How to use this manual

This manual has been prepared for physician reviewers of the Arkansas Foundation for Medical Care (AFMC). It is intended to be a source of instruction and information for new AFMC reviewers and to serve as a reference for experienced reviewers. Careful study of this manual will familiarize reviewers with how the review process is structured, how reviews relate to each other, common procedures between review processes, and the location of important reference lists and sections. This manual is most important as it will assist the reviewer in ensuring the accuracy and consistency of reviews and thus help AFMC maintain its reputation for fair and accurate medical peer review.

Review policies and procedures change regularly, and are dictated by URAC and contracting organizations such as the Arkansas Department of Human Services’ Division of Medical Services (Arkansas Medicaid). Since Arkansas Medicaid frequently sends directives notifying us of changes, additional policy statements will be necessary. Reviewers should occasionally check the online manual for updates.

Any comments or suggestions regarding further improvements to this manual are welcome. The AFMC Physician Reviewer Manual is a reference tool and may be used “open book” style during any phase of the review process. Remember, however, the reviewer’s role is to apply medical education, training and experience to the review process – not application of policies or criteria.
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1. Introduction to AFMC

1.1 Statutory background and authority

1.11 Medicare: The origins of AFMC

Professional Standards Review Organizations (PSROs) were created by Congress in the 1972 Amendment to the Social Security Act. The purpose of the PSRO program was to ensure health care services provided to Medicare beneficiaries conformed to appropriate professional standards and were delivered in the most efficient manner possible. Hospital admissions were the primary interest of study. The *de facto* measure of utilization efficiency soon became the average length of stay. The Arkansas Foundation for Medical Care, Inc. (AFMC) was created in late 1972 as a PSRO.

With the enactment of TEFRA legislation and the Social Security Amendment of 1983, the concept of medical peer review was greatly enhanced and expanded. In addition, the Prospective Payment System radically changed the way hospitals were reimbursed by introducing the diagnosis-related group (DRG) payment system. PSROs became Peer Review Organizations (PROs).

PROs were interested now not in length of stay, but in the medical necessity and appropriateness of hospital admissions, which triggered the DRG payment.

PROs were charged with the responsibility of determining if care provided for Medicare and Medicaid beneficiaries:

1. Was medically necessary
2. Met the quality dictated by professional standards
3. Was provided in the most economical setting

AFMC was awarded its first PRO contract in 1984. Since the Health Care Financing Administration (HCFA) was greatly concerned about the financial consequences of the new hospital payment system, the first PRO contracts focused on hospital admission review and DRG validation (i.e., verifying the accuracy of diagnostic and procedure information that determined payment).

In 1986, AFMC was the first PRO in the nation to sign for an extension of the two-year cycle of review. The contract was renewed consecutively since, until the Centers for Medicaid & Medicare Services (CMS) changed the contract structure for the contract beginning Aug. 1, 2014.

The 1990-1993 PRO contract, which was called the Third Scope of Work (3rd SOW), was significant in the evolution of the PRO program. By this time, the government was confident of the fiscal viability of the DRG payment system and was responding to another set of concerns: reports of premature discharges, under-treatment and quality of care in general. The 3rd SOW mandated elaborate machinery for defining, detecting and dealing with instances of deficient care. These activities were extremely unpopular with PRO contractors and even more so with providers. The response to the 3rd SOW led to the radical change in the PRO program, which began with the subsequent contract cycle and continues today.

*Introduction 1-1*
The 4th SOW (1993-1996) introduced the Health Care Quality Improvement Program (HCQIP). Where the program had been based on individual case review, it now employed a global, statistical approach. Where it had spent resources identifying the poorest performers in the tail of the quality curve, it now focused on “average” care and moving the whole curve forward. Where it had been confrontational and punitive with providers, it was educational and collaborative. This new work plan not only fundamentally changed the nature of the PRO program, it also necessitated large changes in the organizations of PRO contractors, who would now need new cadres of professionals like statisticians, epidemiologists, quality improvement experts and communication specialists. For AFMC, the 4th SOW ran from April 1993 through March 1996. A virtual transformation of the organization was required, and changes were made accordingly.


In the 7th SOW (2002-2005), HCQIP remained a large portion of the contract with additional refinement of the beneficiary complaint process and significant inroads with nursing home data reporting and quality improvement. In 2002, PROs became Quality Improvement Organizations (QIOs), which better described their proactive role in improving health care.

The 8th SOW (2005-2008) expectations and requirements included:

1. Improving quality of care for beneficiaries
2. Protecting the integrity of the Medicare Trust Fund by ensuring Medicare only pays for services and items which are medically necessary, reasonable and are provided in the most appropriate (e.g., clinical, economical) setting
3. Protecting beneficiaries by expeditiously addressing individual cases such as beneficiary complaints, provider-issued notices of non-coverage (HINNs, NODMARs and Medicare Advantage appeals), EMTALA violations (dumping), and other statutory responsibilities

The goal and ultimate purpose of the 8th SOW was to assist providers in adopting and implementing systems, redesigning processes, and achieving organizational culture change to accelerate the rate of quality improvement and broaden its impact. The 8th SOW focused on three domains of activity:

1. Assisting providers in developing the capacity for and achieving excellence in care
2. Creating an environment that promotes, values and rewards quality
3. Protecting beneficiaries and the Medicare program
The 9th SOW (2008 – 2011) focused on four main themes:

1. Beneficiary protection
2. Patient pathways (care transitions)
3. Patient safety
4. Prevention

All QIOs also helped Medicare promote the adoption of value-driven health care, support the adoption and use of health information technology, and reduce health disparities in their communities. QIOs were required to offer help to specific nursing homes and hospitals that had not recently performed well on important quality measures.

The 10th SOW (2011 – 2014), became effective August 1, 2011. The overarching goal of the QIO program remained the same, as stated in the 10th SOW Request for Proposals: “The purpose of this contract is to support CMS in its efforts to seek to improve health and health care for all Medicare beneficiaries and promote quality of care to ensure the right care at the right time, every time.”

However, the 10th SOW was designed to align more closely with CMS’s National Quality Strategy and its broad aims of better health care, better health for people and communities, and affordable care through lowering cost by improvement.

In keeping with the broad aims, the “Aims Tasks” the QIOs would be evaluated on included:

- Beneficiary and family-centered care
- Case review
- Patient and family engagement
- Improving individual patient care
- Reduction of health care-acquired conditions
- Quality reporting and improvement
- Integrating care for populations and communities
- Improving care transitions leading to the reduction of readmissions
- Improving health for populations and communities
- Promotion of immunizations and screenings
- Cardiovascular health campaign

To reach these aims, QIOs were expected and encouraged to set their own goals specific to the needs and strengths of their local communities. Local activities were primarily conducted in coordination with National Coordinating Centers, set up to smooth the flow of information to and from each of the QIOs.

Under the 10th SOW, QIOs were called upon to be “conveners, organizers, motivators and change agents,” providing a “call to action through outreach, education and social marketing; serving as a trusted partner in improvement with beneficiaries, health care providers, practitioners and stakeholders; achieving measurable quality improvement results through data collection, analysis, education and monitoring for improvement; facilitating information exchange within the health care system; and dissemination and spread of best practices.”
In fulfilling this expanded role, QIOs would use “drivers of quality,” which most staffers and stakeholders referred to simply as drivers. The drivers were:

- Supporting and convening learning and action networks
- Providing technical assistance
- Care Reinvention through Innovation Spread model

Each of the 10th SOW aims had specific requirements that primarily fell under specific drivers. The requirements described certain activities to be carried out in support of that aim. The requirements focused on recruitment, education, health information technology and exchange, reporting of quality data, tracking and monitoring, and the type of technical assistance to provided to various groups such as providers, beneficiaries/consumers, and secondary audiences.

With the advent of the 11th SOW for Medicare, which began August 1, 2014, CMS changed its focus to regional review rather than state review. While AFMC’s Medicare review work has been assigned to a regional QIO, it remains the reviewer for Arkansas Medicaid.

1.12 Medicaid: AFMC’s expanded QIO obligations

In the early days of the PSRO/PRO program, HCFA mandated that PROs perform work referred to them by their state’s Medicaid program. The state’s federal match (in Arkansas, a 3:1 match) was assured by the state contracting with the PRO for their utilization review obligations.

In 1982, AFMC began work for Arkansas Medicaid. Generally, services provided by AFMC for Medicaid are governed by contract with the State of Arkansas’ Department of Human Services, Division of Medical Services. The first contracts emphasized retrospective inpatient hospital review with the 1983 addition of emergency room prepayment review.

In 1991, the Medicaid Utilization Management Program (MUMP) was initiated. It involves a telephonic review that determines covered lengths of stay in inpatient, general, and rehabilitative hospitals, in state and out-of-state, but does not apply to lengths of stay in psychiatric facilities.

In 1996, at the request of Arkansas Medicaid, AFMC initiated services to support Medicaid’s Primary Care Physician program (now called ConnectCare), which included data analysis with profiling as well as quality improvement projects. This led to the establishment in 1998 of a new division of AFMC, Medicaid Managed Care Services (MMCS). Through MMCS, AFMC has provider and beneficiary relations teams who interface with Medicaid providers and beneficiaries regarding policy and coverage issues.

State Medicaid programs are no longer required to use QIOs. However, their federal match is assured with the use of a QIO or QIO-like entity. Arkansas Medicaid’s needs have continued to increase and AFMC responds to those needs as requested:

09/1999 – Child Health Management Services (CHMS), prior authorization review, admit
03/2000 – CHMS, prior authorization review, procedure codes
10/2000 – Targeted case management and personal care, prior authorization review
01/2003 – Therapy services, retrospective review
01/2005 – Benefits extension requests, prior authorization review
12/2006 – Hyperalimentation and prosthetic services
1.13 Obligations of health care practitioners and providers

Title XI of the Social Security Act, §1156. [42USC 1320c-5] mandates:

(a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act--

(1) will be provided economically and only when, and to the extent, medically necessary;
(2) will be of a quality which meets professionally recognized standards of health care; and
(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

Despite changes to the Medicare beneficiary review program, AFMC continues to play a key role in ensuring that health care practitioners and providers meet their obligations to Medicaid beneficiaries.

You, as a member of and reviewer for AFMC, play a necessary and integral part in AFMC’s ensuring these obligations are met.
1.2 AFMC: The organization

In the early 1980s, AFMC’s primary review responsibilities were to Medicare with a small percentage to Arkansas Medicaid. Today, AFMC no longer provides review services to Medicare; however, AFMC’s review activities on behalf of Arkansas Medicaid have increased to the point where the majority of our case review functions are tied primarily to Medicaid contracts. AFMC’s review validation and beneficiary complaint activities include a number of outpatient and inpatient review services such as child health management services (CHMS); extension of benefits; durable medical equipment, prosthetics and hyperalimentation; emergency rooms; prior authorization of selected procedures; concurrent inpatient review; and retrospective review of inpatient admissions. Additionally, AFMC provides reconsideration review services, access to specialized computer tools for data entry and clinical information submission, data collection, medical coding, and private peer review.

1.21 A membership organization: Membership benefits

*Lifetime membership:* According to the corporate bylaws, membership is voluntary and may be terminated only if the member resigns, has their medical license is suspended or revoked, or professional activities in Arkansas are discontinued.

*No financial obligation:* You will not pay any dues or be charged fees for membership.

*Eligible to serve as a physician reviewer:* As a member, you may be eligible to lend your expertise in reviewing charts and serving on focus groups.

*Opportunity to influence policies:* You must be a member to be eligible to serve on the AFMC Board of Directors or on one of its committees. As a member, you also will be eligible to nominate and vote for AFMC's board. By serving on or selecting our board, you can ensure your role in improving health care in Arkansas.

AFMC is committed to improving the health of all Arkansans, and accomplishes this goal through cooperation with individual physician members as well as other statewide associations and agencies (Arkansas Medical Society, Arkansas Hospital Association, Arkansas Pharmacy Association, Arkansas State Medical Board, etc.). As a member, you would be a link in these partnerships.

*Information:* As a member, you will receive a copy of AFMC's medical publication, the Arkansas Physician Newsletter. This newsletter will keep you abreast of best medical practices for treatment of patients.

*Continuing education activities:* AFMC sponsors conferences throughout the year to report the latest developments in the health care industry. AFMC is always working toward offering more continuing education conferences and special events.
1.22 Governing board of directors

AFMC’s 15-member governing board of directors includes seven physicians. All board members are elected by the general membership of AFMC at the annual meeting, usually held in conjunction with the Arkansas Medical Society’s annual session.

Board membership for physicians is open to “… members of the Corporation in good standing and who are in the active practice of medicine, subject to review of the Foundation, and no individual shall be elected Director or hold elective office in the Corporation solely by virtue of an office that person holds in another organization. In addition, Directors shall be qualified under applicable state and federal law…” The eight non-physician members are representatives of various interest groups (e.g., Medicare beneficiaries, hospital and business). The physicians on the board of directors include a mix of urban and rural family practice and internal medicine physicians as well as a variety of other specialties.

