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Chapter 1 - Overview

CRIS Overview

Welcome to the Case Review Information System (CRIS) software. CRIS has been designed to improve performance of Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) contractual obligations.

Background

CRIS is the custom application software developed to assist the QIOs in managing and monitoring their CMS contract obligations for case review and Hotline. Several cooperative joint application development (JAD) sessions with QIOs, CMS, and SDPS developers were productive in developing the requirements and design of CRIS.

CRIS will support partial review, including start dates and complete dates for each type of review (coding, quality, utilization, and notice of non-coverage). If necessary, CRIS will allow multiples of the same review type, except coding.

Claim Identifier

The identifiers of a claim (Beneficiary HIC#, Provider ID, Admit Date, Discharge Date, and Inpatient/Outpatient Indicator) may change as bills are received. In CRIS this basic claim identifier information is stored on one table. The primary key, called **Claim Key**, to identify the medical records is an artificial sequential number generated by the system as records are added. When the monthly merge runs to update claims on the warehouse, a process will also search the Claim Identifier table and update the Claim Identifier columns as needed. If this occurs, the previous version of the claim identifiers is stored on the **Claim Identifier History** table with the same Claim Key.

All related information in the database – Record Tracking, Case Review, Beneficiary Complaints, EMTALA review, and HINN/NODMAR review will refer to a claim by its Claim Key, not the claim identifiers. If duplicate records are added to the Claim Identifier table, a process will identify and merge the information back to one record.

Access to the rolled up claim is available throughout the review cycle. A snapshot of the current version of the rolled up claim will always be available for each identified claim. At the time a claim is selected for review, another snapshot version of the rolled up claim is available for each selection reason.

Claim Identifier Selection

The Claim Identifier Selection window is updated either automatically via the monthly merge, monthly processing, or imports, as well as manually through manual additions to the system for claim identifiers resulting in review.

The CRIS application will provide processing to allow you to manage your case review workloads by selection reason, identify required review types, and track review types across time without losing any data.

Record Tracking

The Record Tracking window allows you to record information related to the request, receipt and location of the medical record at any time in the review process. Case review records as well as records requested for project data collection are tracked.

Postage and pages information is recorded on the Record Tracking window.

Automated 15-day reminder reports and technical denial reports can be run in the Record Tracking system. Technical denial information can be added or updated on the window.

Case Review

After the medical record for case review has been received and tracked with an action reason of Received for Case Review, the case is assigned to a reviewer through **Assign Review Records**. At the time the record has been assigned, a **Review** base record and a **Review Type** record are created: Coding, Quality, Utilization, Notice of Non-coverage, or EMTALA.

CRIS will allow more than one instance of a Quality or Utilization Review Type. A start date, due date, and complete date are associated with each of the review types and the data for the review types is stored on one window. Review information associated with a Selection Reason is retained. **PRAF** entries are attached to the review type record. Physician reviewer and coordinator time is entered on the **Reviewer Time** window.

EMTALA Review

When a request for an EMTALA review is received from the Regional Office, the record is added to Claim Identifier, Record Tracking, Review, and the EMTALA windows. Results of EMTALA review are stored on the **EMTALA Results** window. Physician reviewer and coordinator time are entered on the **Reviewer Time** window. For those EMTALA cases that are not Medicare cases, beneficiary demographic (name, address, etc.) information may be stored on the **Alternate Contact Address** table. Even though no claim will exist on the warehouse for non-Medicare cases, the claim identifier information is stored on the Claim Identifier window.

Notice of Non-coverage Review

The **Notice of Non-coverage Log** window allows entry of the key claim identifier information. When a request for a Notice of Non-coverage review is received, the record is added to Claim Identifier, Record Tracking, and Review windows. Results of the Notice of Non-coverage review are stored on the **Notice of Non-coverage Review** window. Physician reviewer and coordinator time are entered on the **Reviewer Time** window.

Beneficiary Complaint

The Beneficiary Complaint windows in CRIS allow you to track information about the complaint from beginning to end. The **Settings** window allows you to enter the settings associated with a beneficiary complaint. The settings on this window tie the record to the Review module.

Helpline

The CRIS **Helpline** module allows you to track activity related to calls to the Beneficiary Helpline. You can record beneficiary, caller, facility, concern, needs of the caller, actions taken, and quality of care or HINN information.

Letters

The **Letters** module consists of automated and electronic Letters. The automated letters allow you to select items from the CRIS database and place into letters developed by your QIO in Microsoft Word. The electronic letters allow you to select a variety of letters modeled after the letter exhibits in the QIO Manual and provides a permanent record of all the letters mailed for a claim throughout the review process.

View

The **View** module is view-only and you cannot update the information. If an update is required submit your request to the SDPS Help Desk to be considered by the Case Review workgroup.

Maintenance

The **Maintenance** module allows you to add or update information. Each value is tied to your state code(s). A value with a state code of XX indicates that it is available to all QIOs.

Reports

Most of the management reports are web based. The Postage and Pages, and the Physician Reviewer reports are available in CRIS.

Development Environment

The CRIS software is written with a graphical user interface (GUI) builder product—Power-Builder, executing against a robust relational database management system (RDBMS)—Oracle. The Help subsystem was built using the on-line help builder, RoboHelp. The Microsoft Windows conventions for menus, dialog boxes, on-line help, and tool bars for the interface of the CRIS software have been adapted by SDPS.

The *CRIS User's Guide* has been formatted to include learning objectives, a chapter overview, step-by-step instructions, a chapter summary, follow-up questions and labs in most chapters.

Several standards used throughout the user's guide make it easier to identify and understand all aspects of the system and instructions:

   Icons are represented by the actual icon.

OK   Buttons are presented in bold as they appear in the CRIS windows.

Name   Field names are italicized with initial capitals.

File   Menu options appear in the same format as illustrated on the CRIS menu bar.

Esc   Keyboard keys are written in large and small capitals in the Arial font.

The following verbs are used to indicate specific features:

- **Select** will precede menu bar options, command choices, button and icon operations.
- **Press** will be used for keyboard functions.
- **Enter** will precede information to be entered as field entries.

Online User's Guide

The *CRIS User's Guide* is available online through the CRIS software.

- To access the online user's guide, select **Options|User's Guide.**

OR

- Select the User's Guide icon, .

Organization of the Guide

The chapters and appendices of the *CRIS User's Guide* are arranged to accommodate both new and experienced users.

- **Chapter 1** provides a high-level overview and describes the background and functionality of CRIS. This chapter also explains how to read the user's guide and the organization of the guide as a whole.

- **Chapter 2** describes all of the necessary steps to complete the installation, setup, and configuration of CRIS. This chapter covers security, user access, and login details as well.

- **Chapter 3** is a guide to the standard design and features of the system. This chapter provides you with an overall view of the system and will introduce you to the basics of successfully navigating through CRIS.

- **Chapter 4** explains how to access and navigate through the record tracking, batch record, batch postage and pages, importing record requests, reprinting record requests, and generating the 15-day reminder report and the 30-day technical denial report, Claim Identifier, Claim Identifier History, and the Claim Identifier Selection windows.

- **Chapter 5** explains how to access and navigate through the Review module including assigning review records, performing case review, EMTALA review, Notice of Non-coverage review and entering beneficiary complaint information.

- **Chapter 6** explains how to access and navigate through Helpline.

- **Chapter 7** explains how to access and print 15-day reminder, 30-day technical denial and other automated letters.

- **Chapter 8** explains how to create and print electronic letters modeled after the letter exhibits in the QIO manual.

- **Chapter 9** explains how to access and navigate through the View and Maintenance modules.

- **Chapter 10** explains how to access and navigate through the Report module.

- **Chapter 11** explains how to access the Sanctions Activity module, add, delete, and modify Sanction information.

- **Chapter 12** explains how to access and navigate the Inter-Rater Reliability module.

- **Chapter 13,** explains how to access and navigate the Quality Improvement Activity module.

- **The APPENDICES,** contains three import file layouts, acronym list, the Inpatient Adjustment Reference Guide, the Outpatient Adjustment Reference Guide, EMTALA questions, a pictorial listing of CRIS icons, the CMS timing of review, and a list of fields appearing in CRIS windows along with descriptions and a window reference.

  - Appendix A contains three import file layouts.
  - Appendix B is a complete list of the acronyms included throughout the User's Guide.
  - Appendix C is the Inpatient Adjustment Reference Guide.
  - Appendix D is the Outpatient Adjustment Reference Guide.
  - Appendix E is the EMTALA Worksheet and Tips
  - Appendix F is the CMS Timing of Review.

Chapter 2 - Set Up

Overview

The Set Up chapter contains detailed information that will help the administrator set up CRIS. The system configuration which includes required hardware and software is discussed. Step-by-step instructions for the installation and set up of CRIS on the workstation are included. Instructions for logging into CRIS on the workstation and exiting CRIS are also included in this chapter. The SDPS Help Desk telephone number, fax number, and GroupWise address are provided for technical support.

System Configuration

CRIS has been designed to run in a client-server environment, providing access to this software on workstations at the local QIOs and the CMS Central and Regional Offices, and access to the Wide Area Network (WAN) and SDPS parent database. Oracle is the database platform on which CRIS is based.

Required Hardware
To implement CRIS, an SDPS workstation with the following minimum hardware configuration is required:

- Pentium3 500 MHZ PC workstation configured with 128 Mbytes of RAM
- 500 Mbyte hard drive
- Dell color monitor, display set at S3 Trio765 1.5B19 800 X 600 256 col SF

Required Software
The following software is required to obtain full benefits of the system:

- Windows 98se (second edition)

Windows 98se is the computer operating environment on which CRIS is based.

CRIS Installation and Setup

CRIS has an automated installation routine that simplifies loading the software onto each client workstation. This installation procedure requires CRIS Version 1.0 files posted on the QIOnet and is similar to other Windows software. There is no network installation for CRIS.

QIO Workstation Installation via SMS

For a QIO LAN workstation, it is recommended that you use the QIO workstation installation via SMS. The QIO LAN administrator must assign a Remedy ticket to the QualityNet Help Desk. The ticket will need to include the workstation name to advertise the CRIS SMS package to. Once advertised the program will automatically run and reboot if necessary. The user can then login to the workstation and CRIS will be available for them to use.

CMS Central and Regional Office and Remote/Standalone Workstation Installation

♫ For a QIO LAN workstation, it is recommended that you use the QIO ZENworks installation. The QIO ZENworks installation instructions are on the QIOnet under Secured Login\QIO Administrative Downloads\ Workstations\SDPS Developed Applications\CRIS.

Always use the defaults during the initial install unless otherwise instructed by IFMC personnel. If re-installing the software, always answer **Yes** or **OK** when asked to replace files.

To cancel the installation at anytime, press Esc.

To install the CRIS software on the CMS Central and Regional Office workstation or remote workstation:

1 Login normally when installing CRIS 1.0 to the CMS workstation or remote/standalone workstation.

2 Select **Start|Run**.

3 Execute the setup.exe file. In the Open: field type: **c:\crisv10\setup.exe**.

4 Select **OK**.

5 A window may appear briefly showing the progress of the installation setup.
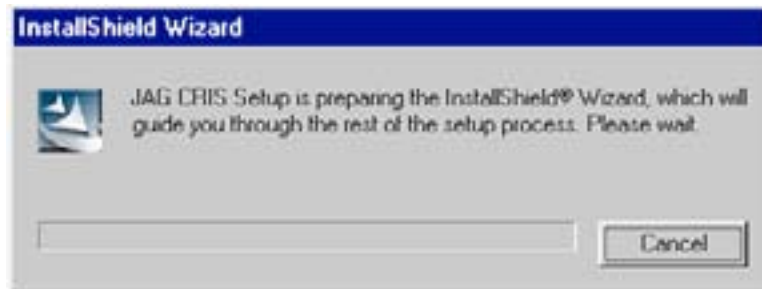
The Welcome window is displayed.
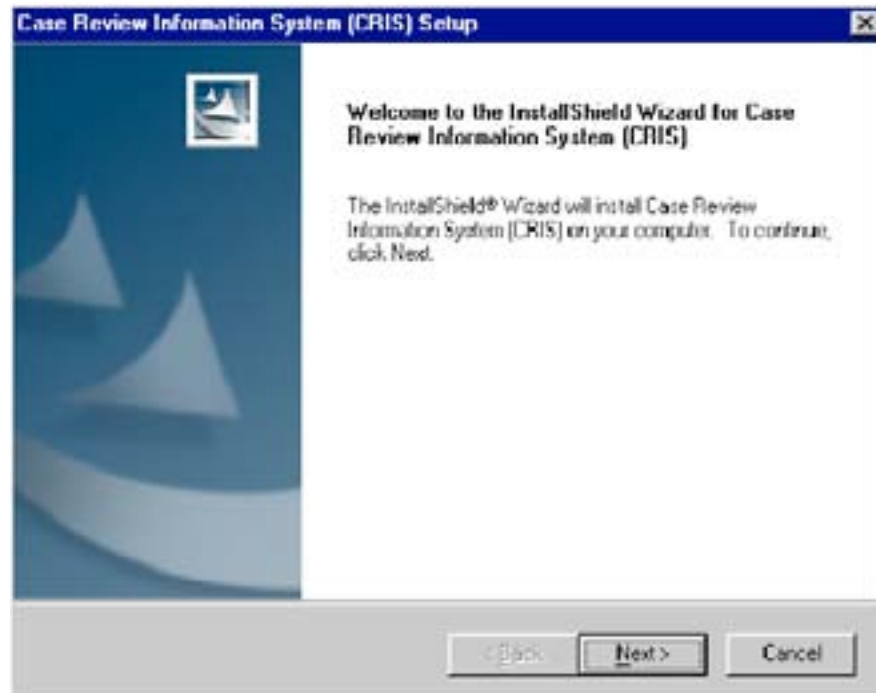
6　Select **Next**.

7　A CRIS window is displayed.
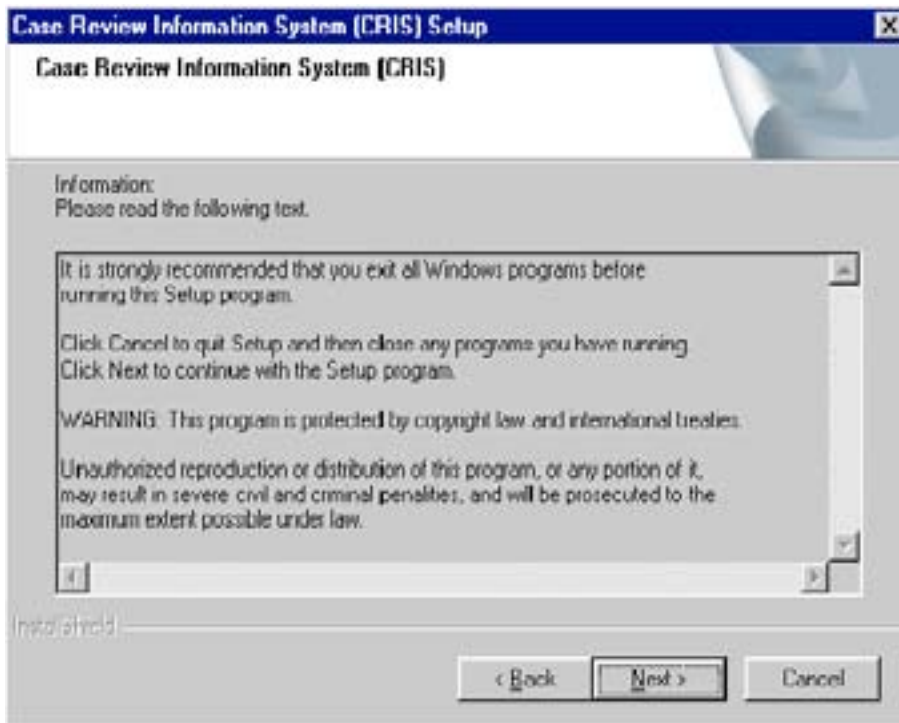
8　When you select **Next**, a window asking you to choose the CRIS software destination location is displayed. (The default is **C:\JAGCRIS**.)
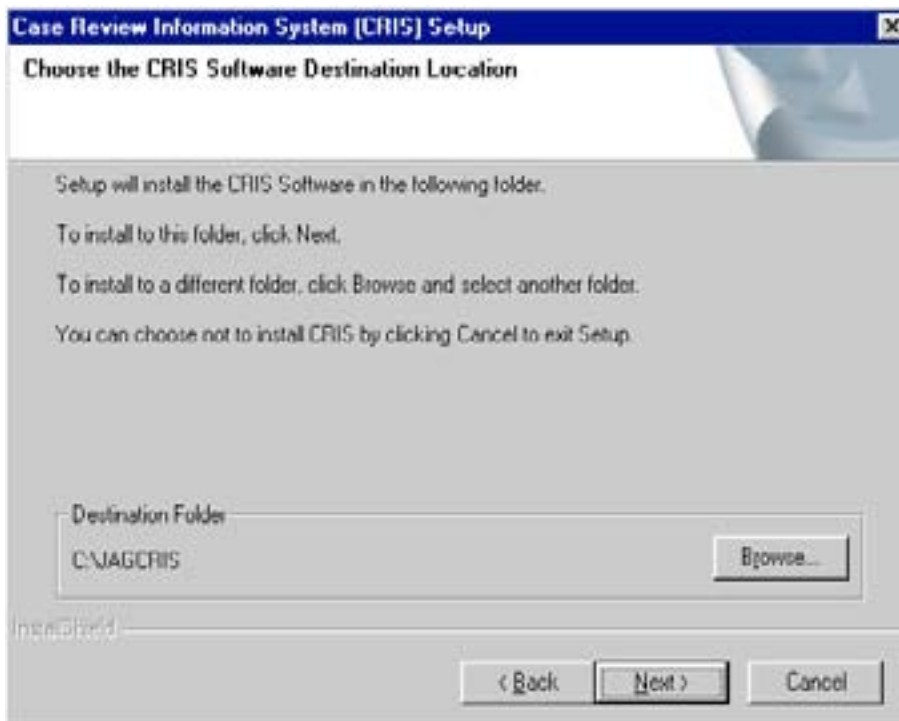
9   Select **Next**.

10 A CRIS Setup Finished window is displayed.
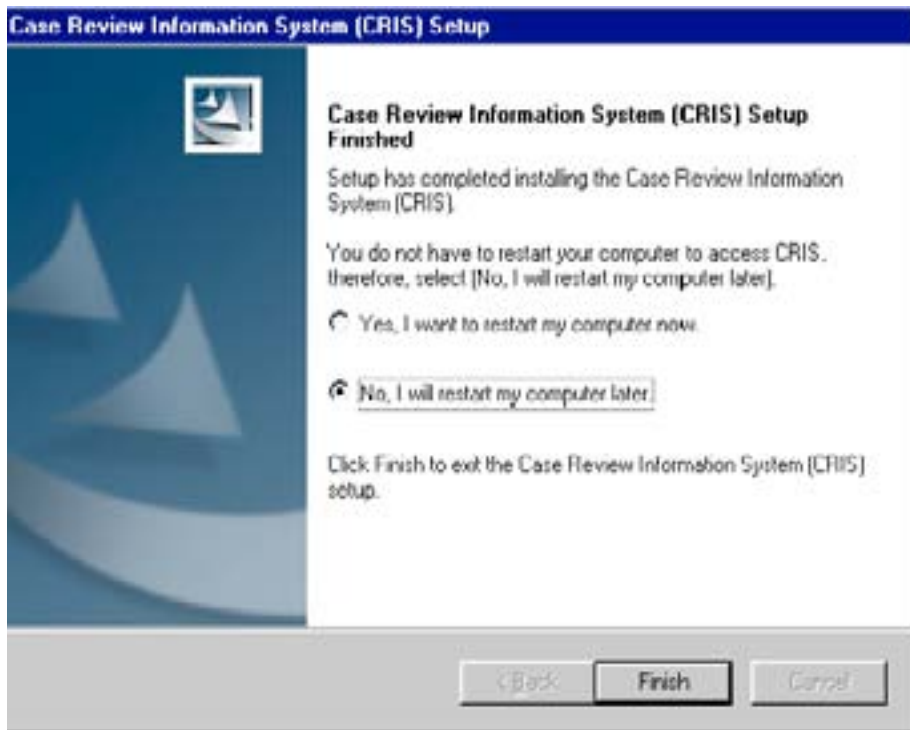
11 Select the radio button next to **No, I will restart my computer later**.

12 Select **Finish**.

Future Releases of CRIS

When new versions of CRIS are released, users will receive a message when they attempt to log into the software telling them that a new version of the software is available.
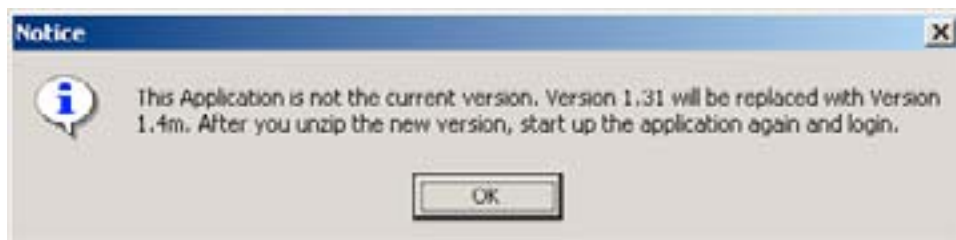
1 When a message is displayed stating a new version of the software is available, select **OK**. A *WinZip Self Extractor - Installjagcris.exe* box will display.
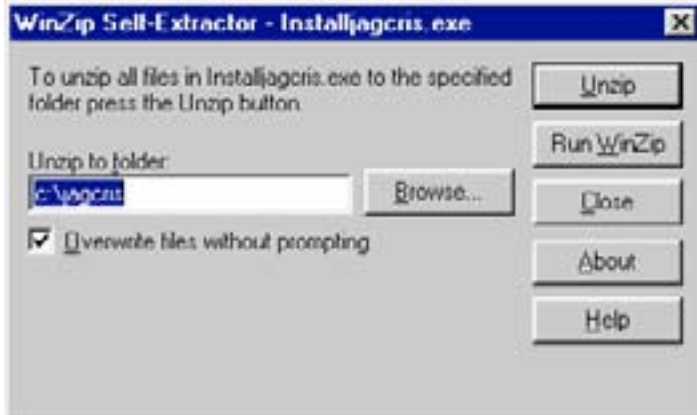
2 Select **Unzip**. A *WinZip Self-Extractor* box will display, indicating that the files were unzipped successfully.
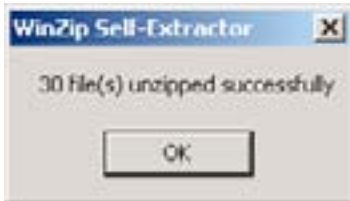
3 Select **OK**.

4 Select **Close.**

5 Select the CRIS icon, , on the desktop.

♫ If the CRIS application is not located in the user's C:\jagcris directory; e.g., has been installed in the C:\Documents and Settings folder, the jagcris.bat file will need to be edited or the user will receive the following error:

After unzipping the CRIS application to the correct folder, edit the jagcris.bat file in the directory. It currently looks like this:

set path=c:\jagcris
set JAGUAR_CLIENT_ROOT=c:\jagcris
start jagcrisrun.exe

You will need to update it to point at the directory where CRIS is installed; e.g.,:

set path= C:\Documents and Settings\UserName\My Documents\Apps\jagcris
set JAGUAR_CLIENT_ROOT= C:\Documents and Settings\UserName\My Documents\
    Apps\jagcris
start jagcrisrun.exe

Printing the CRIS User's Guide

When printing the *CRIS User's Guid*e use the highest resolution possible, 600 dpi minimum recommended.

1   To print the *CRIS User's Guide*, select Acrobat Reader. The Acrobat Reader window will display.

2   Select **File|Open**.

3   Select **T:\INSTRUCT\CRISUG10**.

4   Double click **CRIS User Guide.pdf**).

5   Select **File|Print**. The Print dialogue box is displayed.

6   Select the appropriate Print Range.

7   Select **OK**. The section of the user's guide selected will print.

Starting and Ending a CRIS Session

You will need a valid userid and password to log into CRIS.

1   To access CRIS from windows, select the CRIS program name. The Please Login window is displayed.

At any time, you can select the Exit Application icon to close all CRIS activity.

At any time, you can select the Help icon to access the Help window or the Search icon to search for help on a specific topic.

Enter your user name in the *Userid* field.

Enter your password in the *password* field.
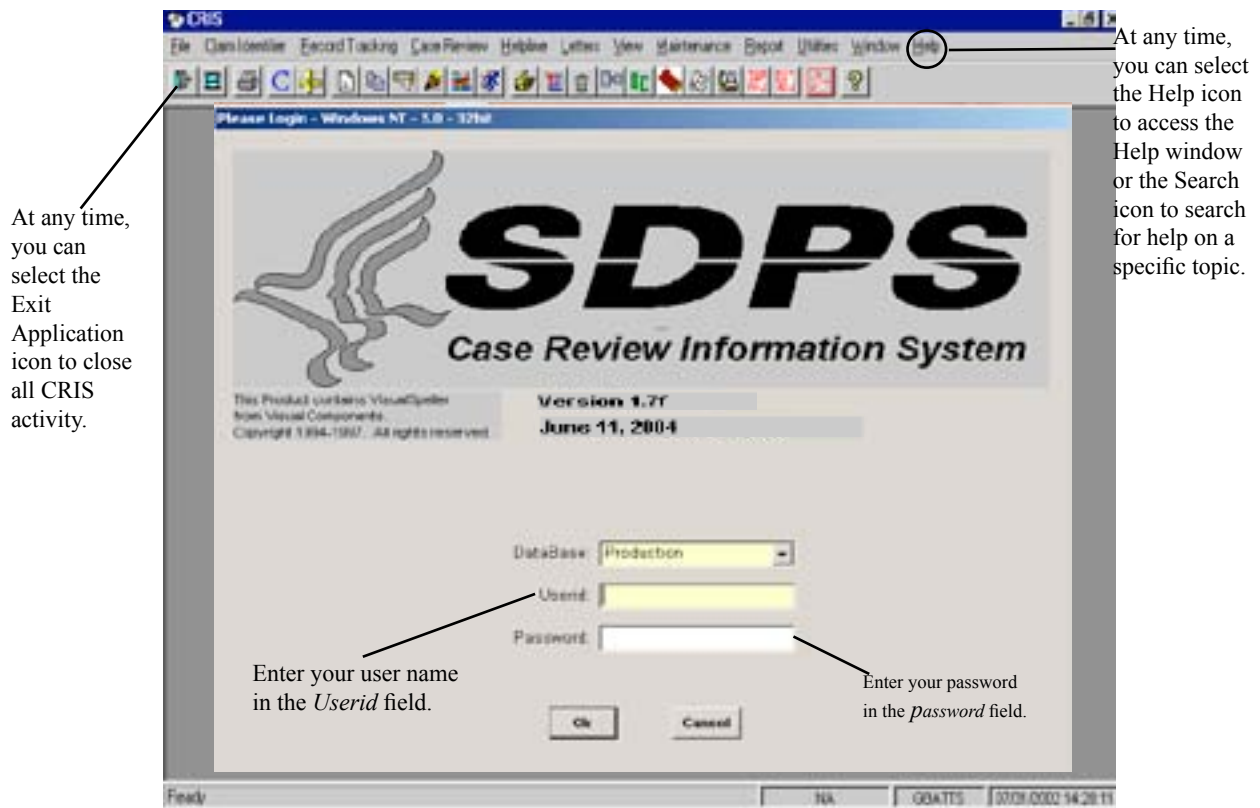
Exit CRIS

• Select the Exit Application icon, [icon] , on the CRIS main tool bar.

Technical Support

A help desk is available if problems are experienced with CRIS software or documentation. The SDPS internal point of contact may leave voice mail at any time, fax a description of the problem, or send a GroupWise to the SDPS Help Desk.

The QualityNet Technical Support telephone number is: 1-866-288-8912

The QualityNet Technical Support fax number is: 1-888-FAX.SDPS (1-888-329-7377)

The QualityNet Help Desk email address is Qnetsupport@sdps.org.

Hours of operation (live coverage) of the QualityNet Help Desk are from 8 a.m. to 8 p.m. EST Monday through Friday.

Chapter 3 - Basics

Basics

Objectives

After completing this chapter, you will be able to:

- Print from CRIS

- Access the User's Guide

- Query, Sort and Scroll

Overview

This chapter provides an overall view of the CRIS software, as well as tips for successful navigation through CRIS. CRIS modules are introduced, and menu commands that are always available from the CRIS menu bar are discussed. The screen layout, navigation information, and functions that you will perform across all modules are provided. These functions include data entry, query, sort, scroll, and error messages. It is recommended that you read this chapter carefully before working in CRIS.

Screen Layout

CRIS has been designed using familiar Windows features: title bar, menu bar, tool bar, window size control arrows, and status bar. Icons for frequently used windows within the modules are available on the CRIS main tool bar. The scroll bar will appear depending on the content within a window. If the content extends to either side or to the bottom of the screen, a scroll bar appears to allow you to scroll to view the remaining portion of the window.

Throughout CRIS, the menu bar and the main CRIS tool bar remain the same. Each window contains an additional tool bar for use in the window you are working in (e.g., Beneficiary Complaint Listing). When you select an icon, another window will open and will contain icons specific to that window (e.g., select the Insert icon and the Beneficiary Complaint window displays). Each window contains its own icons, scroll bars, minimize/maximize buttons, etc.

Menu bar. Use to select CRIS options. While navigating through CRIS, the menu options will remain the same.

Click to close windows.

Title bar.

Click to Minimize or Maximize a window.

Click to close windows.

CRIS main tool bar. Use to select CRIS options by clicking on an icon.

Window tool bar. Appears when a CRIS window is run. Use this tool bar to perform functions specific to the open window.

Scroll Bars. Click on the scroll bar arrows, or click and drag the scroll bar to view information that is too lengthy to appear on the screen all at once. You may scroll horizontally or vertically.

Status Bar. Indicates software activity, cursor position, user name, date, and time.

File

File is always accessible through the CRIS menu bar. This menu command includes Printer Setup, Print, Print Screen, and Exit.

File Menu Commands	
Printer Setup	Select a printer and change printer settings
Print	Print the information retrieved.
Print Screen	Print the screen currently displayed.
Exit	Close the application.

The following icons may also be used to activate three of the File commands:

File Command Icons	
🖨	Print the information retrieved.
🖳	Print the screen currently displayed.
⎚	Exit the application.

Printing

Printing options are printer-specific settings, such as resolution, color and text quality. These options vary depending on the capabilities of the printer. Windows assigns settings that should work for the printer in most situations; however, you may change these settings to specify different options.

Printer Setup allows you to select a specific printer and provides accesss to the Printer Setup dialog box.

1 To select the printer, select **File|Printer Setup** from the CRIS main menu.

2 Select the appropriate printer displayed in the scroll box under Printer.

3 Select **OK** to select the printer and exit the *Printer Setup* box.
   OR
   Select **Setup...** to continue with the printer setup (see following steps).

Set Up Printer or Change Current Settings

    1   To setup the printer or change current settings, select **Setup...** from the *Printer Setup* box.

        A *Printer Setup* box appears displaying the options for the selected printer.
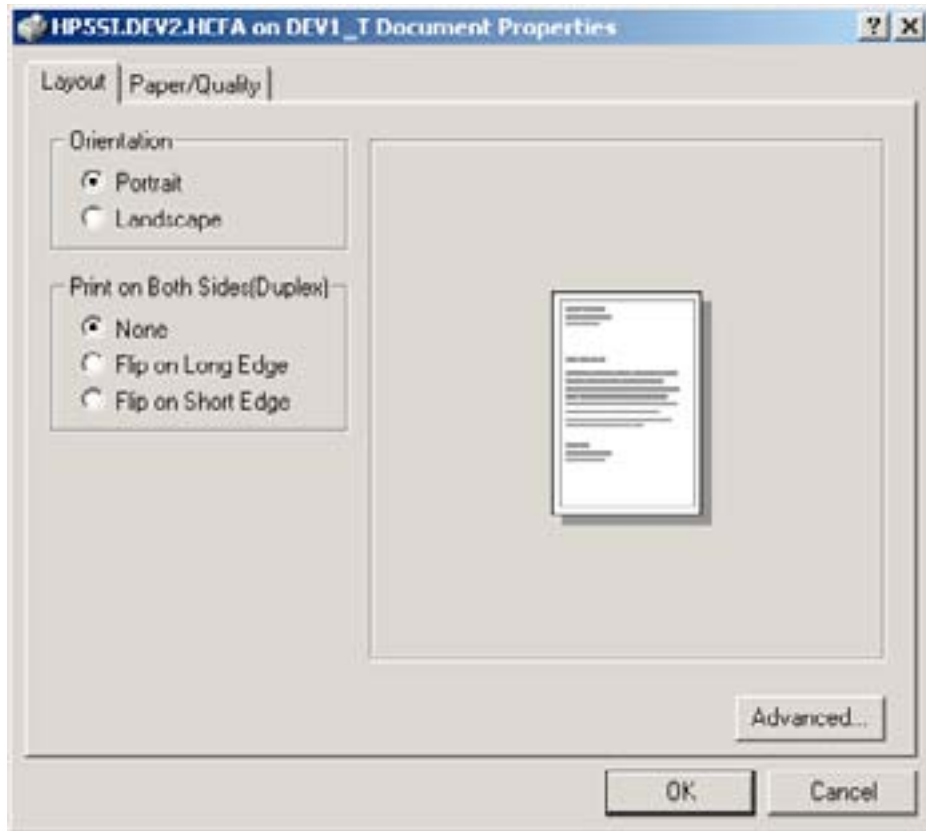
    2   Make any necessary changes to the options and select **OK**.

        The *Printer Setup* box appears.

    3   Select **OK** to exit the *Printer Setup* box.

Printing a Screen

The Print Screen option allows you to print the window currently displayed.

    1   To print a screen, access the window to be printed.

    2   Select **File|Print Screen**.

        OR
        Press **ALT** + **P**.

CRIS Modules

The CRIS modules can be accessed through the CRIS main menu. CRIS software consists of six modules. The modules are:

- *Claim Identifier* allows you to view patient claim identifier information and selection reasons.

- *Record Tracking* allows you to track medical records or components of medical records. You can perform single or multiple record tracking and capture postage and pages information. Through this module you have the ability to generate, view, and print the following items: medical record request lists, cover sheets, facility mailing labels, document labels, a working list of all records, reprint previously generated reports, run Reminder and Technical Denial reports, and process canceled abstractions.

- *Case Review* enables you to capture review results from initial review, re-review, and reconsideration review for preauthorization/concurrent, inpatient, and outpatient cases. From this module you have access to the following windows: Assign Review Records, Review Listing, Review Type Listing, EMTALA Review, Call Grouper, Notice of Non-coverage Log Listing, Alternate Contact Address Listing, Beneficiary Complaint Listing, Beneficiary Complaint Setting Listing, Beneficiary Complaint Medical Record Survey Listing, Beneficiary Complaint ADR Listing, Beneficiary Complaint Westat Survey Listing, Inpatient Adjustment Listing, Outpatient Adjustment Listing, Sanction Activity Listing, IRR Listing, QIA Listing, and QIA Master Listing.

- *Helpline* allows you to track activity related to beneficiary Helpline calls.

- *Letters* allows you to query for specific cases and save the case demographic information in an Microsoft Excel file to create letters in Microsoft Word. You can also access the Electronic Lettes module to create and print letters directly from CRIS.

- *View* allows view-only capabilities. The information displayed on the View windows may not be updated by QIOs. Examples of view windows include: Diagnosis Codes view, Procedure Codes view, and HSE (Health Service Encounter) view.

- *Maintenance* allows users with Review Admin or Helpline Admin roles to maintain tables related to CRIS. Examples of Maintenance windows include: Health Service Provider Maintenance, Physician Maintenance, and Beneficiary Complaint Maintenance, and Electronic Letters Maintenance.

- *Reports* allows you access to reports available within CRIS. You can generate the report, view it online, and/or print the report. The reports available in CRIS are the postage and pages and physician reviewer reports. All other CRIS reports are web based.

Supporting these modules are a query tool and data maintenance capability.

Utilities

From the CRIS menu bar, you can access the Utilities option. This menu option includes User Maintenance, Logon, and User's Guide.

Utilities Options Menu	
User's Guide	Access the CRIS User's Guide on-line.
Database	Access another database.
User Maintenance	Change the password for your User ID.

User Maintenance – Changing Passwords

CRIS provides access to Your QualityNet site and allows you to change your password at any time.

1 To change your password, select **Utilities|User Maintenance**.

The QualityNet sign in screen displays.
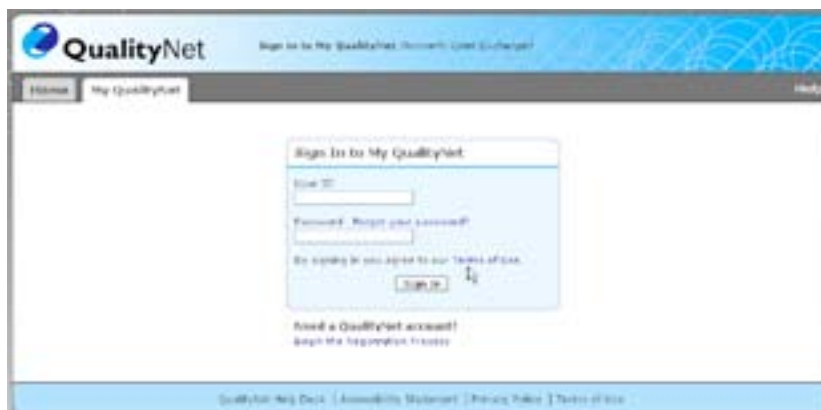
2 Enter your current QualityNet User ID and Password and select **Sign In**.

The My QualityNet page displays.

3   Select the **My Account** button.

The My Account page displays.

4   Click on **Change your password** >

The My QualityNet Account Security page displays.

5   Enter your old password and your new password, making sure to follow all of the password rules listed on the right side of the window.

6   Confirm your new password by entering it again. Click the **Submit** button.

A message displays to let you know your account has been updated.

7   Click **Continue** to return to the My Account page.

8   Select **File|Close** or click the Close button **[X]** at the top of the window to exit QualityNet.

Accessing the User's Guide

The User's Guide option provides access to the *CRIS User's Guide* in .PDF format. You can print the document in Adobe Acrobat Reader. Hypertext jumps are displayed in blue in the comprehensive Table of Contents and the table of contents at the beginning of each chapter. They provide a fast and easy method of locating topics. When you select a hypertext topic listed in the table of contents, the system will jump to the respective topic and page number.

Bookmarks have been added in the left side of the window to allow movement from on ter to another. An Index containing hypertext links is also available.

1   To access the *CRIS User's Guide*, select **Utilities|User's Guide**
     OR

     Select the User's Guide icon, , from the main CRIS tool bar. The Adobe Acrobat Reader opens and the Table of Contents is displayed.

2   To open the desired chapter, click on the chapter name. The first page of the chapter is displayed containing the table of contents for the chapter.

3   Click on one of the topics displayed in blue. The system will go to the topic selected.

4   To view the table of contents page for the selected chapter, click on the chapter title bookmark listed on the left side of the window.

5   To jump to another chapter/section of the user's guide, click on one of the chapter title bookmarks listed on the left side of the window. The table of contents page for that chapter will display.

     OR

If you prefer, you may expand the bookmark on the left side of the window by clicking on the plus sign to the left of a chapter title. All topics located in the chapter will display. The user's guide chapter/sections and their topics are as follows:

Table of Contents
Chapter 1   Overview
Chapter 2   Set Up
Chapter 3   Basics
Chapter 4   Claim Identifier and Record Tracking
Chapter 5   Case Review
Chapter 6   Helpline
Chapter 7   Automated Letters
Chapter 8   Electronic Letters
Chapter 9   View and Maintenance
Chapter 10   Reports
Chapter 11   Sanction Activity
Chapter 12   Inter-Rater Reliability
Chapter 13   Quality Improvement Activity
Appendices
Index

6   If you are not sure where to look for a topic, you can access an alphabetical list of the user's guide contents, the Index. For example, if you are looking for information pertaining to Tracking Medical Records, you could access the Index bookmark on the left side of the window. Expand the Index bookmark by clicking on the plus sign and click on the "T." The system will go to the section of the list containing topics beginning with the letter T. You can use the scroll bar at the right of the window to view the complete list. Once the topic Tracking Medical Records is located, click on it. The system will go to the page in Chapter 4 containing Tracking Medical Record information.

Print the CRIS User's Guide

1   To print a page or pages of the *CRIS User's Guide*, select the User's Guide icon, , and access the desired topic/page.

2   Select **File|Print**. A *Print* box displays.

3   Select the appropriate print options. Selecting ALL will print the entire chapter.

Exit the CRIS User's Guide

1   Select **File|Close**.

2   Select **File|Exit**.

Window

Window is always available on the CRIS menu bar.

Window menu Option	
Tile	View all open windows on the same screen arranged side-by-side.
Layer	Layer the open windows on top of each other so that only the activated window is visible on the screen.
Cascade	Rearrange windows in such a way that all Window Title Bars are visible.
Flat Toolbar	Select a toolbar with flat rather than raised icons.

Rearranging Windows

When several windows are opened at a time, some windows are hidden beneath others. Use the Tile, Layer, and Cascade commands on the Window menu to resize or rearrange windows.

The Tile command resizes and arranges the open group windows side-by-side in the CRIS workspace. This command allows you to view more than one window at one time.
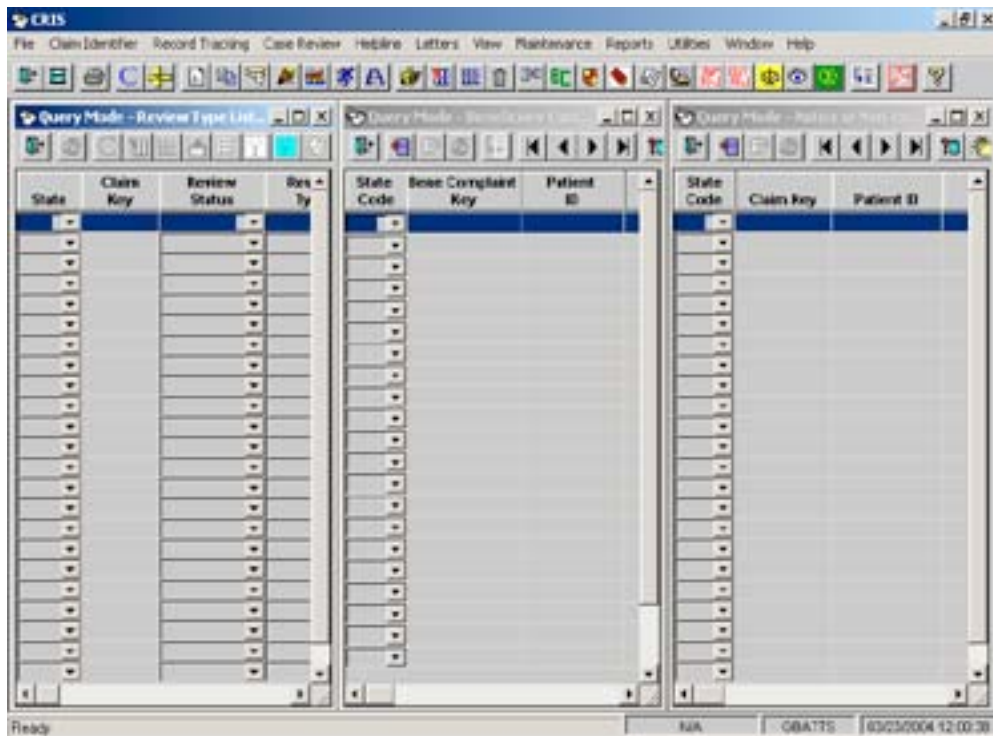
The Layer command places the open windows on top of each other as they are opened. You will view only the window most recently opened.

The <u>C</u>ascade command resizes and layers the open group windows within the CRIS workspace, so that each title bar is visible.
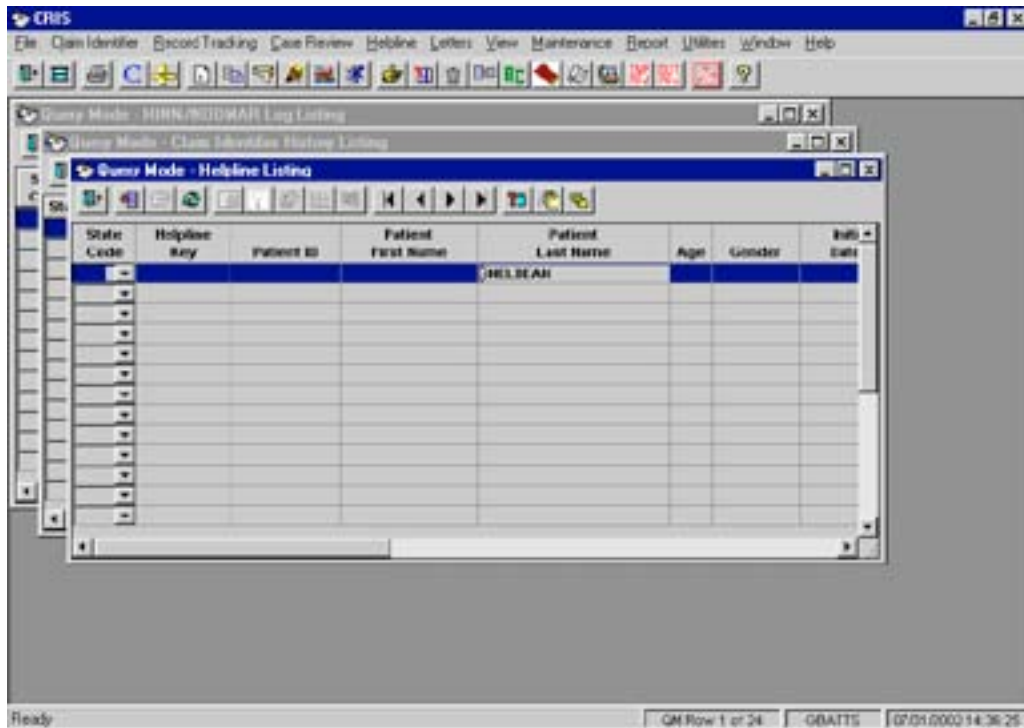
Customizing the Main CRIS Tool Bar

You may customize the main CRIS tool bar by selecting the <u>W</u>indow|<u>F</u>lat Toolbar from the main menu bar. The small boxes around each icon disappear. The boxes display as the cursor is placed on the desired icon.

Help

CRIS provides online help to assist you while working in the software. Online Help is a quick and easy way to look up information about CRIS functionality, features, and usage. Help is always available and may be accessed three ways.

1   Right click on a field or window.
2   Click on the Help icon.
3   Select Help on the main menu bar and choose an option from the drop-down list.

When you open the Help application in any of these three ways, the Help window displayed contains the Help topic on the right side of the window, and the left side of the window contains a column with three tabs: Contents, Index, and Search.
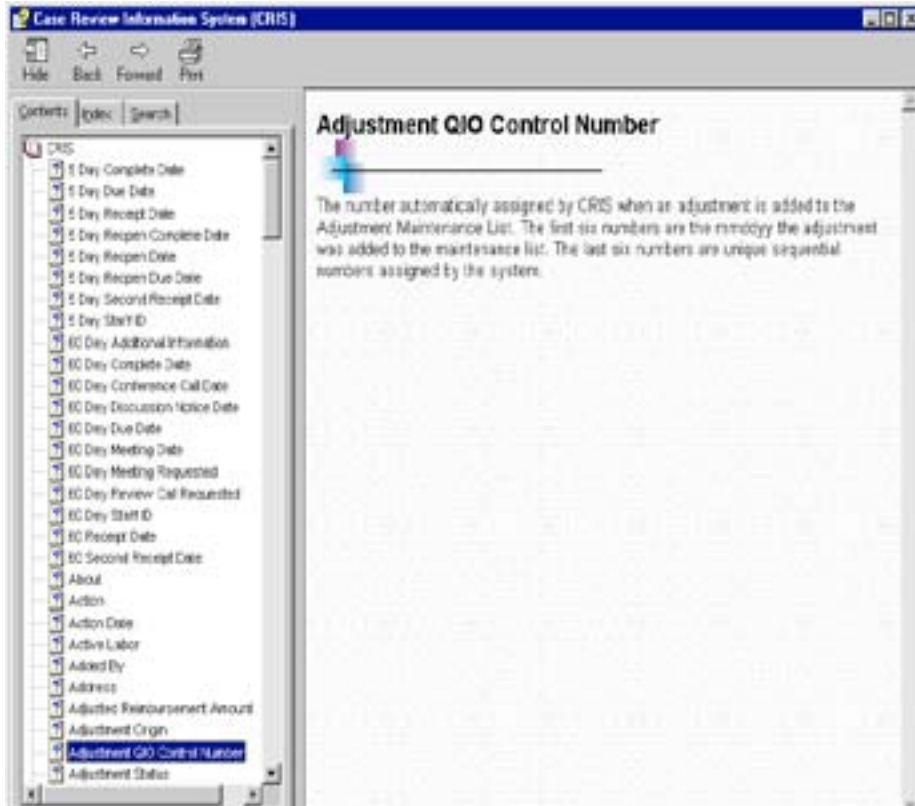
The Contents tab contains an alphabetical list of all the Help topics available in CRIS. Many Help topics are field names or window names. You may scroll through the list to select a help topic.

The Index tab contains an alphabetical list of the Help topics available and a text entry search field near the top of the list where you can type a keyword or the first few letters of a topic to search for a topic. When you type in the search field, the alphabetical list moves to the topic in the list most closely matching the letters entered.
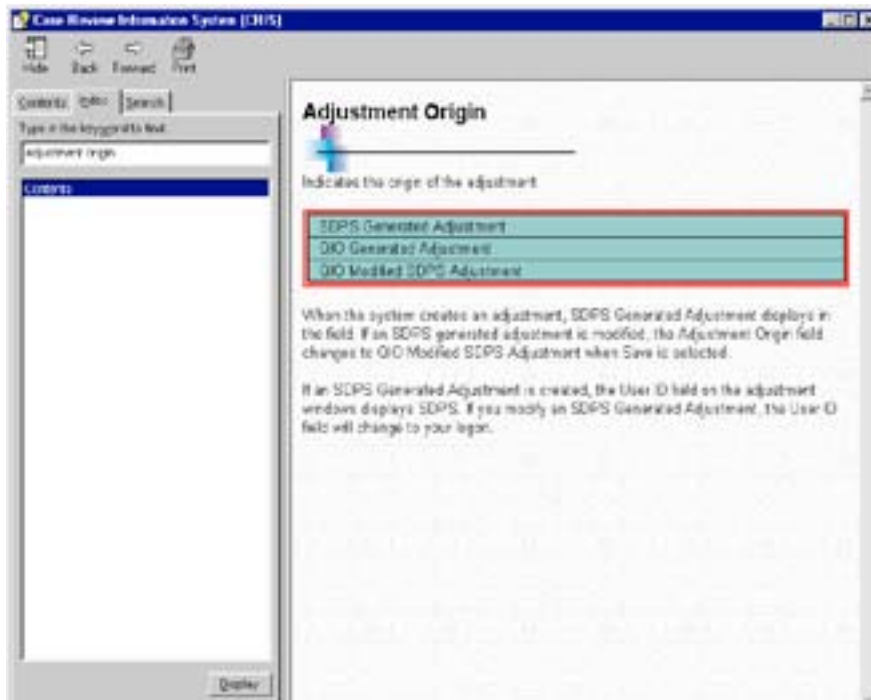
The Search tab also contains a text entry search field near the top of the list, where you can type a keyword to search for a topic. After entering your keyword, select the List Topics button to display only those topics matching your search entry.

To exit the Help window, click on the in the upper right corner of the Help window. You may also minimize the Help window while working in CRIS or you may resize the window to display Help beside your CRIS window(s).

Exit

At any time during the CRIS session, you can exit from the current window or the application. The Exit Application icon is the same as the Close Window icon except that it is located on the CRIS main tool bar rather than the window tool bar. (See screen layout topic in this chapter for a labeled screen graphic.)

Closing the Window

- To close a window, select the Close Window icon, , from the tool bar on the window currently open.
  OR

  Click the box in the upper right corner of the open window.

It is important to save your work before closing the window.

Closing the Application

- To close CRIS, select **File|Exit**.
  OR

  Select the Exit Application icon, , from the CRIS tool bar.

It is important to save your work before closing the application.

Working in CRIS

You will navigate through the CRIS software using menu commands and tool bar icons. The tool bar is a shortcut to selected menu commands. The main menu and main tool bar options are consistent and available throughout the software regardless of which windows may be open. The module tool bar options depend on the window of CRIS in which you are working, so the options will change as you work through the system.

Data Entry

There are a number of ways to enter data throughout the CRIS system. You will need to be familiar with the variety of data fields available to select, enter, modify, and delete information in the CRIS work space.

Data fields include drop-down list boxes, protected fields, and input fields (e.g., alpha-numeric, date). A drop-down list box displays a list of choices when you select the down arrow at the right end of the field. If there are more choices than can fit in the box, scroll bars are provided so you can move quickly through the list.

Required fields are yellow. Data must be entered in the required field(s). Protected fields are grey.

These fields cannot be edited. Input fields that are not required are white. You are free to enter and edit information within these fields. Input fields can be alphanumeric or numeric only, such as the date field. Input fields are limited by the number of characters allowed within a specific field. The cursor will automatically move to the next field when the number of characters allowed in the current field is exceeded.

To move from field to field on the CRIS windows, there are several options: press the TAB key on your keyboard OR click on the field using the mouse OR use the arrow keys on the keyboard.

Drop-down list box field (indicated by down arrow at right end of field) allows selected input. Select the arrow and the available field selections appear in the box below the field. Then select the appropriate input item; OR, enter the first few letters of the desired option in the field. The first option that starts with the letters entered will display. You may continue entering letters until the desired option displays in the field.

Protected field. Appears grey. Data may not be entered or edited in a protected field.

Required field. Appears yellow. Data must be entered in the required fields.

Input field, not required. Appears white. You may enter and edit data in input fields.

Date field. Accepts only numeric input. Enter the month, day, and year (mm/dd/yyyy).

Query, Sort, and Scroll

To navigate through the CRIS tables and organize the information within those tables, you will use the query, sort, and scroll functions. You can create a query, sort data, and move through selected tables using the following icons:

Query, Sort, and Scroll Icons	
	Scroll to the first record.
	Scroll to the previous record.
	Scroll to the next record.
	Scroll to the last record.
	Enter criteria.
	Retrieve query.
	Sort.

Query

CRIS allows you to view a subset of the data in a table. You must be in Query Mode to define the criteria for records you want to retrieve. The Query Mode windows are accessed from the CRIS main menu on the main tool bar or the main menu icons. These windows display with the words "Query Mode" to the left of the window title (e.g., Query Mode - Claim Identifier Selection Listing).

> ♫ To return to Query Mode after retrieving a query, select the Enter Criteria icon, .

If any previous query information displays in the columns of the Query Mode window, select the Enter Criteria icon again to clear the previous information.

1 Move the cursor to the appropriate field (e.g., Claim Key, Patient ID), and enter the information to query.

> ♫ Not all fields in a record are available for defining query criteria. If you move the cursor to the column for a field that is not available, the column will turn black. Remember, you may also click the right mouse button on a column to learn the definition of the data field.

🎵 You may use the Query Mode to build complex searches of the data tables. Entering information in more than one column of a row is the equivalent of a logical AND. Entering information in more than one row is the equivalent of a logical OR. For example:

- If you specify a Claim Key and a Patient ID in the same row, the system will search the data table for the record(s) that contain the Claim Key AND the Patient ID.
- If you specify a Claim Key in one row and a Patient ID in another row, the system will search the data tables for the record(s) that contain the Claim Key OR the Patient ID.

2   To remove query criteria entered in a field, select the Enter Criteria icon, , to clear the Query Mode window fields.

3   When you are satisfied with the criteria specified, select the Retrieve Query icon, . You will exit the Query Mode and the listing window will display all records meeting the specified criteria.

4   If the query does not return any data, use a wildcard formula (the word **like**, a % sign, and the known term) to query with the part of the topic that is known.

If the first part of a topic is known, but the last part is unknown, enter: **like** *knowntopic*%. For example, if you know the Provider name begins with *Metro*, enter **like Metro%**.

If the middle of the topic is known, but the first and last part is unknown, enter: **like** *%knownpart%.* For example, if you know the middle of the Provider name is *Community*, enter **like %Community%**.

If the last part of the topic is known, but the first part is unknown, enter: **like** *%knownpart.* For example, if you know the Provider name ends in *Medical Services*, enter **like %Medical Services**.

Sort

Many CRIS windows allow you to arrange the displayed information in a different order. You may sort the rows in the table by one column or multiple columns and in ascending or descending order.

1   To set the sorting criteria, click the Sort icon, . The Specify Sort Columns window displays.
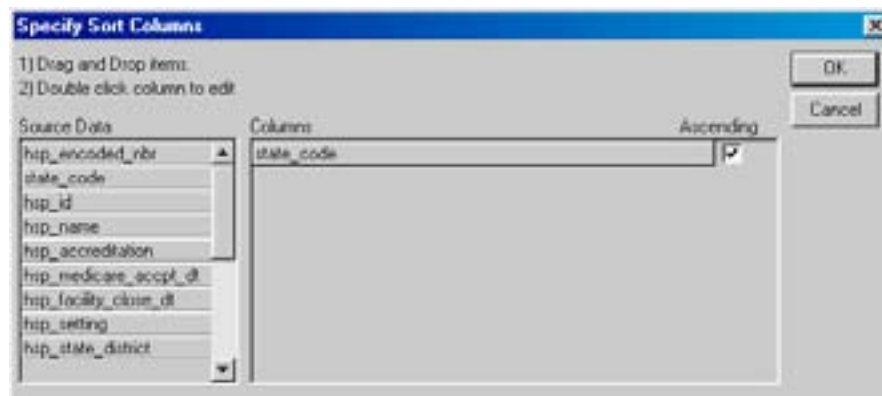
2   Drag and drop the desired item(s) from the *Source Data* scroll box to the *Columns* box.

- More than one data source may be placed under Columns. The information will be sorted first by the first column name selected, and then by the next column name selected, etc.

- CRIS automatically sorts the data in ascending order. A checkmark in the Ascending box indicates sort in Ascending order. To sort in Descending order, click on the checkmark. The checkmark will disappear and the data will be sorted in descending order.

3   Select **OK**. The data on the window is sorted according to the order you selected.

> ♫ The system also provides a quick sort capability. On the listing windows, click on the column title to sort the data in ascending order.

Scroll

To scroll through the data retrieved, use the Scroll icons, [⏮ ◀ ▶ ⏭].

Error Messages

CRIS has several types of error and warning messages to indicate system problems. When CRIS is unable to perform an requested action, you will be notified with a pop-up error window. Generally, these notices indicate the nature of the problem in the pop-up window title, and the corrective action needed in the pop-up window body. If you are unable to correct the problem, contact the point of contact at your QIO who may contact the SDPS Help Desk.

Following are a few samples of error messages that may be encountered:
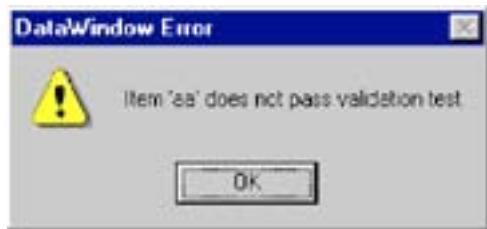
This message means CRIS detected a data entry error. In this case, the entry 'aa' is not valid for the field. CRIS cannot proceed with the request until a correction is made.

This message means CRIS detected a data entry error. In this case, a required field does not contain an entry. CRIS cannot proceed with the request until correction is made.
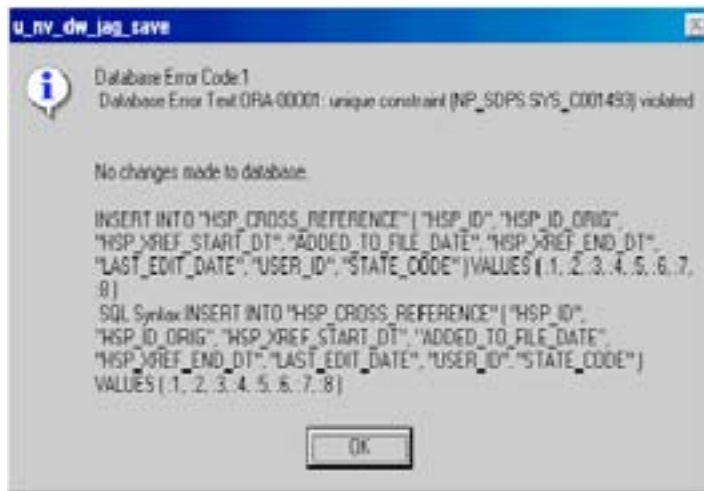
u_nv_dw_jag_save

Database Error Code:1
Database Error Text:ORA-00001: unique constraint (NP_SDPS.SYS_C001493) violated

No changes made to database.

INSERT INTO "HSP_CROSS_REFERENCE" ("HSP_ID", "HSP_ID_ORIG",
"HSP_XREF_START_DT", "ADDED_TO_FILE_DATE", "HSP_XREF_END_DT",
"LAST_EDIT_DATE", "USER_ID", "STATE_CODE") VALUES (:1, :2, :3, :4, :5, :6, :7,
:8)
  SQL Syntax: INSERT INTO "HSP_CROSS_REFERENCE" ("HSP_ID",
"HSP_ID_ORIG", "HSP_XREF_START_DT", "ADDED_TO_FILE_DATE",
"HSP_XREF_END_DT", "LAST_EDIT_DATE", "USER_ID", "STATE_CODE")
VALUES (:1, :2, :3, :4, :5, :6, :7, :8)

OK

This message in the pop-up window is produced by the database software, not by CRIS. In this case, you may print the message and forward it to your system administrator to target and correct the problem.

CRIS Application Roles

CRIS has three roles in two areas, Review and Helpline. The roles are Review Admin, Review Update, Review Read, Helpline Admin, Helpline Update, and Helpline Read.

The **Admin** role allows you to select, insert, update and delete from your Review data tables and the Code maintenance tables and to read the Claim tables.

The **Update** role allows you to select, insert, update and delete from the Review data tables. The Update role allows you to read the Claim data and Code tables.

The **Read** role allows you to read the Review, Claim and Code tables.

CRIS REVIEW DATA TABLES			
Application Role	**CRIS Review data tables**	**CLAIM data tables**	**Special Review Code Tables**
CRIS Review Admin	Select, Insert, Update, Delete from your own state(s)	Select your own state(s)	Select from your own state(s) plus 'XX' state; Insert, Update, Delete your own states
CRIS Review Update	Select, Insert, Update, Delete from your own state(s)	Select your own state(s)	Select from your own state(s) plus 'XX' state
CRIS Review Read	Select your own state(s)	Select your own state(s)	Select from your own state(s) plus 'XX' state

CRIS HELPLINE DATA TABLES

Application Role	**CRIS Helpline data**	**CLAIM data tables**	**Special Helpline Code**
CRIS Helpline Admin	Select, Insert, Update, Delete from your own state(s)	Select your own state(s)	Select from your own state(s) plus 'XX' state; Insert, Update, Delete their own states
CRIS Helpline Update	Select, Insert, Update, Delete from your own state(s)	Select your own state(s)	Select from your own state(s) plus 'XX' state
CRIS Helpline Read	Select your own state(s)	Select your own state(s)	Select from your own state(s) plus 'XX' state

To obtain access to the CRIS application, your security point of contact should submit a QualityNet Access form for each person at the QIO who needs access to CRIS. The QualityNet Access Form is available on the QIOnet at Forms|SDPS|QualityNet Access Request Form.

This message in the pop-up window is produced by the database software, not by CRIS. In this case, you may print the message and forward it to your system administrator to target and correct the problem.

Chapter 4 - Claim Identifier and Record Tracking

Claim Identifier
and
Record Tracking

Objectives

After completing this chapter, you will be able to:

- Access the Claim Identifier, Claim Identifier History and Claim Identifier Select windows

- Manually update the component row in the Record Tracking system

- Process the CMS Selections (HWDRG and HINN records)

- Import and manually add records to CRIS

- Process the HPMP Sample Canceled by CDAC records

- Process Batch records

- Run the 15 day Reminder and 30 Day Technical Denial reports

Overview

Claim Identifier is the starting point for all cases added to CRIS. This includes any case identified for case review or project data collection. There must be a record in the Claim Identifier table before you can request a medical record or perform review. Each case is assigned a unique identification number called a **Claim Key**. The Claim Key stays with the case throughout the system even if one of the five main fields change, i.e., beneficiary claim number, provider ID, claim from date, claim thru date, or inpatient/outpatient indicator.

The Claim Identifier window allows staff with the appropriate security roles to view records that have been added to CRIS. A claim identifier record might be added through the CMS monthly merge selections, imported on the Import/Print Medical Records window, inserted on the HINN/NODMAR Log or added by the HPMP Canceled Abstraction by CDAC processing.

Before a record can be added to Record Tracking or viewed in the Assign Review Records module, it must be in the Claim Identifier table.

Claim Identifier Menu

There are three options in the Claim Identifier menu:
  Claim Identifier Listing – contains a listing of all records in CRIS.

Claim Identifier History Listing – a copy of the previous Claim Identifier record displays. A history record is written to the history table whenever one of the key fields is updated.

Claim Identifier Selection Listing – all selection reasons associated with a medical record displays.

Record Tracking Menu

There are thirteen options in the Record Tracking menu:
Record Tracking Listing – all tracking locations associated with a medical record displays.

Record Tracking Listing Last Location – the last tracking location associated with a medical record displays. If more than one tracking location has the same tracking date both will display.

Batch Record – allows logging of medical records into the record tracking system by Claim Key and Component. The records can be added by using the light pen, wand or by manually adding the records. An unlimited number of records can be logged before saving to the database.

Batch Postage and Pages – allows logging of medical records into the record tracking system by Claim Key, Component, and Postage and Pages. The records can be added by using the light pen, wand or by manually adding the records. An unlimited number of records can be logged before saving to the database.

CMS Selections/Print Medical record Requests – allows processing of the Higher Weighted DRG (HWDRG), retrospective Hospital Notice of Noncoverage (HINN) selections, and the HPMP Cancelled by CDAC records. The HWDRG and HINN selections are added via the CMS monthly merge. The medical record reports necessary to request the medical records can be printed from this window. The CMS monthly merge process and the HPMP processing will add the record to the Claim Identifier and Claim Identifier Selection tables. When the record is processed on this window a component row is added to the record tracking system.

Import/Print Medical Record Requests – allows medical records to be added to CRIS by importing a file or manually inserting the required information. The CMS selections and HPMP records are not processed on this window. If the record already exists in the Claim Identifier table, the existing Claim Key will be assigned to the record, a component row will be added to the record tracking system, and the record will be added to the Claim Identifier Selection table.

If the record does not exist on the Claim Identifier table a new Claim Key will be assigned to the record, a component row will be added to the record tracking system, and the record will be added to the Claim Identifier Selection table. After the record is added and saved, the medical record request reports, coversheets, working lists and labels can be printed.

Reprint Medical Record Requests – any medical record with a component row in the record tracking system can be retrieved and the desired medical record request reports can be printed. Reports can be printed by a single row or multiple rows.

15 Day Reminder Report — any medical record with a component row in the record tracking system can be retrieved and the desired medical record request reports can be printed. Reports can be printed by a single row or multiple rows.

15-Day Reminder Report No Select Reason — provides the same information without displaying the Select Reason. After running either of the reports, an option is available to add the component row to the record tracking system with the Action of 15-Day Reminder Identified.

The following criteria must be met for a record to display on the report:
- the medical record was requested (Action code of 1)
- the medical record has not been received (no Action code of 2)
- there is no technical denial (no Action code of 6)
- no 15-Day reminder letter has been identified (no Action code of 7)

30-Day Technical Denial Report — cases not received at least 30 days from the date of request display on the report. After the report has run an option is available to add a component row in the record tracking system with an Action of 'Technical Denial Identified.'

30-Day Technical Denial Report All Settings — cases for all settings that have not been received at least 30 days from the date of the request display on the report.

The following criteria must be met for a record to display on the report:
- the complete record (Component 0001) was requested (Action code of 1)
- the complete record (Component 0001) has not been received (no Action code of 2)

HPMP Sample Cancelled by CDAC Report — cases identified in the CATS application as Hospital Payment Monitoring Program (HPMP) records that were not received by the CDAC display. The HPMP records must have been processed on the CMS Selections window before they are available to display on this report. After the report has run, an option is available that will add a component row in the record tracking system with an Action of 'Technical Denial Identified', create the technical denial row, and create the technical denial adjustment.

Canceled Abstractions for Technical Denials — allows records that were canceled by the CDAC because they were not received to be processed in CRIS for a technical denial.

Hints

1 Required fields are yellow.

2 Read-only fields are gray.

3 Optional fields are white.

4 Use the TAB key to move between fields within a section of the window.

5   Right click with your mouse on any of the fields to access the online help for the field.

6   To select a row, highlight the row by clicking on it with your mouse.

7   We do not recommend that you query by State Code.

8   When retrieving data, if no data displays check the criteria you entered and retrieve again.

9   If a field is not available for retrieving data, it will turn black when it is clicked on with the mouse.

Claim Identifier Listing

The Claim Identifier Listing window contains all of the cases added to CRIS whether added with the CMS selections, imported or manually inserted, or added on the HINN/NODMAR Log.

1   To access the Claim Identifier Listing window, select **Claim Identifier|Claim Identifier Listing.**
OR
Select the Claim Identifier Listing icon, [C] .

The Claim Identifier Listing window displays in Query Mode.

2   Select the Enter Criteria icon, [?0] .

Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window. You will be able to enter retrieval criteria in most of the fields.

4   Select the Retrieve Query icon, [icon] .
OR
Press Enter.

Claim Identifier records meeting the criteria you entered will display.

Claim Identifier Update

If a record was manually added to CRIS and there is no HSE Unique ID on the claims warehouse on SDDW, you will be able to modify any of the open fields.

If there is a value in the HSE Unique ID field, you will not be able to update the record.

1 To modify one of the open fields for the claim from the Claim Identifier Listing window, highlight the desired row by clicking on it with your mouse.

2 Select the Modify icon, [icon] .

The Claim Identifier Update window displays.

3 Modify the information in one of these fields:
> Patient ID
> Provider ID
> HSP NPI
> UPIN/NPI
> From Date
> Thru Date
> I/O Ind
> Non-billing Provider ID

4 Select the Save icon, [icon] .

The record will be saved and the previous Claim Identifier information will be copied to the Claim Identifier History table.

5   If MA coverage is found, the MA ID field will update.

Check Matching Claims

If a row exists in the Claim Identifier History table on the Claim Identifier window that has a From or Thru Date that matches a record you are trying to import for the same Beneficiary and Provider or Physician:

1   To allow the system to create a new Claim Key, change the Yes to **No** in the Check Matching Claims field for that row.

