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Introduction

eQHealth Solutions is the Utilization Management and Quality Improvement Organization contracted to perform utilization and quality of care review for private duty nursing (PDN) and prescribed pediatric extended care (PPEC) services rendered to Mississippi Medicaid beneficiaries. The purpose of this manual is to assist providers to successfully navigating through eQHealth’s review requirements and process.

Getting Started – Helpful Tips
Providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at https://msmedicaid.acs-inc.com/msenvision/index.do or 1-800-884-3222 or 601-206-3000. The above contact information is also used if you have a billing question.

Review Exclusions
Medicaid policy exempts certain encounters from eQHealth review and the provider should not submit review requests for these situations.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Medicaid Eligibility</td>
<td>No eQHealth review is required if the beneficiary does not have current Medicaid eligibility. If the patient has applied for Medicaid and the eligibility determination is pending, eQHealth cannot perform review. Once eligibility has been determined, eQHealth performs review based on the eligibility begin date.</td>
</tr>
<tr>
<td>Medicare Eligibility</td>
<td>No eQHealth review is required if the beneficiary has Medicare Part A and Part B coverage, and the Medicare benefits are not exhausted.</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>No eQHealth review is required if the beneficiary is in a long-term care facility.</td>
</tr>
<tr>
<td>Adult Beneficiaries</td>
<td>No eQHealth review is required for beneficiaries who have attained age 21. PDN services are only available through the EPSDT Program.</td>
</tr>
<tr>
<td>Family Planning Waiver</td>
<td>No eQHealth review is required if the beneficiary’s Medicaid eligibility is only for the family planning waiver.</td>
</tr>
<tr>
<td>Hospice</td>
<td>No eQHealth review is required if the beneficiary is currently under the care of a hospice.</td>
</tr>
<tr>
<td>Home Health</td>
<td>No eQHealth review is required if the beneficiary is</td>
</tr>
</tbody>
</table>
Currently receiving Home Health Services.

**Note:**
- Certification should be obtained when the beneficiary or youth has Medicaid eligibility and third party insurance.

Request for precertification of PDN and/or PPEC services should be submitted to eQHealth following:
- Identification of the need for PDN and/or PPEC services by a physician.
- Receipt of an order for PDN and/or PPEC services.
- Discussion between the provider and attending physician regarding the need for services and the beneficiary’s plan of care.

**PDN & PPEC Service Codes Requiring Precertification**
Providers must pre-certify services through eQHealth. Service codes and narrative descriptions are listed in the following table.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9123</td>
<td>PDN RN Nursing Hourly Rate</td>
</tr>
<tr>
<td>S9124</td>
<td>PDN LPN Nursing Hourly Rate</td>
</tr>
<tr>
<td>T1025</td>
<td>PPEC Daily (Greater than 4 hours per day)</td>
</tr>
<tr>
<td>T1026</td>
<td>PPEC Hourly (4hrs or less per day) 1 unit = 1 hour</td>
</tr>
</tbody>
</table>
Submitting your prior authorization request:

How to submit your request
Reviews are submitted electronically using eQHealth’s proprietary Web-based software, eQSuite®.

eQSuite’s® Key Features Include:
- Secure HIPAA-compliant technology allows electronically recording and transmission of most information necessary for a review to be completed.
- Secure transmission protocols including the encryption of all data transferred.
- System access control for changing or adding authorized users
- 24x7 access with easy to follow data entry screens
- Rules-driven functionality and system edits which assist by immediately alerting to such things as situations for which review is not required
- A reporting module that provides the real time status of all review requests
- A HELPLINE module through which providers may submit questions about a specific PA request

Minimal System Requirements
- Computer with Intel Pentium 4 or higher CPU and monitor
- Windows XP SP2 or higher
- 1 GB free hard drive space
- 512 MB memory
- Internet Explorer 8 or higher, Mozilla Firefox 3 or higher, or Safari 4 or higher
- Broadband internet connection

eQHealth will provide information explaining everything to access eQSuite®. To get started, a provider web administrator will be designated, and eQHealth will assign a user ID and password for him or her. The administrator does not need to be an information systems specialist; however, this person will be responsible for each provider’s user IDs and passwords. Managing system access is a user-friendly, non-technical process.

