kfmc
HEALTH IMPROVEMENT PARTNERS

urac
ACCREDITED
Independent Review Organization Accreditation: External Review
Expires: 06/01/2027

Peer Reviewer Training Manual

800 SW Jackson St Ste 700 | Topeka, KS 66612
Telephone: 785-273-2552 or 800-432-0770
Fax: 785-273-0237 | www.kfmc.org

Contents

Message from KFMC Medical Director.......... 3
Section I: Case Review Program Overview.......... 4
Section II: Credentials Verification & Reviewer Qualifications.......... 5
Credentialing (CQP 1-1) (CQP 2-1).......... 5
Peer Reviewer (PR) Qualifications (CQP 1-2) (CQP 1-3).......... 6
Reimbursement.......... 7
Section III: Confidentiality & Liability.......... 9
Confidentiality (RM 3-1) (CPE 1-2) (OPIN 2-3(a)).......... 9
Section IV: Review Process.......... 10
Conflict of Interest Attestation (COI 2-1)).......... 10
Reviewer Credentials and Knowledge Attestation (COI 3-1)).......... 11
Reviewer Experience Attestation (COI 3-1).......... 11
Availability to Review.......... 12
Documentation.......... 12
General Categories of Peer Review.......... 12
Level of Care/Admission.......... 12
DRG/CPT/Coding.......... 13
Quality.......... 13
Discharge.......... 14
Medical Necessity (RP 3-1).......... 14
Experimental and Investigational (RP 3-2).......... 14
Expedited (RP 2-2(a)).......... 15
Consumer Safety (CPE 2-1(a)).......... 15
Criteria is Only a Guideline.......... 16
Peer Reviewer (PR) Notables.......... 17

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

Message from KFMC Medical Director

Thank you for your interest in serving as a Peer Reviewer (PR) for KFMC Health Improvement Partners (KFMC). By serving as a PR you will be participating in improving the care for all patients, including your own. In the changing environment of health care, you appreciate that care can only be judged based on the documentation provided. The peer review process is very important. We are defining the "standard of care" for our medical community. This is not a task to be taken lightly. This review process has the potential to positively impact patient's lives and enhance our practice of healthcare.

KFMC's mission statement is simple: "As health improvement partners, we inspire meaningful change and sustained high performance." We strive to promote this mission by working with others in the healthcare community. Through providing high quality medical reviews and evidence-based determinations we will improve the healthcare provided to the patients in our communities and achieve our mission.

Following is the KFMC Peer Reviewer (PR) Orientation Manual. This material will guide you on the most current version of URAC standards related to your roles and responsibilities in the review process. Do not hesitate to contact either Michelle Sigmund msigmund@kfmc.org or myself ktipton@kfmc.org if you have questions.

Thank you for your willingness to participate in this process. We look forward to working with you.

Sincerely:

Kyle Tipton, MD
Medical Director KFMC

Section I: Case Review Program Overview

The case review program is composed of three lines of service:

- Independent Review Organization (IRO)
- Independent Peer Review (IPR) and
- Other case review services, including abstraction services.

External and Internal Review are related to the IRO (OPIN 2-3(b.i)(b.ii)) entire manual

- External review is independent review of adverse decisions by a third-party administrator, a health insurance plan, an insurer or a health care provider acting on behalf of an insured; that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational.
- Internal review is the independent review of an appeal review by an insurance issuer or group health plan or their designee (i.e., such as a TPA) of an adverse benefit determination.

Independent Peer Review (IPR)

- Independent Peer Review is a service provided to hospitals, health systems, ambulatory surgery centers and other providers as they engage KFMC as a part of their internal quality improvement and quality assurance/risk management process to provide an objective, unbiased assessment of the care provided to assure standard of care is met.

Other Case Review Services are designed to meet individual client needs by request such as focused review or clinical case abstraction.

