QIO - Medical Support

Purpose:

The QIO performs various medical support functions outlined within our current contract. The various areas addressed are outlined in the following pages.

Performance Standards:

- Notify provider within 5 business days of receipt of claims inquiry with missing or incomplete information.
- Send final determination letter on a claims inquiry to the provider within 10 business days of receipt of complete documentation.
- Provide recommendations for exceptions to policy within 8 business days of receipt unless additional information is requested. If additional information is needed, request it within 2 business days of receipt.
- Complete 95% of ETP determinations within 10 business days of receipt of complete information. Complete 100% within 20 business days.

Paths of Business Procedures:

Policy Research, Development, and Consulting

See Attachment A: Policy Research

Step 1: QIO team receives request from Policy, Provider Cost Audit (PCA), Provider Services, or another unit for research on a specific topic. The team determines if there is sufficient documentation to perform the review or if additional information is needed. If additional information is needed, the requestor is informed of the documentation and/or information that is needed to complete the review. Review is completed upon receipt of additional documentation.

Step 2: The team will submit a System Action Memo (SAM) or request a Change Management Request (CMR), when necessary.

Administrative Law Judge (ALJ) Appeals

See Attachment B: Administrative Law Judge Appeals

Step 1: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the Notice of Decision (NOD) letter by contacting the local HHS office, by writing a letter to DHS Appeals Section, or by filing request online. The review process begins when an email appeal notice from HHS is received.

Step 2: All appeal activity is maintained on the appeal database and routed to the appropriate team. If the appellant requests a pre-hearing conference the manager will contact the appellant by telephone or email to obtain potential dates and times for the conference and schedules the conference. Arrangements for interpreter or TDD services are also scheduled.

Step 3: If new information is presented during the pre-hearing conference that may reverse the adverse decision, the team will discuss and pursue dismissal, as appropriate. If resolution is not achieved, the hearing proceeds as originally scheduled. The appeal case summary is developed using standard templates specific to each program. If needed, additional information will be requested from the provider, member, or other appropriate source.

Step 4: If RC's review of the case or additional information indicates that the adverse decision can be reversed, the RC will obtain necessary approval of services; i.e., paying the claim, approving the prior authorization, or approving services in IoWANS, and send letter to ALJ, IMW, and member requesting dismissal of appeal. If adverse decision is not reversed, the appeal packet is completed, including an appeal summary and exhibits of the member's medical information that was supplied and utilized in making the decision; program description, if applicable; Iowa Administrative Code (IAC) and/or Provider Manual references and/or criteria used in the decision. The completed packet is sent to the member, ALJ, IMW, and other involved parties, if applicable.

Step 5: Upon receipt of the hearing notice, the appeal database is updated and a calendar invite is sent to the manager and the RC handling the appeal.

Step 6: The appeal hearing is convened and conducted by the ALJ. Following the appeal, the appeal decision is entered into the appeal database and forwarded to the appropriate team. If decision is affirmed no further action is needed. If decision is reversed, the manager reviews the decision to determine if a director review is warranted. The manager may consult with respective DHS Policy specialist. If the DHS Policy specialist approved proceeding with the request for Director's review, the manager composes a memo and sends to DHS Policy appeals committee representative, within 10 days of receipt of the decision. All activity is updated in the appeal database.

Claims Pre-pay – Suspended Claims

See Attachment C: Suspended Claim Review

Step 1: MMIS has established criteria which cause a claim to suspend for review. Upon receipt of a suspended claim, the claim will display on the suspense report in OnBase. The RC will access the claim in MMIS with the Transaction Control Number (TCN) and determine the reason the claim suspended and determine if needed documentation is attached to the claim. The RC will determine if the documents received are sufficient to perform the review.

Step 2: The RC will review the claim to determine if Medicaid guidelines are met, medical necessity is substantiated, the fee schedule can be applied, or if manual pricing is required. Payment will be approved for all reasonable and necessary medical services and

supplies, subject to exclusions and limitations. The RC will also determine that the appropriate diagnoses and/or procedure codes were used and verify that the number of units billed is appropriate for services billed.

Step 3: MMIS will be updated to reflect review outcomes.

Provider Inquiries

See Attachment D: Provider Inquiries

Step 1: When the RC receives a provider inquiry, the appropriate claims information and documentation will be reviewed in MMIS and OnBase. If there is not sufficient documentation for review, the RC will request additional information needed to review the inquiry/appeal/ETP or deny the provider inquiry, utilizing the appropriate Provider Manuals, and IAC. If the service is payable, the RC will complete the response to the inquiry on the appropriate OnBase e-form.

Code Updates

See Attachment E: Code Updates (3 pages)

Step 1: Annually, the QIO will receive a file that includes ICD-10-CM diagnosis and surgical code updates to become effective October 1 of each year. Additionally, the team will receive a file from CMS for annual and quarterly HCPCS updates.

Step 2: The QIO will review these changes to determine if the changes made will affect whether the codes are covered or not.

