

SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE MEDICARE REVIEW PLAN

South Dakota Foundation for Medical Care (SDFMC) has been awarded a three-year contract with the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services to be the physician Quality Improvement Organization (QIO) for South Dakota. The new contract, in effect from August 1, 2008 through July 31, 2011, is called the 9th Statement of Work (SOW). The SOW intends to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to improving quality; monitoring and improving quality of care; communicating with beneficiaries, physicians, and health care providers in order to promote informed health choices; protecting beneficiaries from substandard care; and strengthening the infrastructure of the health care improvement process.

MAJOR ACTIVITIES

1. Quality Improvement Projects

The primary goal of the QIO program is to improve the quality of care for Medicare beneficiaries. SDFMC will achieve this goal by collaborating with providers, Medicare Advantage plans, prescription drug plans, practitioners, beneficiaries, and other stakeholders to implement quality improvement projects. With these collaborators and partners, SDFMC jointly adopts, designs, implements, and/or supports quality improvement interventions; and analyzes data to determine whether an improvement in the quality indicators has occurred.

SDFMC will implement quality improvement projects with a limited number of providers based on CMS-determined criteria designed to improve the quality of care provided to all eligible Medicare beneficiaries in South Dakota on a standardized set of quality indicators. Because some of these indicators will change over the course of the SOW, a detailed description of the current quality indicators within the settings is available on the CMS website at www.cms.hhs.gov/QualityInitiativesGenInfo/.

Patient Safety. QIO activities under the Patient Safety Theme will focus on six primary topics:

1. Reducing rates of health care-associated methicillin-resistant Staphylococcus aureus (MRSA) infections;
2. Reducing rates of pressure ulcers in nursing homes and hospitals;
3. Reducing rates of use of physical restraints in nursing homes;
4. Improving inpatient surgical safety and heart failure treatment in hospitals;
5. Improving drug safety; and
6. Providing quality improvement technical assistance to nursing homes in need.

The requirements of the Patient Safety Theme, also known as the CMS National Patient Safety Initiative (NPSI), are designed to address areas of patient harm for which there is evidence of how to improve safety by improving health care processes and systems. The Theme brings forward several components from the previous SOW (surgical care, heart failure, pressure ulcers and restraints in nursing homes, and drug safety), allowing QIOs to build on the progress they have made with providers over the past three years.

With the new SOW, however, the safety focus also pushes into new areas (MRSA, pressure ulcer prevention in hospitals, and QIO technical assistance for nursing homes in need), giving providers and QIOs the chance to broaden the scope of their patient safety related improvement activities.

Prevention. The overall goal of the Prevention Theme is to improve the quality and frequency of preventive health care services in order to optimize beneficiary quality of life and health care efficiencies. The Prevention work builds on the QIO 8th SOW by focusing on the QIOs' ability to impact the rates of two cancer screenings (mammography and colorectal cancer [CRC] screening) and two immunizations (influenza and pneumococcal) among Medicare beneficiaries in each state/jurisdiction.

QIOs will work with a selected group of practices in their states/jurisdictions to accomplish the national tasks. Practices enrolled with a QIO to improve rates of mammography and CRC screenings and immunizations must have already implemented electronic health records (EHRs) certified by a certifying body recognized by the Secretary of Health and Human Services. Collaborating practices will work with their QIOs to implement care management processes, using their certified EHRs, that focus on breast cancer and CRC screening and influenza and pneumococcal vaccination.

QIO interventions that support health information technology (HIT) have the potential to improve screening rates through timely notification of providers and patients when a mammogram or CRC screening should be scheduled. Influenza and pneumococcal vaccination levels among adults 65 years of age and older remain well below the Healthy People 2010 objective of 90%. There is a need for more effective strategies for delivering vaccines to high-risk persons, their providers, and household contacts.

2. *Beneficiary Protection*

Overview

Under the 9th SOW, QIOs will continue to carry out statutorily mandated review activities, such as:

- Reviewing the quality of care provided to beneficiaries;
- Reviewing beneficiary appeals of certain provider notices;
- Reviewing higher-weighted DRGs;
- Reviewing potential anti-dumping cases; and
- Implementing quality improvement activities as a result of case review activities.

Opportunity for Quality Improvement

Individual patient complaints and provider medical record reviews are important starting points for analysis of quality improvement needs among providers. In the 9th SOW, QIOs will be increasing their efforts to link case review activities to improvements in the quality of care, specifically by developing quality improvement activities focused on system-wide changes. QIOs will utilize all data related to case review activities to identify problems related to the quality of care and design quality improvement activities aimed at helping providers correct these problems. The QIOs will be responsible for collaborating with all pertinent CMS contractors to ensure that all available data are considered and to maximize opportunities for quality improvement.