To maintain continuity of board action, a portion of the board member positions are open to election each year. Two consecutive, three-year terms may be served on the board of directors with a few exceptions allowed by the corporation’s bylaws.

The board is charged with many responsibilities: it must establish and populate appropriate committees, oversee and supervise committee activities, set policy for management of AFMC, and evaluate administrative organization and operations.

AFMC serves as the reviewer for Arkansas Medicaid (Title XIX of the SSA). AFMC is also available to perform private review, including review for small or large corporations, and is capable of any review, from precertification and concurrent review to retrospective review of all health care provided to employees of an organization, as well as physician credentialing for health plans.

1.23 Physician Reviewers

1.23.1 Eligibility

Eligibility to perform review with AFMC is defined as:

A) Eligibility: Authorized to practice medicine by the state or federal government
B) Active practice: On a routine basis engages in the practice of medicine at least 20 hours per week with temporary interruptions acceptable.
C) Licensure: Same licensure as the physician under review*
D) Specialty: Same specialty as physician under review*
E) Setting: Same setting (urban/rural)*
F) Hierarchy of exceptions*: Exception to setting; then specialty; only as a last resort – licensure.
G) First-level physician review: Must meet A-F above
H) Second-level physician: Must meet A-F above; may be same person from initial review
I) Third-level physician:
   i) Reconsideration review: Must meet URAC requirements
      a) If the information provided to the peer reviewer at the second level review results in a recommendation for non-certification (i.e. does not demonstrate medical necessity or appropriateness of the requested service) the patient or attending provider may request an appeal. The attending provider then has another opportunity to submit additional
b An appeal is a formal request, made by either a provider or patient, to contest a previously non-authorized medical service (e.g., services have been denied, delayed or reduced, etc.). This level of review is sometimes referred to as a “third level review”.

c Appeals considerations are conducted by health professionals who:

- are clinical peers of the attending provider;
- hold an active, unrestricted license to practice medicine or a health profession;
- are board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine) or the Advisory board of Osteopathic Specialists (doctors of osteopathic medicine);
- are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment;
- and are neither the individual who made the original non-certification, nor the subordinate of such an individual.

d Appeals often address cases in which:

- The patient’s clinical situation is complex
- The requested procedure is considered experimental or investigational
- The procedure requested falls outside standard guidelines for frequency or duration
- The initial review did not include all the relevant information in the provider’s possession

1.232 Avoiding conflicts of interest

A physician reviewer cannot review a medical record when he or she has, or there is perceived to be, a conflict of interest. Conflict of interest is defined as when a physician:

- Participated in the development or execution of the beneficiary’s treatment plan
- Is an associate or close competitor of the physician under review
- Is a member of the beneficiary’s family
- Is a governing body member, officer, partner, owner or managing employee of a health care facility where the services were or are to be furnished

* If impractical or creates an unavoidable conflict of interest or compromises the effectiveness or efficiency of our review process, use the most appropriate reviewer.

1.233 URAC requirements

URAC (formerly Utilization Review Accreditation Commission) requires that physician reviewers complete an attestation for all reviews to ensure there is no conflict of interest involved with the case being reviewed.

As the major accreditation program for health utilization management organizations in the United States, you may hear their name referenced frequently when involved in utilization review activities. URAC accredits many different types of organizations, such as health plans and preferred provider organizations and many different types of utilization management activities, such as independent review, case management and telephone call centers, to name a few. As an impartial monitoring agency, URAC requires utilization review companies to maintain policies and procedures that comply with URAC’s body of national standards. Some states accept URAC accreditation as a means of meeting state regulatory requirements in lieu of separate reporting to the state. A few states actually require URAC accreditation in order to be licensed to do certain types of business.
URAC standards are developed by a committee of experts and approved by URAC's Board of Directors. Their standards are updated every three years. URAC accredited companies must submit their written policies and procedures and undergo a site visit by a URAC surveyor in order to maintain accreditation.

URAC standards require the Physician Reviewer conducting an appeal to be Board Certified. URAC standards do not require physicians to be in active practice, although there is a requirement for a minimum of five years of full time equivalent (FTE) direct patient care experience. Clients and state regulations may also require some level of active practice. External review participation requires the minimum of five years of direct care experience and that there has been direct care experience within the three prior years.

Following is a brief list of basic responsibilities, expectations, and requirements of all peer reviewers. Many of these requirements are a part of the credentialing process a reviewer must meet prior to participation in the utilization review process.

- Hold a current, active, unrestricted license to practice medicine or appropriate licensure for their health profession.
- Certification (doctors of medicine) by a specific board approved by the American Board of Medical Specialists (ABMS) or the Advisory Board of Osteopathic Specialists (ABOS) from the major areas of clinical services (doctors of osteopathic medicine).
- Have a minimum of five years full time equivalent direct patient care experience, with direct patient care experience within the prior three years to participate in external reviews.
- Be oriented to the principles and procedures of utilization management, URAC UM Standards, and clinical peer review.
- Maintain current liability and malpractice insurance coverage for Non-UR clinical activities.
- Sign a confidentiality statement and adhere to the document’s policies.
- Be qualified to render a clinical opinion about the medical condition, procedures, and treatment under review.
- Remain current in knowledge in the specialty area, including the latest literature, criteria and evidence-based medical practice.
- Be able to provide citations in support of the clinical rationale.
- Be readily accessible by telephone, facsimile, on-line or e-mail.
- Return phone calls from the UR company within a reasonable timeframe (ideally, within one hour).
- Comply with all the procedures and instructions provided, including due dates and times.
- Demonstrate good writing and communication skills.

Appeals Consideration (Third Level Review)
2. Understanding the basics

2.1 Confidentiality

From medical ethics to today’s environment of HIPAA confidentiality constraints and required communications and signatures, physicians in active practice are well aware of the necessities of confidentiality in patient care. Confidentiality is of equal if not greater importance to the peer review process. The document on the following pages spells out the confidentiality requirements of AFMC. These requirements are dictated by the federal government, and the Code of Federal Regulations defining them can be found at 42CFR Part 480, “Acquisition, Protection and Disclosure of Quality Improvement Organization Information” (October 2004). AFMC will provide a copy of this on request or it can be located on the internet at: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr480_04.html

PENALTIES FOR UNAUTHORIZED DISCLOSURE

Essentially, disclosure of any information considered as confidential, as identified in the following pages (e.g., patient specific, physician specific, hospital specific, reviewer specific information), could result in significant legal problems for the physician reviewer, including: a six-month jail sentence, $1,000 fine and the cost of prosecution for each inappropriate disclosure. Please be sure to review the AFMC Confidentiality Agreement, sign the confidentiality attestation, and return it along with the other documents indicated to the AFMC office. If you have any questions about the agreement, please be sure to call and talk with one of the staff contacts listed at the front of this manual.

OUT OF TOWN/OUT OF STATE

You must have written permission to take medical records from AFMC outside the state of Arkansas. If you are planning to be out of state or out of the country, simply notify our offices as soon as possible, preferably by the first of the month that you will be unavailable, and we will make every effort that no records are sent to you during the specified period. Should you return from your trip and discover records have arrived in your absence, you may review and return them if you have the time, or simply return them, unreviewed, to our office in the accompanying return mailer.

FAMILY/OTHERS HANDLING AFMC RECORDS

AFMC policies are in effect whether the work will be performed on or off-site. The following safeguards must be acknowledged:

- Confidential information, including PHI, will not be removed from AFMC without prior approval and a signed confidentiality agreement on file.

- The employee/consultant will be responsible for maintaining the privacy and security of all confidential information that they may be transporting, storing or accessing off-site. This includes, but is not limited to protected health information, electronic protected health information, computers that contain or access confidential information and confidential working papers.
Confidential information or ePHI sent from workstations, laptops, PDAs and other mobile devices must be password protected.

• Electronic media and printed information must be transported and stored in a secure manner.

• AFMC materials must be put away when not being used and kept in a secure location that is not accessible to others including children, spouse and visitors.

Confidentiality Agreement

One of AFMC’s most valuable assets is our reputation within the health care industry. This reputation has remained strong because of the professionalism our employees convey.

Public Law sets forth statutory responsibilities concerning the acquisition, protection and disclosure of information obtained or generated by Quality Improvement Organizations (QIOs). Centers for Medicare & Medicaid Services (CMS) confidentiality regulations were established in the Federal Register on April 17, 1985. These regulations authorize QIOs to acquire information necessary to fulfill their duties and functions, to place limits on disclosure of QIO information, and to establish penalties for unauthorized disclosure. These regulations form the basis for the AFMC confidentiality policies.

The following information may be released with limitations. Before releasing any confidential information, contact your supervisor.

• **Public Information** will be disclosed upon request. This is any information which has, prior to the request, been published or otherwise disclosed to the public and for which disclosure is not prohibited by federal or state law. Public information (§480.120(a)(6)) will only be disclosed in the form in which it is acquired or in the form in which it is maintained for use.

• **Aggregate data** will be disclosed upon request. This consists of summary statistics (such as number of discharges, number of types of procedures, age distribution or patient disposition) that does not implicitly or explicitly identify a particular patient, health care practitioner or reviewer.

• **Physicians’ and facilities’ own data and information.** Subject to restrictions on disclosure of QIO deliberations, health care practitioners and facilities will be allowed access and receive copies of their individual information, with or without request.

• **Patients’ own data and information.** Subject to restrictions on disclosure of QIO deliberations, patients or their authorized representatives will be allowed access to their individual QIO data and information. The patient must request the information in writing and designate a representative as appropriate. If a question arises concerning the accuracy of the data, it will be verified by referring to the primary medical source documents. The physician of record will be notified in writing at least 15 days prior to patient access. The patient will not be required to obtain physician authorization; however, when a physician feels the information could harm the patient, the information will be disclosed to the patient’s designated representative. If the patient is mentally, physically or legally unable to designate a representative, the information will be disclosed to a person whom the QIO (AFMC) determines is responsible for the patient.

• **Sanction proceedings.** As necessary for CMS to carry out its responsibilities for appeals under section 1155 of the Act or for CMS to process sanctions under section 1156 of the Act; The QIO must disclose sanction reports directly to the Office of the Inspector General and, if requested, to CMS.
The QIO must upon request, and may without a request, disclose sanction reports to State and Federal agencies responsible for the identification, investigation or prosecution of cases of fraud or abuse in accordance with §480.137.

CMS will disclose sanction determinations in accordance with part 474 of this chapter.

- **Norms, criteria and standards** used to carry out the program requirements will be released to anyone requesting them.
- **Contractual technical proposals** with the Department of Health and Human Services (except proprietary or business information) will be made available to anyone requesting such information.
- **Routine federal reports** will be disclosed upon written request if the reports do not contain confidential information.
- **Meeting summaries** of the governing board and general membership will be released upon written request, except for portions involving QIO deliberations and other confidential information.
- **CMS Approval** is required for any use, maintenance and destruction of data acquired under the CMS contract for purposes not included under the same contract.

**Disclosure of QIO Deliberations and Decisions**

AFMC will not disclose its deliberations except to—

- CMS;
- The Office of the Inspector General, and the Government Accountability Office as necessary to carry out statutory responsibilities.
- Deliberations will not be disclosed, either in written form or through oral testimony, in connection with the administrative hearing or review of a beneficiary's claim.
- AFMC may disclose to those who have access to QIO information under other provisions of this subpart, the reasons for QIO decisions pertaining to that information provided that the opinions or judgments of a particular individual or practitioner cannot be identified.
- AFMC must disclose, if requested in connection with the administrative hearing or review of a beneficiary's claim, the reasons for decisions. AFMC must include the detailed facts, findings and conclusions supporting the determination. AFMC must insure that the opinions or judgments of a particular individual or practitioner cannot be identified through the materials that are disclosed. [50 FR 15359, Apr. 17, 1985, as amended at 76 FR 26547, May 6, 2011]

**Disclosure of Quality Review Study Information**

(AFMC will disclose quality review study information with identifiers of patients, practitioners or institutions to—

- Representatives of authorized licensure, accreditation or certification agencies as is required by the agencies in carrying out functions which are within the jurisdiction of such agencies under state law; to Federal and State agencies responsible for identifying risks to the public health when there is substantial risk to the public health; or to Federal and State fraud and abuse enforcement agencies;
- An institution or practitioner, if the information is limited to health care services furnished by the institution or practitioner; and
- A medical review board established under section 1881 of the Act pertaining to end-stage renal disease facilities, if the information is limited to health care services subject to its review.
- AFMC will disclose quality review study information with identifiers of patients, practitioners or institutions to the Office of the Inspector General and the General Accounting Office as necessary to carry out statutory responsibilities.
AFMC will disclose information offsite from a particular quality review study to any institution or practitioner involved in that study, provided the disclosed information is limited to that institution or practitioner.

