Institutional Review Record Request

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QUALIS HEALTH

Advancing Healthcare
Improving Health

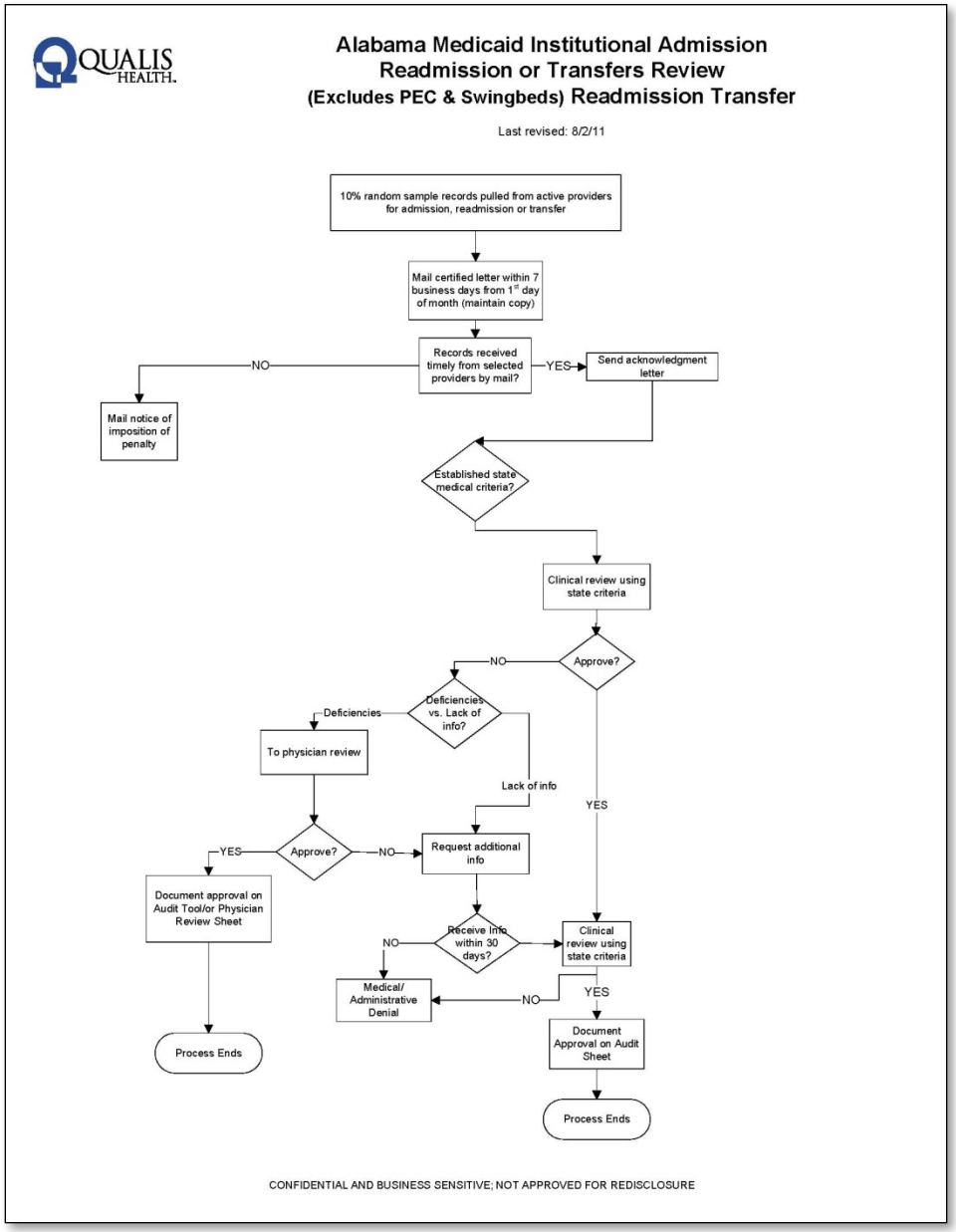
Institutional Admission Reviews

Primary Goal

- Ensure the appropriate utilization and admissions to the Institutional program by performing retrospective reviews of medical records documentation of admission, readmission and transfer certification of Institutional benefits.
- Each admission type, must provide:
  - Form 161 (LTC-9),
  - Minimum Data Set,
  - Preadmission screening information,
  - Physician orders for the requested Medicaid admission date, and any other documentation which supports the nursing home level of care criteria for the requested date of admission.

