

# Annual Medical Services Review Report Georgia

**Time Frame:** From August 2010 through July 2011

## **A. Beneficiary Complaints**

Under Medicare law, Quality Improvement Organizations (QIOs) review complaints about the quality of care that Medicare patients receive. The complaints come from Medicare patients and/or their representatives. In reviewing a complaint, the QIO looks at the services a patient received and decides whether those services met standards of health care that are commonly accepted by physicians and others in the medical community.

Quality of care complaints may involve more than one concern, due to the following: (1) more than one quality of care concern in a single setting; (2) the same quality of care complaint for a single patient episode of illness involving multiple settings and/or providers; (3) or more than one quality of care concern involving more than one setting and/or provider. For example, a Medicare beneficiary complaint related to a hospital stay might include several different quality of care concerns or a beneficiary who was hospitalized and then moved into a skilled nursing facility or other outpatient hospital setting might have the same quality of care concern occur in each type of setting. Consequently, for a specific Setting or Provider type, the number of quality of care concerns confirmed by the QIO may exceed the number of beneficiary cases reviewed.

### **Beneficiary Complaint Cases: Number and Review Results**

Number and Rate	Review Results
Total cases reviewed by the QIO: 22	Cases with confirmed quality concern: 9
Cases per 10,000 Part A Medicare Beneficiaries: 0.0022	Cases without confirmed quality concern: 13
Total Part A Medicare Beneficiaries in the State: 1.1 Million	Cases in process (without completion date): 11

**Note: Individual cases may involve more than one setting and/or provider.**

### **Complaint Cases by Setting or Provider**

Care Setting or Care Provider	Total Number of Concerns	Number and Percent of Confirmed Concerns for the State	
		Number	Percent
Hospital	20	6	30%
Skilled Nursing Facility (SNF) (includes SNF, swing, and swing critical access)	5	3	60%
Home Health Agency	0	0	0%
Medicare Advantage	0	0	0%
Physician	5	0	0%
Other Provider	2	0	0%

**Note: Individual cases may involve more than one setting and/or provider.**

### **Complaint Cases by Type of Problem**

The numbers below represent only complaints by beneficiaries or their representatives. They do not include any other QIO reviews of medical services.

<b>Type of Problem</b>	<b>Number and Percent of Confirmed Concerns for the State</b>		
	<b>Total Number of Concerns</b>	<b>Number of Confirmed Concerns</b>	<b>Percent (%) of Total Confirmed Concerns</b>
Inappropriate or unnecessary services	0	0	0%
Inappropriate setting	0	0	0%
Cases with a quality concern	32	9	28.13%

### **B. Beneficiary Notices and Appeals:**

Under Medicare law, QIOs review the need for inpatient hospital care. They help determine whether a patient received care in the proper place or “care setting.” This review may take place at two different times, either during or after a hospitalization. In the first instance, patients or their representatives ask the QIO to review a “Hospital Issued Notice of Non-Coverage,” or HINN, in which the hospital informs a patient that either an admission or a continued stay in a hospital is not needed. In such cases, the QIO conducts an “immediate review,” whereby the QIO reviews the case within 2 working days following the beneficiary’s request for a pre-admission or admission HINN and within 30 days after discharge or when the beneficiary was not admitted to the hospital. The QIO then issues either a denial notice or a notice explaining that the care would be, or is, covered. In all reviews, the QIO staff looks carefully at the patient’s medical record to decide if an admission or continued stay is/was needed.

In July 2007, original Medicare or Fee for Service (FFS) beneficiaries and Medicare Advantage (MA) enrollees who are hospital inpatients have a statutory right to have the QIO render an opinion of whether they are ready to leave the hospital. FFS/MA continued stay notice appeals are processed based on a request from the Medicare beneficiary or representative.

MA enrollees and FFS beneficiaries have the right to appeal decisions made by MA plans and/or providers about discontinuation of covered services. Discontinuation or termination of covered services includes discharge from a residential provider of services, or a complete cessation of coverage at the end of a course of treatment. Providers include skilled nursing facilities (SNF), home health agencies (HHA), hospice organizations, and comprehensive outpatient rehabilitation centers (CORF).

### Beneficiary Notice Reviews

Type/Timing of Review	Number of Cases	Review Results	
		Appropriate Cases (Agree with notice)	Inappropriate Cases (Disagree with notice)
Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0	0
Notice of Non-coverage FFS Preadmission Notice Non-Immediate Review	0	0	0
Notice of Non-coverage FFS Admission Notice Non-Immediate Review	2	2	0
Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	91	9	82
Notice of Non-coverage Continued Stay Notice Request for QIO Concurrence	2	1	1
MA Appeal Review (CORF,HHA,SNF)	158	50	108
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	173	132	41
FFS Notice of Non-coverage Continued Stay Notice Immediate Review-Attending Physician Concur	134	115	19
FFS Notice of Non-coverage Continued Stay Notice Concurrent Non-Immediate Review	0	0	0
FFS Notice of Non-coverage Continued Stay Retrospective	1	1	0
MA Notice of Non-coverage Continued Stay Notice Immediate Review-Attending Physician Concur	29	23	6

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