2   To prevent the system from creating a new Claim Key, leave the default of **Yes** in the Check Matching Claims field for that row.

Delete a Claim Key

Users with the CRIS Review Admin role can delete Claim Keys from the system.

To delete a Claim Key:

1   Select **Claim Identifier|Claim Identifier Listing**
OR

Select the Claim Identifier Listing icon, .

2   The Claim Identifier Listing window displays. Clear any previously entered criteria and enter the Claim Key you want to delete.

♫   You will not be able to delete Claim Keys with CMS selection reasons, i.e., 113, 120, 200, 210, or 213. If you attempt to delete one of these select reasons, the following message displays.

3   Select the Retrieve Query icon, .

4   Select the Modify icon, .

The Claim Identifier Update window displays.

5   Select the Delete icon, .

A Delete message displays, 'Delete row 1 for Claim Identifier Update....'.
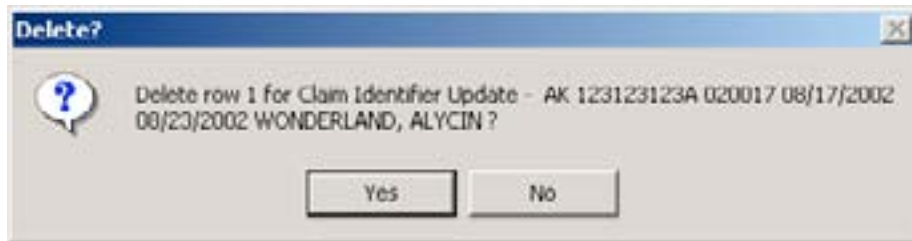
6   Select **Yes** to continue.

A second Delete message displays indicating the number of rows of data that have been entered in the system and asking if you want to delete the Claim Key.

7   Select **Yes** to continue.

A *Reason for Delete* box displays.

8   Enter a brief description of why the Claim Key is being deleted. The field will hold 100 characters and is required prior to continuing with the delete.

9   Select the **OK** button
    OR
    If you determine you do not want to delete the Claim Key, select the **Abort** button.

10 When you select the **OK** button the screen will go blank.

11 Select the Save icon, . A message displays stating that the Claim Key has been deleted. At this point you will not be able to retrieve any of the deleted data.

> ♫ When the Claim Key has been deleted, you will not be able to retrieve any of the data. If the Claim Key was deleted in error, you will need to reenter all of the information.

12 Information regarding the deleted Claim Key has been written to the View module in the Deleted Claim Identifier window.

View a Deleted Claim Key

After the CRIS Review Admin has deleted a Claim Key, you will be able to view information about the Claim Key on the Deleted Claim Identifier window.

To view a deleted Claim Key:

1 Select **View|Deleted Claim Identifier**

The Deleted Claim Identifier Listing window displays.

2 Clear any previously entered criteria and enter the Claim Key you want to view.

3 Select the Retrieve Query icon, .

The information regarding the deleted Claim Key includes who deleted the Claim Key, the date of the deletion, and the reason for the deletion.

Claim Identifier History Listing

The Claim Identifier History Listing is view only and displays the history for a record if one of the key fields have been updated.

1 To access the Claim Identifier History Listing window, select **Claim Identifier| Claim Identifier History Listing.**

The Claim Identifier History Listing window displays in Query Mode.
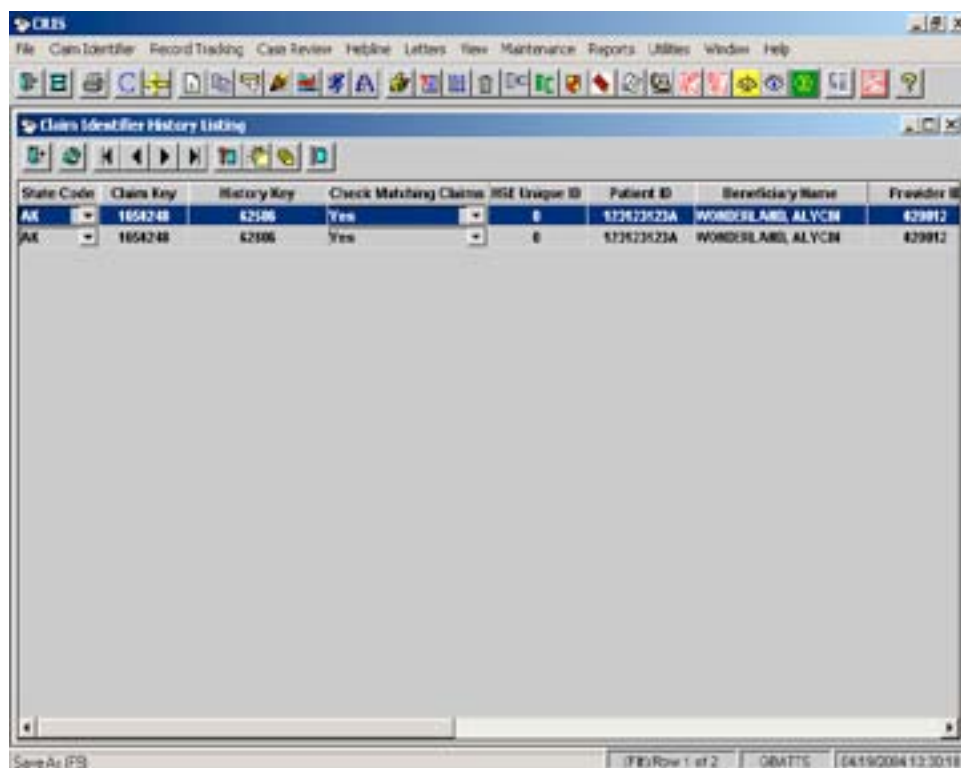
2 Select the Enter Criteria icon, .

Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window. You will be able to enter retrieval criteria in most of the fields.

4   Select the Retrieve Query icon, [icon].
OR
Press ENTER.

Claim Identifier History records meeting the criteria you entered will display.
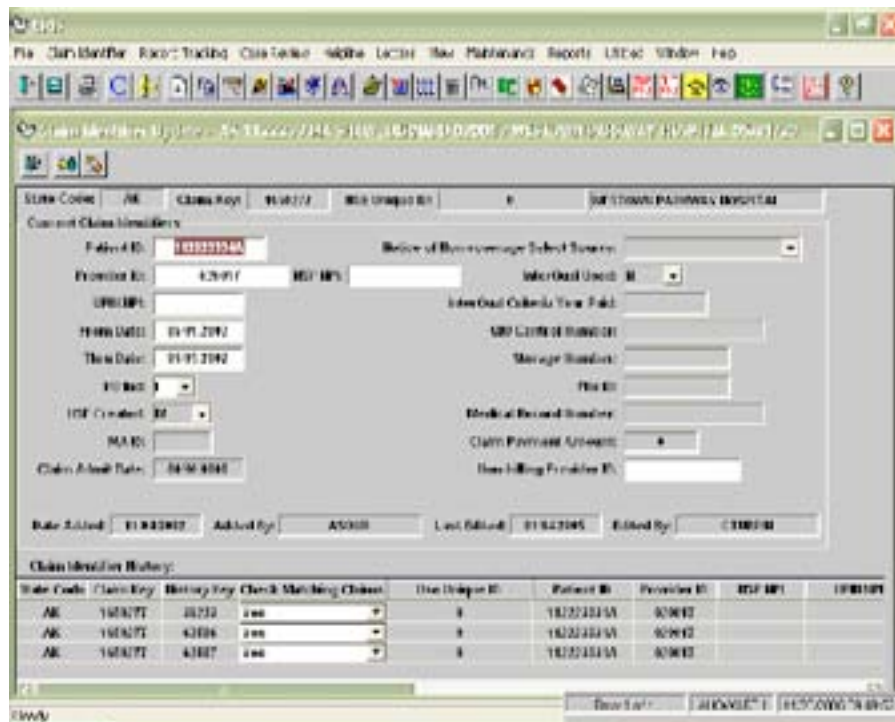

Claim Identifier Selection Listing

When a case is added to CRIS through the CMS selections, imported or manually inserted, a selection reason is added to the record. A record can have multiple selection reasons. All of the selection reasons for a record will display on this window. You will be able to access the record in the Case Review module if it has been assigned to review in the Assign Review Records module.

1   To access the Claim Identifier Selection Listing window, select **Claim Identifier|Claim Identifier Selection Listing**
OR

Select the Claim Identifier Selection Listing icon, [icon].

The Claim Identifier Selection Listing window displays in Query Mode.
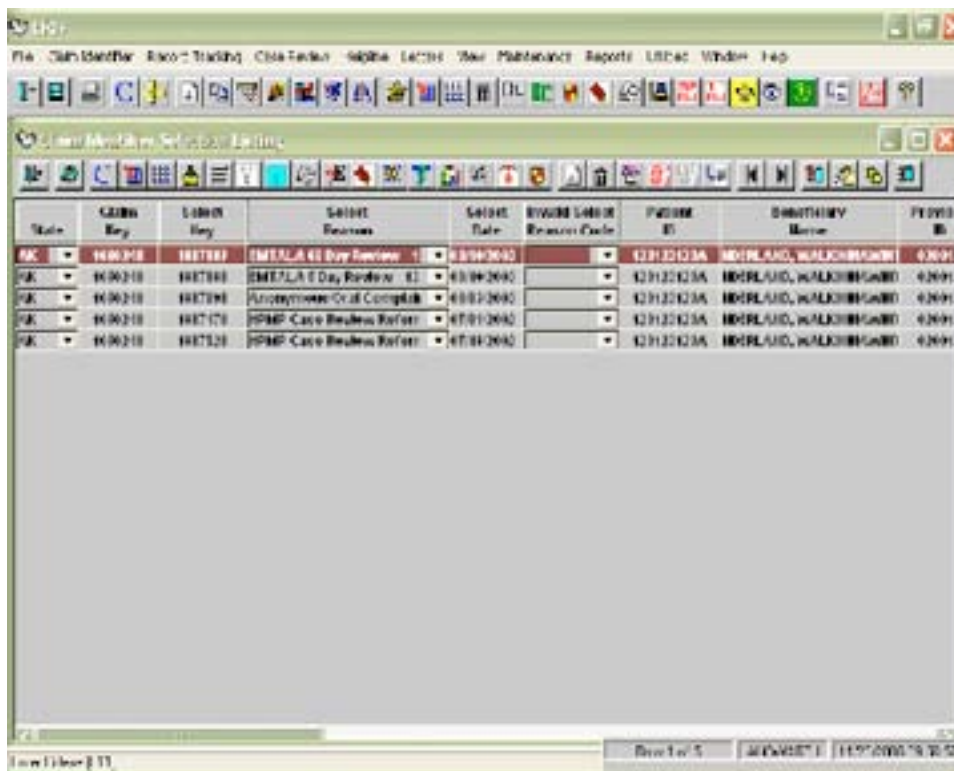
2   Select the Enter Criteria icon, .

Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window. You will be able to enter
retrieval criteria in most of the fields.

4   Select the Retrieve Query icon, .
OR
Press ENTER.

Claim Identifier Selection records meeting the criteria you entered will display.

Add New Selection Reason to an Existing Record

A new selection reason can be added to an existing Claim Key.

To add another selection reason:
1   Highlight the desired row by clicking on it with your mouse.

2   Select the Selection Reasons icon, .

The Selection Reasons window displays.

3 Select the Insert icon and enter a new Select Reason from the drop-down list.
OR
Begin typing the first few letters of the Select Reason and select the appropriate option from the drop-down list.

The Select Date defaults to today's date and can be overwritten.

♬ You will not be able to add the same Select Reason and Select Date for multiple rows.

- A Select Date cannot be in the future.
- A Select Date can be in the past, but a message will display warning that the date is in the past.
- Select Reason "500—QIO Reason for Review", must also have at least one CMS Select Reason.
- A Select Reason cannot be marked as invalid if it is used in Review Type, Notice of Non-coverage, Technical Denial, Reason for Delay, QIO Reopen, ALJ Review, or Beneficiary Complaint Setting window. The Select Reason must be removed from these windows before it can be marked as invalid.
- A Select Reason must be assigned to case review before it will be available to select in the review module.
- If there is a date in the Select Reason End Date field, the Select Reason can no longer be used from that date forward.

4 When a review record has been assigned through the Assign Review Records option, a **Yes** will display in the Review Started field.

5 Select the Close Window icon, ![close window icon], to exit the window.

6 Assign the review on the Assign Review Records window for the new selection reason.

Record Tracking

The Record Tracking module contains a list of all the records tracked throughout the review process. When the CMS Selections are added or records are added through the Import/Print Medical Record Request windows, a component row is added to the Record Tracking system.

1 To access the Record Tracking system, select **Record Tracking|Record Tracking Listing**
OR

Select the Record Tracking Listing icon, ![record tracking listing icon] .

The Record Tracking Listing window displays in Query Mode.

2 Select the Enter Criteria icon, ![enter criteria icon] .

Any previously entered criteria will clear.
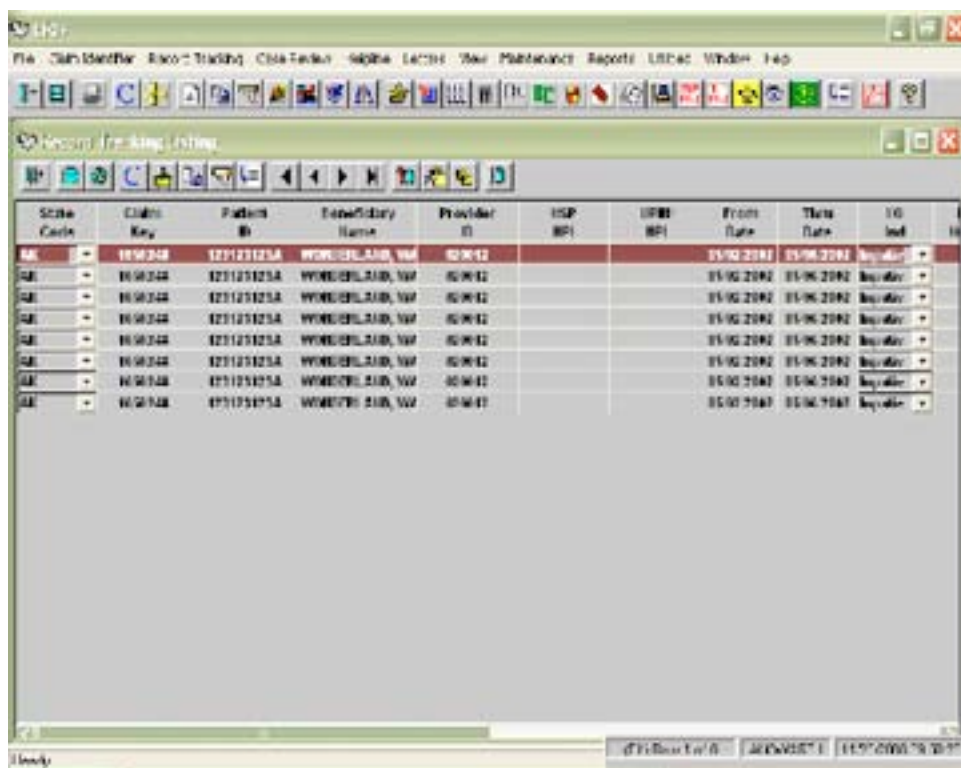
3   Enter data into one or more of the fields on the window. You will be able to enter retrieval criteria into most of the fields.

4   Select the Retrieve Query icon, .
     OR
     Press ENTER.
     Cases meeting the criteria you entered will display.

5   To manually add information to the Record Tracking window, please see the section in this chapter called Manually Add the Record Component to Record Tracking.

6   Highlight the desired record and select the Modify icon, .

The Record Tracking window displays.
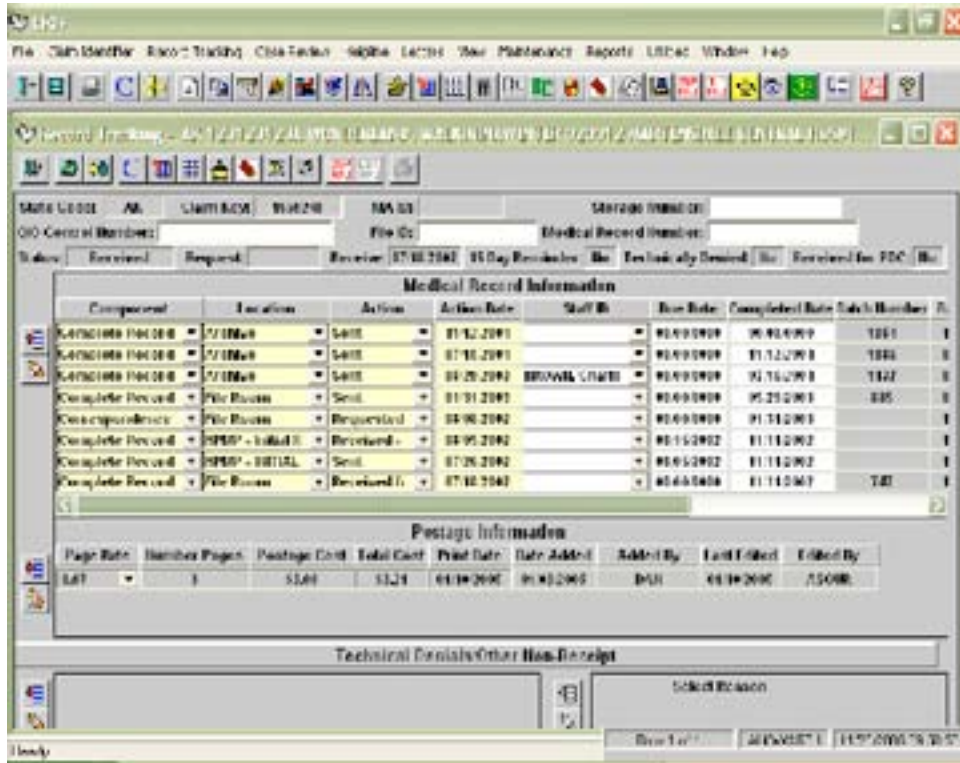
♪ If a Select Reason has been added, and the record has been received for case review, that has not been assigned to case review, the Assign Review Record icon, [icon] , will be available. When you select this icon, the Assign Review Listing window displays in query mode. The state Code and Claim Key autopopulate. (See the Assign Review Records section in the Case Review chapter, beginning with selecting the Retrieve Query icon, [icon] .)

7 To exit the Record Tracking and Record Tracking Listing window, select the Close Window icon, [icon] .

♪ The Record Tacking window can be accessed from most windows in CRIS by selecting the Record Tracking icon, [icon] .

CMS Monthly Merge Selections

When the CMS monthly merge case review selections have been added to the database, your SDPS point of contact, database administrator point of contact, and review point of contact will receive notification via SDPS memo. You can then run the medical record request forms. The records added to CRIS via the CMS monthly merge have been added to the Claim Identifier and Claim Identifier Select table with a Claim Key.

1   To access and run the CMS selections, select **Record Tracking|CMS Selections/ Print Medical Record Requests**
    OR

    Select the CMS Selections/Print Medical Record Requests icon, .
    The CMS Selections/Print Medical Record Requests List window displays in Query Mode.

2   Select the Enter Criteria icon, .

    Any previously entered criteria will clear.

3   You can retrieve cases several ways:
    • Enter the State Code, Claim Key, Patient ID etc.
    • Enter the Select Reason, e.g., Higher Weighted DRG (120), or Notice of Non-cover-age Retrospective (113).

        ♫   Any case added to the Claim Identifier table that does not have a Record Tracking component will display on this window.

4   Select the Retrieve Query icon, .

    Cases meeting the criteria you entered will display.
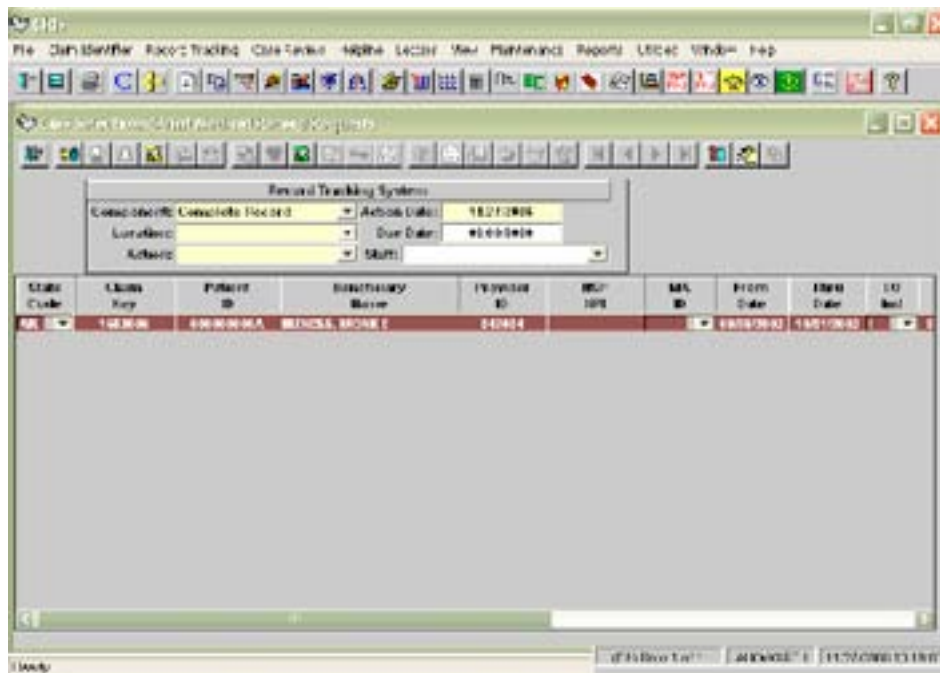
Record Tracking System Section

5   In the Record Tracking System section, the component defaults to Complete Record, Location is null, Action is Null, Action Date defaults to today's date and Due Date is null. You can change these values. However, the Component must be Complete Record (0001) in order to display on the 15 Day and 30 Day Technical Denial Reports.

> ♫   If the number of Days Due has not been entered for the Location on the Record Tracking Location Maintenance window, the system will not calculate the Due Date for the records. You will need to enter the Due Date in this section.

6   Add a Staff ID if desired. This staff ID is added to the component row in Record Tracking.

7   Select the Save icon, . If you leave the Due Date field null, it is filled by the system based on the Location Code Days Due. A batch number is assigned to the component row on the Record Tracking window.

The medical record request icons are enabled.

Printing Medical Record Request Reports

To preview and print medical record request reports after the medical records have been retrieved on the CMS Selections window:

1   To preview and print all of the rows displayed on the window, select the desired icon.

> ♫   See the following section for a complete list of the icons.

2   Select the Print icon, , on the main tool bar to print the reports.

Show/Hide HIPAA Language

HIPAA language has been added to the bottom of the three Medical Record Request reports to assist QIOs in clarifying the HIPAA laws for providers. This language will display unless the Show/Hide HIPAA Language icon, , is selected.

Selecting the icon will hide or show the following language: "When information sought by the QIO is required by statute or regulation, the HIPAA Privacy Rule does not require prior authorization for the release of PHI (Protected Health Information), nor does it require that the provider execute a business associate agreement with the QIO."

Reports and Labels

Previously Requested Report   Selecting this icon will display a list of previously selected records. This report is not available on the Reprint Medical Record Requests window.

Cover Sheet   Selecting this icon will display coversheets for all records on the window without MA.

Cover Sheet for Window Envelopes		Selecting this icon will display coversheets for all records on the window without MA. When folded, the provider contact and address will display in the window of an envelope.
Working List of All Imported Records		Selecting this icon will display a working list for all records on the window without MA.
Medical Record Requests		Selecting this icon will display the medical record request report for all records on the window without MA.
Previously Requested MA		Selecting this icon will display a list of Report records with MA IDs previously selected for review. This report is not available on the Reprint Medical Record Requests window.
Cover Sheet MA		Selecting this icon will display coversheets for all records on the window with MA.
Cover Sheet MA for Window Envelopes		Selecting this icon will display coversheets for all records on the window with MA. When folded, the provider contact and address will display in the window of an envelope.
Working List of All Imported Records MA		Selecting this icon will display a working list for all records on the window with MA not previously requested. The report pages by State Code, MA ID, Select Date, and Due Date.
Medical Record Requests MA		Selecting this icon will display the medical record request report for all records with MA on the window.
Medical Record Request MA Provider		Selecting this icon will display the medical record request report for all records with MA ID not previously requested. This report is similar to the Medical Record Requests MA report; however, this report also dsiplays provider information.
Facility Mailing Label		Selecting this icon will display the facility mailing labels.
Physician Mailing Label		Selecting this icon will display the physician mailing labels.

MA Mailing Labels		Selecting this icon will display the MA mailing labels.
Document Labels		Selecting this icon will display the document labels without a barcode.
Document Labels - Claim Key Top		Selecting this icon will display the Claim Key Top document labels with a barcode on the top of the label.
Document Labels Claim Key Bottom		Selecting this icon will display the Claim Key Bottom document labels with a barcode on the bottom of the label.

For the Provider ID and Provider Name to display on the medical record request reports and labels the following must be done:

1   In PRS on the Contact, Address, and Telephone window for each Health Service Provider, HMO, or PhysicianUPIN/NPI, a row must be added with an Address Phone Type of Medical Records, a Contact Type of Medical Records, and a Contact Name.

2   The medical record contact row must have a corresponding address ID.

For the QIO name and address to display on the medical record request reports and labels the following must be done:

1   In PRS on the Contact, Address, and Telephone window for your QIO, a row must be added with an Address Phone Type of Medical Records, a Contact Type of Medical Records, and a Contact Name.

2   The medical record contact row must have a corresponding address ID.

Printing Labels

To preview and print labels after the medical records have been retrieved on the CMS Selections window, manually inserted or imported on the Import/Print Medical Records Request window, or retrieved on the Reprint Medical Record Requests window:

1   Select the icon for the desired label.

The Print Preview Labels window displays with information on one label.

2   Select the Change Label Type icon, [icon] , to preview the different label sizes.

Mailing labels sizes are:
1" x 2.63" – 3 across and 10 down
1" x 4" – 2 across and 10 down
1.33" x 4" 2 across and 7 down

Document label sizes are:
1" x 4" – 2 across and 10 down
1.33" x 4" – 2 across and 7 down

3 Continue selecting the Change Label Type icon until you find the desired label.

4 Select the Copy Each Row to a Full Page icon, , to create a full page of labels for the label(s) displayed on the window.

5 Select the Copy Each Row to a Specified Number of Labels icon, , to create a limited number of labels for each label display on the window.

   A window displays to allow you to enter the number of labels.

6 Enter the desired number of labels and select **OK**.

7 Select the Print icon, , on the main tool bar to print the label.

Import/Print Medical Record Requests

Cases not added to CRIS via the CMS monthly merge are added through the Import/Print Medical Record Requests window. When the records are inserted on this window, they are added to the Claim Identifier table with a Claim Key and to the Record Tracking Component table with record tracking component row. You can insert or import records for case review or project data collection.

1 To manually insert records into CRIS, select **Record Tracking|Import/Print Medical Record Requests**
   OR

   Select the Import /Print Medical Record Requests icon, .

   The Import/Print Medical Record Requests window displays.

2 Select a State Code if you are a multi-state QIO.

3 Select the Insert icon, , on the second toolbar.

   An empty row displays. The Select Reason and Record Tracking System sections display.

4 Select one or more Select Reasons.

   ♫ To add another selection reason, select the Insert icon, , next to the Select Reason field.

   • A Select Date cannot be in the future.
   • A Select Date can be in the past, but a message will display warning that the date is in the past.
   • Select Reason "500—QIO Reason for Review", must also have at least one CMS Select Reason.

- A Select Reason cannot be marked as invalid if it is used in Review Type, Notice of Non-coverage, Technical Denial, Reason for Delay, QIO Reopen, ALJ Review, or Beneficiary Complaint Setting window. The Select Reason must be removed before it can be marked as invalid.
- A Select Reason must be assigned to case review before it will be available to select in the review module.
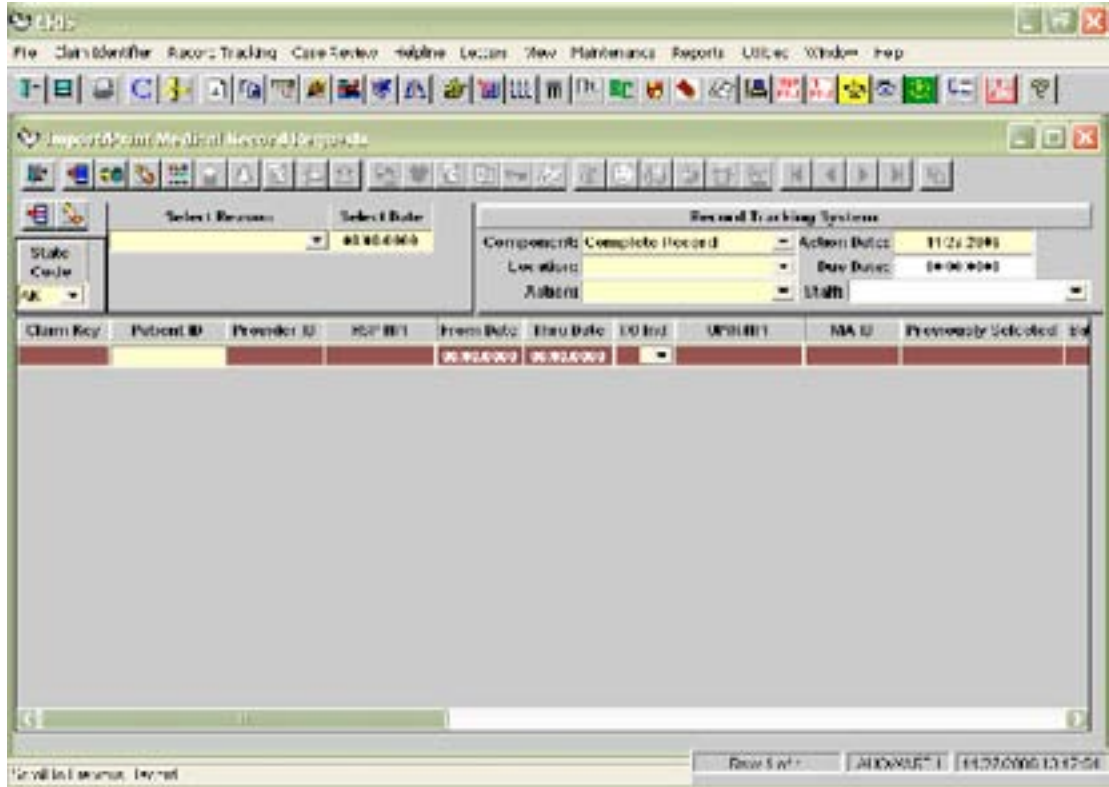
5   Enter the Select Date. An edit will prevent entry of a future date.
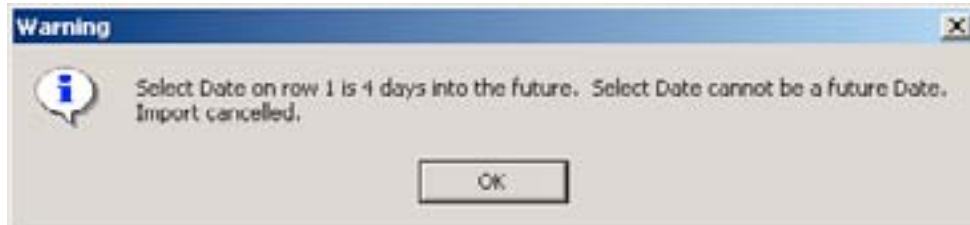
If a past Select Date is entered, a warning will display indicating that the Select Date is in the past. You can override this warning.

Warning

? Select Date on row 1 is 13 days into the past. Are you sure?

[OK] [Cancel]
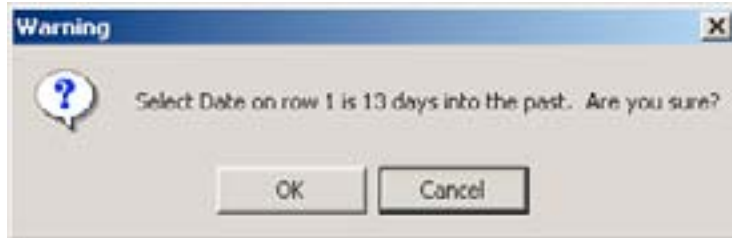
6   Enter data into the following fields:
    Patient ID
    Provider ID **or** HSP NPI or
    Physician UPIN/NPI (if requesting records from a physician office or clinic)
    From Date
    Thru Date
    I/O Indicator
    Non-billing Provider ID (if requesting records from a non-billing provider)

> ♫   If requesting records from a non-billing provider, the provider must be
>   entered into PRS before you can use it in CRIS.

Continue inserting rows as needed. The number of records that can be added at one time
is limited to 1,000 rows.

> ♫   You will only be able to enter a valid provider from your state.

7   In the Record Tracking System section, Component defaults to Complete Record, Lo-
    cation is null, Action is null, Action Date defaults to today's date and Due Date is null.
    These values can be changed.

> ♫   If the number of Days Due has been entered for the Location on the Re-
>   cord Tracking Location Maintenance window, the system will calculate
>   the Due Date for the records.

8   Add a Staff ID if desired. This staff ID appears on the component row in Record
    Tracking.

9   Select the Save icon, .

An update message displays at the lower left of your screen indicating that a Claim Key
is being retrieved.

10 When the save is complete, the medical record request icons are enabled.

Importing a List of Cases

Records can be imported on the Import/Print Medical Record Request window. The number
of records that can be imported at one time is limited to 1,000 rows.

1   To import a list of cases, select **Record Tracking|Import/Print Medical Record
    Requests**
    OR

Select the Import /Print Medical Record Requests icon, [icon] .

The Import /Print Medical Record Requests window displays.

2   Select a State Code if you are a multi-state QIO.

The Select Reason and Record Tracking System sections display.

3   Select one or more Select Reasons. The Select Date is null and a date must be entered.

To add another selection reason, select the Insert icon, [icon] , next to the Select Reason field.

4   Select the Import Claim Identifiers icon, [icon] .

A Select Import File box displays.

♫   The import file layout can be found in the Appendix called Claim Identifier Import Layout.

Printing Medical Record Request Reports and Labels

To print the medical record request reports and labels, see the instructions in the CMS Selections/Printing Medical Record Reports and Labels topic covered previously in this chapter.
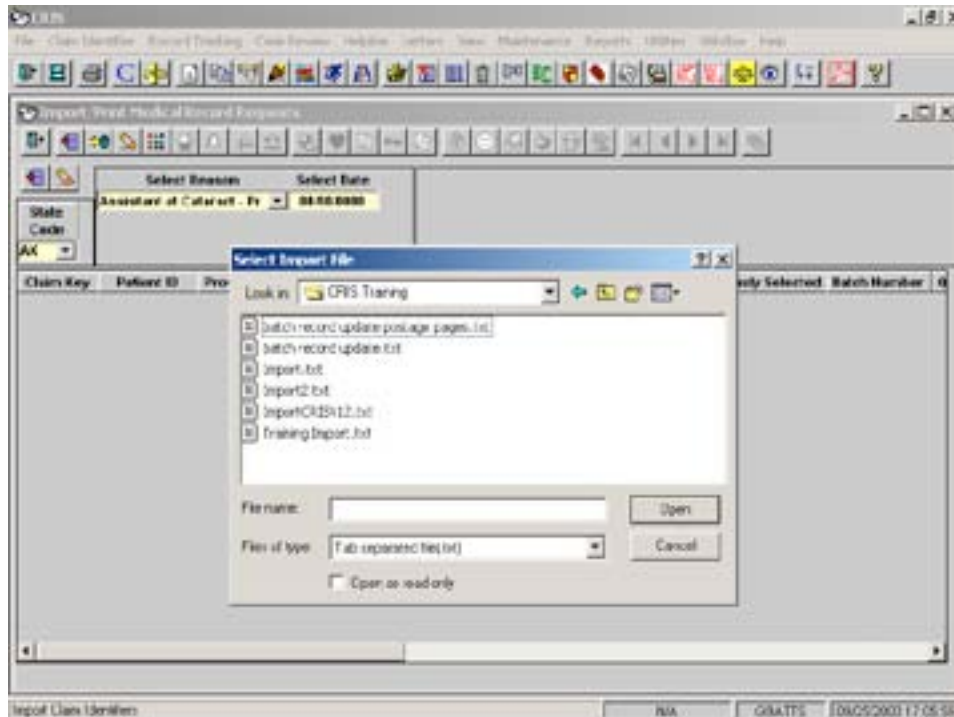
5   Select the drive, directory, and file name to import.

6   Select **Open**.

7   In the Record Tracking System section, Component defaults to Complete Record, Location is null, Action defaults to Requested, Action Date defaults to today's date and Due Date is null. These values can be changed.

♫   If the number of Days Due has been entered for the Location on the Record Tracking Location Maintenance window, the system will calculate the Due Date for the records.

8   Add a Staff ID if desired. This Staff ID appears on the component row in Record Tracking.

9   Select the Save icon, .

An update message displays at the lower left of your screen indicating that a Claim Key is being retrieved.

10   When the save is complete, the medical record request icons are available to select.

11   Run the desired medical record request forms described in the previous section.

Tracking Medical Records

When you receive medical records requested for case review you must track them with an *Action* code of 2 -Received for Case Review. This allows the record to be available in the Assign Review Records module. When the case has been assigned to review, the Review base and Review Type records are created based on the selection reason.

When you receive medical records for project data collection, track them with an *Action* code of 8 - Received for Project Data Collection.

Batch Record Update

1   To add the record through Batch Record Update, select **Record Tracking|Batch Record**
OR

Select the Batch Record Update icon, .

The Batch Record Update window displays.

2   Select a State Code.

3   Select the Insert 1 Row icon, , to insert a single row, or select the Insert 20 Rows icon, .

The system will insert 20 rows. You can continue to select the icon to insert as many rows as desired. This process allows for an unlimited number of rows to insert data.
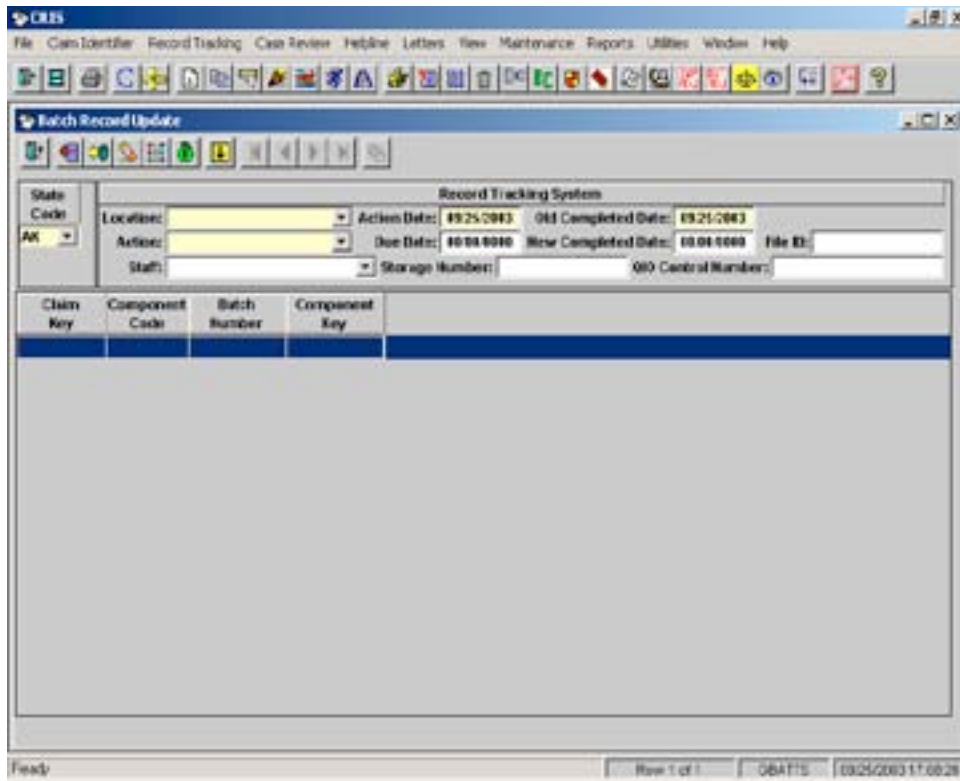
4   In the Record Tracking System section, enter data in the following fields:
Location
Action
Staff

> ♫   If the case(s) is received for case review, you must use Action code 2 -
> Received for Case Review.

5   The Action Date defaults to today's date.

6   The Old Completed Date defaults to today's date.

The date in the Old Completed Date field is copied to the Completed Date field in Record
Tracking for the current Component row.

7   Enter a Due Date if desired.

> ♫   If the number of Days Due has been entered for the Location on the Re-
> cord Tracking Location Maintenance window, the system will calculate
> the Due Date for the records.

8   Enter a New Completed Date if desired.

9   Type or use the wand to insert data into the following fields:
Claim Key
Component Code
OR

Enter the desired Component Code in the first row.   Select the Copy Component

icon, , to copy the Component Code to the remaining rows.

10   Select the Save icon, .

The Batch Number and Component Key are filled by the system. The Batch Number is associated with the new component row added to the record tracking system.

Import Cases on Batch Record Update

1   To import records on Batch Record Update, select **Record Tracking|Batch Record** OR

Select the Batch Record Update icon, .

The Batch Record Update window displays.

2   Select a State Code.

3   Select the Import icon, .

A Select Import File box displays.

♫   The import file layout can be found in the Appendix called Batch Record Update Layout.

4   Select the drive, directory, and file name to import.

5   Select **Open**.

     The records in the import file are added to the window.

6   A message displays indicating the number of imported rows. Select **OK**.

7   In the Record Tracking System section, enter data in the following fields:
     Location
     Action
     Staff

         ♫   If the case(s) is received for case review, you must use Action code 2 -
             Received for Case Review.

8   The Action Date defaults to today's date and can be changed.

9   The Old Completed Date defaults to today's date and can be changed.

     The date in the Old Completed Date field is copied to the Completed Date field in Record
     Tracking for the current Component row.

10   Enter a Due Date if desired.

         ♫   If the number of Days Due has been entered for the Location on the Re-
             cord Tracking Location Maintenance window, the system will calculate
             the Due Date for the records.

11   Enter a New Completed Date if desired.

12   Select the Save icon, ⮕ .

Auto Populate Batch Record Update

Claim Keys displayed on the Record Tracking Listing or Beneficiary Complaint Setting List-
ing window can be auto populated on the Batch Record Update window. All Claim Keys
must be for the same state.

1   To auto populate the Claim Keys on the Batch Record Update window, query for and
     retrieve the Claim Keys on the Record Tracking Listing or Beneficiary Complaint Setting
     Listing window.

2   Select the Batch Record Update icon, ▤ .

     The Claim Keys will auto populate on the Batch Record Update window.

3   Enter the State Code.

4   Enter the Record Tracking System information.

5   Enter the Component Code. You can use the Copy Component icon, , to copy the component to remaining rows.

6   Select the Save icon, .

Batch Postage and Pages Update

1   To add records through Batch Postage and Pages Update, select **Record Tracking|Batch Postage and Pages**
     OR

     Select the Batch Postage and Pages Update icon, .

     The Batch Postage and Pages Update window displays.

2   Select a State Code.

3   Select the Insert 1 Row icon, , to insert a single row, or select the Insert 20 Rows icon, .

     The system will insert 20 rows. You can continue to select the icon to insert as many rows as desired. This process allows for an unlimited number of rows to insert data.

4   Type or use the wand to insert data into the following fields:
     Claim Key
     Component Code
     Number Pages
     Postage Cost
     OR

     Enter the desired Component Code in the first row. Select the Copy Component icon, , to copy the Component Code to the remaining rows.

5   In the Record Tracking System section, enter data in the following fields:
     Location
     Action
     Staff

             ♫ If the case(s) is received for case review, you must use Action code 2-Received for Case Review.

6   The Action Date defaults to today's date and can be changed.

7   The Old Completed Date defaults to today's date and can be changed.

     The date in the Old Completed Date field is copied to the Completed Date field in Record Tracking for the current Component row.

8   Enter a Due Date if desired.

♫   If the number of Days Due has been entered for the Location on the Record Tracking Location Maintenance window, the system will calculate the Due Date for the records.

9   Enter a New Completed Date if desired.

10   Select the Save icon, .

The Batch Number and Component Key will be filled by the system. The Batch Number is associated with the new component row added to the record tracking system.
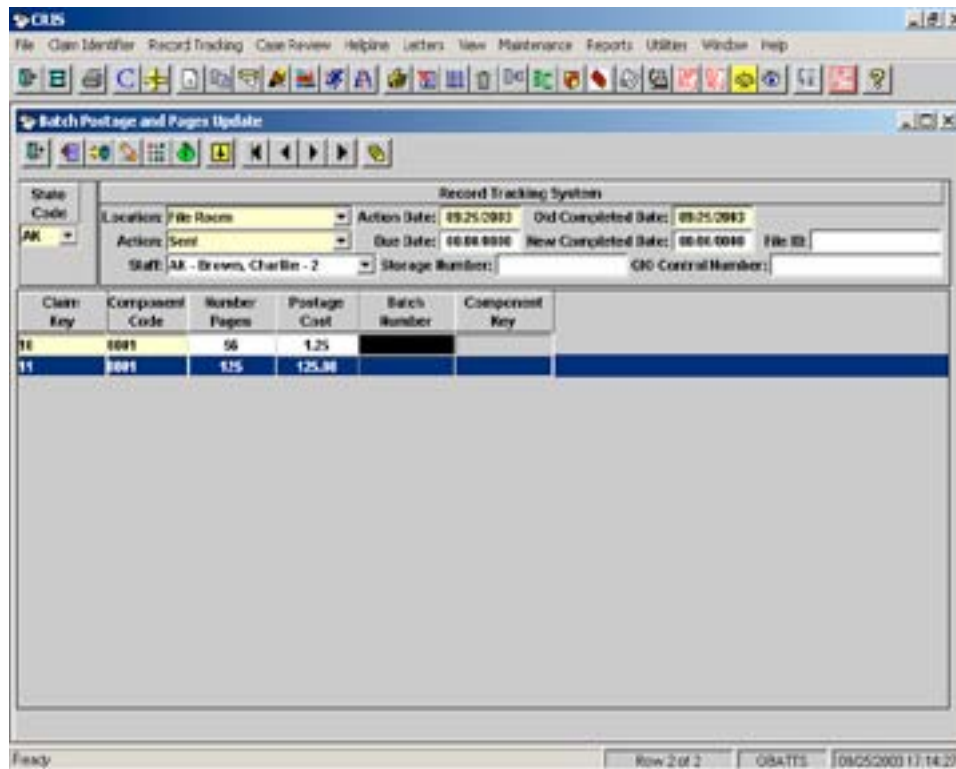
Import Cases on Batch Postage and Pages Update

1   Select **Record Tracking|Batch Postage and Pages**
     OR

     Select the Batch Postage and Pages Update icon, .

     The Batch Postage and Pages Update window displays.

2   Select a State Code.

3   Select the Import icon, .

A Select Import File box displays.

♫ The import file layout can be found in the Appendix called Batch Postage and Pages Update Layout.

4   Select the drive, directory, and file name to import.

5   Select **Open**.

The records in the import file are added to the window.

6   A message displays indicating the number of imported rows. Select **OK**.

7   In the Record Tracking System section, enter data in the following fields:
Location
Action
Staff

♫ If the case(s) is received for case review, you must use Action code 2 - Received for Case Review.

8   The Action Date defaults to today's date and can be changed.

9   The Old Completed Date defaults to today's date and can be changed.

The date in the Old Completed Date field is copied to the Completed Date field in Record Tracking for the current Component row.

10 Enter a Due Date if desired.

♫ If the number of Days Due has been entered for the Location on the Record Tracking Location Maintenance window, the system will calculate the Due Date for the records.

11 Enter a New Completed Date if desired.

12 Select the Save icon, .

Auto Populate Batch Postage and Pages Update

Claim Keys displayed on the Record Tracking Listing and Beneficiary Complaint Setting Listing window can be auto populated on the Batch Postage and Pages Update window. All Claim Keys must be for the same state.

1   To auto populate the Claim Keys on the Batch Postage and Pages Update window, query for and retrieve the Claims Keys on the Record Tracking Listing or Beneficiary Complaint Setting Listing window.

2   Select the Batch Postage and Pages Update icon, .

The Claim Keys will auto populate on the Batch Postage and Pages Update window.

3   Enter the State Code.

4   Enter the Record Tracking System information.

5   Enter the Component Code. You can use the Copy Component icon, ⬇, to copy the component to remaining rows.

6   Select the Save icon, ➔⬤.

Manually Add the Record Component to Record Tracking

1   Select **Record Tracking|Record Tracking Listing**
     OR
     Select **Record Tracking|Record Tracking Last Location Listing**
     OR

     Select the Record Tracking icon, 🔲 .

     The Record Tracking Listing window displays.

2   Select the Enter Criteria icon, 🔲 .

     Any previously entered criteria will clear.

3   Data can be entered in most of the fields to retrieve data. Using the Claim Key is recommended.

4   Select the Retrieve Query icon, 🔲 .
     OR
     Press ENTER.

     Records meeting the criteria you entered will display. If a record has more than one component recorded in Record Tracking, multiple rows for the record will display on the Record Tracking Listing Window.

The Record Tracking Last Location Listing window will display the last entered location for the record based on the Action Date. If a record has the same Action Date in more than one component row, all will display.

5   Select the Modify icon, 🔲 .
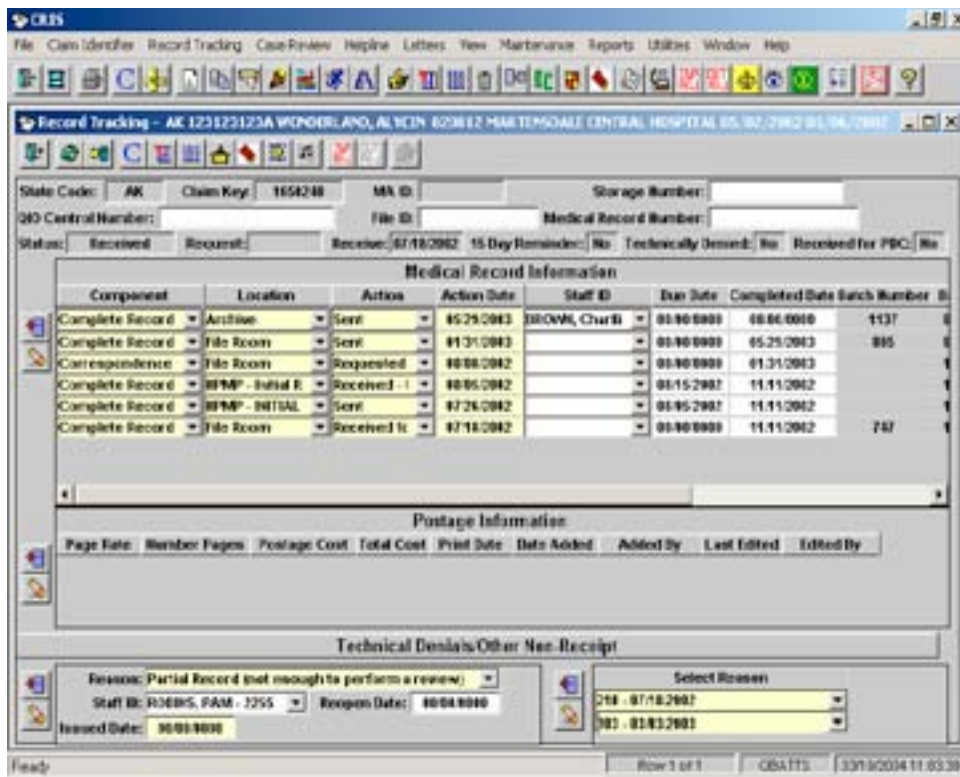
6   In the Medical Record Information section select the Insert icon, [icon] .

    A new Component row is added and today's date fills the Completed Date on the previous row.

7   Insert data into the following fields: Component, Location, and Action. Action Date defaults to today's date and can be changed.

8   Enter a Due Date if desired.

    ♫   If the number of Days Due has been entered for the Location on the Record Tracking Location Maintenance window, the system will calculate the Due Date for the records.

9   Select the Save icon, [icon] .

    ♫   You will not be able to enter duplicate rows with the Component of "Complete Record," an Action of "Received for Case Review," and the same Action Date.

    ♫   You will not be able to enter duplicate rows with the Component of "Complete Record", and an Action of "Requested" unless there is an Action of "Destroyed" between the first request and second request.

10 In the Postage and Pages section, select the Insert icon, [icon] .

A new Postage and Pages row is added.

11 Enter data into the following fields:
Number Pages
Postage Cost

12 The Total Cost will be calculated by the system.

13 Select the Save icon, .

Reprint Medical Record Requests

Medical record reports and labels for any record added to CRIS can be reprinted.

1 To reprint medical record reports and labels, select **Record Tracking|Reprint Medical Record Requests**
OR

Select the Reprint Medical Record Requests icon, .

The Reprint Medical Record Requests Listing window displays in Query Mode.
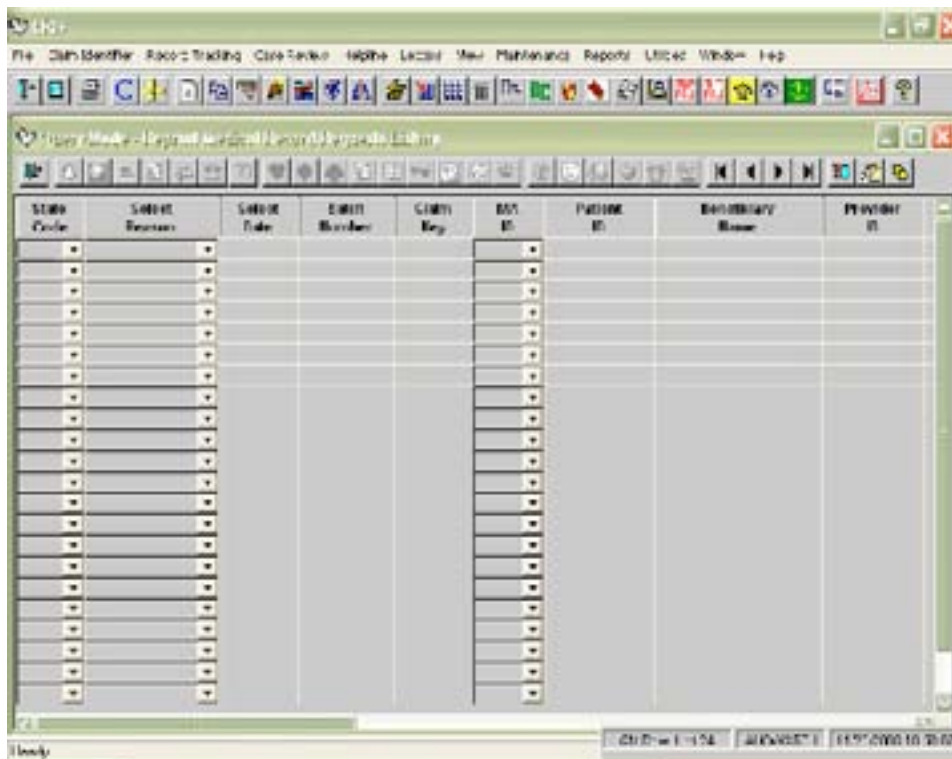
2 Select the Enter Criteria icon, .

Any previously retrieved criteria will clear.

3   Enter data into the one or more of the fields on the window. You can enter retrieval criteria in most of the fields.

4   Select the Retrieve Criteria icon, .

Records meeting the criteria you entered will display.

Printing Medical Record Request Reports

1   To preview and print all of the rows displayed on the window, select the desired icon
OR

2   Click with your mouse on a row and select the one of the icons that displays the reports for only the current row
OR

3   Click with your mouse on a row; hold down the Ctrl key, click with your mouse on another row. Continue this process until only the desired rows are highlighted.

4   Select one of the icons that display the reports for the selected rows.

♫   See the following section for a complete list of the icons.

5   Select the Print icon, , on the main tool bar to print the reports.

Show/Hide HIPAA Language

HIPAA language has been added to the bottom of the three Medical Record Request reports to assist QIOs in clarifying the HIPAA laws for providers. This language will display unless the Show/Hide HIPAA Language icon, , is selected.

Selecting the icon will hide or show the following language: "When information sought by the QIO is required by statute or regulation, the HIPAA Privacy Rule does not require prior authorization for the release of PHI (Protected Health Information), nor does it require that the provider execute a business associate agreement with the QIO."

Printing Labels

1   Select the icon for the desired label.

The Print Preview Labels window displays with information on one label.

2   Select the Change Label Type icon, , to preview the different label size.

    ♫ Mailing labels sizes are:
        1” x 2.63” – 3 across and 10 down
        1” x 4” – 2 across and 10 down
        1.33” x 4” 2 across and 7 down

    ♫ Document label sizes are:
        1” x 4” – 2 across and 10 down
        1.33” x 4” – 2 across and 7 down

3   Continue selecting the Change Label Type icon, , until you find the desired label.

4   Select the Copy Each Row to a Full Page icon, , to create a full page of labels for the label(s) displayed on the window.

5   Select the Copy each Row to a Specified Number of Labels icon, , to create a limited number of labels for each label display on the window.

    A window displays to allow you to enter the number of labels.

6   Enter the desired number of labels and select **OK**.

7   Select the Print icon, , on the main tool bar to print the label.

Reprinting Coversheets

COVERSHEET TYPE	ICON	DESCRIPTION
Coversheet All Rows		Selecting this icon will display coversheets for all rows on the window without MA.
Coversheets Selected Rows		Selecting this icon will display coversheets for only the highlighted rows without MA. To highlight multiple rows, click with your mouse on a row, hold down the CTRL key on the keyboard and click the mouse in the next desired row. Continue this process until all of the desired rows are highlighted.
Coversheet Current Row		Selecting this icon will display the coversheet for the highlighted row without MA.
Cover Sheet for Window Envelopes		Selecting this icon will display the coversheet for the highlighted row without MA When folded, the provider contact and address will display in the window of an envelope.
Coversheet All Rows MA		Selecting this icon will display coversheets for all rows on the window with MA.

Coversheets Selected Rows MA		Selecting this icon will display coversheets for only the highlighted rows with MA. To highlight multiple rows, click with your mouse on a row, hold down the CTRL key on the keyboard and click the mouse in the next desired row. Continue this process until all of the desired rows are highlighted.
Coversheet Current Row MA		Selecting this icon will display the coversheet for the highlighted row with MA.
Cover Sheet MA for Window Envelopes		Selecting this icon will display the coversheet for the highlighted row with MA When folded, the provider contact and address will display in the window of an envelope.

Reprinting Working Lists

WORKING LIST TYPE	ICON	DESCRIPTION
Working List of All Imported Records		Selecting this icon will display a working list for all records on the window without MA.
Working List of All Imported Records MA		Selecting this icon will display a working list for all records on the window with MA.

Reprinting Medical Record Requests

MEDICAL RECORD TYPE	ICON	DESCRIPTION
Medical Record Requests		Selecting this icon will display the medical record request report for all records without MA.
Medical Record Requests Selected Rows		Selecting this icon will display the medical record request report for only the highlighted row.
Medical Record Requests MA		Selecting this icon will display the medical record request report for all records with MA.
Medical Record Requests MA Selected Rows		Selecting this icon will display the medical record request report for only the highlighted rows.
Medical Record Request MA Provider		Selecting this icon will display the medical record request report for all records with MA and includes the Health Service Provider.

		Selecting the icon will display the medi-cal record request report for MA and the Health Service Provider for only the selected rows.
Medical Record Request MA Provider Selected Rows		

Reprinting Labels

LABEL TYPE	ICON	DESCRIPTION
Facility Mailing Labels		Selecting this icon will display the facility mailing labels. Label sizes: 1" x 2.63"--3 across and 10 down 1" x 4" -- 2 across and 10 down 1.33" x 4 " -- 2 across and 7 down
Physician Mailing Labels		Selecting this icon will display the physi-cian mailing labels. Label sizes: 1" x 2.63"--3 across and 10 down 1" x 4" -- 2 across and 10 down 1.33" x 4 " -- 2 across and 7 down
MA Mailing Labels		Selecting this icon will display the MA mailing labels. Label sizes: 1" x 2.63"--3 across and 10 down 1" x 4" -- 2 across and 10 down 1.33" x 4 " -- 2 across and 7 down
Document Labels		Selecting this icon will display the docu-ment labels without a barcode. Label sizes: 1" X 4" -- 2 across and 10 down 1.33" x 4" -- 2 across and 7 down
Document Label - Claim Key Top		Selecting this icon will display the document labels with a barcode on the top of the label. Label sizes: 1" X 4" -- 2 across and 10 down 1.33" x 4" -- 2 across and 7 down
Document Label - Claim Key Bottom		Selecting this icon will display the docu-ment labels with a barcode on the bottom of the label. Label sizes: 1" X 4" -- 2 across and 10 down 1.33" x 4" -- 2 across and 7 down

For the Provider ID and Provider Name to display on the medical record request reports and labels the following must be done:

1   In PRS on the Contact, Address, and Telephone window for each Health Service Provider, HMO, or Physician UPIN/NPI, a row must be added with an Address Phone Type of Medical Records, a Contact Type of Medical Records, and a Contact Name.

2   The medical record contact row must have a corresponding address ID.

For the QIO name and address to display on the medical record request reports and labels the following must be done:

1   In PRS on the Contact, Address, and Telephone window for your QIO, a row must be added with an Address Phone Type of Medical Records, a Contact Type of Medical Records, and a Contact Name.

2   The medical record contact row must have a corresponding address ID.

15-Day Reminder Report/15-Day Reminder Report No Select Reason

The 15-Day Reminder Report and 15-Day Reminder Report No Select Reason will provide a list of medical records by provider that have not been received within 15 days of the request. The 15-Day Reminder Report No Select Reason provides the same information without displaying the Select Reason. After running the report, an option is available to add a component row to the record tracking system with the Action of 15-Day Reminder Identified.

1   To access the report, select **Record Tracking|15-Day Reminder Report**
    OR
    Record Tracking|15-Day Reminder Report No Select Reason.

2   Select a State Code and select **OK**.

3   The report will run and display cases by provider that were requested and not received within 15 days of the request date.

    The following criteria must be met for a record to display on the report:
    •   the Complete Record (0001) was requested (Action code of 1)
    •   the Complete Record (0001) has not been received (no Action code of 2)
    •   there is no technical denial (no Action code of 6)
    •   no 15-day reminder letter has been identified (no Action code of 7)

4   Select the Print icon to print the report.

    ♫   Always print a report of the records. These records will no longer display on the report when the next step has been completed.

5   Select the Update Record Component with 15 Day Reminder icon, .

6   Select a Staff ID and Select **OK**.

On the Record Tracking window a new component row will be added with the *Action* of 7 - 15-Day Reminder Letter Identified.

7 If you select the Close Window icon, , before you have selected the Update Record Component with 15 Day Reminder icon, , the following message will display.
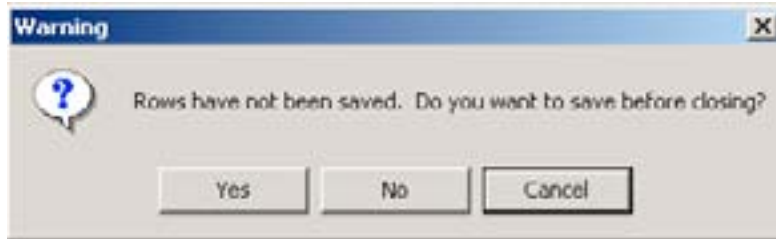
8 Select **Yes** if you want to update the record component.

9 Select **No** if you want to leave the window without updating the record component.

10 Select **Cancel** to remain on the window.

11 If you select the Update Record Component with 15 Day Reminder icon, , twice, the following message will display.

12 If you select the Update Record Component with 15 Day Reminder icon, , when no rows were retrieved, the following message will display.

13 Follow the instructions in Chapter 7, Letters, to create the 15-Day Reminder letter.

30-Day Technical Denial Report

The 30-Day Reminder Report will provide a list of medical records by provider that have been requested and not received within 30 days of the request. After running the report, an option is available to add a component row to the record tracking system with the Action of 30-Day Technical Denial Identified. A technical denial record and a 2A technical denial adjustment is created.

1 To access the report, select **Record Tracking|30-Day Technical Denial Report.**

2 Select a State Code and select **OK**.

3   The report will run and display cases by provider that were requested and not received within 30 days of the request date.

The following criteria must be met for a record to display on the report:
- the Complete Record (0001) was requested (Action code of 1)
- the Complete Record (0001) has not been received (no Action code of 2)

4   Select the Print icon to print the report.

♫   Always print a report of the records that will be technically denied. These records will no longer display on the report when the next step has been completed.

5   Select the Update Record(s) with 30 Day Technical Denial icon, .

6   A window will display prompting you to select the Technical Denial reason and Staff ID. Enter the requested information and select **OK**. The Issue Date defaults to today's date and can be changed.

On the Record Tracking window a new component row will be added with the *Action* of 6 - Technical Denial Identified.

A row will be added to the Technical Denials section on the Record Tracking window with the Technical Denial Reason, Technical Denial Issued Date, and Staff ID. The Selection Reason will populate with the reason(s) for selection at the time of the technical denial.

7   The automated adjustment procedure runs and rows are added to the adjustment table with the technical denial information (2A). Records without a billed claim will have an adjustment created.

8   Use the report you printed in Step 4 to verify the correct adjustment was created for the records on the report.

♫   On the adjustment window you will need to add the FI Number for any record that does not have a billed claim.

9   Follow the instructions in the Letters chapter of this user guide, to create the Technical Denial letter.

10 If you select the Close Window icon, , before you have selected the Update Record(s) with 30 Day Technical Denial icon, , the following message will display.
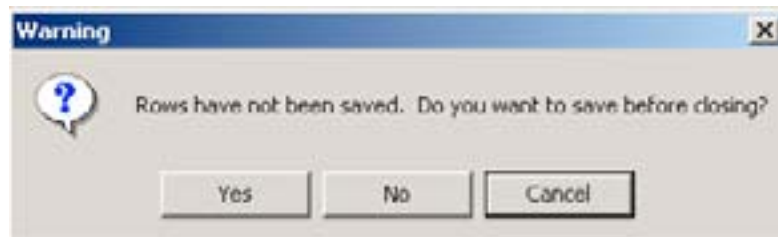
11 Select **Yes** if you want to update the records.

12 Select **No** if you want to leave the window without updating the records.

13 Select **Cancel** to remain on the window.

14 If you select the Update Records with 30 Day Technical Denial icon, [icon] , twice, the following message will display.

15 If you select the Update Records with 30 Day Technical Denial icon, [icon] ,when no rows were retrieved, the following message will display.
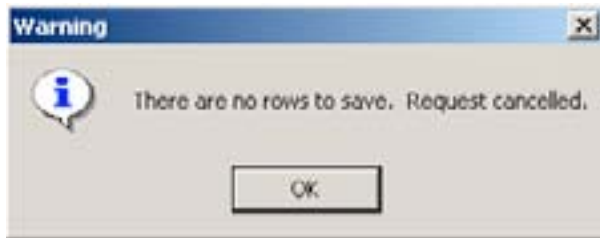
30-Day Records Not Received – All Settings

The 30-Day Technical Denial All Settings Report will provide a list of medical records by provider, for all settings, that have been requested and not received within 30 days of the request.

1 To access the report, select **Record Tracking|30-Day Records Not Received All Selections.**

2 Select a State Code and select **OK**.

3 The report will run and display cases by provider, for all settings, that were requested and not received within 30 days of the request dates.

The following criteria must be met for a record to display on the report:
• The Complete Record (0001) was requested (Action code of 1)
• The Complete Record (0001) has not been received (no Action code of 2)

4   Select the Print icon to print the report.

♫   If the 30 Day Technical Denial Report is run prior to running the 30 Day
Technical Denial Report - All Settings and the records are updated by

selecting the Update Record(s) with 30 Day Technical Denial icon, [icon]
those cases will no longer display on this report.

Canceled Abstractions by Provider for Technical Denials (HPMP)

♫   Final sample selection - April 2008. See SDPS Memo 08-144-DM.

The Canceled Abstractions by Provider for Technical Denials window in CRIS allows you to
view and process abstractions that have been canceled by the CDACs for the Hospital Pay-
ment Monitoring Program (HPMP).

This will make it easier to process the technical denials in CRIS. An icon on this window
allows you to process the records canceled by the CDAC. The processing adds the records to
the CMS Selections/Print Medical Record Requests window with Select Reason 213.

Records that display on the Canceled Abstractions by Provider for Technical Denials window
meet the following criteria:
- Have an abstraction cancel reason (except reasons designated as 'Do not use after
  12/27/2001')
- Have a Sample Reason beginning with '107 – Hospital Payment Monitoring Program'
- Have a 'Request Canceled' Abstraction Event Code
- Have an HSE Unique ID

♫   The CDACs post events on a daily basis. It is recommended that you
check weekly for any canceled abstractions.

Processing Canceled Records

1   Select **Record Tracking|Canceled Abstractions for Technical Denials**
OR

Select the Canceled Abstractions for Technical Denials icon, [icon] .

The Canceled Abstractions by Provider for Technical Denials window displays in Query Mode.
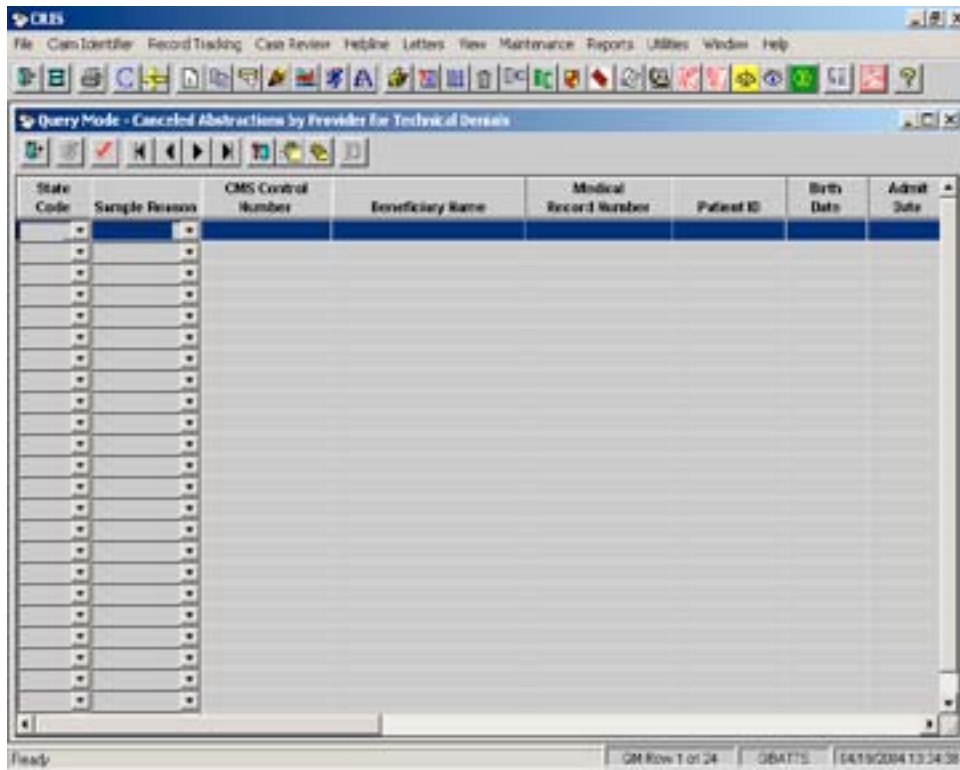
2   Enter your State Code and select the Retrieve Query icon, .

