

**Annual Medical Services Review Report
Arizona
Health Services Advisory Group**

Time Frame: November 1, 2003 to October 31, 2004

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: 54	Cases with confirmed quality concern: 9
Cases per 10,000 Part A Medicare beneficiaries: 0.70*	Cases without confirmed quality concern: 45
	Cases in process (without completion date): 17

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

* Calculation based on Arizona Medicare Population of 767,924. Data source: SDPS beneficiary Denominator File, National EDB Warehouse Tables: Vw_cms_Denominator_2004 table.

Complaint Cases with Confirmed Concerns: The Setting or Provider

Care Setting or Care Provider	Total Number of Concerns	Number and Percent of Confirmed Concerns for the State	
		Number	Percent
Hospital	137	28	20.44%
Skilled Nursing Facility (SNF) (includes SNF, swing, and swing critical access)	30	4	13.33%
Home Health Agency	0	0	0.00%
Medicare Advantage	0	0	0.00%
Physician	56	6	10.71%
Other Provider	9	1	11.11%

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

Complaint Cases with Confirmed Concerns: 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.

Type of Concern Confirmed	Number/Percentage of Confirmed Concerns		
	Total Number of Concerns	Number of Confirmed Concerns	Percent of Total Confirmed Concerns
Inappropriate or unnecessary services	0	0	0.00%
Inappropriate setting	8	4	50.00%
Services with a confirmed quality concern	224	35	15.63%

B. Hospital Admission and Continued Stay Concerns

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 Initiated 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 for review after discharge or when the beneficiary was not admitted to the hospital) and issues either a denial notice or a notice explaining that the care would be, or is, covered. In other cases where a hospital issues a HINN, but the patient does not immediately ask for a review, the QIO automatically reviews the case after the fact in what is called “retrospective review.” 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.

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 Concurrent Immediate Review	1	1	0
Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0	0
Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concur	8	7	1
Notice of Non-coverage Continued Stay Notice Concurrent Non-immediate Review	0	0	0
Notice of Non-coverage Continued Stay Notice - Attending Physician Does not Concur	2	0	2
Notice of Non-coverage Continued			

Stay Retrospective	3	3	0
Notice of Non-coverage Retrospective Monitoring Review	2	2	0
NODMAR Immediate Review MA	16	12	4
MA Appeal Review (CORF, HHA, SNF)	112	78	34

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: AZ-7SOW-2C-011905-01.