Types of Review Requests
A review for initiation of a service(s) is referred to as an admission review. Subsequent reviews are performed to determine if continuation of services is medically indicated and appropriate. These are called continued stay reviews.
The following table describes the types of review, timeframes for submission, and required documentation for each type of review. Forms and instructions are available on our website ms.eqhs.org for emergency use in the event of internet outages.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Timeframe</th>
<th>Required Documentation</th>
</tr>
</thead>
</table>
| Preadmission Certification   | At least 10 business days prior to initiation of PDN and/or PPEC services. | Use eQSuite® to submit the admission request or fax/mail a completed PDN/PPEC Plan of Care Form. The initial plan of care must include at least the following:  
  • Beneficiary’s diagnosis(es)  
  • Skilled teaching/instruction to be provided to family/caregiver  
  • Treatment plan/Physician’s orders (Specify each skill to be performed.)  
  • Expected duration of service  
  • Level of service  
  • Identification of types of other homecare services to be provided (i.e., case management, physical therapy, speech therapy, occupational therapy, respiratory therapy, respite, hospice, home health, personal care attendant, etc.) and the hours, days, and times of the day these services are to be provided  
  • Homebound status  
  • Plan for reducing and/or discontinuing PDN or PPEC services  
  • When applicable, a plan to transition the beneficiary to the most appropriate setting when PDN or PPEC services are no longer required  
  • Agency’s home and social assessment  
  • Physician’s signature  
  • The plan of care must be signed by the PDN Agency’s Registered Nurse or PPEC Director of Nursing. |

The following documents should be
<table>
<thead>
<tr>
<th>Review Type</th>
<th>Timeframe</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>uploaded via eQSuite® or faxed with the PDN/PPEC Plan of Care Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of the PDN agency’s home and social assessment (not applicable for PPEC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• an eQHealth PDN/PPEC Nursing Initial Certification of Medical Necessity Physician Plan of Care Form</td>
</tr>
<tr>
<td>Continued Stay/Recertification request:</td>
<td>At least 10 business days prior to the last date certified by eQHealth</td>
<td>Use eQSuite® to submit the continued stay request or fax/mail a completed PDN/PPEC Continued Stay Request Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following documents should be uploaded via eQSuite® or faxed with the PDN/PPEC Continued Stay Request Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated plan of care form signed by a physician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Progress notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Monthly summaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Visit notes</td>
</tr>
</tbody>
</table>

eQSuite® guides the user through the request submission process. However in this section, an explanation of the prior authorization review process for PDN or PPEC services is provided.
**What eQHealth looks for when reviewing a request**

The eQHealth Review Team:
Is a multidisciplinary team, composed of registered nurses, physicians and physician consultants. The review team is overseen by our Medical Director.

**Automated Administrative Screening**
When the review request is entered in eQSuite®, the system applies a series of edits to ensure authorization by eQHealth is required and that all Medicaid eligibility requirements, Administrative Code and regulations are satisfied. If there is an eligibility issue or the services are not subject to review, the system will inform and prompt the user to cancel the review.

**Clinical Reviewer (1st Level) Screening of the Request**
When there are no review exclusions identified by eQSuite®, the system routes the request to a first level reviewer who screens and reviews the request. The first level reviewer evaluates the entire request for compliance with DOM rules and regulations that cannot be applied by the automated process and for compliance with supporting documentation requirements.

**Screening for Compliance**
If the first level reviewer identifies an issue with the request related to Medicaid requirements, a technical determination (TD) is rendered and the review will not proceed. The requesting provider is notified electronically through eQSuite® and by phone call. Since a technical determination is rendered for an administrative reason (not a clinical or medical necessity reason) it is not subject to reconsideration.

If all required information is not received with the request, the first level reviewer “pends” the request. Providers will be notified electronically and by phone call. The information must be received within one (1) business day. If it is not received within the specified time frame the review request is suspended and the provider will be notified electronically. If the information is submitted at a later date, eQHealth will re-open the review and the review will be performed for services from the date the information is received. eQHealth cannot backdate the request.

**Clinical Information: Screening, Pended and Suspended Requests**

**Clinical Information Screening**
Before performing the medical necessity review, the first level reviewer screens the submitted clinical information for completeness to perform the medical necessity review. When additional clinical information is required or when the available information requires clarification, the first level reviewer
pends the review request and specifies the information or clarification needed.

**Pended and Suspended Review Requests**

When the clinical reviewer pends a review request:

- The provider will receive a phone call and can access the review record to determine what additional information is needed.
- The requested information must be submitted within one (1) business day.
- If eQHealth does not receive the information within one (1) business day, the review request is suspended and no further review processing occurs until the additional information requested has been received. If the information is submitted at a later date, eQHealth re-opens the request and reviews the services beginning from the date the complete information was received. eQHealth cannot backdate the request.