Exception to Policy

See Attachment F: Exception to Policy

Step 1: A member, provider, or MCO may request an exception to policy (ETP) for non-covered services/items, pricing issues, or an adverse decision by contacting the local DHS office, by writing a letter to DHHS Appeals Section, or by filing online at http://dhs.iowa.gov/appeals/exceptions_policy. Additionally, ETPs may be requested for waiver services exceeding waiver rules. QIO staff will provide adequate and timely information to Policy in consideration of ETP requests. ETPs are granted at the discretion of DHS. Denial of an ETP is not appealable.

Step 2: Upon receipt of ETP, RC will review eligibility by member SID in MMIS and ensure all documentation is submitted with the request. If additional information is needed to perform the review, the request will be sent via email, fax, or telephone. If additional information is not received, the ETP will be denied due to insufficient information.

Step 3: If review is needed by the Medicaid medical director (MMD), the review will be forwarded.

Step 4: The RC will format draft recommendations for the request (approved, denied, dismissed, and withdrawn) and include pertinent information from the review to support the

recommended decision and send email notification of completed review to the assigned Policy program manager.

Program Review/Audit

Appropriate QIO staff will be available, as necessary, to assist DHHS with program review and/or audits.

Peer Review Panel

QIO Services provides consultants in a wide variety of specialties to ensure coverage for each type of review function performed. These consultants are utilized to afford like-specialties for review determinations.

Consultants are initially credentialed and then recredentialed every 2 years. Each consultant is required to attest to and sign a conflict of interest policy annually, as well as submit curriculum vitae, copies of professional diplomas, current professional liability claims history, board certification/eligibility, state licensure, non-disclosure statement, and a completed application. Telligen reimburses each consultant utilized.

Certification of New Outpatient Hospital Programs

QIO Services provides certification review for Cardiac Rehabilitation, Diabetic Education, Eating Disorders, Mental Health, Nutritional Counseling, Pain Management, and Pulmonary Rehabilitation programs in outpatient settings. Additional certification reviews may be requested by Policy. Requests for certification reviews are received through Provider Service inquiries and reviewed according to specifications located in the Iowa Medicaid Provider Manual, Acute Hospital Services, Chapter III Provider-Specific Policies.

Minimum Data Set

QIO Services will provide support and technical assistance for updates to the Minimum Data Set (MDS). Utilizing MDS data, the QIO will complete a quarterly nursing facility case mix and submit the case mix index scores to the PCA unit.

PERM Project Support

QIO Services will provide support for the Payment Error Rate Measurement (PERM) project by following up on all provider medical findings of overpayments and underpayments related to the PERM Project.

Claims and Benefit Committee Meeting

QIO staff will provide support for the internal and external Claims and Benefit committee meetings by researching agenda items and participating in discussions.

Administrative Support

QIO staff will provide administrative support to log, assign, and track all appeals and ETP requests for Policy and vendor staff. Additional tasks may be undertaken as assigned by the Medicaid Director or Policy staff.

Medicaid Clinical Advisory Committee

The MMD recruits a panel of Medicaid providers to serve as clinical advisors to the Medicaid program. The panel includes a variety of providers including physicians, physician assistants, and ARNPs. Procedures ensure timely completion and accurate summary of Clinical Advisory Committee (CAC) program activities and recommendations. Meetings are convened quarterly on a set schedule.

