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HEALTH IMPROVEMENT PARTNERS

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ACCREDITED
Independent Review Organization: External Review
Expires 06/01/2024

MEIT 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

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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.

Attached is the KFMC MEIT Peer Reviewer (PR) Training Manual. This material will guide you on the Medical Education and Intervention Team (MEIT) process.

Do not hesitate to contact either Becky Fetters, bfetters@ofmq.com, or Jess Baker, jbaker@kfmc.org if you have questions.

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

Sincerely:

Greg Eichman, MD
KFMC MEIT Medical Director

Kyle Tipton, MD
KFMC Medical Director

Introduction to MEIT

Medical Education and Intervention Team (MEIT) reviews are performed to identify, educate and closely monitor care delivery of medical providers who have been identified by the Oklahoma Health Care Authority (OHCA) and referred to KFMC for evaluation. MEIT utilizes quality review to determine if professionally recognized standards of care (SOC) are met and when SOC are not met, they are assigned a specific level of concern.

- **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 the standard of care and 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 SoonerCare patient, or places the SoonerCare patients unnecessarily in high-risk situations.

The MEIT process involves review and evaluation of a specific provider's claims and corresponding clinic records for a sample of patients (generally 10 patients with visits over a one-year time frame). Reviews are performed to assess the individual provider's practice related to the referral concerns identified by OHCA. Some of the common referral concerns are:

- General practice
- Documentation
- Prescribing habits
- Concerns provided by the Oklahoma Health Care Authority

Providers may undergo two independent peer reviews by different peer reviewers if quality concerns are identified as being either serious risk or gross and flagrant. Following these initial reviews, the provider is usually engaged in a focused MEIT meeting with the Medical Director along with both peer reviewers.

Peer Reviewers participating in the MEIT process are required to participate in a focused MEIT with the provider and the MEIT committee. This is coordinated by KFMC and OHCA staff and led by the KFMC MEIT Medical Director. Focused MEITs involve face-to-face education with SoonerCare providers.

Following a focused MEIT, providers may be placed on a corrective action plan (CAP). During the CAP, providers will work to correct concerns identified during the focused MEIT meeting. At the

end of the CAP period (usually three months) OHCA will identify additional provider claims for review.

Levels of Concern

General Quality – Examples

A quality of concern is defined in the Quality Improvement Organization (QIO) manual as a concern that care provided did not meet a professionally recognized standard of health care.

- General Findings:
  - Appropriate assessments were performed, but limited documentation of these assessments was provided.
  - Appropriate laboratory testing and diagnostic studies were performed, but many times were not documented in the note.
  - The provider did seem to appropriately act on the results of testing, but many times his medical decision making was not documented in the records.
- Patient Specific Findings:
  - A creatinine of 11.1 was not noted in the record, but the provider did state the patient was on dialysis.
  - The chest x-ray showed pneumonia, possibly viral, but was not mentioned in the note.
  - The patient was seen four days later for shortness of breath and was admitted for COVID pneumonia. He was transferred to another hospital for admission because he could not receive dialysis at this facility.
  - The documentation was poor and did not address provider critical thinking, but the care was appropriate.

Serious Risk – Examples

A serious risk is defined in the Quality Improvement Organization (QIO) manual as the quality of care provided did not meet the standard of care and, while not a gross and flagrant or substantial violation of the standard, represents a noticeable departure from the standard that could reasonably be expected to have a negative impact on the health of a beneficiary.

- General Findings:
  - Elevated blood pressures were not addressed.
  - Prescription Monitoring Program (PMP) results and morphine milligram equivalents (MME) were not consistently included in the notes.
  - Documentation was not individualized or unique to each patient and visit.
  - Documentation was often contradictory, and conflicting statements were repeated across visits.
  - No past medical history listed in charts.
  - Unclear if the physician or APRN who signed the chart sent in the controlled dangerous substance (CDS) scripts.
  - Medication lists were frequently not accurate or were not updated at each visit.

- Patient Specific Findings:
  - Morphine milligram equivalent (MME) 135 mg/day; prescribed methadone and oxycodone.
  - Contradictory documentation of methadone dosages.
  - Note stated decreasing methadone to 10 mg BID, yet prescription in assessment and plan was for methadone 5 mg BID.
  - Other visit notes stated decreasing methadone to 5 mg two times daily (BID), yet medication list continues to list methadone 10 mg BID.
  - No PMH or surgical history in visit notes.
  - Elevated blood pressures were not addressed.

Gross and Flagrant – Examples

A gross and flagrant violation is defined in the Quality Improvement Organization (QIO) manual as a violation of an obligation resulting from inappropriate or unnecessary services that do not meet recognized professional standards of care, or services that are not supported by evidence of medical necessity or quality as required by the QIO. The violation must have occurred in one or more instances that 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.

- General findings:
  - Frequent combinations of opioids, benzodiazepines and central nervous system (CNS) depressants or stimulants, such as Ambien, Fioricet, Lyrica, Gabapentin and phentermine.
  - High percentage of patients were prescribed benzodiazepines, especially Xanax, and at high dosages.
  - Poor patient selection for suitability for chronic benzodiazepines.
  - Infrequent benzodiazepine weaning.
  - Apparent absence of provider consideration for other safer anti-anxiety medications such as a SSRI or SRNI.
  - Medications prescribed with multiple potential interactions.
  - Chronic illnesses poorly managed, including no routine laboratory monitoring for patients with hypertension and diabetes.
  - Unaddressed abnormal vital signs.
  - Inadequate medical record documentation, including timely signing of visits.
  - Poor physician collaboration.
- Patient Specific Findings:
  - Consideration was not documented for SSRI/SNRI as a first line to address the patient's anxiety issues.
  - At a visit the patient stated "I just got out of the hospital again, I tried to kill myself. I am very depressed, and I need a refill on my anxiety, blood pressure and depression medications".