    All records that have been requested by the CDAC and have a cancel event will display.

3   Select the Process Selected Records icon, .

    The system will process the records displayed on the window. They will be added to the Claim Identifier and Claim Identifier Select window with a Select Reason of '213 - HPMP Sample Cancel by CDAC'.

4   The records will disappear from the window.

5   Select the View Processed Canceled Abstractions for Technical Denials icon, .

6   Enter your State Code and select the Retrieve Query icon, .

    Records with a Batch Number of 1 were canceled by the CDAC prior to August 1, 2002. All of these records have a Batch Date of 7/31/2002. It is your responsibility to verify that a technical denial was issued for these records.

    Records with a Batch Number greater than 1 were processed using the Process Selected Records icon.

Some old records do not have an HSE Unique ID and will not be processed. Run the Cancelled Abstraction by Provider – Missing HSE Unique ID report to identify these records. These records will need to be manually added to the Import/Print Medical Records Requests window to process for technical denials.

7   Select the Close Window icon, ⬛, to exit the windows.

8   To process the technical denials, select **Record Tracking|CMS Selections/Print Medical Record Requests.**

    OR

    Select the CMS Selections/Print Medical Record Requests icon, ⬛.

    The CMS Selections/Print Medical Record Requests List window displays.
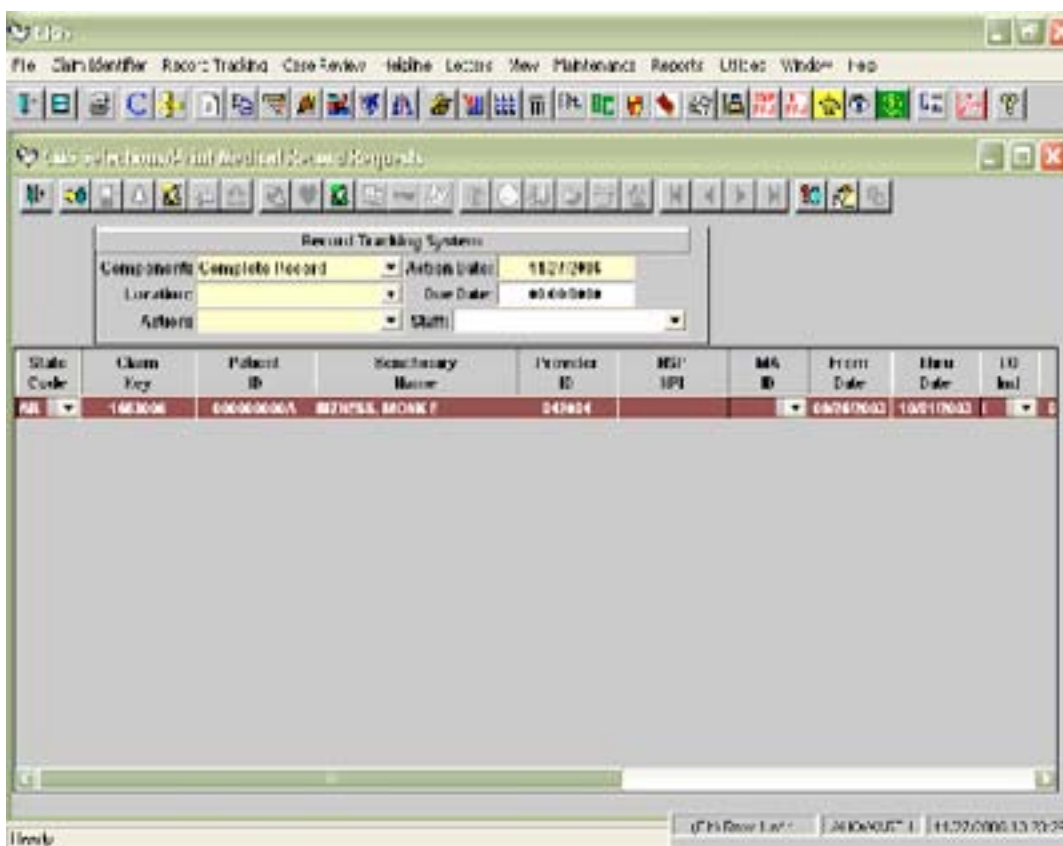
9   Select the Enter Criteria icon, ⬛.

    Any previously entered criteria will clear.

10 In the Select Reason field, select 213 - HPMP Sample Cancel by CDAC.

    Any case added to the Claim Identifier Select table that does not have the Record Tracking Component indicator for the Select Reason of 213 - HPMP Sample Cancel by CDAC set to "Y" will display on this window. When the record has been processed, the Record Tracking Component indicator will be changed from "N" to "Y."

11 Select the Retrieve Query icon, ⬛.

Cases meeting the criteria you entered will display.

12 Select an option in the Location field.

13 Action must be **Requested**.

14 In the Action Date field, enter a date that is 30 days prior to the current date.

> ♫ The HPMP Sample Canceled by CDAC report will not run unless the current date is 30 days greater than the Action date.

15 Select the Save icon, ⇥📇 .

The rows will be processed and a message will display stating, "All CMS Selection rows have been saved. BATCH NUMBER = XXX".

16 Select **OK**.

A component row is added to the Record Tracking System.

To create the technical denial:

1 Select **Record Tracking|HPMP Sample Canceled by CDAC Report.**

2 Select the appropriate State Code from the drop-down list and select **OK**.

The report will run and display cases by provider for 213 - HPMP Sample Cancel by CDAC.

3 Print the report.

4 Select the Update Record(s) with 30 Day Technical Denial icon, ⇥📇 .

A window will display prompting you to select the Technical Denial Reason and Staff ID.

Tech Denial Reason	Staff Id	Issued Date
▼	▼	07/22/2002

OK

5 Enter the requested information and select **OK**. The Issued Date defaults to today's date and can be changed.

On the Record Tracking window a new component row will be added with the *Action* of 6 - Technical Denial.

6   A row will be added to the Technical Denials section with the Technical Denial Reason, Technical Denial Issued Date, and Staff ID. The Selection Reason will populate with the reason(s) for selection at the time of the technical denial. A technical denial adjustment will be created.

7   Use the report you printed to verify that the '2A' adjustment was created.

8   If you select the Close Window icon, [icon] , before you have selected the Update Record(s) with 30 Day Technical Denial icon, [icon] , the following message will display.
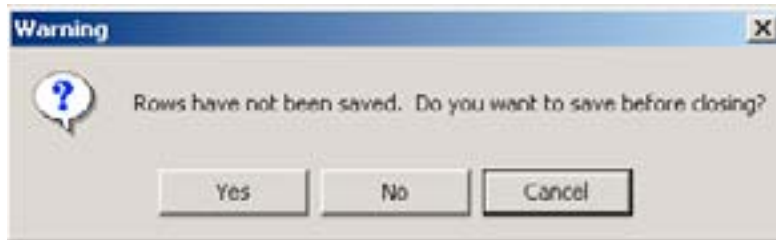
9   Select **Yes** if you want to update the records.

10   Select **No** if you want to leave the window without updating the records.

11   Select **Cancel** to remain on the window.

12   If you select the Update Records with 30 Day Technical Denial icon, [icon] , twice, the following message will display.

13   If you select the Update Records with 30 Day Technical Denial icon, [icon] ,when no rows were retrieved, the following message will display.

Chapter 5 - Case Review

Case Review

Objectives

After completing this chapter, you should be able to:
- Add records to the Case Review system through the Assign Review Records option
- Access and add data to the Review windows
- Enter a Beneficiary Complaint record and associate settings with the complaint record
- Perform coding validation, quality, utilization and notice of non-coverage review
- Add adjustments
- Add records to the Notice of Non-coverage Log
- Perform Retrospective Notice of non-coverage review
- Perform EMTALA review

Overview

After a record has been added to the Claim Identifier table, received from the provider, and tracked into the Record Tracking system with an Action code of 2 - Received for Case Review, the medical record can be assigned to review in the Assign Review Records module.

Medical record case review consists of four main types; Coding, Quality, Utilization and Notice of Non-coverage. In addition records can be created for EMTALA, Notice of Non-coverage and Beneficiary Complaint review.

Icons allow jumps to other parts of the review system and are available on all review windows.

Case Review

There are eighteen options in the Case Review menu:

*Assign Review Record*s - Allows you to query for all records in the Record Tracking system with a Component of Complete Record (0001) or Emergency Room (0005) and an Action code of 2 - Received for Case Review, have no Review Indicator equal to 'Y' (not previously assigned for review). These records can be assigned to review. The review records can be created with or without a Staff ID. This step is required before you can access the case in Review Listing. This will be optional in a future version.

Review Listing – Allows you to query for and perform review for records added to the Case Review system. The windows in the Review module include icons to jump to other windows.

Review Type Listing - Allows you to query for and perform review based on review type. The windows in the Review module include icons to jump to other windows.

EMTALA Review Listing – Allows you to query for and perform review for cases added to the EMTALA Review system.

Call Grouper – Allows you to group diagnosis, procedures or HCPCS codes without saving them back to the database. This option is useful to verify whether codes you added or removed changed the DRG.

Notice of Non-coverage Log Listing – Allows you to access the Notice of Non-coverage Log listing window and to add cases to the log as they are received from the provider.

Alternate Contact Address Listing – Allows you to enter a name or contact address information for a beneficiary who is not in the Beneficiary tables on C1S80 or other contact information for a review.

*Beneficiary Complaint Listin*g – Allows you to insert, view or update information for a beneficiary complaint and attach other settings or hospitalizations associated with the complaint.

Beneficiary Complaint Setting Listing – Allows you to query for and perform beneficiary complaint review by select reason.

Beneficiary Complaint Medical Record Survey Listing – Allows you to query for and update beneficiary complaint medical record surveys that are currently in the system.

Beneficiary Complaint Mediation Listing — Allows you to query for and update beneficiary complaints that are in mediation.

Beneficiary Complaint Mediation Survey Listing — Allows you to query for and update beneficiary complaint mediation surveys that are currently in the system.

Beneficiary Complaint Westat Survey Listing - Allows you to query for and view Beneficiary Complaint Surveys conducted by Westat. A grid view and Print Preview view are available. The survey results can be printed.

Inpatient Adjustment Listing – Allows you to query for and update inpatient adjustment information.

Outpatient Adjustment Listing - Allows you to query for and update outpatient adjustment information.

Sanction Activity Listing – Allows you to query for and enter Sanction Activity information.

IRR Listing - The IRR Listing window allows you to create a random sample of records and enter validity and reliability for Option 1 QIOs. Option 2 QIOs can enter outcome scores for validity and reliability.

QIA Listing - Allows you to insert, update, or delete quality improvement activity records.

QIA Master Listing - Allows you to link related quality improvement activity records under one description.

Hints

1   Required fields are yellow.

2   Read-only fields are gray.

3   Optional fields are white.

4   Use the TAB key to move between fields within a section of the window.

5   Right click with your mouse on any of the fields to access the online help for the field.

6   To select a row, highlight the row by clicking on it with your mouse.

7   We do not recommend that you query by State Code.

8   When querying, if no data displays check the criteria you entered and retrieve again.

9   If a field is not available for retrieving data, it will turn black when it is clicked on with the mouse.

Assign Review Records

The Assign Review Records process must be completed before records will be available in the Case Review system.

When a new Select Reason is added to a record already in the Review module, the record will display on the Assign Review Records window. The record must be assigned before review types will be created for the new Select Reason.

1   To be available for case review, the record <u>must </u>be tracked with a Component of Complete Record (0001) or Emergency Room (0005) and a Record Action code of 2 - Received for Case Review. The Select Reason cannot be marked as invalid.

2   To assign review records, select **Case Review|Assign Review Records**
    OR

    Select the Assign Review Records icon, ![icon] .

♬ The Assign Review Records icon is also available on the Record Tracking window. This icon is enabled if a select reason has not been assigned to case review.

The Assign Review Records window displays in Query mode.

3 Select the Enter Criteria icon, ⬛ .

Any previously entered criteria will clear.

4 Enter data into one or more of the fields on the window.

5 Select the Retrieve Query icon, ⬛ .
OR
Press Enter

♬ Complete Records or Emergency Room records that have been received and tracked with Action code 2 - Received for Case Review and do not have a Review base record will display. The option to assign a staff person to the review types is optional.

♬ The type of required review (Coding, Quality, Utilization, or Notice of Non-coverage) is associated with the Select Reason. To view the Select Reasons and the required review type, access **View|Review Code Tables|Selection Reason**.
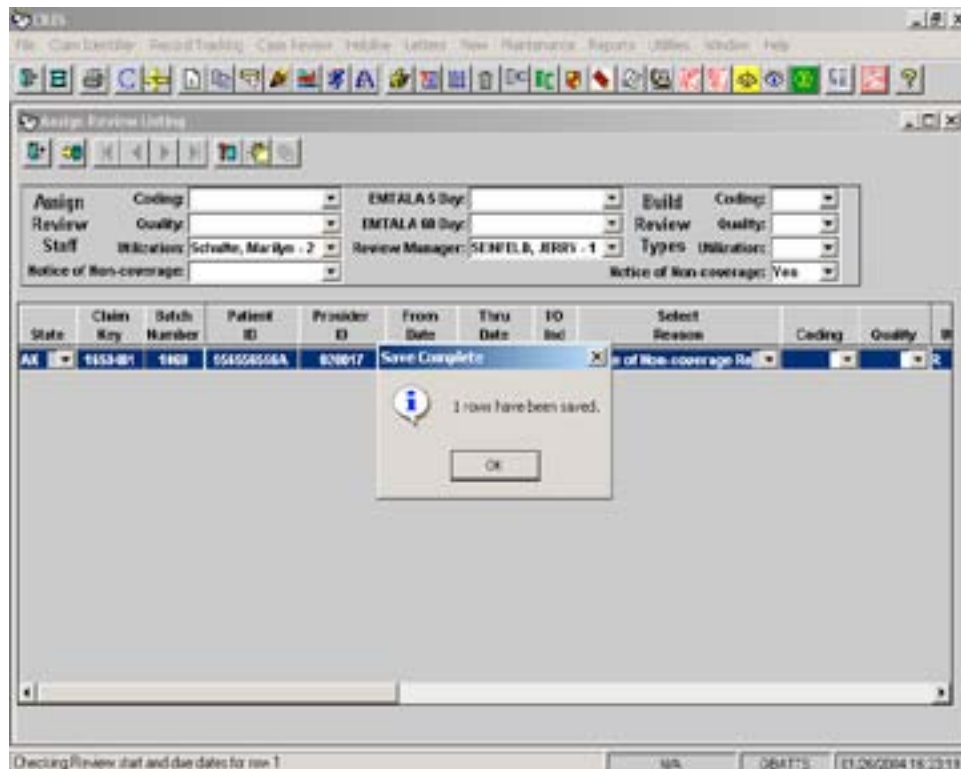
6 If desired, select a Staff ID for each of the required Review Types **or** leave the Staff ID field blank.

7 If desired, select a Review Manager from the drop-down list or leave this field blank.

8   Review Types, that are required for each Select Reason, will be identified by an "R" in the Review Type field for that row. The system will build a Review Type record, for each Review Type that is either required or selected.

9   To create a coding, quality, utilization or notice of non-coverage review type for every row on the window, select **Yes** in the desired review type field in the Build Review Types section. Each row will display **Yes** for the selected review type.

10   To create a coding, quality, utilization or notice of non-coverage review type for one or more rows, select **Yes** in the desired review type field on the individual row.

11   Select the Save icon, .

A message will display indicating that review records were created. Select **OK.**

12   These records are now available to select in the Review Listing window or Review Type Listing window.

Review Listing

The Review Listing window contains a list of all cases which have had a base review record created through the Assign Review Records module. The window contains icons that connect to other windows in the system.

1   To access Review Listing, select **Case Review|Review Listing.**
OR

Select the Review Listing icon, .

The Review Listing window displays in Query Mode.

2   Select the Enter Criteria icon, .

Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window.

4   Select the Retrieve Query icon, .
OR
Press ENTER.

Review records meeting the criteria you entered will display.
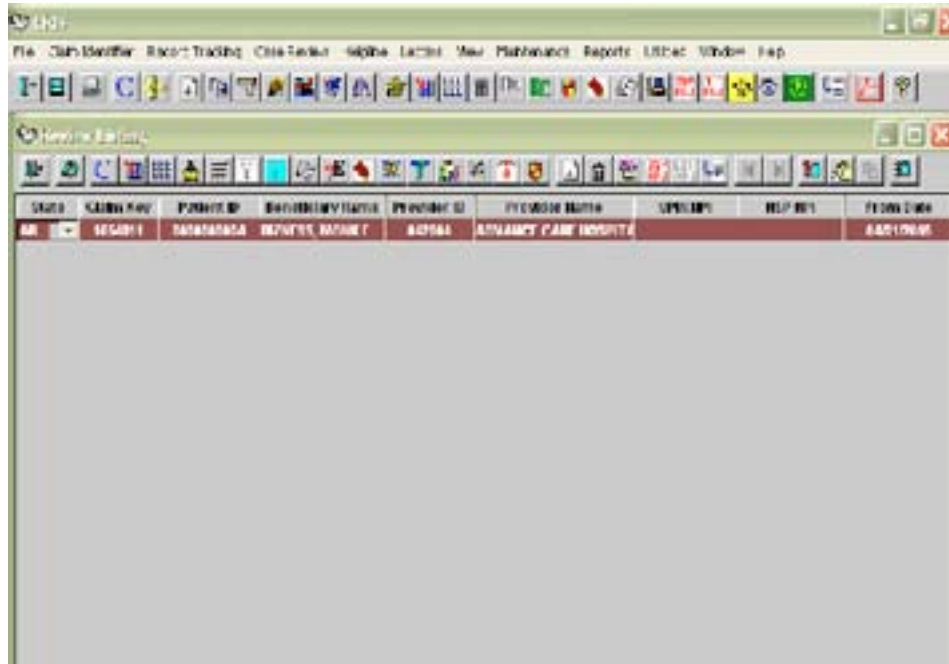
Review Type Listing

The Review Type Listing contains a listing of all review type records. The window contains icons that connect to other windows in the system. You can query by Claim Key, Review Type, Review Status, Start Date, etc. Multiple rows will display if the record has more than one Review Type. If a case has returned to 'Pending' status due to a Rereview or Reconsideration request, the Review Status of 'Pending' will display in blue.

1   To access Review Type Listing, select **Case Review|Review Type Listing**
    OR

    Select the Review Type Listing icon, ⬛ .

    The Review Type Listing window displays in Query Mode.

2   Select the Enter Criteria icon, ⬛ .

    Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window.

4   Select the Retrieve Query icon, ⬛ .

OR
Press ENTER.

Review records meeting the criteria you entered will display.

Review

The Review window contains information specific to the base review record. Select Reasons, Select Dates, Status, and Outcome for each review type can be viewed.

1   On the Review Listing window, select the desired row by clicking on it with your mouse.

2   Select the Review icon, .

The Review window will display.

Review Demographic Information

1   The display only demographic information include:
   •   State Code
   •   Claim Key
   •   Required Review Type (Coding, Quality, Utilization, EMTALA 5 Day, EMTALA 60, and Notice of Non-coverage review)
   •   HSE Unique ID
   •   Select Reason, Select Date and whether the review has been assigned to case review
   •   Status of each review type with Staff ID and Review Outcome

> ♪ If a type of review is required, an 'R' will display in the box next to the review type. If the review coordinator adds a review type 'Yes' will display. To view the required Review Type for the Select Reason, access **View|Review Code Tables** and select Selection Reason View from the drop-down list.

2   The following information can be entered in the demographic section:
   •   Third Party Liability — indicates there is possible third party liability
   •   Advisory Notice date — the date an advisory notice is sent to whoever referred the case for review. Use this when you will not correspond with the facility.
   •   OIG Sent date — date an Office of Inspector General referral is sent.
   •   Review Manager — the person managing the overall case (separate from the staff performing the actual review). This field will autopopulate when Review Manager is selected in the Assign Review Listing window, but can be modified.

Billing Error
You can insert multiple billing error reasons and the date the billing error letter was sent.

Insert Billing Error
1   To insert a billing error reason, select the Insert icon directly to the left of the Billing Error section.

A new row displays.

2   Select a Billing Error reason.

3   Enter the date the billing error letter was sent.

4   Select the Save icon, .

> ♪ Entry of Billing Error 19 or 21 will cause a 1P adjustment to be created.

Delete Billing Error
1   Click with your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the Billing Error section.

A message displays asking if you want to delete the row.

3   Select "**Yes**" to delete the row
     OR
     Select "**No**" if you do not want to delete the row.

4   Select the Save icon, .

Modify Billing Error

1   Click with your mouse on the row you want to modify and select an option from the drop-down box or change the date as appropriate.

2   Select the Save icon, .

Reason for Delay

You can insert multiple reasons for delay in completing review of the medical record. Your CRIS Review Administrator can add additional options on the Maintenance window.

Insert Reason for Delay

1   To insert a reason for delay, select the Insert icon, , directly to the left of the Reason for Delay section.

     A new row displays.

2   Select an option in the Reason for Delay field.

3   Enter the date of the delay if desired.

4   Select an option in the Select Reason field.
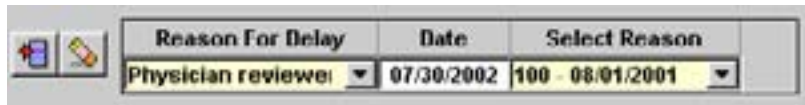
5   Select the Save icon, .

Delete Reason for Delay

1   Click with your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the Reason for Delay section.

     A message displays asking if you want to delete the row.

3   Select '**Yes**' to delete the row
     OR
     Select '**No**' if you do not want to delete the row.

4   Select the Save icon, .

Modify Reason for Delay

1   Click with your mouse on the row you want to modify and select an option from the drop-down box or change the date as appropriate.

2   Select the Save icon, .

QIO Reopen

If you reopen a case to review the initial determination after the final notice was sent to the provider, record the date the record was reopened along with the specific Select Reason. Multiple QIO Reopen rows can be inserted. This section is <u>not</u> used for Re-reviews or Reconsiderations. The Re-reviews and Reconsiderations are recorded on the Review Type window.

Insert QIO Reopen

1   To insert a row for the QIO Reopen date, select the Insert icon, , directly to the left of the QIO Reopen section.

     A new row displays.

2   Enter the date the case was reopened.

3   Select an option in the Select Reason field.

4   Select the Save icon, .

Delete QIO Reopen

1   Click with your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the QIO Reopen section.

     A message displays asking if you want to delete the row.

3   Select '**Yes**' to delete the row
     OR
     Select '**No**' if you do not want to delete the row.

4   Select the Save icon, .

Modify QIO Reopen

1 Click with your mouse on the row you want to modify and select an option from the drop-down box or change the date as appropriate.

2 Select the Save icon, .

Documentation Missing
If you request additional information from the provider following initial receipt of the medical record, enter the missing documentation, date of request, date of receipt and the review type associated with the missing documentation.

Insert Documentation Missing

1 To insert a row for Documentation Missing, select the Insert icon, , directly to the left of the Documentation Missing section.

   A new row displays.

2 Select an option from the drop-down list for the Documentation Missing Reason.

   ♫ The Review Due Date on the Review Type window will update if documentation missing reason code 3, 4, or 5 is selected in the Documentation Missing Reason field of the Review window. This will occur for all Review Types for which the Complete Date is Null and the Start Date is less than the Requested Date for the missing documentation, except for concurrent and immediate Notice of Non-Coverage review types.

   If documentation missing reason code is 4 - Component of medical record is missing, an entry in the Component Missing field is required. A component can be selected from the drop-down list.

3 Enter the date correspondence is sent to the provider requesting missing and/or illegible documentation.

4 Select an option in the Review Type field to indicate the review type the missing documentation is associated with.

5 Select the Save icon, .

6 Select the Review Type window and verify that the Review Due Date has updated. If not select the Save icon, .

The Review Due Date will update by 15 additional days if the documentation missing reason code is 3, 4, or 5.

7   When/if the missing documentation is received, enter the date the information was received on the Review window in the Documentation Missing Received Date field.

Delete Documentation Missing

1   Click with your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the Documentation Missing section.

     A message displays asking if you want to delete the row.

3   Select '**Yes**' to delete the row
     OR
     Select '**No**' if you do not want to delete the row.
4   Select the Save icon, .

Modify Documentation Missing

1   Click with your mouse on the row you want to modify and select an option from the drop-down box or change the date as appropriate.
2   Select the Save icon, .

ALJ/QIC Request

If you receive a request for an Administrative Law Judge (ALJ) review or a case is sent to a Qualified Independent Contractor (QIC), record the date of the request, the date the review was sent to the ALJ/QIC, and the Select Reason associated with the request. Multiple entries are allowed.

If you receive a response from the ALJ, record the date the response was received and the outcome of the ALJ review.

Insert ALJ/QIC Request

1   To insert a row for ALJ/QIC Request, select the Insert icon, , directly to the left of the ALJ/QIC Request section.

     A new row displays.

2   Enter the date the request for administrative law judge or QIC review was received.

3   Enter the date the information was sent to the administrative law judge.

4   Enter the Select Reason associated with the ALJ/QIC review.

▐ ▐	ALJ/QIC Request Date	ALJ/QIC Send Date	ALJ/QIC Response Date	Outcome	Select Reason
	07.20.2001	07/25/2001	11.12.2005	Agree with QIO decision ▼	203 01.01.2001

5   Select the Save icon, ▣ . The Utilization review type will display 'Pending' in blue until an ALJ/QIC Response Date is entered if utilization review is involved.

6   If or when a response is received from the administrative law judge, enter the date the response was received.

        ♫   QICs are not required to respond to QIOs with the outcome of the reconsideration review.

7   Select an option in the Outcome field.

8   Select the Save icon, ▣ .

Delete ALJ Request

1   Click with your mouse on the row you want to delete.

2   Select the Delete icon directly to the left of the ALJ/QIC Request section.

    A message displays asking if you want to delete the row.

3   Select '**Yes**' to delete the row
OR
Select '**No**' if you do not want to delete the row.

4   Select the Save icon, ▣ .

Modify ALJ/QIC Request

1   Click with your mouse on the row you want to modify and select an option from the drop-down box or change the date as appropriate.

2   Select the Save icon, ▣ .

Technical Denial
If a technical denial is issued after the review has started, enter the reason for the denial, the Staff ID, the date the technical denial was issued, and the select reason. When you receive the record, record the reopen date so the Review Edit Errors begin to fire. Multiple entries are allowed.

Insert Technical Denial

1   To insert a row for Technical Denial, select the Insert icon, ▣ , directly to the left of the Technical Denial section.
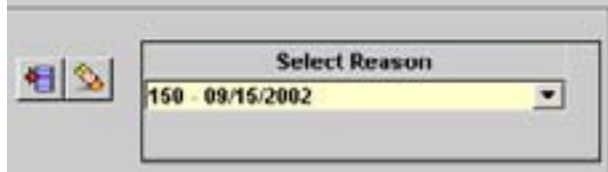
    A new row displays.

2   Select a reason for the Technical Denial from the drop-down list. If an incorrect reason is chosen, you may change it by selecing the drop-down list again or select the Delete icon, ▣ , and the Insert icon, ▣ , to start over.

3   Enter the date the technical denial notice was sent.

4   Enter a Staff ID if desired.

5   Enter the Select Reason associated with the Technical Denial.

> ♫ You will not be able to enter duplicate Select Reasons.

6   Select the Save icon, .

7   The system will create a 2A adjustment if the record has an HSE Unique ID. Please verify that the adjustment is correct.

8   If the missing record is received, enter a date in the Technical Denial Reopen date field.

> ♫ On the Review Type and PRAF windows, a warning message, "This claim has a Technical Denial without a Reopen Date. Please enter a Reopen Date", will display if a Technical Denial has been entered and a Reopen Date has not been entered. You will not be able to save any changes until the Reopen Date has been entered. The Start and Due Date fields on the Review Type window will recalculate, using the Reopen Date as the Start Date.

If the Technical Denial has not been sent to the FI for processing, the adjustment will be deleted. If the Technical Denial has been sent to the FI for processing, you will need to enter a reversal of the technical denial adjustment.

Delete Technical Denial
1   Click with your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the Technical Denial section.

A message displays asking if you want to delete the row.

3   Select '**Yes**' to delete the row
      OR
      Select '**No**' if you do not want to delete the row.

4   Select the Save icon, .

♫ If review rows exist when a Technical Denial is deleted, the Start and Due Dates will recalculate based on the Select Reason, if appropriate.

Modify Technical Denial

1 Click with your mouse on the row you want to modify and select an option from the drop-down box or change the date as appropriate.

2 Select the Save icon, ⬛ .

Review Type

All medical records could have Coding, Quality, Utilization, or Notice of Non-coverage review performed. In CRIS, the type of review that will be performed is based on the Select Reason and this is programmed into CRIS. Some Select Reasons require more than one type of review. To view the review types required by a Select Reason, please access **View|Review Code Tables** and pick Selection Reason View.

Some Select Reasons do not have a predetermined requirement for Coding, Quality, Utilization, or Notice of Non-coverage review. If a Select Reason does not have a required review type, the QIO will determine the type of review that needs to be performed based on the reason for the review. For example, you receive a referral from CMS to perform a utilization review. Select reason '153 - CMS Referral' does not have a required type of review. Add the record to CRIS with Select Reason 153. When you assign the select reason to a case review, select the desired review type on the Assign Review Records window or access the Review Type window and change the Utilization indicator from **No** to **Yes**.

Each Review Type may have more than one Select Reason. An edit will prevent entry of duplicate Select Reasons with the same date on any Review Type.

The Review Type window allows you to collect information specific to each type of review being performed, i.e., Coding, Quality or Utilization. On the Review Type window, all notice dates for 1st, 2nd and 3rd level reviews are entered.

♫ Information for the notice of non-coverage is recorded on the Notice of Non-coverage Review window.

If necessary, more than one of the same review type can be added by the system. For example, if a quality review that was performed as part of the HPMP sample is in Complete status, and now a Beneficiary Complaint is received for the same stay, a new Quality review type row will be created. Previous Review Types must be in Complete status before additional rows for the same review type will be created. A vertical scroll bar will display on the right side of the review type section if another row has been added. Each review type also has a Review Type Key.

1   To access the Review Type window from Review Listing select the desired row by click-
    ing on it with your mouse.

2   Select the Review Type icon, .

    The Review Type window will display.

        ♫   You can jump between the review screens using the icons on the window.

Review Type Demographic Information
1   The display only demographic information include:
    •   State Code
    •   Claim Key
    •   Required Review Type, (Coding, Quality, Utilization), EMTALA 5 Day, EMTALA
        60, and Notice of Non-coverage
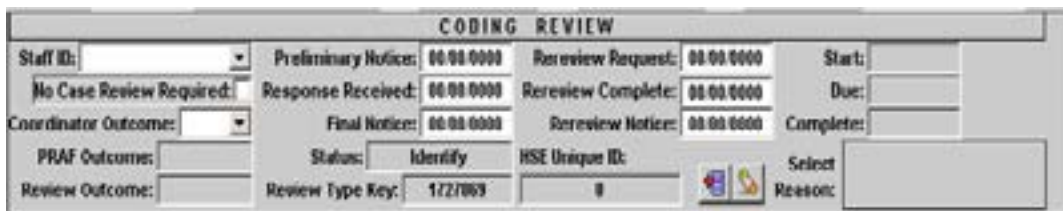
2   If Coding, Quality, or Utilization review is required based on the Select Reason, the Re-
    view Type indicator field will display an '**R**' for required and cannot be changed.

3   When you first access the window, a row will display in each review section if that type
    of review is required.

4   If Coding, Quality, or Utilization is not required based on the Select Reason, the review
    type indicator field will display a '**No**' and the section for the Review Type will be blank.

5   If notes exist, a read only "Notes Exist" entry will appear in red to the left of the HSE
    Unique ID number field.

Add a Review Type
1   To add a Coding, Quality, or Utilization review type that was not required by the Select
    Reason, change the '**No**' to '**Yes**' in the review type indicator field at the top of the win-
    dow.

    The specific review type row will display in the appropriate section. If Coding is se-
    lected, a procedure will retrieve the diagnosis, procedure, DRG or HCPCS codes from the
    Claims Warehouse and add them to the appropriate CRIS windows if the record has an
    HSE Unique ID.

2   In the new review type section, select the Insert icon, , to the left of the Select Rea-
    son field for the review type and select a Select Reason from the drop-down list.

3   Select the Save icon, .

The record Status will update to 'Pending' and the review Due Date will update. The Review Edit Errors will begin to fire.
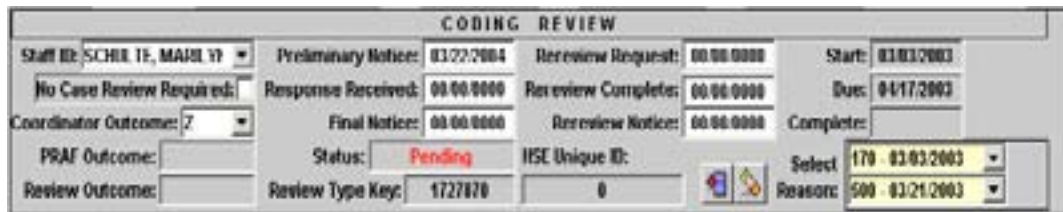
Delete a Review Type

1   To delete a review type that was not required by the Select Reason, change the '**Yes**' to '**No**' in the review type indicator field at the top of the window.

2   A message will display, "Deselecting [review type] will delete review type key = xxxxx. If PRAF rows exist linked to this review type key, they will also be deleted?"

3   Select '**OK**' to delete the review type record or '**Cancel**' if you do not want to delete the review type record.

The review type row will go blank if you select '**OK**'.

4   Select the Save icon, .

Coding Review Type

1   The Coding Review section is used to record the outcome of the coding validation review and the date notices were sent. For the select reasons that require coding validation as part of the review, the Coding indicator field at the top of the window will display an '**R**' and cannot be changed, e.g., 120 - Higher Weighted DRG Assignments.

> ♫   If the No Case Review Required indicator is marked, the Review Edit Errors will stop firing, the system will populate the Complete Date with the current date, and that Review Type will not be available for selection in the PRAF window Review Type field.

2   If during the course of your review, you determine that coding validation needs to be performed and it was not part of the required review for the Select Reason, change the '**No**' to '**Yes**' in the Coding indicator field at the top of the window. A database procedure will retrieve the appropriate codes from the Claims Warehouse and add them to the CRIS windows, if the record has an HSE Unique ID.

3   Record the outcome of the 1st level coordinator review. If 'A - Coordinator Approved' is selected, the Complete Date for the Coding review will be the current system date. If 'Z - Referred' is selected, the Review Edit Errors will fire.

♫ If the case has been completed with a coordinator outcome of 'A – Co-ordinator Approved' and the case is sent on for review with PRAF rows entered, the Case Complete date and the Review Outcome will be deleted and the status of the case returned to Pending, until all review edit errors have been resolved. The Case Complete date and the Review Outcome will then reflect the results of the PRAF entries.

4   After 1st level review is complete and a concern is identified, record the date of the most recent Preliminary Notice. This date can be up to 5 days in the future.

5   When a response is received from the provider, record the date of the **first** valid Response Received. This date cannot be a future date.

6   After the 2nd level review is complete and the concern is confirmed, record the date of the Final Notice. This date can be up to 5 days in the future.

Access the Edit Error window to view the review edit errors. If all review edit errors have been resolved the Coding Review will go to Complete status and the system will populate the Complete Date field. If the complete date is later than the due date, the complete date will appear in red.

♫ It is possible that one type of review can go to Complete status while the other review types are still in Pending status. The Due Date for all review types with the same Select Reason and Select Date will be in sync if the review type is still pending.

7   If a rereview is requested, enter the date of the **first** Rereview Request. This date cannot be a future date.

8   After the 3rd level review is complete, enter the date the rereview was completed. This date cannot be a future date.

9   Enter the date the Rereview Notice was sent to the involved provider(s). This date can be up to 5 days in the future.

Quality Review Type

1   The Quality Review section is used to record the outcome of the quality review and the date notices were sent. For the select reasons that require quality as part of the review, the Quality indicator field at the top of the window will display an '**R**' and cannot be changed, e.g., 102 - Beneficiary Complaint Retrospective.

♫ If the No Case Review Required indicator is marked, the Review Edit Errors will stop firing, the system will populate the Complete Date with the current date, and that Review Type will not be available for selection in the PRAF window Review Type field.

2   If during the course of your review, you determine that quality needs to be performed and it was not part of the required review for the Select Reason, change the '**No**' to '**Yes**' inthe Quality indicator field at the top of the window.

3   Record the outcome of the 1st level coordinator review. If 'A - Coordinator Approved' is selected, the Complete Date for the Quality review will be the current system date. If 'Z - Referred' is selected, the Review Edit Errors will fire.

♫ A 1C PRAF row will not be allowed if the case has a Coordinator Outcome of 'A-Coordinator Approved' or 'X-Not Applicable'. If the Coordinator Outcome is 'I-Failed criteria, but coordinator overrides', a 1C PRAF row with an outcome of 'Z-Referred' will not be allowed.

♫ If the case has been completed with a coordinator outcome of 'A – Coordinator Approved' or 'I – Failed criteria, but coordinator overrides' and the case is sent on for review with PRAF rows entered, the Case Complete date and the Review Outcome will be deleted and the status of the case returned to Pending, until all review edit errors have been resolved. The Case Complete date and the Review Outcome will then reflect the results of the PRAF entries.

4   After 1st level review is complete and a concern is identified, record the date of the most recent Preliminary Notice. This date can be up to 5 days in the future.

5   When a response is received from the provider, record the date of the **first** valid Response Received. This date cannot be a future date.

6   After the 2nd level review is complete and the concern is confirmed, record the date of the Final Notice. This date can be up to 5 days in the future.

Access the Edit Error window to view the review edit errors. If all review edit errors have been resolved, the Quality Review will go to Complete status and the system will populate the Complete Date field. If the complete date is later than the due date, the complete date will appear in red.

♫ It is possible that one type of review can go to Complete status while the other review types are still in Pending status. The Due Date for all review types with the same Select Reason and Select Date will be in sync if the review type is still pending.

7   If a rereview is requested, enter the date of the **first** Rereview Request. This date cannot be a future date.

8   After the 3rd level review is complete, enter the date the rereview was completed. This date cannot be a future date.

9   Enter the date the Rereview Notice was sent to the involved provider(s). This date can be up to 5 days in the future.

Utilization Review Type

1   The Utilization Review section is used to record the outcome of the utilization review and the date notices were sent.   For the select reasons that require utilization as part of the review, the Utilization indicator field at the top of the window will display an '**R**' and cannot be changed, e.g., 116 - Complaint Utilization Issue Only.

   ♫   If the No Case Review Required indicator is marked, the Review Edit Errors will stop firing, the system will populate the Complete Date with the current date, and that Review Type will not be available for selection in the PRAF window Review Type field.

2   If during the course of your review, you determine that utilization needs to be performed and it was not part of the required review for the Select Reason, change the '**No**' to '**Yes**' in the Utilization indicator field at the top of the window.

3   Record the outcome of the 1st level coordinator review. If 'A - Coordinator Approved' is selected, the Complete Date for the Utilization review will be the current system date. If 'Z - Referred' is selected, the Review Edit Errors will fire.

   ♫   A 1C PRAF row will not be allowed if the case has a Coordinator Outcome of 'A-Coordinator Approved' or 'X-Not Applicable'. If the Coordinator Outcome is 'I-Failed criteria, but coordinator overrides', a 1C PRAF row with an outcome of 'Z-Referred' will not be allowed.

   ♫   If the case has been completed with a coordinator outcome of 'A – Coordinator Approved' or 'I – Failed criteria, but coordinator overrides' and the case is sent on for review with PRAF rows entered, the Case Complete date and the Review Outcome will be deleted and the status of the case returned to Pending, until all review edit errors have been resolved. The Case Complete date and the Review Outcome will then reflect the results of the PRAF entries.

4   After 1st level review is complete and a concern is identified, record the date of the most recent Preliminary Notice. This date can be up to 5 days in the future.

5   When a response is received from the provider, record the date of the **first** valid Response Received. This date cannot be a future date.

6   After the 2nd level review is complete and the concern is confirmed, record the date of the Final Notice. This date can be up to 5 days in the future.

Access the Edit Error window to view the review edit errors. If all review edit errors have been resolved the Utilization Review will go to Complete status and the system will populate the Complete Date field. If the complete date is later than the due date, the complete date will appear in red.

♪   It is possible that one type of review can go to Complete status while the other review types are still in Pending status. The Due Date for all review types with the same Select Reason and Select Date will be in sync if the review type is still pending.

7   If reconsideration is requested, enter the date of the **first** Reconsideration Request. This date cannot be a future date.

8   After the 3rd level review is complete, enter the date the reconsideration was completed. This date cannot be a future date.

9   Enter the date the Reconsideration Notice was sent to the involved provider(s). This date can be up to 5 days in the future.

Utilization Additional Fields

1   *Deemed Admission* - after review, enter the date determined to be the admission date.

2   *Admission Criteria* - two fields are provided to enter criteria used by your QIO to approve an admission. A value is required if the Coordinator Outcome is A or V.

3   *InterQual Criteria* - if the criteria was used during the course of the utilization review, change the **No** in the dropdown box to **Yes**.

♪   When InterQual has been paid for the use of the criteria for the current case, the year InterQual was paid will display in the box to the right of the InterQual criteria field.

4   *Covered Days* and *Length of Stay* are display only and are from the claim.

5   *Days Denied* and *Original Days Denied* are calculated from the *Denied From* and *Denied Thru* dates. These fields are used for length of stay review.

6   *TAN* (Treatment Authorization Number) field is used when a review requires you to issue an authorization number i.e., Assistant at Cataract review. The system creates the number for you.

To assign a TAN, select the Assign a TAN icon, .

To delete a TAN, select the Delete a Tan icon, .

7   *HSE Unique ID number*—if a matching record is found on the claims warehouse (C1S80), the HSE Unique ID associated with the record displays.

Notice of Non-coverage Review Type

The Notice of Non-coverage review type is on the Notice of Non-coverage Review window. To view the Notice of Non-coverage Review window, select the Notice of Non-coverage Review icon, , from the Review Type window toolbar.

1   The Notice of Non-coverage Review section is used to record the date and time of the request for review, the outcome, and the dates that verbal and written notices were issued. This review type is located on the Notice of Non-coverage Review window rather than the Review Type window. All Notice of Non-coverage selection reasons will require this review type and the Notice of Non-coverage indicator at the top of the Review Type window will display an 'R' that cannot be changed.

> ♬   If you wish to change the Select Reason associated with a Notice of Non-coverage Review Type and an entry has been made in the Payment Responsibility section that is associated with the current Select Reason, you will need to delete the Payment Responsibility row and re-enter it after the Select Reason has been changed.

> ♬   If the No Case Review Required indicator is marked, the Review Edit Errors will stop firing, the system will populate the Complete Date with the current date, and that Review Type will not be available for selection in the PRAF window Review Type field.

> ♬   When a notice is rescinded for Select Reasons 117 - MA Appeal review (CORF, HHA, SNF), 118 - FFS Expedited Appeal (CORF, HHA, Hospice, SNF), 121 - Notice of Non-coverage Continued Stay Notice Immedicate Review - Attending Physician Concurs, 122 - Notice of Non-coverage Continued Stay Notice Concurrent Non-immediate Review, 124 - MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs, the date entered in the Rescinded field will become the Complete Date.

2   If you determine that Notice of Non-coverage review is appropriate during the course of review for other selection reasons, you can add a Notice of Non-coverage review type by selecting the New Notice of Non-coverage Review icon, , on the Notice of Non-coverage Review window. Insert the select reason used in your other review type(s).

3   Record the Coordinator Outcome Code.

♫ A Request for Review Received date and time is required in the Notice of Non-coverage review type section on the Notice of Non-coverage window for Select Reasons 105, 106, 107, 108, 109, 110, 111, 114, 117, 118, 121, 122, 123, and 124.

♫ A 1C PRAF row will not be allowed if the case has a Coordinator Outcome of 'A-Coordinator Approved' or 'X-Not Applicable'. If the Coordinator Outcome is 'I-Failed criteria, but coordinator overrides', a 1C PRAF row with an outcome of 'Z-Referred' will not be allowed.

♫ If the case has been completed with a coordinator outcome of 'A — Coordinator Approved' or 'I— Failed criteria, but coordinator overrides'and the case is sent on for review with PRAF rows entered, the Case Complete date and the Review Outcome will be deleted and the status of the case returned to Pending, until all review edit errors have been resolved. The Case Complete date and the Review Outcome will then reflect the results of the PRAF entries.

4   Enter 1st level PRAF results. Only A and B categories of concern will be available for selection for a Notice of Non-coverage review type. Some Notice of Non-coverage selection reasons will require a particular category of concern; e.g., selection reason 117 – MA Appeal Review (CORF, HHA, SNF) requires a PRAF row with a category of A12.

5   After 1st level physician review is complete, record the date of Preliminary Notice on the Notice of Non-coverage review type section of the Notice of Non-coverage Review window for retrospective review selections. This date can be up to 5 days in the future.

♫ The Preliminary Notice and Response Received date fields will not be available for entry with immediate/concurrent Notice of Non-coverage selection reasons 105, 107, 109, 110, 111, 114, 117, 118, and 121-124. The Written/Final Notice date will become the Notice of Non-coverage review type Complete date for selection reasons 105, 107, and 110. The Verbal Notice date will become the Complete date for selection reasons 109, 111, 114, 117, 118, and 121-124, although a Written/Final Notice date is still required.

6   When a response is received from the provider, record the date of the first valid Response Received. This date cannot be a future date.

7   After the 2nd level review results are completed on the PRAF, record the Written/Final Notice Date. This date can be up to 5 days in the future.

Access the Edit Error window to view the review edit errors. If all review edit errors for the Notice of Non-coverage review type have been resolved, the system will populate the Complete Date field. If the complete date is later than the due date, the complete date will appear in red.

♫ It is possible that one type of review can go to Complete status while the other review types are still in Pending status. The Due Date for all review types will be in sync for the same selection reason with the same selection date.

8   If reconsideration of the review results is requested, enter the date of the first Reconsideration Request. This date cannot be a future date.

9   After the 3rd level review results are completed on the PRAF, record the date that the reconsideration was completed. This date cannot be a future date.

10 Enter the date the Reconsideration Notice was sent to the provider/practitioner. This date can be up to 5 days in the future.

Creating Another Instance of a Review Type

If a Quality, Utilization, or Notice of Non-coverage review type has been completed, additional instances of the review type can be created if required for additional Select Reasons.To create another instance of a review type:

1   The previous instance must be in Complete status.

2   Import the record on the Import/Print Medical Record Requests window.
OR
Add the new select reason on the Selection Reasons window.

3   Process the review in the Assign Review Records module.

4   Access the review on the Review Type or Notice of Non-coverage window.

5   In the review type section for the newly created review type instance, scroll bars display on the right side of the section.

6   Use the scroll bar to move between the review type instance(s).

7   If the new Select Reason did not create a new review type, use the New Quality Review icon, [icon] , the New Utilization Review icon, [icon] , or the New Notice of Non-Coverage Review icon, [icon] , to add the review type.

♫ The previous review type must be in Complete status before a new review type of Quality, Utilization, or New Notice of Non-coverage can be added.

PRAF

The PRAF window allows you to enter the results of the coding, quality, utilization or notice of non-coverage review for the coordinator or physician reviewer. Results of 1st, 2nd, and 3rd level review are entered.

If utilization review is being performed and A01, A02, A03, or A04 categories are confirmed, the Limitation on Liability is entered on the row with the final outcome of the review, i.e., 2P or 2C.

If a quality review is performed, the Response Determination Categories are required.

1   To access the PRAF, select the PRAF icon, , from any of the Review windows.

    A new row will automatically display when the window is first opened.

2   Enter a 1C Review Level.

3   The Review Date defaults to today's date and can be changed.

4   Enter the Concern Number, i.e., 1, 2 etc.

5   Enter the Category of Concern. The categories that display are those for the type of review being performed. For example, for Coding and Quality review only the D and C categories will display.

> ♫   An edit will prevent entry of multiple Categories of Concern for the same Concern Number. If the physician reviewer changes the Category of Concern for a specific Concern number, previous rows should be modified to match that Category. For example, if Concern #1 has a 1C row with a Category of C01 and the physician reviewer identifies the Category of C02 for Concern #1, then the 1C row should be changed to Category C02 and a notes entry should be made to explain the change. If an additional Category of Concern is identified during the course of review, an additional Concern Number should be added.

6   When you select the category, the Review Type will automatically populate, unless there are multiple Select Reasons that require the same review type.

7   Select the Outcome of the review. If this is a '**C'** Review Level row, only the review coordinator outcomes will display.

8   Indicate the physician reviewer's determination of whether the care met professionally recognized standards of care. (This is not a required field on the PRAF window.)

9   Concern Source is required for Quality review and is optional for Coding, Utilization, and Notice of Non-coverage reviews.

> ♫   Duplicate rows are allowed for quality concerns if the source of the concern is different. For Coding and Utilization, duplicate rows with the same Review Level, Concern Number, and Category are not allowed even with different concern sources, except when the Outcome Code is equal to "Y" or "Z".

10 Origin of Concerns is required for Beneficiary Complaint reasons 101, 102, 103, and
    104 to identify whether a concern came through the beneficiary/representative or from
    medical record review. An Origin of Concern will not be allowed for other selection
    reasons.

11 UPIN/NPI is entered to indicate the physician of concern.

12 Enter either the staff name by typing the first few letters of the last name and selecting the
    name from the drop-down box or enter the staff ID in the Staff ID field.

13 Enter a Limitation on Liability option for utilization reviews of A01, A02, A03, or A04.

14 The Physician Specialty Match field defaults to **Yes** for physician review levels and
    can be changed to **No**. The field defaults to **No** on a coordinator row and the field is
    protected.

♪ Use the Spell Check icon, , on the PRAF window toolbar to check
        the spelling of the PRAF notes.

15 The Response Determination field is completed when a Quality concern is resolved or
    confirmed by a physician reviewer. Enter a response determination from the drop-down
    list for 1P, 2P, 3P, 4P, and 5P rows with an outcome of C, M, R, S, G, or T; or for 2C rows
    with an outcome of C when no response is received from the provider for a confirmed
    concern.

♪ Response Determination and subsequent fields on this window are re-
        quired for all quality of care cases.

16 The Quality Outcome field is completed when a Quality concern is resolved or confirmed
    by a physician reviewer. Enter the quality outcome from the drop-down list.

♪ If a Quality concern is confirmed at 2nd level review or higher, a message
        will display to remind the user to add a record to the QIA Module, if
        appropriate.

17 The Sanction Activity field defaults to No. Select Yes from the drop-down list if the
    physician reviewer recommends that the sanction process be initiated.

18 The Referral Licensure field defaults to No. Select Yes from the drop-down list if the
    physician reviewer recommends immediate referral to the licensing authority.

19 The Intensified Review field defaults to No. Select Yes from the drop-down list if the physician reviewer determines that intensified review should be initiated for the provider/practitioner.

20 The QIP field defaults to No. Select Yes from the drop-down list if the physician reviewer recommends that the provider/practitioner develop and implement a quality improvement program (QIP) or participate in an educational program in order to improve patient care.

21 The Alternative Approach field defaults to No. Select Yes from the drop-down list if the physician reviewer determines that care was grossly and flagrantly unacceptable, did not follow guidelines or usual practice, or could reasonably have been expected to be better (confirmed quality of care concern), and recommends that the provider/practitioner consider an alternative approach to future care.

22 The Offer Advice field defaults to No. Select Yes from the drop-down list if the physician reviewer determines that the care provided was acceptable or within the expected practice (resolved quality of care concern), but wants to give advice about alternative approaches that could help the physician/practitioner optimize future care.

23 The No Recommendations field defaults to No. Select Yes from the drop-down list if the physician reviewer determines that no recommendations for quality improvement are necessary.

24 In the Notes section at the bottom of the window, enter pertinent notes that can be printed and sent to the physician reviewer. A Notes section will display for each row that you add and notes can be entered for each concern. Multiple notes are allowed. Select the Insert icon in the notes section to add notes for the PRAF rows

25 Select the Save icon, , after all of the information for the row has been entered.

> ♫   It is recommended that you save between each row of data you enter.

Printing the PRAF options

Print Preview Selected Review Levels

1   Select the Print Preview Selected Review Levels icon, , to select the specific review levels to view and print.

2   On the PRAF Referral window, select all of the Review Levels you want to view and print.

The selected PRAF rows will display if there is a matching row on the PRAF window.

3   Select the Print icon, 🖶 .

Print Preview All

1   Select the Print Preview All icon, 🖶 , to view and print all rows on the PRAF.

2   Select the Print icon, 🖶 .

Print Preview Selected Row

1   Highlight the row to print by clicking on it with the mouse.

2   Select the Print Preview Selected Row icon, 🖶 , to view and print the selected row on the PRAF.

3   Select the Print icon, 🖶 .

Physicians Not Paid Report

1   Select the Physicians Not Paid icon, 💰 , to view a report of physician who performed review and do not have a date in the Physician Paid Date field on the Reviewer Time window.

2   Access the Physician Not Paid report in the Report module to update the Physician Paid Date field.

Print Quality Form for Selected Row

1   Highlight the row for which you want a quality form (PRAF) printed.

2   Select the Print Quality Form for Selected Row icon, , to view and print the quality form (PRAF) for the selected row.

3   Select the Print icon, .

Copy Row

1   Highlight the row you want to copy.

2   Select the Copy Row icon, . The highlighted row will be copied onto a new row.

Alternate Contact Address

If the patient's name displays 'Not on File' in the Review module, use the Alternate Contact Address window to add the beneficiary name. The window can also be used to capture other contact information. The information you enter is specific to the review row you have high-lighted.

1   To access the window for the record you are on, select the Alternate Contact Address icon

 , from any of the Review windows.

The Alternate Contact Address Listing window displays. If no previous information has been added, the window will display no rows. If previous rows have been added, those-rows will display.

2   Select the Insert icon, .

A blank Alternate Contact Address window displays.

3   The State Code, Claim Key and Contact Key are populated by the system based on the row you were on in the Review module.

4   Select the Contact Type.

> ♫ If you are adding an entry because the patient name displays 'Not on File', you need to select **'Beneficiary'**.

5   Enter the Patient ID number.

6   Enter the patient Last Name. The First Name is optional.

7   Continue adding information as desired to the window. You can also add notes for the contact.

8   Select the Save icon, .

> ♫ Multiple contacts for the same beneficiary can be added.
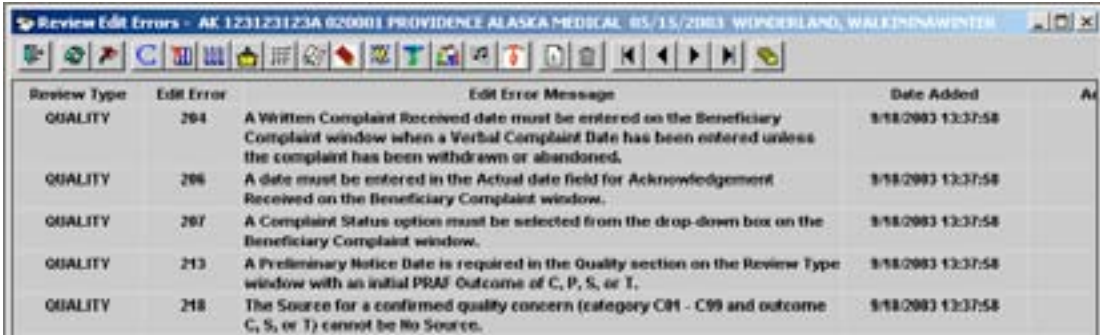
Review Edit Errors

The Edit Error window can be accessed at any time during the review process to view the errors that remain for the case.

1   To view the edit errors highlight the row and select the Edit Error icon, .

The Edit Error window displays as view only.

2   The edit errors display by Review Type (Coding, Quality, Utilization, or Notice of Non-coverage).

3   Each edit error has a number associated with the error description. Single digit edit errors are applicable to all review types. The 100 series are applicable to Coding, 200 series are applicable to Quality and Beneficiary Complaint, 300 series are applicable to Utilization, and the 400 series are applicable to Notice of Non-coverage.

4   Select the Recheck Edit Errors icon, , to refresh the edit errors if you keep the window open while you perform review and want to check the edit errors as you work.

5   To exit the edit error window, select the Close Window icon, .

Reviewer Time

Capturing time spent on the review by the coordinator or physician reviewer is not required.

QIOs can enter coordinator, physician or other staff time as desired.

1   To record time, highlight the row and select the Reviewer Time icon, .

    A new row will automatically display when the window is first opened.

2   Select the desired level of review in the Review Level field.

3   The Review Date defaults to today's date and can be changed.

4   Record the amount of time spent on the review in minutes.

5   Enter the Reviewer Name or Staff number. Type the first few letters of the last name and select the desired name from the drop-down list.

6   Select the Save icon, .

7   If you run the Physician Reviewer Not Paid report in the Report module and use the function to update the paid date, the date you ran the report will display in the Physician Paid Date field.

Physician Not Paid Report

1   Select the Physician Not Paid icon, , to view a report of physician who performed review and do not have a date in the Physician Paid Date field on the Reviewer Time window.

2   Access this report in the Report module to update the Physician Paid Date field.

Physician Information

The Physician Information window allows you to update physician information related to a review that has been or is to be performed. If there is a Health Service Encounter (HSE) for the claim, the physician information from the HSE will automatically display on this screen.

1   To update the Physician Information, highlight the row and select the Physician Information icon, .

    The Physician Information window displays with the billed information if there is a claim for the review.

2   Select the Insert icon, , to insert a new row if necessary.

3   In the Code Set field, select the desired code set from the drop-down list.

4   If desired, enter the UPIN or Phys NPI for the physician and press the TAB key.

    If the physician is in the Physician maintenance table, the Last Name, First Name, and Encoded Number will display.

5   If necessary, TAB to the Last Name field and enter the Last Name of the physician. Press

the T<small>AB</small> key and a list of physicians with that last name displays for selection.

6   T<small>AB</small> to and select the Role Type for the physician from the drop-down list.

7   Select the Save icon, .

Review Contacts

The Review Contacts window allows you to view and update contact information obtained and used during review. Contacts with facilities, physicians, or a beneficiary etc. that occurred while performing review can be entered.

1   To add review contacts, highlight the row and select the Review Contacts icon, .

The Review Contacts Information window displays.

2   Enter the Contact Type. This could be the beneficiary, beneficiary representative, physician etc.

3   Enter the Contact Name.

4   Enter the telephone number and phone extension for the contact if desired.

5   The Date/Time defaults to today's date and the system time and can be changed.

6   Enter a brief description of the contact reason, if desired. This is an alphanumeric field for up to 400 characters.

Notes

The Notes icon, , allows you to access a window to enter free form notes regarding the record. The notes window on Review is accessible to all of the review windows.

1   To enter notes for the record you are on, select the Notes icon, .

2   Enter up to 4000 alphanumeric characters in each Notes field. Additional Notes fields may be inserted if additional space is needed.

3   Select the Spell Check icon, .

4   Select the Save icon, .

5   To print the notes you entered, select the Print Preview icon, . On the Print Preview window, select the Print icon, , near the top of the window.

> ♫ If you have entered any notes for a record, a message in red will display on the Record Tracking Review and Review Type windows stating 'Notes Exist'.

Case Summary

The Case Summary window allows you to view a real time summary of the case at any point in the review. The information on the report includes: demographics; all Select Reasons selected for the review except Select Reasons 212, 193, & those that have Invalid Select Reasons; Selection Dates; Technical Denial Date; Reopen Date; all Review Types, Start Date;

Due Date; Complete Date; Days to Complete; Timeliness; Delays Reported; No Review Required indicator; Coordinator Outcome; Review Outcome; Preliminary Notice date; Response Received Date; Final Notice Date; Rereview/Recon Request Date; Rereview/Recon Notice Date; Rereview/Recon Complete Date; PRAF Outcome; and Status of the review.

1   To view the report for the row you are on, select the Case Summary icon, 🔳 .

2   Select the Print icon, 🖨 , to print a copy of the report.

> ♫   If a confirmed concern exists, the PRAF information will display.

Beneficiary Complaint Setting Listing

The Beneficiary Complaint Setting Listing icon, 🔳 , allows you to jump to the Beneficiary Complaint module for the Claim Key highlighted on the Review or Review Type Listing window.

If there is no Beneficiary Complaint record for the Claim Key, there will be no rows on the Beneficiary Complaint Setting Listing window.

Inpatient Coding Validation

When the Inpatient Coding Validation icon is selected from a review window, you will be taken to the screen that displays the diagnosis codes, procedure codes and the DRG.

These codes will display on the window if the Coding indicator on the base Review or Review Type window is '**R**' Required or '**Yes**' when you add the review type of coding.

For Higher Weighted DRGs, the code sets retrieved from the Claims Warehouse are the BH - Before Higher Weighed DRG and HW - Requested for Higher Weighted DRG.

For other types of review only the BR - Billed at Time of Review code set is retrieved from the Claims Warehouse.

1   To access the Inpatient Coding Validation window from Review, highlight the desired row and select the Inpatient Coding Validation icon, 🔳 . The Inpatient Coding Validation window will display.

2   Select the desired code set in Code Set 1.

3   Select the desired code in Code Set 2, i.e., First Level Review, Second Level Review.

4   Enter the Age, Sex, Discharge Disposition, and at least one diagnosis.

> ♫   Typing a 1, 2, or 0 enters the Sex.

Get BR Code Set

This function allows you to retrieve the DRG, Diagnosis, and Procedure Codes for the Billed Claim at Time of Review (BR) code set if necessary from the Claims Warehouse. These codes may not have been retrieved if the warehouse was unavailable at the time the record was added to CRIS.

1   In Code Set 2, display the BR code set.

2   Select the Get BR Code Set icon, [icon].

     If the claim exists on the Claims Warehouse, the DRG, Diagnosis and Procedure Codes will be retrieved.

Copy Code Set 1 to Code Set 2

This function allows you to copy the diagnosis and procedure codes that display in Code Set 1 to Code Set 2. Codes entered in the first level review in Code Set 2 can be copied to second level review in Code Set 2. You will need to group the codes that you have copied.

1   In Code Set 1, select the code set you want to copy to Code Set 2, i.e., 1L, 2L, BR, etc.

          ♫   In Code Set 1, you can select any available code set that contains codes. For example, if you want to copy the 1L codes from Code Set 2 to the 2L codes in Code Set 2, select First Level Review (1L) in Code Set 1. In Code Set 2, select Second Level Review (2L).

2   Select the Copy Code Set 1 to Code Set 2 icon, [icon].

     A warning message displays asking if you really want to copy Code Set 1 to Code Set 2.

3   Select **Yes** to copy Code Set 1 to Code Set 2.
     OR
     Select **No** if you do not want to copy the code set.

          ♫   You will not be able to copy a code set to itself. A code set cannot be

copied to the HW, BH, BL, or BR code sets.

4   Select the Call Group icon, [icon] , to group the codes you have copied to Code Set 2.

Insert Diagnosis

1   To insert diagnoses codes place the cursor in the Diag 2 column and type in the desired diagnosis code

2   Select the Down arrow key on your keyboard.

     The description of the code will automatically display.

3   Continue to type in the desired diagnoses codes.
     OR

4   Place the cursor in the diagnosis description column.

5   Type in the first few letters of the desired diagnosis description.

     A message displays stating "Please wait while we obtain the diagnosis descriptions for the appropriate date".

6   Scroll through the list of diagnoses on the left side of the window and click on the desired diagnosis with your mouse. It will display in the selected row.

7   Place the cursor in the next row and continue to type in the desired diagnosis description.

8   To insert a diagnosis at the top of the row, select the Insert Diagnosis icon, [icon] , directly to the left of the Diagnosis section.

9   To insert a diagnosis at the bottom of the row, select the Insert Diagnosis at End icon, [icon] .

     ♫   You can enter up to 25 diagnosis codes. If codes are already filled in all the rows, selecting the Insert Diagnosis icon will delete the last code from the list.

Insert Procedures

1   To insert procedure codes place the cursor in the Proc 2 column and type in the desired procedure code.

2   Select the Down arrow key on your keyboard.

     The description of the code will automatically display.

3   Continue to type in the desired procedure codes.
     OR
4   Place your cursor in the Description column.

5   Type in the first few letters of the procedure description.

     A message displays stating "Please wait while we obtain the procedure descriptions for

the appropriate date".

6   Scroll through the list of procedures on the left side of the window and click on the desired procedure with your mouse.   It will appear in the selected row.

7   Place the cursor in the next row and continue to type in the desired procedure description.

8   To insert a procedure at the top of the row, select the Insert Procedure icon, , directly to the left of the Procedure section.

9   To insert a procedure at the bottom of the row, select the Insert Procedure at End icon, .

> ♫   You can enter up to 25 procedure codes. If codes are already filled in all the rows, selecting the Insert Procedures icon will delete the last code from the list.

To insert both diagnosis and procedures select the Insert Diagnosis and Procedures icon, .

Delete Diagnosis or Procedure Codes

1   To delete a diagnosis or procedure place the cursor on the row you want to delete.

2   Select the Delete Diagnosis or Delete Procedure icon, , to the left of the section.

A message will display asking, "Do you want to delete this row?"

3   Select '**Yes**' to delete the row or '**No**' if you do not want to delete the row.

> ♫   You will not be able to delete diagnosis or procedures associated with the BH, BR, or HW Code Sets.

Grouping the Codes

1   Select the desired code set (i.e., first level review, second level review, etc.).

2   Enter the appropriate age, sex, and discharge status.

3   Enter the desired diagnoses and procedures.

4   Select the Call the Grouper icon, .

The information provided by the grouper displays in the pane on the left.

> ♫   The screen may momentarily go black as the system calls the grouper.

5   To print the grouper output, select the Print icon on the Coding Validation window.

HINTS:

1   To call the Grouper or save a row, you must have data in the Age, Sex, and Discharge Status fields and at least one Diagnosis Code must be entered.

2   Make sure you select the appropriate code set under Code Set 2 before you begin entering or updating the diagnosis, procedure, or HCPCS codes.

3   If the review coordinator approves the DRG, it is not necessary to enter any information

into Code Set 2.

4   On 1st level review, use code set 1L when the review coordinator, coding specialist or physician reviewer makes a change in one of the fields (e.g., diagnosis, procedure, discharge status).

5   If the DRG is approved at the DRG coordinator level during 1st level review, it is not necessary to enter anything in Code Set 2. If the DRG is changed at the DRG coordinator level during 1st level review, enter the changes in the 1L Code Set.

6   Code Set 2L is used when there is a coding change on 2nd level review.

7   If you are performing invasive procedure review, the outcome codes can be entered in the BR code set.

8   The codes in the BR code set are the codes on the Claims Warehouse at the time the record was added to CRIS.

9   The codes displayed under the Before Higher Weighted DRG (BH) code set, are those billed before the higher weighted DRG request was received.

Delete Code Set 2

This function allows you to delete all information entered in Code Set 2. You will not be able to delete a BR, BH, or HW code set.

1   On the Inpatient Coding Validation window, select the Delete Code Set 2 icon, .

A warning message displays asking if you really want to permanently delete Code Set 2.

2   Select **Yes** to permanently delete Code Set 2.
    OR
    Select **No** if you do not want to permanently delete Code Set 2.

3   Select the Save icon, .

Outpatient Coding Validation

When the Outpatient Coding Validation icon, , is selected from a review window, you will be taken to the screen that displays the HCPCS codes.

Get BR Codes

This function allows you to retrieve the Diagnosis and Procedure Codes for the Billed at Time of Review (BR) code set if necessary from the Claims Warehouse. These codes may not have been retrieved if the warehouse was unavailable at the time the record was added to CRIS.

1   In Code Set 2, display the BR code set.

2   Select the Get BR Code Set icon, .

If the claim exists on the Claims Warehouse, Diagnosis and Procedure Codes will be retrieved.

Insert HCPCS Codes

1   Place the cursor in the second HCPCS codes column.

2   Type in the desired HCPCS code.

3   Select the Down arrow key on your keyboard.

    The description of the code entered will automatically display. The cursor will move to the second HCPCS column on the next line.

4   Continue to type in the desired HCPCS codes.

    OR
    Place the cursor in the HCPCS description column

5   Type in the first few letters of the desired HCPCS description.

    A message displays stating "Please wait while we obtain the HCPCS descriptions for the appropriate date".

6   Scroll through the list of HCPCS on the left side of the window and select the desired HCPCS.

    It will appear in the selected row.

7   Place the cursor in the next row and continue to type in the desired HCPCS code descriptions.

8   To add another code at the top of the row, select the Insert HCPSC icon, , and a new row will be inserted at the top.

9   To add another code at the end of the list of codes already entered, select the Insert HCPCS at End icon.

10 You can enter up to 25 HCPCS codes. The scroll bar will allow you to scroll down the list of entered codes to view them.

Delete HCPCS Codes

1   To delete a HCPCS code place the cursor on the row you want to delete.

2   Select the Delete HCPSC icon, , to the left of the section.

    A message will display asking, "Do you want to delete this row?"

3   Select '**Yes**' to delete the row or '**No**' if you do not want to delete the row.

Call Grouper

The Call Grouper window allows you to enter diagnosis codes, procedure codes, age, sex and discharge status for a patient and call the grouper. You will not be able to save the codes you group on this window. Use the Inpatient Coding Validation window to save the codes to the database.

> ♫ Follow the instructions in the Inpatient Coding Validation section for adding, deleting and grouping codes on the Call Grouper window.

Long Term Care Hospital (LTCH) Reviews

Selections for these reviews will begin with claims CMS processed in January 2004, and loaded to the SDPS Warehouse in February 2004. Notification that these selections are available in CRIS will be included in the monthly HWDRG memo. The selected records are for discharges after 9/30/2003.