AFMC may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s) or institution(s).

The consent or request must specify the information that is to be disclosed and the intended recipient of the information.

The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or institution as provided under this Subpart B.

An institution or group of practitioners may redisclose quality review study information, if the information is limited to health care services they provided.

Quality review study information with patient identifiers is not subject to subpoena or discovery in a civil action, including an administrative, judicial or arbitration proceeding. This restriction does not apply to HHS, including Inspector General, administrative subpoenas issued in the course of audits and investigations of Department programs, in the course of administrative hearings held under the Social Security Act, or to disclosures to the General Accounting Office as necessary to carry out its statutory responsibilities.

A QIO must disclose quality review study information to CMS with identifiers of patients, practitioners or institutions—

For purposes of quality improvement, activities include, but are not limited to, data validation, measurement, reporting, and evaluation.

As requested by CMS when CMS deems it necessary for purposes of overseeing and planning QIO program activities.


Redisclosure of Information
Confidential data must not be redisclosed except for the following:

- As directed by the QIO
- As directed by the elected secretary of the board
- For necessary payment of claims
- For accounting reasons,
- For the Inspector General to carry out responsibilities
- For fraud and abuse investigations.

Disclosure to the Department

- Except as limited by §480.139(a) and §480.140, AFMC will disclose all information requested by DHHS in the manner and form requested.
- The information can include confidential and non-confidential information and requests can include those made by any component of DHHS, such as CMS.

Disclosure for Civil Litigation

- Confidential information including sanction reports and deliberations will not be subject to subpoena or discovery proceedings in any civil action.
No AFMC member, employee or consultant is subject to a subpoena or discovery proceedings for the purpose of obtaining information related to the above.

Access to QIO Data and Information
CMS may approve the requests of researchers for access to QIO confidential information not already authorized by other provisions in 42 CFR part 480.

Notification to Patients, Practitioners and Providers
- Patients will be notified of the information collected and confidentiality procedures at the time of admission.
- Physicians will be notified by an annual publishing in the *AFMC Newsletter* as to the types of information collected and the access procedures for verification, correction or disclosure.
- Health Care Institutions will be notified by written correspondence attached to the Memorandum of Understanding.

Facility Comment on Information Released
- Any information released that will identify a particular health care institution will require notification and a copy of the information to be released at least thirty (30) calendar days before disclosure in order to allow the institution to submit comments to be included with the information.
- Any comments received after the 30-day comment period will be forwarded to the recipient of the information.

Personal Access to Confidential Information
- Employees/consultants will be trained on confidential QIO information and be aware of the legal penalties which may be assessed for unauthorized disclosure of data and information (fines of not more than $1000 and/or imprisonment up to six months).
- AFMC will provide new hire, annual and on-going training in handling confidential information.
- Employees/consultants within the AFMC review system will be authorized to access only data or information needed to carry out their function within the program.
- Consultants and/or organizations providing data services to AFMC must have established procedures for maintaining the confidentiality of the QIO information.

Transporting Confidential Information
AFMC policies are in effect whether the work will be performed on or off-site. The following safeguards must be acknowledged:
- Confidential information, including PHI, will not be removed from AFMC without prior approval and a signed confidentiality agreement on file.
- The employee/consultant will be responsible for maintaining the privacy and security of all confidential information that they may be transporting, storing or accessing off-site. This includes, but is not limited to protected health information, electronic protected health information, computers that contain or access confidential information and confidential working papers.
- Confidential information or ePHI sent from workstations, laptops, PDAs and other mobile devices must be password protected.
- Electronic media and printed information must be transported and stored in a secure manner.
AFMC materials must be put away when not being used and kept in a secure location that is not accessible to others including children, spouse and visitors.

Storage and Retention Procedures
- Storage will be maintained in an alarmed facility behind a door with a deadbolt.
- Confidential records will be destroyed or returned to the facility from which it was collected when retention requirements are met.
- Purging of personal identifiers from computerized information, patient records and other files is required as soon as it is determined by CMS that those identifiers are no longer necessary.
- Computer data will be stored in a confidential matter.
- All media containing PHI or ePHI must be disposed of appropriately and must never be placed in regular trash. This includes printed information, faxes, hard drives, diskettes and CDs.

Development of Reports
- The cost of developing and compiling information records will be charged to individuals requesting information if the request is not related to program functions.
- Reports developed for private business will be charged a part of the development cost, as would any product when additional utilities or uses are developed. This includes the technical proposal which was not developed with federal funds.
- Requests that require large expenditures may require prepayment of estimated cost.

Confidentiality Officer
- The Chief Compliance Officer (CCO) is assigned the responsibility of maintaining the confidentiality of QIO data and information within the AFMC review system and for the notification of the Department of Health and Human Services of any breaches of confidentiality within the review system.
- Confidentiality breaches will be investigated by the CCO or his/her designee and appropriate action will be taken to resolve any issues. A report of the investigation and the action taken will be forwarded to the parties involved, to the Project Officer and/or to appropriate parties in the Department of Health and Human Services. If the investigation reveals no breach of confidentiality, a report will only be sent to the parties involved.

Additional information regarding the Confidentiality Agreement can be found in the Federal Regulations pertaining to Acquisition, Protection, and Disclosure of Quality Improvement Review Information (Reg. 480.115, 22,106.115).
2.2 Timeliness

AFMC has completed the process of converting all charts provided for review to electronic medical record (EMR) CD format. Technical issues or problems that arise with the format should be brought to the attention of the associate medical director or the senior director of clinical review (see the staff contacts section listed in the appendix to this manual).

It is imperative that AFMC maintain timeliness in reviews. In order to accomplish this, Reviewers **must return** EMR-CDs, along with completed review summaries, to **AFMC before the date** indicated on the reviewer voucher at the bottom of the page (see the following sample voucher) so this review material can be received at the AFMC central office by the date indicated. If the encrypted email format is used, reviews should be completed by that date.

The maximum amount of time allowed is calculated into the return date.

These timeframes may seem difficult, but if AFMC is to remain in compliance with our contractual obligations, the review materials must be returned to the office on time.

If you receive review materials and are unable to complete the review in the time allotted, contact the office immediately so the review materials can be rerouted to another reviewer.

When you know in advance that you will be unavailable for review (e.g., vacation, CME event, etc.) please notify the office immediately (by phone, fax, email or regular mail). The clinical review director will make every effort to route any review materials to another PA so they can be completed within the required timeframe.

As mentioned under Confidentiality (section 2.1), medical records from AFMC are not to be taken outside of the state of Arkansas unless permission is given in writing. If you are planning to be out of state or out of the country, simply notify our offices (by phone, fax, email or regular mail) as soon as possible and we will make every effort to ensure that no records are sent to you during the specified period.

The clinical review director, located in the AFMC Fort Smith office, is responsible for routing reviews to reviewers. Once a month, the clinical review director discusses the upcoming reviews with the AFMC associate medical director. The number of reviews to be handled by each reviewer is determined (taking into account the reviewer’s request) and the clinical review director makes certain those reviews are referred to the appropriate reviewer.

Reviewers who wish to increase or decrease the number of reviews they perform should notify the clinical review director as soon as possible. This information will be disseminated to each review area that could potentially send reviews to the reviewers.

If the reviewer does not return the reviews by the deadline, the associate medical director or the clinical review director will contact the reviewer. If the reviewer cannot complete the reviews quickly, a separate copy of the EMR-CD and review summaries will be sent to a different reviewer, and the first PA will be asked to return the original review materials unreviewed. Once this step is required, the first reviewer will no longer be able to receive reimbursement for that particular set of reviews.
If a reviewer is consistently unable to complete charts within the required timeframe, the reviewer will be reminded of the policy. If the tardy reviews continue, the reviewer will no longer be asked to perform reviews.

2.3 Reimbursement

Reviewers of AFMC are reimbursed at a prorated hourly rate for time spent on review. The reviewer must track and record the actual amount of time for each review. New reviewers can expect to take longer with reviews at first than they will once they are familiar with the review process. The majority of cases should take 10 to 20 minutes to review.

An AFMC reviewer voucher will accompany each set of charts. There is a sample of a reviewer voucher on the following page. The voucher will list all cases included in the mailing, including the hospital and control numbers as well as the patients’ names. It will also indicate the type of charts being reviewed (e.g., initial, second reviewer, reconsideration, etc.). An important piece of information is the date noted at the bottom of the voucher, which is the date the records are expected back at AFMC offices (highlighted in green).

The process is the same for initial reviews, re-reviews and reconsideration reviews. The reviewer will list the amount of time spent for review of each case, sign, date and return the voucher with the medical records to AFMC. The total minutes and the total amount of money do not have to be calculated by the reviewer, as the AFMC accounting office will compute it. Only the number of minutes required for each chart reviewed needs to be listed.

If a voucher is received by AFMC unsigned, it will be returned to the reviewer for signature before payment can be made.

Generally, when reviewer vouchers are received in Accounting by noon on Tuesday, the payment for that review time will be made the following Thursday. This, of course, is dependent on the speed of mail (from the reviewer’s location to the AFMC office), records processing and data entry. If you fail to receive a timely check for review time submitted, please contact the senior executive assistant for the board of directors (see the staff contacts section listed in the appendix to this manual).
### AFMC REVIEWER Voucher

- **Voucher No:** 28838
- **Address:** 123 Street
- **Reviewer License #:** ARZ 1234
- **Reviewer Name:** John Q Public, MD
- **Voucher Type:** Initial, 2nd PA

<table>
<thead>
<tr>
<th>Hosp#</th>
<th>Control #</th>
<th>Patient Name</th>
<th>REVIEWER Time (Min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>123456</td>
<td>Joe Cool</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>123456</td>
<td>Jane Anyone</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>654321</td>
<td>Everyman Jones</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL MINUTES**

- **Run Date:**
- **IRC:**
- **Mailed to REVIEWER:**
- **REVIEWER Received:**
- **Verified By:**
- **Approved By:**

- **Physician Signature:**
- **Date:**

**These charts must be received at the AFMC Central Office on or before 07/31/2012.**
2.4 Record handling

Throughout the month, active reviewers will receive a package from AFMC review staff including an EMR-CD and review summaries, with a mailer to use for the return of the reviews to the AFMC office. Each record will have a case summary and specific questions for the reviewer to answer. A voucher sheet to record time spent reviewing will also be included.

For EMR-CDs, the patient’s name often will not be listed on the voucher sheet due to confidentiality issues. In such cases, the control number on the voucher sheet will match the control number for the chart icon on the CD. EMR-CDs should always be returned with the review summaries in the mailer provided because they contain highly confidential patient information. If the CD will not function or if there are other technical issues please contact the associate medical director or the senior executive assistant for the board of directors immediately.

If a reviewer has any specific comments about a particular chart that might not seem appropriate to place on the review summary, he or she should note them on a sticky note or personal stationary and return them to AFMC along with the records. AFMC will then pursue appropriate action. Reviewers can follow a similar process when reviewing EMR-CDs, using a separate sheet of paper from the review summary.

Reviewers should always feel free to contact the associate medical director with review-related questions at any time via phone or email. If the associate medical director is unavailable, the reviewer may contact the processing department.

Remember, as described in Confidentiality (section 2.1), AFMC must be notified of anyone assisting a reviewer with transcription, mailing, or delivering PHI review material to/from AFMC, and those individuals are required to sign a confidentiality agreement as well.

Also, as detailed in Timeliness (section 2.2), when you know in advance you will be unavailable for review, please notify the office immediately (by phone, fax, email or regular mail). The clinical review director will make every effort to route any review materials to another reviewer so they can be completed within the required timeframe. If the office is not notified before the first of the month, we are unable to guarantee that no records will be sent to your office.

**NOTE:** Reviewers MUST NOT underline or highlight any part of the medical record. Records can eventually end up in the Office of the Inspector General for sanction determinations. Underlined phrases or highlighted areas can be considered “prejudicial.” Sticky notes on the edge of a page marking something in the record the reviewer finds of significance are acceptable.
2.5 The review process

2.51 AFMC responsibilities

The AFMC is a critical monitoring and evaluation entity with the responsibility to ensure patients receive medical care that is necessary and of the highest quality.

AFMC review of cases includes one or more of the following components:

- Review of the reasonableness, necessity and appropriateness of surgical procedures
- Review of the completeness, adequacy and quality of care provided
- Review of the reasonableness, necessity and appropriateness of hospital admissions
- Assurance that payments are correct by identifying whether the diagnostic and procedural information reported by hospitals for DRG assignment is correct and matches the information contained in medical records
- Determination of the patient's medical stability at discharge

AFMC performs various review functions for DMS (Arkansas Medicaid) and other clients, including prior authorization, concurrent review and retrospective review. Our general review activities include acute inpatient, ER utilization, length of stay, DRG validation, beneficiary complaints, etc.