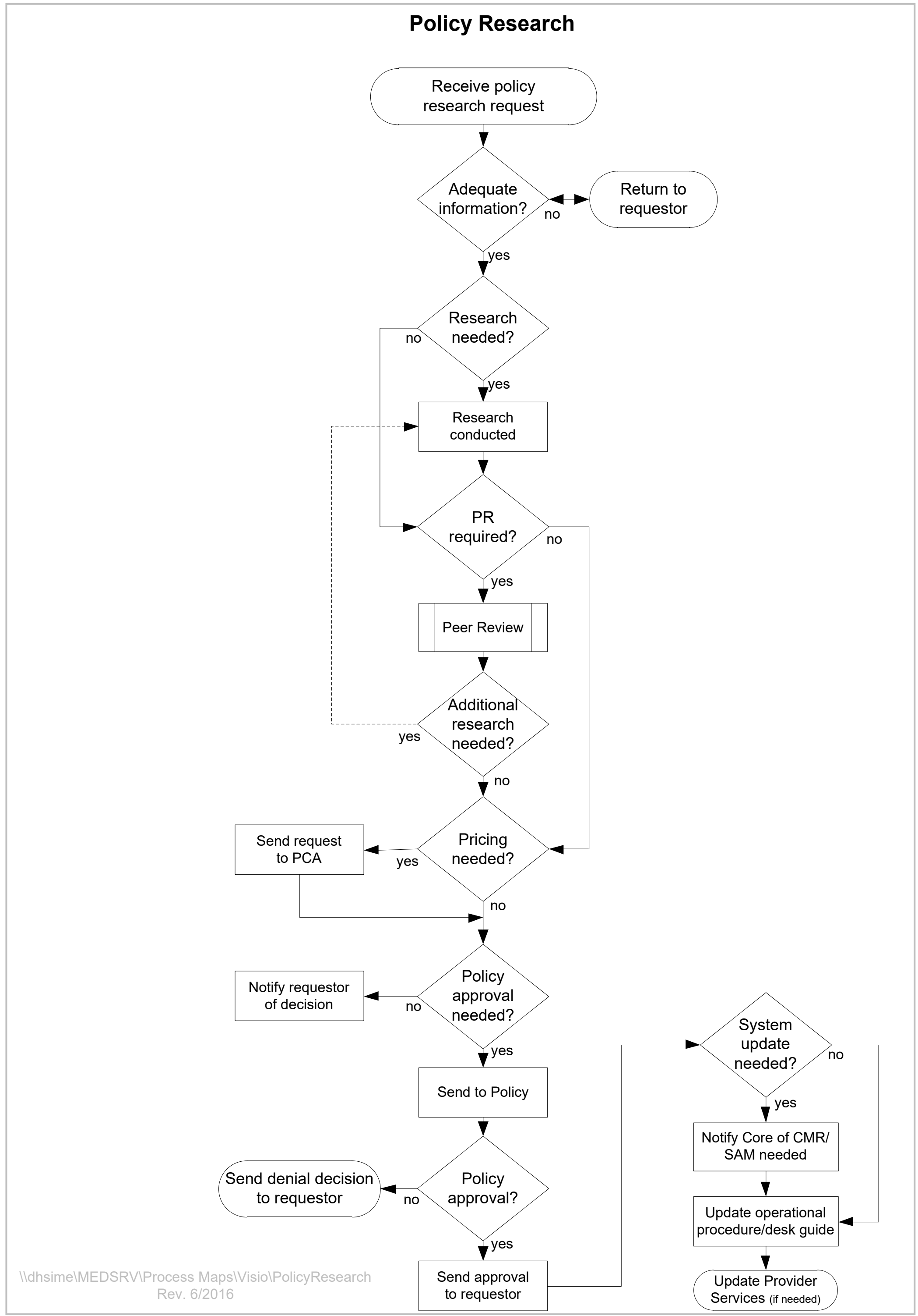
An annual report of CAC activities will be submitted for dissemination by the first of October following the end of the fiscal year.

Forms/Reports:

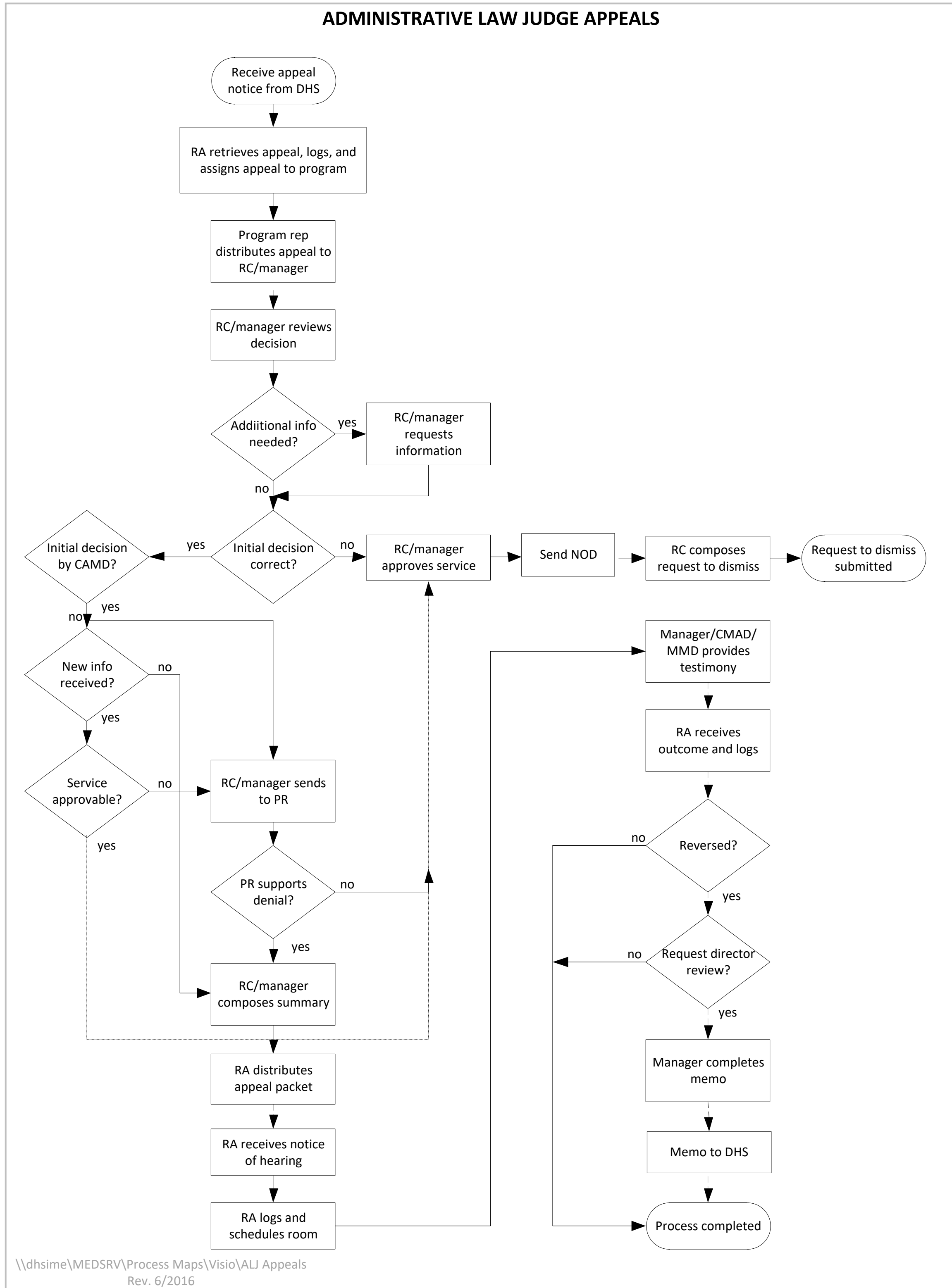
NA

Attachments:

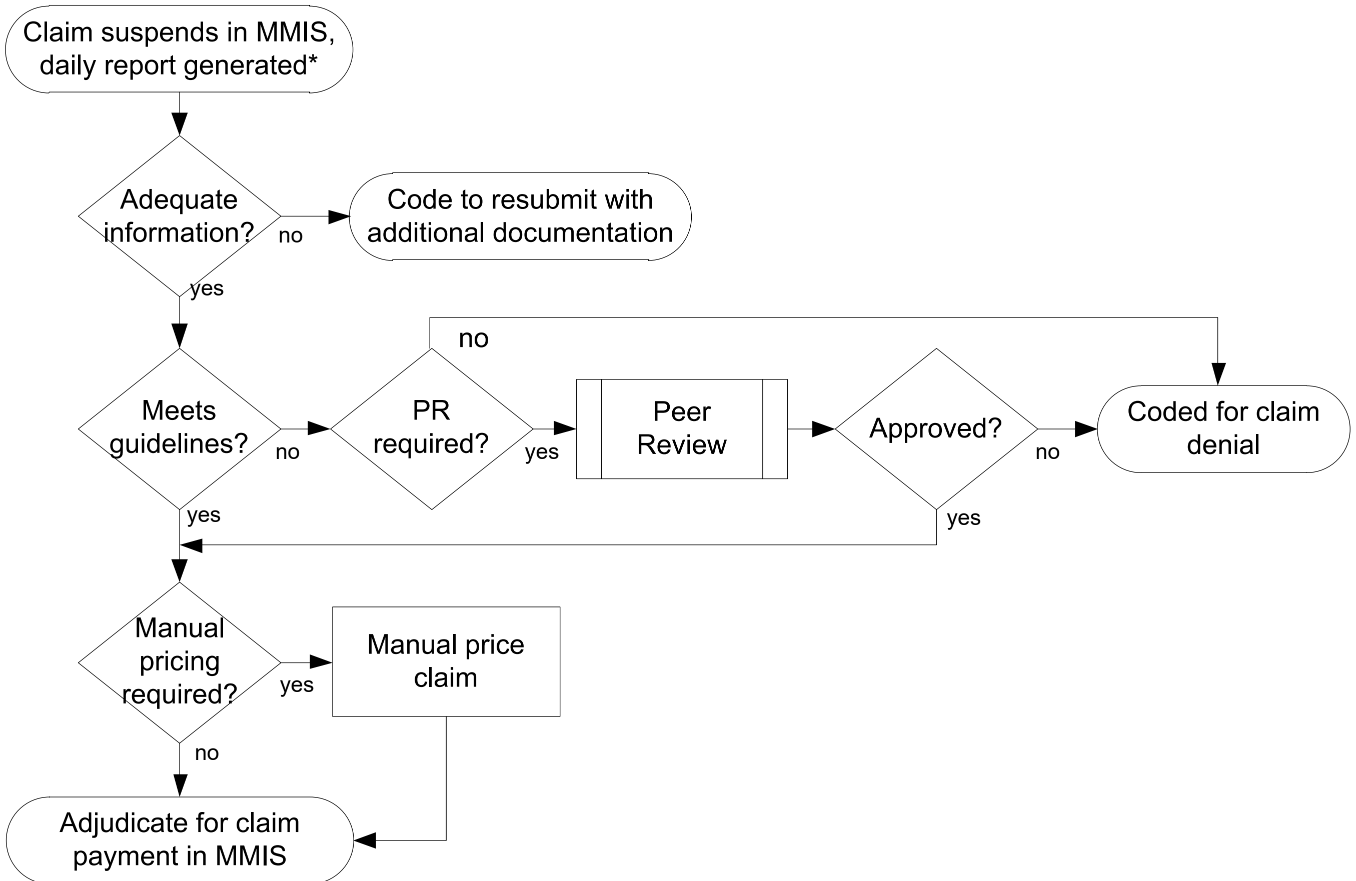
Attachment A: Policy Research flowchart



Attachment B: Administrative Law Judge flowchart



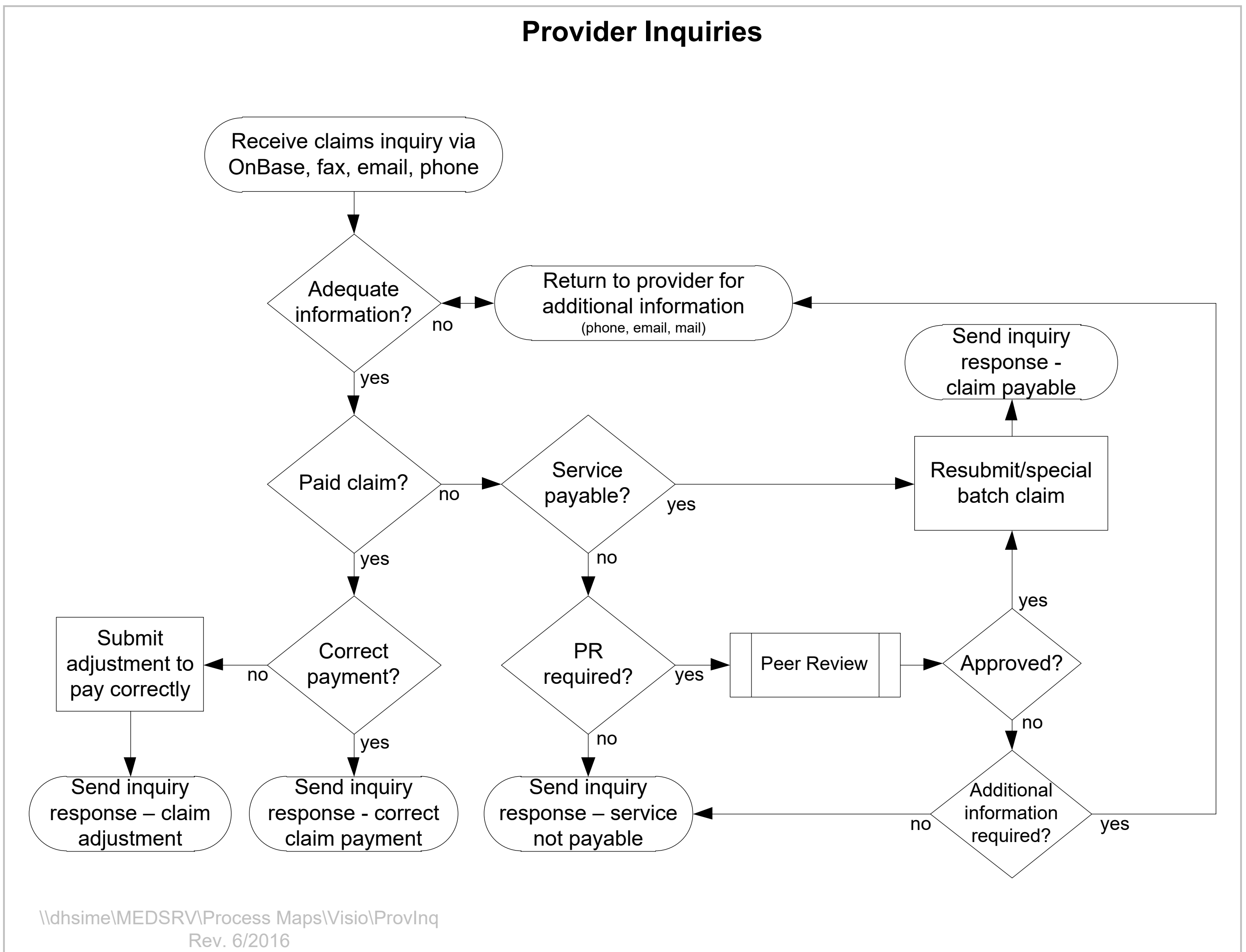
Attachment C: Suspended Claim flowchart



*\\dhsime\IMEUNIVERSAL\Medical Services\Claims Team\Claims Suspense Report.xls

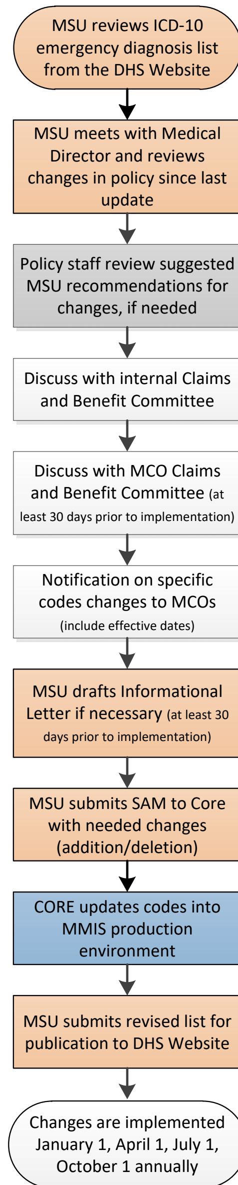
\\dhsime\MEDSRV\Process Maps\Visio\SuspClaim
Rev. 4/2018

