
# Annual Report of Medicare Case Reviews for New Mexico

August 1, 2012 – July 31, 2013

# *HealthInsight* New Mexico
# Annual Report of QIO Case Review Information

*Quality Improvement Organizations (QIOs) perform a variety of activities to facilitate improved health care outcomes for Medicare beneficiaries. This report only reflects case review activities. For information on additional activities conducted by the QIO, please visit:*
http://healthinsight.org

I. **Total Number of Reviews**: The table below reflects the total number and type of reviews performed by *HealthInsight* New Mexico from 08/01/2012 to 07/31/2013.

| REVIEW TYPE | Number of Reviews | Percent of Reviews |
|---|---|---|
| Coding Validation (120 - HWDRG) | 156 | 26.8% |
| Coding Validation (All Other Selection Reasons) | 0 | 0% |
| Quality of Care Review (101 through 104 -Beneficiary Complaint) | 31 | 5.33% |
| Quality of Care Review (All Other Selection Reasons) | 8 | 1.37% |
| Utilization (158 - FI/MAC Referral for Readmission Review) | 0 | 0% |
| Utilization (All Other Selection Reasons) | 204 | 35.1% |
| Notice of Non-coverage (105 through 108 - Admission and Preadmission) | 1 | 0.17% |
| Notice of Non-coverage (118 - BIPA) | 43 | 7.4% |
| Notice of Non-coverage (117 - Grijalva) | 71 | 12.22% |
| Notice of Non-coverage (121 through 124 -Weichardt) | 66 | 11.34% |
| Notice of Non-coverage (111-Request for QIO Concurrence) | 0 | 0% |
| EMTALA 5 Day | 2 | 0.34% |
| EMTALA 60 Day | 0 | 0 |
| TOTAL NUMBER OF REVIEWS COMPLETED | **582** | |

II. **Top 10 Principal Medical Diagnoses –** The top 10 principal medical diagnoses for inpatient claims billed for Medicare beneficiaries.

| Top 10 Medical Diagnoses | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| 1. 486 – Pneumonia, organism unspecified | 2363 | 17.53% |
| 2. V57.89 – Care involving other specified rehabilitation procedure | 2244 | 16.65% |
| 3. 038.9 – Unspecified Septicemia | 2081 | 15.44% |
| 4. 599.0 – Urinary tract infection, site not specified | 1151 | 8.54% |
| 5. 491.21 – Obstructive chronic bronchitis with (acute) exacerbation | 1069 | 7.93% |
| 6. 715.36 – Osteoarthrosis, localized, not specified whether primary or secondary, lower leg | 1049 | 7.78% |
| 7. 410.71 – Subendocardial infarction, initial episode of care | 931 | 6.91% |
| 8. 414.01 – Coronary atherosclerosis of native coronary artery | 910 | 6.75% |
| 9. 584.9 – Acute kidney failure, unspecified | 884 | 6.56% |
| 10. 427.31 – Atrial fibrillation | 798 | 5.92% |
| **TOTAL NUMBER OF BENEFICIARIES** | **13,480** | |

III. **Provider Reviews Geographics –** The count and percent by geographical locations for health service providers (HSPs) associated with a completed QIO review.

| Geographical Area | Number of Providers | Percent of Providers |
|---|---|---|
| Rural | 24 | 40.00% |
| Urban | 36 | 60.00% |
| Unknown | 0 | 0.00% |
| **TOTAL NUMBER OF PROVIDERS** | **60** | **100.00%** |

**IV. Provider Reviews Settings** – The count and percent by setting for health service providers (HSPs) associated with a completed QIO review.

| SETTING | Number of Providers | Percent of Providers |
|---|---|---|
| 0 - Acute Care Unit of an Inpatient Facility | 21 | 35.00% |
| 1 - Distinct Psychiatric Facility | 0 | 0.00% |
| 2 - Distinct Rehabilitation Facility | 4 | 6.67% |
| 3 - Distinct Skilled Nursing Facility | 24 | 40.00% |
| 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 | 6 | 10.00% |
| N - Critical Access Hospital | 2 | 3.33% |
| O - Setting does not fit into any other existing setting code | 0 | 0.00% |
| Q - Long Term Care Facility | 2 | 3.33% |
| R - Hospice | 1 | 1.67% |
| S - Psychiatric Unit of an Inpatient Facility | 0 | 0.00% |
| T - Rehabilitation Unit of an Inpatient Facility | 0 | 0.00% |
| 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 NUMBER OF PROVIDERS** | **60** | **100.00%** |