- This concerning statement needed to be addressed and evaluated. Increased prescription of alprazolam to groups with an increased risk of deliberate self-poisoning is concerning.
- No noted collaboration or consideration for specialist referral or involvement.
- Primarily only treated with Xanax 1 mg three times daily (TID) for anxiety with few other interventions employed for her many other health care needs.
- No weaning plan for chronic Xanax

Focused MEIT Meeting

A focused MEIT is a face-to-face educational meeting with the SoonerCare provider, KFMC staff and OHCA staff. This gives the provider the opportunity to answer any questions regarding the peer reviewers' findings as well as the opportunity for peer reviewers to educate the provider on proper standards of care. Focused MEITs generally last four to five hours and take place in a neutral, Wi-Fi enabled, meeting space. KFMC strongly recommends bringing a laptop or Wi-Fi capable device to access your "MEIT binder" via the SFTP for easy viewing of medical records. Each meeting will start with a conference 30 minutes prior to the providers arrival, giving the medical director and peer reviewers an opportunity to discuss the level and points of concern. The focused MEIT concludes the plan development for the provider to enact better standards of care.

KFMC Staff MEIT Process

1. KFMC obtains a claims batch from OHCA and facilitates medical records requests.
2. Records are organized by patient, with dates in ascending order, highlighted and bookmarked for reviewing ease.
3. KFMC contacts peer reviewers, either by phone or email, with like-specialty and like-setting.
4. Once a peer reviewer has accepted the review, the peer reviewer attestation form, comment form and medical records are uploaded to the SFTP website.
5. The Review Specialist will check in with the peer reviewer one week after the review has been uploaded to address any questions or concerns.
   a. Never hesitate to reach out with questions or concerns at any time in the review process.
6. Once review is completed (two weeks after received date) the peer review is asked to upload the attestation and comment forms to the SFTP site, and an email is sent to the Review Specialist that the review is complete.
7. KFMC staff drafts a letter of findings for OHCA and the provider.
8. The provider has 30 days from the date of the determination to request a reconsideration review.

a. If the level of concern severity is higher than a general quality concern, the review is sent to a second reviewer regardless if a reconsideration request is received from the provider.

9. Once the second review is complete, findings are drafted in a letter and sent to OHCA and the provider.
10. Routinely, due to the severity of concerns identified, a focused MEIT meeting is scheduled. MEIT meetings are scheduled to accommodate both peer reviewers' schedules in addition to the KFMC MEIT Medical Director and the OHCA.
    a. Focused MEIT meetings are generally held six to ten weeks after the second peer review has been completed.
    b. The meeting lasts approximately four to five hours.
    c. Peer Reviewers are paid for their time.
11. Typically following the focused MEIT meeting, KFMC drafts MEIT Summary and CAP letter and mails to OHCA and the provider.
    a. The provider has ten days to sign and return.
    b. This signature begins the CAP period (generally 3 months).
12. After the CAP period, OHCA will send KFMC a second batch of claims. These records are obtained and organized for review.
13. One of the two peer reviewers will be asked to complete the CAP review.
    a. This review typically consists of ten patients and their associated claims during the three-month CAP period.
    b. This review is anticipated to take less time to complete than the initial review.
14. Upon completion of the CAP review, the OHCA and the provider are notified.
    a. Depending upon the outcome of the CAP, a provider may be placed on a second CAP.

Roles and Responsibilities of Peer Reviewer

- Maintain Board Certification in the specialty for which they will review.
- Hold current, unrestricted license or certification as required for clinical practice in a state of the United States.
- Physician Reviewers must have a current certification by a recognized American medical specialty board.
- If a D.P.M., has board certification by the American Board of Podiatric Surgery (AMPS) or the American Board of Podiatric Medicine)
- Must be actively providing direct patient care.
- Have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment for each assigned review.
- Have at least five (5) years full-time equivalent experience providing direct clinical care to patients (FTE minimum of = 37.5. hours per week)
- Have experience providing direct clinical care to patients within the past three (3) years.
- 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."

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

Reimbursement

Peer reviewers will be reimbursed at an hourly rate for medical case review, completed either by phone, onsite, or mail-in review. A Peer Reviewer Timesheet will be included with each case that we send to you for review. This timesheet can typically be found at the bottom of the comment form. 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.

Timeliness

KFMC has specific contract timeliness requirements for our reviews. MEIT reviews should be completed within 14 days after receipt of the review. If you are unable to complete a review in a timely manner, we ask that you contact the Review Specialist and discuss the situation.

KFMC understands that every case is unique in nature and time spent reviewing can differ from case to case. The following are historical averages of peer reviewer time for MEIT reviews based on specialty:

- Anesthesiology/Pain Management – 6 hours
- APRN – 7.25 hours
- Family Practice – 6.7 hours
- Internal Medicine – 6.8 hours
- Neurosurgery – 11 hours
- Physician Assistant – 7.65 hours
- Psychiatry – 8.75 hours

KFMC appreciates our Peer Reviewers assistance in adhering to our timeliness requirements.

Notables

The peer reviewer has the responsibility to study each case in sufficient detail to arrive at a decision regarding the quality of care provided. The medical records provided should be organized and labeled to assist in making your review more efficient. Peer Reviewers are asked to try and put yourself in the physician/practitioner's point of view. Peer reviewers 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.
- Can 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.

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

- Focus on the questions posed or concerns identified.
- 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 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."