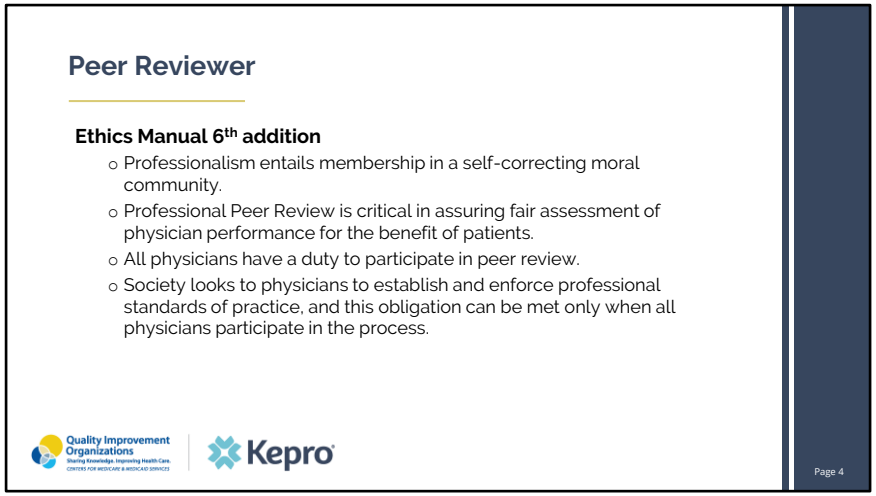
Integrity is the cornerstone of how individuals in a community come to respect and trust a profession. Physicians, more so than any other profession, depend on the integrity of its members to maintain an exceptionally high level of care and mutual trust with their patients. The peer review process is essential to maintaining and promoting high quality health care. Thank you for participating in the peer review process and being committed to improving the quality of health care.

Quality Improvement Organizations (QIOs) are the only federally coordinated infrastructure for improving care in every state and territory and therefore are key players in the national agenda to improve health care in America. The Medicare QIO Program was created by statute in 1982. The purpose of the program is noted in this slide.

Peer Reviewer

- A Peer Reviewer is either a physician or other practitioner who matches, as closely as possible, the variables of licensure, specialty, and practice setting of the physician or practitioner under review.
- Confidentiality requirements conveyed upon Quality Improvement Organizations (QIOs) under the Social Security Act prevent findings of Quality of Care reviews to be subject to discovery in legal proceedings.



The peer review process was started to help to guarantee a high quality of health care for all Americans. Most professional societies promote the peer review process in their ethic's manuals. The statement from the American College of Physicians is given on this slide.

Quality of Care Reviews

- A Quality of Care (QOC) review focuses on whether the quality of services provided to beneficiaries is consistent with professionally recognized standards of health care.
- Quality health care is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality of Care Reviews

In recognition of the revised Chapter 5 Quality of Care Review Manual, the review is to be completed in three (3) days and returned to the Nurse Reviewer.

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Objectives of Quality Review

- **Quality review objectives include:**
  - Determine if care provided meets recognized standard of care
  - Identify the source(s) of quality concerns
  - Determine the extent of systemic problems in the delivery of care that warrant an improvement plan
  - Provide rationale for decision
- **Goal of a Peer Reviewer is ultimately to:**
  - Improve care through educational feedback (primary focus)/and suggest improvements
  - Promote continuous quality improvement

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Paperwork

In the following slides, let's take a look at the paperwork you will receive with the medical record.

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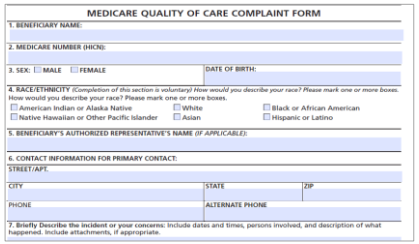
Complaint Form

Gives an overview of the beneficiary's concern



MEDICARE QUALITY OF CARE COMPLAINT FORM

1. BENEFICIARY NAME:

2. MEDICARE NUMBER (HICN):

3. SEX: ☐ MALE ☐ FEMALE | DATE OF BIRTH:

4. RACE/ETHNICITY *(Completion of this section is voluntary) How would you describe your race? Please mark one or more boxes.*
How would you describe your race? Please mark one or more boxes.
☐ American Indian or Alaska Native ☐ White ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Hispanic or Latino

5. BENEFICIARY'S AUTHORIZED REPRESENTATIVE'S NAME *(IF APPLICABLE)*:

6. CONTACT INFORMATION FOR PRIMARY CONTACT:
STREET/APT.
CITY | STATE | ZIP
PHONE | ALTERNATE PHONE

7. **Briefly Describe the incident or your concerns:** Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate.

