Annual Report of QIO Case Review Information



ALABAMA - AQAF

August 1, 2013 – July 31, 2014

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

AQAF

ABOUT THIS REPORT

Medicare Quality Improvement Organizations (QIOs) in every state and territory publish an annual report of their case review information. General requirements for these reports are outlined by the Centers for Medicare & Medicaid Services (CMS). Unless otherwise specified, the information in this report reflects the period August 1, 2013-July 31, 2014.

Case examples or descriptions contain limited data in order to protect confidentiality of beneficiary/patient, provider and/or practitioner information.

INTRODUCTION

As the Medicare Quality Improvement Organization (QIO) for the state of Alabama, AQAF works to improve the quality of healthcare for all Alabamians with Medicare. An important part of this work is to ensure that the care Alabama's Medicare beneficiaries get is medically necessary and appropriate, provided in the most appropriate setting, and meets professionally recognized standards of care. AQAF works with Alabama's healthcare providers to improve the quality of healthcare by sharing tools, resources, best practices, and, when necessary, initiating evidence-based quality improvement activities. Alabama's Medicare beneficiaries and their families or representatives have a voice in the quality of healthcare. AQAF makes sure that voice is heard.

I. TOTAL # OF REVIEWS – Provide the total number of reviews the QIO performed in CRIS by the associated review type.

Review Type	# of Reviews	Percent of Reviews (%)
Coding Validation (120 - HWDRG)	316	23.53%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	48	3.75%
Quality of Care Review (All Other Selection Reasons)	11	0.82%
Quality of Care Review (Immediate Advocacy)	7	0.52%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	384	28.60%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	104	7.74%
Notice of Non-coverage (117 - Grijalva)	375	27.92%
Notice of Non-coverage (121 through 124 -Weichardt)	84	6.25%
Notice of Non-coverage (111-Request for QIO Concurrence)	2	0.15%
EMTALA 5 Day	6	0.45%
EMTALA 60 Day	6	0.45%
Total	1343	100%

II. TOP 10 PRINCIPAL MEDICAL DIAGNOSES – Provide the top 10 principal medical diagnoses for inpatient claims billed for Medicare beneficiaries.

Top 10 Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. V5789 - REHABILITATION PROC NEC	9424	16.47%
2. 486 - PNEUMONIA, ORGANISM NOS	8987	15.71%
3. 49121 - OBS CHR BRONC W(AC) EXAC	5648	9.87%
4. 0389 - SEPTICEMIA NOS	5596	9.78%
5. 41401 - CRNRY ATHRSCL NATVE VSSL	5561	9.72%
6. 5990 - URIN TRACT INFECTION NOS	5405	9.45%
7. 5849 - ACUTE KIDNEY FAILURE NOS	4849	8.47%
8. 42731 - ATRIAL FIBRILLATION	4201	7.34%
9. 43491 - CRBL ART OCL NOS W INFRC	3961	6.92%
10. 71536 - LOC OSTEOARTH NOS-L/LEG	3585	6.27%
Total	57217	100%

III. PROVIDER REVIEWS GEOGRAPHICS – Provide the count and percent by Rural vs. Urban geographical locations for Health Service Providers (HSPs) associated with a completed QIO review.

Geographic Area	# of Providers	Percent of Providers (%)
Rural	50	26.88%
Urban	135	72.58%
Unknown	1	0.54%
Total	186	100%

IV. PROVIDER REVIEWS SETTINGS – Provide the count and percent by Setting for Health Service Providers (HSPs) associated with a completed QIO review.

Setting	# of Providers	Percent of Providers (%)
0 - Acute Care Unit of an Inpatient Facility	48	25.81%
1 - Distinct Psychiatric Facility	1	0.54%
2 - Distinct Rehabilitation Facility	5	2.69%
3 - Distinct Skilled Nursing Facility	102	54.84%
5 - Clinic	0	0.00%
6 - Distinct Dialysis Center Facility	0	0.00%
7 - Dialysis Center Unit of Inpatient Facility	0	0.00%
8 - Independent Based RHC	0	0.00%
9 - Provider Based RHC	0	0.00%
C - Free Standing Ambulatory Surgery Center	0	0.00%
G - End Stage Renal Disease Unit	0	0.00%
H - Home Health Agency	5	2.69%
N - Critical Access Hospital	0	0.00%
O - Setting does not fit into any other existing setting code	0	0.00%
Q - Long Term Care Facility	5	2.69%
R - Hospice	20	10.75%
S - Psychiatric Unit of an Inpatient Facility	0	0.00%
T - Rehabilitation Unit of an Inpatient Facility	0	0.00%

(Contd.) Setting	# of Providers	Percent of Providers (%)
U - Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y - Federally Qualified Health Centers	0	0.00%
Z - Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	186	100%

A. QUALITY OF CARE CONCERNS CONFIRMED – Provide the number of concerns by Quality of Care PRAF Category Code and the number that were confirmed at highest level of review for completed quality of care reviews.