**First Level Medical Necessity Review Process**

When all information has been submitted and the clinical information screening is completed, the first level reviewer performs the medical necessity review. When performing the review, the first level reviewer evaluates all clinical information recorded in eQSuite® and all submitted information.

**Clinical Criteria for PDN and PPEC Services**

eQHealth Solutions first level reviewers use DOM regulations, rules, and approved clinical criteria as tools when making clinical determinations concerning the medical necessity of care.

**Approvals**

First level reviewers apply Medicaid approved clinical guidelines to determine whether the services are medically necessary or otherwise allowable under Medicaid policy. If the criteria are satisfied, the clinical reviewer renders an approval determination for each line item, for the number of units requested and for the requested time frame or policy maximum.

**Approval Notifications**

Approval notifications are generated for all services determined to be medically necessary.

- Electronic notifications are generated to the treating practitioner/provider.
  - When the determination is rendered, the requesting provider’s secure web-based provider status report is updated. The provider may access the report to see the determination.
Within one (1) business day of the determination eQHealth posts a provider notification letter. The notification specifies the authorized service(s), the number of units, the authorization period*, and the Treatment Authorization Number (TAN). Providers may access the notification by logging onto eQSuite®. The notifications may be downloaded and printed.

eQHealth transmits the Treatment Authorization Number (TAN) to the Medicaid fiscal agent.

Referral to a Second Level Reviewer (SLR)
First level reviewers may not render an adverse determination; any requests which cannot be approved by the nurse are referred to a SLR. When the first level reviewer refers a review request to a SLR, the requesting provider’s Web-based status report is updated and displays the referral status.

Second Level (Physician) Review Process
The SLR uses clinical experience, knowledge of generally accepted professional standards of care and judgment.

Approval Determinations and Pended Reviews
For each service the first level reviewer was unable to approve, the SLR determines the medical necessity of the service.

- **Approval on the basis of available information**: When the available information substantiates the medical necessity of the service(s), units and service duration, the SLR approves as requested and the review is completed. Notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.

- **Providers may receive a “pend” if additional information is required**: If a SLR is not able to approve the service(s) on the basis of the available information, the SLR may attempt to speak with the clinician to obtain additional or clarifying information. If the clinician is not available when the SLR calls, the SLR may issue a pend determination at that time. Any information obtained telephonically or via pend is documented in the review record. If the SLR is able to authorize the service(s) on the basis of the additional or clarifying information obtained, an approval determination is rendered. The review is complete and notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.

- **SLR pended review requests**: Providers will receive an electronic notification of the pended review.
  - The information must be provided within one (1) business day.
If the requested information is not received within one (1) business day, the SLR renders a determination on the basis of the information that is available.

**Adverse Determinations**

Only a SLR may render an adverse determination (denial). As noted in the preceding section, prior to rendering an adverse determination the SLR may attempt to discuss the request with the clinician. There are two types of adverse determinations: denial and partial denial.

**Denial**

The SLR may render a (full) medical necessity denial.

- Providers will receive immediate electronic notification, via the eQSuite® review status report, of the denial. EQHealth will also complete a phone notification when there is a denial decision.
- Within two (2) business days of the determination, the final written notification of the denial is posted electronically for in eQSuite®. The notification may be downloaded and printed.
- Written denial notifications also are mailed to the provider and to the beneficiary, the beneficiary’s parent or legal guardian/caretaker.
- The written notification includes information about rights of the provider, the attending physician and the beneficiary to a reconsideration of the adverse determination.
- The beneficiary’s notification also includes information about his/her right to request an appeal.

The eQHealth Medical Director or in their absence, their designee is available to speak with attending physicians to explain clinical denials.

**Reconsideration Reviews**

The provider, the attending physician, the beneficiary, or parent/guardian/caretaker may request a reconsideration of an adverse determination. Adverse determination notices contain instructions for requesting reconsideration. The reconsideration must be requested within 30 calendar days of the date of the denial notification. Additional information may be found in our [Reconsideration Manual](#).