LTCH Higher-Weighted DRG Review

Selection Reason '120 – Higher Weighted DRG Assignments' will be assigned for providers with identification numbers that have 2000 – 2299 in the 3rd through 6th position. The required review types are Coding and Utilization. See Entry of Higher-Weighted DRG Review for entry instructions.

On the Inpatient Coding Validation window, the Outlier Threshold and the Relative Weight values do not display. They can be found in the Federal Register. The Diagnosis, Procedure and DRG codes are correct.

> ♫ In the Review Type window, the Coordinator Outcome field, Coordinator Outcome code 'L – LTCH Admission Review Exception' may be used when the LTCH Provider was acute short-term when the patient was admitted, but changed to acute LTCH during the admission. When this code is used in the Coordinator Outcome field, criteria in the Admission Criteria 1 or Admission Criteria 2 fields will **not** be required. Use of this outcome code will make the review go complete.

Entry of Higher Weighted DRG Review

You will receive GroupWise notification when the retrospective Higher Weighted DRG selection has been performed.

Processing Retrospective Higher Weighted DRG Selections

1   Select **Record Tracking|CMS Selections/Print Medical Record Requests.**
    OR

    Select the CMS Selections/Print Medical Record Requests icon, .

2   The CMS Selections/Print Medical Record Requests List window displays in Query Mode.

3   Select the Enter Criteria icon, [icon] .

     Any previously entered criteria will clear.

4   Enter the Select Reason of Higher Weighted DRG (120) and select the Retrieve Query
     icon, [icon] .

5   Update the default values in the Record Tracking System section if needed. The *Action*
     must be Requested.

6   Select the Save icon, [icon] . Print the desired medical record request forms to request the
     medical record from the provider.

Tracking and Assigning the Medical Record for Review

1   When the medical record is received from the provider, track it in the Record Tracking
     system either through the Batch Update windows or manually inserting the row on the
     Record Tracking window. Use an *Action* code of 2 – Received for Case Review.

     Using the *Action* code of 2 – Received for Case Review, allows the record to be available
     for review assignment.

2   Select **Case Review|Assign Review Records**.

3   Query for and retrieve the cases that do not have a base review or review type record
     created.

     Assign a Staff ID to the Coding and Utilization Review Types
     OR
     Leave the Assign Staff ID section blank.

4   Select the Save icon, [icon] .

This action will create the Review base record and the Review Type record. The review types that will be created are dependent upon the Selection Reason.

Initial (First Level) Coding Validation Review

1   Select **Case Review|Review Listing.**
    OR

    Select the Review Listing icon, .

2   Query for the desired record.

3   With the record highlighted, select the icons on the second button bar to jump to additional windows needed to record the data for the review.

4   Access the Review Type window to record the Coding validation and Utilization review (if applicable) information.

5   In the top section of the Review Type window, an 'R' will display in the Coding and Utilization fields if those review types are required.

6   Select the Coding Validation icon, .

7   In the Code Set 1 section, select HW (Requested for Higher Weighted DRG) in the Code Set drop-down list to view the codes requested for higher weighted DRG payment.

    ♫   If the DRG, diagnosis or procedure codes do not display, select the Get
        Warehouse Information icon, .

8   If you agree with the codes submitted for Higher Weighted DRG, enter an "A" in the Coordinator Outcome field in the Coding Review section on the Review Type window.

9   If you disagree with the codes submitted for Higher Weighted DRG, enter the codes you determine to be correct in the Code Set 2 section as a 1L (First Level Review) code set.

    ♫   Follow the protocol at your QIO for when to enter the codes in Code
        Set 2.

10 Select the Call Grouper icon, , to group the codes if they have changed. The grouper information displays on the left side of the window.

11 Select the Print icon to print the grouper output.

12 Select the Save icon, , and the Close Window icon, .

If the codes you determine to be correct require physician review, record the information on the PRAF.

If you agree with the codes submitted for Higher Weighted DRG or the change in the codes does not change the DRG, do not enter any information regarding the coding validation on the PRAF.

Entering Initial PRAF Information

1   On the Review Listing window, select the PRAF icon, .

2   If a row does not display, select the Insert icon, , to enter a 1C Review level line.

3   Enter the Review Date and a Concern Number.

4   In the Category field, select the appropriate D category (D01 – D16 or D99).

5   If the Review Type field does not automatically fill, select the appropriate Review Type from the drop-down list.

6   In the Outcome field enter a Z. 'No Source' displays in the Source field.

7   Use the **TAB** key to move to the Staff field and enter the Staff name.
8   Select the Save icon, .

The case is ready to go to physician review. When physician review is completed, update the Coding Validation, PRAF, and Review Type windows.

Entering Initial Physician Approved Diagnosis on Coding Validation Window

1   From the Review Listing, Review base, or Review Type window, select the Coding Validation icon, , to access the Coding Validation window.

2   In Code Set 2 section, select the first level (1L) code set.

3   Add or update the codes approved by the physician.
4   Select the Call Grouper icon, , to group the codes if they have changed. The grouper information displays on the left side of the window.

5   Select the print icon to print the grouper output.
6   Select the Save icon, , and the Close Window icon, .

Entering Initial Physician Reviewer Information on the PRAF

1   From the Review Listing, Review base or Review Type window, select the PRAF icon, .

2   Select the Insert icon, , to insert a 1P Review Level row.
3   Enter the date of the physician review.

4   In the Concern Number field, enter the same number as you did in the 1C row.

5   In the Category field, select the same option as on the 1C Review Level line.

6   If the Review Type field does not automatically fill, select the appropriate Review Type from the drop-down list.

7   Enter the appropriate option in the Outcome Code field. Enter a C in the Outcome field if the physician reviewer confirmed a coding validation concern. Enter an "R" if the concern is resolved.
8   Select the Save icon, .

Entering Physician Approved Diagnosis on Coding Validation Window

1   From the Review Listing, Review base or Review Type window, select the Coding Validation icon, [icon] .

2   In Code Set 2 section, select the appropriate code set. If entering codes approved on second level review, select 2L.

3   Select the Call Grouper icon, [icon] , to group the codes. The grouper information displays on the left side of the window.

4   Select the Print icon to print the grouper output.

5   Select the Save icon, [icon] , and the Close Window icon, [icon] .

Entering PRAF Information

1   From the Review Listing, Review base or Review Type window, select the PRAF icon, [icon] .

2   Select the Insert icon, [icon] , to insert a new 2P Review Level row.

3   Enter the same Concern Number and Category as you did on the previous 1P Review Level line for the DRG validation.

4   Enter a "C" in the Outcome field, if the physician reviewer upheld the confirmed concern. Enter an "R" if the concern is resolved.

5   Select the Save icon, [icon] .

Entering Review Type Information

1   From the Review Listing or Review base window, select the Review Type icon, [icon] .

2   In the Coding Review section, in the Final Notice date field, enter the date you sent the final notice to the provider.

3   Select the Save icon, [icon] .

Second Level Review – No Response Received From Provider

Entering PRAF Information

1   From the Review Listing, Review base or Review Type window, select the PRAF icon, [icon] .

2   Select the Insert icon, [icon] , to insert a new 2C Review Level line.

3   Enter the same Concern Number and Category as you did on the previous 1C Review Status line for the DRG validation.

4   Enter a "C" in the Outcome field, because the physician confirmed the change in diagnosis codes on first level review.

5   Select the Save icon, [icon] .

Entering Review Type Information

1   From the Review Listing or Review base window, select the Review Type icon, ⊞ .

2   In the Coding Review section, in the Final Notice date field, enter the date you sent the final notice to the provider.

3   Select the Save icon, 📥 .

    The record will not change to Complete Record status if there are any review edit errors for the case. To review the edit errors, access the Edit Errors window. The Edit Errors

    icon, 🅴 , is accessible from most of the review windows in CRIS.

Notice of Non-coverage Log Listing

When you receive the copy of the notice of noncoverage letter given to the beneficiary, add a new log record for each letter. If the record is selected for retrospective review the Record Select indicator field will display a '1' and a date will display in the Select Date field.
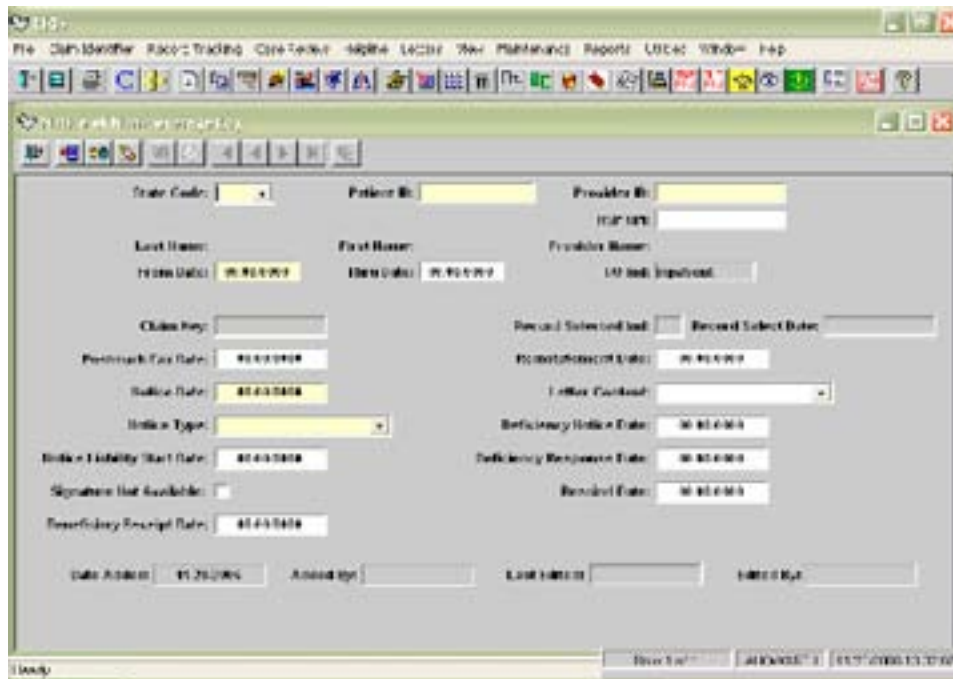
1   To add a record to the Notice of Non-coverage Log select **Case Review|Notice of Non-coverage Log Listing**
    OR

    Select the Notice of Non-coverage Log Listing icon, ◆ .

    The Notice of Non-coverage Log Listing window displays in Query Mode.

2   Select the Insert icon, 🔲 .

    The Notice of Non-coverage Log window displays.

3   Enter your State Code if necessary. Multi-state QIOs will need to select a state from the drop-down list.

4   Enter the Patient ID. This is the HIC# or Medicare Number. The beneficiary name displays.

5   Enter the Provider ID. The provider name displays.

6   Enter the HSP NPI, if known.

> ♫   When either the Provider number or HSP NPI is entered, the system will populate the other field and the Provider Name.

7   Enter the Claim From Date. If the notice was given preadmission, enter the date of the planned admission.

8   Enter the Claim Thru Date if known. If the patient is still hospitalized, use the last known date of the stay.

9   Enter the date the notice was sent from the facility to you. This is the postmark date for regular mail or the fax date.

10 Enter the date the beneficiary received the notice of noncoverage.

11 Select an option from the drop-down list for the type of notice the beneficiary received.

12 Enter the date the beneficiary became liable for payment per the Notice of Non-coverage notice.

13 If applicable, enter the date the beneficiary's Medicare benefits were reinstated after the Notice of Non-coverage is issued.

14 Review the content of the notice and select an option from the drop-down list to describe whether the notice language and/or liability are appropriate.

15 If applicable, enter the date you notified the provider that the notice language or liability was inappropriate.

16 If applicable, enter the date the provider responded to your notice of the deficiency in the Notice of Non-coverage language or liability.

17 If you are notified that the provider rescinded the notice of noncoverage, enter the date the provider rescinded the notice.

18 Select the Save icon, ⬛ .

A procedure will verify that the Provider ID is valid for your state, add the record to the Claim Identifier table and create a Claim Key for the record.

Retrospective Notice of Non-coverage Selection

> ♫   Retrospective NONC Selection ceased, effective June 6, 2008.

SDPS will identify the cases for the retrospective Notice of Non-coverage selections (113 - Notice of Non-coverage Retrospective Monitoring Review). You will be notified when the cases have been identified and added to the Claim Identifier and Claim Identifier Select tables by a SDPS memo.

You will be able to query for the 113 - Notice of Non-coverage Retrospective Monitoring Review cases on the CMS Selections window, update the Record Tracking System information as desired, run the applicable medical record request forms and send the requests to the providers.

To review how to run the CMS Selections, please reference the Claim Identifier and Record Tracking chapter of this manual.

- **Retrospective Notice of Non-coverage Selection Logic**

The selection procedure run by SDPS will identify Notice of Non-coverage Log records and matching Health Service Encounter (HSE) records from the state that meet the following criteria and update the Record Select indicator on the Notice of Non-coverage Log to a 1 – Selected and enter the date of the selection in the Selected Date field.

Records will be selected for LTCH if the 3rd through 6th digit of the provider ID is between 2000 and 2299 and the discharge date is after 9/30/2003.

Criteria for selections based on Notice of Non-coverage Log entry
- Records that were not previously selected (Notice of Non-coverage Record Select Indicator on the Notice of Non-coverage Log is <u>not</u> equal to a 1 – Selected)

OR
- Liability Start Date is null (no date has been entered)
    OR
- If there is a Reinstatement Date and a Liability Start Date on the Notice of Non-coverage Log, the Reinstatement Date must be greater than the Liability Start Date
    OR
- If there is a date in the Liability Start Date field on the Notice of Non-coverage Log, the Liability Start Date must be less than the HSE claim thru date

AND
- The Notice of Non-coverage Log record must have a matching HSE record
- The HSE patient ID must equal the Notice of Non-coverage Log patient ID
- The HSE provider ID must equal the Notice of Non-coverage Log provider ID
- The HSE Claim From Date (admit date) on the Notice of Non-coverage Log must be greater than or equal to the HSE Claim From Date (admit date) and less than the HSE Claim Thru Date (discharge date)

OR
- The HSE Claim From Date (admit date) on the Notice of Non-coverage Log must equal the HSE Claim From Date (admit date) and equal the HSE Claim Thru Date (discharge date (admitted and discharged on the same date)
- The HSE inpatient/outpatient indicator must equal the Notice of Non-coverage Log inpatient/outpatient indicator
- The HSE discharge status must not be equal to 30 (interim bill)
- The HSE state code must equal the QIO state code
- The HSE Intermediary Action Code is not equal to 2 and not equal to 4 (omits voided claims)
- The HSE created is null or equal to B - Billed (omits manual adds)

Criteria for selection based on HSE Claim information

- Records that were added to the HSE table after the last Notice of Non-coverage selection by SDPS

AND

- Records with an HSE inpatient/outpatient indicator of I - Inpatient

AND

- Records with an HSE Occurrence Code of 31 (the date the beneficiary was notified of intent to bill accommodations) or 32 (the date the beneficiary was notified of intent to bill procedures or treatment)

AND

- Records with a HSE Span Code of 76 (indicates patient liability) and the HSE Occurrence Date is not null and is less than or equal to the HSE from date
  OR
- Records with an HSE Span Code of 76 (indicate patient liability) and the HSE Span dates are not null and the HSE Occurrence Date is not null and is greater than the HSE from date and the HSE Value Code is 31 (indicates patient liability amount) and the HSE Value amount is not null and is not equal to zero

AND

- Records that do not have a HSE discharge status of 30 (Interim bill)
- HSE state code must equal the QIO state code
- HSE Intermediary Action Code is not equal to 2, 4, or 6 (omits voided claims)
- HSE created is null or equal to B - Billed (omits manual adds)

Entry of Notice of Non-coverage Review

Receipt of copy of Notice of Non-coverage notice—*See the "Notice of Non-coverage Log Listing" section in this chapter.*

Providers are required to send the QIO copies of the Notices of Non-coverage they issue within three (3) days of the issue date. When you receive a log of the provider Notice of Non-coverage letters issued to the patient, enter it into the Notice of Non-coverage Log window. A claim key will be created for the record. This information is used for part of the retrospective Notice of Non-coverage selection process.

When a Notice of Non-coverage Log record is selected through the retrospective Notice of Non-coverage selection process, the Record Select Indicator field displays a '1' and the selection date displays in the Select Date field.

Retrospective Notice of Non-coverage Selection Review—*See the "CMS Monthly Merge Selections" section of the Claim Identifier and Record Tracking chapter.*

Immediate or Expedited Notice of Non-coverage Review
An immediate or expedited Notice of Non-coverage review request might be received from a beneficiary or their representative, from a provider, from a physician or from an MA or Managed Care Organization. An immediate review is a review requested prior to admission (in the case of a preadmission Notice of Non-coverage), upon admission (in the case of an admission Notice of Non-coverage), or no later than noon of the first working day after the day the notice was received (in the case of a continued stay Notice of Non-coverage). An expedited review is a review requested after noon of the first working day after the day the notice was received, but while the beneficiary is still in the hospital (in the case of a continued stay Notice of Non-coverage).

Notices of Non-coverage are issued to patients receiving service from Home Health Agencies (HHAs), Hospices, Skilled Nursing Facilities (SNFs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) under the Benefits Improvement and Protection Act (BIPA). Before termination of services, the provider must deliver a valid written notice to the beneficiary of the decision to terminate services. A Medicare beneficiary may appeal the notice to terminate services if they disagree with the notice. If the provider is a non-residential provider (CORF or HHA), there must also be physician certification that failure to continue the services may place the beneficiary's health at significant risk.

There will not be a health service encounter (HSE) claim for an immediate or expedited Notice of Non-coverage appeal.

Add an Immediate or Expedited Notice of Non-coverage Review

1   Select **Record Tracking|Import/Print Medical Record Requests**
    OR

    Select the Import /Print Medical Record Requests icon, .

2   Select a State Code.

3   Select the Insert icon, , from the row above the Select Reason.

4   Select the appropriate Notice of Non-coverage Select Reason and enter the Select Date.

5   In the Record Tracking System section, the Component defaults to 'Complete Record' and the Action Date defaults to today's date. Enter an Action of 'Requested' or 'Received for Case Review.' Enter the appropriate Location.

    If the number of Days Due has not been entered in the Record Tracking Location Maintenance window for the Location you selected, enter a Due Date.

6   Enter the Patient ID, Provider ID, From Date, Thru Date, and I/O Indicator.

7   Select the Save icon, , and exit the window.

    CRIS will automatically fill the claim key field with a unique identifying number and assign a batch number for convenient data entry purposes.

8   Use the icons to select and print the desired medical record request reports and labels.

Performing Notice of Non-coverage Review

1   If the medical record request Action was 'Requested', the medical record must be tracked when received. Select **Record Tracking|Record Tracking Listing**
    OR
    Record Tracking|Record Tracking Last Location Listing
    OR

    Select the Record Tracking Listing icon, .

2   Enter the State Code and Claim Key. Select the Retrieve Query icon, , or press

    ENTER. Select the Modify icon, .

3 Insert a new Component row. Enter Component information. The Action must be 2 – Received for Case Review. Select the Save icon, , and exit the window.

4 Select **Case Review|Assign Review**
OR

Select the Assign Review Records icon, .

5 Query for the Claim Key, and select a Staff ID if desired. Notice of Non-coverage selection reasons will automatically create a Notice of Non-coverage review type.

> ♫ Currently, the Staff ID entered here will only display for required review types that are automatically created by the system. See **View|Select Reason View** to see which review types will be automatically created for selection reasons.

Select the Save icon, , and exit the window.

6 Select one of the following options:

Claim Identifier|Claim Identifier Listing (or select the icon,)

Claim Identifier|Claim Identifier Selection Listing (or select the icon,)

Case Review|Review Listing (or select the icon,)

Case Review|Review Type Listing (or select the icon,)

7 Query for the Claim Key on the listing window.

Enter Information on the Notice of Non-coverage Review Window

1 Select the Notice of Non-coverage Review icon, . Enter an outcome in the Coordinator Outcome field. Insert a Select Reason if one was not automatically created for the selection. If the selection reason is 105, 106, 107, 108, 109, 110, 111, 114, 117, 118, 121, 122, 123, or 124, enter a Request for Review Received date and time.

2 Select the Insert icon, , next to the Notice information section to insert a row in the Notice section. If the notice was entered in the Notice of Non-coverage Log, the Notice Type, Beneficiary Receipt Date, and Letter Content fields will populate when you enter the Notice Date, based on the information in the Log.

3 Enter the result of your validation of the notice of non-coverage in the Outcome field. A Notice Date is not required when 'No Notice Issued' is selected as the Outcome.

4 Select the Insert icon, , next to the Notice of Non-coverage Events section to insert an Event row. Select an event from the drop-down box. The date and time default to the current date and can be changed. Enter other information as needed.

5 Select the Insert icon, , next to the Payment Responsibility section to indicate whether Medicare, the Provider, the Beneficiary, or Provider or MA is responsible for payment. Enter the dates the responsible party is liable for and the select reason associated with each row.

6   Select the Save icon, , and the Close window icon, , to exit the window.

Add Information to the Review Contacts Window
For Immediate/Concurrent review

1   Select the Review Contacts icon, .

2   Select the Insert icon, , to insert a new row if necessary.

3   Enter the Contact Type and Contact Name. The Contact Date and Time defaults to the system date and time and can be changed.

4   Select the Save icon, , and the Close Window icon, .

Add Information to the PRAF

1   Select the PRAF Listing icon.

2   Select the Insert icon if necessary to enter a 1C Review Level line.

3   The Review Date defaults to today's date and can be changed.

4   In the Category field select a category. This will usually be category A07, but could be A01, A08, or A09.

5   If the Review Type field does not automatically fill, select the appropriate Review Type from the drop-down list.

6   In the Outcome field enter a "Z". No source displays in the Source field.

7   Use the **TAB** key to move to the Staff field and enter the Staff name.

8   Select the Save icon, .

The case is ready to go to physician review. After the case has returned from physician review, enter the physician reviewer information.

Add Physician Reviewer Information to the PRAF

1   Query for the case on the Review Listing window.

2   Highlight the case and select the PRAF icon, .

3   Select the Insert icon, , to insert a 1P Review level line.

4   Enter the date of the physician review.

5   In the Concern Number field, enter the same number as you did in the 1C row.

6   In the Category field select the same option as on the 1C Review Level line.

7   If the Review Type field does not automatically fill, select the appropriate Review Type from the drop-down list.

8   Enter the appropriate option in the Outcome Code field.

9   Select the Save icon, .

Update Information on the Notice of Non-coverage Review Window
After physician review, update the Notice of Non-coverage Review window.

1   Highlight the desired record on the Review Listing window and select the Notice of Non-coverage Review icon, .

2   In the Responsible for Payment section under Payment Responsibility, select the Insert icon, , to add a line and enter the dates for the beneficiary, provider, or CMS payment responsibility as selected from the drop-down box.

3   Select the Save icon, , and the Close Window icon, .

Update the Notice of Non-coverage Review Type
1   Enter the date the Preliminary, Written/Final, and/or Verbal notice was sent to the pro-vider, physician, and/or beneficiary.

The record will not change to Complete Record status if there are any review edit errors for the case. To review the edit errors, access the Edit Errors window. The Edit Errors icon, , is accessible from most of the review windows in CRIS.

   ♫   If a BIPA appeal request is untimely, select one of the options in the Un-timely Request field.

   ♫   If an appeal for BIPA review comes from a beneficiary receiving services from a CORF or HHA provider, an entry in the physician certification (Phys Cert) field is required. If **No** is entered in the Phys Cert field, entry in the PR Cert field will also be required.

Notice of Non-coverage Summary

The Notice of Non-coverage Summary window allows you to view a real time summary of the Notice of Non-coverage at any point in the review. The information on the report includes: demographics; all Select Reasons selected for the review, those that have Invalid Select Reasons; Selection Dates; Technical Denial Date; Reopen Date; all Notice of Non-coverage Review Types, Start Date; Due Date; Complete Date; Days to Complete; Timeliness; Delays Reported; No Review Required indicator; Coordinator Outcome; Review Outcome; Preliminary Notice date; Response Received Date; Final Notice Date; Rereview/Recon Re-quest Date; Rereview/Recon Notice Date; Rereview/Recon Complete Date; PRAF Outcome; and Status of the review.

1   To view the report for the row you are on, select the Notice of Non-coverage Summary icon, , on the Notice of Non-coverage Review window.

2   Select the Print icon, , to print a copy of the report.

   ♫   If a confirmed concern exists, the PRAF information will display.

EMTALA Review

Emergency Medical Treatment and Active Labor Act (EMTALA) review requests are received from your CMS Regional Office (RO). The RO might request a 5 Day Advisory review or ask you to perform a 60 Day review. A 5 Day Advisory review must be completed before a 60 Day review can be recorded in the EMTALA window.

The 5 Day Advisory review is completed in 5 working days. The 60 Day review is completed in 60 calendar days. Follow the guidelines provided in the TOPS memo: PRO 2002-01 for determining the due date for the 5 Day Advisory review.

You will import the record on the Import/Print Medical Record Requests window using the appropriate EMTALA Select Reason of 130 – 5 Day EMTALA Review or 131 – 60 Day EMTALA Review.

Entering EMTALA Review

1   Select **Record Tracking|Import/Print Medical Record Requests.**

2   Select the appropriate State Code from the drop down list.

3   Select the Insert icon, , to the left of the Select Reason and Select Date section to insert a row for these fields.

4   Select the appropriate EMTALA selection reason, i.e. 130 –EMTALA 5 Day Review or 131 – EMTALA 60- Day review from the Select Reason drop down list and enter the Select Date.

5   Select the top Insert icon, , and add the record in the claim identifier section.

6   In the Record Tracking System section, select the appropriate Component, Location, and Staff. The Component field will default to 'Complete Record' and the Action Date will default to the current date. For EMTALA review, the Component must be 'Complete Record' or 'Emergency Room ' The *Action* should be **2 – Received for Case Review.**

7   Select the Save icon, .

The record will be added to the Claim Identifier, Claim Identifier Selection, and Record Tracking system.

8   Select **Case Review|Assign Review Records** and query for the EMTALA case.

9   Assign a Staff ID to the case, if desired, and select the Save icon, .

10   Select **Case Review|EMTALA Review Listing.**

EMTALA Listing

The EMTALA Listing window allows you to view and update information for an EMTALA review for the row you have highlighted. The record must have been added to CRIS on the Import/Print Medical Record Requests window with one of the two EMTALA Select Reasons, i.e., 130 or 131, to display on the EMTALA Listing window. All EMTALA review is performed in the EMTALA module. If a quality concern is identified during EMTALA review, you can add selection reason 132 - 'Review of quality of care concerns identified during an EMTALA review', assign it for review, and review the quality concern on the Review Type window.
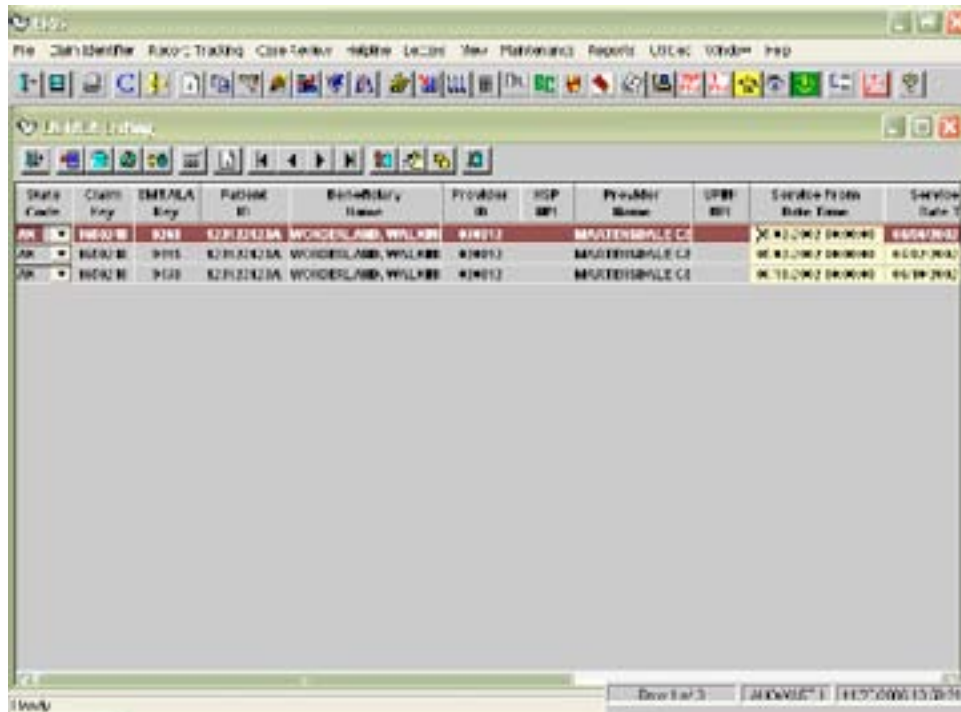
To retrieve an EMTALA review on the EMTALA Listing window;
1   Select **Case Review|EMTALA Review Listing**
     OR

     Select the EMTALA Review icon, [icon] .

2.   Query for the claim key or desired criteria. Click the Retrieve Query icon. Rows meeting the selected criteria will display.

3   If the patient name does not display access the Alternate Contact Address window to add the patient. Use the Contact Type of **Beneficiary.**

Multiple EMTALA Review for the Same Dates
If you are requested to perform an EMTALA review for more than one record for the same patient on the same day, you will be able to enter the additional row on the EMTALA Listing window.

To enter additional EMTALA reviews for the same patient:
1   Highlight the EMTALA row that has more than one record to be reviewed.

2   Select the Insert icon, .

The highlighted row will be copied to another row.

3   Enter the From Date/Time for the second record. The Time field must be different from the first record.

4   Enter the Thru Date/Time for the second record. The Time field must be different from the first record.

> ♪   The Date/Time fields must not be identical to the original row. The system will allow a difference of as little as one second. For example, if the patient was seen on March 29, 2003 at 08:15 through March 29, 2003 at 12:30 and again on March 29, 2003 at 2:30 PM through March 29, 2003 6:30 PM, both records can be added.
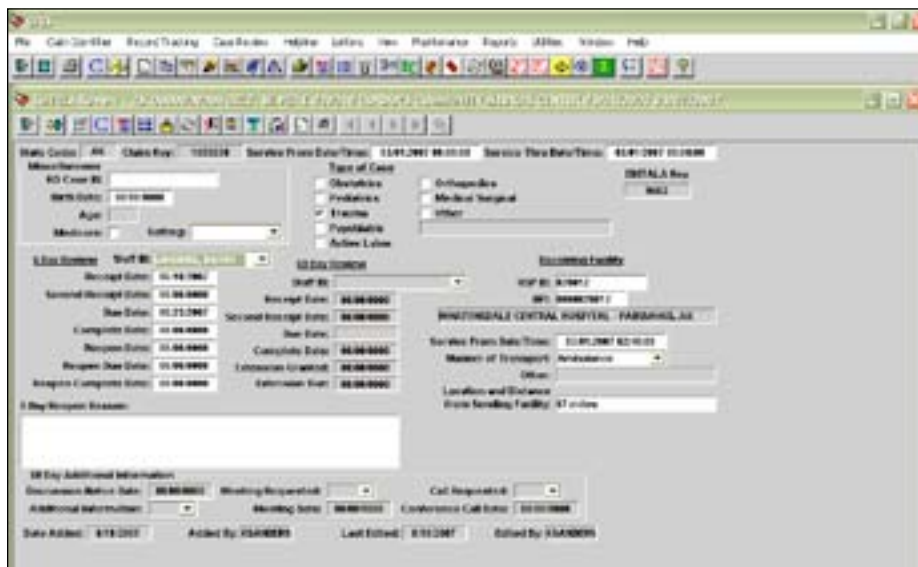
5   Select the Save icon, . If the From Date/Time field or the Thru Date/Time field is not unique from the first record, an error message will display.

EMTALA Review Window

The EMTALA Review window allows you to enter information specific to the patient and the type of review you are performing.

1   From the EMTALA Review Listing window, select the EMTALA Review icon, .

The EMTALA Review window displays.

Service From and Service Thru Date Section

2   The dates and times of service can be changed on this window.

Miscellaneous Section

3   In the **RO Case ID** field, enter the identification number for the case. Use the Control number assigned by the Regional Office (RO) with fields as follows:

___(Region #) ___(state) ___(year) _____ (5 digit #)

Example: 7IA0300123; Region 10 use 0 in the first position.

4   Enter the **Birth Date** for the patient. The age field will auto populate.

5   Indicate if the assessment is for Medicare by checking the **Medicare** box.

6   Select the appropriate **Setting** from the drop-down list.

Type of Case Section

7   One or more of the **Type of Case** must be selected.

8   If **Other** is selected, you are required to enter a brief description in the text box.

EMTALA 5 Day Review

1   In the 5 Day Review section, enter the **Staff ID**.

2   Enter the **Receipt Date**. This is the date you received the medical record necessary to perform the assessment.

> ♫   If there is a 5 day Receipt Date, a 5 day Due Date must exist.

The **Second Receipt Date** field is the date you received the second 5 day assessment referral from the regional office.

3   In the **Due Date** field enter the date the assessment is due to the RO. Follow the TOPS memo: PRO 2002-01 to determine the Due Date.

4   When the assessment is complete and you have provided the results to the RO by telephone and letter, enter the **Complete Date**. This is the fifth working day following the Receipt Date.

> ♫   If you are asked to reopen an advisory review, follow the guidelines for entering the **Reopen Date**, **Reopen Due Date**, and **Reopen Complete Date**. Also enter the reason you were asked to reopen the 5 Day advisory review in the **5 Day Reopen Reason** field.

EMTALA 60 Day Review

> ♫   The 60 Day Review section will be protected until a 5 Day Review has been completed and a Selection Reason of 131-EMTALA 60 Day Review has been assigned.

1   In the 60 Day Review section, enter the **Staff ID**.

2   Enter the **Receipt Date**. This is the date you received the original 60 day review referral from the regional office.

The **Second Receipt** Date is the date you received the second 60 day review referral from the regional office.

3   The **Due Date** will auto populate with 60 calendar days from the Receipt Date.

4   When the 60 day review is complete and you have provided the results to the CMS Regional Office by telephone and letter enter the **Complete Date**.

5   If an extension was granted by the RO, enter the date in the **Extension Granted** field.

6   If an extension was granted by the RO, enter the due date for the extension in the **Extension Due** field.

60 Day Additional Information Section

7   Enter the date correspondence is sent to the health care facility notifying them of the opportunity to discuss the case in the **Discussion Notice Date** field.

8   In the **Additional Information** field select **YES** or **NO** to indicate whether additional written information is submitted by the health care facility prior to or in lieu of the opportunity to discuss.

9   In the **Meeting Requested** field select **YES** or **NO** to indicate whether a meeting was requested by the health care facility. Enter the date of the meeting in the **Meeting Date** field.

10   In the **Call Requested** field select **YES** or **NO** to indicate whether a phone call was requested by the health care facility. Enter the date of the call in the **Conference Call Date** field.

Receiving Facility

Information about the receiving facility can be entered in this section.

1.   Enter the HSP ID or the NPI of the receiving facility. If both an NPI and HSP ID exist in PRS and only one is entered in the EMTALA Review window, the system will populate the other, as well as the provider name.

2.   Enter the Service Date for the Receiving Facility.

3.   Select a Manner of Transport. If "Other" is selected, an entry in the **Other** field is required.

4.   Enter the Location and Distance from the Sending Facility, if known.

♫   This information will display on the Physician Review Worksheet.

EMTALA Results

The EMTALA Results window allows you to print the Physician Review Outline form that contains all of the EMTALA questions; enter the results of the physician review; and print a hard copy of the review to provide to your RO.

1   From the EMTALA Review window, select the EMTALA Result icon, .

The EMTALA Results window displays.

2   For a 5 Day Review, select the Insert All Question 5 Day Review icon, [I₅] .

3   For a 60-Day Review, select the Insert All Questions 60-Day Review icon, [I₆₀] .

    The system will insert rows for the appropriate EMTALA Referral Type and Questions.

4   Select the Save icon, [icon] .

Physician Review Worksheet
The Physician Review Worksheet is used to send the EMTALA questions to the physician reviewer.

1   After the rows have been inserted, a message will display asking if you want to print the Physician Review Worksheet.

2   Select **Yes** if you want to print the Physician Review Worksheet document or select **No** if you want to print the document at another time.

3   You can print the Physician Review Worksheet by selecting the Print Preview icon, [icon] .

4   Select the Print Preview - Tips for the QIO Review icon, [icon], if you want to send this document to the physician.

Print Preview Questions
You can print preview and print information for all of the rows inserted for the EMTALA review at any time. Several options are provided to preview the form.

1   Select the Print Preview All Rows icon, [icon] , to view all of the rows inserted on the EM-TALA Review Information window.

2   Select the Print Preview Selected Row icon, ![icon], to preview only the selected row. If you only want to print preview one row, click on the row with your mouse to highlight the row. If you want to print preview multiple rows, press and hold the CTRL key on your keyboard and click with the mouse on the desired rows.

Entering EMTALA Results
Following physician review, the results are entered on the EMTALA Review Information window.

1   From the EMTALA Review window, select the EMTALA Results icon, ![icon].

2   For each question on the Physician Review Worksheet form, enter the Outcome for each question.

3   Enter the Physician Reviewer, Review Date and Specialty information on the first row.

4   Select the Copy Staff ID and Specialty to Remaining Rows icon, ![icon].

    The Physician Reviewer name, Review Date and Specialty Title will display on the remaining rows.

5   Enter any physician comments for each question in the Notes at the bottom of the window.

6   Select the Summary of Findings icon, ![icon], to record the physician reviewer summary information.

7   Select the Save icon, ![icon].

8   Select the Print Review All Rows icon, ![icon], to print all of the Questions, Outcomes, Notes, and Summary of Findings for all rows.

9   Select the Print Preview Selected Row icon, ![icon], to print the Question, Outcome, Notes, and Review Summary for only the highlighted row.

Beneficiary Complaint

The Beneficiary Complaint module allows you to insert, modify, or delete a complaint record. You will be able to track all Beneficiary, provider or physician events, delay reasons, and any settings associated with the complaint. When a Beneficiary Complaint is received, you will add a new Beneficiary Complaint record. The Beneficiary Complaint record may have one or more hospitalizations, physician office visits, or other settings associated with the complaint. Review will be performed on the individual medical records you have requested in the Case Review module. The Beneficiary Complaint Final Notice (BCFN) is recorded on the Beneficiary Complaint Review Summary window.

Beneficiary Complaint Listing
The Beneficiary Complaint Listing window allows you to insert new Beneficiary Complaint records and to retrieve records previously entered into the system.
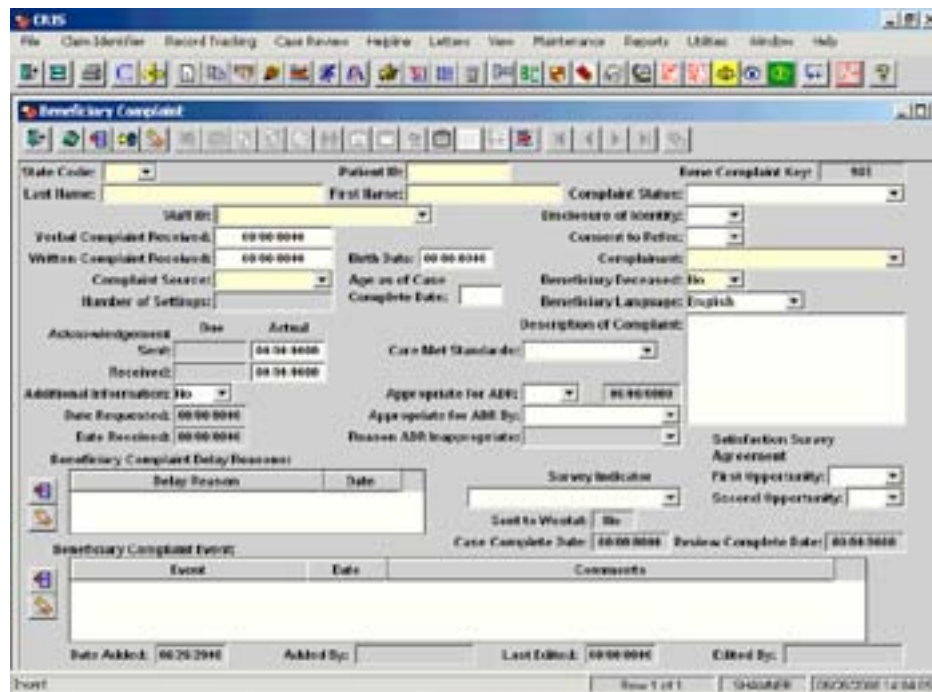
Insert a Beneficiary Complaint Record
1   To insert a new Beneficiary Complaint record, select **Case Review|Beneficiary Complaint Listing**
    OR

Select the Beneficiary Complaint Listing icon, ![BC] .

2   On the Beneficiary Complaint Listing window, select the Insert icon, ![icon] .

A new Beneficiary Complaint record will display.

3   Enter data into the following required fields:

- State Code
- Patient ID – if the beneficiary is on the Beneficiary Enrollment Database on c1s80, the Last Name and First Name will populate when the Patient ID is entered. If not, the fields will populate with 'Not on File'. You will be able to overwrite 'Not on File' with the Last Name and First Name of the Beneficiary.
- Staff ID
- Complaint Source
- Complainant
- Beneficiary Deceased defaults to 'No', but can be overwritten

4   Enter a date in the Verbal Complaint Received or Written Complaint Received field.

The Due date for the Acknowledgement Sent field autopopulates.

5   When the Acknowledgement is sent, enter a date in the Actual date field.

The Due date for the Acknowledgement Received field autopopulates.

6   Enter a date in the Acknowledgement Received field when the beneficiary or representative returns the form.

7   If additional information is requested, select **Yes** from the drop-down list in the Additional Information section.

8   Record the Additional Information Date Requested and Date Received as appropriate.

9   If a beneficiary complaint case is considered appropriate for the Alternative Dispute Resolution (ADR) process, complete the Appropriate for ADR date and the Disclosure of Identity fields. The Care Met Standards field must display **Met**. Select an option for the Appropriate for ADR By field to indicate who determined that ADR was appropriate.

> ♫   Disclosure of Identity must be **Yes** before **Appropriate for ADR** becomes available for entry.

> ♫   The ADR icon will become available on the Beneficiary Complaint window when the following requirements are met: Disclosure of Identity must be **Yes**, Care Met Standards must be **Met**, and a date must be entered in the Appropriate for ADR date field. (See Beneficiary Complaint Alternative Dispute Resolution later in this section.)

10   If a beneficiary complaint case is considered inappropriate for the ADR process, complete the Appropriate for ADR field by selecting **No** from the drop-down list and complete the corresponding date field. Complete the Reason ADR Inappropriate field by selecting an option from the drop-down list.

> ♫   Disclosure of Identity must be **Yes** before **Reason ADR Inappropriate** becomes available for entry.

11   If a survey is conducted for the Beneficiary Complaint, select the survey type from the drop-down list in the Survey Indicator field.

> ♫   If ADR is performed with an external outcome resolution, do not select the Mediation survey type. Leave this field blank.

Create Beneficiary Complaint Record from Helpline

1   To create a Beneficiary Complaint record from the Helpline Detail in the Helpline module, select the Create Beneficiary Complaint Record icon, .

A message displays stating that a new Beneficiary Complaint record will be created.

2   Select **OK** to create the Beneficiary Complaint Record.

The Beneficiary Complaint window displays with information you entered on the Helpline Detail window.

3   The fields copied from the Helpline Detail window (if data has been entered) to the Beneficiary Complaint record are: State Code, Patient ID, First and Last Name, Language, and Deceased. The Complaint Source defaults to Helpline.

4   Complete entry on the Beneficiary Complaint record and save the information.

Beneficiary Complaint Event
The Beneficiary Complaint Event section allows you to enter and track the events that occur for and during the Beneficiary Complaint review process. For example, you can record the date you made the initial contact with the Beneficiary or their representative. Additional Beneficiary Complaint Events can be added on the Beneficiary Complaint Maintenance window in the Maintenance module.

Insert a Beneficiary Complaint Event

1   In the Beneficiary Complaint Event section, select the Insert icon, , to the left of the section.

    A new event row displays.

2   Select an Event from the drop-down list box.

3   Enter the Date associated with the Event.

4   Enter information in the Comments section as desired. This field allows 400 characters.

5   Select the Save icon, .

If information is required in any of the fields, you will receive a message indicating which field(s) requires information.

Delete a Beneficiary Complaint Event
1   Highlight the row to be deleted by clicking on the row with your mouse.

2   Select the Delete icon to the left of the Beneficiary Event section.

    A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row, or select **No** if you did not intend to delete the row.

4   Select the Save icon, .

Abandoned, Withdrawn, or No Medical Record Beneficiary Complaint Event

If a Beneficiary complaint is abandoned, withdrawn, or no medical record received, enter the Abandoned, Withdrawn or No Medical Record - Unable to Continue Bene Complaint Review event in the Beneficiary Complaint Event section. Enter the date the Beneficiary complaint was abandoned, withdrawn, or no medical record received. This event date will be the Case Complete Date for the Beneficiary complaint record.

> ♫ If there are any Beneficiary Complaint Settings displayed on the Beneficiary Complaint Settings window, the 'No Medical Record - Unable to Continue Bene Complaint Review' Events option is <u>NOT</u> allowed.

The QIO can determine whether the quality review should continue in the Case Review module. If you continue with the quality review, the Review Complete Date will be the maximum Complete Date from the Review Type window for all of the settings in the Beneficiary Complaint Settings window.

If you determine that the quality review will not continue, mark the No Case Review Required indicator on the Review Type window for all of the associated settings.

Beneficiary Complaint Delay Reasons
The Beneficiary Complaint Delay Reason section allows you to enter and track reasons the complaint review was delayed. Additional Beneficiary Complaint Delay Reasons can be added on the Beneficiary Complaint Maintenance window in the Maintenance module.

Insert a Beneficiary Complaint Delay Reason

1   Select the Insert icon, ![insert icon], to the left of the Beneficiary Complaint Delay Reasons section.

    A new row displays.

2   Select a Delay Reason from the drop-down list box.

3   Enter the Date associated with the Delay Reasons.

4   Select the Save icon, ![save icon] .

    If information is required in any of the fields, you will receive a message indicating which field(s) requires information.

Delete a Beneficiary Complaint Delay Reason
1   Highlight the row to be deleted by clicking on the row with your mouse.

2   Select the Delete icon to the left of the Beneficiary Event Delay Reasons section.

    A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row, or select **No** if you did not intend to delete the row.

4   Select the Save icon, ![save icon] .

Beneficiary Complaint Setting
The Beneficiary Complaint Settings window allows you to add the record(s) you are reviewing for the current beneficiary complaint. You must enter the record(s) on this window before the edit error in the Case Review module will fire. The record that will be added to the Beneficiary Complaint Settings window must first have been received and assigned to Case Review.

> ♫ A setting can be associated with only <u>one</u> open Beneficiary complaint record at a time. Edits will prevent entry of a duplicate Claim Key with either a different or a duplicate Select Reason.

Insert a Beneficiary Complaint Setting

1   From the desired Beneficiary Complaint record window, select the Settings icon, ![settings icon] .

    The Beneficiary Complaint Settings window displays.
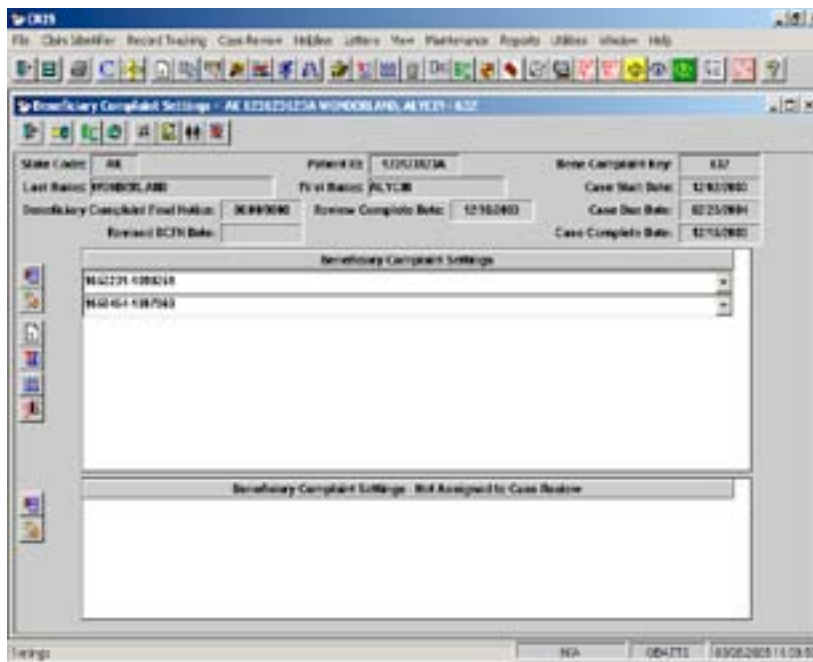
2   When you first access this window the Case Start, Case Due, and Case Complete date fields are empty.

3   Select the Insert icon, ⬚ , to the left of the Beneficiary Complaint Settings section.

4   Select the record(s) from the drop-down list box. If more than one medical record is under review for the beneficiary complaint, select the Insert icon, ⬚ , to add additional records.

>   ♫   Only medical records with a beneficiary complaint selection reason will be available to select.

5   Select the Save icon, ⬚ .

6   Click with your mouse on one of the setting rows.

7   Select the Review icon, ⬚ , Review Type icon, ⬚ , the Record Tracking icon, ⬚ , or the Edit Errors icon, ⬚ , to the left of the Beneficiary Complaint Settings window to jump to the Case Review screens, the Record Tracking window or the Edit Errors, for the setting highlighted in the Beneficiary Complaint Settings window.

Beneficiary Complaint Settings—Not Assigned to Case Review
Records requested for Beneficiary Complaint review that have not yet been assigned for review are available for selection in the Beneficiary Complaint Settings —Not Assigned to Case Review section of the Beneficiary Complaint Settings window.

Once a record has been assigned to review, the system removed the row from the Not Assigned to Case Review section to the Beneficiary Complaint Setting section, where it automatically displays as a Case Review setting associated with the Beneficiary Complaint.

Use the Insert, , and Delete, icons to the left of the window to insert and delete rows.

Beneficiary Complaint Setting Listing
After a record has been added to the Beneficiary Complaint Settings window, you can query for the record on the Beneficiary Complaint Settings Listing window. This query listing window allows you to retrieve records by Bene Complaint Key, Claim Key, etc.

Delete a Beneficiary Complaint Setting
1   Highlight the row to be deleted by clicking on the row with your mouse.

2   Select the Delete icon, , to the left of the Beneficiary Event Settings section.

    A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row, or select **No** if you did not intend to delete the row.

4   Select the Save icon, .

Beneficiary Complaint Review Summary

The Beneficiary Complaint Review Summary window allows you to record physician and provider-specific event information. You will also record the quality improvement activity information that you might request from the provider or practitioner. You will record the Beneficiary Complaint Final Notice (BCFN) on this window. The Review Complete Date field auto populates with the maximum Case Review Complete Date for all of the settings under review that you have entered on the Beneficiary Complaint Settings window.

Beneficiary Complaint Provider Events
The Beneficiary Complaint Events section allows you to enter provider or practitioner-specific events. You will also enter the quality improvement plan information in this section.

Insert a Beneficiary Complaint Provider Event
1   From the desired Beneficiary Complaint record window, select the Review Summary icon, .

The Beneficiary Complaint Review Summary window displays.
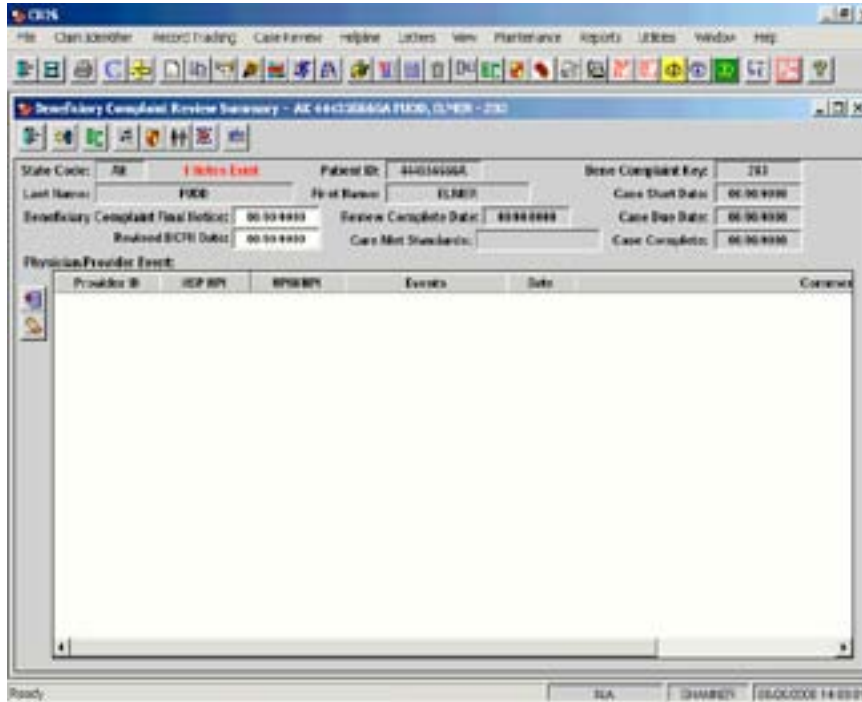
2   Select the Insert icon, ![insert icon], to the left of the Physician/Provider Event section.

A new row displays.

3   Enter a Provider ID or a Physician UPIN on the new row.

You can only enter one, not both, on the same row.

4   Select an option from the drop-down list in the Events field. Additional Beneficiary Complaint Events can be entered on the Beneficiary Complaint Maintenance window.

5   Enter a date in the Date field associated with the Event.

6   Enter notes in the Comments section as desired. This is a 400 character field.

7   Select the Save icon, ![save icon] .

Delete a Beneficiary Complaint Provider Event
1   Highlight the row to be deleted by clicking on the row with your mouse.

2   Select the Delete icon, ![delete icon] , to the left of the Physician/Provider Event section.

A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row, or select **No** if you did not intend to delete the row.

4   Select the Save icon, ![save icon] .

Beneficiary Complaint Final Notice
The Beneficiary Complaint Final Notice (BCFN) is recorded on the Beneficiary Complaint Review Summary window. The BCFN date is entered when the Case Review of all settings has been completed. If the Review Complete Date field is null, you will not be able to record the BCFN date. The BCFN date must be on or after the Review Complete Date.

♫ If the BCFN date has not been entered for a Beneficiary Complaint, the BCFN date field on the listing window will display in red. If the complaint is Abandoned or Withdrawn, the BCFN date field will display in blue. If you have entered an Anonymous complaint in the Beneficiary Complaint module, the BCFN date field will display in blue.

Beneficiary Complaint Review Complete Date
The Beneficiary Complaint Review Complete Date auto populates when all of the settings associated with the complaint are in Complete status. The Complete Date is found on the Review Type window for the setting. The Review Complete Date field must be populated before you will be able to enter the Beneficiary Complaint Final Notice.

Revised BCFN Date
When a complainant requests disclosure of Beneficiary Complaint results in closed cases (Public Citizen TOPS Memo 2003 — 12), this field captures the date a revised beneficiary complaint notice was sent. See Public Citizen TOPS Memo 2003 — 12, *CRIS User Guide*, Chapter 5.

Care Met Standards
Indicate the physician reviewer's determination of whether the care met professionally recognized standards of care. An option is required when the BCFN date is entered.

Beneficiary Complaint Case Complete Date
The Beneficiary Complaint Case Complete Date is the date entered in the Beneficiary Complaint Final Notice date field. If the complaint is abandoned, withdrawn, or no medical record is received, the Case Complete Date is the date on the Beneficiary Complaint Events section associated with the Abandoned, Withdrawn, or No Medical Record event. If the Complainant is Anonymous, the Case Complete Date is the date in the Review Complete Date field. If review is complete and the case goes to Alternative Dispute Resolution (ADR), the ADR Outcome Date will become the Beneficiary Complaint Case Complete Date when the Final ADR Outcome option is 1, 3, 5, 7, or 8.

Beneficiary Complaint Quality Improvement Activity
The Beneficiary Complaint Physician/Provider Events section on the Beneficiary Complaint Review Summary window allows you to record information about quality improvement plans developed for the physician and/or provider.
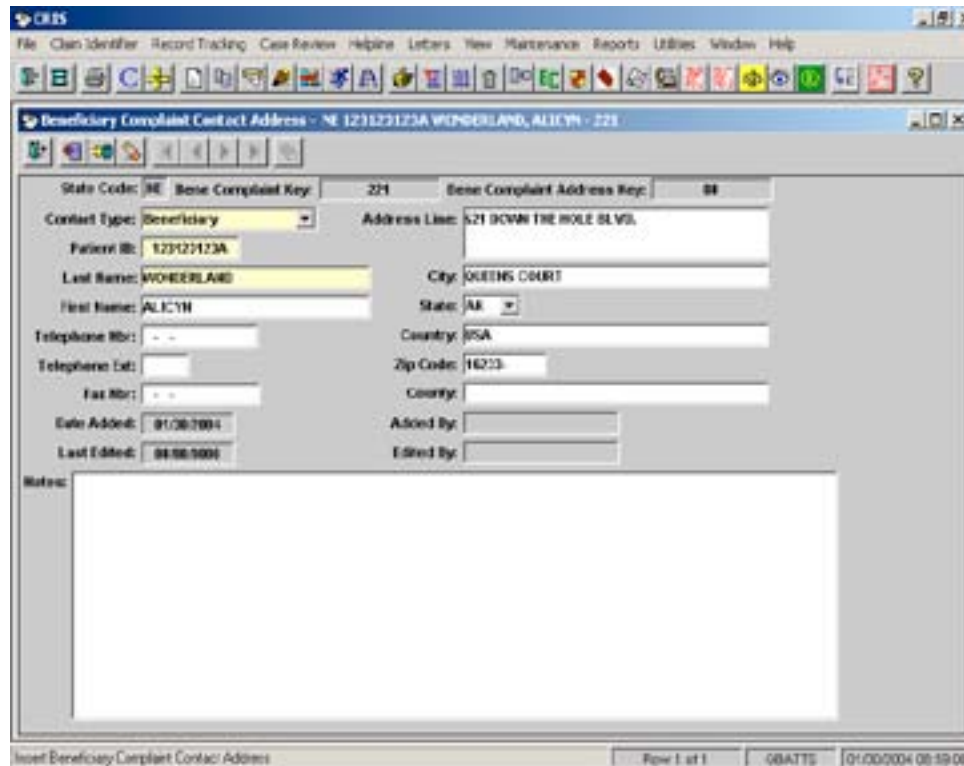
Beneficiary Complaint Contact Address
The Beneficiary Complaint module includes a Contact Address window to allow you to insert address information and notes for the complainant. Multiple rows can be inserted for address or phone number information you need to capture. This window is useful if you need to record multiple addresses or phone numbers for the complainant.

1   From the desired Beneficiary Complaint record window, select the Beneficiary Complaint Contact Address icon, .

The Beneficiary Complaint Contact Address Listing window displays. If no previous information has been added, the window will display no rows.

2   Select the Insert icon, .

A blank Beneficiary Complaint Contact Address window displays.

3   Select the Contact Type.

4   The Patient ID field will display the number entered on the Beneficiary Complaint record.

5   Enter the Last Name. The First Name is optional.

6   Continue adding information as desired to the window. You can also add a phone number and notes for the contact.

7   Selct the Save icon, .

♫   Multiple contacts for the same Beneficiary Complaint record can be added.

Beneficiary Complaint Alternative Dispute Resolution (ADR)

The Beneficiary Complaint (ADR) module allows you to record information related to the ADR process. The Beneficiary Complaint ADR window contains sections in which to record beneficiary/representative, provider/physician and QIO events, events related to the ADR meeting, ADR agreements/improvement plans, the final ADR outcome, the date of the ADR outcome and the reason a resolution was not reached.

Beneficiary Complaint ADR Data Entry

1 Access the Beneficiary Complaint Listing window by selecting **Case Review|Beneficiary Complaint Listing** or select the Beneficiary Complaint Listing icon, ![BC icon]. .

OR

Access the Beneficiary Complaint Settings Listing window by selecting the Beneficiary Complaint Settings Listing icon, ![icon], from one of the review windows related to the complaint.

2 Retrieve the Beneficiary Complaint row and select the Modify icon, ![icon]. The Beneficiary Complaint window displays.

3 Select **Yes** from the drop-down list for **Disclosure of Identity**. (Required)

4 Select **Met** from the drop-down list for **Care Met Standards**. (Required)

5 Enter a date in the **Appropriate for ADR Date** field. (Required) Disclosure of Identity must be **Yes** before this field becomes available.

> ♫ The ADR icon, ![ADR icon], will not become available unless the Disclosure of Identity is **Yes,** Care Met Standards is **Met,** and a date is entered into the Appropriate for ADR date field.

> ♫ If Appropriate for ADR is **Yes**, a Final ADR Outcome option must be entered before the Beneficiary Complaint Case Complete Date can populate (assuming all other requirements have been met).

6 Select one of the options in the drop-down list for the Appropriate for ADR By field. Although this field is not required, it indicates who determined the case was appropriate for the ADR process.

7 Provider/Practitioner consent can be entered in the Physician/Provider Event section on the Beneficiary Complaint Review Summary window. (Not Required)

8   Select the ADR icon, ⬜. The Beneficiary Complaint ADR window displays.

9   Enter a Staff ID.

10   Select the Insert icon, ⬜ , to add an ADR Method Selected row. Select an ADR
     Method from the drop-down list and enter an Actual Date, if appropriate.

              ♫   Multiple ADR Method Selected options may be selected.

              ♫   When ADR Method Selected is saved and the Select Reason of a setting
                  is 101 - Beneficiary Complaint Concurrent or 102 - Beneficiary Com-
                  plaint Retrospective, the Beneficiary Complaint Case Due Date will be
                  increased by 85 days.

11   Select the Insert icon, ⬜ , to add a Beneficiary/Representative ADR Events row. Select
     a Beneficiary/Representative Event from the drop-down list. Enter the Due Date and/or
     Actual Date. Select an Event Reason from the drop-down list if the Event option selected
     is 9 or 13.

12   Select the Insert icon, ⬜ , to add a Provider/Physician ADR Event row. Select a Provid-
     er ID from the drop-down list, *or* enter a physician UPIN, *or* select an MA. Only one of
     these options is allowed per row. Select one of the Provider/Physician ADR Events from
     the drop-down list. Enter a Due Date and/or Actual Date. Select an Event Reason from
     the drop-down list if the Event option selected is 10 or 11.

13   Select the Insert icon, ⬜ , to add an ADR Meeting Event row. Select an ADR Event
     from the drop-down list. Select a Meeting Type from the drop-down list. Enter a Due
     Date and/or Actual Date.

♫ If an event of **3 – Mediation Meeting Delay** is selected, a Delay Reason is required. If the Delay Reason is **4 – QIO Problem** or **5 – Other**, an explanation in the Notes is required. The Delay Reason section allows you to enter and track reasons the ADR process was delayed.

14 Select the Insert icon, ![icon], to add an ADR Agreements/Improvement Plan Event row. Select an Event from the drop-down list and enter the date the event occurred in the Actual Date field. Select an ADR IP category from the drop-down list.

15 Select the Insert icon, ![icon], to add a QIO ADR Event Row. Select an Event from the drop-down list and enter the Due Date and Actual Date. Select an Event Reason from the drop-down list if the Event option selected is 2.

♫ Notes icons have been provided for each Event section.

16 Select a Final ADR Outcome from the drop-down list.

♫ If option 4 - ADR terminated case reverted to MRR or option 5 - ADR terminated case not reverted to MRR is selected in the Final ADR Outcome field, one of the following termination options must be selected from the associated Events sections:
   • 2 - ADR terminated by QIO (QIO ADR Events section)
   • 13 - ADR terminated by beneficiary/representative (Beneficiary/Representative ADR Events section)
   • 23 - ADR terminated by provider (Provider/Physician ADR Events section)
   • 24 - ADR terminated by physician (Provider/Physician ADR Events section)

♫ If the Final ADR Outcome is 2 - ADR complete without resolution case reverted to MRR, 4 - ADR terminated case reverted to MRR, or 6 - Participants declined participation in ADR case reverted to MRR, the Beneficiary Complaint Case Due Date will be recalculated to be the ADR Outcome Date plus 35 days.

17 Enter a date in the ADR Outcome Date field. The ADR Outcome Date is the date an outcome was determined for the ADR. The ADR Outcome Date will become the Beneficiary Complaint Case Complete Date when the Final ADR Outcome option is 1, 3, 5, 7, or 8.

♫ A Due Date or Actual Date is required for all rows in the Events sections on the Beneficiary Complaint ADR window.

Delete A Beneficiary Complaint ADR Event Section

1 Highlight the row under the appropriate ADR section by clicking once on the row.

2 Select the Delete icon, ![icon], to the left of the ADR Event of the appropriate section. A message displays asking if you want to delete the row.

3 Select **Yes** to delete the row or select **No** if you did not intend to delete the row.
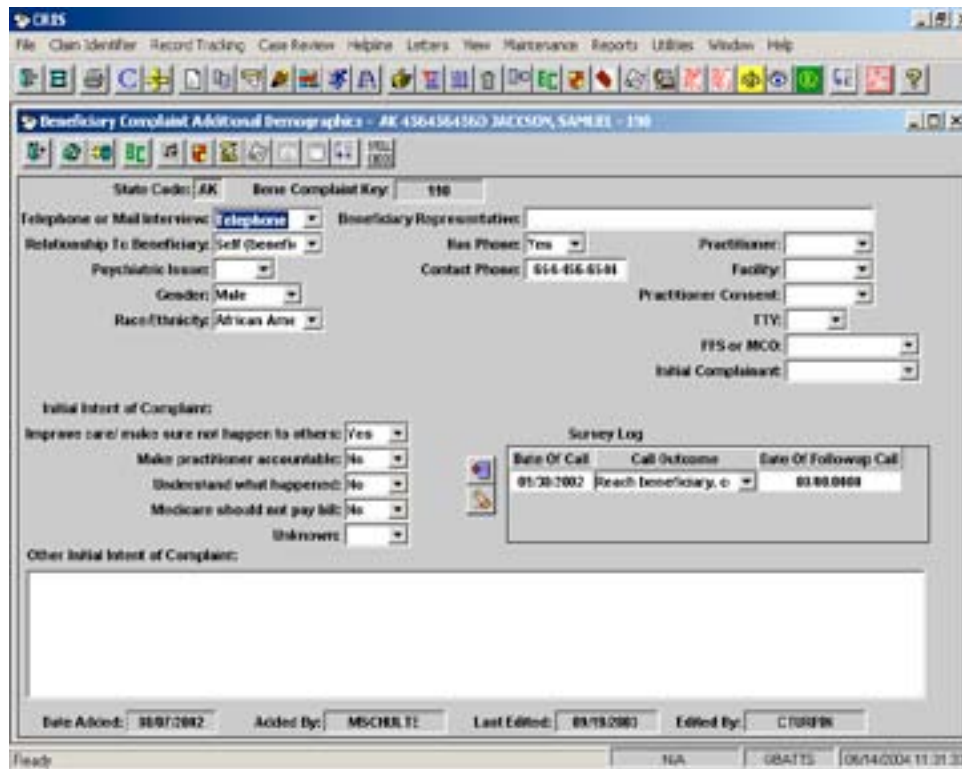
4 Select the **Save** icon, .

Additional Demographics

The Additional Demographics window allows you to enter additional information from the Beneficiary Complaint Medical Record or Mediation Satisfaction Survey regarding the Beneficiary Complaint/Complainant.

1 Select the Additional Demographics icon, .

A new Beneficiary Complaint Additional Demographics window displays.

2 Many of the fields on this screen are required for satisfaction survey purposes. Please complete the required fields and as many optional fields as possible using the drop down lists provided.

♫ Utilize the right click feature on your mouse to see the Help definitions associated with these fields.

3 If further clarification of Initial Intent of Complaint is needed, enter an explanation in the text field provided for Other Initial Intent of Complaint.

Survey Log

Professional interviewers from Westat, an independent research firm in Maryland under contract with the Centers for Medicare & Medicaid Services (CMS), conduct the Beneficiary Complaint Satisfaction Surveys. The record of their attempts to contact the beneficiary or beneficiary representative is imported into the Survey Log at the time the survey results are imported.

Beneficiary Complaint Medical Record Survey Listing

1   To access the Beneficiary Complaint Medical Record Survey Listing window, select **Case Review| Beneficiary Complaint Medical Record Survey Listing.**

The Beneficiary Complaint Medical Record Survey Listing displays in Query Mode.

2   Select the Enter Criteria icon, 🔳 .

Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window.

4   Select the Retrieve Query icon, 🔳 .
OR
press ENTER.

Survey records meeting the criteria you entered will display.

🎵   To display on this window, the survey must already exist.

5   Select the Modify icon, 🔳 , to access, view or update survey information.

Beneficiary Complaint Mediation Survey Listing

1   To access the Beneficiary Complaint Mediation Survey Listing window, select **Case Review|Beneficiary Complaint Mediation Survey Listing.**

2   Select the Enter Criteria icon, 🔳 .

3   Enter data into one or more of the fields on the window.

4   Select the Retrieve Query icon, 🔳 , or press ENTER.

Existing survey records meeting the criteria you entered will display.

Beneficiary Complaint Westat Survey Listing

1.   To access the Beneficiary Complaint Westat Survey Listing window, select Case Review|Beneficiary Complaint Westat Survey Listing.

2.   Select the Enter Criteria icon, 🔳 .

3.   Enter data into one or more of the fields on the window.

4.   Select the Retrieve Query icon, 🔳 , or press ENTER.

Survey records completed by Westat that meet your criteria will display.

Beneficiary Complaint Satisfaction Surveys

Two types of satisfaction surveys can be conducted in CRIS; however, only one survey is allowed per beneficiary complaint case. The Beneficiary Complaint Medical Record Satisfaction Survey and the Beneficiary Complaint Mediation Satisfaction Survey are similar in structure but are intended to measure the complainant's overall satisfaction of different processes.

Interviewers from Westat, an independent research firm from Maryland under contract with CMS, conduct the satisfaction surveys. General information related to the beneficiary/ representative must be entered in the Additional Demographics screen so that the interviewers have the background necessary to conduct the interview. Information regarding completed Beneficiary Complaints in which the complainant has agreed to participate in a survey is uploaded to Westat on a weekly basis.

Westat will conduct the surveys and upload a file containing the results on a monthly basis. These survey results are then imported into CRIS and are available for the QIO to view.

Beneficiary Complaint Westat Survey

If the complainant agrees to participate, Westat will schedule a Beneficiary Complaint Medical Record Satisfaction Survey or Mediation Survey interview within two weeks of receiving the Beneficiary Complaint information. The Mediation Survey interview will be directed toward either Mediation or Facilitated Resolution (ADR), depending on the method of dispute resolution performed. The surveys will measure the complainant's overall satisfaction with the review or alternative dispute resolution/mediation process.