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)
C01 - Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02 - Apparently did not make appropriate diagnoses and/or assessments	26	0	0.00%
C03 - Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14]	2	1	50.00%
C04 - Apparently did not carry out an established plan in a competent and/or timely fashion	15	0	0.00%
C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results	11	0	0.00%
C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	0	0.00%
C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	13	0	0.00%

(Contd.) Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)
C08 - Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09 - Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10 - Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11 - Apparently did not demonstrate that the patient was ready for discharge	3	0	0.00%
C12 - Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13 - Apparently did not order appropriate specialty consultation	0	0	0.00%
C14 - Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15 - Apparently did not effectively coordinate across disciplines	4	0	0.00%
C16 - Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	3	1	33.33%
C17 - Apparently did not order/follow evidence-based practices	0	0	0.00%
C18 - Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C99 - Other quality concern not elsewhere classified	0	0	0.00%
Total	71	2	2.82%

B. SERIOUS REPORTABLE EVENTS ON QUALITY OF CARE REVIEWS

- Provide the number of Quality Improvement Activities (QIAs) initiated (initial activity date within the reporting period) for all quality of care reviews with confirmed concerns. Indicate the number and percent of those QIAs that are associated with quality of care concerns you deemed to fall into the category of "Serious Reportable Events."

# of QIAs Initiated	# of QIAs Initiated for Serious Reportable Events	Percent of QIAs Initiated for Serious Reportable Events (%)
2	0	0.00%

C. CONFIRMED QUALITY OF CARE CONCERNS WITH ASSOCIATED INTERVENTIONS

- Provide the number of Initial Quality Improvement Activities initiated, by Activity Type, for reviews with one or more confirmed Quality of Care concerns. Provide the percent of total activities that each comprises.

Initial Quality Improvement Activity	# of Interventions (QIAs) with this Initial Quality Improvement Activity	Percent of Interventions (QIAs) with this Initial Quality Improvement Activity
1 - Send educational/alternative approach letter	0	0.00%
2 - Perform intensified review	0	0.00%
3 - Require continuing education	0	0.00%
4 - Request/review policy/procedure	0	0.00%
5 - Request development of QIP	1	50.00%
6 - Accept provider-initiated QIP	1	50.00%
7 - Conduct informal meeting or teleconference	0	0.00%
8 - Refer to licensing board	0	0.00%
9 - Initiate sanction activity	0	0.00%
10 - Other	0	0.00%
Total	2	100%

D. DISCHARGE/SERVICE TERMINATION - Provide discharge location of beneficiaries linked to discharge/service termination reviews for Selection Reasons 111 (Request for QIO Concurrence) and 121 – 124 (Weichardt Selection Reasons). Note: Data represents discharge/service termination reviews from 8/1/2011 – 4/30/2012, 8/1/2012 – 4/30/2013, and 8/1/2013 – 2/28/2014 for the first, second and third annual reports respectively. A shortened data timeframe is necessary to allow for maturity of claims data which is the source of "Discharge Status" for these cases.

Discharge Status	# of Beneficiaries	Percent of Beneficiaries (%)
01 - Discharged to home or self-care (routine discharge)	8	17.78%
02 - Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03 - Discharged/transferred to skilled nursing facility (SNF)	18	40.00%
04 - Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05 - Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06 - Discharged/transferred to home under care of organized home health service organization	16	35.56%
07 - Left against medical advice or discontinued care	0	0.00%
09 – Admitted as an inpatient to this hospital	0	0.00%
20 – Expired (or did not recover – Christian Science patient)	0	0.00%
21 – Discharges or Transfers to Court/Law Enforcement)	0	0.00%
30 – Still a patient	0	0.00%
40 - Expired at home (Hospice claims only)	0	0.00%
41 - Expired in a medical facility (e.g. hospital, SNF, ICF or free standing Hospice)	0	0.00%
42 - Expired – place unknown (Hospice claims only)	0	0.00%

(Contd.) Discharge Status	# of Beneficiaries	Percent of Beneficiaries (%)
43 - Discharged/transferred to a Federal hospital	0	0.00%
50 - Hospice home	0	0.00%
51 - Hospice - medical facility	1	2.22%
61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	0	0.00%
62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	1	2.22%
63 - Discharged/transferred to a long term care hospital	1	2.22%
64 - Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66 - Discharged/transferred to a Critical Access Hospital	0	0.00%
70 - Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%

E. BENEFICIARY DEMOGRAPHICS - Provide the number of beneficiaries for whom a case review activity was started, by demographic category, and the percent of beneficiaries each category represents.