Section II: Credentials Verification & Reviewer Qualifications

Credentialing (CQP 1-1) (CQP 2-1)

Credentials verification serves three functions:

- Initial credentialing is the evaluation of an individual's application for participation on the KFMC panel of Peer Reviewers (PRs). (CQP 1-1(a.ii)) (CQP 1-1(c))
- Re-credentialing/re-verification assesses the individual reviewer qualifications for continued participation as a Peer Reviewer with KFMC. (CQP 1-1(a.iii)) (CQP 2-1(a.ii))
- Ongoing monitoring of license and certification actions, as well as sanctions or disciplinary actions, assures that only those reviewers meeting the program requirements will provide review services. (CQP 2-1(a.iii)) This includes reviewing the List of Excluded Individuals/Entities (LEIE) maintained by the OIG. (CQP 2-1(iv))

Annually KFMC will verify your licensure within your area of practice. (CQP 2-1(a.i)) Every three years, KFMC will update self-reported information in the initial application form and require new attestations. This will include a release of information related to your certification status.

Credential Status Changes (CQP 2-2)

Credential status changes will usually be captured in reports addressing licensure or certification status; however, some will be self-reported. Consistent with the policy of maintaining a panel of qualified reviewers, KFMC PRs must notify us within three business days of any adverse change in licensure or certification status. (CQP 2-2(a.i)) Adverse changes include not only loss of a license or board certification, but also any sanction or disciplinary action related to their credentials and loss of hospital privileges or pending hospital action. Notice of an adverse change can be provided in any form, i.e. written, phone call, fax.

An adverse change in licensure, certification, or sanction/disciplinary action is treated as any other piece of confidential information. Reviewers who are levied with an adverse change of this nature are considered out of compliance with qualifications to participate as a Reviewer with KFMC, unless the Credentialing Committee determines otherwise. (CQP 1-1(b)) (CQP 2-2(a.ii))

A copy of the form, "Self-Reported Adverse Change in Licensure, Certification or Sanction and Disciplinary Action" is provided with the application and is available on the KFMC website.

Peer Reviewer (PR) Qualifications (CQP 1-2) (CQP 1-3)

There are nine (9) requirements an applicant must meet to be considered for placement on our Panel of Reviewers: (CQP 1-1(c))

- Maintain Board Certification in the specialty for which they will review, if a specialty board exists. (CQP 1-3(a.iii))
- Hold current, unrestricted license or certification as required for clinical practice in a state of the United States. (CQP 1-2(a.i)(a.ii)(a.iii)) (KAR 40-4-42e (b)(3))
- Physicians Reviewers must have a current certification by a recognized American medical specialty board. (CQP 1-3(a.iii)) KAR 40-4-42e (b)(3))
- Must be actively providing direct patient care on a full time basis. (KFMC)
- Have at least five (5) years' full-time equivalent experience providing direct clinical care to patients (FTE minimum of = 37.5. hours per week). (CQP 2-1(a.v)) (CQP 1-3(a.iv))
- Have experience providing direct clinical care to patients within the past three (3) years. (CQP-Ext 1-1(a))
- Have "no history of disciplinary actions or sanctions, including loss of staff privileges or any participation restriction that has been taken or is pending by any hospital, governmental agency or unit, or regulatory body, that raises a substantial question as to the clinical Peer Reviewer's physical, mental or professional competence, or moral character." (KAR 40-4-42e (b)(4))
- Completion and return of the Application to Review and attestations. (KFMC)
- Must be approved as a Reviewer by the KFMC Medical Director or Credentialing Committee. (KFMC)

At the time of application, additional self-reported information is provided by the applicant and includes but is not limited to, basic identifying information such as name, address, contact sources, license number, sub-specialties, and the length of time providing direct patient care and dates indicating when the direct patient care occurred. (CQP 2-1(a.v))

Additionally, PRs should:

- Be reasonable and fair-minded.
- Possess a good general understanding of the healthcare delivery environment, and a commitment to quality.
- Be willing and able to devote the time required.
- Be flexible and willing to be called on short notice if necessary.
- Possess excellent judgment.
- Have the ability to keep things in perspective, look at the whole picture, and determine importance.
- Have the finesse to provide constructive criticism.
- Have the willingness to confront another peer when appropriate and necessary.
- Be well respected as clinicians by their peers.
- Provide educational feedback when appropriate.