Review Process

- Review performed by registered nurse
- 10% sample of all admissions, readmissions and transfers from COLD Long Term Care reports
- Retrospective review to establish compliance with Alabama Medicaid established criteria
- Refer to Medical Director if unable to make determination



Alabama Medicaid Institutional Admission Readmission or Transfers Review

Long Term Care Administrative Code

Rule No. 560-X-10- 07 Review of Medicaid Residents

(1) The Alabama Medicaid Agency or its designated agent will perform a review of Medicaid nursing home or ICF/MR facility residents' records to determine appropriateness of admission.

(a) A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Alabama Medicaid Agency Long Term Care Division or its designee within ten working days from receipt of the certified letter shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Long Term Care Division may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Long Term Care Division with supporting documentation.

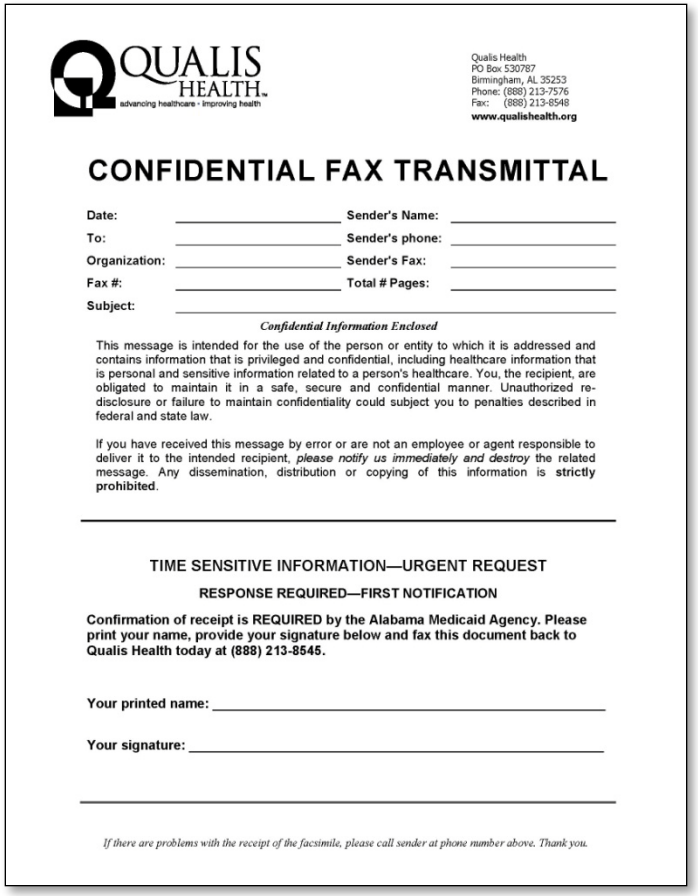
Fax Process

Qualis Health fax request sent to facility with attached letter identifying recipient selected for review.

- First Fax Notification: Acknowledgment of fax receipt. Confirmation is complete with printed name and signature. Mail medical records to HP for record review.
- Second Fax Notification: Acknowledgment of fax receipt. Confirmation is complete with printed name and signature. Mail medical records to HP for record review.
- Final Fax Notification: Mail medical records to HP for record review.
- Letter of Imposition: Mail medical records to HP for record review.

First Fax Letter

- Confirmation of receipt is REQUIRED by the Alabama Medicaid Agency. Please print your name, provide your signature below and fax this document back to Qualis Health today at (888) 213-8545.



QUALIS HEALTH
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CONFIDENTIAL FAX TRANSMITTAL

Date: _____ Sender's Name: _____
To: _____ Sender's phone: _____
Organization: _____ Sender's Fax: _____
Fax #: _____ Total # Pages: _____
Subject: _____

Confidential Information Enclosed

This message is intended for the use of the person or entity to which it is addressed and contains information that is privileged and confidential, including healthcare information that is personal and sensitive information related to a person's healthcare. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

If you have received this message by error or are not an employee or agent responsible to deliver it to the intended recipient, *please notify us immediately and destroy* the related message. Any dissemination, distribution or copying of this information is **strictly prohibited**.