AFMC also performs highly specialized review functions, particularly for Arkansas Medicaid. These review activities involve specialized care and draw from a pool of physician reviewers who are involved in one way or another with this type of medical care. These reviews include: extension of benefits, targeted case management (TCM), child health management services (CHMS), organ transplants, etc. It must be noted that, as with all AFMC reviews, a reviewer cannot review family, friends, enemies or competitors.

These activities are performed under AFMC’s contracts with DMS and other clients.

2.52 Individual case review

The generalized review process, depicted by the flowchart below, is dependent upon the flow of information from the hospitals to the fiscal intermediary (FI) to the AFMC. Virtually all records can be selected for review after a bill is submitted and paid. Occasional delayed billing of records sometimes gives the appearance that AFMC is concentrating its attention on certain types of cases or individuals. This is not the case. The process merely begins as soon as the FI forwards the electronic data.

At the beginning of each month, the AFMC information services department takes the data tape from the FI, and, through randomized computer selection processes, produces a selection of cases for review.

This information is communicated to the hospitals along with a request to submit all selected records to the Fort Smith office for review by internal review coordinators (IRCs).
IRCs are the first level of review – non-physician review. They may only approve a case based on screening criteria developed by national organizations or organizational policy. IRCs are encouraged to exercise their clinical judgment in bringing an unusual record to the attention of a reviewer.

Records that are approved at the non-physician reviewer level are entered into the database from which AFMC generates various reports for Arkansas Medicaid and other clients.

Cases questioned by the IRC are placed on an EMR-CD and sent to a reviewer for review.

The majority of records are approved at the IRC level. Generally, approximately 20 percent of the cases in any review category are referred to reviewer and denied. Some of these are overturned upon reconsideration at the third level of review when the physician or provider has submitted additional information.

Adverse decisions, or “denied” cases, are based on a determination that a service is not medically indicated or necessary and include all the types of review performed by AFMC (quality of care, acute care inpatient admission, long-term acute care admission, length of stay, procedure, extension of benefits, DRG changes and billing errors).
AFMC Information Services Department

Receives tape from fiscal intermediary of paid claims from the contracting organization/agency.

AFMC Information Services Department

Computer selects cases for review based on or DMS requirements. Review sheets printed.

Review

Initial review conducted by IRC using established screening criteria. IRCs may only approve a case based on criteria.

AFMC Review Staff

Sends review selection to hospitals.

Approved Cases

Rationale for approval entered into review system.

Questioned Cases

Referred for REVIEWER review and decision.

Diaspproved Cases

Pre-denial procedures for admissions and pre-decision procedures for quality issues.

Denied Cases

Correspondence sent to all parties. Reconsideration opportunity given for utilization denials. Third-level REVIEWER review (different physician involved).

Approved

Notification forwarded to all parties involved.

Denied

Notification forwarded to all parties
2.53 **Reviewer responsibilities**

Primarily, reviewers are instructed not to review cases when there is a relationship with the patient, physician(s) who rendered care or the facility that might be considered a conflict of interest. Reviewers are also not to review cases from a facility where they have privileges or other working relationship. AFMC has set in place safeguards to prevent such an occurrence in most cases, but there may be instances when a reviewer receives a record where a possible conflict of interest may exist. In such a case, the reviewer should contact the AFMC office and return the record, unreviewed, bearing in mind the confidentiality restrictions that reviewers shall not discuss any case or physician or facility with non-AFMC staff.

IRCs perform an initial screening review of the record and will refer, if necessary, to an appropriate reviewer. The EMR-CD is sent to the reviewer and should be systematically reviewed. The discharge summary is usually the most helpful place to begin. After reviewing it, the reviewer should review the history and physical, physician orders and notes, and nurses’ notes, as well as lab and X-ray reports. Then, the reviewer should provide a separate answer for ALL questions posed by the IRC.

The IRC uses screening criteria to determine whether or not to refer a chart to a reviewer. The IRC/non-physician reviewer cannot make negative decisions — that is, decisions that would negatively affect a patient, hospital, health care provider or physician. Only a reviewer or provider with similar background can do that. Therefore, **any chart that falls outside of the screening criteria applied by the IRC must be referred to a reviewer or appropriate consultant.**

The reviewer must answer any question posed by the IRC with a written statement. It is not appropriate to answer a question with a simple “yes” or “no.” The reviewer must provide specific medical rationale for the decision. That rationale is the foundation of the information provided to the physician and/or hospital (and in some instances, the beneficiary) any time there is an admission denial, procedure denial, DRG change or quality-of-care concern. In addition, the information provided is educational feedback for the IRCs.

The reviewer should answer only the questions posed by the IRC, with the exception of identifying any significant quality-of-care concern the IRC did not identify. If the diagnosis has not been questioned, it should not be changed.

AFMC pays reviewers for the application of medical judgment, not for the application of criteria. Therefore, reviewers should base their rationale on medical training, knowledge and experience and in accordance with professionally recognized standards of care, rather than on a statement that something does or does not meet “criteria” or “guidelines.”

Reviewers should not use the words “criteria” and “guidelines” in any rationale, whether it is a question of the necessity of admission, a question about a diagnosis or DRG change, a question about the necessity of a procedure, or a question about quality of care. While screening criteria helps decide what cases should be referred to reviewers for review, a reviewer must use medical
expertise obtained through years of medical school, postgraduate training, practice experience and continuing medical education. Therefore, AFMC does not provide screening criteria to reviewers. Determinations and rationale based upon medical knowledge must address the questions posed by the IRC.

The reviewer must be thorough in responding to questions. If there is not enough space to answer a question, the reviewer should use a separate piece of paper. AFMC forms are printed on paper compatible with any laser jet printer. AFMC provides a copy of reviewer answers to the IRC as an educational tool. The most common problem with reviews is that the reviewer provides no, or inadequate, rationale. Another common problem is that reviewer neglect to answer one question or fail to turn to a second review sheet containing additional information and/or questions. This is especially the case when an IRC may have listed four or five questions. The reviewer must be certain that ALL questions on every page are answered. Any physician review summary that is incomplete must be referred for in-house physician review, duplicating costs and efforts.

Physicians have a reputation for poor handwriting. It is particularly important that handwriting is legible for AFMC personnel. The processors take a reviewer’s review statements and type a rationale telling why the diagnosis was changed, why the admission or procedure was denied, or why quality of care was substandard, etc. Reviewers whose handwriting consistently found to be illegible will be required to submit their reviews in typed form. Due to the potential for confusion, use of abbreviations are discouraged. Review sheets are compatible with any laser jet printer and can be used by the reviewer, or the reviewer may use plain paper and simply attach the review to the appropriate review sheet, being certain to identify at minimum the patient name and date of service. If the reviewer has someone transcribe dictation relating to AFMC review, that individual must sign a confidentiality agreement (see Confidentiality section).

Reviewers should avoid any inflammatory wording. Commentary should be non-judgmental, factual and based on medical knowledge rather than on feeling. “I feel…” and “I think…” should not preface any answer or appear in any rationale.

Since the rationale will be used substantially unchanged in the letter sent to appropriate parties (e.g., attending physicians, providers and, in some instances, beneficiaries) it must be complete and factual.

2.531 Evaluation of reviewers

As you may know, AFMC has a credentialing process by which potential reviewers are identified and information relative to their education, training and experience is obtained from the Centralized Credentials Verification Service (CCVS) of the Arkansas State Medical Board, as designated by Arkansas law. This decreases the amount of paperwork a potential reviewer is required to complete and submit for consideration as a reviewer.

Once the application has been evaluated and approved for each potential reviewer, the physician is provided with a link to the reviewer manual and test. Successful completion of the test indicates a reviewer’s understanding of the manual and their readiness to begin review. Once AFMC receives this form, the reviewer is placed on probationary status, during which time the
associate medical director re-reviews generally 30 records reviewed by the reviewer as soon as the Fort Smith office receives them. A dialogue is established and constructive feedback related to the review and other general review process issues are provided to the reviewer. Once reviewers have successfully completed the probationary period, they are moved to full active status and undergo routine internal quality control activities.

This credentialing information is gathered and forwarded by the associate medical director with recommendation to the Credentials Committee of the AFMC Board of Directors.

In the pursuit of continuous quality improvement, AFMC monitors the ongoing performance of reviewers. The AFMC associate medical director conducts internal quality control activities on a monthly basis, consisting of a re-review of a sample of previously reviewed records for each reviewer. If the associate medical director finds problems, the physician reviewer is reminded of the proper procedures and monitored for compliance. If it is apparent that the reviewer’s review decisions are in error, the associate medical director provides appropriate feedback in the form of constructive analysis of each decision that was considered to be in error. Reviewers who make errors repeatedly may be moved from active to inactive status, and AFMC will send no additional records until the reviewer completes another probationary review period after re-review of the reviewer manual.

In addition to the organized monthly assessment, the review departments make copies on a daily basis of review summaries when a problem is detected with an individual review. The staff members have been with AFMC for years, understand AFMC policies and procedures, and are familiar with the reviewer instruction manual. When a problem is noted, a copy of the review summary is referred to the associate medical director. After evaluating the review (including the medical record, when indicated), the associate medical director will contact the reviewer with direct feedback, as indicated.

As stated in Record Handling (section 2.4), reviewers will not underline, highlight or write in any part of a paper medical record sent from AFMC for review.
2.54 The 10 commandments of peer review

I. Thou shalt review the records within the allotted timeframe and return records promptly.
II. Thou shalt base all decisions upon facts available at the time of care.
III. Thou shalt give benefit of doubt to the physician at the bedside.
IV. Thou shalt base no decisions upon the outcome.
V. Thou shalt utilize dynamic community standards.
VI. Thou shalt match review to true peers, whenever possible.
VII. Thou shalt not review friends, enemies or competitors.
VIII. Thou shalt not jump to a premature decision.
IX. Thou shalt not use vague language or personal references in your review.
X. Thou shalt not use strong, irritating or inflammatory words in review responses.
3. Peer review: Initial review

Peer review is a fundamental form of ensuring appropriate application of medical care. It includes an evaluation of the medical necessity, appropriateness of setting and the quality of care as compared to professionally recognized standards. Utilization review is the cornerstone of peer review.

By performing peer review, AFMC is fulfilling its obligation to ensure that providers and practitioners are fulfilling theirs, which mandates:

(a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority, that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act –

   a. will be provided economically and only when, and to the extent, medically necessary;
   b. will be of a quality which meets professionally recognized standards of health care; and
   c. will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

AFMC plays a key role in assuring that health care practitioners and providers meet their obligations to patients. You, as a member of and reviewer for AFMC, play a necessary and integral part in AFMC’s role in ensuring that these obligations are met.

AFMC does not provide screening criteria to our physician reviewers. While screening criteria helps the non-physician reviewer decide which cases require referral to a reviewer, the reviewer’s role with AFMC is the application of medical judgment based on medical training, knowledge and experience, not the application of criteria.

3.2 Medicaid reviews

3.21 Medicaid observation vs. acute care

In determining whether acute care was utilized correctly in these instances, reviewers should use the “24-hour benchmark” mentioned in the Arkansas Medicaid Provider Manual, section 213.610, which states:

“The physician or other practitioner responsible for deciding whether the patient should be admitted as an inpatient should use a 24-hour benchmark. That is, he or she should order admission for patients who are expected to need hospital care for 24 hours or more and treat other patients on an outpatient basis. This can be on outpatient observation status.”
Thus, at the time of admission, if a patient’s illness process would normally be expected to resolve within 24 hours to a point where the patient could safely receive further care as an outpatient, the observation status, rather than an acute care admission, should be utilized. As the decision for utilization of observation vs. acute care must be made at the time of admission, it is essential the reviewer performing the review not use a benign outcome and/or a discharge that occurs more rapidly than could be expected at the time of admission as a reason to deny an acute care admission. The review decision should be made solely on what the admitting physician would have known at the time the patient presented for admission. It is acceptable for the reviewer to consider the time of admission in the decision process. For example, if a patient is admitted at 2 a.m., the admitting physician does not actually have 24 hours of observation available, as it is not reasonable to discharge a patient at 2 a.m. the next day. In such a case, the review decision should be based on whether the patient could be expected to be stable for outpatient management by that evening. It is also important for the reviewer to understand that this is a billing issue only. The care provided to a patient admitted to observation status or to a patient admitted to an acute care facility as an inpatient may be identical. As such, any facility that has identified itself as an acute care facility for the care of Arkansas Medicaid patients is required to have some method of outpatient observation, whether it is a formal observation unit or not. Thus, absence of hospital bylaws or operating rules for the facility creating an “observation” status for patients cannot be used as justification for failure to admit a patient to observation status, when appropriate.