Reimbursement

PRs will be reimbursed at an hourly rate for actual medical case review, completed either by phone, onsite, or mail-in review.

A PR timesheet will be included with each case that we send to you for review. Reimbursement for your time will be based on this form, so it is important that you document your review time, sign and date the form, and return it to us with the case.

Roles and Responsibilities of Peer Reviewer

- Maintain Board Certification in the specialty for which they will review. (KFMC)
- Hold current, unrestricted license or certification as required for clinical practice in a state of the United States. (CQP 1-2(a.i)(a.ii)(a.iii) (KAR 40-4-42e (b)(3))
- Physician Reviewers must have a current certification by a recognized American medical specialty board. (KAR 40-4-42e (b)(3)) (CQP 1-3(a.iii)
- If a D.P.M., have board certification by the American Board of Podiatric Surgery (AMPS) or the American Board of Podiatric Medicine. (CQP 1-3(a.iii)
- Must be actively providing direct patient care. (KFMC)
- Have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment for each assigned review. (CQP 1-3(a.i))
- Have at least five (5) years' full-time equivalent experience providing direct clinical care to patients (FTE minimum of = 37.5. hours per week). (CQP 2-1(a.v)) (CQP 1-3(a.iv))
- Have experience providing direct clinical care to patients within the past three (3) years. (CQP-Ext 1-1(a)
- Have "no history of disciplinary actions or sanctions, including loss of staff privileges or any participation restriction that has been taken or is pending by any hospital, governmental agency or unit, or regulatory body, that raises a substantial question as to the clinical Peer Reviewer's physical, mental or professional competence, or moral character." (KAR 40-4-42e (b)(4))
- Determine, for every case assigned, if a conflict of interest exists.
- Maintain confidentiality of all review information and communication.
- Provide review determinations on assigned cases only within his/her knowledge and experience.
- Determinations should be timely, articulate, accurate, and supported by evidence-based rationale.

As a Reviewer for KFMC, you are required to report any adverse change in your licensure, certification, and sanction or disciplinary action. Sanction activity includes participation restriction that has been taken or is pending by any hospital, governmental agency or unit, or regulatory board that raises a substantial question as to the clinical Peer Reviewer's physical, mental, professional competence, or moral character. (CQP 2-2(a.i))

Within three (3) business days of a change in status, you must notify KFMC. (CQP 2-2(a.i))

Notice of an adverse change can be provided by the Reviewer in any form: written, email, voice notification, fax, etc. KFMC has an official form you may use for reporting changes of this nature. A copy of the form is included with this packet of information.

Section III: Confidentiality & Liability

Confidentiality (RM 3-1) (CPE 1-2) (OPIN 2-3(a))

When you become a PR, you are required to sign a Confidentiality of Information form agreeing not to disclose medical information to unauthorized sources. (CPE 1-2(a.ii) In addition, KFMC Peer Reviewers are advised that security measures must be taken to prevent unauthorized access to confidential information. To ensure compliance with this requirement, KFMC asks that you take special privacy precautions. As you review records in your office or home, be sure that unauthorized individuals do not have access to the records. Records are to be kept in a locked area when left unattended. Review-related documents should be double wrapped when transporting or mailing medical records. (RM 3-1(b)) (CPE 1-2(a.i)(a.ii)

Liability

In today's litigation-prone society, the question of Peer Review liability decisions often arises. KFMC is protected from most liability under state legislation.