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	566	64.32%
Male	314	35.68%
Unknown	0	0.00%
Total	880	100%
Race		
Asian	0	0.00%
Black	193	21.93%
Hispanic	1	0.11%
North American Native	1	0.11%
Other	7	0.80%
Unknown	1	0.11%
White	677	76.93%
Total	880	100%

F. QUALITY OF CARE REVIEWS AND CONCERNS BY INTERVENTION TYPE - Using a QIA started within the reporting period for the current year's report, please provide a short description as to the type of intervention(s)/QIA(s) employed, per C.6 Technical Assistance requirements in the Contract, for three diverse or different quality categories (C1-99). Intervention/QIA types may include, but are not limited to: Educational or Alternative Approach to Care letter; Continuing Education; Assistance in Developing Policy & Procedure; Modification to Existing Policy & Procedure; Formal Quality Improvement Plan and/or Corrective Action Plan. Note: If the QIO does not have three diverse or different quality categories, please indicate such on the report each category represents.

DESCRIPTION 1 – TYPE OF INTERVENTION FOR QUALITY CATEGORY C 16 (APPARENTLY DID NOT ENSURE A SAFE ENVIRONMENT-MEDICATION ERRORS, FALLS, PRESSURE ULCERS, TRANSFUSION REACTIONS, NOSOCOMIAL INFECTION) - The patient was admitted to a Skilled Nursing Facility for rehabilitation following a hospital admission. For rehabilitation the patient was to receive physical therapy, occupational therapy, and speech therapy. The physical therapy and occupational therapy were started the day after admission but the speech therapy was not started for seven days. Root Cause Analysis revealed the speech therapist was not available due to vacation and there was no replacement therapist scheduled. The Skilled Nursing Facility developed a plan of action to have a PRN speech therapist available in times and situations when the full time speech therapist is not available. If there is no speech therapist available the resident will not be accepted for admission.

DESCRIPTION 2 – TYPE OF INTERVENTION FOR QUALITY CATEGORY C 03 (APPARENTLY DID NOT ESTABLISH AND/OR DEVELOP AN APPROPRIATE TREATMENT PLAN FOR A DEFINED PROBLEM OR DIAGNOSIS WHICH PROMPTED THIS EPISODE OF CARE.) - The patient was admitted to a Skilled Nursing Facility for physical therapy after a hospital admission. The patient received physical therapy and the services were terminated but the patient did not receive the required Medicare Notice of Non-Coverage informing her of the right to appeal the termination of services. There was no documentation of the notice in the medical record. AQAF provided education to the facility including the CMS website http://www.cms.gov/bni and a copy of Med Learn Matters Number MM7903 Revised. The facility performed chart audits for three months and identified the appropriate Medicare notice was given.

DESCRIPTION 3 – TYPE OF INTERVENTION FOR QUALITY CATEGORY C 99 (OTHER QUALITY CONCERN NOT ELSEWHERE CLASSIFIED.) - Three Diverse or different quality categories are not available.

USING ONE EXAMPLE FROM THE PREVIOUSLY IDENTIFIED INTERVENTIONS/QIAS, DESCRIBE HOW THE INTERVENTION/QIA WAS DETERMINED, ALONG WITH ANY IDENTIFIED "BEST PRACTICES" FOR THE RESOLUTION OF THE IDENTIFIED QUALITY CONCERN.

EXAMPLE FROM DESCRIPTION 2: HOW INTERVENTIONS DETERMINED/BEST PRACTICES

Providing education to the provider on the CMS requirements for issuing Medicare Notice of Non-Coverage will ensure future rehabilitation residents will be given their Medicare right to appeal termination of skilled services. The provider is now aware of this requirement and has resources available to educate staff in case of turn over. The Administrator now has an active role in the monitoring of this requirement.

G. EVIDENCE USED IN DECISION-MAKING - Drawing upon your QIO's case review practices, please describe the one or two most common types of evidence/standards of care criteria used to support Review Analysts' assessments and Peer Reviewers' decisions for Medical Necessity/Utilization Review and Appeals. Provide a brief statement of rationale for how the specific evidence/standards of care were chosen. The types of evidence/standards of care may include, but are not limited to, Local Coverage Determinations (LCD), Medicare Conditions Coverage, Medicare Conditions of Participation and National Coverage Determinations (NCD).