QIO Activities

The activities involved in the Beneficiary Protection Theme will focus on nine tasks:

1. Case reviews
2. Quality improvement activities (QIAs)
3. Alternative dispute resolution (ADR)
4. Sanction activities
5. Physician acknowledgement monitoring
6. Collaboration with other CMS contractors
7. Promoting transparency through reporting
8. Quality data reporting
9. Communication (education and information)

In carrying out these activities, QIOs are required to ensure consistency and value and must adhere to CMS policies and procedures. This includes the QIOs' responsibility to refer cases to the Department of Health and Human Services' Office for Civil Rights for further investigation if the QIO finds that care is being compromised or denied due to discrimination on the basis of race, color, national origin, disability, or age.

In the 9th SOW, QIOs will now be required to use ADR techniques in appropriate beneficiary complaint cases for which there are no significant concerns about the quality of care provided. ADR options include mediation, facilitated resolution, and external resolution. Mediation involves a mediator in a face-to-face or telephone meeting. Facilitated resolution consists of a QIO facilitator interacting with all parties to generate a resolution or

agreement, and does not typically involve a face-to-face meeting. External resolution occurs through direct communication between the provider and the complainant facilitated by the QIO, which follows up to ensure that direct communication occurred and no further review is needed.

With regard to confirmed quality of care concerns, QIOs must follow all CMS instructions. This includes allowing the provider an opportunity for discussion, imposing a corrective action plan where appropriate, and referring cases to the Office of Inspector General (OIG) when a QIO identifies a case in which the provider violates or fails to comply with any obligation in Section 1156(a) of the Social Security Act.

Each QIO must maintain a beneficiary hotline to provide callers with information concerning Medicare beneficiary rights and responsibilities, beneficiary protections, and the various QIO programs and initiatives. The helpline must be staffed during normal business hours with the capability to record calls received outside business hours.

In addition, QIOs must actively promote and support hospitals in submission of quality data for reporting and Annual Payment Update (APU) purposes. QIOs must have a basic understanding of all measures, deadlines for submission, and the impact on the APU. QIOs will offer educational and technical assistance to providers on the use of CMS systems and reporting tools such as CART, QualityNet, and the QIO Clinical Warehouse.

Finally, QIOs will continue to fulfill other responsibilities on a regular basis. These responsibilities include physician acknowledgement monitoring, whereby the QIOs ensure that hospitals have a physician acknowledgement statement on file for physicians billing for services provided in the hospital. The QIOs must also work with the Beneficiary Satisfaction Survey Contractor that is surveying beneficiaries regarding their satisfaction with the QIO complaint process. The QIO is responsible for providing complete and timely information to the Survey Contractor. Finally, QIOs must provide an annual public report of all medical service reviews, using a template provided by CMS.

SDFMC will continue to perform retrospective case review for the following categories of cases:

- Beneficiary complaint review (all settings and Medicare Advantage plans);
- EMTALA violations;
- Beneficiary Improvement and Protection Act (BIPA) notices;
- Hospital discharge appeal notices;
- Higher-weighted DRG payment adjustments;
- DRG validation review;
- Requests from CMS, Office of the Inspector General (OIG), Fiscal Intermediaries (FIs), Medicare Integrity Program (MIP) Contractors, Program Safeguard Contractors (PSCs), Rural Home Health Intermediaries (RHHIs), Medicare Advantage plans, CDACs, and other referrals; and
- Potential instances of gross or flagrant violations of professionally recognized standards of care.

The Nurse Reviewer (NR) will initially screen all cases for admission necessity using a written set of criteria approved by CMS. All complaints, BIPA notices, hospital discharge appeal notices, anti-dumping violations, beneficiary complaints (BIPA reviews), other agency referrals, and potential instances of gross or flagrant care will be further reviewed by a physician advisor, as only a physician can determine if a hospital stay is necessary or if a quality of care concern exists. Hospital requests for higher-weighted DRG adjustments will only need review by a physician advisor if the NR is unable to validate the diagnosis being billed. Full case review is performed on cases selected for higher-weighted DRGs.

SDFMC will notify each facility of the cases subject to review. Arrangements will be made to have the records copied where reviews are conducted outside the facility. Where reviews are conducted at the facility, arrangements will be made for the records to be available for the SDFMC NR's visit. All SDFMC notices and findings are sent to the designated admission/DRG/quality contact person at each hospital. Facilities are requested to notify SDFMC of any changes regarding designated contact individuals.