In 1976, the Kansas Legislature passed a bill that became Kansas statute 65-4909, which provided limited liability for certain associations of healthcare providers, review organizations, and committee members thereof. It states:

> *There shall be **no liability** on the part of and no action for damages shall arise against any state, regional, or local association of healthcare providers or any organization delegated review functions by law, and the individual members are healthcare providers, which in good faith investigates or communicates information regarding the quality, quantity, or cost of care being given patients by healthcare providers for any act, statement or proceeding undertaken or performed with the scope of the functions and within the course of the performance of the duties of any such association, organization, or committee **if** such association, organization, or committee or such individual members thereof **acted in good faith and without malice.***

As long as you exercise due care, and act in good faith and without malice, you are well protected, even if you happen to be wrong in a particular case. Since Peer Reviewers are KFMC's agents with the authority to make final determinations, it is particularly important that they exercise due care. The PR is required to evaluate the medical record and make reasonable medical judgments based upon all the information provided in the medical records. In order to exercise due care, the Peer Reviewer must review the entire medical record. If it is apparent that the information presented for review is inadequate, or in such form that the PR cannot interpret it, additional information must be requested. KFMC will contact the hospital or appropriate party to request any additional information you need to complete a review.

Section IV: Review Process

As part of your review, you are first required to consider conflict of interest.

Conflict of Interest Attestation (COI 2-1))

For each case you accept, you will need to attest that you do not have a conflict of interest as follows:

- The *reviewer* does not accept compensation for review activities that is dependent in any way on the specific outcome of the *case*; (COI 2-1(a))
- To the best of the *reviewer's* knowledge, the *reviewer* was not involved with the specific episode of care (specific case) prior to referral of the case for review; (COI 2-1(b)) **and**
- The *reviewer* does not have a material professional, familial, or financial *conflict of interest* regarding any of the following:
    i. The referring entity; (COI 2-1(c.i))
    ii. The insurance issuer or group health plan that is the subject of the review; **Peer Reviewers, may be a performing provider of services with an insurer, this role does not prohibit a Peer Reviewer from conducting external review. However, it is a conflict if the PR conducts reviews for an insurance issuer or group health plan that is the subject of a review, or participates in management, including supervising others on behalf of the insurance issuer/health plan, or participates on their board of directors (BOD) or BOD subcommittees.* (COI 2-1(c.ii))
    iii. The *covered person* whose treatment is the subject of the review and the *covered person's authorized representative*, if applicable; (COI 1-2(c.iii))
    iv. Any officer, director or management employee of the insurance issuer that is the subject of the review;(COI 2-1(c.iv))
    v. Any *group health plan* administrator, plan fiduciary, or plan employee;(COI 2-1(c.v))
    vi. The health care *provider*, the health care *provider's* medical group or independent practice association recommending the health care service or treatment that is the subject of the review; (COI 2-1(c.vi))
    vii. The *facility* at which the recommended health care service or treatment would be provided; (COI 2-1(a.vii)) or
    viii. The developer or manufacturer of the principle drug, device, procedure, or other therapy being recommended for the *covered person* whose treatment is the subject of the review. Having used a procedure or device under review does not necessarily create a conflict of interest as long as the PR is not financially benefiting from using that procedure or device. (COI 2-1(c.viii))

You will be exposed to two different Conflict of Interest (COI) attestations.

During the application process, you will be required to complete the document titled, "Organizational Conflict of Interest and Disclosure of Affiliations."

During the review process, you will receive a "PR Conflict of Interest; Credentials and Knowledge; and Experience Attestation" form for each case assigned. This form must be completed and returned with every individual case review.

If you have received a case in which you have a conflict of interest, STOP the review, complete the appropriate section on the form indicating the identified conflict and arrange to return the assigned case to KFMC (COI 2-1).

Some examples of COI include but are not limited to:

- Previous involvement in the case.
- Association with the hospital at which the care was provided.
- Prior conflict with the physician/practitioner involved.
- Affiliation with the physician/practitioner involved in the care.
- You are in economic competition with the physician/practitioner involved.