**A. Quality of Care Concerns Confirmed –** The number of concerns by Quality of Care Category Code and the number that were confirmed at highest level of review for completed quality of care reviews.

| Quality of Care Category Codes | Number of Concerns | Number of Concerns Confirmed | Percent Confirmed Concerns |
|---|---|---|---|
| **C01 - Apparently did not obtain pertinent history and/or findings from examination** | 2 | 0 | 0.00% |
| **C02 - Apparently did not make appropriate diagnoses and/or assessments** | 9 | 3 | 33.33% |
| **C03 - Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care** | 11 | 2 | 18.18% |
| **C04 - Apparently did not carry out an established plan in a competent and/or timely fashion** | 8 | 4 | 50.00% |
| **C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results** | 6 | 0 | 0.00% |
| **C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results** | 1 | 0 | 0.00% |
| **C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed** | 4 | 2 | 50.00% |
| **C08 - Apparently did not perform a procedure that was indicated** | 1 | 0 | 0.00% |
| **C09 - Apparently did not obtain appropriate laboratory tests and/or imaging studies** | 3 | 3 | 100.00% |
| **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** | 4 | 2 | 50.00% |
| **C12 - Apparently did not provide appropriate personnel and/or resources** | 1 | 0 | 0.00% |
| **C13 - Apparently did not order appropriate specialty consultation** | 1 | 1 | 100.00% |
| **C14 - Apparently specialty consultation process was not completed in a timely manner** | 0 | 0 | 0.00% |
| **C15 - Apparently did not effectively coordinate across disciplines** | 0 | 0 | 0.00% |

| *(continued from Page 5)* Quality of Care Category Codes | Number of Concerns | Number of Concerns Confirmed | Percent Confirmed Concerns |
|---|---|---|---|
| **C16 - Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)** | 7 | 2 | 28.57% |
| **C17 - Apparently did not order/follow evidence-based practices** | 2 | 0 | 0.00% |
| **C18 - Apparently did not provide medical record documentation that impacts patient care** | 1 | 1 | 100.00% |
| **C40 - Apparently did not follow-up on patient's (non) compliance** | 2 | 0 | 0.00% |
| **C99 - Other quality concern not elsewhere classified** | 8 | 2 | 25.00% |
| **TOTAL NUMBER OF CONCERNS** | **71** | **22** | **30.99%** |

**B. Serious Reportable Events on Quality of Care Reviews** - The number of quality improvement activities (QIAs) initiated for all quality of care reviews with confirmed concerns

| # of QIAs Initiated | Number of QIAs Initiated for Serious Reportable Events | Percent of QIAs Initiated for Serious Reportable Events (%) |
|---|---|---|
| **16** | 0 | 0% |

**C. Confirmed Quality of Care Concerns with Associated Interventions –** The number of initial quality improvement activities initiated, by activity type, for reviews with one or more confirmed quality of care concerns.

| Initial Quality Improvement Activity | Number 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 | 8 | 50% |
| 2 - Perform intensified review | 0 | 0% |
| 3 - Require continuing education | 0 | 0% |
| 4 - Request/review policy/procedure | 0 | 0% |
| 5 - Request development of QIP | 7 | 43.75% |
| 6 - Accept provider-initiated QIP | 1 | 6.25% |
| 7 - Conduct informal meeting or teleconference | 0 | 0 |
| 8 - Refer to licensing board | 0 | 0 |
| 9 - Initiate sanction activity | 0 | 0 |
| 10 - Other | 0 | 0% |
| **TOTAL** | **16** | **100%** |

**D. Discharge/Service Termination** – Location of beneficiaries linked to discharge/service termination reviews.

Note: *Data represents discharge/service termination reviews from 8/1/2012 – 4/30/2013*

| Discharge Status | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| **01 - Discharged to home or self-care (routine discharge)** | 9 | 34.62% |
| **02 - Discharged/transferred to another short-term general hospital for inpatient care** | 1 | 3.85% |
| **03 - Discharged/transferred to skilled nursing facility (SNF)** | 11 | 42.31% |
| **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** | 4 | 15.38% |
| **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 – Discharged/transferred 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% |
| **43 - Discharged/transferred to a Federal hospital** | 0 | 0.00% |
| **50 - Hospice - home** | 0 | 0.00% |
| **51 - Hospice - medical facility** | 0 | 0.00% |
| **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** | 0 | 0.00% |

| *(continued from page 8)* Discharge Status | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| 63 - Discharged/transferred to a long term care hospital | 0 | 0.00% |
| 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 | 1 | 3.85% |
| Other | 0 | 0.00% |
| **TOTAL NUMBER OF MEDICARE BENEFICIARIES** | **26** | **100.00%** |