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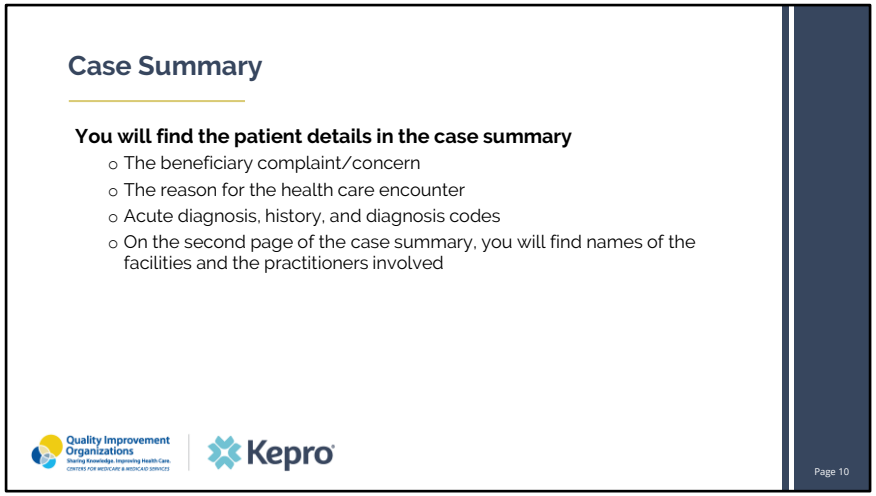
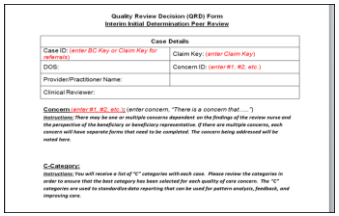
The Medicare Quality of Care Complaint form is completed by the beneficiary. The form is mailed out after the beneficiary has called into Kepro with their concerns regarding the care received.



All the information on the case summary will be completed by the Kepro staff and is for the reviewer's information only. There are no areas that need to be completed by the reviewer on the case summary page. There will be one case summary for each quality of care review.

Case Summary

The Quality Review Decision (QRD) form includes patient demographics, a case summary, and diagnostic information.



Quality Review Decision (QRD) Form
Interim Initial Determination Peer Review

Case Details	
Case ID: (enter BC Key or Claim Key for reference)	Claim Key: (enter Claim Key)
DOS:	Concern ID: (enter #1, #2, etc.)
Provider/Practitioner Name:	
Clinical Reviewer:	

Concern (enter #1, #2, etc.): (enter concern, "There is a concern that….")
Instructions: There may be one or multiple concerns dependent on the findings of the review nurse and the perspective of the beneficiary or beneficiary representative. If there are multiple concerns, each concern will have separate forms that need to be completed. The concern being addressed will be noted here.

C-Category:
Instructions: You will receive a list of "C" categories with each case. Please review the categories in order to ensure that the best category has been selected for each quality of care concern. The "C" categories are used to standardize data reporting that can be used for pattern analysis, feedback, and improving care.