Sample reviews:

“A 5-year-old child was admitted with symptoms of nausea and vomiting for 24 hours. Vital signs were normal, and abdominal exam was reported as ‘soft, with no specific tenderness.’ Mucous membranes were dry, but skin turgor was good. BUN was 25, electrolytes were normal.”

Was acute care admission necessary for this child, or could a stay of less than 24 hours have been anticipated at the time of admission, allowing the care to be provided in an observation setting?

Reviewer response:

The patient had only minimal dehydration findings at the time of admission, with no indication of serious infection or an acute abdominal process. A stay of less than 24 hours should have been anticipated at the time of admission. Therefore, the observation setting should have been used to provide initial care. The patient was adequately improved by the next morning to allow discharge to outpatient management within a 24-hour period. Thus, this admission to acute care was not necessary and should be denied.

“A 30-year-old male was admitted with a history of several days of vomiting and diarrhea. Minimal jaundice was noted on physical exam, along with dry mucous membranes and poor skin turgor. K+ was 2.8, BUN was 35, total bilirubin was 5, and LFTs were all minimally elevated.”

• Was acute care admission necessary for this patient, or could a stay of less than 24
hours have been anticipated at the time of admission, allowing the care to be provided in an observation setting?

- If acute care admission is determined to be medically necessary, were all days of the inpatient stay necessary?

**Reviewer response:**

At the time of admission, the patient had elevated liver functions that were not consistent with a benign GI tract problem. The patient had both significant vomiting and diarrhea history and significant dehydration on physical exam. A period of more than 24 hours was anticipated to evaluate and treat this patient sufficiently for outpatient management to be safe. The patient was very slow to return to normal GI function, and could not be advanced to regular diet until the day of discharge. Therefore, use of the acute care setting in this case and the acute care stay were medically necessary.

“A 25-year-old female was admitted with a history of cough and congestion for two days. There is no mention of outpatient treatment failure in the record. Vital signs were normal at the time of admission. Lungs were described as ‘clear’ on exam. There were no dehydration findings. WBC count was 11,000 with 72% leukocytes, all other labs were normal. The patient was continued on home medications, given a regular diet and received Rocephin IM once daily for three days. During that time, she was allowed to be ambulatory and had no problems with oral intake.”

- Was acute care admission necessary for this patient, or could a stay of less than 24 hours have been anticipated at the time of admission, allowing the care to be provided in an observation setting?
- If acute care admission is determined to be medically necessary, were all days of the inpatient stay necessary?

**Reviewer response:**

There was no indication of a need for acute care in this case. There was no evidence of systemic infection or a serious respiratory infection. No outpatient treatment had been attempted prior to this admission. The patient was given numerous oral medications and allowed to be ambulatory. Once daily Rocephin administration could have been safely and effectively managed in the outpatient setting. Therefore, this acute care admission should remain denied due to lack of medical necessity. As the acute care admission was not necessary, all days of the acute care stay should be denied.

“A 35-year-old female was admitted through the ER at 3 a.m. on 48 with a history of a recent C-section and reported redness and drainage from the op site. Initial exam showed normal vital signs with no fever, but did confirm redness in the C-section incision with minimal drainage and questionable fluctuance. The patient was admitted for IV antibiotic therapy and routine wound care. The patient’s wound rapidly improved, and she was discharged to outpatient management on the afternoon of 4-9, to continue oral antibiotic therapy and follow up in the office.”
Was acute care admission necessary, or could this patient have been managed in a 24-hour observation setting?

Reviewer response: 
The patient was admitted early in the morning of 4-8. Completion of care in a 24-hour observation period, with discharge at a reasonable hour, would have required discharge by the evening of 4-8. Given the initial findings suggesting a potential surgical abscess and the subsequent need for empiric parenteral antibiotic coverage pending culture results, this would not have been a reasonable goal at the time of admission. Therefore, use of the acute care setting in this case was medically necessary.

An example of an incorrect review follows:

“A 7-year-old child was admitted with an acute exacerbation of asthma. Respiratory rate was 46 with moderate retractions noted. Pulse oximetry was 84%. The patient was admitted for IV steroids, mist tent therapy and frequent updraft treatments. By the next morning, the child had no wheezing, no retractions and pulse oximetry of 99% on room air. The patient was discharged at that time.”

Could this patient have been managed in a 24-hour observation setting, or was acute care necessary?

Incorrect reviewer response: 
As this patient was discharged in less than 24 hours, the observation setting should have been used. Deny the acute care admission.

Correct reviewer response: 
This patient was admitted with a significant exacerbation of her underlying asthma condition, with retractions and hypoxia noted on admission. Aggressive treatment with parenteral steroids and frequent respiratory treatment was anticipated and ordered. A physician would not normally expect a patient with this level of asthma exacerbation to recover to the point where outpatient treatment could be attempted in less than 24 hours. Thus, the choice of admission to acute care was correct. The patient’s benign course and rapid recovery, with discharge the next day, could not have been anticipated at the time of admission and cannot be used retrospectively to deny the apparent necessity of this admission.

3.211 Medical necessity of conversion to acute care

Medicaid observation is limited to a strict 24-hour time limit. If the patient remains in the facility more than 23 hours and 59 minutes, the patient is said to be a “deemed” admission to acute care. Often, the IRC will question whether a patient admitted for observation required continued care long enough to necessitate conversion from observation to acute care. In these instances, the reviewer is not asked to determine if the observation stay was necessary, but rather, whether it was medically necessary to admit the patient to acute care at the time the observation period expired, or to allow the patient to remain long enough to require the
automatic conversion to acute care. The issue that must be addressed to answer this question correctly is asked to determine if the patient required further inpatient care at the time the observation period expired, making it medically necessary to admit the patient to acute care. If the patient still required inpatient care at the time conversion was made, then the acute care admission was appropriate. If the patient could have been safely discharged for further management in the outpatient setting prior to the elapse of the 24-hour observation period, then the conversion to acute care was not medically necessary and should be denied.

As noted above, it is reasonable to consider the time of day that the observation period expires in this decision. If a patient’s observation period expired at midnight, the attending physician would have to confirm the patient stable for discharge earlier on that day to complete the patient’s care without conversion to acute care, as we cannot expect the attending physician to make this decision at midnight.

Sample reviews:

“A 36-year-old female was admitted on the evening of 7-8 with history of migraine headaches, and alleged intractable headache for 2 days. Initial vital signs were normal. Initial exam did not reveal any neurological abnormalities. The patient was placed on bed rest and was given IM Demerol every 2 hours for relief of headache symptoms. MRI was performed the next morning and was negative. The patient was ambulatory for bathing and bathroom and ate 80% of lunch. She continued to ask for, and receive, Demerol injections on a 2-hour basis. No attempt to convert to oral medications was made until 7-10, even though no emesis or nausea was reported on 7-9.”

Was conversion to acute care necessary on 7-9, or could the patient have been discharged prior to expiration of the observation period on that day?

Reviewer response:

The patient’s observation period did not expire until the evening of 7-9. The patient had no findings during the day of 7-9 suggesting a need for further inpatient monitoring. Objective exam and diagnostic evaluation failed to support the patient’s somatic complaints. This patient could have been safely discharged to outpatient management prior to the evening of 7-9. As it appears that this patient could have been safely discharged prior to expiration of the observation period, this acute care admission should be denied.

“A 21-year-old G3P2, at 33 weeks gestation, was admitted to observation on 10-5 at 10 a.m., due to suspected uterine contractions. Cervix was 2 cm, 50% effaced, -2 station. She was placed on bed rest and IV MGSO4 was begun. IV MGSO4 was continued until 10 that evening, and then discontinued. The patient continued to complain of contractions until the afternoon of 10-6, but fetal and maternal monitoring was normal. No cervical changes were noted. Conversion to acute care was ordered at 10 a.m. on 10-6 due to the observation period expiring. By the evening of 10-6, the patient had no further complaints of contractions and expressed a desire to be discharged. She was discharged to office follow-up.”

Peer review: Initial review 3-5
Was the conversion to acute care on 10-6 medically necessary, or could the patient have been discharged before the observation period expired?

**Reviewer response:**
Findings during the observation period were not benign enough to confirm discharge to outpatient management to be safe on a prospective basis. The patient had ongoing symptoms suggestive of uterine irritability and confirmed cervical dilation and effacement sufficient to make imminent delivery a possibility. Therefore, conversion to acute care setting, in this case, was medically necessary.

A special case arises when the patient’s observation period expires in the afternoon or evening, but the physician makes rounds that morning. The decision on whether to approve a conversion to acute care in this instance must be based on the attending physician’s documentation. If it is apparent from the record that the attending merely wished to watch the patient a few more hours, and make a decision for discharge later that day, then it is incumbent on the attending physician to be aware of the observation time limit, and make that decision before it expires. If, on the other hand, the morning progress note reflects that the patient is not stable for discharge and further inpatient care will be needed, then the decision to convert to acute care that day is acceptable, even if the patient does better than expected and could actually have been safely discharged prior to expiration of the observation period.

**Sample reviews:**

“A 4-year-old child was admitted to observation at 6 p.m. on March 6 with fever, cough and mild retractions. Initial lung exam suggested left lower lobe rales and WBC count was 12,300. Initial CXR was normal. The patient was started on IV Rocephin, mist tent and regular diet. By next morning, the patient had a normal lung exam, no fever and no retractions. In the progress note on the morning of March 7, the physician specifically documented ‘Child improved more than expected. Will discontinue mist tent, change to oral antibiotics and see how she does through the day. If no problems, will discharge this afternoon.’ The child was not seen again until the morning of March 8, at which time discharge was ordered.”

Could this child have been discharged on the afternoon of March 7 as apparently planned, or was it necessary for the patient to stay long enough to require conversion to acute care?

**Reviewer response:**
This patient was stable for discharge on the afternoon of March 7, before the observation period expired. Sufficient clinical improvement had been noted by the morning of March 7 to suggest that the child could have been discharged later that day, and subsequent events during the day confirmed this. As the physician’s stated plan was to discharge the patient by the afternoon of March 7, and as no medical events required the patient to stay beyond that point, the conversion to acute care on March 7 was not medically necessary and should be denied.
“A 17-year-old female was admitted from the ER to observation at 6 p.m. for an emergent laparoscopic appendectomy, due to confirmed appendicitis. Initial surgery was performed without adverse events, and the patient was admitted overnight for observation. The next morning, she had persistent severe nausea and could not tolerate oral intake. The physician noted in the progress note for that day that the patient would require further GI rest and IV fluid support until this complication resolved and converted the patient to acute care for this treatment. The patient’s nausea began to subside through the day. She was able to tolerate a full liquid lunch and desired outside food by mid-afternoon. The patient was fed a regular diet for the evening meal, which was tolerated without incident. She was discharged on the next morning.”

Could this patient have been discharged prior to expiration of the observation period at 6 p.m., or was conversion to acute care medically necessary?

Reviewer response:
This patient was appropriately admitted to observation for routine monitoring after laparoscopic surgery. However, by the next morning, the patient was having unexpected complications that could not be presumed to resolve by that evening. Thus, the physician made the decision to convert the patient to acute care for further therapy that was expected to be needed until the following morning. The fact that the patient did better than expected cannot be used to retrospectively deny the apparent necessity of acute care admission at the time it was ordered. Thus, the conversion to acute care in this case was medically necessary.

An example of an incorrect review on this issue follows:

“A 13-year-old female was admitted to observation at 6 p.m. on 5-15 for evaluation and treatment of protracted emesis and diarrhea for three days prior to admission. At the time of admission, skin turgor was noted to be poor with dry mucous membranes. Electrolytes showed a Na+ of 130 and a K+ of 3.1. BUN was 32, urine specific gravity was 1.025. The patient was placed NPO and IV fluids at 150cc/hr were begun. By the next morning, GI symptoms had resolved, but Na+ and K+ were still slightly low at 132 and 3.3, respectively. The patient was started on a clear liquid diet, and IV fluids were reduced to 50 cc/hr. The physician ordered conversion to an acute care admission at the time of morning rounds, indicating in the progress note that he planned to keep the child until 5-17 due to the severe dehydration and electrolyte disturbances noted on admission, which had still not yet completely resolved. The patient did well through the day, with diet advanced to regular for the evening meal upon the parents’ request. The patient had no further emesis or diarrhea and was discharged the following morning.”

Since the patient did well on 5-16, could she have been discharged on 5-16, or was acute care necessary until 5-17?

Incorrect reviewer response:
This patient did well through the day of 5-16 and was tolerating a regular diet by that evening. There was no need to continue IV fluids or inpatient care at that point. The
patient could have been safely discharged on 5-16. There was no need to convert to acute care that morning.