**E. Beneficiary Demographics** – Number of beneficiaries for whom a case review activity was started, by demographic category, and the percent of beneficiaries each category represents.

| Demographics | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| **Sex/Gender** | | |
| Female | 203 | 61.70% |
| Male | 126 | 38.30% |
| Unknown | 0 | 0.00% |
| **TOTAL** | **329** | **100.00%** |
| **Race** | | |
| Asian | 0 | 0.00% |
| Black | 5 | 1.52% |
| Hispanic | 22 | 6.69% |
| North American Native | 15 | 4.56% |
| Other | 6 | 1.82% |
| Unknown | 2 | 0.61% |
| White | 279 | 84.80% |
| **TOTAL** | **329** | **100.00%** |

## F. Quality of Care Reviews and Concerns by Intervention Type

| Quality of Care Concern | Provider Quality Improvement Activities |
|---|---|
| **Failure to provide Medication Reconciliation upon patient's discharge.** | 1. The provider implemented a Med Tracker system that also provides an electronic medication reconciliation process and capability to send electronic feed to local pharmacies.<br>2. They provided staff education on the Med Tracker system and medication reconciliation.<br>3. Medication reconciliation education was added to their new hire orientation trainings.<br>4. The Pharmacist will perform a medication reconciliation audit of home, admission and discharge medications during the patient's hospital stay and upon discharge. The provider's audit indicators includes:<br>- Home medication listed in Meds Tracker<br>- Meds tracker reconciliation of home medication with admission orders<br>- Med tracker reconciliation of home and admission medications at discharge<br>- Complete med tracker discharge medication list provided to patient |
| **Failure to prevent patient fall.** | 1. The provider created a fall tracking log and report to understand and monitor fall trends and occurrences.<br>2. The Director of Nursing provided staff training on fall prevention, provider policies and procedures requirements.<br>3. The Director of Nursing provided staff training on proper documentation, staff handoffs and internal communication needs to ensure continuity of patient safety.<br>4. There will be designated staff to perform a 72-hour post admission review of the medical documentation/staff communication process to ensure continued compliance and proper care planning is present to meet patient needs and safety. |
| **Failure to initiate and carry out physician orders in a timely manner** | 1. The provider conducted staff education regarding policies and procedures on physician orders which included: accountability regarding physician order(s), initiating physician order(s) within 2 hours of written time, and the completion of 24 hour chart checks to ensure all physician orders have been captured and implemented.<br>2. Routine communication of compliance performance and daily |

| | |
|---|---|
| | safety staff huddles.<br>3. There will be designated staff to conduct chart audits to check for chart integrity including: noting of physician order(s); initiating and carrying out orders(s); 24 hour chart check; physician order completion; medication administration accuracy, and ensuring that the required documentation has been completed.<br>4. The Chief Nursing Officer will be reviewing audit findings on a weekly basis.<br>5. Continuous education will be provided based on audit findings and reinforcement of staff competency. |

## How Interventions Determined/Best Practices

| | |
|---|---|
| **Failure to provide medication reconciliation upon patient's discharge.** | The facility conducted a root cause analysis to determine reasons that contributed to the quality of care concern identified. As a result, the provider implemented an electronic medication system that standardizes and enhances medication audits, and communication between clinical staff and community pharmacies. |

## G. Evidence Used in Decision-Making

| Review Type | Diagnostic Categories | Evidence/ Standards of Care Used* | Rationale for Evidence/Standard of Care Selected |
|---|---|---|---|
| **Quality of Care** | Pneumonia | No cases were reviewed during the reporting period | N/A |
| | Heart Failure | Milliman Care Guidelines/CMS and Joint Commission National Hospital Quality Measures | Milliman Care Guidelines and National Hospital Quality Measures are evidence based |
| | Acute Myocardial Infarction | No cases were reviewed during the reporting period | N/A |
| | Pressure Ulcers | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |
| | Urinary Tract Infection | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |
| | Sepsis | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |
| | Adverse Drug Events | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |
| | Falls | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |
| | Patient Trauma | No cases were reviewed during the reporting period | N/A |
| | Surgical complications | No cases were reviewed during the reporting period | N/A |
| **Medical Necessity/Utilization Review** | | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |
| **Appeals** | | Milliman Care Guidelines | Milliman Care Guidelines are evidence based |

Below are three examples where case review was linked to another Aim of the QIO contract, the evidence based criteria used to support review decisions on those cases, and what influenced the selection of that criteria.