Attachment D: Provider Inquiries flowchart



Attachment E: Code Updates flowcharts

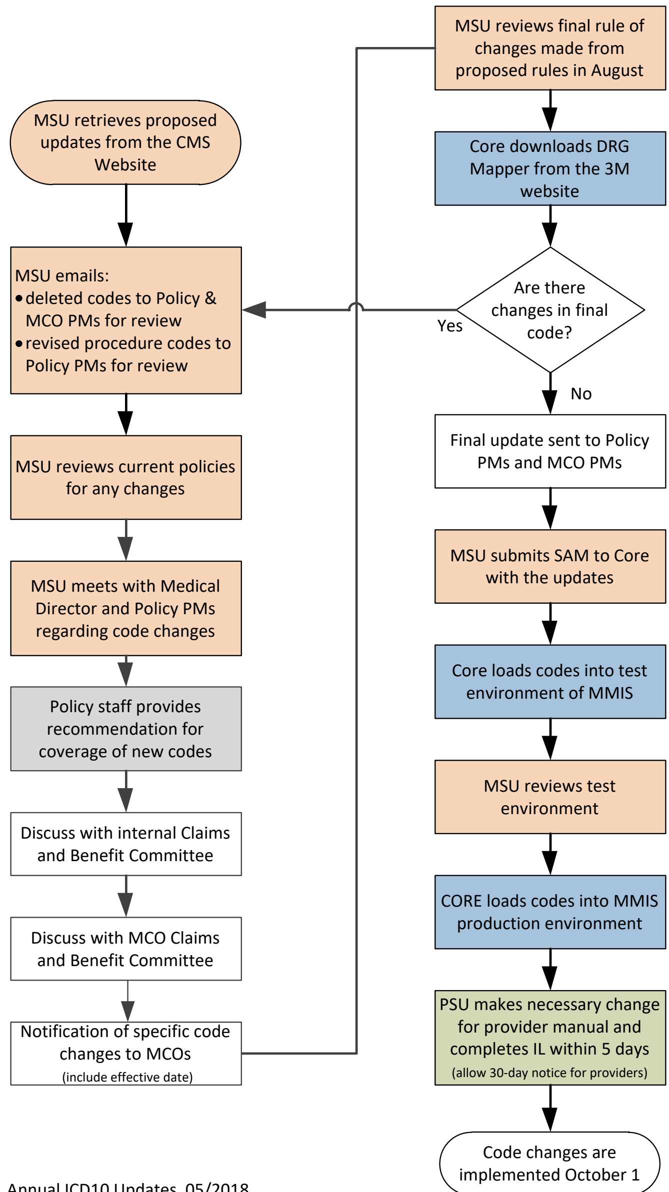
Process Blueprint – Quarterly ICD-10 Emergency Diagnosis Code Updates



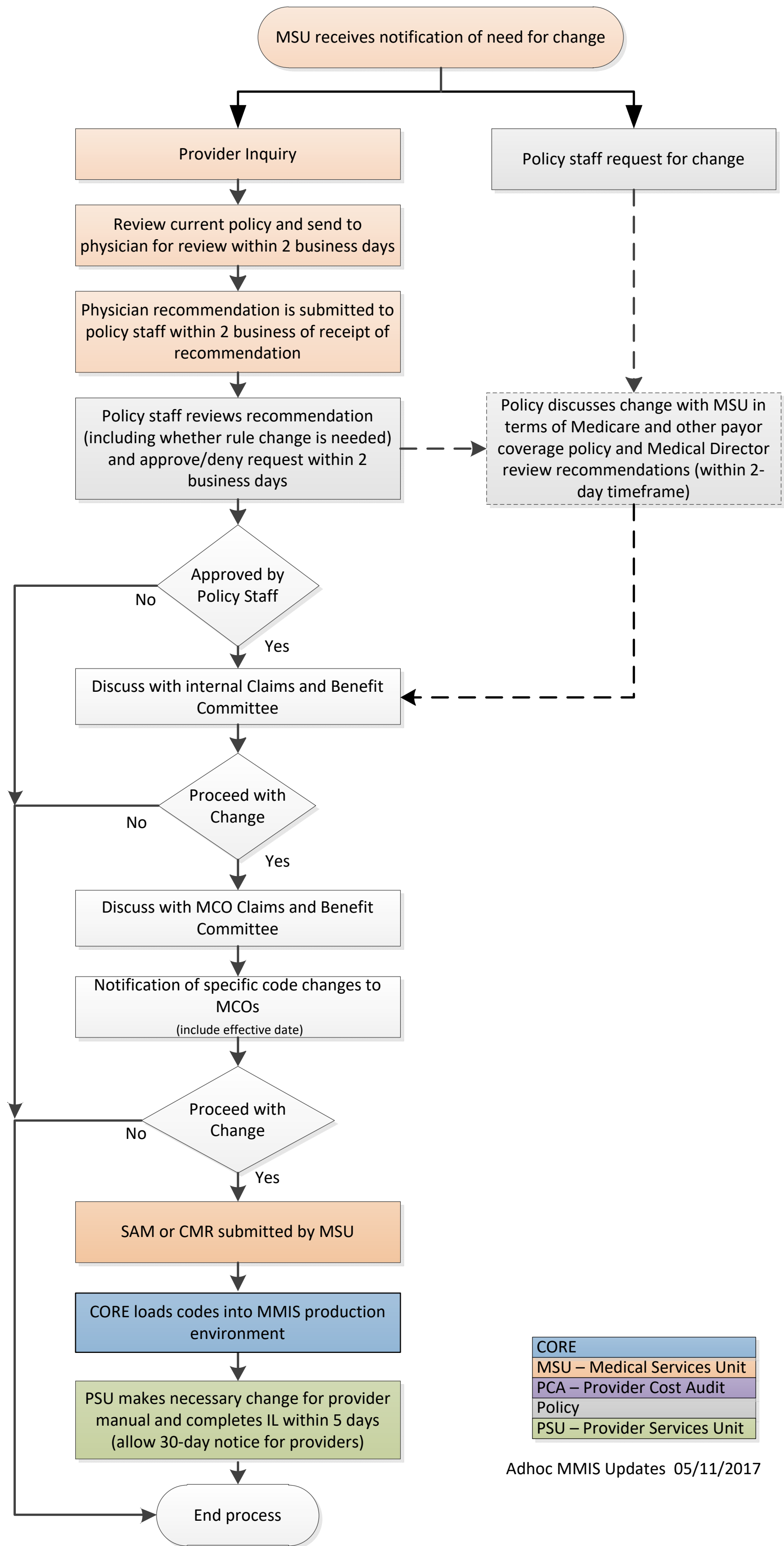
CORE
MSU – Medical Services Unit
PCA – Provider Cost Audit
Policy
PSU – Provider Services Unit

