Annual Report of Medicare Case Reviews for Nevada

August 1, 2013 – April 30, 2014

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HealthInsight Nevada
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* NV from August 1, 2013 to April 30, 2014.

REVIEW TYPE	Number of Reviews	Percent of Reviews
Coding Validation (120 - HWDRG)	155	14.03%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	87	7.87%
Quality of Care Review (All Other Selection Reasons)	3	0.27%
Immediate Advocacy	8	0.72%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	326	29.50%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	125	11.31%
Notice of Non-coverage (117 - Grijalva)	147	13.30%
Notice of Non-coverage (121 through 124 -Weichardt)	242	21.90%
Notice of Non-coverage (111-Request for QIO Concurrence)	0	0.00%
EMTALA 5 Day	6	0.54%
EMTALA 60 Day	6	0.54%
TOTAL NUMBER OF REVIEWS COMPLETED	**1105**	

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. V5789 - REHABILITATION PROC NEC	6914	28.70%
2. 486 - PNEUMONIA, ORGANISM NOS	3159	13.11%
3. 0389 - SEPTICEMIA NOS	2631	10.92%
4. 49121 - OBS CHR BRONC W(AC) EXAC	1913	7.94%
5. 5849 - ACUTE KIDNEY FAILURE NOS	1798	7.46%
6. 41401 - CRNRY ATHRSCL NATVE VSSL	1653	6.86%
7. 51881 - ACUTE RESPIRATRY FAILURE	1588	6.59%
8. 5990 - URIN TRACT INFECTION NOS	1565	6.50%
9. 42731 - ATRIAL FIBRILLATION	1499	6.22%
10. 41071 - SUBENDO INFARCT, INITIAL	1369	5.68%
TOTAL NUMBER OF BENEFICIARIES	24,089	

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	8	10.53%
Urban	68	89.47%
Unknown	0	0.00%
TOTAL NUMBER OF PROVIDERS	**76**	**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	20	26.32%
1 - Distinct Psychiatric Facility	1	1.32%
2 - Distinct Rehabilitation Facility	3	3.95%
3 - Distinct Skilled Nursing Facility	31	40.79%
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	3	3.95%
N - Critical Access Hospital	2	2.63%
O - Setting does not fit into any other existing setting code	0	0.00%
Q - Long Term Care Facility	6	7.89%
R – Hospice	10	13.16%
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	**76**	**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	0	0	0.00%
C02 - Apparently did not make appropriate diagnoses and/or assessments	8	2	25.00%
C03 - Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care	28	0	0.00%
C04 - Apparently did not carry out an established plan in a competent and/or timely fashion	31	4	12.90%
C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results	7	0	0.00%
C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	4	0	0.00%
C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	8	2	25.00%
C08 - Apparently did not perform a procedure that was indicated	7	1	14.29%
C09 - Apparently did not obtain appropriate laboratory tests and/or imaging studies	8	0	0.00%
C10 - Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	7	0	0.00%
C11 - Apparently did not demonstrate that the patient was ready for discharge	15	0	0.00%
C12 - Apparently did not provide appropriate personnel and/or resources	5	2	40.00%
C13 - Apparently did not order appropriate specialty consultation	6	1	16.67%
C14 - Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15 - Apparently did not effectively coordinate across disciplines	2	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)	28	5	17.86%
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	0	0.00%
C40 – Apparently did not follow up on patient's noncompliance (only applies to MA patient)	0	0	0.00%
C99 - Other quality concern not elsewhere classified	102	7	6.86%
TOTAL NUMBER OF CONCERNS	**270**	**24**	**8.89%**

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 (%)
13	0	0.00%

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	9	69.23%
2 - Perform intensified review	0	0.00%
3 - Require continuing education	2	15.38%
4 - Request/review policy/procedure	0	0.00%
5 - Request development of QIP	2	15.38%
6 - Accept provider-initiated QIP	0	0.00%
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	**13**	**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 – 1/31/2014.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01 - Discharged to home or self-care (routine discharge)	16	38.10%
02 - Discharged/transferred to another short-term general hospital for inpatient care	1	2.38%
03 - Discharged/transferred to skilled nursing facility (SNF)	7	16.67%
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	12	28.57%
07 - Left against medical advice or discontinued care	1	2.38%
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%
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	5	11.90%

(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	0	0.00%
Other	0	0.00%
TOTAL NUMBER OF MEDICARE BENEFICIARIES	**42**	**100.00%**

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	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	368	55.17%
Male	296	44.38%
Unknown	3	0.45%
TOTAL	**667**	**100.00%**
Race		
Asian	17	2.55%
Black	78	11.69%
Hispanic	16	2.40%
North American Native	1	0.15%
Other	11	1.65%
Unknown	4	0.60%
White	540	80.96%
TOTAL	**667**	**100.00%**