Reviewer Credentials and Knowledge Attestation (COI 3-1))

Reviewer Attestation Regarding Credentials and Knowledge

For each case you accept, you will need to attest to:

- Having a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review; (COI 3-1(a.i)) **and**
- Current, relevant experience and/or knowledge to render a determination for the *case* under review. (COI 3-1(a.ii))

For every individual case assigned, you must complete and return the "PR Conflict of Interest, Credentials and Knowledge; and Experience Attestation" form. This form provides direction to refuse any case based on your compliance with the requirements for credentials and knowledge

Reviewer Experience Attestation (COI 3-1)

Reviewer Attestation Regarding Experience

For each case you accept, you will need to attest to meeting the identified minimum requirements for direct patient care experience related to:

- Length of time providing direct patient care; (COI 3-1(a.iii)) **and**
- How recent the reviewer's relevant direct patient care experience is. (CQP-Ext 1-1(a))
- No delegation of the review rendered (COI 3-1(a.iv))

For every individual case assigned, you must complete and return the "PR Conflict of Interest; Credentials and Knowledge; and Experience Attestation" form. This form provides direction to refuse any case based on your ability to meet the requirements for credentials, knowledge and experience.

Availability to Review

A KFMC Review Coordinator (RC) will call or email you, or your designated contact person, prior to sending any cases for review.

Please return completed reviews within 7 days of receiving.

We have a strict review timeframe. If you are unable to complete reviews in a timely manner, we ask that you contact the RC and arrange for the return of un-reviewed cases.

Documentation

Documentation habits vary from person to person, and a complete picture of the patient's care may not always be present. Documentation provided with the medical record is the only documentation you may consider as you make your determination.

In the event that you believe there may be a missing/critical piece of documentation, please contact the review staff and we will make efforts to request the missing documentation.

General Categories of Peer Review

- Level of Care/Admission Review
- DRG Validation/CPT Validation/Coding Review
- Quality of Care/Standard of Care
- Discharge Review
- Medical necessity
- Experimental and Investigational
- Expedited Review

Level of Care/Admission

Level of Care/Admission Review is to determine if the admission was medically necessary and if the medical services were provided in the most appropriate setting.

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.

- **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. At the time of admission of the patient to the hospital, did the patient require acute level of care or could the patient have been treated at a lower level of care?

DRG/CPT/Coding

DRG/CPT Validation/Coding Review is to determine if the diagnostic and procedural information that led to the DRG assignment or procedural code assignment is correct and substantiated in the medical record.

- 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 required hospital centered care. Likewise, it is usually possible to determine one condition that was the focus of treatment, requiring more of the physician/practitioner's management skill, hospital resources, staff time, etc. than other problems; that condition is usually the principal diagnosis.
- Secondary diagnoses may be coded/reported 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.

Quality

Quality Review is to determine if professionally recognized standards of care are met. Standards of Care (SOC) are assigned a level and reflect the level of concern.

- **Definitions:**
    - Level 1: Standards of Care met.
    - Level 2: Standards of Care not met, but with no reasonable probability of causing injury.
    - Level 3: Standards of Care not met, with injury occurring or reasonably probable.
    - Level 4: Possible grounds for disciplinary action by the appropriate licensing agency.

- General Quality – the quality of care provided did not meet the professionally recognized standard of health care.

- Serious Risk – the quality of care provided did not meet that standard of care ad while not a gross and flagrant or substantial violation of the standard, represents a noticeable departure from the state that could reasonably be expected to have a negative impact on the health of a beneficiary.

- Gross and Flagrant – a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or wellbeing of a patient, or places the patients unnecessarily in high-risk situations.

  Example: A case is grossly and flagrantly unacceptable when, in the opinion of the reviewer, it is determined that the care 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 42 CFR 1004.1 states gross and flagrant violation means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety, or well-being of a program patient or places the program patient unnecessarily in high-risk situations.

  There should be great caution in assigning this level of concern. All serious risk and gross and flagrant cases will be evaluated by the Medical Director and appropriate action will be taken as indicated.

Discharge

Discharge Review is to determine if the patient was medically stable on discharge from all settings or if the discharge was initiated prematurely.