**Correct reviewer response:**
This patient was appropriately admitted to observation initially to treat an apparent case of gastroenteritis. By the next day, the patient was clinically improved, but the physician documented specific concerns about the patient’s continued electrolyte levels due to the severe nature of the initial presenting symptoms. Therefore, at the time rounds were made that morning, the physician did not feel that the patient could be stabilized sufficiently for outpatient management to be considered that evening and made the specific decision to convert to an acute care admission with discharge planned for the following day. The fact that the patient did better than expected through the day, which allowed diet to be advanced more rapidly than originally expected, should not be used retrospectively to deny the apparent necessity of acute care admission at the time the physician made that decision. Thus, acute care admission was medically necessary.

### 3.22 Length of stay

Currently, any inpatient day of a Medicaid admission can be questioned for medical necessity of the provision of care in the inpatient setting. The REVIEWER must respond to questions of this nature with a rationale specifying the exact day the patient no longer required acute care and should support this decision with relevant information confirming the patient’s stability on the proposed day of discharge. As Medicaid does not reimburse for the day of discharge, the clearest way to state the denial is to specify the day after which acute care was no longer needed. Please note that only acute care qualifies. Custodial care, patient awaiting transportation, rehabilitative care and patient refusal to accept reasonable discharge are not sufficient reasons to approve continued acute care.

**Sample reviews:**

“A 21-year-old male was admitted with symptoms consistent with a sickle cell crisis. Initially, parenteral fluids and analgesia were required. On 6-24, the patient was improved, and IV narcotics were changed to an oral route. The patient continued to do well on an oral regimen. By 6-25, the IV was discontinued. Minor adjustments were made in the patient’s oral medications on 6-25 and 6-26. There was apparently some difficulty in arranging transportation home until 6-26.”

Did the patient require the acute care setting on 6-25, or could discharge have been ordered on that date?

**Reviewer response:**
The patient no longer required acute care on 6-25. The patient’s medical condition was stable and parenteral fluids were discontinued. The patient remained in the hospital the next two days while oral medications were adjusted and transportation home was arranged. As of 6-25, routine monitoring of the patient’s condition and adjustments of oral therapy could have been safely addressed in the outpatient setting. Any
transportation difficulties should have been noted at the time of admission and addressed with appropriate discharge planning. Deny the stay after 6-24.

“A 5-year-old male was admitted on 1-12 with fever of 103, rales in the right lung, WBC count of 24,000 and CXR confirming an acute RLL infiltrate. The patient had been seen in the office on 1-9 and started on oral Zithromax for suspected bronchitis. The patient was started on IV Rocephin daily with close respiratory treatment and support. The patient’s fever broke on 1-15 and the patient was allowed out of bed to the playroom. WBC count was down to 11,800. Regular diet was being tolerated. IV Rocephin was continued until 1-16, at which time the patient was changed to oral antibiotics and discharged that afternoon.”

Could this patient have been changed to oral medication and discharged on 1-15?

Reviewer response:
Given the failure of outpatient treatment, the severe nature of the initial infection as apparent from clinical exam, leukocytosis and high fever, an extended course of parenteral antibiotic therapy was a reasonable clinical approach. Adequate resolution of the infection and stability on oral treatment could not be confirmed until the day of discharge. The entire stay was medically necessary in this case.
4. Reconsideration review

4.1 Medicaid reconsideration review

When a provider disagrees with an initial adverse determination, a reconsideration review may be requested. The reviewer should note the specific type of review required (e.g., admission to acute care, length of stay, procedure, etc.), and carefully evaluate the original record and any accompanying supplemental documentation within that context.

If reconsideration review of a denied length of stay is requested, the reviewer should not address the issue of initial admission, only the days actually denied on the original notification.

Please remember from the previous section on initial review that Medicaid observation is based solely on the anticipated stay being less than 24 hours at the time of admission and not on the level of care to be administered. The use of the observation setting involves billing issues only. It has no impact on the location or level of care delivered. Thus, any acute care facility has an obligation to provide for observation for Medicaid patients, whether or not there is a formal observation unit in that facility. Therefore, any claim that the patient could not be admitted to observation due to hospital policy, staff bylaws, lack of a formal observation unit or other similar reasons is invalid and cannot be used as a basis for overturning an admission denial.

Reconsideration review requests are performed by physicians in the same specialty as the attending physician whenever possible.

In summary, the following procedure should be used upon receipt of a reconsideration review:

1. The reconsideration request form should be checked for the type of initial denial (e.g., admission to acute care, length of stay, unnecessary procedure or quality of care issue).
2. The original correspondence sent to the provider should be reviewed and checked for transcription accuracy against the original reviewer’s rationale. Any significant discrepancies should be referred to the AFMC associate medical director – the person who oversees reviewers.
3. All correspondence and supplemental documentation submitted should then be reviewed. Points of contention should be checked against the original chart documentation. Dates of any supplemental documentation should be checked to ensure it reflects the timeframe in question.
4. A decision is then made regarding all of the issues, considering all of the relevant data, with particular attention to any mitigating circumstances noted in the supplemental documentation. The rationale should specifically address any points raised in the reconsideration letter and provide case specific information as to why the denial is upheld or overturned. A specific rationale should be provided for each question posed by the IRC.
5. Admission denials may be overturned while upholding denial of subsequent days of the stay. It is not appropriate to deny more days on reconsideration than were
originally denied on initial notification. It is particularly important, if an unfavorable initial decision is upheld, to refute any valid points made in the reconsideration request letter.

**Sample review responses:**

“Further reconsideration of an admission denial is requested in this case. After review of the pertinent information, the initial admission denial is upheld. The reconsideration letter does not change the basic facts that this child did not exhibit any evidence of an acute abdominal process at the time of admission and that a 24-hour observation period would have been more than sufficient to establish whether an occult acute abdominal process was present or not. The distance of travel expected was not excessive enough to prevent further outpatient testing once the absence of acute pathology was confirmed.”

“Further reconsideration of an admission denial is requested in this case. After review of the pertinent information, the initial admission denial is overturned. The reconsideration letters point out that at the time of admission, with the stated purpose being to initiate insulin pump therapy, it would not have been reasonable to presume that a 24-hour observation period would have been sufficient to provide enough time for adequate treatment. Intensive monitoring of glucose levels for 48 to 72 hours is required in this setting while the patient’s previous long acting insulin clears from the body and the response to the continuous administration of regular insulin is measured. Therefore, the initial admission to acute care was appropriate.”

“No new information was submitted in the reconsideration letter. While this patient may well have needed an overnight admission to evaluate the presenting history and symptoms, a 24-hour observation period would have been more than sufficient to allay any concerns about an unstable cardiovascular condition and allow further evaluation and follow-up to be safely conducted in the outpatient setting. As such, this acute care admission remains denied.”

“The reconsideration letter does not provide any additional clinical information cogent to the issue of whether the patient needed acute care on 7-5. On that day, the patient’s vital signs were stable and oral intake was adequate. There appears to have been no material difference in the patient’s medical condition, mental status or glucose regulation on 7-5 as opposed to 7-6. As discharge would have been just as reasonable on 7-5 as 7-6, denial of the last day of the stay is upheld.”

“The patient had persistent abdominal pain with oral intake noted on 4-27. As reliable oral intake would have been necessary to finish the patient’s treatment course in the outpatient setting safely, this finding would have led the physician to be reluctant to initiate discharge without further acute care monitoring. Denial of the last day of the stay is now overturned.”
“The physician’s reluctance to initiate discharge can be attributed to the patient’s slightly lower platelet count on March 21 as compared to March 20 (35,000 vs. 36,000) and vague abdominal complaints. Denial of day 3-21 is now overturned. However, the platelet count had returned to 36,000 on 3-22. If the abdominal ultrasound was essential to acute care management, it should have been performed on 3-21 when ordered, not delayed until 3-22. There are no apparent differences between the patient’s clinical conditions on 3-22 as compared to 3-23, when discharge was suggested. Day 3-23 was unnecessary, due solely to lack of transportation after expected discharge. Thus, denial of the stay after 3-21 is upheld.”

A special review situation arises when it has been initially determined that a potentially unnecessary procedure has been performed on a Medicaid patient. In such cases, a potential denial of the procedure, a potential denial of the admission to perform the procedure and a potential quality of care issue with the physician performing the procedure are all issued. The reconsideration decisions on these matters hinge entirely on the determination of medical necessity of the procedure. If, on reconsideration, the procedure was determined to be necessary, then a brief statement overturning the potential admission denial and quality of care issue should be included in the rationale submitted:

“The patient had a history of severe left hip pain and exam findings suggesting advanced osteoarthritis. Surgical intervention to replace the joint would have been the only remaining alternative in this setting. The patient was sufficiently mobile otherwise to benefit clinically from this intervention. Path report did confirm the advanced osteoarthritis. Thus, the total hip replacement procedure was medically necessary and should not be denied. As the procedure was necessary, there is no QOC issue for performing it. As the procedure was necessary, the admission to perform it was also medically necessary.”

If the procedure is determined on reconsideration to be unnecessary, then the denial of admission as well as the potential QOC issue must be upheld.

“Information provided on reconsideration is inadequate to confirm the medical necessity of hysterectomy in this patient’s case. The patient is relatively young (22) and there has been no trial of hormone therapy and/or NSAID treatment attempted. Given the patient’s young age, all conservative medical options should be exhausted prior to proceeding to irreversible surgical intervention. Therefore, the hysterectomy remains denied as medically unnecessary. As the procedure was not medically necessary, the admission to perform it should remain denied. As the procedure was not medically necessary, the QOC issue for performing it is upheld.”
5. Quality of care review

When providing peer review for Medicaid cases with potential quality of care concerns, the reviewer is responsible for determining whether the quality of care provided met professionally recognized or expected standards. IRCs refer medical records in which it appears care failed to meet established standards to reviewers for review. While quality of care is perhaps the most difficult type of review to perform, it is one of the most critical aspects of beneficiary protection and the improvement of medical care. During the course of a review of a medical record, a reviewer may occasionally identify an apparent quality of care concern that was not identified by the IRC. In such instances, the reviewer should write a rationale clearly identifying the concern.

With quality of care review, it is critical reviewers objectively apply their medical education, training, experience, and any professionally recognized standards of care to the question at hand and their review of the medical record. Reviewers must provide a complete rationale with substantiating information obtained directly from the record. They may reference any supporting resources and documentation and must avoid inflammatory or judgmental wording. This rationale will be provided substantially unchanged to the involved practitioner/provider, who will then be given the opportunity to submit additional information to support their course of treatment, decisions, actions, etc., through the reconsideration process.

A quality of care issue may arise as an aberrant, single episode in which care could have reasonably been expected to be better. Quality of care issues may also be recognized as a part of a pattern of substandard care, or as an example of egregious substandard care in which the patient was harmed or placed at imminent risk of harm.

On rare occasions, reviewers may run across a case with a considerable quality of care concern that on initial review may appear egregious in nature. A gross and flagrant violation of a health care provider’s obligation may occur in one or more instances and presents an imminent danger to the health, safety or well-being of a program patient, or unnecessarily places the program patient in high-risk situations, such as risk of substantial and permanent harm. (Please note that due to the potentially inflammatory nature of this term – “gross and flagrant” – we do not use it in rationales, which are a point of direct communication with a practitioner/provider.)

Please note on the review summary – but not within the rationale, which will be used largely unchanged in correspondence – if the quality of care issue appears to represent a gross and flagrant concern.

The practitioner/provider will be notified of any quality of care concern via correspondence from AFMC. A reconsideration request letter is usually submitted, detailing mitigating facts concerning the issue or disputing the facts used to cite the initial concern. Quality issues may be overturned or confirmed on reconsideration review, based on careful consideration of the data available and application of general medical expertise. The reviewer should take particular care to avoid applying the advantage of hindsight in a situation where the outcome was less than optimal. Once the reviewer reaches a final decision, he or she should provide a specific, case-
based rationale justifying the determination. If the quality of care concern is overturned on reconsideration review, the rationale confirming this is all that is needed.

An example of such a rationale follows:

“The patient presented to this facility with bradycardia and unexplained abdominal pain. Federal law requires a facility to perform adequate examination and diagnostic evaluation to determine if a patient is stable for transfer, prior to transfer being effected. In this case, that exam and evaluation confirmed a potential small bowel obstruction and the need to transfer to another facility for treatment intervention. The CT scans performed at this facility were thus medically necessary, even though repeat studies were done elsewhere. The fact that CT scans of the abdomen and pelvis were performed at this facility is clearly confirmed by the medical record. There is no QOC issue here. No opportunity for quality improvement exists.”

The CT scans performed at this facility were thus medically necessary, even though repeat studies were done elsewhere. The fact that CT scans of the abdomen and pelvis were performed at this facility is clearly confirmed by the medical record.

Should a reviewer identify a case that suggests that the practitioner’s management of the care represents a danger to the patient or caused actual harm to the patient, the reviewer should write a rationale explaining why the care was below the expected standard of care and how the patient was harmed, or placed at risk for harm, from this management. A case of this nature will usually be referred for appropriate investigation for potential sanctions.
6. Medicaid specialized reviews

The following sections provide a brief description of specialized reviews performed by AFMC for Arkansas Medicaid. If a reviewer is enlisted to perform any of these types of review, AFMC will provide additional detailed instructions as necessary to be inserted in the appropriate section of the reviewer manual.