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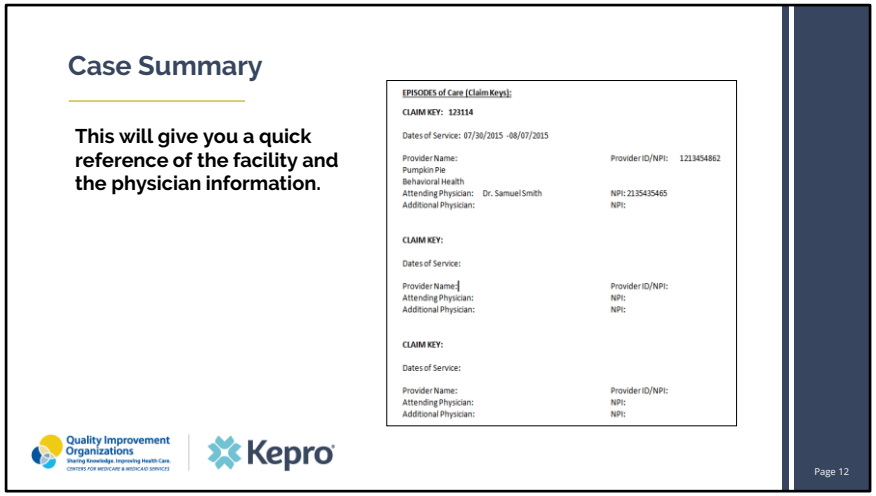
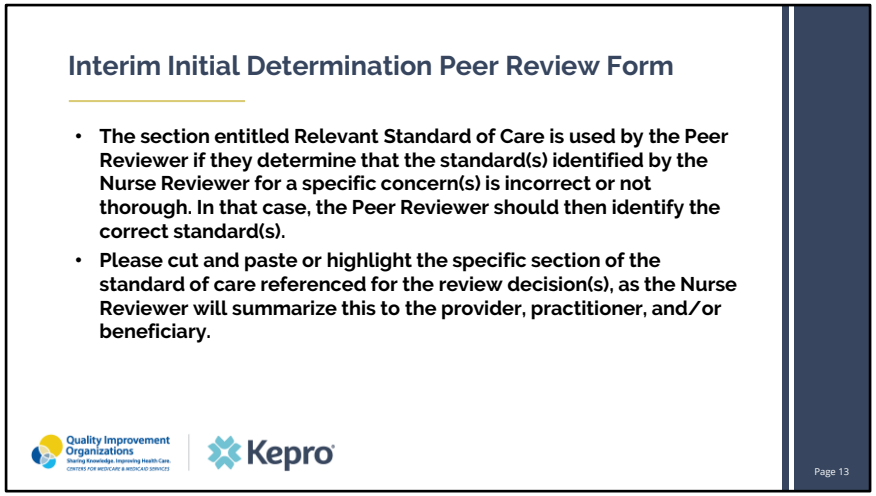
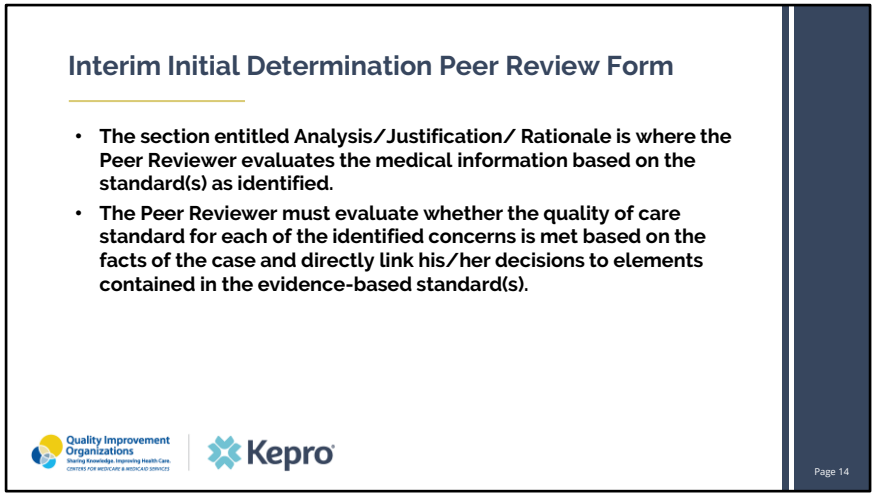
This is what the case summary will look like. Again, there is no area that needs to be completed by the Peer Reviewer on this form; it is for information only.



This is the second page of the Case Summary. There is no area that needs to be completed by the Peer Reviewer; it is for information only.



QIOs serve as a national infrastructure that helps doctors, hospitals, home health agencies, and nursing homes utilize best practices to improve care. QIOs employ skilled physicians and health professionals from a wide range of specialties who are knowledgeable about best practices in medicine. By providing the correct and relevant standard of care, Peer Reviewers are helping to incorporate best practices into day-to-day patient care.



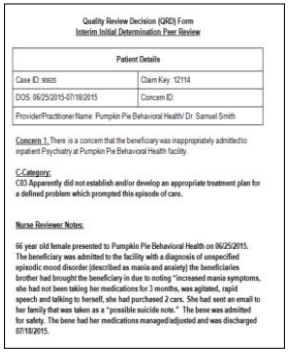
The rationale in this section is used to justify the Peer Reviewer's decision of whether or not the standard of care was met. The reviewer's identity is kept confidential, but the rationale behind the decision is shared with the beneficiary or their representative and the provider or practitioner that is responsible for the care provided.

