/14/07 with periods of confusion and difficulty managing meds since that time. Family noted pt was hallucinating, brought to ER for eval. Found with new onset bradycardia; hx of A-fib. PMH: CAD; CABG; PVD; stable abd aortic aneurysm; HTN; hyperlipidemia; DJD. Tx: Cardiac & psych consults, telemetry, EKG which showed A-fib w/frequent PVC's. Labs monitored; Digoxin level 0.5, PT/INR 27.3/2.46 and 21.5/1.81. Cardiac enzymes & thyroid studies wnl. Meds changed or dc'd. Pt dc'd home 06/14/07.

Review Coordinator Questions:

1. Discharge documentation states Coumadin was discontinued as pt appears to be unreliable in managing this medication. Digoxin also dc'd. Due to pt's PMH of
2. CAD, CABG, PVD, and A-fib, is it appropriate for the pt to be without an anticoagulant medication or antiarrhythmic medication? Is this a quality of care concern? Your comments are appreciated.

3. The nursing care plan states that collaboration with Social Services is appropriate, however this reviewer is unable to locate documentation in the medical record that Social Services completed an evaluation. The history of present illness states the pt was not managing Coumadin properly prior to admission and upon discharge Coumadin was dc'd due to inability to manage this medication. Should Social Services have evaluated the pt and assisted with resources available for medication management? Is this a quality of care concern? Your comments are appreciated.

4. Discharge orders are for office visit in 14 days. Is this an appropriate time frame, due to changes in and discontinuation of medications? Is this a quality of care concern? Please explain.

CONCERN SOURCE LEGEND (Information located on back of Case Summary Form)

RESOLVED CONCERN	0
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CONFIRMED CONCERN for quality concerns (list all that apply)	P1 Attending	P4 Consultant P99 Other Physician	F2 Nursing	F5 Radiology F6 Administration F7 Social Service	F8 Therapy
	P2 Surgeon		F3 Lab		F9 Dietary
	P3 Anesthesiologist		F4 Pharmacy		F99 Other facility

ADMISSION CATEGORIES

- A01 Medical condition appears not to require inpatient hospital level of care.
- A02 Services rendered appear not to require hospital level of care.
- A03 Admission solely for a procedure that appears unnecessary (also consider category C07).
- A04 Apparent unnecessary days of stay in a non-PPS admission or PPS day-outlier case.
- A05 Patient whose admission was initially noncovered subsequently developed a condition requiring covered inpatient care (assign a deemed date of admission).
- A06 Apparent medically unnecessary days/items/services in a PPS cost-outlier case.
- A07 Notice of noncoverage level of care determination appears to be inappropriate.
- A08 Notice of noncoverage level of care determination appears to be appropriate, but subsequently patient required reinstatement to covered level of care.
- A09 Notice of noncoverage liability dates appear incorrect.
- A10 Assistant at cataract does not appear to be medically necessary.
- A12 Termination of service determination appears to be inappropriate (CORF, HHA, SNF, Hospice).
- A99 Other utilization concern not elsewhere classified.

PROHIBITED ACTIONS

- B01 Readmission apparently resulted from a previous premature discharge (also report the inappropriate/premature discharge quality concern for first admission).
- B02 Readmission for services that should have been rendered during previous admission.
- B03 Apparent inappropriate transfer from PPS unit to non-PPS unit or vice-versa in same hospital.

GENERAL QUALITY CATEGORIES

- C01 Apparently did not obtain pertinent history and/or findings from examination.
- C02 Apparently did not make appropriate diagnoses and/or assessments.
- C03 Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)].
- C04 Apparently did not carry out an established plan in a competent and/or timely fashion (e.g. omissions, errors of technique, unsafe environment).
- C05 Apparently did not appropriately assess and/or act on changes in clinical/other status.
- C06 Apparently did not appropriately assess and/or act on laboratory tests or imaging study results.
- C07 Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed.
- C08 Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09).
- C09 Apparently did not obtain appropriate laboratory tests and/or imaging studies.
- C10 Apparently did not develop and initiate appropriate discharge, follow-up and/or rehabilitation plans.
- C11 Apparently did not demonstrate that patient was ready for discharge.
- C12 Apparently did not provide appropriate personnel and/or resources.
- C13 Apparently did not order appropriate specialty consultation.
- C14 Apparently specialty consultation process was not completed in a timely manner.
- C15 Apparently did not effectively coordinate across disciplines.
- C16 Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)
- C17 Apparently did not order/follow evidence-based practices.
- C18 Apparently did not provide medical record documentation that impacts patient care.
- C40 Apparently did not follow-up on patient=s noncompliance.
- C99 Other quality concern not elsewhere classified.