Review determination and notification timeframes are displayed in the following table.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Determination and Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission</td>
<td>Within ten business days of receipt of review request</td>
<td>Within one business day of review determination.</td>
</tr>
<tr>
<td>Continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stay</td>
<td>and necessary information.</td>
<td></td>
</tr>
</tbody>
</table>
IF MORE INFORMATION OR ASSISTANCE IS NEEDED

eQHealth Solutions offers a variety of ways to obtain information or assistance when submitting prior authorization (PA or review) requests. In the following sections is listed, by topic or type of assistance needed, useful resources.

Questions about the PDN and PPEC Services Utilization Management Program
For questions or information about the PDN and PPEC Services Utilization Management Program, the following resources are available:

- Resources available on our Web site: http://ms.eqhs.org:
  - eQHealth PDN and PPEC Services Provider Manual
  - Training presentations: Copies of training and education presentations are available under the “Training/Education” tab
  - eQHealth’s HELPLINE Toll free number 1-866-740-2221

Questions about Using our Web-based Review System
eQSuite® is eQHealth Solutions’ proprietary Web-based review system. It is used to submit PA requests. For questions or to report problems contact us at 1-866-740-2221.

Submitting Prior Authorization Requests by Means Other than Web
If a provider does not use computers in day-to-day operations, please contact eQHealth’s HELPLINE Toll free number 1-866-740-2221.

How to submit documentation when needed or requested
Providers can upload the file directly or create a barcode fax coversheet.

DO NOT REUSE OR COPY BAR CODED FAX COVER SHEET(S) – THEY ARE SPECIFIC TO THE REVIEW TYPE FOR A PARTICULAR BENEFICIARY AND ARE SPECIFIC TO THE TYPE OF DOCUMENT.

Checking the Status of a PA Request or Submitting an Inquiry about a Request
To determine the status of a previously submitted PA request, log in to eQSuite® login and check the information in review status report. If there are additional questions about a previously submitted PA request, submit an inquiry using eQSuite’s® HELPLINE module. Both options are available 24 hours a day. Although using eQSuite® is the most efficient way to obtain
information about PA requests, providers also may call our HELPLINE Toll free number 1-866-740-2221.

**eQHealth Solutions HELPLINE**

For general inquiries, or questions that cannot be addressed through eQSuite® or if there is a complaint or a compliment, contact eQHealth Solutions' HELPLINE Toll free number 1-866-740-2221 available 8:00AM – 5:00PM Central Time, Monday through Friday. eQHealth Solutions is closed Saturday, Sundays, and some holidays. A call placed during non-business hours (anytime outside of 8:00AM – 5:00PM Central Time, Monday through Friday), will have the option of leaving a message.