**Discharge Planning: Care Transitions Initiatives to Reduce Readmissions**

A Medicare beneficiary complaining of headache, dizziness, and pressure in her chest was prescribed medication for high blood pressure and admitted to the hospital for further observation. Upon discharge, the physician wrote orders for medications to be given at discharge, but did not specify the amount of the medication or the number of refills. The nursing staff did not follow up with the prescribing physician to clarify and the beneficiary left the facility without the prescribed medications. Ultimately, the beneficiary's efforts to obtain the medications prescribed were so stressful, her blood pressure rose again and she was admitted to another facility for treatment.

To avoid further incidents, the physician reviewer advised the facility to implement improvement activities to address the quality of care concerns. The provider's quality improvement plan included the establishment of an electronic medication reconciliation system; nursing, pharmacy and physician staff education and collaboration; and monitoring audits to ensure compliance and patient safety. The QIO and physician reviewer referenced Milliman Care Guidelines as the basis of case determination.

**Infections: Reduce Healthcare Associated Infections**

A Medicare beneficiary with paraplegia and a chronic indwelling Foley catheter was admitted to the hospital for malaise, fever, and chills. The physician wrote orders for the staff to replace the existing catheter. It took over two days to have the beneficiary's catheter changed.

As a result of the physician reviewer's determination, the facility implemented a quality improvement plan to address the identified concerns. The improvement actions included process changes in carrying out physician orders, documentation requirements, staff education and medical record chart audits to ensure completion of physician orders. Milliman Care Guidelines were utilized as the standards of care for the determination of this case.

**Medication Management: Reduce Adverse Drug Events**

Following an open suprapubic prostatectomy, a Medicare beneficiary produced bloody urine, and Amicar was ordered for immediate administration. There was a two hour delay in administering the medication and the beneficiary subsequently required a blood transfusion. Citing Milliman Care Guidelines, it was determined that the delay was unacceptable, and changes in the facility's provisions and processing of Amicar orders were recommended to avoid future delays.

The provider implemented a quality improvement plan to address the concerns regarding Amicar supply and order processing; the plan included the placement of Amicar into the existing Automated Dispensing Cabinets for immediate availability, and the pharmacist's designation of all Amicar orders to be moved to the front of their order queue. Following the implementation of these improvement changes and continuous monitoring efforts, no further delays in this medication administration occurred.

## H. Effectiveness of QIAs

The Quality Improvement Organization (QIO) 10th Scope of Work program emphasizes Beneficiary and Family Centered Care and focuses on the following three Aims; better patient care, better individual and population health, and lower health care costs through improvement.

HealthInsight's Quality Assurance Division provides case review activities that are designed to empower Medicare beneficiaries and their families by expanding dialogue opportunities and allow their quality of health care services to be reviewed. Additionally, the division is responsible to conduct many other types of health care related review that are referred from other private and public agency entities.

All confirmed health care quality problems that jeopardizes the Medicare federal program or Medicare beneficiaries requires improvement action. HealthInsight works with the provider to identify the underlying reasons of the problem(s) in terms of the nature, the magnitude, the location, and the timing of the harmful outcome. Consequently, the provider is then able to modify their processes to deliver better quality of care. The provider's improvement activities are referred to as Quality Improvement Activities (QIA). The intent of a QIA is to promote action that will change and solve problems before they occur or escalate.

Section C and F of this report provide examples of QIA activities. All proposed action plans may entail a single or a system-wide improvement change. These plans are reviewed by HealthInsight's QIA committee members and subject to committee approval and continuous monitoring efforts to ensure successful change.

Based on the 10th SOW Aims, this unique combination of the quality of care case review process and quality improvement activities provides a positive impact by encouraging collaboration through the patient's experience and perspective, performing an analysis of the health care delivery system, and aligning patient care with current nationally recognized evidence-based standards.