F. Quality of Care Reviews and Concerns by Intervention Type

Quality of Care Concern	Provider Quality Improvement Activities
Change of condition: Failure to address in timely manner	The provider completed the following quality improvement activities: 1. Conducted a root cause analysis to further understand quality of care concern and identify gaps in service. 2. Series of staff education related to identifying signs and symptoms of a urinary tract infection in the elderly and use of antibiotics. 3. Dedicated assignment to oversee 4. Daily clinical meeting to review on-call activities for previous day and providing notification to the case manager/other team members.
Failure in the prevention and treatment of decubitus ulcers	The provider addressed the quality of care concern by: 1. Reviewing and updating their current policies and procedures. 2. Enhancement of initial assessment that addresses pain. 3. Implementing a new tool, the Braden-Scale for Predicting Pressure Sore Risk to provide better management and treatment of pressure ulcers. 4. Creating and implementing new staff communication tools for any change of condition and continuity of patient care. This includes a 24 hour change in condition form and the use of the tool: Interact, Stop and Watch. 5. Weekly audits by the Director of Nursing 6. Utilizing a Quality Assurance team to monitor improvement activities and conduct adjustments when needed. 7. Creating clinical outcome reports for Administrator and Physician Panel.
Delay in treatment: Delivery of blood transfusion	The provider completed the following quality improvement activities: 1. Conducted a root cause analysis to further understand quality of care concern and identify gaps in service. 2. Activate their internal peer review process in addition to QIO QIA. 3. Conduct ongoing performance monitoring which may include: • Periodic chart review • Direct observation • Monitoring of diagnostic and treatment techniques • Discussion with other individuals involved in the patient care

How Interventions Determined/Best Practices	
Failure in the prevention and treatment of decubitus ulcers	The facility conducted a root cause analysis to determine the reasons that contributed to the quality of care concerns identified. Based on this information, collective and system-wide quality improvement efforts were conducted.

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	AAFP	U.S. DHHS Agency
	Heart Failure	ACCF/AFA	National Medical Professional Association
	Acute Myocardial Infarction	ACCF/AHA	National Medical Professional Association
	Pressure Ulcers	AHRQ	U.S. DHHS Agency
	Urinary Tract Infection	AHRQ/AUA	U.S. DHHS Agency; National Medical Professional Association
	Sepsis	AHRQ	U.S. DHHS Agency
	Adverse Drug Events	AHRQ	U.S. DHHS Agency
	Falls	AHRQ/AGS	U.S. DHHS Agency; National Medical Professional Association
	Patient Trauma	AHRQ	U.S. DHHS Agency
	Surgical complications	AHRQ	U.S. DHHS Agency
Medical Necessity/Utilization Review		InterQual	Commercial evidence-based clinical decision support criteria
Appeals		InterQual	Commercial evidence-based clinical decision support criteria

* ACCF: American College of Cardiology Foundation
AHA: American Heart Association
AAFP: American Academy of Family Physicians
AHRQ: Agency for Health Care Research & Quality
AUA: American Urological Association
AGS: American Geriatric Society
DHHS: U.S. Department of Health and Human Services

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.

Improving Individual Patient Care: Reducing Pressure Ulcers

The Medicare beneficiary acquired pressure ulcers during a hospital stay. Upon medical record review of the health care services received, it was determined the beneficiary did not receive health care services that incorporated best practices for the prevention of and/or treatment for these wounds.

The QIO provided the evidence-based criteria from the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality for pressure ulcers to the facility and upon completion of the review findings, the provider developed quality improvement actions using these standards of care to address the identified quality of care concerns.

Improving Individual Patient Care: Delay in treatment

The Medicare beneficiary went to the emergency room where it was determined that the beneficiary needed a blood transfusion. It took more than 12 hours for the beneficiary to have the required laboratory blood work performed to determine a cross-match, and more than 24 hours to have the beneficiary sign the consent to receive the blood transfusion.

The standards of care for this procedure were not met based on evidence-based criteria found at the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality. The provider was informed of the criteria and instructed to conduct quality improvement activities to address the identified quality-of-care concerns.

Improving Individual Patient Care: Reducing Wrist Restraints

The Medicare beneficiary's tracheostomy plug became dislodged and due to the beneficiary's wrist restraints which were tied to the bed rails, the beneficiary was unable to verbalize his needs or use his bedside call light system. The representative also reported that routine rounds to check on the beneficiary were not being adequately performed.

It was determined that standards of care were not met. The QIO utilized the evidence-based criteria found in the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality during the case review process. This information was also provided to the facility to reference as they developed their quality improvement efforts to address the identified quality-of-care concerns.

H. Effectiveness of QIAs

Quality Improvement Activity (QIA) is meant to enhance the safety, efficiency and effectiveness of health care services provided to patients. The intent of the QIA is to establish collaborative work efforts between *HealthInsight* and the provider or practitioner to ensure that identified system failures are corrected to avoid risk to future patients.

HealthInsight assists providers with the development and implementation of corrective actions to enhance the providers' or practitioners' internal operations, standards of care practices and clinical decision-making processes. In all of the scenarios described above in this report, there are enormous opportunities for lessons learned and to promote safety and Beneficiary and Family Centered Care.

In all QIAs, the provider first completes a root cause analysis of the situation to understand the confirmed quality of care issue. This gives the provider the ability to review current practices and policies and procedures against the recognized standards of care. A cross-reference of all information typically reveals the gaps of service and an understanding of the underlying cause(s) that prompted or contributed to the adverse outcome. Secondly, the provider has the opportunity to review and understand a patient's perspective of the care they are receiving. In addition, the provider develops a detailed plan reflecting their corrective actions with the specific timelines in which this action will occur. Finally, the provider is required to monitor their plan, outcomes and adjustments made to their plan to ensure that all corrective actions are completed and successes are sustained. Throughout the entire QIA process, *HealthInsight* continues to extend their support and monitor the provider's progress.

This material was prepared by HealthInsight Nevada, the Medicare Quality Improvement Organization for the state, under contract with the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. NV-2014-CORP-03