In order for Westat to conduct the Beneficiary Complaint Westat Surveys, the following must be met:

♫ If the Complainant is "Anonymous", a survey indicator is not allowed.

Medical Record Satisfaction Survey
- First Opportunity must be **Yes**
  OR
  Second Opportunity must be **Yes** if First Opportunity is **No** or **Undecided**
- Survey Indicator must be **Medical Record Satisfaction**
- There must be a Case Complete Date for the Beneficiary Complaint record.

Mediation or Alternative Dispute Resolution (ADR) Satisfaction Survey
- First Opportunity must be **Yes**
  OR
  Second Opportunity must be **Yes** if First Opportunity is **No** or **Undecided**
- Survey Indicator must be **Mediation Satisfaction**
- A Beneficiary Complaint Event of Abandoned (1) or withdrawn (10) does not exist.

♫ If ADR was performed that had an external outcome resolution, do not select the Mediation Satisfaction Survey Type. Leave this field blank.
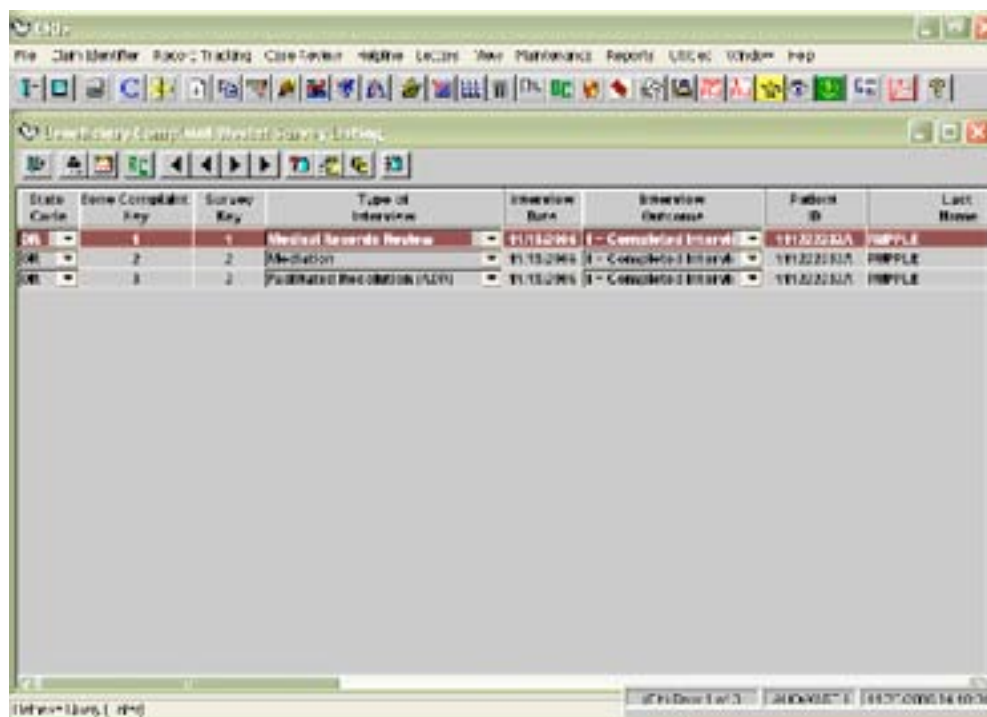
♫ If ADR method 3, 4, or 5 is selected, a Mediation Satisfaction survey indicator will not be allowed.

- There must be a Case Complete Date for the Beneficiary Complaint record.
- The ADR Outcome Date is filled.

Westat will conduct the surveys and upload a file containing the results on a monthly basis. The survey results are then imported into CRIS and are available for the QIO to view.

To view the Beneficiary Complaint Westat Surveys:

1. Select Case Review | Beneficiary Complaint Westat Survey Listing

2. Select the Enter Criteria icon, [icon], and query for your State Code and/or select other criteria for the surveys you wish to view.

3. Select the Retrieve Query icon, [icon]. Rows meeting the criteria you requested will display.

To view a grid version of the completed survey:

1. Highlight a row and select the Westat Survey icon, [icon].

The survey displays in a non-printable grid format for viewing purposes only.
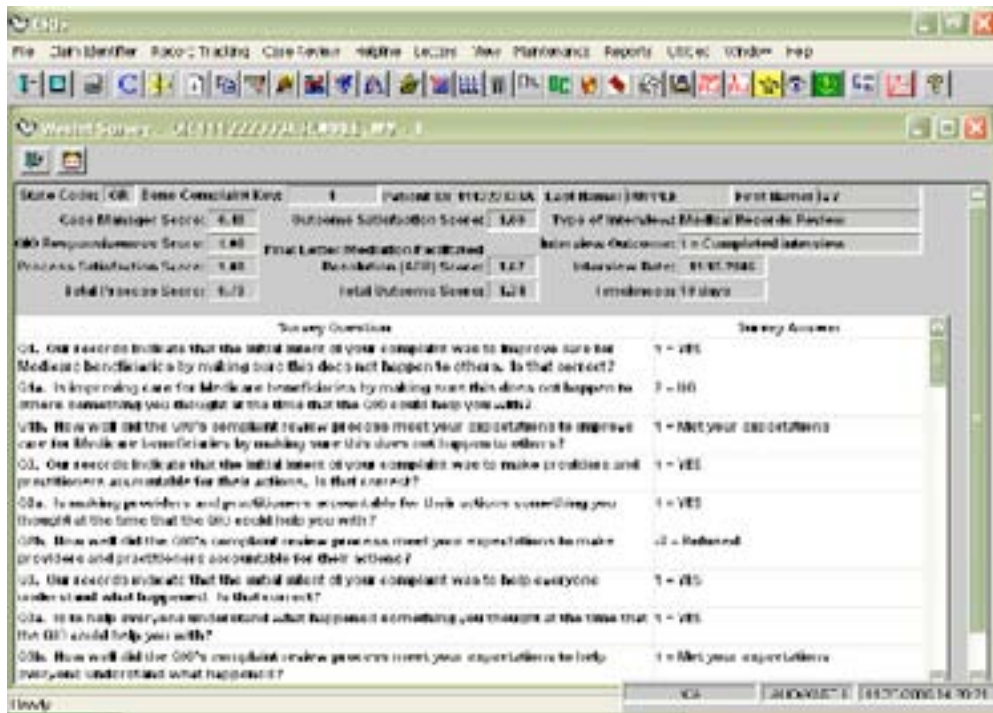
A Print Preview version of the survey is available from this window, also. Select the Print Preview icon, (icon), to view and print the survey.

To view a printable version of the survey from the Beneficiary Complaint Westat Survey Listing window:

1. Highlight a row and select the Westat Survey Print Preview icon, (icon).

The survey displays in Print Preview format.
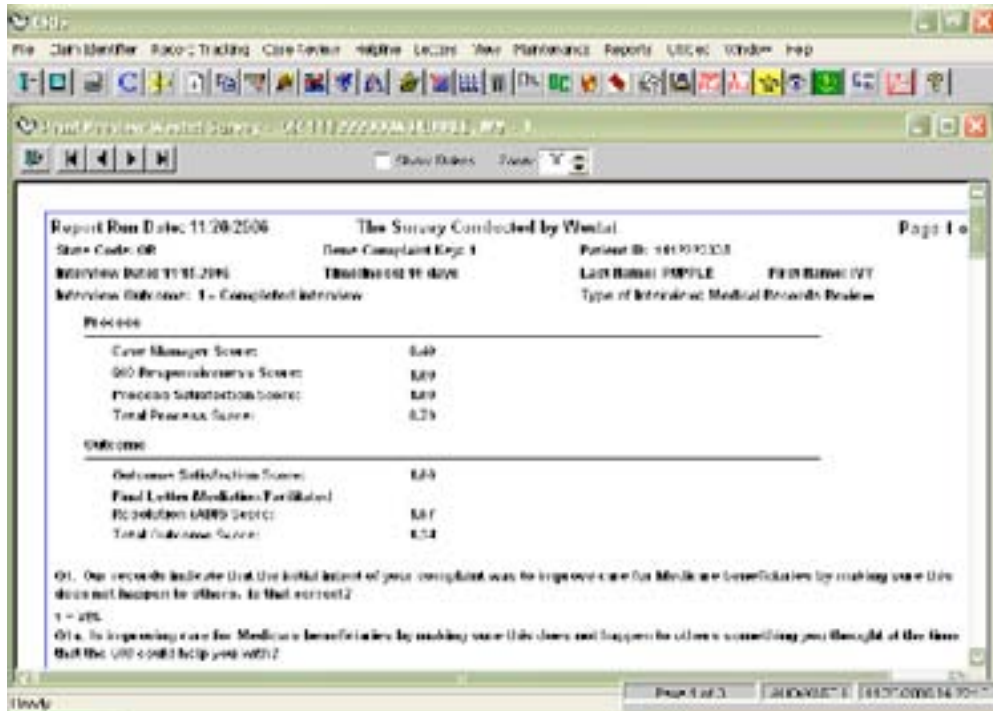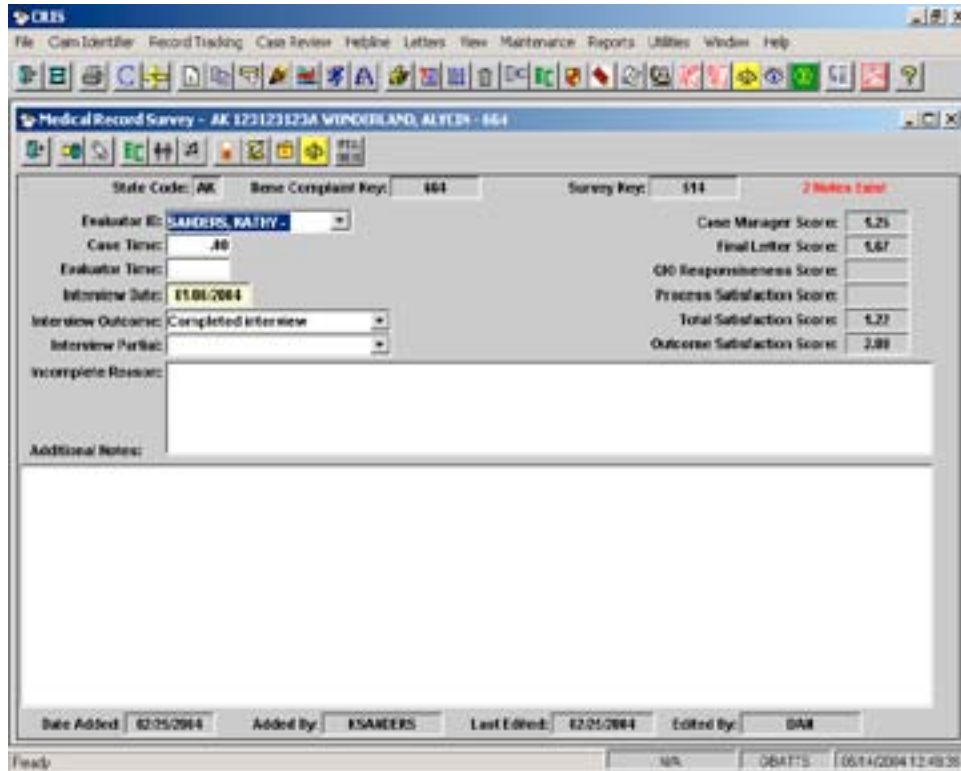
To Print:

1. Select the Print icon, , from the top row of icons

Medical Record Satisfaction Survey

To view surveys completed prior to the release of CRIS v1.11.0 (12/06):

1   Select Medical Record Satisfaction from the drop-down list in the Survey Indicator field on the Beneficiary Complaint window.

2   Select the Medical Record Survey icon, , to view the main survey screen.

3   The following fields are populated with complainant satisfaction scores from the results of the Satisfaction Survey:

Case Manager Score
Final Letter Score
QIO Responsiveness Score
Process Satisfaction Score
Total Satisfaction Score
Outcome Satisfaction Score

    ♫ Once the survey questions have been completed, the Satisfaction Scores are automatically reflected in the Satisfaction Score field on the applicable window and also on the Medical Record Survey window.

    ♫ Utilize the right click on your mouse to see the Help definitions associated with the fields on this window.

♫ If notes are entered, "Notes Exist" displays in red text on the Beneficiary Survey window.

Medical Record Survey Case Manager
The Medical Record Survey Case Manager window has four questions regarding the complainant's satisfaction with the case manager who handled the review.

1 From the Medical Record Survey window, select the Medical Record Survey Case Manager icon, ![icon] .

The Medical Record Survey Case Manager Screen displays.
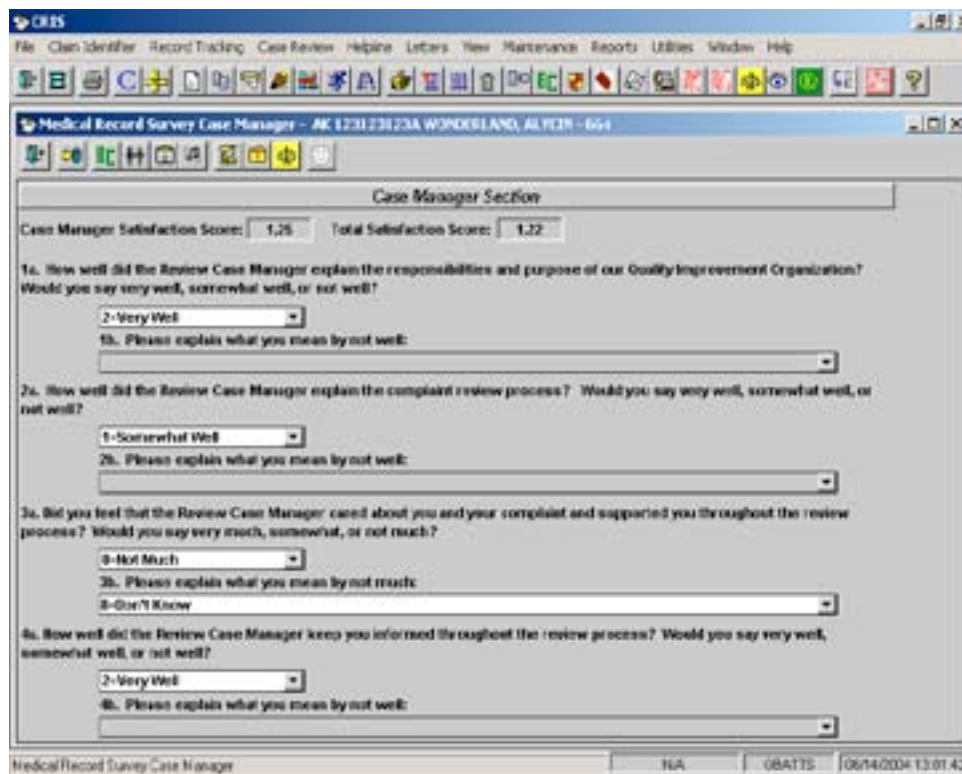
2 Each of the four questions has a drop-down list. The responses indicate the complainant's answer to the question.

3 If the answer to a question is 'Not Well' or 'Not Much', the narrative row will explain what the complainant means by 'Not Well' or 'Not Much'.

Medical Record Survey Final Letter
The Medical Record Survey Final Letter window has five questions regarding the complainant's satisfaction with the final letter received from the QIO.

1 From the Medical Record Survey window, select the Medical Record Survey Final Letter icon, ![icon] .

The Medical Record Survey Final Letter window displays.

2   If the answer to a question is 'Not Clearly' or 'Not Satisfied', the narrative explains the complainant's response.

Medical Record Survey QIO Response
The Medical Record QIO Response Section window has two questions regarding the complainant's satisfaction with the responsiveness of the QIO to the complaint and whether the complainant's expectations regarding the initial intent of the complaint were met.

1   From the Medical Record Survey window, select the Medical Record survey QIO Response icon, .

The Medical Record Survey QIO Response window displays.

2   If the answer to a question is 'Not Responsive,' the narrative explains the complainant's response.

Medical Record Survey Process Satisfaction
The Medical Record Survey Process Satisfaction window has three questions: the complainant's overall satisfaction with the beneficiary complaint review process; whether the complainant would ever use the review process again; complainant suggestions on ways to improve the QIO responsiveness to beneficiary complaints.

1   From the Medical Record Survey window, select the Medical Record Survey process Satisfaction icon, .

The Medical Record Survey Process Satisfaction window displays.

2   If the answer to a question is 'Not Satisfied,' the narrative explains the complainant's response.

> ♫   The Expand Survey Question icon, , is available for the narrative rows on each Survey window. Select the narrative row you wish to view and select the Expand Survey Question icon. An Expanded Survey Question window displays the full narrative response to the Survey questions.

Mediation Satisfaction Survey
If the complainant and physician/provider agreed to participate in the mediation process in order to resolve the complaint, a Beneficiary Complaint Mediation Satisfaction Survey can be conducted to measure the complainant's overall satisfaction with the mediation process. The Case Complete Date must be filled by entering an ADR Outcome Date on the Mediation window or by entering a BCFN Date on the Beneficiary Complaint Summary window before Westat can conduct the survey.

> ♫   If ADR was performed with an external outcome resolution, do not select the Mediation survey type on the Beneficiary Complaint window. Leave this field blank.

To view surveys completed prior to the release of CRIS v1.11.0 (12/06):
1   Select Mediation Satisfaction from the drop-down list in the Survey Indicator field on the Beneficiary Complaint window.

2   Select the Mediation Survey icon, .

The Mediation Survey window opens.

🎵 The Satisfaction Scores are automatically reflected in the Satisfaction Score fields on the applicable window and also on the Mediation Survey window.

Mediation Survey Case Manager
The Mediation Survey Case Manager window contains questions regarding the complainant's satisfaction with the case manager who handled the beneficiary complaint mediation.

1   Select the Mediation Survey Case Manager icon, , from the Mediation Survey window.

The Mediation Survey Case Manager window displays.

2   If the answer to a question is 'Not Well,' the narrative explains the complainant's response.

Mediation Survey Mediation Satisfaction
The Mediation Survey Mediation Satisfaction window contains questions regarding the complainant's satisfaction with the mediation process and the mediators involved in conducting the mediation.

1   Select the Mediation Survey Mediation Satisfaction icon, , from the Mediation Survey window.

The Mediation Survey Mediation Satisfaction window displays.

2   If the answer to a question is 'Not Well' or 'Not Satisfied,' the narrative explains the complainant's response.

Mediation Survey QIO Response
The Mediation Survey QIO response window contains questions regarding the complainant's satisfaction with the responsiveness of the QIO to the complaint and whether the complainant's expectations were met regarding the mediation process.

1   Select the Mediation Survey QIO Response icon, [icon] , from the Mediation Survey window.

The Mediation Survey QIO Response window displays.

2   If the answer to a question is 'Not Responsive' or 'Not Much,' the narrative explains the complainant's response.

Mediation Survey Process Satisfaction
The Mediation Survey Process Satisfaction window contains questions regarding the complainant's satisfaction with the mediation process, whether the complainant would use the mediation process again in the future, and requests suggestions for improving QIO responsiveness to beneficiary complaints.

1   Select the Mediation Survey Process Satisfaction icon, [icon] , from the Mediation Survey window.

The Mediation Survey Process Satisfaction window displays.

2   If the answer to a question is 'Not Satisfied' or 'No,' the narrative explains the complainant's response.

     If the answer to question 14a is 'Yes,' the narrative explains the complainant's response.

> ♬ The Expand Survey Question icon, [icon], is available for the narrative rows on each survey window. Select the narrative row you wish to view and select the Expand Survey Question icon. An Expanded Survey Question window displays the full narrative response to the survey questions.

Entry of Beneficiary Complaint Review

1   Select **Case Review|Beneficiary Complaint Listing**
     OR

     Select the Beneficiary Complaint icon. [icon] .

2   Select the Insert icon, [icon] .

3   Enter information in the required fields and send the Acknowledgement information.

4   If appropriate, enter information in the Beneficiary Complaint Event section. Throughout the review of the complaint, continue to enter information in the event section as needed.

♬ To capture additional Reviewer Time that is not specifically related to the "setting" reviews but to the overall Beneficiary Complaint process requirements, select the BC Reviewer Time icon, ![icon]. Data entry in this window is optional. The reviewer time entered on the Beneficiary Complaint Reviewer Time window is not intended to reflect physician review time and will not display on the Physician Reviewer — Not Paid with Page Break and Physician Reviewer — Paid with Page Break reports.

5 Select the Save icon, ![icon] .

♬ Follow the timing guidelines, in the Timing of Review document in the Appendix, to determine when the medical records should be requested.

6 When ready to request the medical records, select **Record Tracking|Import/Print Medical Record Requests**.
OR

Select the Import Print Medical Record Requests icon, ![icon] .

7 You can import a file of cases or manually insert cases you want to request for review as described in the Claim Identifier and Record Tracking chapter.

8 Update the default values in the Record Tracking System section if needed.

9 Print the desired medical record request forms to request the medical record from the provider.

10 When the medical record is received from the provider, track it in the Record Tracking system with an *Action* code of 2 – Received for Case Review.

Using the *Action* code of 2 – Received for Case Review allows the record to be available to assign to review.

11 Select **Case Review|Assign Review Records.**

12 Query for and retrieve the cases by Claim Key, Select Reason, or Select Date, etc.

13 Assign a Staff ID to the Review Type
OR
Leave the Assign Staff ID section blank.

14 Select the Save icon, ![icon] .

This action will create the Review base record and the Review Type record. The review types that will be created are dependent upon the Selection Reason.

15 Select **Case Review|Beneficiary Complaint Listing**
OR

Select the Beneficiary Complaint icon, ![icon] .

16 Query for the Beneficiary Complaint record.

17 Select the Modify icon, [icon], and then the Beneficiary Complaint Settings icon, [icon].

18 On the Beneficiary Complaint Settings window select the Insert icon, [icon], to the left of the settings section.

19 Insert the settings associated with the Beneficiary Complaint. Continue this process until all records associated with the complaint have been added.

20 Select the Save icon, [icon].

> ♫ Continue to update the main Beneficiary Complaint record as the review proceeds.

21 Select **Case Review|Review Listing** to access the review record
OR

Select the Review Listing icon, [icon].

> ♫ You can also access the review record by clicking with your mouse on the desired setting on the Beneficiary Complaint Settings window and selecting the Review or Review Type icon to jump to the record in Case Review.

22 Query for the desired record on the Review Listing or Review Type Listing window

23 Select the Review Type icon, [icon].

24 If the Quality Review row is not displayed, select **Yes** in the Quality drop-down list at the top of the window.

A new Quality Review section is added.

25 Enter information in the appropriate fields. Beneficiary Complaints require quality review.

26 Select the Save icon, [icon].

27 Select the PRAF icon, [icon], and enter information on the PRAF window.

28 When the review of the medical record for the beneficiary complaint is complete, enter the outcome of the review in the Beneficiary Complaint Outcome field on the PRAF.

29 Continue to update the Beneficiary Complaint record as necessary throughout the case review process.

30 When the Beneficiary Complaint review process is complete, enter the date the BCFN is sent on the Beneficiary Complaint Summary window. This date is the Case Complete Date for the Beneficiary Complaint.

Public Citizen TOPS Memo 2003 – 12

TOPS Memo 2003 – 12 released December 3, 2003 directed QIOs to disclose the results of their investigation (using the language specified in TOPS 200310) in response to all pending and future complainant requests regardless of whether the request had been denied on any prior occasion, including prior to June 20, 2003. The QIO must, prior to issuing the revised notice of final disposition, provide notice of disclosure to the provider or practitioner involved in the complaint.

CRIS allows the QIOs to record the outcome of the Beneficiary Complaint investigation for any currently open or future complaints. CRIS was revised to accommodate requests on closed cases.

TOPS Memo 2003 – 12: Data Entry for Closed Cases in CRIS

When a request for a revised disclosure is received for a closed Beneficiary Complaint case that is already in CRIS, you will be able to enter the information on the Beneficiary Complaint windows.

Data Entry for Closed Cases in CRIS

1 To access the Beneficiary Complaint Listing window, select **Case Review|Beneficiary Complaint Listing.**
    OR

    Select the Beneficiary Complaint Listing icon, .

    The Beneficiary Complaint Listing window displays in Query Mode.

2 Select the Enter Criteria icon, .

    Any previously entered criteria will clear.

3 Enter the Bene Complaint Key or Patient ID for the closed record.

4 Select the Retrieve Query icon, .
    OR
    Press ENTER.

    Beneficiary Complaint records meeting the criteria you entered will display.

5 Highlight the desired row by clicking on it with your mouse and select the Modify icon, .

    The main Beneficiary Complaint window displays.

6 In the Beneficiary Complaint Event section, select the Insert Event icon, , and select **Written Request for Revision Disclosure Received - TOPS Memo 2003 – 12** from the Event field drop-down list.

7 Enter the date the request was received and select the Save icon, .

8 Select the Insert Delay Reasons icon, , in the Beneficiary Complaint Delay Reasons section, and select one of the following options from the Delay Reason field drop-down list, if applicable.

Pending – Physician Deceased
Pending – Provider Closed
Pending – Documentation not available

9   Enter the date for the delay reason and select the Save icon, .

10 Select the Review Summary icon, .

The Beneficiary Complaint Review Summary window displays.

11 Select the Insert Review Summary icon, , in the Physician/Provider Event section. Select Revision Notice of Disclosure - TOPS Memo 2003 – 12 sent to provider and/ or Revision Notice of Disclosure – TOPS Memo 2003 - 12 sent to physician from the Events field drop-down list.

12 Enter the date for the Physician/Provider Event.

13 Enter the Provider ID and/or Physician UPIN.

14 Select the Save icon, .

15 If not previously entered, select either the Did Not Meet or Met option from the drop-down list in the Care Met Standards field, and select the Save icon, .

16 Enter the date the Revised BCFN was sent. This date will **not** overwrite the existing Case Complete Date. Select the Save icon, .

> ♫   The Beneficiary Complaint Final Notice date field must have a value before you can enter the date in the Revised BCFN Date field.

TOPS Memo 2003 – 12: Retroactive Minimal Data Entry
When a request for a revised disclosure is received for a closed Beneficiary Complaint case that was reviewed prior to, or in PROvantage and was not part of the conversion to CRIS, minimal data needs to be entered into the Beneficiary Complaint windows.

> ♫   Settings, Survey, and Mediation will **not** be required for Retroactive Minimal Date Entry.

Retroactive Minimal Data Entry
1   To insert a new Beneficiary Complaint record for a Retroactive Minimal Data Entry case, select **Case Review|Beneficiary Complaint Listing**
OR

Select the Beneficiary Complaint Listing icon, .

The Beneficiary Complaint Listing window displays in Query Mode.

2   On the Beneficiary Complaint Listing window, select the Insert icon, .

A new Beneficiary Complaint record will display in the Beneficiary Complaint window.

3   Enter the Patient ID, Last Name and First Name of the beneficiary and the Staff ID.

4	In the Complaint Source field, **Retroactive Request - TOPS Memo 2003 – 12 must** be selected from the drop-down list.

> ♫	If a Complaint Source other than 'Retroactive Request — TOPS Memo 2003 — 12' is selected and saved, it can't be corrected to reflect the required source and a Revised BCFN Date will not be allowed. The record must be deleted. A new Beneficiary Complaint can be added with the corrrect Complaint Source.

5	In the Complainant field, select the appropriate option from the drop-down list.

6	In the Written Complaint Received field, enter the date the complaint was received in writing and select the Save icon, ⬛ .

7	In the Beneficiary Complaint Delay Reasons section, select the Insert Delay Reasons icon, ⬛ , and select one of the options below from the Delay Reason field drop-down list, if applicable.

Pending – Physician Deceased
Pending – Provider Closed
Pending – Documentation not available

8	Enter the date for the delay reason and select the Save icon, ⬛ .

9	Select the Review Summary icon, ⬛ .

The Beneficiary Complaint Review Summary window displays.

10	In the Physician/Provider Events section, select the Insert Review Summary icon, ⬛ , and select Revision Notice of Disclosure - TOPS Memo 2003 – 12 sent to provider and/or Revision Notice of Disclosure – TOPS Memo 2003 - 12 sent to physician from the Events field drop-down list.

11	Enter the date for the Physician/Provider Event.

12	Enter the Provider ID and/or Physician UPIN and select the Save icon, ⬛ .

13	Select an option from the Care Met Standards field drop-down list.

14	Enter a date in the Revised BCFN Date field.

> ♫	The date entered in the Revised BCFN Date field, on the Beneficiary Complaint Review Summary window, will set the Case Complete Date for the Beneficiary Complaint record.

Adjustments

The Inpatient Adjustments and Outpatient Adjustments windows allow you to update or view the identifying information on cases in which an adjustment was performed. When a claim record exists for a case, it is located on the database and is accessible through the HSE View window. Previous adjustment information and new adjustment information can be viewed and recorded on the Inpatient Adjustments and Outpatient Adjustments windows. Multiple adjustments can be recorded.

Adding Manual Adjustments from the Review Windows
When the Adjustment Listing window is accessed from any of the review windows, i.e., Review, Review Type, PRAF etc. the system will add a row if none exists.

1   On one of the Review windows, highlight the desired row by clicking on it with your mouse.

2   Select either the Inpatient or Outpatient Adjustment icon,   .

    If an adjustment does not exist for the review, a message displays stating, "No adjustments were found matching these criteria. Do you want to automatically insert and populate one row?"

3   Select **Yes** to insert a new row.

    The Patient ID, Provider ID, Provider Name, Admit Date, Sequence Number, QIO Control Number, Last Name, First Name, Adjustment Origin, Date Added, and Added By fields automatically populate.

4   Select the appropriate Reason for QIO Action and QIO Review Adjustment Code from the drop-down list.

5   Select the Save icon, .

    The Last Edited and Edited By fields automatically populate.

6   Select **No** if you do not want to insert and populate a row. You can enter the patient information manually.

7   Select the Base/RCC Information icon, . Add the appropriate information on the window.

8   Select the Save icon, .

♬   Reference the Inpatient or Outpatient Adjustment Guide in the Appendix for the appropriate adjustment codes.

Sending Adjustments to the FI
The process for sending the adjustment electronically to the FI is not automated at this time but will be automated in the future. For now, it will be necessary for QIOs to send all adjustments manually to the FI and to set the adjustment status flag for sent records.

1   When the adjustment is sent to the FI, set the Adjustment Status Flag to '2 - Sent' and enter the date the adjustment was sent.

2   If more than one adjustment is necessary for a record (e.g., a Technical Denial is sent to the FI/Carrier and is later reversed with a subsequent confirmed DRG change), enter additional rows to the Inpatient Adjustment Listing window.

3   On the Inpatient Adjustment Listing window for the desired claim, select the Insert icon, .

The system will insert a new row with a new sequence number.

4   Enter data in the Reason for QIO Action and QIO Review Adjustment Code fields and select the Save icon, [icon] .

> ♪ If multiple adjustment rows are needed for the same record, the first row must be entered and saved before the next row can be entered.

5   Select the Base/RCC Information icon, [icon] .

6   Enter the appropriate information for the adjustment.

7   Select the Save icon, [icon] .

8   When the adjustment is manually sent to the FI/Carrier for the adjustment, change the adjustment status flag to 2-Sent.

In the future, when the adjustments are sent to the FI electronically, only one adjustment per month will be sent for individual cases.

Changing an SDPS Generated Adjustment
When an adjustment is created by the system, the value displayed in the Adjustment Origin field on the adjustment windows is 'SDPS Generated Adjustment'.

When you modify an SDPS Generated Adjustment, the User ID on the adjustment windows will change from SDPS to your current user ID. The value displayed in the Adjustment Origin fields will change from 'SDPS Generated Adjustment' to 'QIO Modified SDPS Adjustment'

> ♪ The Adjustment Origin field does not change if an SDPS TD Generated Adjustment is modified.

Automated Inpatient Adjustment Overview
Automated adjustments are created by the system for specific confirmed initial decisions. At this time, only the initial adjustment will be created on inpatient records. You will need to continue sending the adjustments to your FI/Carrier until they are ready to receive the automated adjustment electronically.

The Inpatient Adjustment Reference Guide can be found in Chapter 10, Appendix E. This guide contains level and outcome codes, adjustment codes, and notes for adjustments that are automatically created, as well as for the adjustments that are manually entered.

Automated adjustments are not created for:
*   HMO records
*   Notice of Non-coverage records
*   3rd Level reviews
*   OIG referral reviews where there is an OIG sent Date and there is not a utilization final notice or coding final notice with a later date.
*   HSE manual add records except for technical denials that are created in the Record Tracking system.

- Outpatient records
- Selection Reason 212 - HPMP Data Collection

Automated Adjustment Procedure
The automated adjustment procedure runs at three points:

1   When the medical record has not been received and you run the 30 Day Technical Denial Report and select the Update Record(s) with 30 Day Technical Denial icon.

2   When the Record Status for a case changes to 'Complete'.

3   When the Record Status for a case changes from 'Complete' to 'Pending'.

Technical Denial Adjustments in the Record Tracking System

To create the technical denial when the medical record has been requested and has never been received:

1   Select **Record Tracking|30 Day Technical Denial Report**.

2   Select a State Code and select **OK**.

The report will run and display all records requested at least 30 days ago and have not been tracked as 2 – Received for Case Review.

3   Select the Print icon, 🖨 , to print the report

> ♫   Always print a report of the records that will be technically denied. These records will no longer display on the report when the next step has been completed.

4   Select the Update Record(s) with 30 Day Technical Denial icon, 📲 .

5   An adjustment will be created on the Adjustment window. You will need to use the report you printed to verify that the correct 2A adjustment was created and to add the FI Number the record does not have a billed claim.

6   The Adjustment Origin for the system generated technical denial adjustments will be ' SDPS TD Generated Adjustment'

Record Status Changes From Pending to Complete
1   When a record changes from Pending to Complete status, a message will display indicating that the record has no edit errors and the case is complete.

2   The Adjustment Procedure Information message will display. This message will depend on the review information and the PRAF lines entered.

3   If no other adjustment exists and the information entered on the PRAF window matches the criteria for creating an initial adjustment, as indicated on the Inpatient Adjustment Reference Guide, the system will create a new adjustment.

Record Status Changes From Complete to Pending

1 When a case changes from complete to pending (e.g., a reconsideration review) and a previous adjustment was sent to the FI/Carrier, the automated adjustment procedure runs and a message will display: 'An adjustment record already exists - no changes were made. Please verify the adjustment is correct.'

2 If the existing adjustment has not been sent, a message will display: 'An adjustment record that was "NOT SENT" was deleted.' The system will then create a new adjustment if needed, as determined by the PRAF lines entered for the review, when the record status changes to complete.

3 When a Technical Denial Reason and Date are entered, an automated adjustment will be created. When a date is entered in the Reopen Date field, the case will return to a pending status and a message will display. If the Technical Denial adjustment has not been sent, the message will state: 'A Technical Denial adjustment record (2A) that had not been sent was deleted.'

4 If appropriate, a new automated adjustment will be created for this case when all requirements are met and the case converts to a complete status.

5 If the adjustment was already sent to the FI/Carrier, a message will display: 'A Technical Denial adjustment record (2A) has already been sent - please manually add a reversal adjustment if needed.' 5. If the case requires an adjustment after review, a manual adjustment must be entered.

 ♫ Manually entered adjustments will not be deleted or adjusted by the automated adjustment procedure, except when the adjustment flag is set to 'Rerouted' (see Adjustment Messages). If a manual adjustment exists, a new automated adjustment will not be created.

Initial Adjustments

The system will automatically create initial adjustments when the following circumstances are true:

1 When an Admission - Utilization category A01, A02, A03, or A04 has a confirmed concern and a limitation on liability code of LL1, LL2, or LL3.

2 When an admission denial due to premature/inappropriate discharge of prior admission category B01, B02, or B03 has a confirmed concern.

3 When a DRG category D01, D02, D03, D07, D08, D09, D10, D11, D12, D13, D14, D15, D16, or D99 has a confirmed concern and the DRG changes.

4 When the Discharge Status changes to or from 02 (Discharged/transferred to other short-term general hospital for inpatient care) and the DRG does not change.

5 When the final DRG is 014, 113, 209, 210, 211, 236, 263, 264, 429, or 483 and the discharge status is 03, 05, or 06, and the discharge date is after October 1, 1998, and DRG does not change (Selected DRGs for Postacute Transfer Provision).

6 When a technical denial reason and technical denial date are entered on the Review Information window but there is no reopen date entered.

7   When a record is never received and the 30 Day Technical Denial report is run from Record Tracking.

> ♫   If the claim was not yet billed, i.e., no HSE Unique ID, you will need to enter the FI number on the adjustment window.

Viewing Automated Adjustments
Adjustment rows containing patient and provider information, admission date, sequence of adjustment, etc., can be viewed on the Inpatient Adjustments window. Adjustment details can be viewed on the Inpatient Adjustment - Base/RCC Information window.

Manual Adjustments
The following adjustments must be manually entered:
1   All adjustments after the initial adjustment
2   Combination adjustments
3   Deemed admit date adjustments (Category A05)
4   Notice of Non-coverage adjustments (Categories A07, A08, A09)
5   Other utilization concerns (Category A99)
6   Reversal adjustments
7   Third level review adjustments

Guidelines for Creating an Automated Adjustment
Example steps in creating an automated adjustment:

1   Case is selected for DRG/Coding Validation review.

2   Coordinator reviews the record, identifies a concern that the principal diagnosis was not present at admission, which changes the DRG, and sends the case to physician review.

3   Coordinator enters a 1C review status line on the PRAF window for category D01 with a 'Z' outcome code.

4   Confirmed concern review determination is received from the physician reviewer.

5   Coordinator enters a 1P review status line on the PRAF window for category D01 with a 'C' outcome code, and sends a preliminary notice to the provider of concern.

6   No response is received from the provider regarding the preliminary notice.

7   Coordinator enters a 2C review status line on the PRAF window for category D01 with a 'C' outcome and sends a final notice type.

8   The record status changes to complete and the adjustment procedure message displays: 'An adjustment record was created by the system. If this review requires a combination adjustment, you must modify the one that was just created.'

9   Check the Inpatient Adjustment Base Information window to verify the correct adjustment was created.

Adjustment Messages

No adjustment exists.
If a case which was previously Complete and had no adjustment record is reopened, this message notifies you that there is no existing adjustment.

No review required - Automated Adjustment process bypassed.
The record was marked with 'No Review Required' on the Review Information window. An automated adjustment is not created for these cases.

Adjustment Procedure failed.
Retry the action.

Delete of adjustment failed.
Retry the action.

Modify of adjustment failed.
Retry the action.

An adjustment record already exists - no changes were made. Please verify the adjustment is correct.
A previous adjustment for this record already exists on the adjustment tables. An update to the record did not change the adjustment codes. Always verify that the adjustment is correct.

An existing adjustment record was changed from "REROUTED" to "NO ADJUSTMENT" - will go back to "REROUTED" when review record changes to complete.
If the Adjustment Status flag was 3 - Rerouted and the case is updated, the Adjustment Status flag is set to 0 - No adjustment until the record changes to Complete status. The Adjustment Status flag will go back to 3 - Rerouted.

An existing adjustment record was changed from "NO ADJUSTMENT" to "REROUTED".
If the Adjustment Status flag was previously 3 - Rerouted (see the adjustment message above), then set by the system to 0 - No adjustment, and the record was updated so that the Record Status changes back to 'Complete', the Adjustment Status flag is set to 3 - Rerouted.

An adjustment record that was "NOT SENT" was deleted.
An adjustment record, which was marked as Not Sent, was deleted. This message is usually received when a case returns to a pending status for some reason (e.g., a reconsideration request is received before the adjustment is sent). A new automated adjustment will be created when the case reaches a complete status again, if appropriate as determined by the information entered on the PRAF lines.

No automated adjustment was created. Please verify that no adjustment was needed.
The automated adjustment procedure did not create an adjustment based on the PRAF lines entered. Please see the Inpatient Adjustment reference guide to determine whether a manual adjustment is needed.

An adjustment record was created by the system. If this review requires a combination adjustment, you must modify the one that was just created.
An automated adjustment was created for this review record. If this is a combination adjustment, e.g., Discharge and DRG change, manually change the Reason for QIO Action and QIO Review Adjustment Code to reflect the combination adjustment.

An existing record was found with the same adjustment code - no changes were made. Please verify the adjustment is correct.
If you make a change to a record in which an adjustment was previously created, verify that all information on the Inpatient Adjustment Base Information window is correct, including the DRG codes, DRG and Discharge Status.

An existing adjustment record was modified by the system. Please verify the adjustment is correct.
An automated adjustment already exists on the system, which was modified. Always verify the adjustment codes are correct.

Record is an OIG Referral - an adjustment is not required.
The record has an OIG Notice Date and there is not a later Coding or Utilization notice date. No automated adjustments are created for OIG records.

A Technical Denial adjustment record (2A) that had not been sent was deleted.
If you enter a reopen date on the Review Information window for a case which was technically denied, the Record Status changes from 'Complete' to 'Pending'. If the previous Technical Denial adjustment (2A) has not been sent, the adjustment is deleted when the review is reopened. A new adjustment will be created, if appropriate, when the case is completed.

A Technical Denial adjustment record (2A) has already been sent - please manually add a reversal adjustment if needed.
If you enter a reopen date on the Review Information window for a case that was technically denied, the Record Status changes from 'Complete' to 'Pending'. If the previous Technical Denial adjustment (2A) has already been sent, the adjustment is not deleted when the review is reopened. Manually add a reversal adjustment if it is needed.

An adjustment was found that has not been sent, but was not generated automatically, so no changes were made. Please verify the adjustment is correct.
A manual adjustment, which has not been sent to the FI/Carrier, was found for the case. No changes are made to manual adjustments.

No automated adjustment was created at this time, but there is an existing adjustment for this record. Please verify the adjustment is correct.
A previous adjustment has been sent to the FI/Carrier for this case. Please verify the information and add a manual adjustment if necessary.

No automated adjustment was created. A manual adjustment may be needed. Please refer to the Inpatient Adjustment Reference Guide.
An automated adjustment was not created for the specific category. If you determine that an adjustment is necessary, manually add the adjustment information to the adjustment window.

An existing record was found with the same adjustment code and may have been modified by the system. Please verify the adjustment is correct.
An adjustment record was previously created. An update to the review may have changed data in the adjustment record. Verify that the adjustment record is correct.

Record is an HSE Manual Add - Automated Adjustment process bypassed. A manual adjustment may be needed. Please refer to the appropriate Adjustment Reference Guide.
The record was manually added to the HSE table. No data is available to create an adjustment. Manually add the information to the adjustment windows.

Record is an Outpatient - Automated Adjustment process bypassed. A manual adjustment may be needed. Please refer to the Outpatient Adjustment Reference Guide.
Automated adjustments are not created for outpatient cases. If an adjustment is necessary, manually add the information to the Outpatient adjustment windows.

Record is an HMO - no adjustment required for an HMO review.
The beneficiary has HMO coverage at the time of the inpatient services. No adjustments are required for HMO reviews.

Record has a Document Tracking Selection Reason 212 - Automated Adjustment process bypassed.
The record was selected for HPMP Data Collection - No automated adjustments are created for this selection reason.

Chapter 6 - Helpline

Helpline

Objectives

After completing this chapter, you will be able to:

- Access the Helpline windows
- Insert a new Helpline record
- Access and move between the open Helpline windows
- Create a Beneficiary Complaint record from the Helpline Detail

Overview

The Helpline windows assist staff responsible for answering the Helpline phone to record pertinent information about the call. The Helpline Listing window allows you to view records that have been added to the Helpline module. From the Helpline Listing window, you can access the Detail, Actions, Needs, Quality of Care/Facilities, New Record Encounter and Caller Concern/CSR notes windows.

These windows can also be accessed within the Helpline record itself. In the Helpline record you can select one of the icons to jump to another page of the Helpline record. Each window in the Helpline record contains the icons for the other pages of the record. When you use the icons, the jump will take you back to the opened page of the record if you have the page open.

QIO staff with CRIS Helpline Admin roles can add options to the code tables used throughout the Helpline module. Review the instructions in the View and Maintenance chapter for help in adding options to the code tables.

> ♫ If a user who does not have a Helpline role attempts to access the Helpline module, a message will display stating, "You are not authorized to use this window."

Helpline Windows

Helpline Detail
The Helpline Detail window allows you to enter basic information about the beneficiary, the Helpline caller, Inquiry Information, Referrals, HINN/NODMAR information, Beneficiary Insurance and Notes fields to record information provided by the caller and a notes field to record customer service representative information.

Actions

The Actions window allows you to capture information about the actions taken regarding the Helpline call. Duplicate actions and action dates are not allowed. You can add Helpline Actions through the Maintenance module on the Helpline window.

Needs

The Needs window has three sections to enter information. The Nature of Inquiry section allows you to indicate the reason for the call.

The Material(s) Sent section allows you to record what materials you sent to the caller.

The Referred To section allows you to enter who the caller was referred to.

Quality of Care/Facilities

The Quality of Care/Facilities window has two sections to enter information. The Result section allows you to record information about the quality of care review and the result of the quality of care concern.

The Facilities section allows you to enter information about the provider or physician and the dates of service.

New Record Encounter

The New Record Encounter window allows you to record information about time spent on the Helpline record.

Caller Concern/CSR Notes

The Caller Concern/CSR Notes is an extension of these note fields from the Detail window. This window provides a full screen to type in notes.

Insert a Helpline Record

A new Helpline record can be inserted from the Helpline Listing or Helpline Detail window.

1   Select **Helpline|Helpline Listing**.

The Helpline Listing window displays in Query Mode.
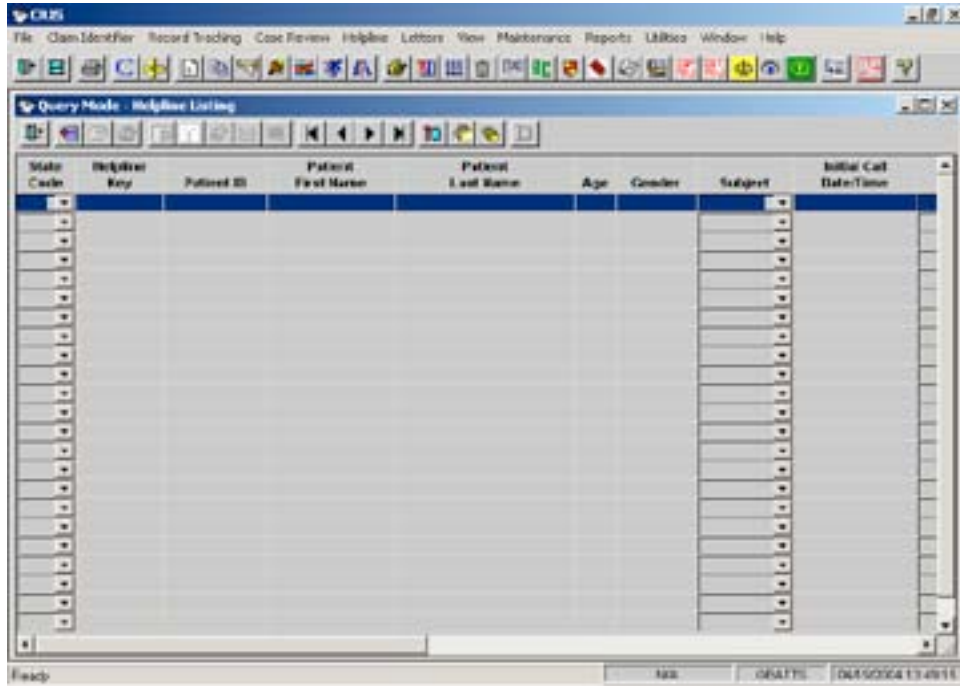
2 Select the Insert icon, .

A new Helpline Detail window displays.
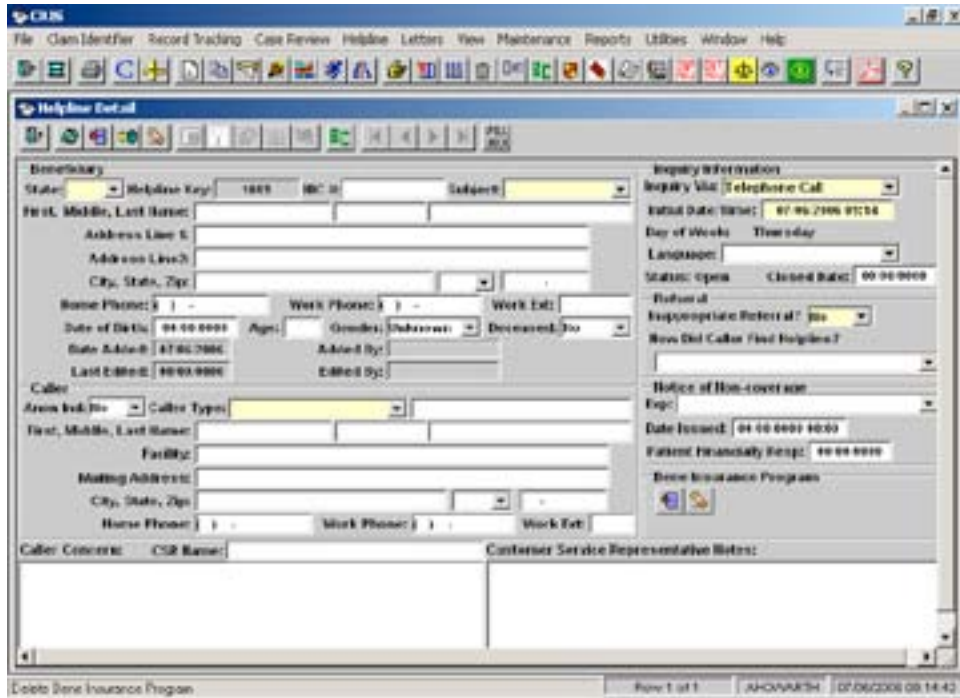
3 Enter information into the Detail window as described in the following sections.

4 Select the Save icon, .

The Actions, Needs, Quality of Care/Facilities, New Record Encounter, and Caller Concerns/CSR Notes icons are enabled.

5   Select one of the other Helpline icons to move between the Helpline windows.

> ♫   The Helpline icons allow you to jump to different windows of the Helpline record.

6   Enter information on the desired window and select the Save icon, .

7   To insert another new Helpline record, return to the Helpline Detail window and select the Insert icon, , or close the current Helpline record and return to the Helpline Listing window and select the Insert icon, .

Delete a Helpline Record

To delete a Helpline record you must have the CRIS Helpline Admin role.

1   Select **Helpline|Helpline Listing**.

The Helpline Listing window displays in Query Mode.

2   Select the Enter Criteria icon, , to clear previously entered criteria.

3   Enter data into any of the fields to retrieve the desired record and select the Retrieve Query icon, .

Data matching the criteria you entered displays.

4   Highlight the row you want to delete by clicking on it with your mouse.

5   Select the Modify Helpline Detail icon, .

The Detail window displays.

6   Select the Delete icon, .

A message will display asking, 'Delete current row for Helpline Detail?'

7   Select **Yes** to delete the Helpline record or **No** if you do not want to delete the record.

8   Select the Save icon, .

Modify a Helpline Record

1 Select **Helpline|Helpline Listing**.

The Helpline Listing window displays in Query Mode.

2 Select the Enter Criteria icon, , to clear previously entered criteria.

3 Enter data into any of the fields to retrieve the desired record and select the Retrieve Query icon, .

Data matching the criteria you entered displays.

4 Highlight the row you want to modify by clicking on it with your mouse.

5 Select the desired Helpline icon and update or modify information on the window.

6 Select the Save icon, .

Helpline Detail

The Helpline Detail window allows you to enter the basic information about the beneficiary, the Helpline caller, and provides note space to begin recording information about the caller concerns and your own customer service representative notes. You can use the icons on the window to jump to any part of the Helpline record. You can go back and forth between windows by selecting the icon for that window.

Insert Helpline Detail Information

1 From the Helpline Listing window, select the Insert or Modify Helpline Detail icon, .

The Helpline Detail window displays.

2   Enter information in the following required fields:
     State Code – defaults to your state code if you are a single state QIO
     Subject
     Caller Type
     Inquiry Via – defaults to 'Telephone Call' and can be changed
     Initial Date/Time – defaults to current date/time and can be changed
     Inappropriate Referral – defaults to 'No' and can be changed

3   Enter additional information as applicable.

4   Select the Save icon, [icon] .

     ♫   Additional options for Inquiry Via, Caller Type, How Did Caller Find
          Helpline, and Bene Insurance Program can be added through the Mainte-
          nance windows.

Modify Helpline Detail Information

1   From the Helpline Listing window, select the Modify Helpline Detail icon, [icon] .

2   Click on the field with the information you want to modify.

3   Update or modify the information.

4   Select the Save icon, [icon] .

Create Beneficiary Complaint Record

  1 To create a Beneficiary Complaint record from the Helpline Detail in the Helpline module, select the Create Beneficiary Complaint Record icon, **BC** .

     A message displays stating that a new Beneficiary Complaint record will be created.

  2 Select **OK** to create the Beneficiary Complaint Record.

     The Beneficiary Complaint window displays with information you entered on the Helpline Detail window.

  3 The fields copied from the Helpline Detail window (if data has been entered) to the Beneficiary Complaint record are: State Code, Patient ID, First and Last Name, Language, and Deceased. The Complaint Source defaults to Helpline.

  4 Complete entry on the Beneficiary Complaint record and save the information.

Helpline Actions

The Helpline Actions window allows you to enter information pertinent to the actions taken regarding the Helpline call. You can use the icons on the window to jump to any part of the Helpline record. You can go back and forth between windows by selecting the icon for that window.

Insert Helpline Actions Information

  1 From the Helpline Listing, or other Helpline window, select the Actions icon, .
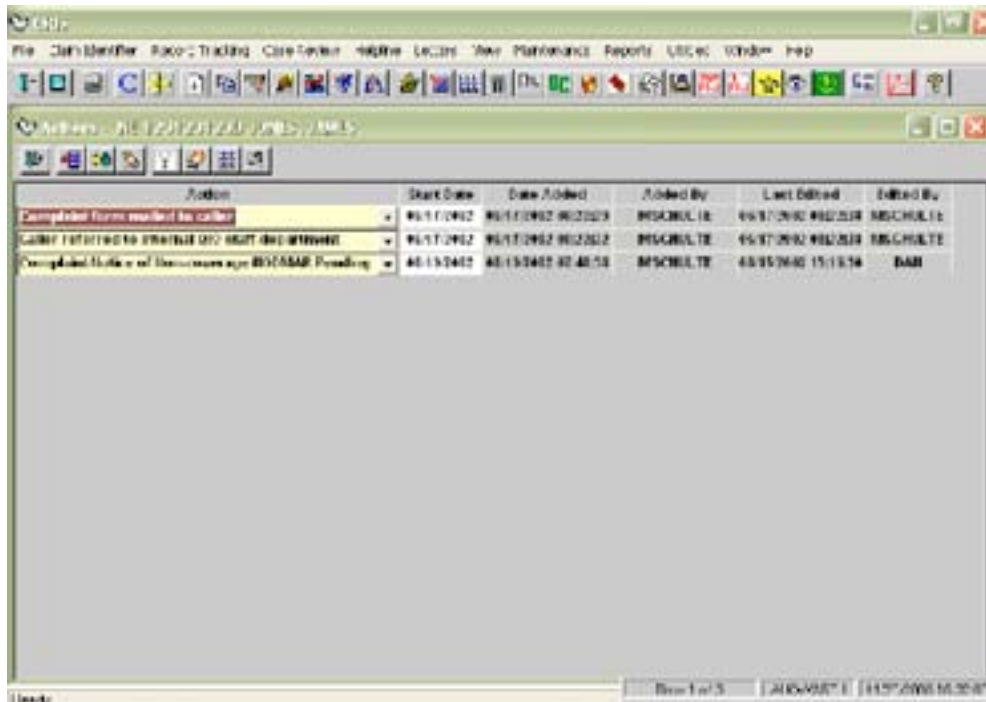
2   If a new row does not display, select the Insert icon, , on the Actions window.

3   Enter the appropriate information

♫   Duplicate actions for the same date cannot be entered. If you attempt to enter a duplicate row, a unique constraint error message will display.

4   Select the Save icon, .

♫   Additional options for Actions can be added through the Maintenance windows.

Delete Helpline Actions Information

1   From the Helpline Listing, or other Helpline window, select the Actions icon, .

2   Click on the Actions row you want to delete.

3   Select the Delete icon, , on the Actions window.

A message displays asking if you want to delete the row.

4   Select **Yes** to delete the Actions row or **No** if you do not want to delete the Actions row.

5   Select the Save icon, .

Modify Helpline Actions Information

1   From the Helpline Listing, or other Helpline window, select the Actions icon, .

2   Click on the Actions row you want to modify.

3   Update or modify the information in the Actions row.

4   Select the Save icon, .

Helpline Needs

The Helpline Needs window allows you to enter information pertinent to the needs of the Helpline caller. You can use the icons on the window to jump to any part of the Helpline record. You can go back and forth between windows by selecting the icon for that window.

Insert Helpline Needs Information

1   From the Helpline Listing or other Helpline window, select the Needs icon, [ ] .
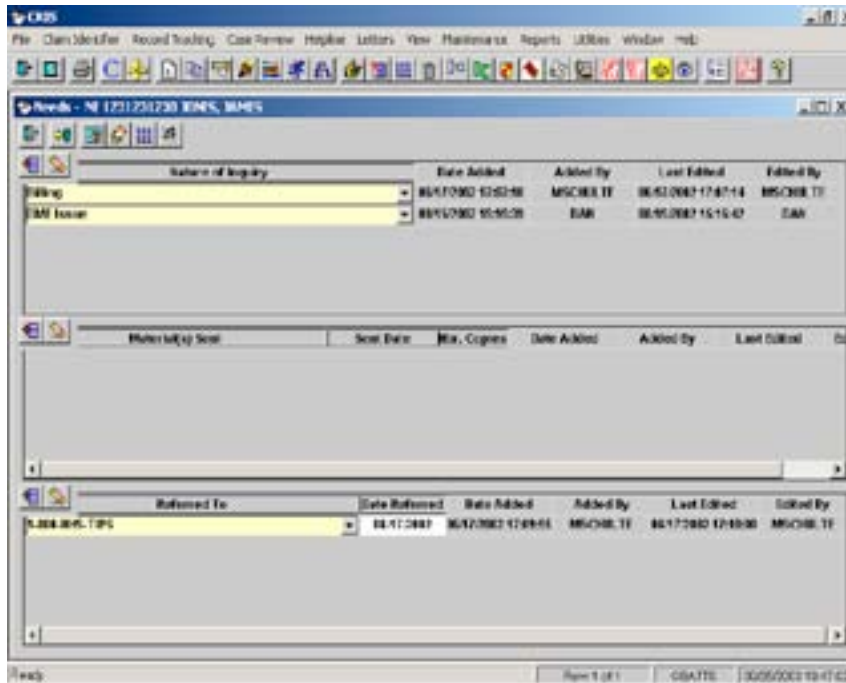
2   If a new row does not display, select the Insert icon [ ] , directly to the left of the appropriate Needs section, i.e., Nature of Inquiry, Material(s) Sent or Referred To.

3   Enter the appropriate information.

> ♫   Duplicate rows for the same date cannot be entered. If you attempt to enter a duplicate row, a unique constraint error message will display.

4   Select the Save icon, [ ] .

> ♫   Additional options for Nature of Inquiry, Material(s) Sent, or Referred To can be added through the Maintenance windows.

Delete Helpline Needs Information

1   From the Helpline Listing or other Helpline window, select the Needs icon, [ ] .

2   Click on the Needs row you want to delete, i.e., Nature of Inquiry, Material(s) Sent or Referred To.

3   Select the Delete icon, [ ] , directly to the left of the Needs section, i.e., Nature of Inquiry, Material(s) Sent or Referred To.

A message displays asking if you want to delete the row.

4   Select **Yes** to delete the row or **No** if you do not want to delete the row.

5   Select the Save icon, [icon].

Modify Helpline Needs Information

1   From the Helpline Listing or other Helpline window, select the Needs icon, [icon].

2   Click on the Needs row you want to modify i.e., Nature of Inquiry, Material(s) Sent or Referred To.

3   Update or modify the information in the row.

4   Select the Save icon, [icon].

Helpline Quality of Care/Facilities

The Helpline Quality of Care/Facilities window allows you to enter information about the quality of care review and the result of the review as well as the involved facility and/or physician. You can use the icons on the window to jump to any part of the Helpline record. You can go back and forth between windows by selecting the icon for that window.

Insert Helpline Quality of Care/Facilities Information

1   From the Helpline Listing or other Helpline window, select the Quality of Care/Facilities icon, [icon].

2   If a new row does not display, select the Insert icon, , directly to the left of the appropriate Quality of Care/Facilities section, i.e., Quality Form Sent To or Facilities.

♬   The Provider ID and Provider Name fields under the Facilities section can display and store any or all of the following:
Provider ID (HSP ID)
HSP NPI
Physician Group UPIN
Physician Group NPI
Physician UPIN
Physician NPI

Enter all or part of either the ID or Name in the Provider ID or Provider Name fields. Select the Tab button on your keyboard. You can make a selection from the drop-down list which displays all IDs and corresponding names that match your entry.

3   Enter the appropriate information.

♬   Duplicate rows for the same date cannot be entered. If you attempt to enter a duplicate row, a unique constraint error message will display.

4   Select the Save icon,

♬   Additional options for Result, and Quality Form Sent To, can be added through the Maintenance windows.

Delete Helpline Quality of Care/Facilities Information

1   From the Helpline Listing or other Helpline window, select the Quality of Care/Facilities icon, .

2   Click on the Quality of Care/Facilities row you want to delete, i.e., Quality Form Sent To or Facilities.

3   Select the Delete icon, , directly to the left of the Needs section, i.e., Result or Facilities.
A message displays asking if you want to delete the row.

4   Select **Yes** to delete the row or **No** if you do not want to delete the row.

5   Select the Save icon, .

Modify Helpline Quality of Care/Facilities Information

1 From the Helpline Listing or other Helpline window, select the Quality of Care/Facilities icon, ![icon] .

2 Click on the Quality of Care/Facilities row you want to modify i.e., Result, Quality Form Sent To, or Facilities.

3 Update or modify the information in the row.

4 Select the Save icon, ![icon] .

Helpline New Record Encounter

The Helpline New Record Encounter window allows you to enter information about the staff and time spent on the Helpline record. You can use the icons on the window to jump to any part of the Helpline record. You can go back and forth between windows by selecting the icon for that window.

Insert Helpline New Record Encounter Information

1 From the Helpline Listing or other Helpline window, select the New Record Encounter icon, ![icon] .

2   If a new row does not display, select the Insert icon, , directly to the left of the New Record Encounter section.

3   Enter the appropriate information.

> ♫   Duplicate rows for the same date cannot be entered. If you attempt to enter a duplicate row, a unique constraint error message will display.

4   Select the Save icon, .

Delete Helpline New Record Encounter Information

1   From the Helpline Listing or other Helpline window, select the New Record Encounter icon, .

2   Click on the New Record Encounter row you want to delete.

3   Select the Delete icon, , directly to the left of the New Record Encounter section.

A message displays asking if you want to delete the row.

4   Select **Yes** to delete the row or **No** if you do not want to delete the row.

5   Select the Save icon, .

Modify Helpline New Record Encounter Information

1   From the Helpline Listing or other Helpline window, select the New Record Encounter icon, .

2   Click on the Quality of New Record Encounter row you want to modify.

3   Update or modify the information in the row.

4   Select the Save icon, .

Helpline Caller Concerns/CSR Notes

The Helpline Caller Concerns/CSR Notes window provides you with more screen area to add notes pertinent to the Helpline call. If you began entering your notes on the Helpline Detail window, you can access this window to continue adding your notes. The notes you entered on the Detail window will display on this window. The Caller Concerns section allows you to enter information about the caller concerns and the Customer Service Representative section allows you to enter your notes about the call. You can use the icons on the window to jump to any part of the Helpline record. You can go back and forth between windows by selecting the icon for that window.

Add Information to Caller Concerns or Customer Service Representative Notes

1   From the Helpline Listing or other Helpline window, select the Caller Concerns/CSR
    Notes icon, [icon].
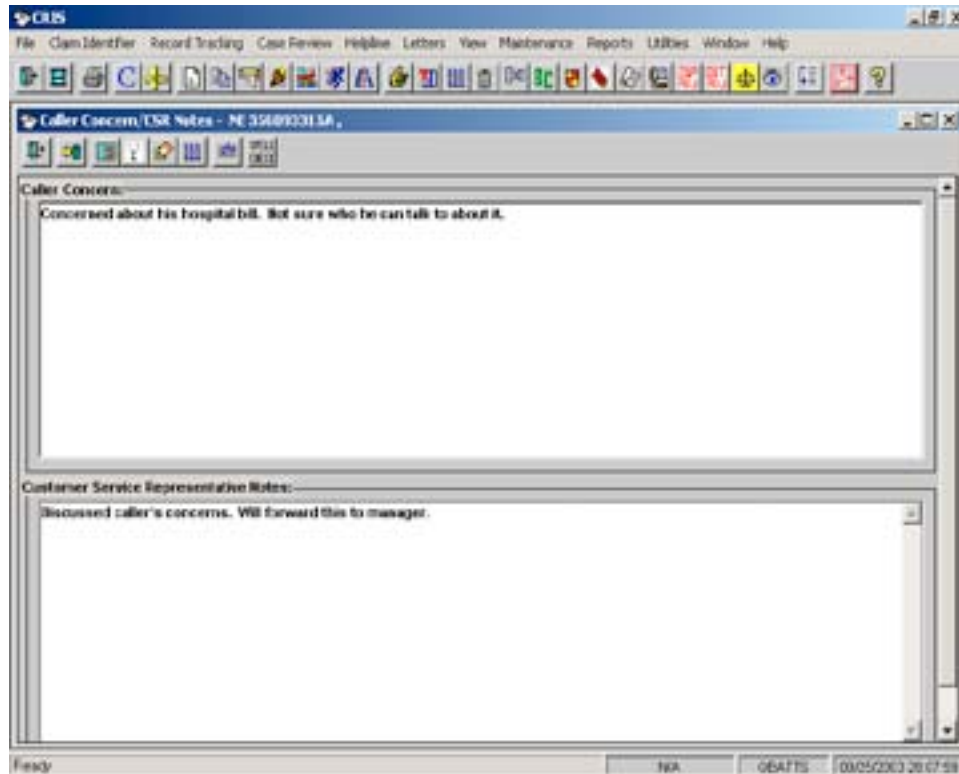
2   Click with your mouse in the notes section you want to add information and begin typing.

3   To delete information you have typed, highlight the word(s) and press the
    Delete key.

4   To spell check the notes section click the Spell Check icon, **SPELL CHECK** .

5   To save the information you have entered, select the Save icon, [icon] .

Chapter 7 - Automated Letters

Automated Letters

Objectives

After completing this chapter, you should be able to:
- Access and retrieve data for the Automated Letters
- Save the data in an Excel file
- Add columns to a Word document
- Merge data into the Word document

Overview

The Letter module allows you to select items from the CRIS database to place into letters developed by your QIO in Microsoft Word. The mail merge feature of Word is used to pull data from a text file created in CRIS into the letter created by your QIO. You will be able to print letters from Word.

Prior to using the Letter module, please save your current QIO letters in Word. The "Add Columns to Word to Use Mail Merge Feature" section of this chapter explains how to use the mail merge feature of Word to select the column names from CRIS to insert in your letters.

Automated Letters Listing

The Automated Letters Listing windows are used to query for information on records in CRIS and save the information in an Excel (.xls) file. The information saved in the Excel file can be used in the form letter(s) developed by your QIO in Word.

1   To access the desired Automated Letters Listing window, select **Letters** from the main menu and select the desired type of letter. The letter types are: Helpline, Record Tracking, Non-Coding Review, Preliminary Coding Review, Final Coding Review, HWDRG Preliminary Coding Review, HWDRG Final Coding Review, 15 Day Reminder, 30 Day Technical Denial, and Notice of Non-coverage Education Listing.

The Automated Letters Helpline Listing window displays in Query Mode.
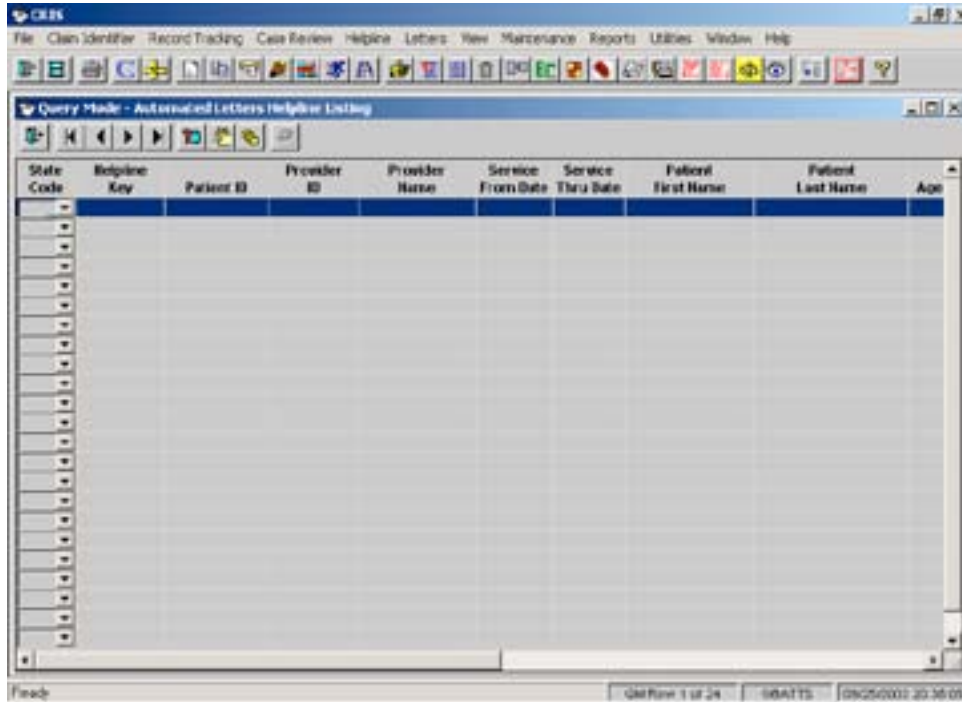
2   Query for the desired records (e.g., Claim Key, Action Date, Batch Number, Helpline Key, etc.).

> ♫   Records meeting the criteria you entered will display.

3   Select the Automated Letters icon, [icon] . The *Save As…* box displays.

4   Name the file. Keep the default, **Excel5 with headers,** in the **Save as type:** field. Select the drive/directory where you will save the file.

5   Select the **Save** button.

> ♫   To update your letters, pulling the information from the Excel file, see the "Add Columns to Word to Use Mail Merge Feature" section of this chapter.