Quarterly ER Codes 5/22/2017

Process Blueprint – Annual ICD-10 Updates



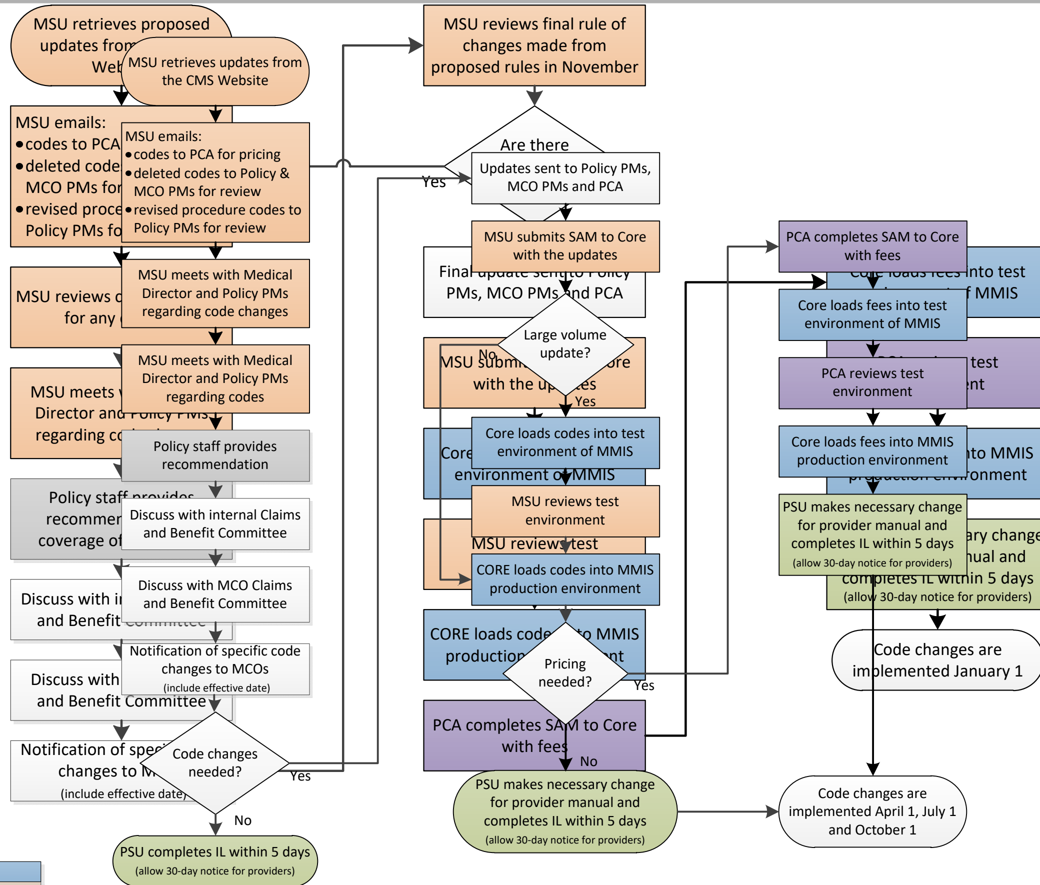
AD HOC CHANGE REQUESTS FOR MMIS UPDATES



Types of changes include, but are not limited to, place of service, provider type, fee schedule, physician administered drugs, etc.