An IRC first performs a screening review. If the IRC cannot approve the services in question, he or she refers the medical record to a reviewer for consideration of the medical necessity of services (see section 2.53 of this manual for the reviewer’s responsibilities in review).

Medicaid specialized reviews include:

- Medicaid Utilization Management Program (MUMP)
- Extension of benefits (EOB)
- Procedure prior authorization
- Assistant at surgery
- Child health management services (CHMS)
- Targeted case management (TCM)
- Transplant
- Hyperalimentation and prosthetic services

6.1 Medicaid Utilization Management Program (MUMP)

In-house specialized review

AFMC performs a MUMP concurrent review to determine reimbursement for all Medicaid extended lengths of stay for all inpatient acute care/general and rehabilitative hospital services. Services performed in freestanding psychiatric facilities are excluded.

This policy affects all age groups and Medicaid eligibility categories except for beneficiaries under age 1. The policy includes all acute care/general and rehabilitative hospitals, in or out of state.

These reviews are performed primarily by an in-house reviewers. Reconsideration review should focus on the medical necessity of the admission or day(s) denied in the initial notification. More days cannot be denied on reconsideration review than were denied in the initial notice.

The patient must actually require and receive an acute level of care for either admission or length of stay initial denials to be overturned. Custodial care, patient awaiting transportation, rehabilitative care or patient refusal to accept reasonable discharge are not sufficient reasons to approve continued acute care.
6.2 Extension of benefits (EOB)

In-house specialized review

Below is a brief description of this type of review. If a reviewer is enlisted to perform any of these types of review, AFMC will provide additional detailed instructions as necessary to be inserted in the appropriate section of the Physician Reviewer Manual.

Arkansas Medicaid has a benefit limit of $500 for lab and x-ray services, 12 physician visits (in a physician’s office, patient’s home or nursing home), and 12 outpatient hospital visits (non-emergency ER visits, therapy services and related physician services) per state fiscal year (July 1 – June 30).

At the request of Arkansas Medicaid, effective February 2005, AFMC began review for Medicaid EOB requests for lab, x-ray, clinic/office and outpatient services. A request for EOB is considered only after a beneficiary has exhausted his or her benefit limit. A request for EOB must be for medically necessary services and a provider may file the request on behalf of a beneficiary.

The beneficiary is responsible for payment of all services that exceed the benefit limit. However, if the provider files an EOB and it is denied as not medically necessary, the beneficiary is responsible only if the provider informed him or her prior to the service that Medicaid may not pay and the beneficiary signed a waiver indicating an understanding that he or she would be financially responsible. Only if the beneficiary signs such a waiver and elects to receive the service(s) may the provider then bill the beneficiary.

If the provider files the EOB request and omits information or fails to return information that is requested based on Medicaid policy, it is considered a billing error by the provider and the beneficiary is not financially responsible.

A reviewer’s review of this issue would be restricted to whether the provided treatment was medically necessary. Technical issues regarding failure to submit proper documentation, improper billing techniques, etc., would not enter into the reviewer’s decision.

6.3 Procedure prior authorization

In-house specialized review

Below is a brief description of this type of review. If a reviewer is enlisted to perform any of these types of review, AFMC will provide additional detailed instructions as necessary to be inserted in the appropriate section of the reviewer manual.

Medicaid requires that some surgical procedures be authorized by AFMC prior to the performance of the procedure. Procedures can require authorization regardless of whether they are performed on an inpatient or outpatient basis.
CPT codes that require prior authorization by AFMC can be found in the Arkansas Medicaid Provider Manual (Section 262.000). Medicaid disseminates these manuals, as well as the manual updates, to all Arkansas Medicaid providers.

These reviews are performed primarily by an in-house reviewer. Reconsideration review should focus on the medical necessity of the proposed procedure that was initially denied.

### 6.4 Assistant at surgery

**In-house specialized review**

For medical payment to be made to an assistant surgeon, the physician who wishes to use an assistant surgeon must obtain prior authorization from AFMC. See Section 261.100 of the Arkansas Medicaid Provider Manual for prior authorization instructions. This provision applies to all surgery. (See also Section 251.110 in the Arkansas Medicaid Provider Manual for information about assistant surgery program coverage.)

These reviews are performed primarily by an in-house reviewer. Reconsideration review should focus on why a second surgeon (not a scrub technician or other staff) was required to complete the procedure safely. Unwillingness of a facility to provide appropriate support OR staff is not justification for an assistant surgeon; nor is failure of the primary surgeon to have adequate training to perform a procedure unassisted, when that procedure is normally performed by a single surgeon, is also not justification for an assistant surgeon.

### 6.5 Child health management services (CHMS)

*Below is a brief description of this type of review. If a reviewer is enlisted to perform any of these types of review, AFMC will provide additional detailed instructions as necessary to be inserted in the appropriate section of the reviewer manual.*

AFMC performs prior authorization review of CHMS admission and procedures/services. CHMS clinics provide both developmental and medically focused treatment for children who are Arkansas Medicaid beneficiaries and meet the qualifying criteria. A broad array of services is available to diagnose and treat both developmental delays and chronic medical conditions. These services are available in a day school setting and include physician and nursing services, physical therapy, occupational therapy, speech therapy, nutrition, early childhood developmental teaching, and psychological services.

All services provided to a child must be included in an individual treatment plan signed by the CHMS pediatrician and must include follow-up to ensure that the treatment has been done. The child’s primary care physician must approve the plan for treatment before services can begin. CHMS are delivered to children with the most significant medical and/or developmental diagnoses who require multidisciplinary treatment.

Prior authorization is required for all treatment services provided in a CHMS clinic. If a non-physician reviewer is unable to approve services as requested, the record is referred to a
reviewer for medical necessity review. The review should be performed using medical expertise and training to decide the medical necessity of the individual case. The review should not be performed based on criteria or guidelines.

6.6 Targeted case management (TCM)

_Below is a brief description of this type of review. If a reviewer is enlisted to perform any of these types of review, AFMC will provide additional detailed instructions._

TCM is an activity that assists individuals in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. TCM services are referrals for service that assist beneficiaries in accessing all medical, social, educational and other services appropriate to the child’s needs. TCM does not include the services themselves, transportation to services, observation of services, etc. AFMC performs prior authorization review for TCM services for Medicaid-eligible beneficiaries under age 21.

To be reimbursed under Medicaid, TCM services must be:

- Medically necessary
- Prescribed because of a need identified on an EPSDT exam for children who are not eligible for developmental disabilities services (DDS)
- Provided to outpatients only (discharge planning is a required condition for payment under Medicaid to inpatient facilities, whether they are acute care hospitals, rehabilitative hospitals, inpatient psychiatric facilities, nursing homes or residential treatment facilities; all new equipment needs identified prior to the patient’s discharge must be coordinated by the inpatient facility)
- Provided by a case management provider chosen by the family
- Provided to beneficiaries who have no reliable and available family members to provide the needed case coordination
- For services that directly affect the patient

If a non-physician reviewer is unable to approve services as requested, the record is referred to a reviewer for medical necessity review. The reviewer should use medical expertise and training — not criteria or guidelines — to decide the medical necessity of the individual case.

6.7 Transplants

_Below is a brief description of this type of review. If a reviewer is enlisted to perform any of these types of review, AFMC will provide additional detailed instructions as necessary._

Corneal, kidney, pancreas, meniscus and skin transplants are pre-certified through the MUMP pre-certification process utilizing in-house reviewers. If the in-house reviewer is unable to approve the procedure, it is denied. If the physician or hospital requests a reconsideration review, the case file is forwarded to a specialist in the area under review.
All other proposed transplants (heart, liver, lung, bone marrow, stem cell, etc.) are processed individually by Arkansas Medicaid. When Medicaid receives a request, it forwards the entire medical record to AFMC for review. AFMC then forwards the record to an appropriate reviewer in the specialty under review. Generally, the information is sent overnight to the reviewer with a three- to five-day turnaround on review. In the case of an emergency transplant, the reviewer is asked to do a special expedited review and to follow-up with a telephone call and fax to AFMC with the review results (approval/denial with rationale) within 24 hours. The reviewer should then return the medical record(s) and the original review sheet to AFMC. AFMC notifies the requesting physician and hospital of the review decision. If the practitioner/provider disagrees with the review decision, they can request a reconsideration review. As with any denial, both the provider and the beneficiary may request an appeal of the AFMC determination through the Office of Appeals and Hearings at the state Department of Human Services.

6.8 Hyperalimentation and prosthetic services

AFMC performs medical necessity reviews for hyperalimentation and prosthetic services. The hyperalimentation program includes total parenteral nutrition and sole source enteral nutrition. Under the prosthetics program, AFMC is responsible for the prior authorization review of respiratory and diabetic equipment, some medical supplies, enteral nutrition infusion pump and enteral feeding supplies for beneficiaries under age 21, durable medical equipment, orthotic/prosthetic devices, specialized rehabilitation equipment, and augmentative communication devices.

If a non-physician reviewer is unable to approve medical necessity of the requested services, the record is referred to a reviewer for review. The reviewer must give a specific rationale for any service that is denied or approved at a reduced level. This rationale is incorporated into the provider and beneficiary notification letters and must explain why the services were not approved as requested.

As with all reviews performed by Reviewers, if you are asked to perform a review of this nature, you should use your medical expertise and training — not criteria or guidelines — to decide the medical necessity of the individual case.
Sections 7 – 14 RESERVED
15. Appendix

15.1 Glossary

**AFMC**
Arkansas Foundation for Medical Care. The QIO for the State of Arkansas since 1972.

**Beneficiary**
Any recipient of services paid for by Medicaid or other programs.

**Billing error denial**
A one-day length of stay ordered by the physician as observation yet billed by the hospital as an acute care stay.

**Child health management services (CHMS) review**
Specialized review. Prior authorization review for the medical necessity of admission and procedures administered under the CHMS program of Arkansas Medicaid. CHMS clinics provide both developmental and medically focused treatment for children who are Arkansas Medicaid beneficiaries and who meet the qualifying criteria. A broad array of services is available to diagnose and treat both developmental delays and chronic medical conditions. These services are available in a day school setting and include physician and nursing services, physical therapy, occupational therapy, speech therapy, nutrition, early childhood developmental teaching and psychological services.

**CMS**
The federal Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration, or HCFA). The government entity responsible for the administration of Medicare and oversight of state health care programs.

**Criteria**
Predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of a health care service may be compared.

**EMR-CD**
An electronic medical record in CD format.

**EMR (no “CD attachment”)**

**Health Care Finance Administration (HCFA)**
Former name of the Centers for Medicare & Medicaid Services (CMS).

**Health Care Quality Improvement Program (HCQIP)**
Instituted in the early 1990s during the Peer Review Organization’s 4the Scope of Work with a
focus on evaluation, intervention, and follow-up related to health care topics. HCQIP encourages partnerships and collaborative efforts.

**Health care practitioners/providers’ obligations**
Defined in Section 1156 of the Social Security Act (42USC 1320c-5), a health care practitioner/provider’s obligations are to ensure, to the extent of his/her authority, that services or items ordered or provided:

1. will be provided economically and only when, and to the extent, medically necessary;
2. will be of a quality that meets professionally recognized standards of health care; and
3. will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

**Health care service(s)**
Those services or items for which payment may be made (in whole or in part) by state health care programs or other programs.

**Internal review coordinator (IRC)**
A registered nurse, working in the Fort Smith office of AFMC, reviewing medical records as assigned and performing precertification review of certain procedures and lengths of stay reimbursable by Medicaid or private companies.

**Medicaid**
A state-managed health plan for low-income individuals that is largely funded by the federal government. In Arkansas, the federal match is 3:1 – i.e., 75¢ of every Medicaid dollar is federal, with the remaining 25¢ coming from the state coffers.

**Medicaid Managed Care Services (MMCS)**
A division of AFMC that provides external quality review services to Arkansas Medicaid's ConnectCare, ARKids First, and other waivered managed care programs. MMCS includes five major areas of activity that monitor utilization and provide quality assurance and improvement: provider relations, beneficiary relations, transportation assistance, physician profiling information, quality improvement projects).

**Medicaid Utilization Management Program (MUMP)**
Telephonic review performed by AFMC IRCs that determines covered lengths of stay in inpatient, general and rehabilitative hospitals, in state and out-of-state, but does not apply to lengths of stay in psychiatric facilities.

**Medically necessary**
The American Medical Association has defined this term as: Health care services or products that a prudent physician would provide to a patient for preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician or
other health care provider. Under federal statute, Medicaid reviewers are obligated to consider the appropriateness of the extent to which and setting in which the care or proposed care takes place, as well as the standard of generally accepted practice.