For QoC, describe the one or two most common types of evidence/standards of care criteria used to support Review Analysts' assessments and Peer Reviewers' decisions for the specific list of diagnostic categories provided in the table. **Note:** The list is from other 10th SoW initiatives in which QIOs are involved. If there are any categories for which you did not conduct a QoC review during the reporting period, denote that in the table.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	AHRQ National Guidelines Clearinghouse & CMS Quality Measures	A public resource for evidence based clinical practice guidelines
	Heart Failure	AHRQ National Guidelines Clearinghouse & CMS Quality Measures	A public resource for evidence based clinical practice guidelines
	Acute Myocardial Infarction	AHRQ National Guidelines Clearinghouse & CMS Quality Measures	A public resource for evidence based clinical practice guidelines
	Pressure Ulcers	AHRQ National Guidelines Clearinghouse & CMS Quality Measures	A public resource for evidence based clinical practice guidelines
	Urinary Tract Infection	AHRQ National Guidelines Clearinghouse & CMS Quality Measures	A public resource for evidence based clinical practice guidelines

(Contd.) Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Sepsis	AHRQ National Guidelines Clearinghouse	A public resource for evidence based clinical practice guidelines
	Adverse Drug Events	AHRQ National Guidelines Clearinghouse	A public resource for evidence based clinical practice guidelines
	Falls	AHRQ National Guidelines Clearinghouse	A public resource for evidence based clinical practice guidelines
	Patient Trauma	AHRQ National Guidelines Clearinghouse	A public resource for evidence based clinical practice guidelines
	Surgical complications	AHRQ National Guidelines Clearinghouse & CMS Quality Measures	A public resource for evidence based clinical practice guidelines
Medical Necessity/ Utilization Review		McKesson criteria InterQual ® CMS criteria for Skilled services – CMS website	Evidence based criteria Frequent updates performed by McKesson to remain current with best practices. Criteria provide definitions of skilled services required.
Appeals		McKesson criteria InterQual ® CMS criteria for Skilled services – CMS website	Evidence based criteria Frequent updates performed by McKesson to remain current with best practices. Criteria provide definitions of skilled services required.

Please provide three brief examples/case studies where case review was linked to another Aim of the QIO contract, for example, readmissions, pressure ulcers, adverse drug events, etc. Identify the evidence based criteria used to support review decisions on those cases and what influenced the selection of that criteria. Documentation should be two paragraphs or less per example/case study.

Example/Case Study 1

The Beneficiary and Family Centered Care (BFCC) staff encourages case managers to work with the patient and their families during the discharge appeal process to ensure all discharge needs are met. This process will assist the "Integrate Care for Populations and Communities Aim" in its efforts to reduce readmissions. CMS has created a Discharge Planning Guide that has been used to review medical records to determine if discharge needs are met. Providers are encouraged to go to the CMS website and obtain this guide.

Example/Case Study 2

The BFCC staff encourages providers to participate in the "Improve Individual Patient Care Aim" involving the reduction of adverse drug events. BFCC staff learns from families during the skilled services termination appeal process of patients not being able to participate in therapy due to side effects/adverse effects of medications. The Patient Safety Pharmacy Collaborative (PSPC) provides tools such as the Antipsychotic Medication Reference which can be used to provide information on medications and the potential side effects/adverse effects. The reduction in these medications could potentially improve the patient participation in skilled therapies.

Example/Case Study 3

The BFCC staff encourages providers to participate in the "Improve Individual Patient Care Aim" in the pressure ulcer reduction collaborative. Collaborative members receive education tools that can aid in the reduction of pressure ulcers as well as other technical assistance will be provided to nursing home members.

H. EFFECTIVENESS OF QIAS - Please provide an analysis of how the findings in tables B, C and F can be used to support the effectiveness of QIAs conducted as part of the BFCC Aim. The QIO should provide a narrative analysis on the information provided and recommendations for how the information could be used to make a positive impact on the work done in other 10SOW Aims.

NARRATIVE ANALYSIS:

The BFCC review process can identify issues that providers are not aware of or have not monitored for compliance. The receipt of a quality concern letter will provide the hospital, nursing home, physician, and other providers with an opportunity to perform a Root Cause Analysis (RCA) on current processes and/or procedures. The results of a RCA will be addressed by the provider and interventions implemented. The results of these interventions will improve care for Medicare Beneficiaries by making a positive impact on the care they receive.The effectiveness of the QIO identified in the data on tables B, C and F can assist the other 10th Scope of Work Aims in reducing the use of adverse drug events, pressure ulcers, and reduce unnecessary readmissions to hospitals. Working together with Alabama providers care can be improved for the Alabama Medicare population.

THIS MATERIAL WAS PREPARED BY AQAF, ALABAMA'S MEDICARE QUALITY IMPROVEMENT ORGANIZATION (QIO), UNDER CONTRACT WITH THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), AN AGENCY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. CONTENTS PRESENTED DO NOT NECESSARILY REFLECT CMS POLICY. 10SOW-AL-C6-14-11

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