Medical Necessity (RP 3-1)

Medical Necessity means a service required to diagnose or to treat an illness or injury. To be "Medically Necessary", the service must: be performed or prescribed by a Doctor; be consistent with the diagnosis and treatment of the patient's condition; be in accordance with the standards of good medical practice; not be for the convenience of the patient or his Doctor; and is provided in the most appropriate setting.

Experimental and Investigational (RP 3-2)

Experimental and Investigational review of a proposed treatment considers the following, unless otherwise prohibited by state or federal law or regulation; the recommended or requested health care service or treatment has been approved by the Federal Food and Drug Administration, if applicable, for the condition; or medical or scientific evidence or evidence-based clinical practice guidelines or criteria demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

Expedited (RP 2-2(a))

Expedited Review - KFMC is responsible for receiving and responding to expedited reviews referred from Insurance Departments. Expedited Reviews are to be conducted within 72 hours starting with the receipt of the request and ending with the notice of final determination.

Emergency medical condition means the sudden and (at the time) unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place a person's health in serious jeopardy; a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

A Review Coordinator (RC) will examine medical and other records that pertain to the services in question. Oftentimes these cases will be discussed with a PR over the phone; however, information can be faxed to the PR or uploaded to KFMC's FTP account if needed.

The RC will provide a case summary and identify content from the medical record. The PR should use his/her medical training, experience, judgment, and knowledge to make a determination and provide evidence-based rationale to explain the decision.

Consumer Safety (CPE 2-1(a))

Expedited review requests are conducted in a more concurrent time frame and may identify an issue felt to be a current or immediate threat to consumer health and safety.

If a PR were to identify documentation that may reflect an immediate threat to the health and safety of a consumer, one that requires a response more expeditiously than the routine process of a quality inquiry, we request the following actions to be taken:

1. PR will immediately call the Case Review Manager and provide identifying information related to the case, and their contact number.
2. The Case Review Manager will determine the most appropriate course of action with the PR.
3. The course of action may include, but is not limited to:
    a. Resolve without further investigation.
    b. Quality of care referral through a non-expedited review process.
    c. Referral to the Case Review Quality Committee.
    d. Call to the KFMC Medical Director for Guidance.
4. If the Case Review Manager engages the Medical Director, together they will determine how to proceed with the review activity.

Criteria is Only a Guideline

KFMC non-physician reviewers currently use MCG© (formerly Milliman Care Guidelines©). If a case fails MCG©, the RC refers the case to a PR. As a PR, KFMC is asking for you to apply your medical expertise to the question asked.

When you receive a review, the screening criteria used by KFMC that resulted in the case being referred for peer 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 MCG© 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 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 may 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 and provide an evidence-based determination.

Rationale 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 riskier 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. Please see Zorc JJ, Hall CB. Bronchiolitis: recent evidence on diagnosis and management. Pediatrics 2010;125(2):342-9."
      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, we are asking for your medical judgment, based on your training and experience. Remember to include evidence-based support for your determination.

As a reviewer, you are not bound by any decisions or conclusions previously reached during the insurance issuer's or group health plan's utilization review process or internal grievance process if applicable. More specifically, many Insurance Departments have stated that PR's are to avoid referring to an insurance issuer or a group health plan's own policies or guidelines used during their internal review process, but rather to refer to evidence-based guidelines and standard practices when making a decision. (COI-Ext 1-1(a.ii))

Peer Reviewer (PR) Notables

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/practitioner's point of view.

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

- 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 evidence-based rationale that:
    - ✓ Explains and supports the decisions rendered.
    - ✓ Identifies the source of the concern if a concern is identified.
    - ✓ Supported by evidence based professionally recognized standards of healthcare.
    - ✓ 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 qualities of care concerns are found, list them as well.

Your rationale will be incorporated into the response letter to the physician/practitioners or facility. Please keep this in mind when formulating your determination.

If you have questions or concerns about previous review comments and/or determinations, please contact the Case Review Team.