TIME SENSITIVE INFORMATION—URGENT REQUEST

RESPONSE REQUIRED—FIRST NOTIFICATION

Confirmation of receipt is REQUIRED by the Alabama Medicaid Agency. Please print your name, provide your signature below and fax this document back to Qualis Health today at (888) 213-8545.

Your printed name: _____

Your signature: _____

If there are problems with the receipt of the facsimile, please call sender at phone number above. Thank you.

Second and Final Fax Letter

- Confirmation of receipt is REQUIRED by the Alabama Medicaid Agency. Please print your name, provide your signature below and fax this document back to Qualis Health today at (888) 213-8545. Failure to comply may result in financial penalties.

Fax Notification of Imposition

- After three attempts (first, second, final), a certified letter of imposition is sent from Qualis Health on behalf of AMA.
- Your failure to submit the requested information within 10 working days from the date of receipt of the fax notification will result in Qualis Health recommending assessment of a penalty of $100.00 per day as per the AMA Administrative Code Chapter 10, Rule Number 560-X-10-07

Process for Mailing Medical Records to HP

- Mail the medical records and a cover sheet to HP, the Agency's fiscal agent:
  HP Enterprise Services
  PO Box 244032
  Montgomery, AL 36124-4032

- Records will be scanned into the system by HP so that Qualis Health staff can review them electronically.

- The coversheet MUST be used to ensure that the records are added to the correct site electronically. Remember, you must add the 13th digit unique identifier to the recipient ID. This 13th digit can be located on the member's eligibility screen as the check digit.

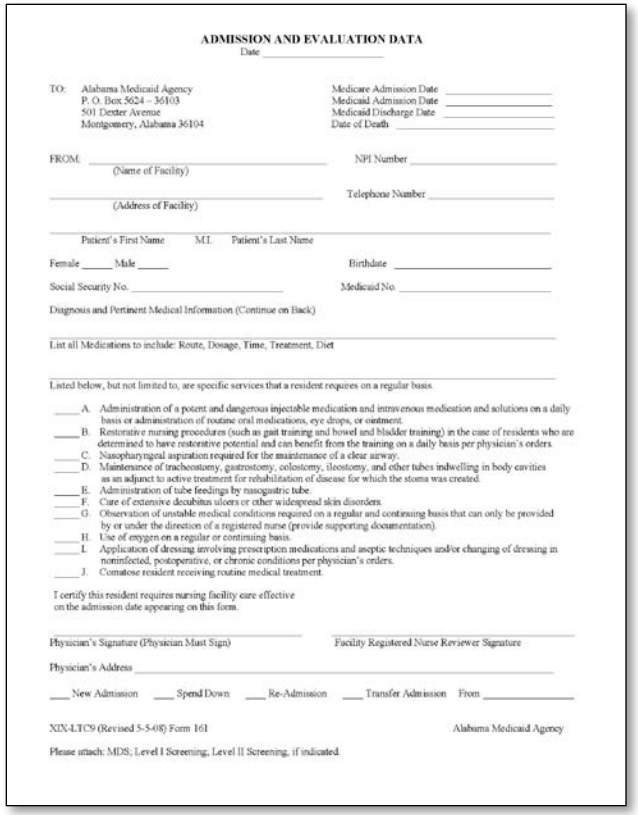
- Failure to submit the requested information within 10 working days from the date of receipt of the fax notification may result in Qualis Health recommending assessment of a penalty of $100.00 per day as per the AMA Administrative Code Chapter 10, Rule Number 560-X-10-07.

- If you have questions regarding this request you may contact the Qualis Health call center number at (888) 213-7576.

Admission Evaluation Data Sheet Form 161/LTC9

Go to medicaid.alabama.gov, then click on

- Resources
- Forms Library
- Long Term Care
- Form 161



ADMISSION AND EVALUATION DATA

Date _____

TO: Alabama Medicaid Agency
P. O. Box 5624 – 36103
501 Dexter Avenue
Montgomery, Alabama 36104

Medicare Admission Date _____
Medicaid Admission Date _____
Medicaid Discharge Date _____
Date of Death _____

FROM: _____ NPI Number _____
(Name of Facility)

_____ Telephone Number _____
(Address of Facility)

_____
Patient's First Name M.I. Patient's Last Name

Female _____ Male _____ Birthdate _____

Social Security No. _____ Medicaid No. _____

Diagnosis and Pertinent Medical Information (Continue on Back)

List all Medications to include: Route, Dosage, Time, Treatment, Diet

Listed below, but not limited to, are specific services that a resident requires on a regular basis.