Helpline Letter Listing

The Helpline Letter Listing window can be used to retrieve specific data for records that have been entered in the Helpline module.

Retrieval Criteria
1   There must be a record in the Helpline module

2   The Health Service Provider entered in the Helpline module must match a HSP ID in the PRS Health Service Provider table.

Record Tracking Letter Listing

The Record Tracking Letter Listing window can be used to retrieve information for records that have been added to the Record Tracking module. These include requesting medical records from a provider or physician office.

Retrieval Criteria

1   There must be at least one component row in the Record Tracking window.

2   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

3   If requesting medical records from a Health Service Provider, there must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

4   If requesting medical records from a Physician, there must be a row in the Contact, Address, and Telephone window in PRS for the Physician with a Phone Type of "Medical Records", and a Contact Type of "Medical Records", and there must be an associated address.

5   If requesting medical records from a physician group, the business address is used to retrieve the address.

Non-coding Review Letter Listing

The Non-coding Review Letter Listing window can be used to retrieve records that have been added to the Case Review module. All records that have been added to Case Review will display on the listing window. No DRG coding information will display for these records. If DRG coding information is required for your letter, use one of the coding letters described in this section.

This listing window can be used for beneficiary complaint letters, quality letters or utilization letters when you do not need to include the DRG coding validation information. The physician information is retrieved for the physician that is displayed on the Physician Information window for the BR code set with the Role Type of '01-Primary Care'. The "Preferred Billing" address from PRS is used for this physician. If the provider is a Physician Group, the business address is used to retrieve the address.

Retrieval Criteria

1   The record must have been assigned to Case Review

2   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

Preliminary Coding Review Letter Listing

The Preliminary Coding Review Letter Listing window can be used to retrieve records that have had first level DRG coding review performed. This letter-listing window excludes HWDRG records.

The Billed at Time of Review (BR) and the First Level Review (1L) code sets are retrieved in this listing. The physician information is retrieved for the physician that is displayed on the Physician Information window for the BR code set with the Role Type of '01-Primary Care'. The "Preferred Billing" address from PRS is used for this physician. If the provider is a Physician Group, the business address is used to retrieve the address.

Retrieval Criteria
1   The record must have been assigned to Case Review

2   There must be a First Level (1L) Code Set 2 DRG coding review in the Coding Valida-tion window.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

4   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

Final Coding Review Letter Listing

The Final Coding Review Letter Listing window can be used to retrieve records that have had DRG coding review performed. This letter-listing window excludes HWDRG records.

The Billed at Time of Review (BR), First Level Review (1L), Second Level Review (2L), and the Third Level Review (3L) code sets are retrieved in this listing. The physician information is retrieved for the physician that is displayed on the Physician Information window for the BR code set with the Role Type is '01-Primary Care'. The "Preferred Billing" address from PRS is used for this physician. If the provider is a physician group, the business address is used to retrieve the address.

Retrieval Criteria
1   The record must have been assigned to Case Review.

2   There must be a Second Level (2L) Code Set 2 DRG coding review in the Coding Validation window.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

4   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

HWDRG Preliminary Coding Review Letter Listing

The HWDRG Preliminary Coding Review Letter Listing window can be used to retrieve records that have been identified for HWDRG.

The Requested for Higher Weighted DRG (HW), and First Level Review (1L) code sets are retrieved in this listing. The physician information is retrieved for the physician that is displayed on the Physician Information window for the BR code set with the Role Type of '01-Primary Care'. The "Preferred Billing" address from PRS is used for this physician. If the provider is a Physician Group, the business address is used to retrieve the address.

Retrieval Criteria
1   The record must have been assigned to Case Review.

2   There must be a First Level (1L) Code Set 2 DRG coding review in the Coding Validation window.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

4   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

HWDRG Final Coding Review Letter Listing

The HWDRG Final Coding Review Letter Listing window can be used to retrieve records that have been identified for HWDRG.

The Requested for Higher Weighted DRG (HW), First Level Review (1L), Second Level Review (2L), and the Third Level Review (3L) code sets are retrieved in this listing. The physician information is retrieved for the physician that is displayed on the Physician Information window for the BR code set with the Role Type of '01-Primary Care'. The "Preferred Billing" address from PRS is used for this physician. If the provider is a Physician Group, the business address is used to retrieve the address.

Retrieval Criteria
1   The record must have been assigned to Case Review.

2   There must be a Second Level (2L) Code Set 2 DRG coding review in the Coding Validation window.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

4   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

15 Day Reminder Letter Listing

The 15 Day Reminder Letter Listing window can be used to retrieve records that have an Action code in Record Tracking of '7 – 15 Day Reminder Letter Identified.

This letter listing can be used when you are sending a reminder letter to the provider when the medical record has not been received within 15 days of the initial request.

Retrieval Criteria
1   There must be record tracking Action code of '7 – 15 Day Reminder Letter Identified.'

2   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

Run 15 Day Reminder Report

Prior to accessing the Automated Letters 15 Day Reminder Listing window run the 15 Day Reminder Report and update records in the Record Tracking module with the Action 15 Day Reminder Letter identified. (See Chapter 4)

1   Select **Record Tracking|15 Day Reminder Report**.

2   In the State Code field, select the appropriate state code.

3   Select **OK**.

4   Select the Update Record Component with 15 Day Reminder icon, .

5   Select the Staff ID.

6   Select **OK**.

The Action 15 Day Reminder Letter Identified is added to the records displayed on the report.

♬ You may want to print the report or record the Batch Number displayed on the report after you select the Update Record Components with the 15 Day Reminder icon. You may choose to query by Batch Number on the Automated Letters 15 Day Reminder Listing window.

30 Day Technical Denial Letter Listing

The 30 Day Technical Denial Letter Listing window can be used to retrieve records that have an Action code in Record Tracking of '6 – Technical Denial Identified.

This letter listing can be used when you are sending a technical denial letter notification to the provider and beneficiary when the medical record has not been received within 30 days of the initial request.

Retrieval Criteria
1   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

2   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of 'Medical Records' and a Contact Type of 'Medical Records' and there must be an associated address.

3   There must be record tracking Action code of '6 – Technical Denial Identified.'

Run 30 Day Technical Denial Report

Prior to accessing the Automated Letters 30 Day Technical Denial window run the 30 Day Technical Denial Report and update records in the Record Tracking module with the Action Technical Denial Identified. (See Chapter 4)

1   Select **Record Tracking|30 Day Technical Denial Report**.

2   In the State Code field, select the appropriate state code.

3   Select **OK**.

4   Select the Update Record(s) with 30 Day Technical Denial icon, [icon] . A Select Tech Denial Reason, Staff ID and Issue Date box displays.

5   Select the desired options in the Tech Denial Reason and Staff ID fields. Update the Issue Date if desired (the current date displays).

6   Select **OK**. The Action Technical Denial Identified is added to the records displayed on the report.

♬ You may want to print the report or record the Batch Number displayed on the report after you select the Update Records with 30 Day Technical Denial icon. You may choose to query by Batch Number on the Automated Letters 30 Day Technical Denial Listing window.

Notice of Non-coverage Education Listing

The Notice of Non-coverage Education Listing window can be used to retrieve information from records that have been entered into the Notice of Non-coverage Log window. The Utilization Review Contact Name and Address will be retrieved from PRS, if available.

Retrieval Criteria
1   There must be a record in the Notice of Non-coverage Log.

2   There must be a row in the Contact, Address, and Telephone window in PRS for the QIO with a Phone Type of Medical Records and a Contact Type of Medical Records and there must be an associated address ID.

3   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Phone Type of Medical Records and a Contact Type of Medical Records and there must be an associated address ID.

4   There must be a row in the Contact, Address, and Telephone window in PRS for the Health Service Provider with a Contact Type of Utilization Review and an associated address before the Utilization Review contact name and address become available for insertion into an automatic letter.

Add Columns to Word to Use Mail Merge Feature

Prior to performing the following steps, create the letter(s) in Word. Then, create the Excel file of columns to be used in the letter. Create the Excel file in CRIS from the desired Automated Letters Listing windows. Instructions for creating the Excel files are in this chapter under the Automated Letters Listing section.

Perform the following steps for each letter in Word. Once the steps are performed and the Word letter contains the appropriate column names to be used with the mail merge, this does not need to be completed again. If the letter is updated so different column names are needed, you need to perform the following steps to update the column names in the letter.

1   Access **Microsoft Word** .

2   Select the drive/directory where the desired letter is saved.

3   Open the letter.

4   Go to **Tools|Mail Merge. . .**

5   Under 1 Main Document, select **Create**.

6   Select **Form Letters. . .**

7   When the Microsoft Word box displays, select **Active Window**.

8   Under 2 Data Source, select **Get Data**.

9   Select **Open Data Source. . .** In the **Files of type**: field, select **MS Excel Worksheets (*.xls)**.

10   Go to the drive and directory where the Excel file with headers was saved.

11   Highlight the desired Excel file and select **Open**.

12   When the *Microsoft Excel* box displays, select **OK**.

13   When the *Microsoft Word* box displays, select **Edit Main Document**.

14   Place the cursor on the section of the letter that you want to populate with text.

15   Select the **Insert Merge Field** button. The column names from the Excel file will display on the left side of the window.

16   Select the desired column name.

♫   For 15 Day Reminder and 30 Day Technical Denial letters, two Action Date columns are available for selection:
1   Action_dt_print. Only the date will display in the letter.

2   Action_dt. Both date and time will display in the letter.

17   Repeat steps 14 through 16 for each area of the letter for which you will populate text.

18   Select the Save icon, , in Word.

Populate Letters with Data from Excel File--Print Letters

Prior to performing the following steps, the letter must contain the column names to be used with the Mail Merge feature of Word. See the "Add Columns to Word to Use Mail Merge Feature" section of this chapter.

1   Open **Word**.

2   Access the desired letter with the column names.

3   Select **Tools|Mail Merge…**.

4   Under 2 Data Source, select **Get Data**.

5   Select **Open Data Source…** In the **Files of type:** field, select **MS Excel Worksheets (*.xls).**

6   Go to the drive and directory where the Excel file with headers was saved.

7   Highlight the desired Excel file and select **Open**.

8   When the *Microsoft Excel* box displays, select **OK**.

9   Under 3 Merge the data with the document, select **Merge**.

10 When the *Merge* box displays, select, **Merge**.

11 Select the Save icon, , in Word.

12 Name the file and select the drive and directory where you will save the file.

13 Select **Save**.

14 Select the Print icon, , to print the letters.

Chapter 8 - Electronic Letters

Electronic Letters

Objectives

After completing this chapter, you will be able to:
- Access, select and modify merge code values in electronic letters
- Select electronic letter recipients
- Preview and print draft models of an electronic letter
- Process the completed version of the electronic letter for mailing

Overview

The Electronic Letters module allows you to select a variety of letters modeled after the letter exhibits in the QIO Manual. A user cannot modify the base phrasing of the letters. However, any of the electronic merge code values can be changed or expanded to suit your needs.

The Electronic Letters module also provides you with a permanent record of all the letters mailed for a claim throughout the review process. Once the letter is mailed, it remains in the database and can be viewed at any time from several locations in CRIS.

A letter becomes read-only once a Sent Date is entered on the Electronic Letters window.

Electronic Letters Listing

The Electronic Letters Listing window is used to query for or create a letter related to your review. It can be conveniently accessed from many windows in either the Review or Beneficiary Complaint modules of CRIS. You can also select **Letters** from the main menu and choose the **Electronic Letters Listing** option or click on the Electronic Letters Listing icon, [icon] , on the main menu bar to query for an existing letter or claim key.

Create a Letter for a Case Currently in Review

1   Select **Case Review** from the main menu and choose either Review Listing or Review Type Listing.

The listing window you selected displays in Query mode.

2   Query for an existing review. Click on the row to highlight it.

3   Select the Electronic Letters Listing icon, [icon] .

The Electronic Letters Listing window displays. If any electronic letters already exist for the claim key, they will also display.

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4   Select the Insert icon, .

The Electronic Letters window displays.

5   The Claim Key field defaults to the selected claim key. If more than one claim key exists for the beneficiary, they are available for selection in the drop-down box.

6   If a Beneficiary Complaint exists for the selected claim key, select it from the drop-down box available in the Bene Complaint Key field.

> ♫   Do not enter a date in the Sent Date field until you are ready to print and send the final version of a letter. Once the Sent Date is saved, the letter becomes read-only and no further options or values can be entered.

7   Select a Letter Type from the drop-down box. The following electronic letters are available:

Admission Denial Notice
Beneficiary Complaint – Request for Information
Beneficiary Complaint – Request for Information Form
Beneficiary Final Response — No Consent to Identify
Beneficiary Final Response Regarding Facility
Beneficiary Final Response Regarding Practitioner
Billing Error Denial Notice
Billing Inquiry
Continued Stay Denial
Continued Stay Denial – SNF/Swingbed
Cost Outlier Denial Notice
Cost Outlier Technically Denied Services
CPT Decision
CPT Inquiry
CPT ReReview Decision
Documentation Error Inquiry
DRG Decision
DRG Inquiry
DRG ReReview Decision
FI Referral Decision
No Concerns Decision
No Review Required
Quality Inquiry
Quality Rereview
Quality Upheld
Quality/Utilization Inquiry
Quality/Utilization Resolved
Reconsideration - Admission
Reconsideration - Continued Stay Expedited
Reconsideration - Continued Stay — MA
Reconsideration - Length of Stay
Reconsideration - Preadmission
Reconsideration - Readmission (Circumvention)
Reconsieration Schedule Letter
Technical Denial
Technical Denial - CDAC

The letter displays in sections, with a check box at the left of each section. An automatic check mark in the box means that section of the letter is required and cannot be omitted from the letter.

8   Place a check mark in the box beside each portion of the electronic letter that you wish to display in the actual letter. Some letters have several options to choose from so that they can best apply to your review findings; e.g., the Admission Denial Notice allows you to select different conditions and liabilities.

9   Select the Save icon, , to save the options you have selected.

10 Either select Merge Code Description values from the drop-down boxes in each row or manually enter the data required to complete the letter. If you need more typing space than is displayed in the row, select the Expand Merge Code Description icon, . A text window appears that will allow you to type up to 4000 characters for insertion into the letter. Some Merge Code Description values are auto-populated from data in CRIS; however, these can be overwritten as needed.
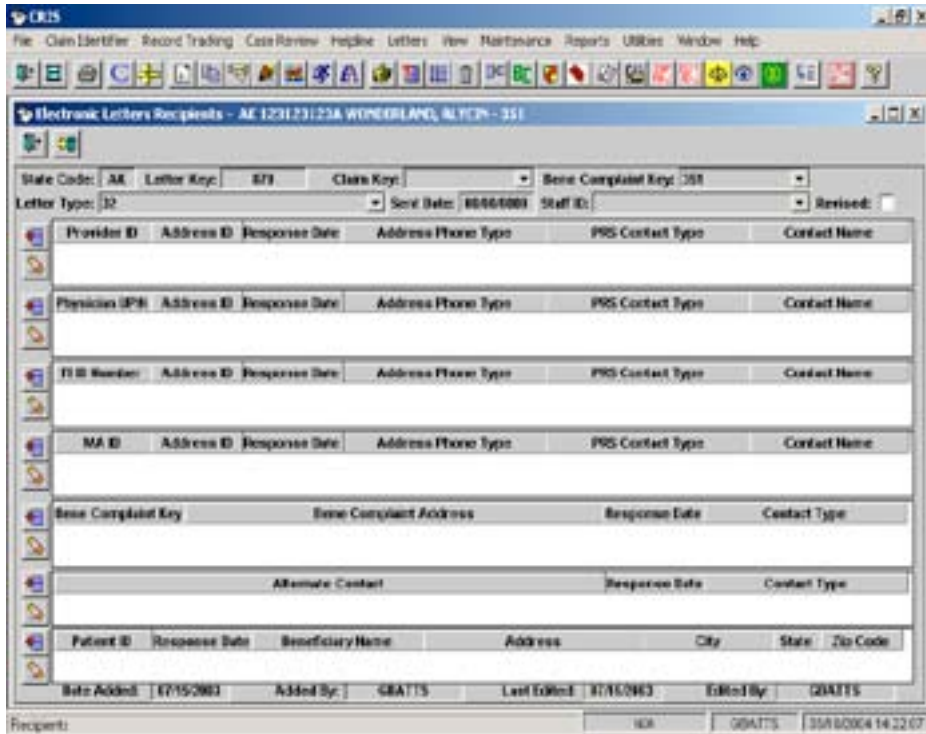
The Electronic Signature Merge Code Description allows you to select a file location of the signature if it exists on the Maintenance|Electronic Letter|Electronic Letter Signature window (see Chapter 9 for instructions regarding Electronic Signature Maintenance). Selecting a file location from the Merge Code Description will place the signature in the proper position inside the letter.

> ♫   All of the Merge Codes that are available for the letter display at the bottom of the window. (A Merge Code displays only one time in the Merge Code section even if it is used more than once in the letter.) A valueplaced in the Merge Code Description area will cause that value to be inserted into the letter wherever the Merge Code directs it to appear.

11 Select the Save icon, , to save the values you have entered. Until the Sent Date field is saved, you can change letter sections, merge code values, or the letter type, if desired.

Select the Recipients of the Electronic Letter

1   Select the Recipients icon, .

The Electronic Letters Recipients window displays. This window contains seven child tables that contain name and address information that you can select to have inserted as recipient address(es) in the electronic letter. Manual entry of name and address information is not allowed. Name and address information can be selected for the following recipients:

Provider
Physician (from the Health Service Encounter record)
Fiscal Intermediary
Medicare Advantage (if applicable)
Beneficiary Complaint Contact (if applicable)
Alternate Contact (if applicable)
Beneficiary (from current beneficiary address information in PRS)

♫   An address row must exist on the Provider Contact Address and Telephone, FI Contact Address and Telephone, the Physician Contact Address and Telphone, and the MA Contact Address and Telephone windows before options for those selections will display in the drop-down lists on the Electronic Letters Recipients window in Electronic Letters. If a contact name is not entered in PRS, it will not display on the letter.

The recipient information is added to the letter in the top left third of the page. When the letter is folded, the name and address information will display inside a #10 regulation business window envelope.

2   Select the Insert icon, [icon], located at the left of each section (e.g., Providers, Physicians, FI Contacts) to add a row for a letter recipient. You can select as many recipients as you wish from the options available in the drop-down lists. To delete an electronic letter recipient, select the Delete row icon, [icon] .

Print the Electronic Letter

You can view and print a draft version of the letter at any time for editing purposes. However, once the Sent Date on the Electronic Letters window is entered and saved, the program creates the final version of the letter and no further editing is allowed. **Do not enter a Sent Date until you are certain the letter is ready for mailing**.

1   Select the Print Preview icon, [icon] , from the Electronic Letters window.

A draft version of the electronic letter displays with the word 'DRAFT' printed at the top left of each page. A letter for each recipient you selected is available for viewing. You can look at each letter by selecting the Next Recipient icon, [icon] , in the Print Preview window.

The recipient name and address default to an initial capitalization format. If you would like this information to display and print in all capital letters, select the Capitalize icon, [icon] . All copies of the letter will then display the recipient name and address in capital letters.

If you would like to change the letter margins and/or the font size, select the Set Margins icon, [icon] . A *User Preferences* box displays.
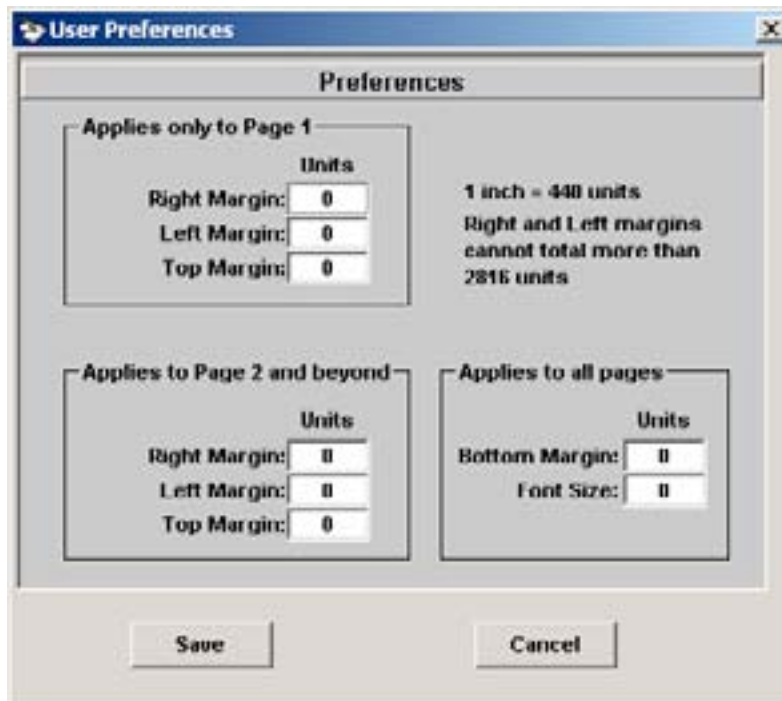
Set your margins using the instructions on the *User Preferences* box. Change your font size in the Font Size field. Selecting the **Save** button will save your preferences. Selecting the **Cancel** button will cancel the *User Preferences* box and will not save any changes you have made.

> ♫ The Electronic Signature will not move to your selected left margin when you save your preference to place the signature at the required margin. Left click and hold onto the signature with your mouse and move it to the desired area on the letter.

2   Select the Print icon, ⊟ , from the main menu bar to print the draft copies of your letter.

The word 'DRAFT' prints on each page for easy identification.

3   Return to the Electronic Letters window to make any corrections or changes to the letter.

4   Enter the date that you plan to mail the letter in the Sent Date field on the Electronic Letters window. The current date or a date up to 5 days into the future is allowed. Select the Save icon, ➡ .

The letter is now a read-only document. No further additions or changes can be made.

5   Select the Print Preview icon, ≣ .

The final version of the electronic letter is displayed. The Sent Date now appears on the letter.

6   Print the electronic letter(s) by selecting the Print icon, ⊟ , from the main menu bar to print the final version of the letter for mailing.

> ♫ If you are preparing a revised letter, placing a check mark in the Revised field of the Electronic Letters window will add the word *Revised* to the top of your letter.

Modify an Electronic Letter

An electronic letter can be modified at any time during the draft letter process. You can change module selections and/or change the wording in the any of the merge code descriptions, including those that are automatically populated by the program. Once the Sent Date is entered, however, modification is no longer possible.

Delete an Electronic Letter

An electronic letter can be deleted by a QIO staff member with CRIS Admin roles at any time during the draft process. Once a Sent Date has been entered, the letter cannot be deleted.

1   Query for a review from either the Review or Beneficiary Complaint module window.

2   Select the Electronic Letters icon, .

     The Electronic Letters Listing window displays.

3   Highlight the electronic letter row that you want to delete by clicking on it.

4   Select the Delete icon, .

     A message appears: "Delete row X for Electronic Letters Listing?"

5   Select **Yes**.

Chapter 9 - View and Maintenance

View and Maintenance

Objectives

After completing this chapter, you will be able to:

- Access the View and Maintenance windows

- Query for desired windows in the View and Maintenance module

- Insert, update or delete QIO information on the Maintenance windows (if you have appropriate rights)

- Copy and modify Electronic Letter Types to create letters exclusive to your QIO (if you have appropriate rights)

Overview

The **View module** is used to search for and view code values that are used in the drop-down lists throughout the CRIS software. You can sort the information or save it to a text file if desired. The QIOs cannot update the View code tables.

The **Maintenance module** is used to insert, update, and delete QIO added code values. QIO staff with Review Admin or Helpline Admin roles can update the Maintenance code tables. Standard code values have been added to the tables. The standard code values have an 'XX' in the State Code field. The standard code values cannot be modified or deleted. You can sort the information or save it to a text file if desired.

Viewing CRIS Code Tables

1   Select **View** from the main menu.

2   Select the desired View table from the drop-down list.

3   On the selected window, select the desired table from the drop-down list near the top left of the window.

    The selected View window displays in Query Mode.

4   Query for the desired information by selecting the Retrieve Query icon, .

5　Use the Scroll icons, ⏮ ◀ ▶ ⏭ , to move through the list.

6　The Sort icon, ▣ , allows you to sort the information by any of the fields on the window.

7　The Save As icon, ▣ , allows you to save the information on the table to an external file.
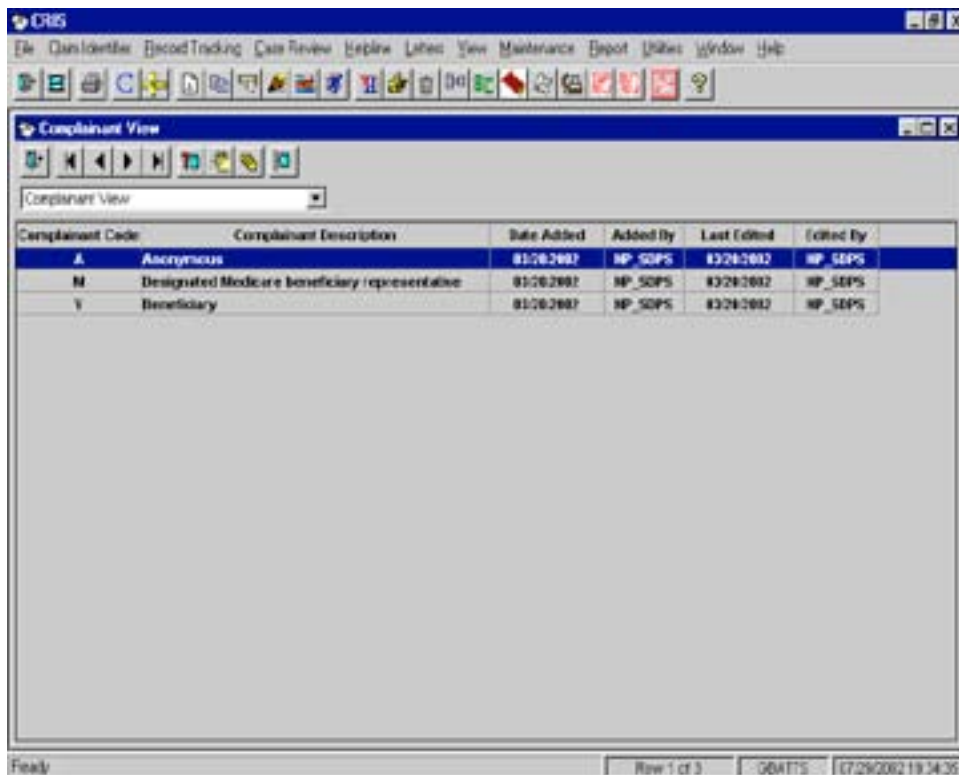
List of Available View Code Tables

Adjustment Code Tables—These codes are used on the Inpatient and Outpatient Adjustment windows.
Adjustment Action
Adjustment Origin
Adjustment Outcome
Adjustment Status
QIO Review Adjustment Code Inpatient
QIO Review Adjustment Code Outpatient
Reason for QIO Action Inpatient
Reason for QIO Action Outpatient

Beneficiary Code Tables—These codes are used on the Beneficiary Complaint windows.
ADR Agreements Improvement Plans Event
ADR Meeting Delay Reason
ADR Meeting Event
ADR Meeting Type
ADR Method
ADR Outcome
ADR Reason Resolution Not Reached

ADR Reason
Appropriate for ADR By
Beneficiary Representative ADR Event
Complainant
Provider Physician ADR Event
Source
Status
Survey Type

General Code Tables—These codes are used in the Case Review and Helpline windows or are provided as reference.
CMS Cycles
Discharge Status
Gender
Language
Race
Region
Setting
State Codes
State Number Code

Notice of Non-coverage Code Tables—These codes are used in the Notice of Non-Coverage Log and Notice of Non-Coverage windows.
Notice of Non-Coverage Letter Content
Notice of Non-Coverage Notice Type
Notice of Non-Coverage Outcome
Notice of Non-Coverage Select Source
Responsible for Payment

Helpline Code Tables
Helpline Subject View
Helpline Notice of Non-Coverage Expedited View
HSE—This is a link to the Claims Warehouse on C1S80. If a medical record has a billed claim.

HSE Code Tables–These codes are used on the HSE record and in the Review windows.
Condition Codes
Diagnosis Codes
DRG Codes
HSE Code Tables *(continued)*
HCPCS Codes
HSE Code Set
HSE Roles
Major Diagnostic Category
Occurrence Code
Primary Payer
Procedure Codes
Revenue Center Codes
Span Codes
Value Codes

Review Code Tables—These codes are used in the Review windows.
ALJ Outcome
Billing Error
Coordinator Outcome
Documentation Missing
EMTALA Question
EMTALA Review Type
Invalid Selection Reason
PRAF Category
PRAF Concern Source
PRAF Level
PRAF Limitation on Liability
PRAF Outcome
QI Activity
QIA Category
QIA Frequency
QIA Improvement
QIA Initiated By
QIA Trending
QIA Type
Record Action
Record Page Rate
Review Edit Error
Review Outcome
Review Status
Review Type
Selection Reason
Technical Denial Reason
Third Party Liability

Deleted Claim Identifier—Query for deleted claim identifiers

Provider Tables—This is a view to the PRS tables.
Health Service Provider View
MA View
Physician View

Physician Group Table—This is a view to the PRS tables.

Physician Group Member Table—This is a view to the PRS tables.

Beneficiary Table—This is a view to the PRS tables.

Viewing CRIS Maintenance Code Tables

1   Select **Maintenance** from the main menu.

2   Select the desired Maintenance table from the drop-down list.

3   On the window, select the desired option from the drop-down list near the top left of the
    window.

The selected Maintenance window displays in Query Mode.

4 Query for the desired information by selecting the Retrieve Query icon, [icon] .

5 Use the Scroll icons, [icons] , to move through the list.

6 The Sort icon, [icon] , allows you to sort the information by any of the fields on the window.

7 The Save As icon, [icon] , allows you to save the information on the table to an external file.

Select the desired Maintenance window from this drop-down list.
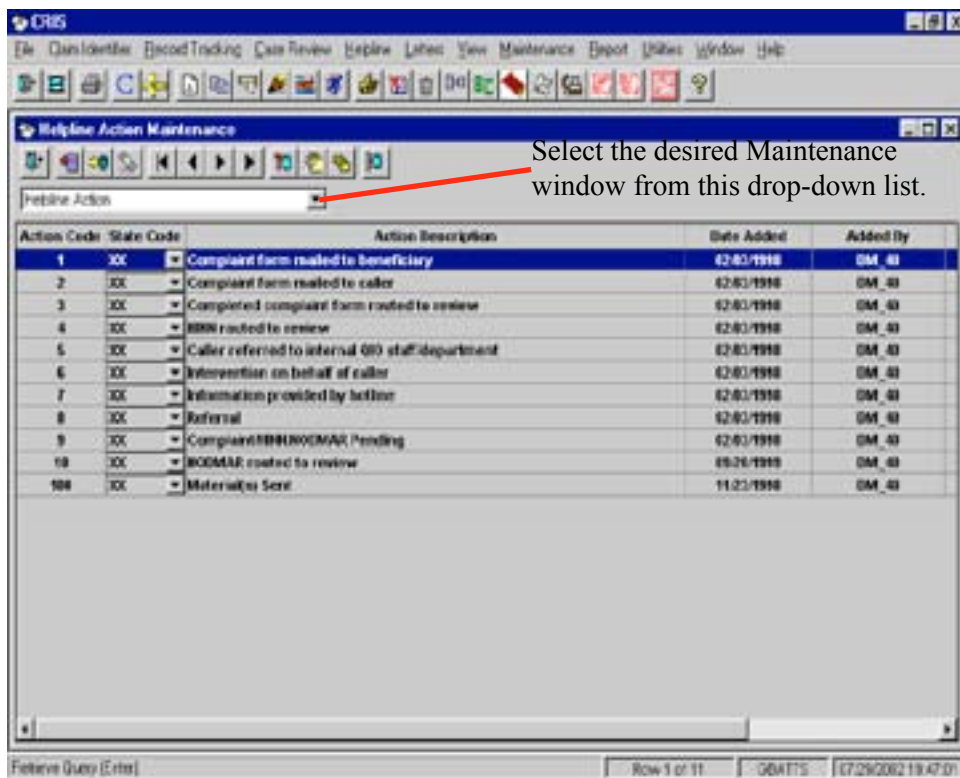
List of Available Maintenance Code Tables

Beneficiary Complaint Code Tables—These are updateable code tables used in the Beneficiary Complaint windows. Only QIO staff with CRIS Review Admin roles can update the codes.
Beneficiary Complaint Delay
Beneficiary Complaint Event
Beneficiary Complaint Provider Event
Beneficiary Complaint Reviewer Type
QIO ADR Event

Helpline Code Tables—These are updateable code tables used in the Helpline windows. Only QIO staff with CRIS Helpline Admin roles can update the codes.
Helpline Action
Helpline Bene Insurance Program

Helpline Caller Type
Helpline How Caller Found
Helpline Inquiry Via
Helpline Materials Sent
Helpline Nature of Inquiry
Helpline Quality Form Sent To
Helpline Quality of Care Result
Helpline Referred To

Record Tracking Code Tables—These are updateable code tables used in the Record Tracking windows. Only QIO staff with CRIS Reivew Admin roles can update the codes.
Record Component
Record Location

Review Code Tables—These are updateable code tables used in the Review windows. Only QIO staff with CRIS Review Admin roles can update the codes.
Alternate Contact Type
NODMAR Discussion Event
QIA Action
QIA Resolution
Reason For Delay
Reviewer Type

Staff—This table contains staff ID information used throughout CRIS.
Staff

Electronic Letter Signature—This table contains the location of the electronic letter signatures (.gif or .bmp) to be seleted in the Electronic Signature merge code description field in electronic letters.
Electronic Letter Signature

Electronic Letter Maintenance—This table contains the existing Electronic Letter types. The Letter Types can be copied and modified by staff with a CRIS Admin role for the production of electronic letters unique to your QIO.
Electronic Letter Maintenance Listing

Electronic Letter Merge Code—This table contains the existing merge codes and values used in the Electronic Letters. New merge codes and their values can be added in this window by staff with a CRIS Review Admin role.

Insert a New QIO Maintenance Code Value

QIO staff with the CRIS Review Admin role will be able to update the Review tables. QIO staff with the CRIS Helpline Admin role will be able to update the Helpline tables.

1   Select **Maintenance** from the main menu.

2   Select the desired Maintenance table from the drop-down list.

3   Select the code table from the drop-down list near the top left of the window.

4　Select the Insert icon .

A new row displays with the code column populated with a number of 500 or above.
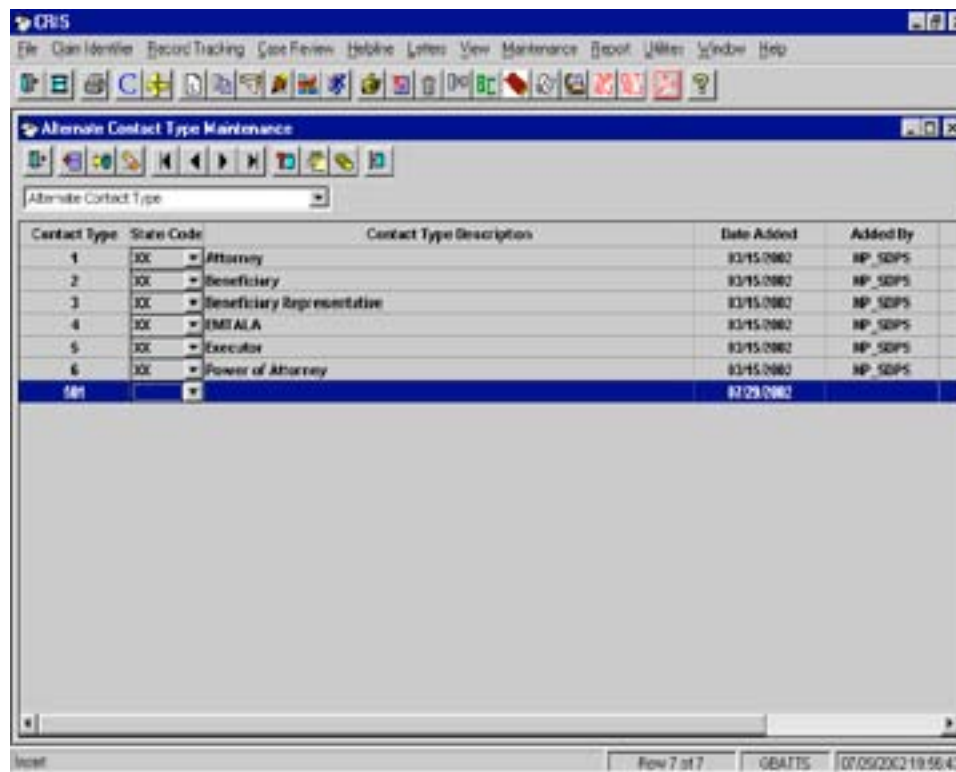
5　Select your State code.

6　Enter the description of the new code.

7　Select the Save icon, .

Delete QIO Entered Maintenance Code Value

1　Select **Maintenance** from the main menu.

2　Select the desired Maintenance table from the drop-down list.

3　Select the code table from the drop-down list near the top left of the window.

4　Query for the code you want to delete.

> ♫　Only QIO added codes can be deleted.　The QIOs cannot delete codes with a State Code of 'XX'.

5　Click on the row to be deleted with your mouse.

6   Select the Delete icon, .

A message displays asking if you want to delete the code.
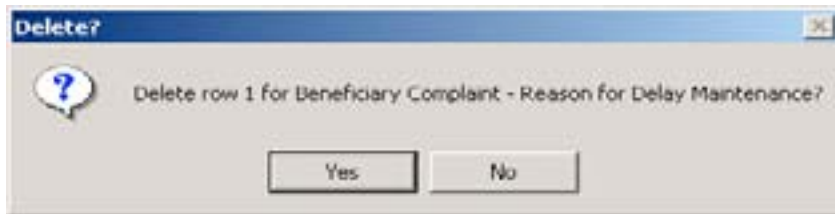
7   Select 'Yes' to delete the code or 'No' if you do not want to delete the code.

8   Select the Save icon, .

Modify a QIO Entered Maintenance Code Value

1   Select **Maintenance** from the main menu.

2   Select the desired Maintenance table from the drop-down list.

3   Select the code table from the drop-down list near the top left of the window.

4   Query for the code you want to modify.

5   Click on the row with your mouse.

6   Update or modify the information on the selected row by clicking in the field and enter-ing the information.

7   Select the Save icon, .

Insert Staff ID Information

Before a Staff ID can be selected from the Staff or Staff ID field, the information must be entered on the Staff ID window. All review coordinators and physician reviewers must be added to the Staff ID window. QIO staff with CRIS Review Admin or CRIS Helpline Admin roles can add information to the Staff ID window.

To insert staff on the Staff window:

1   Select **Maintenance|Staff.**

2   Select the Insert icon, .

A new row displays.

3   If you are a multi-state QIO, select the State Code for the staff you are entering.

> ♫   If you are a multi-state QIO, you will need to enter the staff person for each of the applicable states. The Staff ID is tied to the State Code.

4   Enter a Staff ID. This must be a numeric entry. Alpha characters cannot be used.

5   Enter the staff persons Last Name.

6   Enter the staff persons First Name and Initials if desired.

7   For Physician Reviewers, you must enter the UPIN.

      ♪ For physician reviewers, the correct Physician UPIN must be entered.
The physician UPIN is used to update the Physician Paid Date on the
Reviewer Time window. The Physician Not Paid and Physician Paid
reports also use the physician UPIN.

8   If desired you can enter the Start Date and End Date for the staff.

9   Select the Save icon, .

10 Continue entering all of your staff as needed and save between each entry.

Delete Staff ID Information

1   Select **Maintenance|Staff.**

2   Query for the staff you want to delete.

3   Highlight the row by clicking on it with your mouse.

4   Select the Delete icon, .

A message displays asking if you want to delete the row.

5   Select **Yes** to delete the row or **No** if you do not want to delete the row.

6   Select the Save icon, .

Modify Staff ID Information

1   Select **Maintenance|Staff.**

2   Query for the staff you want to modify.

3   Highlight the row by clicking on it with your mouse.

4   Update or modify the information on the selected row by clicking in the field and entering the information.

5   Select the Save icon, .

Insert Electronic Letter Signature

The location of an electronic letter signature must be entered on the Electronic Letter Signature maintenance list window before it will become available for selection in the Electronic Letters Merge Code Description drop-down box. QIO Staff with CRIS Review Admin roles can add signature locations to the Electronic Letter Signature maintenance list window.

1   Select **Maintenance|Electronic Letter Signature.**

2   Select the Insert icon, .

     A new row displays.

3   If you are a multi-state QIO, select the State Code for the electronic signature you are entering.

4   Enter the file location and file name.

5   Select the Save icon, .

6   Enter additional electronic signature locations as needed.

Delete Electronic Letter Signature

1   Select **Maintenance|Electronic Letter Signature.**

     Query for the signature location you wish to delete.

2   Highlight the row by clicking on it with your mouse.

3   Select the Delete icon, .

     A message displays asking if you want to delete the row.

4   Select **Yes** to delete the row or **No** if you do not want to delete the row.

5   Select the Save icon, .

Modify Electronic Letter Signature

1   Select **Maintenance/Electronic Letter Signature.**

2   Query for the signature location you wish to modify.

3   Highlight the row by clicking on it with your mouse.

4   Update or modify the information on the selected row by clicking in the field and enter-
     ing the information.

     Select the Save icon, .

Electronic Letter Maintenance

The Electronic Letter Maintenance (ELM) module allows QIO Staff with CRIS Review
Admin privileges to copy and modify existing Electronic Letter Types for the purpose of
creating electronic letters suited to individual QIO production needs. The method you will
use to create a new letter is to copy an existing letter and change it as needed.

Electronic letters are made up of sections called **modules**. Modules contain the text and
merge codes included in the body of the letter. The modules can stand alone for required
parts of the letter, be grouped together to allow users to select sections of text, or be linked
with either required or optional sections of text.

Each module has a Module Key, Module Number, and Module Sequence. The Module
Key and Module Number will be unique to each module. The **Module Sequence** is in
chronological order within the letter, increasing in increments of ten.

9   Grouped or linked modules will share a module sequence number.

Merge codes are used to allow insertion of data into the letter that are relevant to the
individual case. Several of the available merge codes will cause the program to automatically
fill the letter with data present in CRIS, e.g., the provider name, dates of service, etc. Other
merge codes require staff to type in data; e.g., the rationale for the review decision, and some
merge codes allow staff to select options from a drop-down list and will populate the letter
with the selected option for each instance the merge code appears in the letter. Electronic
Letter Maintenance will allow you to create merge codes that can be inserted into letters as
needed. For instructions on how to create merge codes that will provide options for selection
in the letters, please see the Electronic Letter Merge Code Maintenance section in this
chapter.

Copy an Existing Electronic Letter Type

The current Electronic Letter Types will have an 'XX' in the State Code field. These letters
can be copied, given a new description, and modified.

1   Select **Maintenance|Electronic Letter Maintenance.**

     The Electronic Letter Maintenance Listing window displays.

2   Query for a Type Key or Letter Type, or select the Retrieve Query icon, , to retrieve
     all available letters.

3   Select the letter you want to copy and modify it by clicking on the row.

4   Select the Copy icon, .

     The Letter Maintenance window displays with the message, "Copy Type Key 15 – FI
     Referral Decision." Are you sure?

Copy Letter Type

Copy Type Key 15 - FI Referral Decision. Are you sure?

OK   Cancel

5   Select **OK** to copy the letter.

     A new row displays with a Type Key number of 5000 or above.

6   If you are a multi-state QIO, select a state code from the drop-down list in the State column.

7   In the Letter Type field, change the name of the letter to uniquely identify the new letter. Duplicate Letter Type descriptions are prohibited by the system. Either click anywhere in the field to add to the description, or click and drag the cursor to highlight the description and create a new description for the letter.

     ♬ The Production field defaults to No. Do not select Yes in this field until the letter has been modified completely and is ready to be placed into production. Once this field is changed to Yes and the letter is saved, the letter type can no longer be modified.

8   Select the Save icon, .

Modify an Electronic Letter Type

Once an existing electronic letter type has been copied and saved, it can be modified to suit your QIO's specifications.

1   Select **Maintenance|Electronic Letter Maintenance**.

     The Electronic Letter Maintenance Listing window displays.

2   Query for a Type Key or Letter Type, or select the Retrieve Query icon, , to retrieve all available letters. Select the letter you wish to modify by clicking on it.

     ♬ Letters with 'XX' in the State field cannot be modified.

3   Select the Modify icon, .

The Letter Maintenance window displays.

♫ The Production field defaults to **No**, meaning the letter cannot be select-
ed by a user in the Electronic Letters module. Once this field is changed
to **Yes** and saved, the letter becomes available for production of letters
and cannot be deleted or modified. The only field available after that
time will be the Production End Date.

4 Do not enter a date in the Production End Date field unless production of the letter will
end on a certain date. If a date is saved in this field, the letter will not be available for
selection on the Electronic Letters window after that date. For more information about
the Production End Date field, see the "Production End Date" section in this chapter.

Modify an Existing Module

The letter modules are the text and merge codes used to make up the body of the letter.
The modules are limited to 4,000 characters, so it is best to break the letter into sections
containing no more than a few paragraphs. To modify an existing module:

1 Click anywhere in the yellow area of the module you wish to change.

2 Select the Expand Module Text icon, 😊 .

The Expanded Module Text window displays.
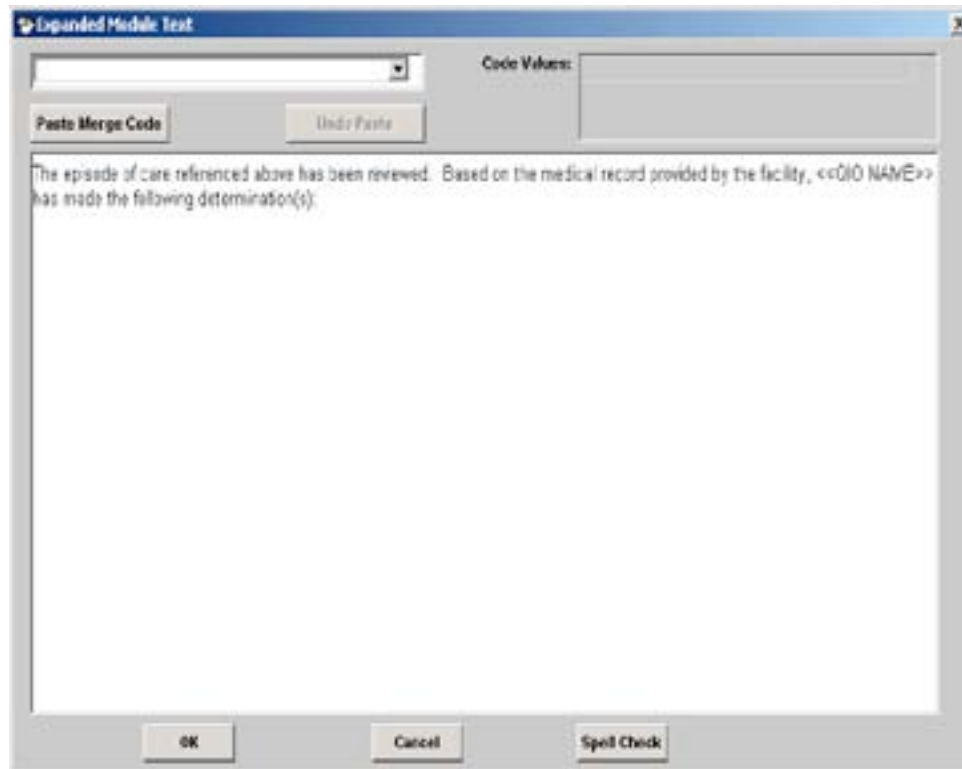
3   To delete text, highlight the text to be deleted and click on the DELETE key on your key-
    board.

4   To modify text, highlight the text to be modified and type in the desired text.

5   To add text, place your cursor where you want to insert text and type in the new text.

6   To insert merge codes, click on the down arrow in the Merge Code field at the top of the
    window and select a merge code or begin typing the code you want to enter into the mod-
    ule. If you select a merge code that contains more than one value; e.g., Did/Did Not, the
    values will display in the Code Values field next to the merge code you have selected.

7   *Create your own merge code for the letter:* Once a merge code is saved, it becomes
    available for selection in any letter you modify. Merge codes must be in ALL CAPS.

        ♫ If a merge code is typed directly into the module from the Electronic
           Letters Maintenance window or in the Expanded Module Text window,
           remember to place two less-than symbols (<<) before the code and two
           more-than symbols (>>) after the code. Type the merge code in all capi-
           tal letters.

8   Click in the area of the module where you want to place the selected merge code and
    select Paste Merge Code [Paste Merge Code] option.

The merge code displays in the module where you placed the cursor. If you decide you

don't want the merge code placed there, select the Undo Paste [Undo Paste] option.

> ♫ If you delete, modify, or add text after pasting in a merge code, the Undo Paste option becomes disabled. Once the Undo Paste option is disabled, you must highlight the merge code and select Delete on your keyboard in order to delete it.

9   Select the Spell Check option to check your changes, then select **OK** to return to the Letter Maintenance window.

Insert a New Module

1   To insert a module before or after a selected paragraph, click on the module to select it, then select the Insert Letter Module Before icon, [icon], or the Insert Letter Module After icon, [icon], to insert a blank module before or after the selected module.

2   The Part of a Group field defaults to **No**. If a module should be a required part of the letter, this field should remain set to **No**. A checkmark will display next to the module in the Electronic Letters window and the module will always appear in the letter when viewed or printed.

3   If the module you have inserted should be part of a group, select **Yes** in the Part of a Group field and enter the Group Number either by clicking on the up/down arrows for that field, or by typing in the group number. Group numbers within a letter can be automatically renumbered as needed by clicking on a module and selecting the Renumber Groups Up icon, [icon], at the top of the screen.

4   Select the Expand Module Text icon, [icon].

5   Type the text you want in the blank text area and insert merge codes as instructed in the 'Modify an existing module' section.

6   Click **OK** to exit the Expand Module Text window and return to the Letter Maintenance window.

Grouping Modules

Multiple modules can be grouped together. Grouped modules will not have a checkmark in the box next to the module in the Electronic Letters window because they are not required text for the letter type. Grouped modules allow staff to select the paragraphs or section of text most appropriate for the letter being created. Grouped modules will have the same Module Sequence number, display in chronological order, and cannot be separated by nongrouped modules or modules that have a different group number.

In order to be grouped, more than one module must have **Yes** selected in the Part of a Group field with the same Group Number. Group Numbers must be in sequential order. For example, if several modules already exist in Group Number 3, you can't insert a module following this group and insert a 2 in the Group Number field. If you want to add a module to group 2, insert the module where the text should be placed in group 2.

If you want to group modules that were not previously part of a grouped set and numbering them will cause the other group numbers to be out of chronological order:

1   Select **Yes** in the Part of a Group option for the modules you wish to group.

2   Enter the logical Group Number in each module.

3   Renumber the other grouped sets: Select the Renumber Group Up icon, , to add 1 to group numbers after the current row.

Sections of Text That Should Always Display

Insert a new module as instructed in the "Insert New Module" section of this chapter and leave the Part of a Group field defaulted to **No** in the drop-down box. The system will automatically renumber the rest of the modules. This section of text will appear in the Electronic Letters window as a module with a checkmark in the box next to that section.

Sections of Text Selected on an As-Needed Basis

1   Insert a new module as in the "Insert a New Module" section of this chapter.

2   Select **Yes** from the drop-down list in the Part of a Group field.

3   Determine whether the module is part of an existing group. If so, enter the group number in the Group Number field or select the up or down arrow to display the correct group. Follow the instructions in the Grouping Modules section of this chapter if modules need to be renumbered.

4   Select the Expand Module Text icon, . Type the text you want in the blank text area and insert merge codes as instructed in the "Modify an Existing Module" section.

5   Click **OK** to exit the Expand Module Text window and return to the Letter Maintenance window.

Link Modules

If you want to continue a section of text to another module, you can link another module to it. A linked module will display in the letter along with the required text, without having to be selected by staff.

To link modules:

1   Insert a new module as instructed in the "Insert New Module" section of this chapter and leave the Part of a Group field defaulted to **No**. The system will automatically renumber the rest of the modules.

2   Type CONT:| before typing the rest of the text or inserting a merge code. No space should be inserted between CONT:| and the text. For example:
CONT:|<<YOU CAP>>   or   CONT:|Please return the enclosed form.

View and Print All Modules of the Electronic Letter

You can view and print all of the modules in the electronic letter.

1   On the Letter Maintenance window, select the Print review icon, .

The Print Preview – Electronic Letters window displays the letter with all options that will be available for letter production.

2   Print the letter by selecting the Print icon, , from the main menu bar.

Delete an Electronic Letter Type

An electronic letter with your state's code can be deleted as long as the Production field is set to **No .** It is recommended that the Production field remain as **No** until your QIO determines a letter is ready for staff to use in electronic letter production. Once the field is set to **Yes**, the letter cannot be deleted.

1   Select **Maintenance|Electronic Letter Maintenance.**

2   Query for a Type Key or Letter Type, or select the Retrieve Query icon, , to retrieve all available letters.

3   Select the letter you want to delete.

4   Select the Modify icon, .

5   Select the Delete icon, .

A message box displays.

6   Select **Yes** to delete the letter.

7   Select the Save icon, , and close the window.

Production Status

When all modifications for the electronic letter are complete, the letter is made available for production.

1   Select **Maintenance|Electronic Letter Maintenance.**

2   Query for a Type Key or Letter Type, or select the Retrieve Query icon, [image] , to retrieve all available letters.

3   Select the letter you want to make available for production by clicking on the row.

4   Select the Modify icon, [image] .

    The Letter Maintenance window displays.

5   Select **Yes** from the drop-down box in the Production field.

6   Select the Save icon, [image] .

> ♫   **Once you exit the window, no further modifications can be made to the electronic letter.** However, until you exit the window, the Production field can be returned to **No** and all options will once again be available.

7   The modified letter is now available for selection in the Electronic Letters window.

Production End Date

A Production End Date indicates the last day an electronic letter type can be selected for production of letters in the Electronic Letters window. Electronic letter types cannot be deleted once **Yes** has been entered and saved in the Production field.

Enter a Production End Date in the following instances:
*   if modification of a letter is necessary and a new letter is created for use in future production,
    OR
*   if you plan to create a letter that will be used for a particular purpose and would not be suitable after that purpose is accomplished.

Electronic Letter Merge Code Maintenance

The Electronic Letter Merge Code maintenance option allows QIO staff with CRIS Review Admin privileges to enter merge codes and their values. When used in an electronic letter, these merge codes will allow staff to select various options for the code from the drop-down box in the Merge Code Description area of the Electronic Letters window. Merge codes with 'XX' in the State Code field can be retrieved and viewed; however, they cannot be copied or altered.

Insert Merge Code and Merge Code Description

1 Select **Maintenance|Electronic Letter Merge Code.**

The Electronic Letter Merge Code Maintenance Listing window displays.

2 Query for a Merge Code Key, State Code, Merge Code Description, or select the Retreive

Query icon, , to retrieve all available merge codes.

> ♪ If you want to query by Merge Code, you must enter LIKE %; e.g., LIKE %<<YOU>> or LIKE %<<YO% . A query that uses the less-than or more-than symbol as the first character is invalid.

3 Select the Insert icon, .

A new row displays.

4 If you are a multi-state QIO, select a State from the drop-down list.

5 Enter a merge code in the Merge Code field, enclosing it in double less-than (<<) and more-than (>>) symbols, e.g., <<BLUE/GREEN/YELLOW/RED>>.

6 Enter a value in the Merge Code Description field, e.g. blue.

7 Select the Copy Merge Code icon, , to copy your entry to another row.

8 Click on the Merge Code Description field of the new row and replace the original entry with a new option, e.g., green.

9 Continue copying the current row and replacing the merge code descriptions as needed.

10 Select the Save icon, .

Chapter 10 - Reports

Reports

Objectives

After completing this chapter, you will be able to:

- Access and run postage and pages and physician reviewer reports
- Access and log into the Web-based Program Progress Reports

Overview

The Report module allows you to run two types of reports, Postage and Pages and Physician Reviewer. The report windows display as query listing windows. You can query for all cases or a subset of cases. All other CRIS reports will be web based.

Run the Reports

1 Select **Report** and select the desired report from the drop-down list.

The selected report window displays in a Listing Query Mode.
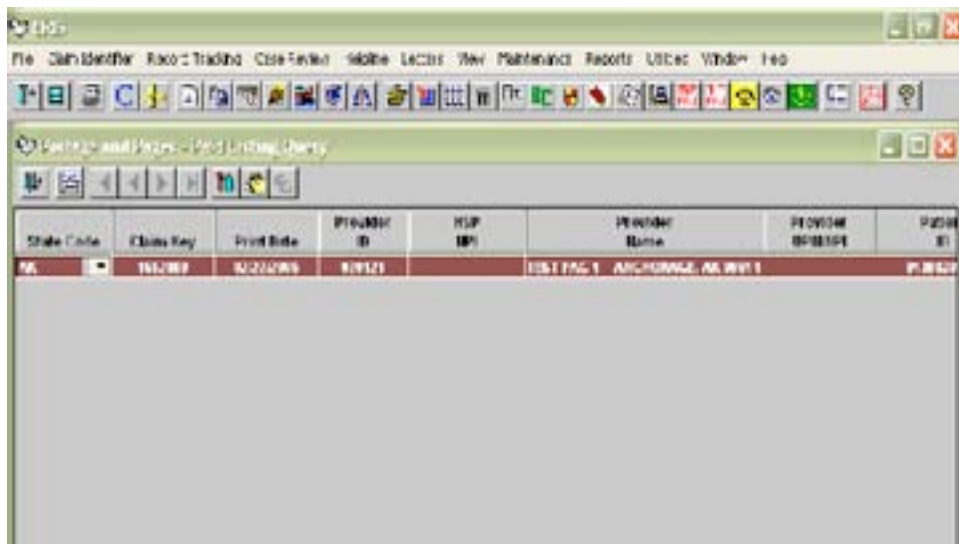
2   Select the Enter Criteria icon, [icon] .

    Any previously entered criteria will clear

3   Enter data to be retrieved.

        ♫   To query by a date range, use the qualifiers of > or < in the Date Added
            field. For example, to retrieve data between 8/1/2002 and 10/1/2002,
            enter and <10/1/2002 in the Date Added field on the first row, and on the
            second row, enter and <10/1/2002 in the Date Added field.
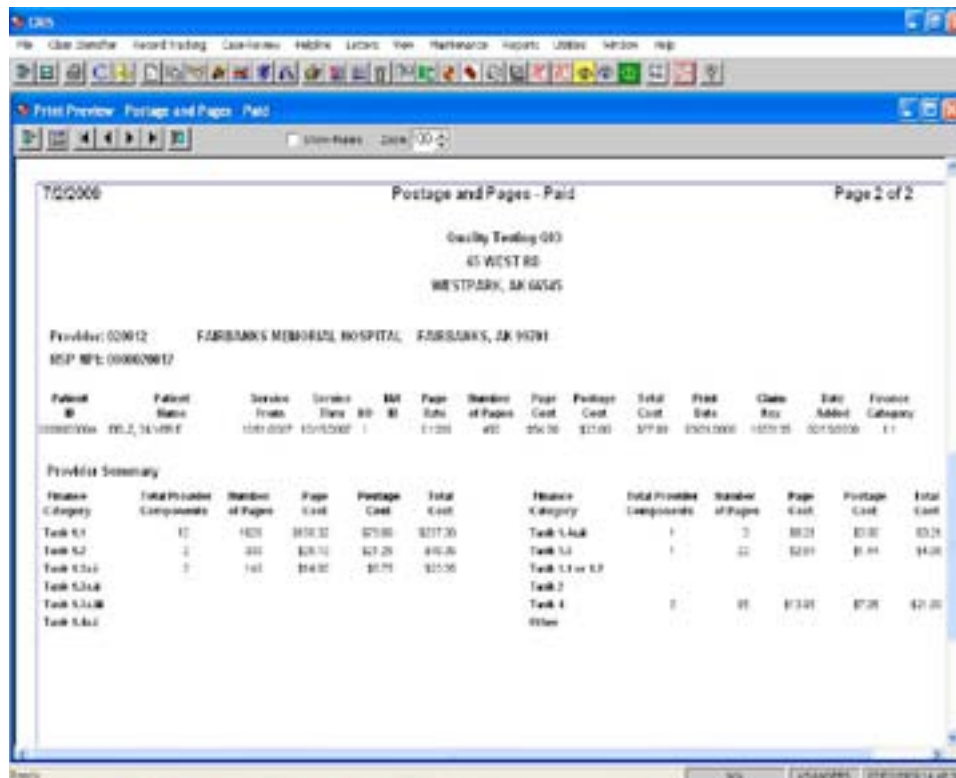
4   Select the Retrieve Query icon, [icon] .
    OR
    Press Enter.

    Data meeting your retrieval criteria will display.

        ♫   If no data displays check the criteria you entered and retrieve again.

5   Select the Print Preview icon, [icon] .

    The report window displays.

6   Select the Print icon, [icon] , on the main toolbar, at any time after the report displays to
    print the report.

7   Select the Update Print Date With Current Date icon, , on the Postage and Pages Not Paid report and the Physician Reviewer Not Paid report.

8   If you select the Close Window icon, , before you have selected the Update Print Date With Current Date icon, , the following message will display.
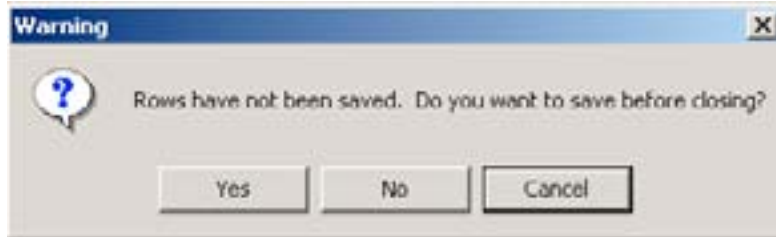
9   Select **Yes** if you want to update the print date.

10   Select **No** if you want to leave the window without updating the Print Date.

11   Select **Cancel** to remain on the window.

12   If you select the Update Print Date with Current Date icon, , twice, the following message will display.

13   Select **OK** and select the Close Window icon, , to exit the window.

View Postage and Pages Summary

A summary page for each report is available to preview and print.

1   After running the desired report, select the Print Preview - Summary icon, .

A single page summary report displays.

2   Select the Print icon, , on the main toolbar to print the report summary for all providers.

3   Select the Close Window icon, , to return to the Postage and Pages Detail window.

Postage and Pages Reports

Postage and Pages All
This report displays the postage and pages costs for all providers (HSP, Physician, and MA), paid or unpaid. A provider total by Finance Category follows each provider listing and a summary for all Providers is included on a Summary window. If the Print Date field is blank, the provider update has not been run. To update the Print Date, run the appropriate Postage and Pages – Not Paid report.

Retrieval Criteria
To display on this report, there must be a row in the Postage and Pages section on the Record Tracking window. The Print Date field can be filled or blank.

Postage and Pages Not Paid
This report displays the postage and pages costs for all unpaid providers (HSP, Physician, and MA), and allows you to update the Print date for the postage and pages row that was entered on the Record Tracking window in the Postage and Pages section.

All MA providers will display on their own report with a heading of Postage and Pages – Not Paid MA. HSP and Physician providers will display on a report with a heading Postage and Pages – Not Paid Excluding MA. A provider total by Finance Category follows each provider listing and a summary for all providers is included on a summary window.

If any MA providers display on the report, and you select the Update Print Date With

Current Date icon, , the MA providers will have their Print Date updated on the Record Tracking window in the Postage and Pages section.

If you need a separate report for the MA providers or the HSP or Physician providers, select the Postage and Pages – Not Paid MA (Provider Break) report or the Postage and Pages – Not Paid Excluding MA (Provider Break) report. Both of these reports are available in the Reports drop-down list.

Retrieval Criteria
To display on this report, the Print Date field in the Postage and Pages section on the Record Tracking window is blank.

Postage and Pages Not Paid MA (Provider Break)
This report displays the postage and page costs for all unpaid MA providers and allows you to update the Print Date on the Record Tracking window in the Postage and Pages section. The page break is by provider. A provider total by Finance Category follows each provider listing and a summary for all providers is included on a summary window.

Retrieval Criteria
To display on this report, the Print Date field in the Postage and Pages section on the Record Tracking window is blank.

Postage and Pages Not Paid Excluding MA (Provider Break)

This report displays the postage and page costs for all unpaid providers except MA and allows you to update the Print Date on the Record Tracking window in the Postage and Pages section. The page break is by provider. A provider total by Finance Category follows each provider listing and a summary for all providers is included on a summary window.

Retrieval Criteria

To display on this report, the Print Date field in the Postage and Pages section on the Record Tracking window is blank.

Postage and Pages Paid (Provider Break)

This report displays the postage and page costs for all paid providers including HSP, Physician, and MA. The page break is by provider. A provider total by Finance Category follows each provider listing and a summary for all providers is included on a summary window.

Retrieval Criteria

To display on this report, the Print Date field in the Postage and Pages section on the Record Tracking window is not blank.

Postage and Pages Report Definitions

Field	Description
Date	The date the report was run.
Page	The number of pages in the report.
Provider ID	The Health Service Provider Identification Number. This is the unique identification number for the facility. If the provider is a physician, the physician UPIN/NPI will display.
Provider Name	The name of the health service provider. If the provider is a physician, the physician name will display. The provider name will display if it has been entered in the Program Resource System (PRS).
HSP NPI	The National Provider Identifier for the facility.
Patient ID	The patient identification number also referred to as HIC (health insurance claim number).
Patient Name	The first and last name of the beneficiary.
Service From	The first day of the institutional provider or physician/supplier's billing statement for services rendered to the beneficiary.
Service Thru	The last day of the institutional provider or physician/supplier's billing statement for services rendered to the beneficiary.
I/O	Indicates if the record was inpatient, outpatient, Medicare Part B, or Preadmission. It indicates the source of the CMS data.
MA ID	The identification number for the Medicare Advantage plan assigned by CMS.

Field	Description
Page Rate	The reimbursement rate for each page of copying completed by the facility or M+C when sending in medical record documentation. The current page rate for the provider can be found on the Records Tracking window in the Postage and Pages section.
Number of Pages	The number of pages of the component of the medical record.
Page Cost	A calculation of the Page Rate times the Number of Pages.
Postage Cost	The cost of the postage.
Total Cost	The total cost of postage and pages. The amount displayed is calculated from the information entered in the Postage Cost, Number of Pages, and Page Rate fields. Postage Cost + (number of pages X page rate) = Total Cost.
Print Date	The date the postage and pages report is run. When the Postage and Pages Not Paid report is run and the Update Print Date with Current Date icon is selected, the print date is automatically entered in this field.
Claim Key	An artificial sequential number generated by the system when the record is first added.
Date Added	The date the postage and pages row is added to the Postage Information section of the Record Tracking window.
Finance Category	Identifies the finance category the cost is to be assigned to as determined by the Select Reason on the Selection Reasons window. If there is more than one selection reason for a claim key, the Select Reason with the closest Select Date equal to or prior to the Postage and Pages Added Date will be used to determine the finance category. The finance categories are: Task 1.1 Quality of Care Reviews Task 1.2 Utilization Review Task 1.3a.i Hospital Based Notice Appeals Task 1.3a.ii Fee-for-Service Expedited Appeals Task 1.3a.iii Medicare Advantage Fast Track Appeals Task 1.4a.i EMTALA: 5-day Reviews Task 1.4a.ii EMTALA: 60-day Reviews Task 1.5 Assistant at Cataract Task 1.1 QCR or Task 1.2 UR Task 2 Quality Improvement Activities (QIA) Task 4 Sanction Activities Other Non-Review Activities 3aP Post (Review level 3P or 4P) 3aS Sanction (Select Reason 240 or Review level 5P)

Field	Description
Provider Summary	A summary of the number of postage and pages rows and calculations of the postage costs for the listed provider by finance category. The finance categories are: Task 1.1 Quality of Care Reviews Task 1.2 Utilization Review Task 1.3a.i Hospital Based Notice Appeals Task 1.3a.ii Fee-for-Service Expedited Appeals Task 1.3a.iii Medicare Advantage Fast Track Appeals Task 1.4a.i EMTALA: 5-day Reviews Task 1.4a.ii EMTALA: 60-day Reviews Task 1.5 Assistant at Cataract Task 1.1 QCR or Task 1.2 UR Task 2 Quality Improvement Activities (QIA) Task 4 Sanction Activities Other Non-Review Activities 3aP Post (Review level 3P or 4P) 3aS Sanction (Select Reason 240 or Review level 5P)
Summary for All Providers	A separate Summary page will display when the Print Preview - Summary icon is selected from the Print Preview page of the report. The total number of postage and pages rows, calculation of pages and costs display for all rows and providers listed in the report, according to the finance category.

♫ If the Select Reason for Which Costs Were Incurred is marked as an Invalid Select Reason on the Selection Reasons window, the Finance Category for that claim key will be blank and the cost for that row will not be included in the summary sections.

Physician Reviewer Reports

Physician Reviewer Not Paid with Page Break
This report displays the physicians whose Physician Paid Date on the Reviewer Time window has not been updated. The page break is by physician reviewer. Review Time by Finance Category and Total Review Time is provided for each physician reviewer.

Retrieval Criteria
To display on this report, the Physician Paid Date field on the Reviewer Time window is blank.

Physician Reviewer Paid with Page Break
This report displays the physicians whose Physician Paid Date on the Reviewer Time window has been updated. The page break is by physician reviewer. Review Time by Finance Category and Total Review Time is provided.

Retrieval Criteria
To display on this report, the Physician Paid Date field on the Reviewer Time window is not blank.