Arkansas Medicaid defines a “medically necessary” service as one that “is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions which endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a ‘course of treatment’ may include mere observation or (where appropriate) no treatment at all.”

**Medicare**
The federal health plan for the elderly and disabled.

**Norm**
A pattern of performance in the delivery of health care services that is typical for a specified group.

**Norms**
Numerical or statistical measures of average observed performance in the delivery of health care services.

**Office of Inspector General**
The investigative and legal counsel to government agencies.

**Practitioner**
A physician or other health care professional licensed under state law to practice his/her profession.

**Peer Review Organization (PRO)**
See Quality Improvement Organization (QIO)

**Physician Reviewer**
A physician member of AFMC performing review for AFMC on a prorated reimbursement basis.

**Peer review**
Peer review is a fundamental form of assuring appropriate application of medical care. It includes an evaluation of the medical necessity, appropriateness of setting and the quality of care as compared to professionally recognized standards.

**Personal care review**
Specialized review. Prior authorization review of personal care services which are designed to assist Arkansas Medicaid eligible children under the age of 21 with physical dependency needs related to the following activities of daily living: eating, bathing, dressing, personal hygiene, bladder and bowel requirements, or taking medications (tasks similar to those that a nurse's aide
would perform if the patient were in a hospital or a nursing facility). These services should supplement, not supplant other resources available to the child.

**Prenotification period**
The period after review from the date of the initial notification letter of a pending adverse decision before a final determination is made based on information available in the medical record and/or submitted by the provider/practitioner. The length of time varies according to the review.

**Principal diagnosis**
The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital.

**Principal procedure**
The procedure performed for definitive treatment of the principal diagnosis, rather than for diagnostic or exploratory purposes, or to treat a complication. The procedure most related to the principal diagnosis.

**Prior auth/prior authorization**
Review prior to performance of a procedure or admission to determine medical necessity of that procedure or admission in that setting.

**Profile**
Aggregate data in formats that display patterns of health care services over a defined period.

**Profile analysis**
Review and analysis of profiles to identify and consider patterns of health care services.

**Provider**
A hospital or other health care facility, agency, or organization.

**Quality Improvement Organization (QIO)**
Originally named Professional Standards Review Organization (PSRO), these organizations were mandated to assist in evaluating costs to Medicare beneficiaries. In the early 1980s, the PSRO became known as the Peer Review Organization (PRO). In 1992 – with the 4SOW, the Health Care Financing Administration (HCFA, now known as CMS) shifted the focus to quality improvement and developing partnerships with practitioners/providers to encourage excellence in quality of care. In 2002, CMS renamed the PRO to the QIO.

**QIO Medicaid review responsibilities**
Application of QIO Medicare review responsibilities to a Medicaid contract (as detailed in the SSA 1903(a)(3)(C); 42 USC 1396b-(a)(3)(C)); 42 CFR 431 §630: Coordination of Medicaid with QIOs).

**Quality of care concern**
An issue found at review to represent possible substandard care. The practitioner/provider is
afforded an opportunity to address the quality of care concern(s) and defend his/her position, course of treatment, etc. during the pre-notification period.

**Quality of care issue**
An issue found after the pre-notification period to represent substandard care. Any additional information provided during the pre-notification period by the practitioner/provider failed to substantiate course of treatment, etc. The quality of care issue is confirmed.

**Quality Review Study**
An assessment conducted by AFMC of a patient care problem for improving patient care through peer analysis, intervention, resolution of a problem and follow-up.

**Reconsideration**
Pertains to Medicaid review: second level physician review performed at the request of the provider/practitioner with the submission of additional information to rebut issues confirmed at first level review.

**Response determination category (RDC)**
In quality of care review, after review a reviewer must make a determination of whether “care could have been better” or “no substantial improvement opportunities are identified.” If “care could have been better,” the second RDC includes whether “care could reasonably have been expected to be better,” “care failed generally accepted guidelines or usual practice,” or “care was grossly and flagrantly unacceptable.”

**Review sheet**
The computer-generated front sheet sent to IRCs designating a specific case for review. It contains information including patient identifiers, dates of service, principal diagnosis code, etc.

**Review summary**
A form designed by AFMC, which is changed periodically, due to review requirements. The top portion is completed by the IRC. The bottom portion is completed by a PA, answering questions raised by the IRC. Review rationale for both favorable and adverse decisions is documented here.

**Scope of work (SOW)**
A Medicare contractual term to differentiate a contract cycle (a contract cycle lasts three years).

**Screening criteria**
Criteria developed by Arkansas physicians and/or CMS, for use by IRCs and IRCs to allow the non-physician reviewers to make a positive decisions regarding necessity of admission and continued stay or necessity of procedure(s) performed.

**Secondary diagnoses**
Those conditions that played relevant roles during the hospital stay. They include, but are not limited to:
1. Comorbidity: A preexisting condition, which has been shown statistically to increase the length of stay by at least one day in approximately 75% of the cases for a particular DRG.

2. Complication: A complication arising during the hospital stay, which has been shown statistically to prolong the length of stay by at least one day in 75% of the cases in a particular DRG.

**Serious risk**
Includes situations that may involve the risk of unnecessary treatment, prolonged treatment, incorrect treatment, medical complication, premature discharge, physiological or anatomical impairment, disability, or death.

**Significant procedure**
A procedure that is surgical in nature, carries a procedural risk, carries an anesthetic risk or requires specialized training.

**Social Security Act (SSA)**
Signed into law in 1935 as a means of aiding the elderly and needy. Many changes have been enacted through the years. Title XVIII is representative of Medicare while Title XIX defines the Medicaid program.

**Targeted case management (TCM)**
Specialized review. Review for the medical necessity and appropriateness of TCM, which is an activity that assists individuals in gaining and coordinating access to necessary care and services appropriate to the needs of the individual (including medical, social, and educational). TCM does not include the services themselves, transportation to services, observation of services, etc.

**Urban vs. Rural**
URAC has suggested that review be performed by true peers, with reviewing physicians from rural areas reviewing cases involving rural hospitals and rural physicians and urban reviewing physicians reviewing cases involving urban providers and practitioners. Urban areas in the state of Arkansas, as designated by CMS, are Little Rock, North Little Rock, Hot Springs, Pine Bluff, Texarkana, Fort Smith, Fayetteville, Springdale, Rogers, Jonesboro and West Memphis. All other areas in the state are considered rural.
### 15.2 Abbreviations and acronyms

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AFMC</td>
<td>Arkansas Foundation for Medical Care</td>
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<td>ASMB</td>
<td>Arkansas State Medical Board</td>
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<tr>
<td>Bene</td>
<td>Medicare beneficiary</td>
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<tr>
<td>BIPA</td>
<td>Benefits Improvement and Protection Act</td>
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<tr>
<td>BOD</td>
<td>AFMC board of directors</td>
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<tr>
<td>CAP</td>
<td>Corrective action plan</td>
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<tr>
<td>CCVS</td>
<td>Centralized Credentials Verification Service</td>
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<td>CDAC</td>
<td>Clinical Data Abstraction Center</td>
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<tr>
<td>CEU</td>
<td>Continuing education units</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CHMS</td>
<td>Child Health Management Services</td>
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<tr>
<td>CME</td>
<td>Continuing medical education</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>CPT</td>
<td>Current procedural technology</td>
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<tr>
<td>DHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>DME</td>
<td>Durable medical equipment</td>
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<tr>
<td>DMS</td>
<td>DHS, Division of Medical Services – Arkansas Medicaid</td>
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<td>DRG</td>
<td>Diagnostic related group</td>
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<td>EOB</td>
<td>Extension of benefits</td>
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<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment and Labor Act</td>
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<tr>
<td>FI</td>
<td>Fiscal intermediary</td>
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<tr>
<td>G&amp;F</td>
<td>Gross and flagrant violation</td>
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<tr>
<td>HCQIP</td>
<td>Health Care Quality Improvement Program</td>
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<tr>
<td>HCFA</td>
<td>Health Care Finance Administration – now CMS</td>
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<tr>
<td>HINN</td>
<td>Hospital issued notice of noncoverage</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<tr>
<td>HPMP</td>
<td>Hospital Payment Monitoring Program</td>
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<tr>
<td>IPPS</td>
<td>Inpatient Prospective Payment System</td>
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<tr>
<td>IRC</td>
<td>Internal review coordinator</td>
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<tr>
<td>LTACH</td>
<td>Long-term acute care hospital</td>
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<td>MMCS</td>
<td>Medicaid Managed Care Services</td>
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<tr>
<td>MUMP</td>
<td>Medicaid Utilization Management Program</td>
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<tr>
<td>NODMAR</td>
<td>Notice of discharge and Medicare appeal rights</td>
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<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
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<tr>
<td>PA</td>
<td>Physician Reviewer</td>
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<tr>
<td>PCP</td>
<td>Primary care physician</td>
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<tr>
<td>PL</td>
<td>Public law</td>
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<tr>
<td>PPS</td>
<td>Prospective Payment System</td>
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<td>Precert</td>
<td>Precertification</td>
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<td>Prior Auth</td>
<td>Prior authorization</td>
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<tr>
<td>PRO</td>
<td>Peer Review Organization</td>
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<tr>
<td>QIO</td>
<td>Quality Improvement Organization</td>
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<tr>
<td>QIP</td>
<td>Quality improvement plan</td>
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<tr>
<td>QOC</td>
<td>Quality of care</td>
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<tr>
<td>Abbreviation</td>
<td>Definition</td>
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<tr>
<td>QRC</td>
<td>Quality review committee</td>
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<tr>
<td>Recon</td>
<td>Reconsideration review</td>
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<tr>
<td>SCHIP</td>
<td>State Children’s Health Insurance Program</td>
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<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
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<tr>
<td>SOW</td>
<td>Scope of work</td>
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<tr>
<td>SSA</td>
<td>Social Security Act</td>
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<tr>
<td>TCM</td>
<td>Targeted case management</td>
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<tr>
<td>TEFRA</td>
<td>Tax Equity &amp; Fiscal Responsibility Act</td>
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<tr>
<td>USC</td>
<td>United States Code</td>
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15.3 Statutory and regulatory references

For those interested, below are applicable references to the Social Security Act (SSA), US Code (USC), and Code of Federal Regulations (CFR) that compose the background and authority of the quality improvement organization activities performed by AFMC for both Medicare and Medicaid. You may find full text at the cited internet address.

Statutory references

SSA Title XI, Part B – Peer Review of the Utilization and Quality of Health Care Services

42USC 1320c – codification of SSA Title XI (QIOs)


Public Law 106-554, section 521 – Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

Regulatory references

42CFR 480 – Confidentiality
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr480_04.html

42CFR 476 – QIO Review responsibilities
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr476_04.html

42CFR 478 – Reconsideration and Appeals
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr478_04.html
15.4 AFMC staff contacts

For the medical aspect of review:

Tom Tinsman, MD  
AFMC Associate Medical Director  
(479) 573-7710 – voice  
(877) 650-2362, ext. 7710 – voice  
(479) 649-0799 – fax  
ttinsman@afmc.org  
drdedlift@aol.com

Jarrod McClain, RN, CPHM  
Assistant Vice President of Clinical Review  
(479) 573-7780 – voice  
(877) 650-2362, ext. 7780 – voice  
(479) 573-7781 – fax  
jmcclain@afmc.org

Amy Carson, RN, CPHM  
Director, Clinical Review  
(479) 573-7760 – voice  
(877) 650-2362, ext. 7760 – voice  
(479) 573-7761 – fax  
acarson@afmc.org

For questions relating to reimbursement and the technical aspect of the review process:

Patricia Williams

Senior Executive Assistant, Board of Directors  
(479) 573-7612 – voice  
(877) 650-2362, ext. 7612 – voice  
(479) 573-7613 – fax  
pwilliams@afmc.org

To notify of unavailable dates or issues relating to mailing records:

Ami Winters

Senior Program Coordinator, Internal Review B  
(479) 573-7746 – voice  
(479) 649-0776 – fax  
awinters@afmc.org
Karla Batey

Senior Program Coordinator, Internal Review C
(479) 573-7756 – voice
(479) 573-0799 – fax
kbatey@afmc.org
16. Physician reviewer memos

Periodically, it will be necessary for AFMC to issue memorandum directed by review patterns and issues, contract requirements with CMS or Arkansas Medicaid, legislative changes, etc. that will provide direction to reviewers in their review activities.

The information contained in this manual, as well as other internal AFMC memos, correspondence, or newsletters, may not be released to any non-AFMC employee or physician unless instructed to do so by a supervisor. The information distributed through internal documents is intended solely for staff and reviewers of AFMC. Information that needs to be communicated to non-AFMC employees and physicians will be directed to their attention through other established means. Anyone requesting copies of any communication between AFMC and reviewers should be directed to the senior executive assistant for the board of directors, who is listed in the staff contacts section of this manual.

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