CMS has developed a uniform, structured systems approach to individual case review designed to enhance the reliability of review decisions and to standardize the method for collecting data for comparisons, feedback, and improving quality of care. The system integrates the tasks of the non-physician and physician reviewers and provides a method for categorizing the decisions that a reviewer must make (i.e., utilization, quality, and DRG/coding concerns) and an integrated format for recording those decisions. The decision sets can apply to a case from any review setting (i.e., inpatient, ambulatory surgery, outpatient care, skilled nursing, or intervening care). The NR presents an issue of potential concern, suggests the appropriate category, and identifies any screen failures for the physician advisor's consideration. If the criteria indicate a physician advisor should be contacted, then a physician advisor will review the record. The physician advisor confirms the suggested category or assigns a category to each potential concern. Only a physician can determine that a stay is not medically indicated. The appeal process is available for cases where SDFMC issues a Denial Notice. All DRG Change Notices issued by SDFMC may also be appealed, as well as all Final Quality Concern Notices. Requests for appeals must be received within 60 days of the date of the final determination notice.

Documentation review is an added component to the review process to assure the physician advisor has access to all pertinent information before a review determination is made. If documentation necessary for review completion is absent from the medical record or is illegible, the NR will issue notification requesting the additional information, which will result in a technical denial after 15 days if the documentation is not provided.

It is the responsibility of SDFMC to ensure that complete, adequate quality of care is rendered to Medicare beneficiaries by individual hospitals and/or other health care providers. CMS has developed generic quality screens that must be applied to all cases reviewed retrospectively. Generic screens have been developed specifically for the following areas of patient care: acute inpatient care, skilled level care, home health care, outpatient department care, psychiatric care, and ambulatory surgery care.

All variations from the approved criteria or other quality of care concerns will be referred to SDFMC's physician advisors for a determination as to whether the quality of care provided was appropriate and acceptable. If a potential quality concern is identified by a physician advisor, the responsible party will receive a written indication of the physician advisor's findings. The responsible party will be provided 20 days to respond to any adverse determinations of the physician advisor. SDFMC will send notices of final determinations on potential concerns to physicians and providers in all cases, whether the determination was negative or positive. Hospitals will be notified regarding physicians having cases with potential quality issues involving care performed in their facilities; physicians will be provided with copies of notices sent to hospitals about their cases. Physicians and hospitals will have the opportunity to ask SDFMC, within 30 days, to re-review final determinations on quality issues.

Complaints. SDFMC will review all hospital issued notices of non-coverage in which the patient is liable for charges, and all written beneficiary complaints.

Practice Guidelines. SDFMC's Board of Directors is required to consider the Agency for Health Care Policy and Research (AHCPR) and medical specialty society guidelines when developing review criteria. Physician and non-physician reviewers will be familiar with SDFMC criteria. CMS may specify criteria to be used by SDFMC for the review process.

3. *Educational Feedback*

SDFMC will provide feedback information about the patterns of medical care in an area to the medical community as a whole and to individual hospitals. The data may come from SDFMC pattern analysis or case review analysis at both provider and statewide levels.

Hospital Feedback. When SDFMC identifies the potential for a hospital to improve patterns of practice and/or outcomes, the hospital will be asked to seek the underlying factors, outline specific actions to improve these patterns, and verify that improvement has occurred. Similar data sharing and improvement will take place with

identified patterns of utilization concerns or DRG inaccuracy. SDFMC may use data analysis to monitor the hospital's success.

Physician Feedback. SDFMC supports a greater emphasis on the system of interaction between the QIO and the physician, hospital, and medical staff, instead of focusing on individual physicians. For example, inquiries regarding potential quality concerns will go to both the hospital and the involved physician. Thus, when SDFMC identifies a pattern of quality concerns for an individual physician, it will work cooperatively to improve this pattern with both the physician and the hospital.

4. Other Issues

Physician Advisors. SDFMC believes only physicians should make final medical determinations. SDFMC screens cases with CMS provided criteria but only a physician advisor may make an adverse determination. CMS requires that physician advisors be licensed doctors of medicine or osteopathy who have active admitting privileges in South Dakota hospitals and are in active practice. Active practice means that the reviewing physician is engaged in active practice at least 20 hours a week and admits and prescribes treatment for Medicare beneficiaries on a routine basis. Physicians of like specialty, when possible, will make review determinations. Whenever possible, SDFMC will use board certified physicians of like specialty to perform reconsiderations of denial determinations. Consultation, however, from health care practitioners other than physicians and non-board certified physicians may be utilized by the review physician in making their medical determinations.