_____A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.
_____B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.
_____C. Nasopharyngeal aspiration required for the maintenance of a clear airway.
_____D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
_____E. Administration of tube feedings by nasogastric tube.
_____F. Care of extensive decubitus ulcers or other widespread skin disorders.
_____G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (provide supporting documentation).
_____H. Use of oxygen on a regular or continuing basis.
_____I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.
_____J. Comatose resident receiving routine medical treatment.

I certify this resident requires nursing facility care effective on the admission date appearing on this form.

_____ _____
Physician's Signature (Physician Must Sign) Facility Registered Nurse Reviewer Signature

Physician's Address _____

___New Admission ___Spend Down ___Re-Admission ___Transfer Admission From _____

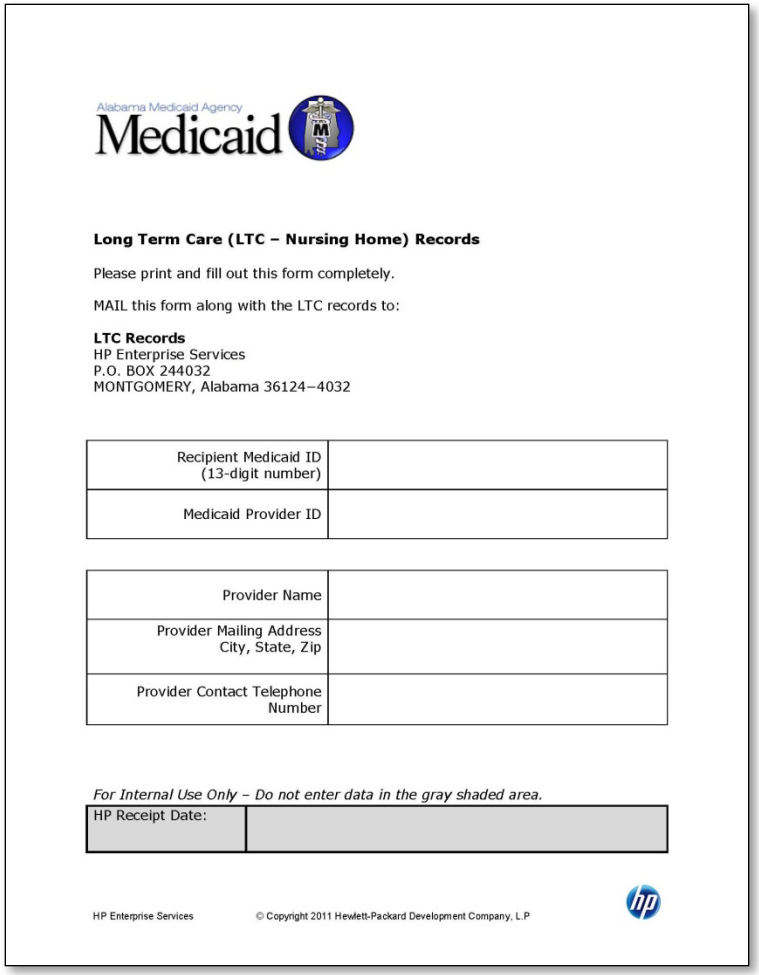
XIX-LTC9 (Revised 5-5-08) Form 161 Alabama Medicaid Agency

Please attach: MDS; Level I Screening; Level II Screening, if indicated.

Cover Sheet

Go to medicaid.alabama.gov, then click on

- Resources
- Forms Library
- Long Term Care
- LTC Records



Alabama Medicaid Agency
Medicaid

Long Term Care (LTC – Nursing Home) Records

Please print and fill out this form completely.

MAIL this form along with the LTC records to:

LTC Records
HP Enterprise Services
P.O. BOX 244032
MONTGOMERY, Alabama 36124–4032

Recipient Medicaid ID (13-digit number)	
Medicaid Provider ID	

Provider Name	
Provider Mailing Address City, State, Zip	
Provider Contact Telephone Number	

For Internal Use Only – Do not enter data in the gray shaded area.

HP Receipt Date:	

HP Enterprise Services

Thank You

Qualis Health

(888) 213-7576

www.qualishealth.org