Physician Reviewer Report Definitions

Field	Description
Date	The date the report was run.
Page	The number of pages in the report.
State	The QIO state.
Physician Reviewer Name	The first and last name of the physician reviewer. The name is pulled from PRS and is associated with the UPIN entered on the Staff Maintenance table. The reports do not pull the name entered in the Staff Maintenance table.
Physician Reviewer UPIN	The UPIN (unique physician identification number) of the physician. The correct UPIN must be entered on the Staff Maintenance window in the Maintenance module. A user with the ADMIN role can add or update the Physician UPIN field on the Staff Maintenance window.
Encoded Number	The unique physician encoded number assigned to each physician when they were added to PRS. This number cannot be changed.
Reviewer ID	The staff identification number of the physician reviewer. This is the identification number entered on the Staff Maintenance window in the Maintenance module for the physician reviewer.
Physician NPI	The National Provider Identifier for the Physician Reviewer.
Finance Category	Identifies the finance category the cost is to be assigned to as determined by the Select Reason on the Selection Reasons window. If there is more than one selection reason for a claim key, the Select Reason with the closest Select Date equal to or prior to the Reviewer Time Added Date will be used to determine the finance category. The finance categories are: Task 1.1 Quality of Care Reviews Task 1.2 Utilization Review Task 1.3a.i Hospital Based Notice Appeals Task 1.3a.ii Fee-for-Service Expedited Appeals Task 1.3a.iii Medicare Advantage Fast Track Appeals Task 1.4a.i EMTALA: 5-day Reviews Task 1.4a.ii EMTALA: 60-day Reviews Task 1.5 Assistant at Cataract Task 1.1 QCR or Task 1.2 UR Task 2 Quality Improvement Activities (QIA) Task 4 Sanction Activities Other Non-Review Activities 3aP Post (Review level 3P or 4P) 3aS Sanction (Select Reason 240 or Review level 5P)
Paid Date	Date physician was paid for review. This field is updated when the Physician Not Paid report is run and the Update Paid Date icon is selected
Review Level	The code indicating the level of review performed for the physician reviewer. The information for this field is pulled from the Reviewer Time window in the Case Review module.

Field	Description
Review Date	The date of the review from the Review Date field on the PRAF window.
Review Time	The time entered for the physician reviewer on the Reviewer Time window in the Case Review module.
Claim Key	An artificial sequential number generated by the system when the record is first added.
Patient ID	The patient identification number also referred to as HIC (health insurance claim number).
Provider ID	The Health Service Provider Identification Number. This is the unique identification number for the facility.
From Date	The first day of the institutional provider or physician/supplier's billing statement for services rendered to the beneficiary.
Thru Date	The last day of the institutional provider or physician/supplier's billing statement for services rendered to the beneficiary.
I/O Indicator	Indicates if the record was inpatient, outpatient, Medicare Part B, or Preadmission. It indicates the source of the CMS data.
Physician Summary	Review time by Physician Reviewer by finance category and total review time.
Grand Total Physician Summary	Review time for all physician reviewers by finance category and total review time.

♫ If the Select Reason for Which Costs Were Incurred is marked as an Invalid Select Reason on the Selection Reasons window, the Finance Category will be blank for that claim key. The Review Time will not display in the Physician or Report Summary sections for a specific Finance Category but will be included in the Total Review Time.

Web Reports

Many reports for CRIS are now Web-based. Instructions for accessing and running these reports can be found in the Program Progress Reports manual.

1   Select **Reports|WEB Reports.**

2   Enter your User ID and Password on the Program Progress Reports page.

3   Select the desired options.

Chapter 11 - Sanction Activity

Sanction Activity

Objectives

After completing this chapter, you will be able to:

- Access and enter Sanction Activity information

- Enter, update, and delete information about Preliminary Sanction Notification, Meeting Dates, Corrective Action Plans, and Final Sanction Outcome through child tables

Overview

The Sanction Activity module displays information pertaining to sanctions that have been or are being pursued and allows you to add, delete, and modify this information as necessary. The Sanction Activity window includes four sections to facilitate documentation of sanction activity as it progresses. You will be able to add and print notes.

Sanction Activity

The Sanction Activity window allows you to enter the results of sanction activity associated with a provider, physician, or MA as you progress through each step.

Hints

1 Required fields are yellow.

2 Read-only fields are gray.

3 Optional fields are white.

4 Use the TAB key to move between fields within a section of the window.

5 Right click with your mouse on any of the fields to access the online help for the field.

6 To select a row, highlight the row by clicking on it with your mouse.

7 We do not recommend that you query by State Code.

8 When retrieving data, if no data displays check the criteria you entered and retrieve again.

9 If a field is not available for retrieving data, it will turn black when it is clicked on with the mouse.
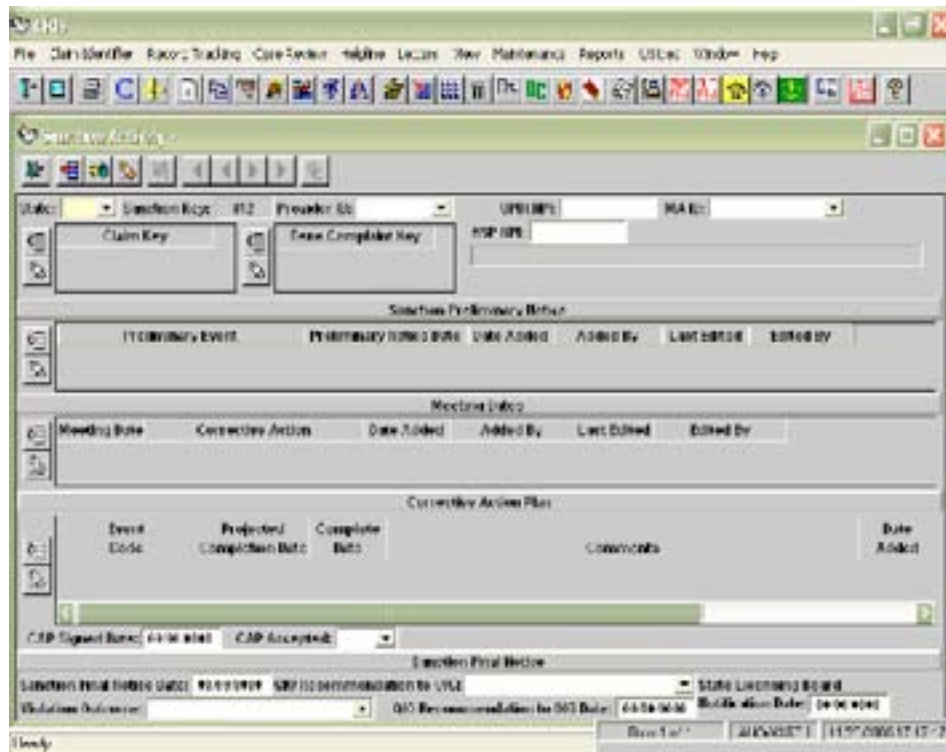
Entering Sanction Activity

1 Select the Sanction Activity Listing icon, , from the main tool bar.

The Sanction Activity Listing window displays in query mode.

2 Select the Insert icon, .

The Sanction Activity window displays.

Sanction Activity Demographic Information

The display only demographic information includes:
State Code
Sanction Key

1 Select the appropriate State Code from the drop-down list if you are a multistate QIO.

2 Enter the Provider ID, or Physician UPIN/NPI, or the MA identifier from the drop-down list. Only one field can be populated per Sanction Activity window. If a sanction applies to more than one entity, (ie: to both a provider and a physician,) separate Sanction Activity windows must be created for each.

3 Select the Save icon, .

Subsequent sections will not be enabled until the Demographic Information has been saved.

4   Claim Key and Bene Complaint Key fields are available. The Insert icon, , located to the left of each field, provides a drop-down box for selection, and you can delete a row with the Delete icon, .

Insert Sanction Preliminary Notice

1   To insert a Sanction Preliminary Notice, select the Insert icon, , directly to the left of the Sanction Preliminary Notice section.

A new row displays.

2   From the drop-down list, select the appropriate Preliminary Event.

3   Enter the Preliminary Notice Date.

4   Select the Save icon, .

Delete Sanction Preliminary Notice

1   To delete a Sanction Preliminary Notice, click your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the Sanction Preliminary Notice section.

A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row
OR
Select **No** if you do not want to delete the row.

4   Select the Save icon, .

Insert Meeting Dates

1   To insert a Meeting Date, select the Insert icon, , directly to the left of the Meeting Dates section.

A new row displays.

2   Enter the date the meeting was held with the provider/practitioner to discuss the sanction.

3   From the drop-down list, select the appropriate Corrective Action option to indicate whether a corrective action applies. If multiple meetings occur, you can record the corrective action resulting from each meeting.

> ♫   A meeting can be face-to-face, telephone conference, video conference, etc.

4   Select the Save icon, .

Delete Meeting Dates

1   To delete a Meeting Dates entry, click your mouse on the row you want to delete.

2   Select the Delete icon, .

A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row
OR
Select **NO** if you do not want to delete the row.

4   Select the Save icon, .

Insert Corrective Action Plan

1   To insert a Corrective Action Plan, select the Insert icon, , directly to the left of the Corrective Action Plan section.

A new row displays.

2   From the drop down list, select an Event Code.

3   Enter the Projected Completion Date.

4   When the Corrective Action Plan is complete, enter the Complete Date.

5   Enter any comments in the Comments field. This field allows 400 characters.

6   Select the Save icon, .

Corrective Action Plan Additional Fields

1   If applicable, enter the date the Corrective Action plan was signed.

2   From the drop-down list, select the appropriate response to indicate if the Corrective Action Plan was accepted.

3   Select the Save icon, .

Delete Corrective Action Plan

1   To delete a Corrective Action Plan, click your mouse on the row you want to delete.

2   Select the Delete icon, , directly to the left of the Corrective Action Plan section.

A message displays asking if you want to delete the row.

3   Select **Yes** to delete the row
OR
Select **No** if you do not want to delete the row.

4   Select the Save icon, .

Enter Sanction Final Notice

1   In the Sanction Final Notice Date field, enter the date of the final notice.

2   From the drop-down list, select the appropriate Violation Outcome.

3   From the drop-down list, select the appropriate QIO Recommendation to OIG, if appropriate.

4   Enter the date the QIO Recommendation was sent to the OIG, if appropriate.

5   Enter the date the State License Board was notified, if appropriate.

Delete Sanction Final Notice

To delete information from the Sanction Final Notice fields, highlight the field you wish to delete and select the Delete key on your keyboard.

Modify Sanction Activity

1   To access the Sanction Activity window to modify an existing sanction record, select the Sanction Activity icon, , from the main toolbar.

The Sanction Activity Listing window displays in Query Mode.

2   Select the Enter Criteria icon, .

Any previously entered criteria will clear.

3   Enter data into one or more of the fields on the window.

4   Select the Retrieve Query icon, .
OR
Press Enter.

Review records meeting the criteria you entered will display.
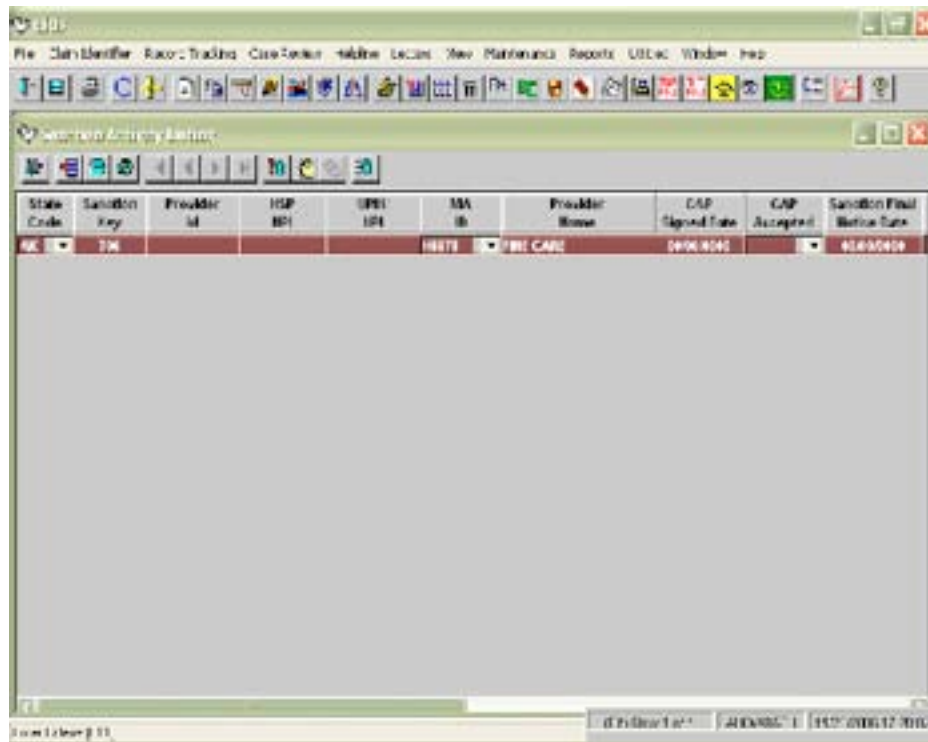
5   On the Sanction Activity Listing window, select the desired row by clicking on it with your mouse.

6   Select the Modify icon, .

The Sanction Activity window for the highlighted row displays.

7   Insert or update existing data on the Sanction Activity window.

Deleting Sanction Activity

1   To delete Sanction Activity, on the Sanction Activity Listing window, select the Sanction Activity that you wish to delete.

2   Select the Modify icon, .

3   When the chosen Sanction Activity window displays, select the Delete icon, .

A message displays asking if you want to delete the Sanction Activity.

5   Select "**Yes**" to delete the row
OR
Select "**No**" if you do not want to delete the row

6   Select the Save icon, .

Notes

The window allows you to enter free-form alphanumeric information relevant to the record.

1   To enter notes for the record you are on, select the Notes icon, ![icon] .

2   Enter up to 4,000 alphanumeric characters.

3   Select the Spell Check icon, ![icon] .

4   Select the Save icon, ![icon] .

5   To print the notes you entered, select the Print Preview icon, ![icon] . On the Print Preview window, select the Print icon, ![icon] , near the top of the window.

> ♪   If you have entered any notes for a record, a message in red will display on the Sanction Activity window stating, "Notes Exist."

Chapter 12 - Inter-Rater Reliability (IRR)

Inter-Rater Reliability (IRR)

Objectives

After completing this chapter, you should be able to:
- Access IRR Listing window
- Insert and create an IRR sample
- View the created sample and access the Process Validity and Outcome/Reliability windows
- View sample listings and replace sample selections with spare selections as necessary
- Enter validity and outcome/reliability responses for individual IRR cases
- Record reviewer time spent during IRR review
- Preview and print an IRR sample listing

Overview

The Inter-Rater Reliability module allows you to create IRR samples and complete the validity and reliability assessments for those samples. The system automatically selects the sample from completed HWDRG, HPMP, and Beneficiary Complaint case reviews and calculates the Process Validity scores for non-physician and physician reviewer results once assessment answers have been entered.

IRR Listing

The IRR Listing window allows you to query for previously selected IRR sample selections by month and year and allows you to create new samples for completed Beneficiary Complaints, HPMP, and HWDRGs (Selections Reasons 101, 102, 210, 213, and 120). From this window, you can also access the validation and reliability listing windows.

To access and view previous IRR samples:

1. Select **Case Review** | **IRR Listing**
   OR

   select the IRR Listing icon, on the main menu bar.

The IRR Listing window displays.

2. Query for existing sample selections by entering data into any of the fields on the window and selecting the Retrieve Query icon, . Cases meeting your retrieval criteria will display.
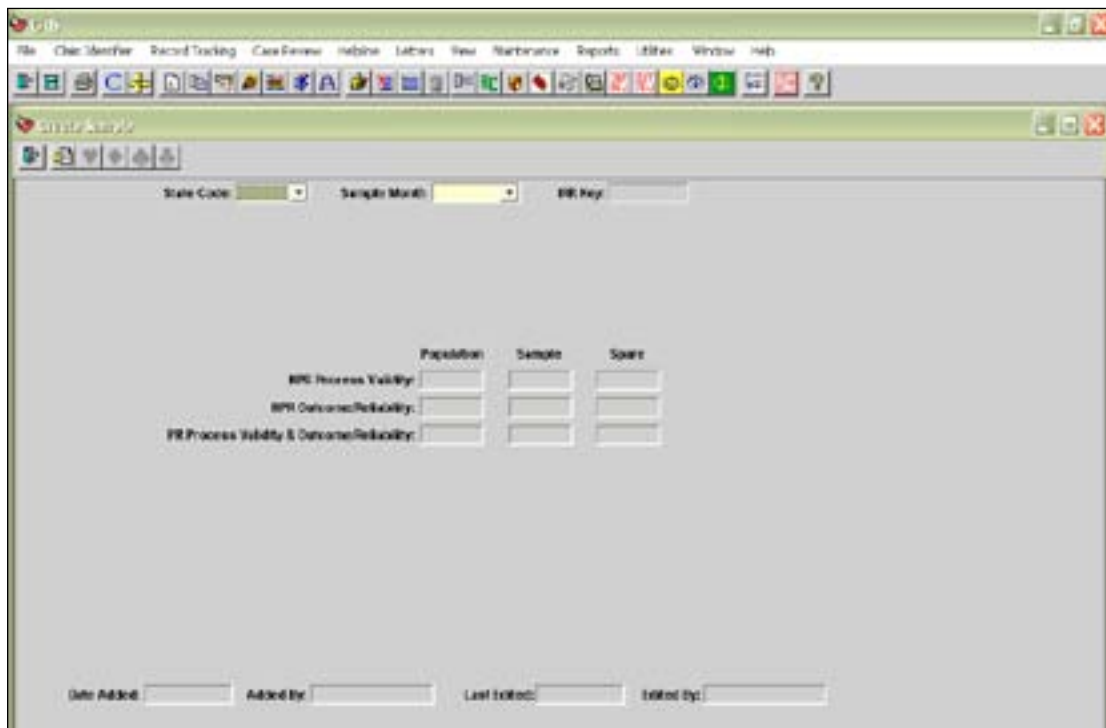
IRR Insert Sample

You must have a CRIS Admin or Update role to creat an IRR sample.

To create an IRR sample:

1. Select the IRR Insert Sample icon, , on the IRR Listing window. The Create Sample window displays.

2. Select a **State Code**, if appropriate, and choose a **Sample Month** from the available options.

> ♬ A sample can be created after the 5th of each month for cases that meet all of the sample criteria for the previous month; e.g., on August 6th, you can create an IRR sample for HWDRGs, HPMP cases, and Beneficiary Complaints that were completed in July.

3. Click the Create Sample icon, [icon]. If a Sample Month has been previously selected, the system will issue a warning message and won't allow another sample to be created for that month/year.

    The Population, Sample Size, and Spare sample types selected will display and access to the IRR NPR and PR Process Validity and Outcome/Reliability windows becomes available.

> ♬ Sample size is determined by multiplying the Population for the sample types by 3 to project a three-month review volume. A table provides sample sizes for the 3-month volume. The sample size is then divided by 3 and rounded upward to obtain the monthly sample size for the sample types.

> ♬ If the 3-month volume of eligible cases for NPR Outcome Reliability and/or PR Process Validity and Outcome Reliability exceeds 299, 299 is used as the maximum volume for determining a maximum sample size of 19 cases.

> ♬ If the 3-month volume of eligible cases for NPR Process Validity exceeds 299, 299 is used as the maximum volume for determining a maximum sample size of 13 cases.

4. Close the window or click any of the icons to access those windows and begin IRR review.

IRR Modify Sample

The IRR sample cannot truly be modified; however, you can view the population and sample sizes and access the IRR NPR and IRR PR Process Validity and Outcome/Reliability windows from this screen.

1. Click the IRR Modify Sample icon, [icon].

The Create Sample window displays.
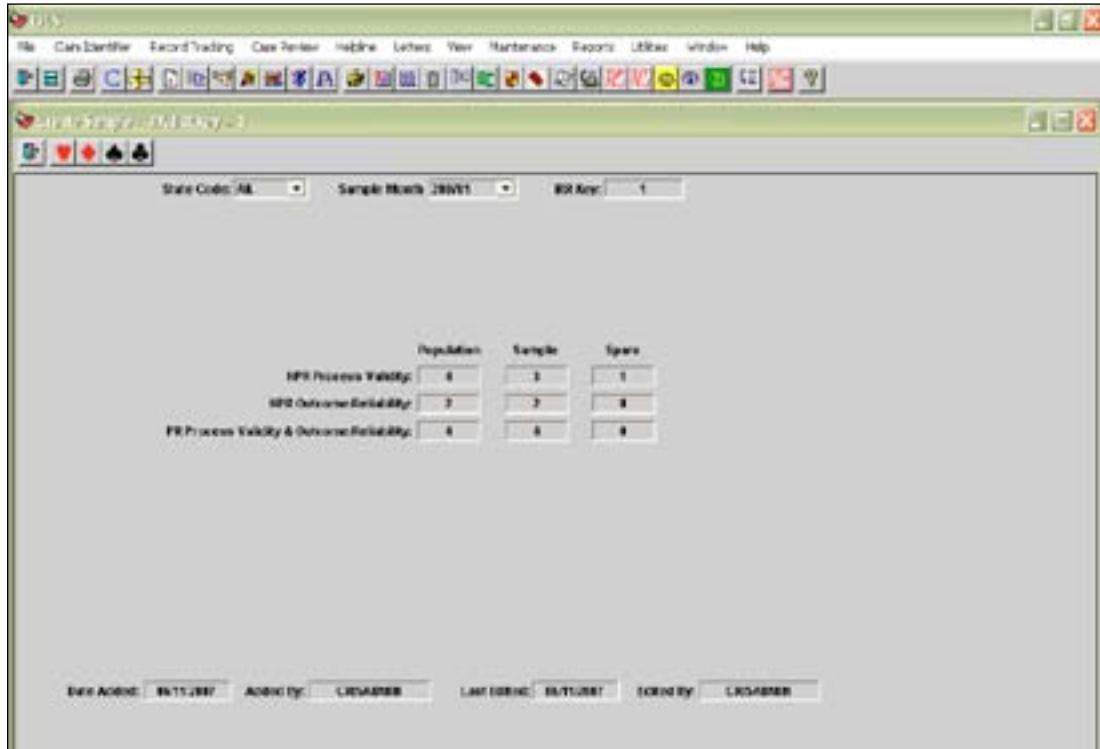
2. View the sample information for the selected IRR key.

3. Exit the window or click an icon to access the Process Validity and/or Outcome/ Reliability windows.

IRR NPR Process Validity Listing

The IRR NPR Process Validity Listing window displays all of the cases and spares selected for NPR Process Validity for the time period. This window allows you to replace up to three of the selected cases with alternative cases, if needed.

1. From the IRR Listing window, select the IRR NPR Process Validity Listing icon, [heart icon]. The NPR Process Validity Sample Listing window displays.

The Selected column indicates which claim keys are part of the original sample selection and which claim keys are spare cases. If there are enough eligible cases in the population to allow for spares, a spare case can be used to replace any of the original sample selections, as long as the sample size remains the same.

Replacing a Sample selection With a Spare

If the row has a 'Y' in the Selected field, this claim key has been selected for IRR review. An 'N' indicates the claim key is available to use as a spare case. If you need to replace one or more of the sample selections with a spare:

1. Click the Enable Select Field icon, . The entries in the **Selected** column become available.

2. Exchange a 'Y' for an 'N' by selecting 'No' from the available options. Exchange an 'N' for a 'Y' by selecting 'Yes' from the available options. You may exchange as many as three cases, if available. The number of 'Y' entries must equal the number displayed in the Sample Size column.

3. Click the Save icon, , to save your changes.

NPR Process Validity Detail

The NPR Process Validity Detail window allows you to enter your determination of the original non-physician reviewer's assessment during original review.

1. Click the NPR Process Validity Detail icon, , on the NPR Process Validity Sample Listing window.

The NPR Process Validity Sample window displays.

♫ All available fields must be filled in before a score will be calculated.

2. Select the original non-physician reviewer's name for each available review type from the list of available QIO staff members.

3. Enter the date the non-physician reviewer processed the review for that review type.

4. Select the name of the non-physician reviewer who is performing the IRR assessment from the list of available QIO staff members.

5. Enter the date the IRR assessment is being performed.

6. Select Yes, No, or N/A for each available assessment statement.

7. Click the Save icon, , to save the record and view the score. The score will not calculate unless all available fields have an entry.

8. Click the Reviewer Time icon, , and enter a row for the time spent for this IRR assessment of NPR Process Validity by selecting Review Level IR1 on the Reviewer Time Information window. Save.

9. Exit the Reviewer Time window, NPR Process Validity Sample window, and the NPR Process Validity Sample Listing window.

IRR NPR Outcome/Reliability Listing

The IRR NPR Outcome/Reliability Listing window displays all of the cases and spares selected for NPR Outcome/Reliability for the time period. This window allows you to replace up to three of the selected cases with alternative cases, if needed.

1. From the IRR Listing window, select the IRR NPR Outcome/Reliability Listing icon,

   ![red diamond icon]. The NPR Outcome/Reliability Sample Listing window displays.

   The Selected column indicates which claim keys are part of the original sample selection and which claim keys are spare cases. If there are enough eligible cases in the population to allow for spares, a spare case can be used to replace any of the original sample selections, as long as the sample size remains the same.

Replacing a Sample selection With a Spare

If the row has a 'Y' in the Selected field, this claim key has been selected for IRR review. An 'N' indicates the claim key is available to use as a spare case. If you need to replace one or more of the sample selections with a spare:

1. Click the Enable Select Field icon, ![smiley icon]. The entries in the **Selected** column become available.

2. Exchange a 'Y' for an 'N' by selecting 'No' from the available options. Exchange an 'N' for a 'Y' by selecting 'Yes' from the available options. You may exchange as many as three cases, if available. The number of 'Y' entries must equal the number displayed in the Sample Size column.

3. Click the Save icon, ![save icon], to save your changes.

NPR Outcome/Reliability Detail

The NPR Outcome/Reliability Detail window allows you to enter a determination of the correct non-physician reviewer outcome for the review types involved in the original review.

1. Click the NPR Outcome/Reliability Detail icon, , on the NPR Outcome/Reliability Sample Listing window.

   The NPR Outcome/Reliability Sample window displays. The Select Reason and review indicators display. Information about the original NPR and outcome of review do not display until the IRR reviewer's outcome information is entered and saved.

2. Select the name of the non-physician reviewer who is performing the IRR assessment from the list of available QIO staff members.

3. Enter the date the IRR assessment is being performed.

4. Select an IRR Outcome for each available review type.

5. Click the Save icon, , to save the record and view the original NPR review information.

   ♫ The system compares the original NPR outcome and the IRR outcome and indicates whether they agree or not. If there is a disagreement between the two outcomes, 'No' will display in the Coding Agreement or Utilization Agreement field.

6. If there is a disagreement between the original NPR's review outcome and the IRR NPR review outcome, enter row(s) into the Disagreement section at the bottom of the screen to explain the disagreement in review outcomes. Save.

7. Click the Reviewer Time icon, , and enter a row for the time spent for this IRR assessment of NPR Outcome/Reliability by selecting Review Level IR1 on the Reviewer Time Information window. Save.

8. Exit the Reviewer Time window, NPR Outcome/Reliability Sample window, and the NPR Outcome/Reliability Sample Listing window.

IRR PR Process Validity Listing

The IRR PR Process Validity Listing window displays all of the cases and spares selected for PR Process Validity for the time period. This window allows you to replace up to three of the selected cases with alternative cases, if needed.

1. From the IRR Listing window, select the IRR PR Process Validity Listing icon, . The PR Process Validity Sample Listing window displays.

The Selected column indicates which claim keys are part of the original sample selection and which claim keys are spare cases. If there are enough eligible cases in the population to allow for spares, a spare case can be used to replace any of the original sample selections, as long as the sample size remains the same.

Replacing a Sample selection With a Spare

If the row has a 'Y' in the Selected field, this claim key has been selected for IRR review. An 'N' indicates the claim key is available to use as a spare case. If you need to replace one or more of the sample selections with a spare:

4. Click the Enable Select Field icon, . The entries in the **Selected** column become available.

5. Exchange a 'Y' for an 'N' by selecting 'No' from the available options. Exchange an 'N' for a 'Y' by selecting 'Yes' from the available options. You may exchange as many as three cases, if available. The number of 'Y' entries must equal the number displayed in the Sample Size column.
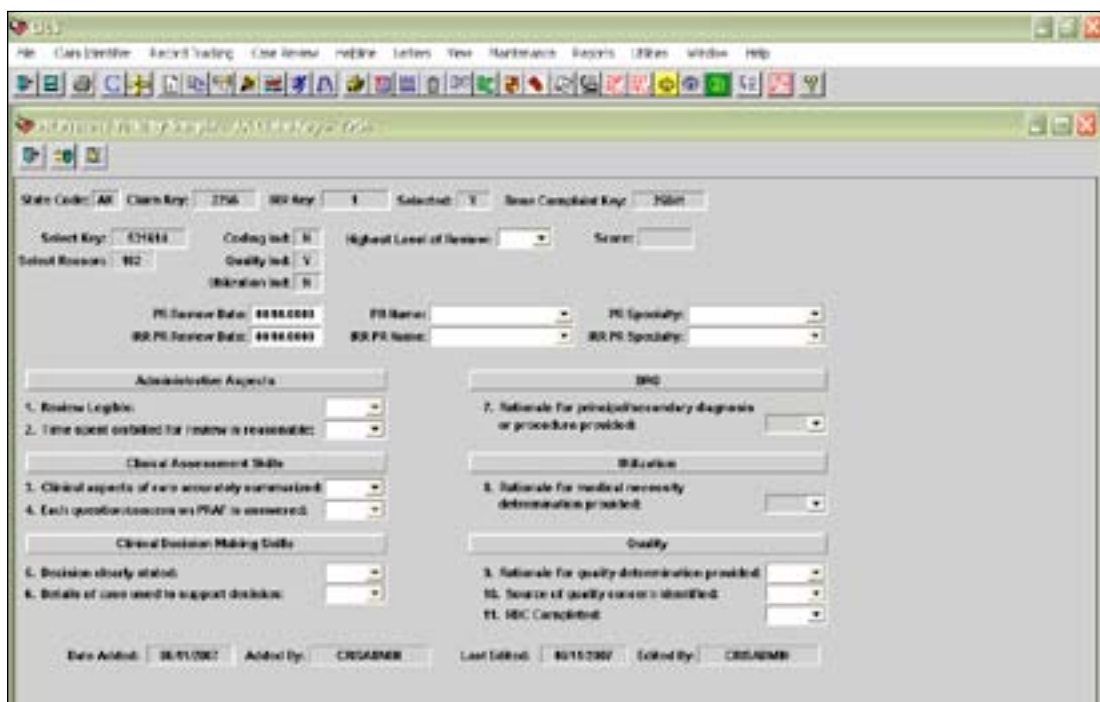
6. Click the Save icon, , to save your changes.

PR Process Validity Detail

The PR Process Validity Detail window allows you to enter the IRR physician reviewer's determination of the original physician reviewer's assessment during review.

1. Click the PR Process Validity Detail icon, , on the PR Process Validity Sample Listing window.

The PR Process Validity Sample window displays.

♪ All available fields must be filled in before a score will be calculated.

2. Select the Highest Level of Review performed during case review (excludes reconsideration or rereview).

3. Enter the date the original physician reviewer reviewed the case.

4. Select the original physician reviewer's name for each available review type from the list of available QIO staff members.

5. Enter the date the IRR assessment is being performed.

6. Select the name of the physician reviewer who is performing the IRR assessment from the list of available QIO staff members.

7. Select Yes, No, or N/A for each available assessment statement.

8. Click the Save icon, ![icon], to save the record and view the score. The score will not calculate unless all available fields have an entry.

9. Click the Reviewer Time icon, ![icon], and enter a row for the time spent for this IRR assessment of PR Process Validity by selecting an IRR Review Level option on the Reviewer Time Information window. Save.

   Exit the Reviewer Time window, PR Process Validity Sample window, and the PR Process Validity Sample Listing window.

IRR PR Outcome/Reliability Listing

The IRR PR Outcome/Reliability Listing window displays all of the cases and spares selected for PR Outcome/Reliability for the time period. This window allows you to replace up to three of the selected cases with alternative cases, if needed.

1. From the IRR Listing window, select the IRR PR Outcome/Reliability Listing

   icon, ![icon]. The PR Outcome/Reliability Sample Listing window displays.

   The Selected column indicates which claim keys are part of the original sample selection and which claim keys are spare cases. If there are enough eligible cases in the population to allow for spares, a spare case can be used to replace any of the original sample selections, as long as the sample size remains the same.

Replacing a Sample Selection With a Spare

If the row has a 'Y' in the Selected field, this claim key has been selected for IRR review. An 'N' indicates the claim key is available to use as a spare case. If you need to replace one or more of the sample selections with a spare:

1. Click the Enable Select Field icon, ![icon]. The entries in the **Selected** column become available.

2. Exchange a 'Y' for an 'N' by selecting 'No' from the available options. Exchange an 'N' for a 'Y' by selecting 'Yes' from the available options. You may exchange as many as three cases, if available. The number of 'Y' entries must equal the number displayed in the Sample Size column.

Click the Save icon, , to save your changes.

PR Outcome/Reliability Detail

The PR Outcome/Reliability Detail window allows for entry of the IRR physician reviewer's determination of the outcome for the review types involved in the original review.

1. Click the PR Outcome/Reliability Detail icon, , on the PR Outcome/Reliability Sample Listing window.

The PR Outcome/Reliability Sample window displays. The Select Reason and review indicators display.

2. Select the name and specialty of the physician reviewer who originally performed the review for the case.

3. If Quality review was performed, enter the Response Determination.

4. Select the original review outcome in the Outcome field for each available review type.

5. Enter date(s) of IRR PR review, IRR PR name and Specialty.

6. If Quality review was performed, enter the IRR PR's Response Determination.

7. Enter the IRR PR's Outcome determination for each review type.

8. Click the Save icon, , to save the record.

> ♫ The system compares the original PR Response Determination and review Outcome and the IRR PR Response Determination and review Outcome and indicates whether they agree or not. If there is a disagreement between the outcomes, 'N' will display in the Agreement and/or Response Determination Agreement field.

9. If there is a disagreement between the original Response Determination and/or review Outcome and the IRR PR Response Determination and/or review Outcome, enter row(s) into the Disagreement section at the bottom of the screen to explain the disagreement in review outcomes. Save.

10. Click the Reviewer Time icon, , and enter a row for the time spent for this IRR assessment of PR Process Validity by selecting an IRR Review Level option on the Reviewer Time Information window. Save.

11. Exit the Reviewer Time window, PR Outcome/Reliability Sample window, and the PR Outcome/Reliability Sample Listing window.

Print Preview IRR Select Report

The Print Preview IRR Select Report displays detailed information regarding the claim keys involved in the IRR sample selected. The report does not display IRR outcomes.

1. Query for the Sample Month on the IRR Listing window that you wish to display on your report.

2. Click the Print Preview IRR Select Report icon, .

The Print Preview IRR Select Report screen displays detailed information for the sample selections.

Chapter 13 - Quality Improvement Activity

Quality Improvement Activity

Objectives

After completing this chapter, you will be able to:

- Access the QIA (Quality Improvement Activity) Listing window and query for QIA records

- Insert new QIA records

- Complete data entry for a QIA record

- Access the QIA Master Listing window and query for QIA Master records

- Insert new QIA Master records

- Complete data entry for a QIA Master record

Overview

The Quality Improvement Activity module is used to record information related to improvement plans requested from providers or physicians.

The Claim Keys, Beneficiary Complaint Keys, and trending information that led to the QIA can be recorded.

Information regarding the request, monitoring, and resolution of the QIA can be entered.

Multiple QIA records may be grouped together by creating a QIA Master record.

QIA Listing

The Quality Improvement Activity Listing window contains all of the records added to the QIA module. The QIA module allows you to enter new QIA records and update or modify data on existing records.

1. To access the Quality Improvement Activity Listing window, select **Case Review|QIA Listing**

    OR

    Select the QIA Listing icon, .
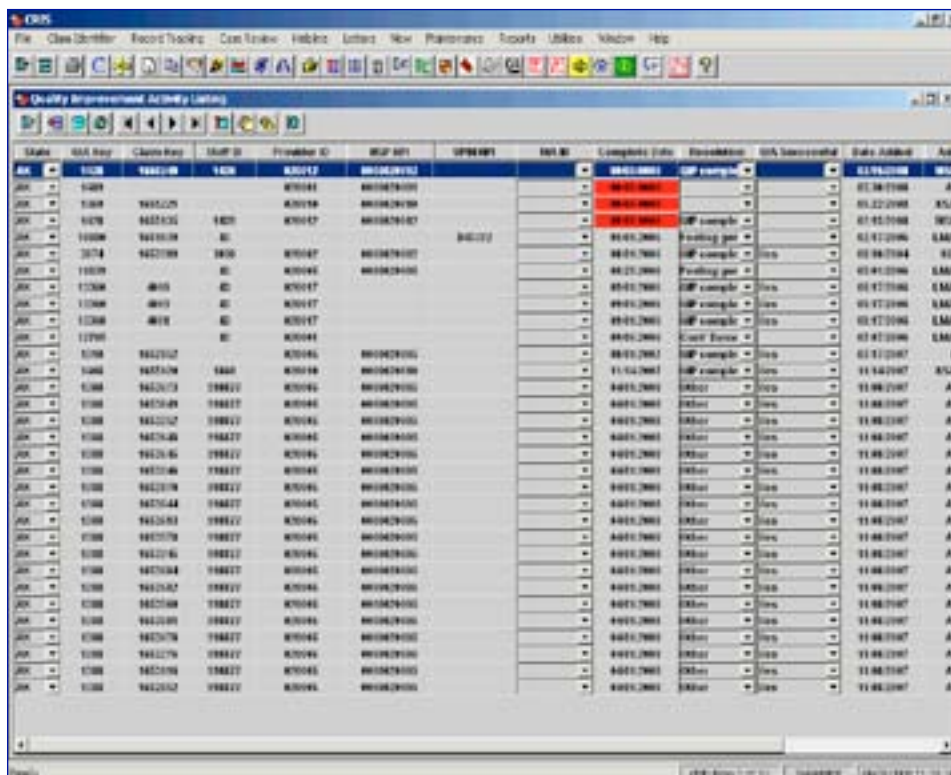
The Quality Improvement Activity Listing window displays in Query Mode.

2. Select the Enter Criteria icon, ![icon].

   Any previously entered criteria will clear.

3. Enter data into one or more of the fields.

4. Select the Retrieve Query icon, ![icon].
   OR
   Press ENTER.

   QIA records meeting the criteria you entered will display.

Insert QIA Record

The QIA window allows you to insert a new QIA record, delete a QIA record, and add or modify data for an existing record.

1. To insert a new QIA record, select the Insert icon, ![icon], from the Quality Improvement Activity Listing window.

A blank QIA window displays.

QIA Demographic Information

The Demographic section allows entry of the provider, physician or MA that has been identi-fied as needing a quality improvement activity.

Multiple Claim Keys and Bene Comp Keys as well as the category of the QIA can be added.

1. Select a State Code if you are a multi-state QIO. If you are a single-state QIO, your State Code will be populated by the system.

2. The system will create a unique QIA Key.

3. Enter a Provider ID, HSP NPI, UPIN/NPI, or MA ID. A list of valid Provider and MA IDs for your state displays in the drop-down list. The Name field will automatically populate.

   ♫ You will only be able to enter data into one of these fields.

   ♫ If you enter an invalid Physician UPIN/NPI (one that is not in PRS), 'UPIN/NPI Not Found' will display below this field.

4. Select a Staff ID name from the drop-down list.

5. Enter a brief description of the QIA in the QIA Description field (200 character maximum).

♫ You can expand this field for data entry by selecting the Expand QIA Description icon, , from the QIA window toolbar.

6. To enter a Claim Key, select the Insert icon, , to the left of the Claim Key field. The drop-down list displays all Claim Keys associated with the Provider ID, Physician UPIN, or MA ID on this record. Select a claim key by clicking on it. Manual entry is not advised. Multiple Claim Key rows can be entered.

7. To delete an entry, highlight the row to be deleted, select the Delete icon, , to the left of the Claim Key field, and select **Yes** at the "Delete row X for Claim Key?" prompt.

8. To enter a Bene Complaint Key, select the Insert icon, , to the left of the Bene Complaint Key field. The drop-down list displays all Bene Complaint Keys associated with the Provider ID, Physician UPIN/NPI, or MA ID on this record. Multiple Bene Complaint Keys can be entered.

♫ If the Beneificiary Claim Key field has a value, at least one Claim Key field entry is required.

9. To delete an entry, highlight the row to be deleted, select the Delete icon, , to the left of the Bene Complaint Key field, and select **Yes** at the "Delete row X for Complaint Key?" prompt.

10. To enter a QIA Category, select the Insert icon, , to the left of the QIA Category field. Select a QIA Category option from the drop-down list. At least one category entry is required. Multiple Categories can be selected.

11. To delete an entry, highlight the row to be deleted, select the Delete icon, , to the left of the QIA Category field, and select **Yes** at the "Delete row X for Category?" prompt. This will delete both the QIA category and the associated QIA Type entry.

12. To enter a QIA Type, select an option from the drop-down list. The QIA Type options listed in the drop-down list are based on the QIA Category option selected.

Only one QIA Type option can be selected for each QIA Category selected. A QIA Type is required for each QIA Category selected.

13. The Notes icon, , on the QIA window toolbar allows you to access a window to enter free-form notes regarding the QIA record. Each Notes section holds a maximum of 4,000 alphanumeric characters. You may insert additional notes sections if more documentation is needed.

QIA Trending

The QIA Trending section is used to enter information about how the need for a quality improvement activity was identified.
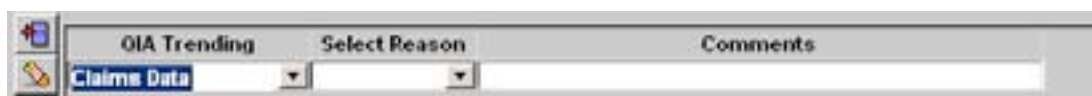
1. To document QIA trending information, select the Insert icon, , to the left of the QIA Trending section. A new row displays.

2. Select a Trending option from the drop-down list.

     ♫ If **Other** is selected, documentation in the Trending Comments field is required.

3. Select a Select Reason from the drop-down list if desired.

4. To delete an entry, highlight the row to be deleted, select the Delete icon, , to the left of the QIA Trending field, and select **Yes** at the "Delete row X for Trending?" prompt.

5. In the Comments field, enter free-form text up to 200 characters. You can expand the field for ease of documentation by selecting the Expand Comments icon, , to the left of the Trending section.

QIO Approach

The QIO Approach field is used to document the approach the QIO uses with the Quality Improvement Acitivity.
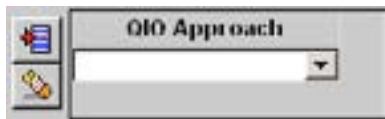
1. To document QIO Approach, select the insert icon, , to the left of the field. A new row displays.

2. Select an option from the drop-down list. Multiples are allowed.

Quality Improvement Activity

The Quality Improvement Activity section is used to enter information about the initial request for a quality improvement activity.
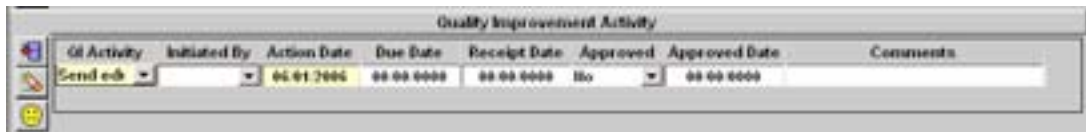
1. To enter information in the Quality Improvement Activity section, select the Insert icon, , to the left of the Quality Improvement Activity section. A new row displays.

2. Select an option from the QI Activity drop-down list. At least one QI Activity entry is required.

     ♫ If Other is selected, documentation in the Quality Improvement Activity Comments is required.

3. Select an option from the drop-down list in the Initiated By field.
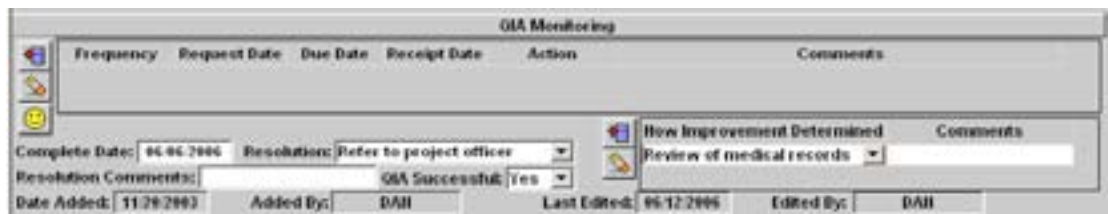
4. Enter the date the QI Activity was completed in the Action Date field. This is a required field.

5. Enter the date the QI Activity is due to the QIO in the Due Date field.

6. When the QI Activity is received, enter the date in the Receipt Date field.

7. When the QI Activity has been approved, select **Yes** in the Approved field.

8. Enter the date the QI Activity was approved. The date is required if you selected **Yes** in the Approved field.

> ♫ If you selected **No** in the Approved field, you will not be able to document an Approved Date.

9. Enter the goal for the QI Activity. This is a free-form text field with a 50 character capacity.

10. In the Comments field enter free-form text up to 200 characters. You can expand the field for ease of documentation by selecting the Expand Comments icon, , to the left of the Quality Improvement Activity section.

11. To delete an entry, highlight the row to be deleted, select the Delete icon, , to the left of the QI Activity field, and select **Yes** at the "Delete row X for Intitial Request?" prompt.

QIA Monitoring

The QIA Monitoring section is used to record the follow-up monitoring for the quality improvement activity.

1. To enter QIA Monitoring information, select the Insert icon, , to the left of the QIA Monitoring section. A new row displays.

2. Select an option from the drop-down list in the Frequency field to indicate how often the plan is monitored.

> ♫ If **Other** is selected, documentation in the QIA Monitoring Comments field is required.

3. Enter the date the activity being monitored is requested in the Request Date field.

4. Enter the date the requested activity is due in the Due Date field.

5. When the activity being monitored is received, enter the date in the Receipt Date field.

6. Indicate the action taken regarding the monitored activity in the Action field by selecting an option from the drop-down list.

> ♫ If there is a value in the Receipt Date field, the Action field is required.

7. In the Comments field, enter free-form text up to 200 characters. You can expand the field for ease of documentation by selecting the Expand Comments icon, , to the left of the QIA Monitoring section.

8. To delete an entry, highlight the row to be deleted, select the Delete icon, ,to the left of the QIA Monitoring field, and select **Yes** at the "Delete row X for Monitoring?" prompt.

QIA Resolution

When the provider has successfully completed the quality improvment activity, information is entered in the Resolution fields.

1. Enter the date the activity was completed in the Complete Date field.

> ♫ The Complete Date field remains protected until a Resolution value has been entered.

2. Enter the final action taken by the QIO at the completion of the Quality Improvement Activity in the Resolution field by selecting an option from the drop-down list.

> ♫ If **Other** is selected, documentation is required in the Resolution Comments field.

3. The Resolution Comments field holds up to 200 characters and can be expanded for ease of documentation by clicking on the Expand Resolution Comments icon, , to the left of the QIA Monitoring window.

4. Enter whether the QIA was successful by choosing an option from the drop-down list.

> ♫ If the QIA Successful field has a value of **Yes**, the How Improvement Determined field is required.

5. Select an option from the drop-down list in the How Improvement Determined field to indicate the means of how improvement was determined. Multiple How Improvement Determined options can be selected.

> ♫ If **Other** is selected, documentation in the How Improvement Determined Comments field is required.

Modify QIA Record

An existing QIA record can be modified or updated at any time.

1. To update an existing record, highlight the desired row on the Quality Improvement Activity Listing window, by clicking on it with the mouse.

OR

Select the Modify icon, .

The QIA window displays.

2. On the QIA window, insert or update existing data.

3. Select the Save icon, .

4. Select the Close Window icon, .

Delete QIA Record

A QIA record can be deleted. If the record has been deleted, the data cannot be retrieved.

1. To delete a QIA record, highlight the desired row on the Quality Improvement Activity Listing window by clicking on it with the mouse.

2. Select the Modify icon, .

The QIA window displays.

3. Select the Delete icon, . A message displays asking if you want to delete the entire record.

4. Select **Yes** to delete the record.
OR
Select **No** if you do not want to delete the record.

5. Select the Save icon, .

6. Select the Close Window icon, .

QIA Master

The QIA Master module allows you to group together QIA records that have an association with each other. An example of this would be QIA records that are part of a system-wide change effort.
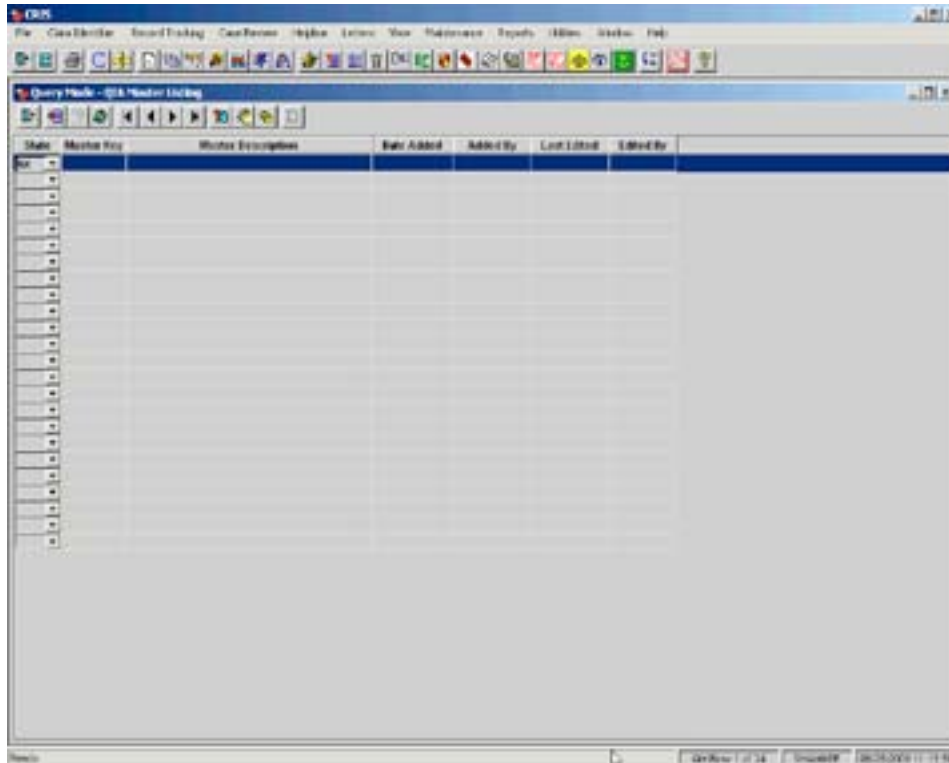
QIA Master Listing

The QIA Master Listing window allows you to insert new QIA Master records and to retrieve existing records.

Insert a QIA Master Record

1. To insert a new QIA Master record, select **Case Review** | **QIA Master Listing**

2. On the QIA Master Listing window, select the Insert icon, .

A new QIA Master record will display.
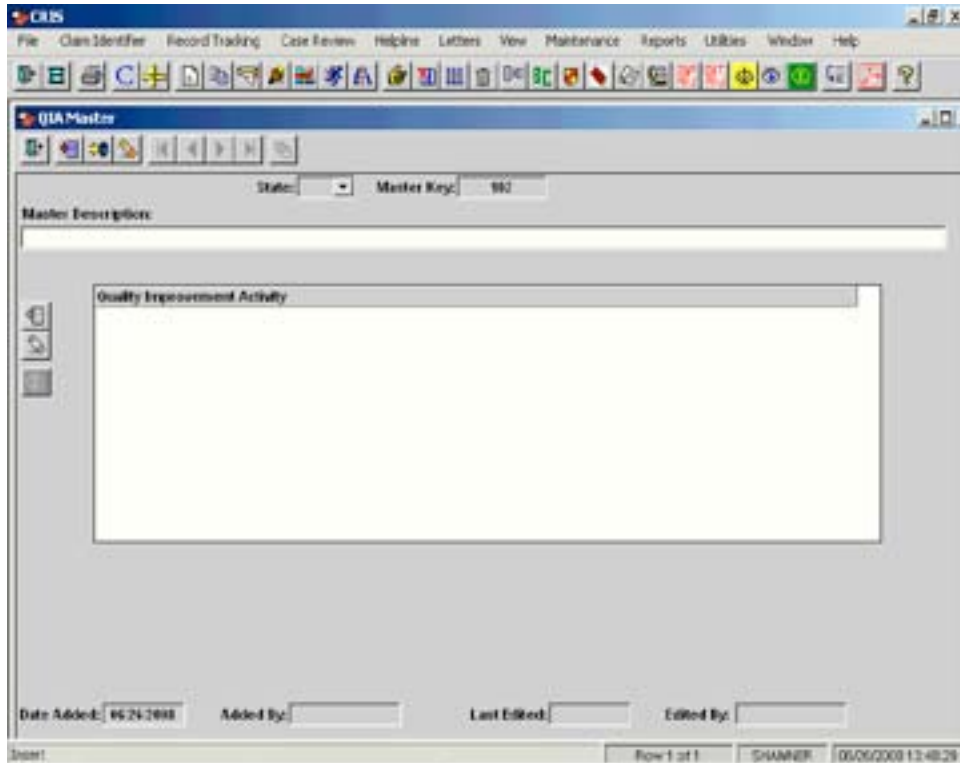
3. State Code is the only required field on the QIA Master window. If you are a single state QIO, this field will be pre-populated. If you are a multi-state QIO, you will be required to select a State Code from the drop-down list.

4. Document the reason for the QIA Master record in the Master Description field.

Insert Quality Improvement Activity Records

1. To add QIA records to the Master QIA, select the Insert icon, ▣.

2. Click on the arrow to display all QIA records for your state.
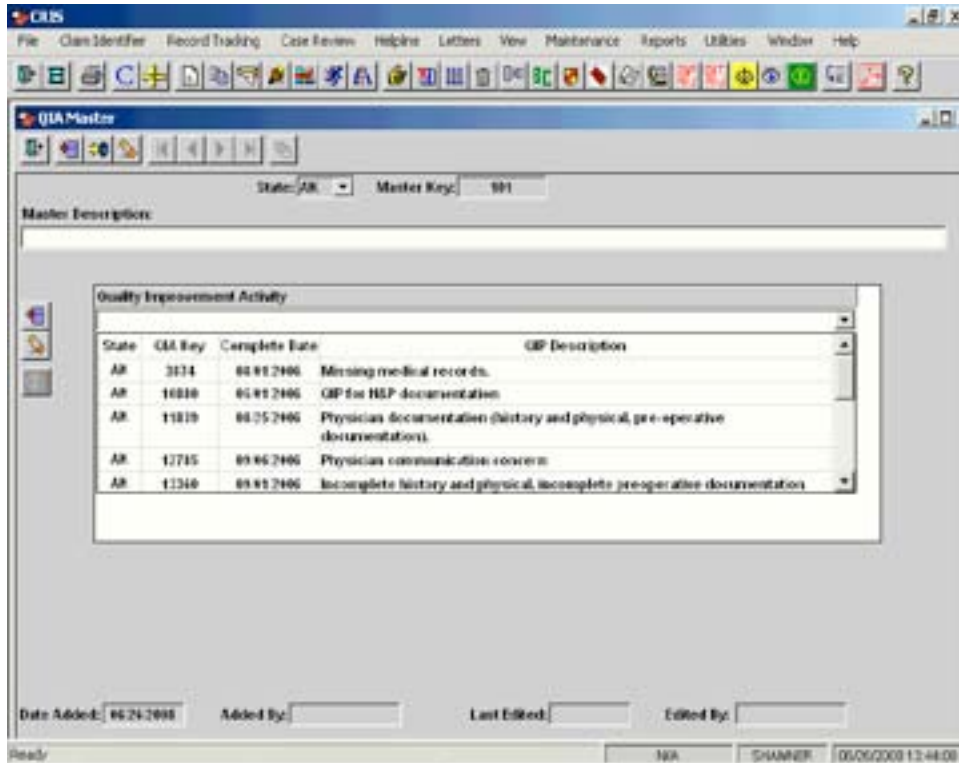
3. Select the desired record from the drop-down list by clicking on it.

4. Insert a new row for each QIA record you wish to add to the Master QIA.

5. Select the Save icon, ▣.

> ♫ You may link to a QIA record by clicking on the desired QIA record to highlight the row and selecting the QIA icon, ▣, to the left of the Quality Improvement Activity field.

6. To return to the Master QIA window, select the Close Window icon, ▣, on the QIA window.

Delete Quality Improvement Activity Records

1. To delete QIA records from the Master QIA, click with your mouse on the desired QIA record to highlight the row and select the Delete icon, at the left of the Quality Improvement Activity field.

> ♫ Deleting a child record from the Master QIA will not delete the original QIA record.

Delete a QIA Master Record

1. To delete a QIA Master record, select the Delete icon, at the top of the QIA Master window.

Appendices

Appendix A

Import File Layouts

The import file must be ASCII tab-delimited format. Enter all dates as 'mm/dd/yyyy'. Time stamps may also be entered in the date field if desired, in the hh:mm:ss format. Do not leave the optional fields blank - they must be nulls. (If there is no entry for a field, press TAB to go to the next field.) If the entry in the field is less than the allowed number of characters, enter the characters you have and then press Tab. Do not enter spaces. For complete field descriptions, see the CRIS User's Guide. Enter the data in upper case.

NOTE: Multi-state QIOs must import one state at a time.

Batch Record Update Layout

Parent table (np_sdps.cris_rectrk_component):

Column Name	Window Name	Data Type	Description
claim_key	Claim Key	Number	An artificial sequential number generated by the system when the record is first added. Use this number to track the medical record.
component_cd	Component Code	VARCHAR2(4)	The section(s) of the medical record, which is used in review of the record. The following component options are available to all QIOs. Additional component options can be added in the Maintenance module in the Record Tracking Maintenance. 0001 - Complete Record 0002 - Review Worksheet 0003 - X-Ray 0004 - Face Sheet 0005 - Emergency Room 0006 - Laboratory Studies 0007 - History and Physical 0008 - Correspondence File

Batch Postage and Pages Update Layout

Parent tables (np_sdps.cris_rectrk_postage and np_sdps.cris_rectrk_component):

Column Name	Window Name	Data Type	Description
claim_key	Claim Key	Number	An artificial sequential number generated by the system when the record is first added. Use this number to track the medical record.
component_cd	Component Code	VARCHAR2(4)	The section(s) of the medical record, which is used in review of the record. The following component options are available to all QIOs. Additional component options can be added in the Maintenance module in the Record Tracking Maintenance. 0001 - Complete Record 0002 - Review Worksheet 0003 - X-Ray 0004 - Face Sheet 0005 - Emergency Room 0006 - Laboratory Studies 0007 - History and Physical 0008 - Correspondence File
number_pages	Number Pages	Number	The number of pages of the component of the medical record.
postage_cost	Postage Cost	Number	The cost of the postage.

Claim Identifier Import Layout

Parent table (np_sdps.cris_claim_identifier):

Column Name	Window Name	Data Type	Description
bene_clm_num	Patient ID	VARCHAR2(12)	Required: The patient identification number also referred to as HIC (health insurance claim number).
hsp_id	Provider ID	VARCHAR2(15)	Either a Provider ID or Physician UPIN is required. The Health Service Provider Identification Number. This is the unique identification number for the facility.
hse_clm_from_dt	From Date	Date	Required: The first day of the institutional provider's or physician/ supplier's billing statement for services rendered to the beneficiary.
hse_clm_thru_dt	Thru Date	Date	Required: The last day of the institutional provider's or physician/supplier's billing statement for services rendered to the beneficiary.
hse_inpat_outpat_ind	I/O Ind	VARCHAR2(1)	Indicates if the record was inpatient, outpatient, or Medicare Part B.
physician_upin	Physician UPIN	VARCHAR2(12)	Either a Physician UPIN or a Provider ID is required. The UPIN number of the physician.
qio_control_nbr	QIO Control Number	VARCHAR2(20)	The QIO's own unique internal record identifier. This QIO Control Number is used in Record Tracking only.
storage_nbr	Storage Nbr	VARCHAR2(12)	The number of the box or storage area in which the medical record is located if the medical record is in storage. The QIO assigns the storage number.
file_id	File ID	VARCHAR2(12)	Identification number of the file. The QIO assigns ID the file.
medical_record_nbr	Medical Record Nbr	VARCHAR2(17)	The number of the medical record assigned by the provider.
npi	HSP NPI	VARCHAR2 (10)	National Provider Identification (NPI). The unique health identifier for health care providers.

Appendix B

ACRONYMS

ADR ....Alternative Dispute Resolution
AHRQ ....Agency for Healthcare Research and Quality
AHQA ....The American Health Quality Association
ALJ .... Administrative Law Judge
AMA .... American Medical Association
ASC .... Ambulatory Surgery Center
CDC ....Center for Disease Control and Prevention
CD—ROM ....Compact Disk —Read Only Memory
CEU .... Continuing Education Unit
CME .... Continuing Medical Education
CMS ....Centers for Medicare & Medicaid Services
CO .... (CMS) Central Office
COTS ....Commercial Off–The–Shelf
CQI ....Continuous Quality Improvement
DBA ....Database Administrator
DRG .... Diagnosis Related Group
ESRD ....End Stage Renal Disease
FACCT.. Foundation for Accountability
FI ....Fiscal Intermediary
GHO ....Group Health Organization
GQS .... Generic Quality Screen
GUI ....Graphical User Interface
HCF .... Health Care Facility
HCFA .... Health Care Financing Administration (Name changed to CMS--see above)
HCPCS ....Healthcare Common Procedure Coding System
HCPOTP ....Health Care Professionals Other Than Physicians
HCQIP .... Health Care Quality Improvement Program
HHA ....Home Health Agency
HIC ....Health Insurance Claim Number
HINN ....Hospital Issued Notice of Noncoverage
HLC ....HINN Letter Content
HMO ....Health Maintenance Organization
HOPD .... Hospital Outpatient Department
HSE ....Health Service Encounter
HSP .... Health Service Provider
ICD-9-CM ....International Collection of Diseases 9th revision Clinical Modification
ID .... Identification
IMS ....Information Management System
IP ....Invasive Procedure
LOS ....Length of Stay
MA ....Medicare Advantage

MeSH ....Medical Subject Headings
MQIS .... Medicare Quality Indicator System
MS ....Microsoft
NONC ....Notice of Non-coverage
NPD ....Narrative Project Document
OMB .... Office of Management and Budget
PC ....Personal Computer
PDC .... Project Data Collection
PET .... Program Evaluation Team
POV ....Physician Office Visit
PRAF ....Physician Reviewer Assessment Form
PROID .... Peer Review Organization Identification
QI ....Quality Indicators
QIA .... Quality Improvement Activity
QIO .... Quality Improvement Organization
QIOSC.. QIO Support Center
QIP .... Quality Improvement Projects
RAD ....Rapid Application Development
RAM .... Random Access Memory
RDBMS .... Relational Data Base Management System
RO .... (CMS) Regional Office
SDPS ....Standard Data Processing System
SNF .... Skilled Nursing Facility
SOW ....Scope of Work
SQL .... Structured Query Language
TAN .... Treatment Authorization Number
UPIN .... Unique Physician Identification Number
URFN ....Utilization Final Notice
WAN ....Wide Area Network
WFW .... Windows For Workgroups

Appendix C

INPATIENT ADJUSTMENT
REFERENCE GUIDE

INTRODUCTION

The Inpatient Adjustment Reference Guide was developed as a quick reference guide for single-issue inpatient adjustments. This guide shows the initial automated adjustment created by the system when specific categories are confirmed. The adjustment codes for 3rd level review and re-opened technical denials are included for reference. **All adjustments after the initial adjustment must be manually entered on a new adjustment window.**

Notes that contain requirements for creating an automated adjustment may be found under each category section. For example, under Admission – Utilization Categories, the note states that when categories A01, A02, or A03 have a confirmed outcome code of C, an automated adjustment will only be created when there is also a limitation on liability category (LL1, LL2, LL3).

In order for the system to create an automated adjustment for categories A01, A02, A03, or A04, cases that will not be reimbursed under limitation on liability must have:
1) a PRAF row with a category code of A01, A02, A03, or A04 with an outcome of C <u>and</u>
2) a limitation on liability code LL1, LL2, or LL3

Cases that will be reimbursed under limitation on liability do not require adjustments.

At this time, automated adjustments are not created for Deemed Admission (Category A05), Notice of Non-coverage Review (Categories A07, A08, A09), and Other Utilization Category A99. All adjustments for these categories must be manually entered on the Inpatient Adjustment window. Automated adjustments are not created for MA claims.

Combination adjustments must also be manually entered on the Inpatient Adjustment window. When more than one category has a confirmed concern for an individual review, you may refer to the Combination Adjustments table for the appropriate adjustment codes. The system may create an automated adjustment for one of the categories, however, the combination table should be utilized to determine if a combination adjustment should be manually entered and the automated adjustment revised or reversed.

A list of CMS' Denial Reasons and Adjustment Codes is also included for your reference.

CATEGORY DESCRIPTION	INITIAL & 2ND LEVEL CONFIRMED		3RD LEVEL OR REOPENED TECHNICAL DENIALS (Not automated. Must be manually entered.)			
			RESOLVED		CONFIRMED	
	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
Admission – Utilization Categories NOTE: When categories A01, A02, OR A03 have a confirmed outcome code of C, an automated adjustment will only be created when there is also a limitation on liability category (LL1, LL2, or LL3 category).						
A01 <u>Medical Condition</u> appears not to require inpatient hospital level of care.	C	1A See Note	R	4N	C	NO ADJ
A02 <u>Services Rendered</u> appear not to require hospital level of care.	C	1A See Note	R	4N	C	NO ADJ
A03 Admission solely for a procedure that appears unnecessary (also consider category C07).	C	1A See Note	R	4N	C	NO ADJ
Referral to Physician Reviewer for Length of Stay NOTE: When category A04 has a confirmed outcome code of C, an automated adjustment will only be created when there is also a limitation on liability code (LL1, LL2, or LL3).						
A04 Apparent unnecessary days of stay in a non-PPS admission or PPS day outlier case.	C	1B See Note	R	4N	C M	NO ADJ 5O
NOTE: The system will create a 1B adjustment if the third position of the provider number is 2, 3, 4, S, T, U, V.						

CATEGORY DESCRIPTION	INITIAL & 2ND LEVEL CONFIRMED		3RD LEVEL OR REOPENED TECHNICAL DENIALS (Not automated. Must be manually entered.)			
			RESOLVED		CONFIRMED	
	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
Question Day Outlier Days						
NOTE: When category A04 has a confirmed outcome code of C, an automated adjustment will only be created when there is also a limitation on liability code (LL1, LL2, or LL3).						
A04 Apparent unnecessary days of stay in a non-PPS admission or a PPS day outlier case.	C	ID See Note	R	4N	C M	NO ADJ 5O
NOTE: The system will create a 1D adjustment if the third position of the provider number is a zero.						
Deemed Date of Admission						
NOTE: Automated adjustments are not created for category A05. If the category is confirmed, you should manually enter a 1J adjustment on the Adjustments window.						
A05 Patient whose admission was initially noncovered subsequently developed a condition requiring covered inpatient care (assign a deemed date of admission).	C	See Note	R	4N	C M	NO ADJ 5O
Question Cost Outlier Charges						
A06 Apparent medically unnecessary day/items/services in a PPS cost outlier case.	C, P	1E	R	4N	C M	NO ADJ 5O
Notice of Non-coverage Review						
NOTE: Automated adjustments are not created for categories A07, A08, and A09. If the category is confirmed, you should manually enter an 1F adjustment on the Inpatient Adjustments window.						

| | | INITIAL & 2ND LEVEL | | 3RD LEVEL OR REOPENED TECHNICAL DENIALS (Not automated. Must be manually entered.) | | | |
| CATEGORY | DESCRIPTION | CONFIRMED | | RESOLVED | | CONFIRMED | |
		OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
A07	Hospital-issued notice of noncoverage level of care determination appears to be inappropriate if the Notice of Non-coverage given earlier than should have been given (patient liable at later date) or if Notice of Non-coverage should not have been issued (patient not liable for payment)	C	See Note	R	4N	C M	NO ADJ 5O
A08	Hospital-issued notice of noncoverage level of care determination appears appropriate, but subsequently patient required reinstatement to covered level of care	C	See Note	R	4N	C M	NO ADJ 5O
A09	Hospital-issued notice of noncoverage liability dates appear incorrect	C, P	See Note	R	4N	C M	NO ADJ 5O
Other							
NOTE:	An automatic adjustment will not be created when category A99 is confirmed. If an adjustment is required, it must be manually entered on the Adjustment window.						
A99	Other utilization concern not elsewhere classified	Optional Per Case	See Note				
Admission Denial Due to Premature/Inappropriate Discharge of the Prior Admission							
B01	Readmission apparently resulted from a previous premature discharge (also report the inappropriate /premature discharge as quality concern for first admission)	C	1A	R	4N	C	NO ADJ
B02	Readmission for services that should have been rendered during the	C	1A	R	4N	C	NO ADJ

	CATEGORY DESCRIPTION	INITIAL & 2ND LEVEL CONFIRMED		3RD LEVEL OR REOPENED TECHNICAL DENIALS (Not automated. Must be manually entered.)			
				RESOLVED		CONFIRMED	
		OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
	previous admission						
B03	Apparent inappropriate transfer from PPS unit to non-PPS unit or vice-versa in same hospital	C	1A	R	4N	C	NO ADJ
NOTE:	**FOR CATEGORIES D01-D99, AN ADJUSTMENT WILL ONLY BE CREATED IF THE DRG CHANGES**						
Changes in Principal Diagonosis							
D01	Principal diagnosis not present at admission	C	1C	R	4N	C M	NO ADJ 5O
D02	Principal diagnosis not treated/evaluated during the stay	C	1C	R	4N	C M	NO ADJ 5O
D03	Principal diagnosis not principal reason for hospitalization	C	1C	R	4N	C M	NO ADJ 5O
D04	Principal diagnosis not billed (No longer available after 3/1/2001)						
Changes in Secondary Diagnosis							
D05	Complication/comorbidity/secondary diagnosis omitted from claim (no longer available after 8/1/2002)						
D07	Complication/comorbidity/secondary diagnosis billed, but not substantiated by record	C	1C	R	4N	C M	NO ADJ 5O
D08	Complication/comorbidity/secondary diagnosis is substantiated in record, but not billed and it changes the DRG	C, P	1C	R	4N	C M	NO ADJ 5O
Procedure Changes							
D09	Procedure omitted from claim (no longer available after 08/01/2002.)	C, P	1C	R	4N	C M	NO ADJ 5O

		INITIAL & 2ND LEVEL CONFIRMED		3RD LEVEL OR REOPENED TECHNICAL DENIALS (Not automated. Must be manually entered.)			
CATEGORY	**DESCRIPTION**			**RESOLVED**		**CONFIRMED**	
		OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
D10	Procedure billed, but not substantiated by record	C, P	1C	R	4N	C M	NO ADJ 5O
D11	Procedure is substantiated in record, but not billed, and it changes the DRG.	C, P	1C	R	4N	C M	NO ADJ 5O
D12	Procedure determined medically unnecessary, is billed, and must be removed from DRG.	C	1C	R	4N	C M	NO ADJ 5O
D18	Therapeutic procedure removed in relation to the Three Day Payment Window regulation.	C, P	1C				
Changes in Disposition, Age, Coding							
D13	Disposition status code is incorrect and changes the DRG	P	1C	R	4N	P	NO ADJ
D14	Patient's age is incorrect and changes the DRG	P	1C	R	4N	P	NO ADJ
D15	Non-clinical/non-medical errors that affect the DRG	C, P	1C	R	4N	P	NO ADJ
Deemed Admit Date							
D16	Deemed date of admission established which changes the DRG	C	1C	R	4N	C M	NO ADJ 5O
Other DRG Concern							
D99	Other DRG concern not elsewhere classified	C, P	1C	R	4N	C M	NO ADJ 5O
Disposition Status 02							
When the disposition status changes to or from 02 and the DRG does not change			1P		4N		
NOTE: If the 1P adjustment needs to be reversed, you must manually enter a							

CATEGORY DESCRIPTION	INITIAL & 2ND LEVEL CONFIRMED		3RD LEVEL OR REOPENED TECHNICAL DENIALS (Not automated. Must be manually entered.) RESOLVED		CONFIRMED	
	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
4N adjustment.						
Selected DRGs for Postacute Transfer Payment Provision-Discharge Status Changes and No DRG Changes NOTE: If the adjustment 1P needs to be reversed, you must manually enter a 4N adjustment.		1P		4N		
Technical Denial When there is a technical denial reason and a technical denial date and no reopen date on review information window.		2A		4N		

♪ Entry of Billing Error 19 or 21 will cause an adjustment to be created.