If providers have a complaint or compliment and would prefer to write to eQHealth Solutions, there are two options. Fax the information to the toll free Quality Concerns fax number: 1-888-204-0221 or mail the information to:

```
eQHealth Solutions- Mississippi Division
Attention: Quality Concerns
460 Briarwood Drive, Suite #300
Jackson, MS 39206
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Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving PDN or PPEC services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by eQHealth.

eQHealth identifies aberrant patterns and/or trends by provider. Quality sampling may include health care services provided to all age groups.

Please see the Quality Review Process Manual for additional details.
# DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Appeal</td>
<td>If the reconsideration outcome was to uphold the denial and there is a disagreement with this decision, the beneficiary/legal representative may request an administrative appeal from the Division of Medicaid.</td>
</tr>
<tr>
<td>New Service/Admission Review</td>
<td>The review performed by eQHealth when a new or existing patient’s information is entered into the eQHealth web portal for the first time or is new to the precertification process. New Service/Admission Review is interchangeable with Precertification Review.</td>
</tr>
<tr>
<td>Continued Stay Review</td>
<td>The review performed by eQHealth when a beneficiary receiving services requires care beyond the originally approved unit amount and time span.</td>
</tr>
<tr>
<td>Bar Coded Fax Coversheet</td>
<td>Web utility option that allows the provider to print a specialized cover sheet encrypted with bar code technology that links required documents directly to a specific review. The coversheet is designed for one use and may not be altered in any way.</td>
</tr>
<tr>
<td>Denial</td>
<td>Occurs when requested services are not approved. Only a Second Level Reviewer can clinically deny a request.</td>
</tr>
<tr>
<td>Errors or Error Message</td>
<td>An eQSuite® message indicating the request is incorrect and can not be submitted, (i.e. submitting a prior authorization request for a MSCAN enrolled beneficiary will cause an error and is displayed as such.)</td>
</tr>
</tbody>
</table>
**First Level Reviewers**

eQHealth first level reviewers:
- Apply DOM policy
- Apply DOM approved medical necessity clinical guidelines
- Request additional information
- Refer requests that cannot be approved for review and determination by a second level reviewer
- Authorize care
- Are Mississippi licensed Registered Nurses

**International Classification of Diseases coding system**

“ICD-10-CM Diagnosis” means the International Classification of Diseases, 10th Revision, and Clinical Modification, which is a method of classifying written descriptions of diseases, injuries, conditions, and procedures using alphabetic and numeric designations or codes.

**Pend**

Refers to the process of placing a review request on hold until additional information has been received. eQHealth Solutions will notify the provider of the information needed along with a time frame for submission.

**Prior Authorization**

Process for receiving approval for services.

**Quality Improvement Organization (QIO)**

A federally designated organization as set forth in Section 1152 of the Social Security Act and 42 CFR Part 476. (QIOs were formerly called Peer Review Organizations [PROs].) They are firms that operate under the federal mandate to provide quality and cost-management services for the national Medicare Program and for states’ Medicaid programs.

The Center for Medicare and Medicaid Services (CMS) oversees the national Medicare QIO Program, and it requires that states contract with QIOs to assist them in managing the cost and quality of health care services provided to Medicaid recipients. By law, the mission of the federal QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to recipients. CMS reports that “Throughout its history, the Program has been instrumental in advancing national
efforts to motivate providers in improving quality, and in measuring and improving outcomes of quality.”

<table>
<thead>
<tr>
<th>Reconsideration</th>
<th>Following a clinical denial, either the beneficiary/legal representative, service provider and/or attending physician can request reconsideration or “another look” by an eQHealth SLR, (different from the initial SLR) to review the request and any additional information submitted.</th>
</tr>
</thead>
</table>

| Second Level Reviewers | eQHealth second level reviewers (SLR):  
- Make certification, denial or reconsideration determinations. That decision is:  
  - Based on documentation that supports prognosis and medical appropriateness of setting  
  - Patient-centered and takes into consideration the unique factors associated with each patient care episode  
  - Sensitive to the local healthcare delivery system infrastructure  
  - Based on his or her clinical experience, judgment and accepted standards of healthcare  
- Request additional information  
- Clinically deny certification  
- Are Mississippi licensed and credentialed physicians  

*Only a SLR can clinically deny a request.*  
The second level reviewer may contact the ordering physician, clinician, or service provider to obtain additional information when the documentation submitted does not clearly support medical necessity. |

| Supporting documentation | Supporting documentation is particular documentation required at the time of an authorization request for particular services.  
The nature of the required documentation varies according to the type of service and may vary according to the type of authorization request. |
| --- | --- |

| Suspended review | The status of a review request when a provider is notified that additional clinical information is needed to complete a |
review, but the provider does not submit the requested information within the required timeframe. If the requested information is submitted at a later date, the review request is unsuspended and review is performed.

<table>
<thead>
<tr>
<th>Treatment Authorization Number (TAN)</th>
<th>The acronym for “Treatment Authorization Number” is the number issued by eQHealth following the review approval process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upload</td>
<td>Web utility option that allows required documents in a .tif, .jpeg, or pdf files to be directly linked from a provider’s computer to a specific review.</td>
</tr>
<tr>
<td>Unsuspended review</td>
<td>The status of a review request when a provider submits all additional clinical information that was needed to complete a review. When all required information is submitted, eQHealth “unsuspends” the review request and completes the review.</td>
</tr>
</tbody>
</table>
Section VII. Review Process Flow Chart

- Request for Certification
  - Suspend Review
    - No
      - Information received?
        - Yes
          - First level review
        - No
          - Complete Information?
            - Yes
              - Second level review (peer to peer) discussion may occur
            - No
              - May pend for information

- Information received – reopen.

- Referral – medical necessity
  - May pend for information
  - Utilization and quality review completed at the same time
    - Yes
      - UR determination (if referred)
        - Yes
          - Quality issue resolved?
            - Yes
              - Report to DOM
            - No
              - Track and trend: Quality patterns
        - No
          - Flag record for 5% Quality sample
    - No
      - Refer to Medical Director
        - Discussion with involved physician
          - Resolved
          - Report to DOM
          - Track and trend: Quality patterns
          - Flag record for 5% Quality sample

Note: Utilization review and quality outcomes are included in pattern analysis activities.