Criteria. SDFMC will use CMS provided criteria approved by SDFMC's Board of Directors in conducting medical review. CMS may require or recommend use of specific criteria.

- A. For screening for medical necessity, SDFMC will use InterQual Intensity of Service/Severity of Illness criteria adapted and approved by SDFMC's physician Board members.
- B. SDFMC will use SDFMC's Board approved skilled nursing facility care guidelines from Medicare in reviewing the SNF level of care and quality of care.
- C. SDFMC will use rehabilitation hospital criteria approved by SDFMC's Board members for review of admission to the appropriate specialty hospital/distinct unit.
- D. SDFMC will use CMS provided criteria for conducting quality of care review for acute care, skilled care, HHA care, hospital outpatient care, psychiatric care, and ASC care.
- E. SDFMC will use CMS provided criteria for conducting discharge review.
- F. SDFMC will use SDFMC's Board approved invasive procedure criteria.
- G. SDFMC will adhere to principles of ICD-9-CM/CPT 4 coding and applicable Medicare guidelines.

Coordination with State Medical Boards. SDFMC will coordinate with state licensing agencies and certification and accreditation bodies to discuss information sharing and to execute formal written agreements to assure the exchange of specific data.

Sanctions. SDFMC will develop corrective action plans in collaboration with providers and/or physicians when SDFMC identifies gross and flagrant problems or a substantial number of problems in a substantial number of cases. The provider/physician will be given the opportunity to successfully complete the plan. SDFMC will recommend sanction action only when the provider/physician is then found unwilling or unable to provide appropriate care.

Reimbursement for Pass-Through Expenses. On a periodic basis, SDFMC or the CDAC will reimburse PPS hospitals for the cost of copying and mailing inpatient Title XVIII (Medicare) prospective payment system (PPS) records and Title XIX (Medicaid) records to the SDFMC office. Hospitals will be reimbursed based on the actual number of pages copied and the actual postage incurred. Presently, the CMS approved rate of reimbursement is \$.12 per page.

With respect to the Medicare review program, only those costs associated with the copying and mailing of PPS Title XVIII charts are reimbursable. These same costs associated with non-PPS Title XVIII charts are not reimbursable.

Monitoring Physician Acknowledgments. The hospital will provide SDFMC a copy of the Physician Acknowledgment Statement as required in 42 CFR 412.46 for all newly privileged physicians. SDFMC will monitor compliance with this requirement once each year.

BILLING CHANGE NOTICE APPEAL

APPEALS

SDFMC

Overview of Appeal Process

When Preliminary Billing Change Notice is Issued

|

SDFMC notifies hospital and attending physician
and issues written notice to
attending physician and hospital

|

Attending physician/hospital provides additional
information to SDFMC office

SDFMC receives additional
information within 20 days
of preliminary notice

|

Chart and request returned
to physician advisor

|

Physician advisor
reverses
determination

|

Attending physician/
hospital notified

Physician advisor
upholds
determination

|

Attending physician/
hospital notified

|

Fiscal intermediary
notified

|

Attending physician/
hospital may request
further review
within 60 days

SDFMC receives a request
after 20 days of
preliminary notice

|

Fiscal intermediary
notified of billing change

|

Chart and additional
information sent to another
physician advisor

|

Physician
advisor
reverses
determination

|

Attending
physician/
hospital &
FI notified

Physician
advisor
upholds
determination

|

Attending
physician/
hospital &
FI notified

DENIAL NOTICE APPEAL

APPEALS

SDFMC

Overview of Appeal Process

When Preliminary Denial Notice is Issued

|

After the physician advisor makes the determination,
SDFMC notifies the hospital and attending physician
by telephone and written notice

|

Attending physician/hospital provides additional
information to SDFMC office requesting reconsideration

SDFMC receives request within
20 days of preliminary notice

|

Chart and request returned
to physician advisor

|

Physician advisor
reverses
determination

|

Attending physician/
hospital notified

Physician advisor
upholds
determination

|

Attending physician/
hospital/patient
notified

|

Fiscal intermediary
notified

|

Attending physician/
hospital/patient may
request further appeal
within 60 days

SDFMC receives request after
20 days of preliminary notice

|

Fiscal intermediary
notified of denial

|

Chart and request sent to
reconsideration physician
(other than attending physician
or initial physician advisor)

|

Reconsideration
physician reverses
determination

|

Attending
physician/patient/
hospital notified

|

Fiscal intermediary
notified

Reconsideration
physician upholds
determination

|

Attending
physician/hospital
notified

|

Affected parties
may request
further appeal

FLOW CHART FOR QUALITY OF CARE REVIEW