CATEGORY DESCRIPTION	INITIAL AND 2ND LEVEL CONFIRMED	
	OUTCOME CODES	ADJUSTMENT CODES
NOTE: For combination adjustments, the adjustment will reflect only one of the confirmed categories. These adjustments require manual modification on the Inpatient Adjustment window to reflect the appropriate combination adjustment code.		
At least 1 utilization category (A01-A03, B01-B03) and at least 1 DRG category (D01-D99) when the DRG does change.	Utilization Category – C and DRG Category – C, P	1T
At least 1 DRG category (D01-D99) when the DRG does change,and day outlier category A04.	DRG Category – C, P and Day Outlier Category – C	1G
At least 1 DRG category (D01-D99) when the DRG does change, and cost outlier category A06.	DRG Category – C, P and Cost Outlier Category – C, P	1H
At least 1 DRG category (D01-D99) the DRG does change, and HINN category A07, A08, or A09.	DRG Category – C, P and HINN Category – C	1I
At least 1 DRG category (D02-D99) when the DRG does change, and deemed admit date	DRG category – C, P and	1K

category A05.	Category A05 – C	

CATEGORY	INITIAL AND 2ND LEVEL	
DESCRIPTION	**CONFIRMED**	
	OUTCOME CODES	**ADJUSTMENT CODES**
Cost outlier category A06 and deemed admit date category A05.	Cost Outlier Category – C, P and Category A05 – C	1M

DENIAL REASONS AND ADJUSTMENT CODES

Reason for QIO Action:

1. Medical record reviewed, days or procedures denied, (include all DRG changes) (e.g., use for original QIO adjustment)

2. Medical record/portion of medical record not provided (e.g., technical denial)

3. Physician attestation missing (not used at this time)

4. Complete reversal of previous adjustment (e.g., reversal of technical denial)

5. Medical record reviewed (modification of previous adjustment)

QIO Review Adjustment Code:

A - Entire admission denied (admission denial, inappropriate readmission, inappropriate transfer to/from distinct part or another hospital, questionable admission from code editor, etc.)

B - Non-PPS hospital days (denied or increased).
     NOTE: If entire admission in non-PPS hospital is denied, the QIO uses code A.

C - DRG change resulting from change (single or multiple) in discharge status or any diagnosis or procedure.
     NOTE: Where change in age or sex appears appropriate, notify the FI outside the automatic notice process. Consult with FI for appropriate action to resolve age or sex discrepancies.

D - Day outlier days (denied or increased).

E - Cost outlier cost (denied or increased).

F - Incorrect date for hospital to begin to charge beneficiary. From date indicates first day of beneficiary liability; thru day indicates last day of beneficiary liability; there may be multiple carve-outs for hospitals. No dates indicates no beneficiary liability.

G - Combination of C and D; DRG change and day outlier (denial or increased).

H - Combination of C and E; DRG change and cost outlier (denial or increased).

I - Combination of C and F; DRG change and incorrect date to begin charging beneficiary.

J - Deemed admission (covered level of care following a noncovered admission).

K - Combination of C and J; DRG change and deemed admission.

L - Combination of D and J; day outlier denial and deemed admission.

M - Combination of E and J; cost outlier denial and deemed admission.

N - Entire previous adjustment reversed (reverse last action).

O -   Previous adjustment modified (modifies your last action) requires detail.

P -   Change in discharge status 'to' or 'from' 02 or selected DRGs for postacute transfer payment provision

T -   Combination of A and C; admission denied and DRG change

Appendix D

OUTPATIENT ADJUSTMENT
REFERENCE GUIDE

INTRODUCTION

Outpatient Adjustments are not automated at this time. You will need to manually enter adjustment information on the Outpatient Adjustment Listing window, Outpatient Adjustment Base Information window, and the Outpatient Adjustment RCC Information window.

The Outpatient Adjustment Reference Guide was developed as a quick reference for single-issue Outpatient adjustments. This guide shows the codes for initial adjustments, 3rd level adjustments, and re-opened technical denial adjustments when specific categories are confirmed.

Notes that contain requirements for creating an adjustment (when outpatient adjustments are automated) can be found under each category section. For example, under Utilization Categories, the note states that when outpatient adjustments are automated, and category A03 has a confirmed outcome code of C, an automated adjustment will only be created when there is a limitation on liability category (LL1, LL2, OR LL3 CATEGORY).

Cases that will be reimbursed under limitation on liability do not require adjustments. If the PRAF row containing category code WV1, WV2, or WV3 has an outcome code of A or R, the system will not create an automated adjustment.

A list of CMS' Outpatient Ambulatory Denial Reasons and Adjustment Codes is included for your reference.

CATEGORY		INITIAL & 2ND LEVEL		3RD LEVEL OR REOPENED TECHNICAL DENIALS			
DESCRIPTION		CONFIRMED		RESOLVED		CONFIRMED	
		OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
Outpatient I/O Indicator - Utilization Categories							
NOTE:	When outpatient adjustments are automated, and category A03 has a confirmed outcome code of C, an automated adjustment will only be created when there is a limitation on liability code (LL1, LL2, OR LL3).						
A03	Admission solely for a procedure that appears unnecessary (also consider category C07)	C	1A See Note	R	4N	C	NO ADJ
Other							
NOTE:	When outpatient adjustments are automated, an automatic adjustment will not be created when category A99 is confirmed. If an adjustment is required, it must be manually entered on the adjustment window.						
A99	Other utilization concern not classified	Optional Per Case	See Note				
An adjustment will only be created if the group changes or if the number of procedures in a group changes							
Procedure Changes							
D09	Procedure omitted from claim	C, P	1R	R	4N	C M	NO ADJ 5O
D10	Procedure billed, but not substantiated by record	C, P	1R	R	4N	C	NO ADJ 5O

CATEGORY	INITIAL & 2ND LEVEL		3RD LEVEL OR REOPENED TECHNICAL DENIALS			
DESCRIPTION	CONFIRMED		RESOLVED		CONFIRMED	
	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES	OUT CODES	ADJ CODES
D12 Procedure determined medically unnecessary, is billed, and must be removed from DRG	C	1R	R	4N	C M	NO ADJ 5O
Changes In Disposition, Age, Coding D15 Non-clinical, non-medical errors that affect the DRG	C, P	1R	R	4N	P	NO ADJ
D99 Other HCPCS coding concern not elsewhere classified	C, P	1R	R	4N	C M	NO ADJ 5O
Technical Denial When there is a technical denial reason and a technical denial date and no reopen date on the review information window.		2A		4N		

AMBULATORY DENIAL REASONS AND ADJUSTMENT CODES

Reason for QIO Action:

     1 - Medical record reviewed, procedures or services denied (includes all HCPCS coding changes) (e.g., use for original QIO Adjustment)

     2 - Medical record/portion of medical record not provided (e.g., Technical Denial)

     3 - Physician attestation missing (not used at this time)

     4 - Complete reversal of previous adjustment (e.g., reversal of Technical Denial)

     5 - Medical record reviewed (modification of previous adjustment)

QIO Review Adjustment Code:

     A – Full denial

     N - Entire previous adjustment reversed (reverse last action)

     O - Previous adjustment modified (modifies your last action) requires detail

     Q - Outpatient Ancillary Services denied or approved

     R - Procedure codes changed, procedures denied, or procedures added

     S - Combination of Q and R: Outpatient Ancillary Service and Change in Outpatient Coding (denied or approved)

     U – Combination of A and R (full denial and change in procedure codes)

Appendix E

EMTALA Worksheet and Tips

Effective July 1, 2007

EMTALA Physician Review Worksheet

☐ **5 - Day Review**   ☐ **60 - Day Review**

SECTION I

Regional Office staff or QIO may complete.

Complaint Control Number:_____ Patient ID:_____

Name of Patient: _____ DOB: _____

Name of Alleged Violating Facility and/or Physician: _____

NPI Number: _____

City: _____ State: _____ CMS Certification Number: _____
(formerly the Medicare Provider Number)

Date and Time of Admission to Emergency Services: _____

Date and Time of Discharge from Emergency Services: _____

Name of Receiving Facility (if applicable): _____

NPI Number: _____

City: _____ State: _____ CMS Certification Number: _____
(formerly the Medicare Provider Number)

Date and Time of Admission Receiving Facility (if applicable): _____

Manner of Transport: _____

Location and Distance from Sending Facility (if known): _____

SECTION II

*Note to Physician Reviewer: Please complete the following questions to address issues related to EMTALA. Please be sure to include your clinical rationale for your determinations, and make any summary comments and comments on other aspects of the case in the summary section on the last page of this document. Please keep in mind that the purpose of your comments is to provide your clinical perspective on the care rendered, for the CMS 5-day review or for the OIG 60-day review. **Therefore, please refrain from making ANY statements about whether or not a violation of EMTALA has occurred, as that decision is the responsibility of CMS and the OIG only.** (Violations of EMTALA may also constitute negligence under state malpractice law.)*

MEDICAL SCREENING EXAMINATION

Note to Physician Reviewer: Depending upon an individual's presenting symptoms, an appropriate medical screening examination can range from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar puncture, clinical laboratory tests, CT scans and other diagnostic tests and procedures.

EMTALA Physician Review Worksheet

A facility must provide appropriate screening and treatment services within the full capabilities of its staff and facilities, including access to specialists who are on call.

1 a. Did the hospital provide a medical screening examination that was *appropriate* to the individual's medical complaint(s) and symptoms?

☐ **YES**   ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

1 b. Did the hospital provide (within its capability - including ancillary services routinely available and consultations by on–call specialist physicians) a medical screening examination that was, within reasonable clinical confidence, *sufficien*t to determine whether or not an EMERGENCY MEDICAL CONDITION (as defined below) existed?

☐ **YES**   ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

Note: An **Emergency Medical Condition** is defined by statute as **EITHER**: (1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: placing the individual's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; **OR** (2) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another facility before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child.

EMERGENCY MEDICAL CONDITION

2. Did this individual have an EMERGENCY MEDICAL CONDITION as defined by Part (1) of the statutory definition noted above? (Individual conditions meeting the definition in Part 2 above are addressed in subsequent questions.)

☐ **YES**   ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

EMTALA Physician Review Worksheet

3. Was this individual a pregnant woman who was having contractions?

☐ **YES**   ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

_____

    a) If "Yes" and the pregnant woman was transferred/discharged, at the time of transfer/discharge, could it be determined with reasonable medical certainty that there would be adequate time to affect a safe transfer to another facility before delivery?

         ☐ **YES**   ☐ **NO**   ☐ **N/A**

         Please explain your clinical rationale: _____

_____

_____

_____

    b) If the pregnant woman with contractions was transferred/discharged, at the time of transfer/discharge could it be determined, with reasonable medical certainty, that the transfer/discharge would not pose a threat to the health or safety of the individual or the unborn child?

         ☐ **YES**   ☐ **NO**   ☐ **N/A**

         Please explain your clinical rationale: _____

_____

_____

_____

EMTALA Physician Review Worksheet

STABILIZING TREATMENT

Note to Physician Reviewer: Terms relating to "stabilization" are specifically defined under EMTALA. These terms DO NOT REFLECT the common usage in the medical profession, but instead focus on the medical risks associated with a particular transfer/discharge. Thus, when answering questions related to "stability" for EMTALA, please be very careful to refer to the definition provided in parentheses in question 4 below. In addition, the clinical outcome of an individual's condition is not a proper basis for determining whether a person transferred was stabilized. However, the individual's outcome may be a "red flag" indicating that a more thorough evaluation of the individual's condition at the time of transfer was needed.

4. If an emergency medical condition (EMC) existed, at the time of transfer/discharge, was the individual's EMC "stabilized" (meaning that no material deterioration of the condition was likely, within reasonable medical probability, <u>to result from or occur during the transfer/discharge</u> of the individual from the facility, or in the case of a pregnant woman in labor, that the pregnant woman had delivered the child and placenta)?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale:

5 a. Is there any evidence that the facility was equipped with such staff, services, or equipment necessary to "stabilize" (assure within reasonable medical probability, that no material deterioration of the condition is likely <u>to result from or occur during the transfer</u> of the individual from a facility, or a pregnant woman has delivered both the child and the placenta) the emergency medical condition?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale:

5 b. If the facility had the capability to stabilize the individual and the individual was not stabilized prior to transfer/discharge, is there any information available to indicate WHY the emergency medical condition was NOT "stabilized" prior to discharge/transfer?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale:

EMTALA Physician Review Worksheet

APPROPRIATE TRANSFERS

6 a. If the individual was transferred to another facility, is there evidence that the sending facility lacked the capabilities and facilities to provide further medical examination and treatment to stabilize the individual's medical condition?

☐ **YES**   ☐ **NO**   ☐ **N/A**

If yes, what were the specialized capabilities that were required for the individual's emergency medical condition that the sending hospital lacked?

Please explain your clinical rationale:

6 b. If the individual was transferred to another facility, did the transferring facility provide further examination and stabilizing treatment, within its capabilities (including ancillary services routinely available to it) to minimize the risks of transfer to the individual's health and, where relevant, the health of the unborn child?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale:

7. If the individual was transferred to another facility, to minimize the risks of transfer, did the transfer of the individual require the use of qualified personnel and transportation equipment, including life support measures if medically appropriate?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale:

EMTALA Physician Review Worksheet

8.   If the individual was transferred to another facility, were the transportation equipment and personnel provided appropriate to the transferred individual's needs?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

9 a.   At the time of transfer, did a physician, or if a physician was not physically present, another qualified medical person (in consultation with a physician, who subsequently countersigned the certification) certify in writing that, based upon the reasonable risks and benefits to the individual, and based upon information available at the time of transfer, the medical benefits reasonably expected from medical treatment at another facility outweighed the increased risks to the patient from effecting the transfer?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain: _____

_____

_____

_____

9 b.   Do you agree that <u>at the time of transfer</u>, based upon the reasonable risks and benefits to the individual and based upon information available at the time of transfer, the medical benefits reasonably expected from medical treatment at another facility outweighed the increased risk to the individual being transferred?

☐ **YES**   ☐ **NO**   ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

9 c.   If the individual (or a legally responsible person acting on the individual's behalf) requested the transfer in writing, was he/she informed of the facility's obligations and of the medical risks of transfer?

☐ **YES**   ☐ **NO**   ☐ **N/A**

EMTALA Physician Review Worksheet

Please explain: _____

_____

_____

_____

10. Did the transferring facility obtain the agreement of the receiving facility to accept the transfer and to provide appropriate medical treatment?

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain, including, if "yes," how this was documented: _____

_____

_____

_____

11. Does the documentation suggest that the transferring facility sent to the receiving facility all available and pertinent medical documentation related to the emergency medical condition?

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain: _____

_____

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_____

12. If the individual refused to consent to necessary stabilizing treatment or to an appropriate transfer, is there evidence that the facility first offered the individual the further medical examination and treatment or appropriate transfer, informing him/her of the risks and benefits, and obtained the individual's informed written refusal?

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain: _____

_____

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_____

_____

EMTALA Physician Review Worksheet

RESPONSIBILITY OF HOSPITALS WITH SPECIALIZED DIAGNOSTIC OR TREATMENT CAPABILITIES OR FACILITIES

Note to physician reviewer: While "specialized capabilities or facilities" include such facilities as burn units, shock-trauma units, neonatal intensive care units or regional referral centers, it also includes much more. Most simply, if an individual with an emergency medical condition needs services to stabilize that condition that cannot be made available in a clinically appropriate timeframe at the hospital where the individual presented, but are available at another hospital, the hospital with these capabilities/services must accept a request for transfer if it has the capacity to provide the needed capabilities/services.

13. Is there any evidence that a Medicare-participating hospital that refused a transfer request has specialized capabilities or services (not available at the transferring hospital) that an individual required?

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain:

_____

_____

DELAY IN TREATMENT

14. Is there any evidence that the facility under review delayed for an inappropriate length of time the provision of an appropriate medical screening examination or further medical examination and treatment?

☐ **YES** ☐ **NO**

Please explain:

_____

_____

_____

QUALITY

15. Do you have any specific concerns about the quality of care rendered to the individual that have not already been addressed fully above?

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

_____

EMTALA Physician Review Worksheet

<u>SUMMARY OF FINDINGS</u>:

16. Please summarize the key facts of the case below and any concerns or clarifications to your answers above with regard to this case. *Remember, do <u>not</u> state an opinion regarding whether EMTALA was violated.*

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I agree to provide medical advice to the Centers for Medicare & Medicaid Services and/or the Office of Inspector General, as necessary, to properly adjudicate any issues and to testify as an expert witness on behalf of the Office of Inspector General, if necessary.

_____

Physician Reviewer Name (printed): _____

Physician Reviewer Signature: _____

Specialty: _____ **Date:** _____

Tips for Completing the EMTALA Peer Review Worksheet

The Physician Review component of the EMTALA review process is a key element of the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) EMTALA enforcement activities. The clinical answers that you provide on the peer review worksheet are instrumental in guiding CMS' and OIG's actions in EMTALA cases. This tip sheet has been developed to assist you in completing the worksheet as thoroughly as possible, so that CMS and OIG can use your responses most effectively.

Notable Revisions:

CMS has recently revised the "Physician Review Outline for Emergency Care Obligations of Medicare Hospitals" which has been renamed the "EMTALA Peer Review Worksheet."
It should be noted that there are no *material* changes in the focus of review—evaluating the adequacy of a medical screening examination, stabilization and transfer of a patient who has presented with an emergency medical condition. A workgroup consisting of CMS, OIG and Quality Improvement Organization (QIO) representatives provided input on refinements to the worksheet.

Changes include additional directions to help you frame your responses to best meet CMS/OIG's' needs, as well as revised phrasing of questions, to clarify the information CMS/OIG requires. While these changes help make the worksheet easier to use this tip sheet can assist you as you complete the worksheet questions.

Worksheet Areas:

Section I: This is usually completed by the QIO or State Agency Physician, although the Regional Office may complete it as part of the referral for physician review. Either the 5-day or 60 – day review box must be checked. Other data fields should be completed as completely as possible.

> **Section II:** The note preceding the questions in Section II stresses the importance of providing your **clinical** assessment when you answer the questions.
> - Your clinical rationale and any clarifying clinical details, evidence from the record, etc. to substantiate your determinations are crucial in assisting CMS/OIG's EMTALA activities. Therefore, please ensure that you answer **EACH** question as completely as possible.
> - Please do NOT skip any questions—answer N/A if the question is not pertinent to the case under review.

In addition, it is **CMS' and the OIG's responsibility** to determine if an EMTALA violation has occurred, NOT the physician reviewer's.
- Therefore, it is imperative that you **refrain** from making ANY statements about whether or not a violation has occurred.
- The peer review worksheet should document only your **clinical** assessment and supporting commentary.

__Medical Screening Examination__: Question 1 has two parts—whether or not a medical screening examination (MSE) was appropriate for the individual's medical complaints and symptoms; and if it was sufficient to determine if an emergency medical condition (EMC) existed, since one answer does not necessarily predict the other.
- Please be sure to provide your **clinical rationale** with your response to every question.
- Your clinical details are critical in assisting CMS/OIG in understanding your clinical perspective on the case under review.

__Emergency Medical Condition__: EMC for an acute medical condition **or** a pregnant woman having contractions is addressed in this section.
- Do not skip any questions—each question needs to be answered with yes/no or N/A.

__Stabilizing Treatment__: This section has been updated significantly to facilitate your understanding of what "stabilization" means under EMTALA, which is often quite different than common usage in the medical profession.
- It is important to focus on the explanation of "stability" in the Note to Physician Reviewer and definition in question 4 so that you can respond to the questions in this subsection as accurately as possible.
- Your clinical perspective on stability *__as defined by the EMTALA law__* is critical, and your clinical rationale is crucial in this section, so please explain in detail.
- Questions 5a and 5b in this section focus further on what services were available at the facility, and whether or not they were used appropriately.
    - These two parts are separate so that your response can help CMS/OIG determine if services were available, and if so, why they might not have been used prior to transferring a patient.
    - This additional level of detail is key in providing necessary clinical guidance to CMS/OIG, so please be as specific as possible.

__Appropriate Transfers__: It is recognized that not all cases involve patients who are transferred to another facility; however, you need to answer every question in this section, regardless of whether or not the patient was transferred.

- For those patients who were **not** transferred, you now have the option of indicating this in your response.
- Since an appropriate transfer involves adequate documentation of the reason for the transfer, who requested it and agreement by the receiving facility, you now have specific questions to answer that address these areas.
- Again, your clinical rationale for any of your yes/no answers is crucial, so please respond in detail.

__Responsibilities of Receiving Hospitals with Specialized Capabilities__: This area again focuses on transfer, and the question in this section is designed to elicit whether the reviewer found any evidence that a hospital inappropriately refused to accept a transfer.

__Delay in Treatment__: This question is designed to determine whether there were inappropriate delays, in terms of the patient's medical condition, in providing the MSE and/or stabilizing treatment.

**Quality**: This question has not changed. Please provide the clinical rationale for your answer.

**Summary of Findings**: This question has not changed. Please summarize your clinical findings, including the clinical rationale for your answer. Again, remember:

- It is imperative that you **refrain** from making ANY statements about whether or not you believe an EMTALA violation has occurred.

Appendix F

CMS Timing of Review

Type of Review: **Assistant Cataract Surgery**   Code: **140**   Rev Date: **8/28/02**

Review Requirements	Timing of Review	CRIS Entry
Pre-Procedure (concurrent Review) Determine if the use of the assistant is medically necessary. *(§4020 D QIO Manual)*	Complete review in a timely manner before the procedure is performed.	**Selection Date:** The date the QIO received the request to approve an assistant at cataract surgery. **MR Request Date:** If applicable, the date the QIO received the requested MR, otherwise leave blank. **Completion Date:** The date prior to the surgery that the QIO notifies the surgeon and the assistant of the determination. *(§4020 B QIO Manual)* **Review Start Date:** The date the QIO received the request to approve the use of an assistant (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Assistant Cataract Surgery**   Code: **141**   Rev Date: **8/28/02**

Review Requirements	Timing of Review	CRIS Entry
Post-procedure (retrospective review)	Complete the review on a pre-payment basis when the physician notifies the QIO that an assistant was used on an emergency basis, or under exception, on a non-emergency basis and the MR is provided by the requesting physician. *(§4020 D QIO Manual)*	**Selection Date:** The date the physician notifies the QIO that an assistant was used at cataract surgery. **MR Request Date:** If applicable, the date the QIO requested the MR to support/validate a review determination, otherwise leave blank. **MR Receipt Date:** If applicable, the date the QIO received the requested MR, otherwise leave blank. **Completion Date:** The date the QIO completed its review determination and notified affected parties. **Review Start Date:** The date the physician notifies the QIO that an assistant was used at cataract surgery (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Assistant Cataract Surgery**   Code: **142**   Rev Date: **8/28/02**

Review Requirements	Timing of Review	CRIS Entry
Validation Review Validate the information provided at the initial review using the MR submitted by the provider on all (if small number of cases) or a sample *(§4020 F QIO Manual)*	**Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO selects the case. **MR Request Date:** If applicable, the date the QIO requested the MR to validate a review determination, otherwise leave blank. **MR Receipt Date:** If applicable, the date the QIO received the requested MR, otherwise leave blank. **Completion Date:** The date the QIO completed its review determination and notified affected parties. **Review Start Date:** The date the QIO received the necessary MR to perform the review (i.e., the MR Receipt Date).

Type of Review: **Beneficiary Complaints – Other Complaints**   Code: **100**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
QIO requests additional records A complaint is received, and during the course of the review, additional medical records must be requested.	Follow the instructions described in this document for beneficiary complaint review. Provide the information along with the information from the original beneficiary complaint to the complainant in one final letter.	

Timing of Review Requirements

Type of Review: **Beneficiary Complaint –** Code: **101** Rev Date: **7/13/06**
Concurrent

Review Requirements	Timing of Review	CRIS Entry
Beneficiary complaint concurrent Beneficiary is still an inpatient or receiving health care services	**Review** within one full **working** day of receiving the complaint, send an acknowledgment and request the MR (the 15 extra days for submittal of additional documentation does not apply). *(§§5020 A and B and Exhibit 5-20 QIO Manual)* Complete cases with **no concerns** identified within 38 days. • 1 working day for acknowledgement/request MR • 1 working day to receive the MR • 1 working day to complete the review. (Includes opportunity for discussion) • 30 calendar days for notice of disclosure • 5 calendar days to prepare response to complainant Complete cases **with concerns** within 68-83 days • 1 working day for acknowledgment/request MR • 1 working day to receive the MR • 1 working day to complete the review. (Includes opportunity for discussion) • 30 calendar days for request for re-review • 15 calendar days to complete re-review • 30 calendar days for notice of disclosure • 5 calendar days to prepare response to complainant • Complete review within 68 days from the review start date for those cases where a re-review was not requested • Complete review within 83 days from the review start date for those cases where a re-review was requested. • Add 85 days if **ADR** is selected • If ADR is terminated and returns to medical record review, add 35 days to complete the review process.	**Selection Date:** The date the QIO received either a beneficiary's (or his/her representative's) written or a verbal complaint. **MR Request Date:** The date the QIO requested the medical record to perform the review. **MR Receipt Date:** The date the QIO received the medical record(s) necessary to perform the review. **Completion Date:** The date the QIO issues the final response to the beneficiary or his/her representative. **Review Start Date:** The date the QIO received either written or verbal complaint (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Beneficiary – Quality of Care Complaints under 1154(a)(14)** Code: **102** Rev Date: **7/13/06**

Review Requirements	Timing of Review	CRIS Entry
Beneficiary Complaint retrospective Beneficiary discharged or currently not receiving health care services Complete Quality Review *(§§5020 D and 4540 A. QIO Manual)* In addition, if during review of the complaint evidence is found that a HINN was issued, then review the HINN**. *(§§7025 B.3 QIO Manual)*	Within 5 calendar days of receiving the complaint, send an acknowledgement and request the MR**. *(§§5020 A and Exhibit 5-19 QIO Manual)* Complete cases with **no** concerns identified within 85 calendar days: • 5 days for acknowledgement • 30 days to receive the MR • 15 extra days for submission of requested information if MR documentation is incomplete or illegible. (Total timeframe will increase accordingly.) • 15 days to complete review (both non-physician and physician reviews) • 30 days for notice of disclosure • 5 days to prepare response to complainant **Complete cases with concerns identified** within 120-165 calendar days. (Includes the 20-day practitioner's/provider's opportunity for discussion.) • 120 days (plus 15 extra days when applicable) to complete review – for resolved concerns. • 150 days (plus 15 extra days when applicable) to complete review when re-review **not** requested. • 165 days (plus 15 extra days when applicable) to complete review when re-review requested. • Complete review within 120 days (plus 15 extra days when applicable) from the review start date for those cases where the concerns that were resolved. • Complete review within 150 days (plus 15 extra days when applicable) from the review start date for those cases where a re-review was not requested. • Complete review within 165 days (plus 15 extra days when applicable) from the review start date for those cases where a re-review was requested. • Add 85 days if **ADR** is selected • If complainant requests to return to medical record review, add 35 days to the date of the request. **Note: When a case is questioned for DRG validity and/or utilization, the final notices (for these 2 type of reviews) are sent following the completion timeframes for the quality of care review.** *(§4540 A QIO Manual)*	**Selection Date:** The date the QIO received either a beneficiary's (or his/her representative's) written or a verbal complaint. **MR Request Date:** The date the QIO has all the necessary information to request the MR to perform a review. **MR Receipt Date:** The date the QIO received the initial MR necessary to perform the review. (May show 2 dates: initial MR request and additional MR documentation request.) **Completion Date:** The date the QIO sent the final notice to the beneficiary/beneficiary representative. (See Note in Timing of Review column.) **Review Start Date:** The date the QIO requested the necessary MR to perform the review (i.e., the MR Request Date)

Type of Review: **Beneficiary Complaints, Other Complaints**　　　Code: **103**　　　Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Anonymous complaint concurrent	The medical record must be provided by the close of business of the next working day after receipt of the complaint. The QIO must complete the review and send written determination notices to the provider/involved practitioner within one full working day after the receipt of the medical record. **Do not:** (1) Acknowledge receipt of complaint; (2) send notice of disclosure to provider and/or practitioner and (3) send the complainant a final response	

Timing of Review Requirements

Type of Review: **Beneficiary Complaints Other Complaints (Do not meet the statutory requirements of §1154(a)(14))**   Code: **104**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Anonymous complaint retrospective Anonymous/Oral or Written Complaints about quality of care	Follow the quality of care time frames when requesting/receiving the MR information, completing review, and providing re-review, as applicable. These time frames are different from the ones applicable to the review of beneficiary complaints for quality of care. **Do not:** (1) Acknowledge receipt of complaint; (2) Send notice of disclosure to provider and/or practitioner and (3) Send the complainant a final response. **Completion Date Timeframes (includes the 30-day MR period and 20-day opportunity for discussion when applicable):** • Complete review within 60 calendar days (plus 15 extra days when applicable) from the review start date for cases with no concerns identified. • Complete review within 90 calendar days (plus 15 extra days when applicable) from the review start date for those cases where the physician questions utilization/DRG concerns. • Complete review within 100 calendar days (plus 15 extra days when applicable) from the review start date for those cases where the physician questions quality of care concerns. **Note: When a case is questioned for DRG validity and/or utilization, the final notices (for these 2 type of reviews) are sent following the completion timeframes for the quality of care review.** *(§4540 A QIO Manual)*	**Selection Date:** The date the QIO received either the anonymous/oral complaint. **MR Request Date:** The date the QIO has all the necessary information to request the MR to perform a review. (May show 2 dates: initial MR request and additional MR documentation request.) **MR Receipt Date:** The date the QIO received the initial MR necessary to perform the review. (May show 2 dates: initial MR receipt and additional MR documentation receipt.) **Completion Date:** The date the QIO sent final notices to affected parties. **Review Start Date:** The date the QIO has requested the initial MR to perform the review (i.e., the MR Request Date).

Type of Review: **Beneficiary Complaints Other**   Code: **115**   Rev Date: **08/28/02**
                     Complaints

Review Requirements	Timing of Review	CRIS Entry
Complaint is Withdrawn- QIO is continuing review A complaint is received, but the complainant withdraws the complaint. However, the QIO decides to continue the review	Follow the quality of care time frames when requesting/receiving the MR information (if the QIO does not have the medical record), completing review, and providing re-review, as applicable. These time frames are different from the ones applicable to the review of beneficiary complaints for quality of care. Do not: (1) Send notice of disclosure to provider (2) Send the complainant a final response	

Type of Review: **Beneficiary Complaints Other Complaints**   Code: **116**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Complaint-Utilization issue only	Complete review within 90 calendar days (plus 15 extra days when applicable) from the review start date for those cases where the physician questions utilization/DRG concerns.	

Type of Review: **EMTALA**   Code: **130**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
5-Day Assessment QIO Assessment of the information that the physician had or should have considered at the time of the visit	Complete review within 5 full working days from receipt of all necessary medical record information (MR). The CMS Regional Office (RO) will provide the MR. *(§ 9150B QIO Manual)*	**Selection Date:** The date the QIO received the request from the RO to perform a 5-day assessment. **MR Request Date:** The date the QIO requested the applicable MR from the RO if inadvertently not included with the request, otherwise, leave blank. **MR Receipt Date:** The date the QIO received the MR necessary to proceed with the assessment. (This date will be the same as the Selection Date if medical documentation was included in the request from the RO as is the normal practice.) **Completion Date:** The date the QIO completed the assessment and provided the results to the RO. (The fifth (5) working day, following the review start date.) *(§ 9150B QIO Manual)* **Review Start Date:** The first <u>full</u> working day after the QIO received all necessary MR materials to perform the 5-day assessment (i.e., the MR Receipt Date). *(§ 9150B QIO Manual)*

Timing of Review Requirements

Type of Review: **EMTALA**   Code: **131**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
60 Day Review A Physician Reviewer (PR) determines: • Medical Screen Exam • Emergency Condition • Stabilizing Treatment • Appropriate Transfer (If applicable) The PR will complete the outline form found at *(Part 9, Exhibit 9-15 of the QIO Manual)*		**Selection Date**: The date the QIO received the request from the RO to perform a 60-day review. **MR Request Date:** The date the QIO requested the applicable MR from the RO if inadvertently not included with the request, otherwise, leave blank. MR necessary to proceed with the 60-day review. (This date will be the same as the Selection Date if medical documentation was included in the request from the RO as is the normal practice.) **MR Receipt Date:** The date the QOI received the MR necessary to proceed with the assessment. (This date will be the same as the Selection Date if medical documentation was included in the request from the RO as is the normal practice.) **Completion Date:** The date the QIO completed the 60-day review and provided the results to the CMS RO by telephone and letter. The sixtieth (60) calendar day, following the review start date (i.e., the MR Receipt Date). *(§9150C QIO Manual)* **Review Start Date:** The date the QIO received the necessary MR to perform the review (i.e., the MR Receipt Date).

Timing of Review Requirements

Type of Review: **EMTALA**   Code: **132**   Rev Date: **07/03/03**

Review Requirements	Timing of Review	CRIS Entry
Review of quality of care concerns identified during an EMTALA review	**Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern(s) were identified.	**Selection Date:** The date the QIO determined the need for additional review as part of an EMTALA referral. **MR Request Date**: The date the QIO requested the MR to perform the review. **MR Receipt Date**: The date the QIO received the MR necessary to perform the review. **Completion Date:** The date the QIO completed review of the MR (includes the 30-day MR period and 20-day opportunity for discussion when applicable): **Review Start Date:** The date the QIO determined the need for additional review (i.e., the Selection Date).

Type of Review: **FFS Expedited Appeal (CORF, HHA, Hospice, SNF)**	Code: **118**	Rev Date: **7/31/08**

Review Requirements	Timing of Review	CRIS Entry
BIPA Fee for Service Expedited Appeal Review (effective July 1, 2005) Immediate Notice of Non-coverage review of FFS notices issued in CORFs, SNFs, Hospices, and HHAs	Request made no later than noon of the day prior to the effective date. Telephone notice of Notice of Non-coverage determination must be made within 72 hours of receipt of appeal. If the request is untimely and the patient is still receiving services, the QIO has 7 days to complete the Notice of Non-coverage review. If the request is untimely and the patient is no longer receiving services, the QIO has 30 days to complete the Notice of Non-coverage review. **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO received a request to review the notice. **MR Request Date:** the date the QIO notified the FFS facility and requested the MR to perform the review. The MR must be requested the same day the patient requests the review. **MR Receipt Date:** The date the QIO received the MR necessary to perform the review. (The facility is required to provide the MR the same day as the request). **NONC Completion Date:** The date the QIO notified by telephone (followed by written notice) all affected parties of the review determination. Complete the review within 72 hours of receipt of the appeal. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Start Date:** The date the QIO received the request for review (i.e., the Selection Date).

Type of Review: **Fast Track Appeal/MA Appeal**   Code: **117**   Rev Date: **07/31/08**
Review (CORF, HHA, SNF)

Review Requirements	Timing of Review	CRIS Entry
Fast Track MA Review Immediate review of MA notices issued in CORFs, SNFs, and HHAs	Request made no later than noon on the day following the day the notice was issued to the enrollee (or his/her representative) Complete the Notice of Non-coverage review by the COB on the day following receipt of the MR from the MA. **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO received a request to review the notice. **MR Request Date:** The date the QIO notified the MA and requested the enrollee's MR to perform the review. The MR must be requested the same day enrollee requests the review. **MR Receipt Date:** The date the QIO received the MR necessary to perform the review. (The MA is required to provide the MR the same day as the request). **NONC Completion Date:** The date the QIO notified by telephone (followed by written notice) all affected parties of the review determination. Complete the review by COB on the day following receipt of the MR from the MA. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Start Date:** The date the QIO received the request for review (i.e., the Selection Date).

Type of Review: **Hospital Issued Notice of Non-Coverage (HINN)**   Code: **105 & 107**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
FFS-Pre-admission Notice Review (Code 105) **FFS Admission Notice Review (Code 107)** Immediate review – request made within 3 working days of notice receipt or admission to hospital (while beneficiary remains in the hospital) Determine the appropriateness of the admission and the content of the notice. Non-PPS Notice Review Determine: • The medical necessity of the admission: • If the care was not covered when the hospital indicated; and • The appropriateness of the length of stay. *(§7025 QIO Manual)*	Complete the Notice of Non-coverage review (includes notification) within 2 working days of the receipt of the beneficiary's (or his/her representative's) request and the MR. *(§7015 A.1. QIO Manual)* **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO received either a written or a verbal request to review the HINN. **MR Request Date:** The date the QIO requested the MR to perform the review. In most instances, the date will be the same as the Selection Date when the MR is requested at the time of the notice review request. **MR Receipt Date:** The date the QIO received the MR to perform the review. In most instances, the date will be the same as the selection date when the MR is requested at the time of notice review request. **NONC Completion Date:** Complete the review within 2 working days after receiving the request and the MR information necessary to make a review determination **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered **Review Start Date:** The date the QIO received the request and the necessary MR to perform the review (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Hospital Issued Notice of Non-Coverage (HINN)**   Code: **106 & 108**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
FFS-Pre-admission Notice Non-immediate Review (106) **FFS Admission Notice Non-immediate Review (108)** Request **not** made within 3 working days of notice receipt or admission to hospital.	**Completion Timeframes:** • 60 calendar days (plus 15 extra days when appropriate) to complete a review with no concerns identified • 90 calendar days (plus 15 calendar days when appropriate) to complete a review with UR/DRG concerns questioned by the physician. • 100 calendar days (plus 15 extra days when applicable) from the review start date for those cases where the physician questions quality of care concerns.	**Selection Date:** The date the QIO received either a written or a verbal request to review the HINN. **MR Request Date:** The date the QIO requested the MR to perform the review. In most instances, the date will be the same as the Selection Date when MR is requested at the time of the notice review request. (May show 2 dates: Initial MR request and additional MR documentation request.) **MR Receipt Date:** The date the QIO received the initial MR to perform the review. (May show 2 dates: initial MR receipt and additional MR documentation receipt.) **Review Start Date:** The date the QIO has made MR request to perform the review (i.e., the MR Request Date).

Timing of Review Requirements

Type of Review: **Hospital Issued Notice of Non-Coverage (HINN)**   Code: **109**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued Stay Notice Review *(Do not use after 7/31/2008)* With attending physician concurrence. Appealed no later than noon of the first working day after the day the notice was received. Determine: • The medical necessity of the admission; • If the care was not covered when the hospital indicated; and • The appropriateness of the content of the notice. Immediate Review: • Solicit beneficiary's (Representative's) views • Give provider and/or practitioner an opportunity to discuss.	Request the MR the same day of the request. The hospital must provide the MR by COB the same day as the request. Complete the review (includes notification) within 1 working day of the receipt of the request and the MR. *(§7015 B.1.a. QIO Manual)*	**Selection Date:** The date the QIO received either a written or a verbal request to review the HINN. **MR Request Date:** The date the QIO requested the MR to perform the review. In most instances, the date will be the same as the Selection Date when the MR is requested at the time of the notice review request. **MR Record Receipt Date:** The date the QIO received the MR to perform the review. In most instances, the date will be the same as the Selection Date when the MR is requested at the time of the notice review request. **Completion Date:** The date the QIO provides notification by telephone, (followed-up with a written notice) of the review determination. Complete review within 1 working day of the request and receipt of the MR. **Review Start Date:** The date the QIO received the request and the necessary MR to perform review (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Hospital Issued Notice of Non-coverage**   Code: **110**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued stay notice (non-immediate review) *(Do not use after 7/31/2008)* Appealed after noon of the first working day after the day the notice was received and beneficiary remains in the hospital.	Complete the review (includes notification) within 2 working days of the receipt of the request and the MR. *(§7015 B.1.b. QIO Manual)*	**Selection Date:** The date the QIO received either a written or a verbal request to review the HINN. **MR Request Date:** The date the QIO requested the MR to perform the review. In most instances, the date will be the same as the Selection Date when the medical records is requested at the time of the notice review request. **MR Record Receipt Date:** The date the QIO received the medical record to perform the review. **Completion Date:** The date the QIO issued the final notice of the results of the review determination. Complete the review within 2 working days from receipt of the request and the necessary MR. **Review Start Date:** The date the QIO received the request and the necessary MR to perform the review (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Hospital Issued Notice of Non-Coverage (HINN)**　　　Code: **111**　　　Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued Stay Notice Attending physician does not concur with the issuance of the notice; hospital requests QIO to determine if a HINN should be issued. The hospital is required to give written notice informing about the physician's non-concurrence with the proposed notice. At the time the beneficiary's views are solicited by the QIO, the beneficiary is asked if he/she received the hospital's mandatory notice	Complete the Notice of Non-coverage review (includes notification) within 2 working days of receipt of the request and the MR. *(§7005 B.2. QIO Manual)* **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date**: The date the QIO received a request from the hospital to review the HINN. **MR Request Date:** The date the QIO requested the MR to perform the review. In most instances, the date will be the same as the Selection Date when the MR is requested at the time of the notice review request **MR Receipt Date:** The date the QIO received the MR to perform the review. In most instances, the date will be the same as the Selection Date when the MR is requested at the time of the notice review request **NONC Completion Date:** The date the QIO provides notification by telephone, (followed-up with a written notice) of the review determination. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered **Review Start Date:** The date the QIO received the request and the necessary MR to perform review (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Hospital Issued Notice of Non-coverage**   Code: **112**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued stay notice – retrospective within 30 days *(Do not use after 7/31/2008)* Request made within 30 calendar days from receipt of the notice or at any time, for good cause.	**Completion Date Timeframes** (includes the 30-day MR period and 20-day opportunity for discussion when applicable): • 60 calendar days (plus 15 extra days when appropriate) to complete a review with no concerns identified • 90 calendar days (plus 15 calendar days when appropriate) to complete a review with UR/DRG concerns questioned by the physician. • 100 calendar days (plus 15 extra days when appropriate) to complete review with UR/DRG and quality of care concerns questioned by the physician.	**Selection Date:** The date the QIO received either a written or a verbal request to review the HINN. **MR Request Date:** The date the QIO requested the MR to perform the review. In most instances, the date will be the same as the Selection Date when the medical record is requested at the time of the notice review request. **MR Record Receipt Date:** The date the QIO received the MR to perform the review. **Review Start Date:** The date the QIO received a written or a verbal request to review the HINN. (i.e., the Selection Date).

Type of Review: **Hospital Issued Notice of Non-coverage**   Code: **113**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
HINN Retrospective Monitoring Review (without a beneficiary request) These cases will be selected for the QIOs by CMS. The QIOs will be notified via e-mail that the selection process is complete. The QIOs have 5 calendar days to request the MR. Review all cases where the beneficiary is liable for charges after notice or for any other selection reason.	**Completion Date Time Frames:** Complete review according to the following time frames (includes the 5 calendar days to request the MR, 30-calendar day MR request period and 20-calendar day for opportunity for discussion when applicable): • 65 calendar days (plus 15 extra days when appropriate) to complete a review with no concerns identified • 95 calendar days (plus 15 calendar days when appropriate) to complete a review with UR/DRG concerns questioned by the physician. • 105 calendar days (plus 15 extra days when appropriate) to complete review with UR/DRG and quality of care concerns questioned by the physician.	**Selection Date:** The date the QIO is notified by e-mail that the selection process is complete. The QIO has 5 calendar days from the receipt of the selection to request the MR. **MR Request Date:** The date the QIO requested the MR to perform the review. **MR Receipt Date:** The date the QIO received the initial MR necessary to perform the review (It may show 2 dates – initial MR request and additional documentation request.) **Completion Date:** The date the QIO completed its review determination. **Review Start Date:** The date the QIO is notified of the selection (i.e., the Selection Date). **Note: When a case is questioned for DRG validity and/or utilization, the final notices (for these 2 types of reviews) are sent following the completion timeframes for the quality of care review.** *(§ 4540 A QIO Manual)*

Type of Review: **Hospital Issued Notice of Non-Coverage (HINN)**   Code: **121**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued Stay Notice Immediate Review With attending physician concurrence. Appealed no later than the day of discharge. Appeal may be in writing or by telephone. Determine: • The medical necessity of the admission; • If the care was not covered when the hospital indicated; and • The appropriate-ness of the content of the notice. • The validity of the notice; and Solicit beneficiary's (Representative's) views Give provider and/or practitioner an op-portunity to discuss.	Notify the hospital of the appeal and request the MR the same day of the request for an expedited determination. The hospital must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. Complete the Notice of Non-coverage review within 1 calendar day of the receipt of the MR. *(§405.1206(d)(6)(I) Federal Register/Vol.71. No 227)* **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO receives either a written or a verbal request to review the notice. **MR Request Date:** The date the QIO requests the MR to perform the review. The hospital must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. **MR Record Receipt Date:** The date the QIO receives the MR to perform the review. In most instances, the date will be the same as the Selection Date when the MR is requested at the time of the notice review request. **NONC Completion Date:** The date the QIO provides notification to the beneficiary, the physician, and the hospital by telephone, followed by written notice, of the review determination. Complete review within 1 calendar day of the request and receipt of the MR. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Review Start Date:** The date the QIO receives all requested pertinent information to perform the review (i.e., the MR Receipt Date).

Type of Review: **Hospital Issued Notice of Non-coverage**   Code: **122**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued stay Notice Concurrent Non-immediate Review Untimely appeal for expedited determination at any time during the hospitalization and beneficiary remains in the hospital without coverage. Determine: • The medical necessity of the admission; • If the care was not covered when the hospital indicated; • The appropriate-ness of the content of the notice. Solicit beneficiary's (Representative's) views Give provider and/or practitioner an opportunity to discuss.	Notify the hospital of the appeal and request the MR the same day of the request for an expedited determination. The hospital must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. Complete the Notice of Non-coverage review within 2 calendar days of the receipt of the MR. *(§405.1206(d)(6)(ii) Federal Register/Vol.71. No 227)* **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO receives either a written or a verbal request to review the notice. **MR Request Date:** The date the QIO requests the MR to perform the review. The hospital must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. **MR Record Receipt Date:** The date the QIO receives the medical record to perform the review. **NONC Completion Date:** The date the QIO provides notification to the beneficiary, the physician, and the hospital by telephone, followed by written notice, of the review determination. Complete the review within 2 calendar days from receipt of the MR. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Review Start Date:** The date the QIO receives all requested pertinent information to perform the review (i.e., the MR Receipt Date).

Type of Review: **Hospital Issued Notice of Non-coverage**   Code: **123**   Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
Continued Stay Notice – Retrospective Within 30 Days Request for expedited determination made within 30 calendar days from receipt of the notice, *or at any time*, for good cause. Determine: • The medical necessity of the admission; • If the care was not covered when the hospital indicated; • The validity of the notice; and • The appropriate-ness of the content of the notice. Solicit beneficiary's (Representative's) views Give provider and/or practitioner an opportunity to discuss.	Notify the hospital of the appeal and request the MR the same day of the request for an expedited determination. The hospital must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. Complete the Notice of Non-coverage review within 30 calendar days of the receipt of the request and the MR. *(§405.1206(d)(6)(iii) Federal Register/Vol.71. No 227)* **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO receives either a written or a verbal request to review the notice. **MR Request Date:** The date the QIO requests the MR to perform the review. The hospital must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. **MR Record Receipt Date:** The date the QIO receives the MR to perform the review. **NONC Completion Date:** The date the QIO provides notification to the beneficiary, the physician, and the hospital by telephone, (followed by written notice) of the review determination. Complete the review within 30 calendar days from receipt of the request and the necessary MR. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Review Start Date:** The date the QIO receives all requested pertinent information to perform the review (i.e., the MR Receipt Date).

Type of Review: **Hospital Issued Notice of Non-coverage** Code: **124** Rev Date: **07/31/08**

Review Requirements	Timing of Review	CRIS Entry
MA-Continued Stay Notice Immediate Review Physician concurrence required. Appealed no later than the day of discharge. Appeal may be in writing or by telephone. Determine: • The medical necessity of the admission; • If the care was not covered when the hospital indicated; • The validity of the notice; and • The appropriate-ness of the content of the notice. Solicit beneficiary's (Representative's) views Provide the MA organization an opportunity to discuss.	Notify the MA organization and the hospital of the appeal and request the MR the same day of the request for an immediate determination. The MA organization must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. Complete the Notice of Non-coverage review within 1 calendar day of the receipt of the MR. *(§422.622(d)(6) Federal Register/Vol.71. No 227)* **Completion Time Frames for Coding Validation, Quality of Care, and/or Utilization review:** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a quality of care concern was questioned.	**Selection Date:** The date the QIO receives either a written or a verbal request to review the notice. **MR Request Date:** The date the QIO requests the MR to perform the review. The MA organization must provide the MR no later than noon of the day after the QIO notifies them of the appeal request. **MR Record Receipt Date:** The date the QIO receives the MR to perform the review. **NONC Completion Date:** The date the QIO provides notification by telephone to the enrollee, the MA organization, the physician, and hospital, (followed by written notice) of the review determination. Complete review within 1 calendar day of the request and receipt of the MR. **Other Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Review Start Date:** The date the QIO receives all requested pertinent information to perform the review (i.e., the MR Receipt Date).

Timing of Review Requirements

Type of Review: **Hospital Payment Monitoring Program (HPMP) Case Review**   Code: **210**   Rev Date: **06/19/09**

Review Requirements	Timing of Review	CRIS Entry
HPMP Case Review – Cases referred by the QIO by the CDAC. (Do not use after July 16, 2009) Perform a retrospective review for utilization review, DRG validation and when applicable, a quality review. *(§§11005 and 11020 QIO Manual)*	**Completion Time Frames (does not include the 30-day MR request period used by CDACs):** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete the review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG and or quality of care concern was questioned. *(§4540 B QIO Manual)*	**Selection Date:** The date the QIO received the referral from the CDAC for review. **MR Request Date:** Not applicable to cases selected by the CDAC. **MR Receipt Date:** The date the QIO received the medical record from the CDAC. It may show 2 dates – the initial MR receipt and the additional information receipt. **Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review if not questioned or the date the final notice is issued if opportunity to discuss is offered. **Review Start Date:** The date the MR is received by the QIO (i.e., the Medical Record Receipt Date).

Timing of Review Requirements

Type of Review: **Hospital Payment Monitoring Program (HPMP) Case Review**   Code: **211**   Rev Date: **06/19/09**

Review Requirements	Timing of Review	CRIS Entry
Cases selected by the QIO when the need for HPMP <u>case review</u> is identified (Do not use after July 16, 2009)	**Completion time Frames (includes the 30-day MR request period):** • Complete review within 60-calendar day (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without or UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO determined the need for case review. **MR Request Date:** The date the QIO requested the MR to perform the review. **MR Record Receipt Date:** The date the QIO received the MR necessary to perform the review. **Complete Date:** The date the QIO completed review of the MR. **Review Start Date:** The date the QIO determined the need for HPMP case review. (i.e., the Selection Date).

Type of Review: **Hospital Payment Monitoring**   Code: **212**   Rev Date: **06/19/09**
Program (HPMP) Case Review

Review Requirements	Timing of Review	CRIS Entry
Cases selected by the QIO when the need for HPMP <u>data collection</u> is identified. (Do not use after July 16, 2009)		**Selection Date:** The date the QIO determined the need for data collection. **MR Request Date:** The date the QIO requested the MR to perform data collection. **MR Receipt Date:** The date the QIO received the MR necessary to perform data collection. **Completion Date and Completion Time Frames do not apply to data abstraction.**

Type of Review: **Hospital Payment Monitoring**   Code: **213**   Rev Date: **06/19/09**
Program (HPMP) Case Review

Review Requirements	Timing of Review	CRIS Entry
Cases referred to the QIO by the CDAC (Do not use after July 16, 2009) The medical record is not provided by the hospital. The QIOs must issue a technical denial for any case cancelled by the CDACs because a medical record was not provided. See "Additional Activities" for other technical denial activities. Effective with the QIOs 7th SOW, the QIO must issue a TD for records not provided for all types of reviews, except for HCQIP.	• The QIO may hold the issuance of the TD from day 31 until day 45. • Issue the TD by day 46 from the date of the initial MR request.	**Selection Date:** The date the CDAC requested the MR from the hospital. **Completion Date:** The date the QIO issues the technical denial letter and sends the adjustment to the FI.

Type of Review: **Hospital Payment Monitoring**   Code: **214**   Rev Date: **06/19/09**
                      Program (HPMP) Review of
                      Denied Claims

Review Requirements	Timing of Review	CRIS Entry
HPMP Case Review – FI Denied cases referred to the QIO by the CDAC (**Do not use after July 16, 2009**) As applicable, perform retrospective review for utilization, DRG validation, or quality. Because payment will be unaffected by lack of MR receipt, a technical denial created by the QIO for this select reason will reflect 'No record, no technical denial authority (TD not applicable).'	**Completion Time Frames (does not include the 30-day MR request period used by the CDAC):** • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete the review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG and/or quality of care concern was questioned. **(§4540 B QIO Manual)**	**Selection Date:** The date the QIO received the referral from the CDAC for review. **MR Request Date:** Not applicable to cases selected for the CDAC. **MR Receipt Date:** The date the QIO received the medical record from the CDAC. It may show 2 dates – the initial MR receipt and the additional information receipt. **Completion Date:** The date the QIO completed the review (i.e., the date the review coordinator or first level physician reviewer completed review, if not questioned, or the date the final notice is issued, if opportunity to discuss is offered. **Review Start Date:** The date the MR is received by the QIO (i.e., the Medical Record Receipt Date).

Type of Review: **Hospital Requested Higher Weighted DRG Assignments**   Code: **120**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Higher-weighted DRG review Hospitals submit request for higher-weighted DRG assignment, directly to the fiscal intermediary (FI) for processing and payment. Cases paid by the FI will be selected by CMS for QIO review. Perform medical necessity (utilization review) and DRG validation on a post-payment basis. Perform a quality of care review, when applicable. *(§4050 B. QIO Manual)*	**Completion Time Frames:** The QIOs will be notified via e-mail that the selection process is complete. The QIO has 5 calendar days to request the MR, the 30 calendar-day MR request period and the 20 calendar-day opportunity for discussion, when applicable: • Complete review within 65 calendar days (plus 15 extra days, when applicable) when no concerns are identified • Complete review within 95 calendar days (plus 15 extra days, when applicable) when utilization (UR)/DRG concerns are questioned by the physician. • Complete review within 105 calendar days (plus 15 extra days, when applicable) when the physician questions quality of care concerns with or without UR and/or DRG concerns. (§4540-QIO Manual) **Note: When a case is questioned for DRG validity and/or utilization with quality of care concerns, all final notices are sent following the completion time frames for the quality of care review.**	**Selection Date:** The date the QIO is notified by e-mail that the selection process is complete **MR Request Date:** The date the QIO requested the MR to perform the review. The request is made within 5 calendar days from receipt of the case selection. (It may show 2 dates: the initial MR request and additional information request.) **MR Receipt Date:** The date the QIO received the initial MR to perform the review. (It may show 2 dates: the initial MR request and additional information request.) **Completion Date:** The date the QIO completed the review (including notification of all affected parties) within the time frames specified in the Timing of Review column under the Completion Time Frames heading. **Review Start Date:** The date the QIO is notified of the selection (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Long Term Care Hospital Random Sample**   Code: **200**   Rev Date: **6/19/09**

Review Requirements	Timing of Review	CRIS Entry
LTCH Random Sample determined by CMS (Do not use after July 16, 2009) These cases will be selected for the QIOs by CMS. The QIOs will be notified via e-mail that the selection process is complete. The QIOs have 5 calendar days to request the MR.	Complete review according to the following time frames (includes the 5 calendar days to request the MR, 30-calendar day MR request period and 20-calendar day for opportunity for discussion when applicable): • 65 calendar days (plus 15 extra days when appropriate) to complete a review with no concerns identified • 95 calendar days (plus 15 calendar days when appropriate) to complete a review with UR/DRG concerns questioned by the physician. • 105 calendar days (plus 15 extra days when appropriate) to complete review with UR/DRG and quality of care concerns questioned by the physician. **Note: When a case is questioned for DRG validity and/or utilization with quality of care concerns, all final notices are sent following the completion time frames for the quality of care review.**	**Selection Date:** The date the QIO is notified by e-mail that the selection process is complete **MR Request Date:** The date the QIO requested the MR to perform the review. The request is made within 5 calendar days from receipt of the case selection. (It may show 2 dates – the initial MR request and additional information request.) **MR Receipt Date:** The date the QIO received the initial MR to perform the review. (It may show 2 dates – the initial MR receipt and additional information receipt.) **Completion Date:** The date the QIO completed the review (including notification of all affected parties). **Review Start Date:** The date the QIO is notified of the selection (i.e., the Selection Date).

Type of Review: **Medical Record Tracking for PDC Cases**   Code: **193**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
PDC only (no case review)	Medical record review not required	

Type of Review: **Medical Record Tracking for** Code: **310** Rev Date: **12/24/03**
Surveillance or Validation Sample

Review Requirements	Timing of Review	CRIS Entry
Surveillance Sample/Validation Sample	No Case Review Required Used for tracking purposes only.	

Timing of Review Requirements

Type of Review: **Notices of Discharge and Medicare**   Code: **114**   Rev Date: **07/31/08**
               Appeal Rights (NODMAR)
               (Immediate Review-only)

Review Requirements	Timing of Review	CRIS Entry
NODMAR – Immediate Review – Medicare+Choice (MA) *(§7055 D 2-QIO Manual)* *(Do not use after 7/31/2008)* Request made no later than noon of the first working day after the day the notice was received by the beneficiary (or his/her representative Determine if the care was not covered when the MA indicated. If the NODMAR content is inappropriate, report these findings to the CMS regional office. The QIO must notify the MA on the day the request is received. The MA must: • Supply any necessary information by phone or in writing to the QIO by COB of the first working day following the day of the beneficiary request. • Contact the hospital and request the MR and other pertinent information be sent to the QIO by COB of the first full working day immediately following the MA's request.	Complete the review within 1 working day of the receipt of the MR from the hospital.	**Selection Date:** The date the QIO received either a written or a verbal request to review the NODMAR. **MR Request Date:** The date the QIO notified the MA and requested the hospital's MR to perform the review. In most instances the date will be the same as the Selection Date when the MR is requested at the time of the notice review request. **MR Receipt Date:** The date the QIO received the hospital's MR necessary to perform the review. **Completion Date:** The date the QIO notified by telephone (followed by written notice) all affected parties of the review determination. Complete the review by COB of the first full working day following receipt of the hospital's MR. *(§7055 D.2. QIO Manual)* **Review Start Date:** The date the QIO received the written or verbal request for review and notified the MA (i.e., the Selection Date)

Timing of Review Requirements

Type of Review: **Other**　　　　　　Code: **171**　　　　Rev Date: **11/05/02**

Review Requirements	Timing of Review	CRIS Entry
Cost Outlier Review Type 1-FI selected inpatient hospital claims having outlier payments of 80% or more of the hospitals' operating and capital DRG payments. Cost outlier review requires full case review. In addition to the full case review, the medical record and the itemized bill must be utilized to determine that all services provided were medically necessary and appropriate and that the services billed were: • Not duplicated or erroneously billed; • Actually furnished; and • Ordered by the physician.	**Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO received the referral. **MR Request Date:** The date the QIO requested the MR and the itemized bill to perform the review. **MR Record Receipt Date:** The date the QIO received the MR and the itemized bill necessary to perform the review. (This may be the same date as the selection date if the MR is provided with the request.) **Completion Date:** The date the QIO completed review of the MR and provided review results to the referring agency, when applicable. **Review Start Date:** The date the QIO received the referral (i.e., the Selection Date).

Type of Review: **Other**   Code: **172**   Rev Date: **01/13/03**

Review Requirements	Timing of Review	CRIS Entry
Cost Outlier Review Type 2-FI selected inpatient hospital claims having met both the estimated outlier payments greater than 20% of hospitals' operating and capital DRG payments. Cost outlier review requires full case review. In addition to the full case review, the medical record and the itemized bill must be utilized to determine that all services provided were medically necessary and appropriate and that the services billed were: • Not duplicated or erroneously billed; • Actually furnished; and • Ordered by the physician	**Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra day, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO received the referral. **MR Request Date:** The date the QIO requested the MR and the itemized bill to perform the review. **MR Record Receipt Date:** The date the QIO received the MR and the itemized bill necessary to perform the review. (This may be the same date as the selection date if the MR is provided with the request.) **Completion Date:** The date the QIO completed review of the MR and provided review results to the referring agency, when applicable. **Review Start Date:** The date the QIO received the referral (i.e., the Selection Date).

Type of Review: **Other**   Code: **180**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Intensified Review – Physician	Perform the review required based on the reason for intensification. Follow the completion time frames applicable to the category under review	

Timing of Review Requirements

Type of Review: **Other**   Code: **181**   Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Intensified Review – Hospital	Completion Time Frames: • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO received the referral **MR Request Date:** The date the QIO requested the MR to perform the review if applicable, otherwise, leave blank. **MR Record Receipt Date:** The date the QIO received the MR necessary to perform the review. (This may be the same date as the selection date if the MR is provided with the request.) **Completion Date:** The date the QIO completed review of the MR and provided review results to the referring agency, when applicable. **Review Start Date:** The date the QIO determines the need for intensification (i.e., the Selection Date).

Timing of Review Requirements

Type of Review: **Other** Code: **220** Rev Date: **08/28/02**

Review Requirements	Timing of Review	CRIS Entry
Readmission Review A case that is part of a readmission pair that requires further review by the QIO to determine the quality of care provided, the medical necessity and appropriateness (utilization) of services, and the correctness of the coding used (DRG validation). **Note: When to use type 220: Example:** During the course of review of a HPMP case, the QIO identifies that there may have been a premature discharge, the QIO would request the second case and assign it type 220. Conversely, if the second case is part of the HPMP sampling and the QIO believes that there may have been a premature discharge, the QIO would request the first case and assign it type 220.	**Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO determined the need to review a case as part of a readmission pair. **MR Request Date:** The date the QIO requested the MR to perform the review. **MR Record Receipt Date:** The date the QIO received the MR necessary to perform the review. **Completion Date:** The date the QIO completed review of the MR (includes the 30-day MR period and 20-day opportunity for discussion when applicable): **Review Start Date:** The date the QIO determined the need for additional review (i.e., the Selection Date).

Type of Review: **Other**   Code: **240**   Rev Date: **11/05/02**

Review Requirements	Timing of Review	CRIS Entry
Cases identified for further review of a sanction case	**Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO received the referral. **MR Request Date:** The date the QIO requested the MR to perform the review if applicable, otherwise, leave blank. **MR Record Receipt Date:** The date the QIO received the MR necessary to perform the review. (This may be the same date as the selection date if the MR is provided with the request.) **Completion Date:** The date the QIO completed review of the MR and provided review results to the referring agency, when applicable. **Review Start Date:** The date the QIO determines the need for additional review (i.e., the Selection Date).

Type of Review: **Potential Concerns Identified**   Code: **190-192**   Rev Date: **04/04/03**
                During PDC

Review Requirements	Timing of Review	CRIS Entry
Potential quality of care concern (190) **Potential utilization concern (191)** **Potential coding concern (192)** Cases referred for potential circumvention of PPS and quality of care concerns. Complete review according to instructions found in §4105 of *the QIO Manual*.	**Completion Timeframes:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) when no concern is identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) when UR/DRG concerns are questioned referred for potential circumvention of the PPS and quality of care concerns. • Complete within 100 calendar days (plus 15 extra days, when applicable) when quality of care concern with or without a UR and/or DRG concern are questioned. *(§4540 B QIO Manual)*	**Selection Date:** The date the QIO identified the need to perform review. **MR Request Date:** The date the QIO requested the MR to perform review, if applicable, otherwise, leave blank. It may include 2 dates: the initial MR request and the additional information request. **MR Receipt Date:** The date the QIO received the MR necessary to perform review. It may include 2 dates: initial MR receipt date and additional information receipt date. **Completion Date:** The date the QIO completed the review. **Review Start Date:** The date the QIO identified the need to perform a review (i.e., the Selection Date)

Timing of Review Requirements

Type of Review: **Referrals**   Code: **150-158**   Rev Date: **06/19/09**

Review Requirements	Timing of Review	CRIS Entry
The scope of review will depend on the reason for the referral. Referrals may involve FFS and MA reviews. (*§4070-QIO Manual*) **FI/MAC referrals for coverage exclusion cases (150)** **FI/MAC referrals (e.g. coding issues, medical necessity issues) Excluding coverage exclusion cases (151)** **Carrier referrals related to ASC procedures that are terminated due to medical complications. (152)** **CMS referrals (RO or CO referrals) (153)** **Other federal referrals – referrals received from another federal agency, including FBI and DOJ referrals (154)** **OIG referrals (excluding payment audits). May include advisory reviews. (155)** **Center for dispute resolution referrals (156)** **Other FI and Carrier referrals (These types of referrals must be sent to the RO who will decide whether they should be referred to the QIO.) (157)** **FI/MAC Referrals for Readmission Review (158)**	Follow the completion time frames applicable to the category under review or as specified by the agreement between you and the referring agency. **Completion Time Frames:** • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date when no concerns were identified. • Complete review within 90 calendar days (plus 15 extra days, when applicable) from the review start date when a UR/DRG concern was identified. • Complete review within 100 calendar days (plus 15 extra days, when applicable) from the review start date when a quality of care concern with or without a UR and/or DRG concern(s) were identified.	**Selection Date:** The date the QIO received the referral. **MR Request Date:** The date the QIO requested the MR to perform the review if applicable, otherwise, leave blank. **MR Receipt Date:** The date the QIO received the MR necessary to perform the review. (This may be the same date as the selection date if the MR is provided with the request.) **Completion Date:** The date the QIO completed review of the MR and provided review results to the referring agency, when applicable. **Review Start Date:** The date the QIO received the referral or the date the QIO received CMS approval to proceed with the review (i.e., the Selection Date).

Timing of Review Requirements

Review Requirements	Timing of Review	CRIS Entry
Fraud and abuse referrals from agencies other than CMS. These types of referrals must be approved by CMS Central Office and receive PO instructions before beginning review. *(§9200 QI Manual)*	Complete a written evaluation within 45 calendar days of receipt of the fraud and abuse referral. All relevant material will be provided on the day the case(s) are referred to the QIO, therefore, the entire 45 days is available to the QIO to complete the review. *(§9210 QIO Manual)*	**Selection Date:** The date the QIO received the CMS approval to proceed with the referral. **MR Request Date:** The date the QIO requested the MR if applicable, otherwise, leave blank. **MR Receipt Date:** The date the QIO received the MR necessary to perform the review. (This may be the same date as the selection date if the MR necessary for review is provided at the time of the request.) **Completion Date:** The date the QIO completed the review and provided the results to referring agency. **Review Start Date:** The date the QIO received the referral or the date the QIO received CMS approval to proceed with the review (i.e., the Selection Date)

Type of Review: **Referrals**   Code: **173**   Rev Date: **7/13/06**

Review Requirements	Timing of Review	CRIS Entry
Fraud and abuse referrals from the Program Safeguard Contractor (PSC), such as the Benefit Integrity Support Center. These types of referrals do not need to be approved in advance by the project officer as indicated in **TOPS PRO 2000-24**	**Completion Time Frames (does not include the 30-day MR request period):** All relevant material should be provided on the day the case(s) are referred to the QIO *(§9210 QIO Manual).* • Complete review within 30 calendar days (plus 15 extra days, when applicable) from the review start date for cases with no concerns identified. • Complete review within 60 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG concern was questioned. • Complete the review within 70 calendar days (plus 15 extra days, when applicable) from the review start date for those cases where a UR/DRG and or quality of care concern was questioned. *(§4540 B QIO Manual)*	**Selection Date:** The date the QIO received the request for review. **MR Request Date:** The date the QIO requested the MR if applicable, otherwise, leave blank. **MR Receipt Date:** The date the QIO received the MR necessary to perform the review. (This may be the same date as the selection date if the MR necessary for review is provided at the time of the request.) **Completion Date:** The date the QIO completed the review and provided the results to the PSCs. **Review Start Date:** The date the QIO received the request for review (i.e., the Selection Date).

ADDITIONAL ACTIVITIES TO REMEMBER   Rev Date: **11/05/02**

Review Requirements	Timing of Review	CRIS Entry
Re-review Applies to DRG changes and quality of care confirmed concerns	**DRG Changes Re-review-** The provider must request the re-review within 60 calendar days after the date of receipt of the notice. The QIO must complete the re-review within 30 **working** days (including notification) of receipt of the request. **Quality of Care Re-review**- The provider/practitioner must request a re-review within 30 calendar days after the date of receipt of the notice. The QIO must complete the re-review within 30 calendar days (including notification) of receipt of the request	

ADDITIONAL ACTIVITIES TO REMEMBER   Rev Date: **11/05/02**

Review Requirements	Timing of Review	CRIS Entry
Reconsideration- Applies to medical necessity (utilization) final determination	**Utilization Reconsideration** The beneficiary, provider, or practitioner must request the reconsideration within 60 calendar days after the date of receipt of the initial determination notice (or past this time with good cause). The QIO must complete the reconsideration within 30 working days (including notification) of receipt of the request. **Expedited Reconsideration** of a pre-admission, pre-procedure or concurrent initial determinations. The QIO must complete the reconsideration within 3 working days (including notification) after receipt of the request.	

ADDITIONAL ACTIVITIES TO REMEMBER   Rev Date: **11/05/02**

Review Requirements	Timing of Review	CRIS Entry
Issuance of Technical Denials for all other review types Note: Medical records not provided for HPMP review use code 213	Effective with the QIO's 7th SOW, the QIO must issue a TD for records not provided for all types of reviews, except for HCQIP. • The QIO may hold the issuance of the TD from day 31 until day 45 • Issue the TD by day 46 from the date of the initial MR request	