Process Blueprint – Annual HCPCS Updates

Process Blueprint – Quarterly HCPCS Updates

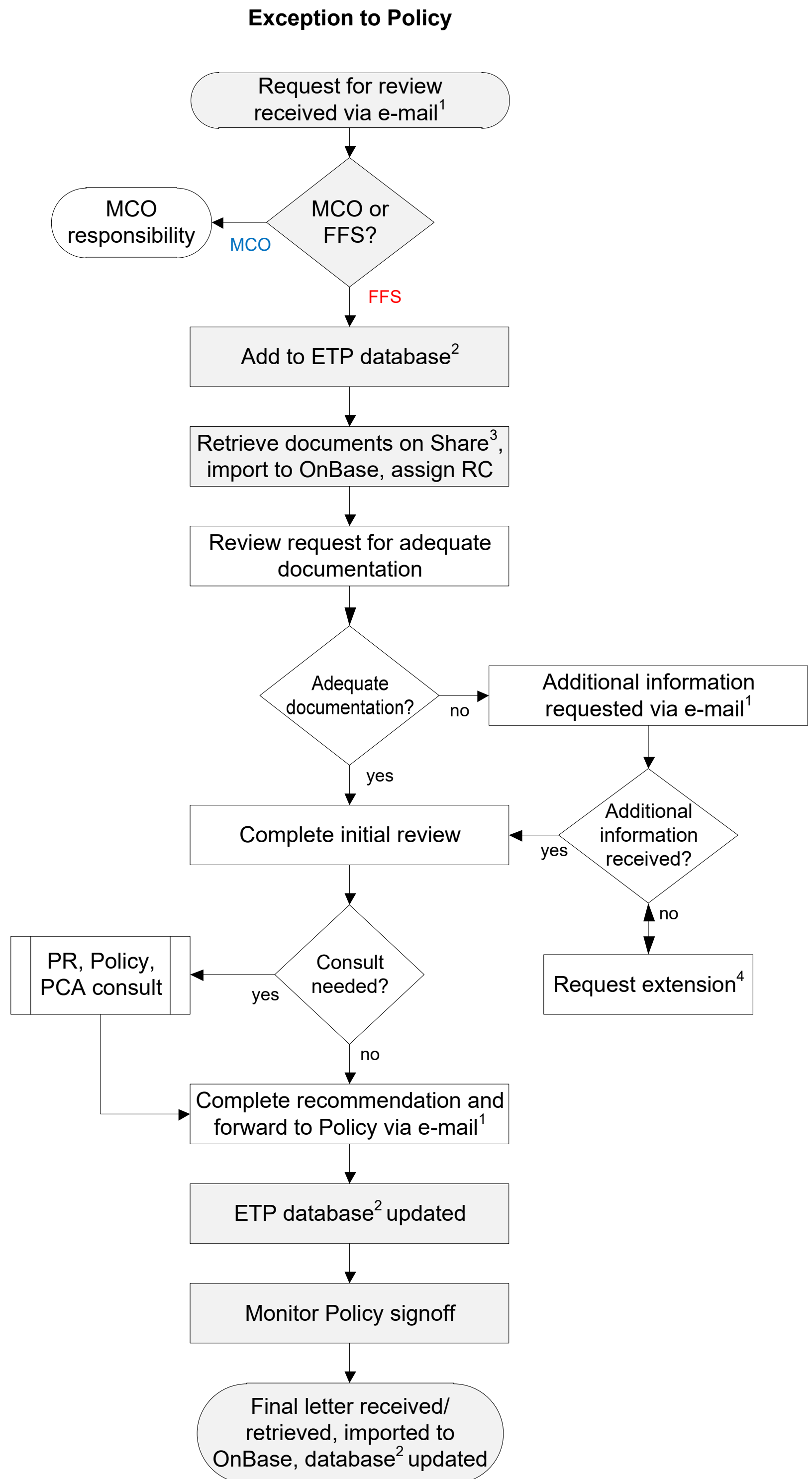


CORE
MSU – Medical Services Unit
PCA – Provider Cost Audit
Policy
PSU – Provider Services Unit

Annual HCPCS Updates 05/11/2017

CORE
MSU – Medical Services Unit
PCA – Provider Cost Audit
Policy
PSU – Provider Services Unit

Attachment F: Exception to Policy flowchart



[1]MedSrvETP@dhs.state.ia.us (cc'd on all ETP emails)
[2]\\Dhsime\medical.772\LTCMCETP\2018 ETP
[3]\\Dhsime\medical.772\LTCMCETP\ETP Log's\ETP Admin\ETP2018
[4]Extension may be requested at any point in process

Support staff task
\\dhsime\MEDSRV\Process Maps\Visio\ETP
Rev. 5/2018