DRG CATEGORIES

- D01 Principal diagnosis not present at admission. Use D15 if the admitting diagnosis is reported incorrectly - technical error; the hospital sequenced or reported the diagnosis incorrectly - ICD-9-CM rule; or the correct code was transposed or truncated - reporting error.
- D02 Principal diagnosis not treated/evaluated during stay. Use D15 if the admitting diagnosis is reported incorrectly - technical error; the hospital sequenced or reported the diagnosis incorrectly - ICD-9-CM rule; or the correct code was transposed or truncated - reporting error.
- D03 Principal diagnosis not principal reason for hospitalization. Use D15 if the admitting diagnosis is reported incorrectly - technical error; the hospital sequenced or reported the diagnosis incorrectly - ICD-9-CM rule; or the correct code was transposed or truncated - reporting error.
- D07 Complication/comorbidity/secondary diagnosis billed but not substantiated by record. Use D15 if the hospital sequenced or reported the diagnosis incorrectly - ICD-9-CM rule; or the correct code was transposed or truncated - reporting error.
- D08 Complication/comorbidity/secondary diagnosis is substantiated in record but not billed and it changes the DRG. Use D15 if the hospital sequenced or reported the diagnosis incorrectly - ICD-9-CM rule; or the correct code was transposed or truncated - reporting error.
- D10 Procedure billed, but not substantiated by record.
- D11 Procedure is substantiated in record but not billed and it changes the DRG.
- D12 Procedure determined medically unnecessary is billed and must be removed from DRG.
- D13 Disposition status code is incorrect and changes the DRG.
- D14 Patient=s age is incorrect and changes the DRG.
- D15 Non-clinical/non-medical errors that affect the DRG.
- D16 Deemed date of admission established which changes the DRG.

D99 Other DRG concern not elsewhere classified.



Completion of the PRAF Case Summary Form

Reference The Concern Source Legend and Categories of Concern

Concern

- Document each concern number in the “Concern #” box. The concern # is the same as the question # on the PRAF Referral.

Category of Concern

- If you do not identify a concern, place a zero (0) in the box marked “Category of Concern.”
- If you do identify a concern, assign a category in the “Category of Concern” box for each concern (refer to the Category of Concern definitions, e.g. A01, C01, D01).

Concern Source

- Record the Concern Source and name of physician(s) (if applicable) to receive an inquiry letter (refer to the Concern Source legend, e.g. P1, F2).

Provide your medical rationale in the “Rationale” column for each concern.

PRAF (Physician Reviewer Assessment Form) CASE SUMMARY

Concern #	Category of Concern (for <u>each</u> concern; see back)	<u>Concern Source for each concern:</u> <ul style="list-style-type: none"> • Only for confirmed concerns • See <u>Source Legend</u> on back • If physician, include name(s) 	Rationale
1	C03	P1-Dr. Sam Smith	<p>This 81-year-old man with multiple medical problems including coronary artery disease, cardiac arrhythmias, diabetes mellitus, and hypertension was hospitalized with delirium secondary to medications.</p> <p>The patient was thought to be unsafe on coumadin and this anticoagulant was therefore discontinued. This is appropriate clinical judgment in some cases, but a physician would ordinarily have placed this patient on aspirin prophylaxis. This is a potential quality concern, as it appears the patient should have some type of anticoagulant medication.</p>
2	C12	F2-Nursing F7-Social Services	<p>In the nursing care plan it states that collaboration with social services is appropriate, however the reviewer is unable to locate documentation in the medical record that social services completed an evaluation. It does appear that social services was consulted to assist with discharge planning and assist with resources available for medication management. It is a potential quality concern that there is no documentation of their involvement.</p>
3	0		<p>A follow-up office visit for this individual in 14 days is acceptable within community standards. He was discharged with his wife who could establish an earlier appointment if necessary. No quality concern.</p>

In an effort to focus on 'opportunities for improvement' and 'working with providers and practitioners to improve the delivery of health care', CMS implemented Response Determination Categories (RDCs) to be assigned by physician reviewers on all Medicare cases involving all **quality of care issues**.

With each Medicare case involving quality of care concerns, we include a Response Determination Category Summary form. Please complete this form for each case, whether you resolve or confirm quality concerns, and provide your insights (recommendations, alternative approaches to future care, etc.) as to what went wrong or what could have been done better, so that we can respond meaningfully to the providers. Below is an example of the Response Determination Category form filled out.

RESPONSE DETERMINATION CATEGORY (RDC) SUMMARY

CONFIRMED QUALITY CONCERNS (*additional explanations are on the back of this form when it is sent to PRs*):

Care could have been better.

1. Confirmed concerns must be assigned to one of the following 3 categories (see definitions on back):

Concern #:

- _____ A. Care was grossly and flagrantly unacceptable (*possible grounds for disciplinary action by the appropriate licensing agency).
- _____ B. Care failed to follow generally accepted guidelines or usual practice (*standards of care not met, with injury occurring or reasonably probable).
- 1,2 C. Care could reasonably have been expected to be better (*standards of care not met, but with no reasonable probability of causing injury).

2. Which of the following action(s) would you propose to address the concern(s)?

Concern #:

- _____ A. Immediate referral to licensing authority.
- _____ B. Initiation of sanction activity.
- _____ C. Initiation of intensified review activity.
- _____ D. Recommend that provider/practitioner develop and implement a Quality Improvement Plan (QIP).
- 1,2 E. Recommend that provider/practitioner consider an alternative approach to future care (where you are **confirming** a quality of care concern).

RESOLVED QUALITY CONCERNS (*see additional explanations on the back of this form*):

No substantial improvement opportunities identified (*standards of care met).

Which of the following action(s) would you propose to address the concern(s)?

Concern #:

- _____ F. Offer advice to provider/practitioner to consider as an alternative approach to future care (where you are **resolving** or **do not find** a quality of care concern).
- 3 G. No recommendations are made.

Please explain your choice(s); please list any pertinent guidelines or cite any pertinent literature here, if applicable: _____

Nursing services and social services need to work together to develop and establish discharge plans for patients. Physicians need to review medications during hospitalization and at the time of discharge to determine the appropriate medication prescriptions.

Dr. Joseph Goldstandard, MD

Physician Reviewer Signature

12/30/2008

Date