Interim Initial Determination Peer Review Form

- The Peer Reviewer should consider any historical data pertinent to the concern(s) as provided by the Nurse Reviewer and highlight specific evidence from the review of the medical information that demonstrates that specific elements within the standard(s) of care are met or not met.
- The Peer Reviewer should also include any other information deemed relevant to his/her Interim Initial Determination.

Interim Initial Determination Peer Review Form

- This form will provide the Peer Reviewer with the patient details.
- This includes the concern to be reviewed as well as the C-category provided by the Nurse Reviewer.
- Nurse Reviewer notes are the Nurse Reviewer's quick overview of the case, providing a brief description of findings from the record.



Quality Review Decision (QRD) Form
Interim Initial Determination Peer Review

Patient Details	
Case ID: 99935	Claim Key: 12114
DOS: 06/25/2015-07/18/2015	Concern ID:
Provider/Practitioner Name: Pumpkin Pie Behavioral Health/ Dr. Samuel Smith	

Concern 1: There is a concern that the beneficiary was inappropriately admitted to inpatient Psychiatry at Pumpkin Pie Behavioral Health facility.

C-Category:
C03 Apparently did not establish and/or develop an appropriate treatment plan for a defined problem which prompted this episode of care.

Nurse Reviewer Notes:

66 year old female presented to Pumpkin Pie Behavioral Health on 06/25/2015. The beneficiary was admitted to the facility with a diagnosis of unspecified episodic mood disorder (described as mania and anxiety) the beneficiaries brother had brought the beneficiary in due to noting "increased mania symptoms, she had not been taking her medications for 3 months, was agitated, rapid speech and talking to herself; she had purchased 2 cars. She had sent an email to her family that was taken as a "possible suicide note." The bene was admitted for safety. The bene had her medications managed/adjusted and was discharged 07/18/2015.

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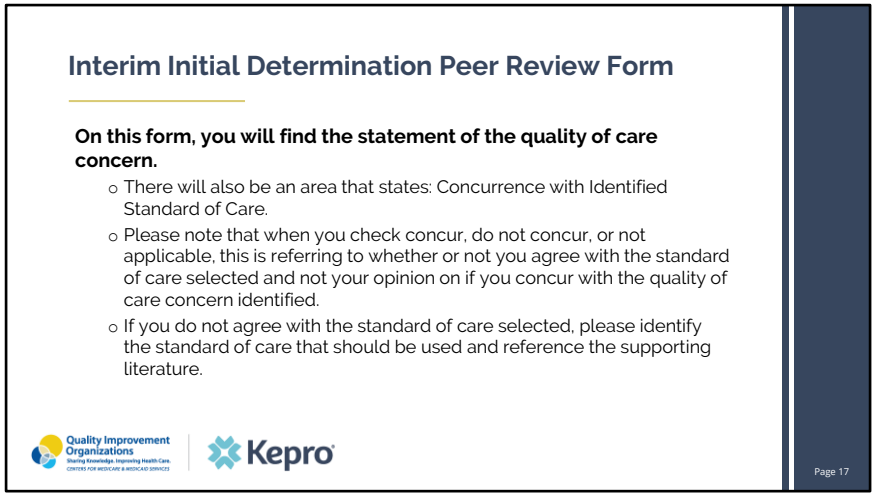

This form has very important information that needs to be completed by the Peer Reviewer. Each section that must be completed is discussed on the next three slides. Please call our nurse reviewers at any time if you have any questions.

Interim Initial Determination Peer Review Form

- **Do you agree with the identified standard of care (provided to you by the Nurse Reviewer)?**
- **If you do not agree, please choose an appropriate standard of care and write it on this sheet.**
- **Please provide the rationale for your conclusion concerning whether or not the identified area of concern met or did not meet the standard of care.**

If you do agree with the concern, please list who you feel the responsible party/parties are for the concern

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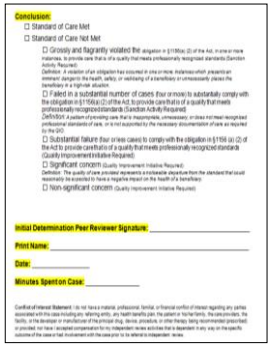
The arrows point to the sections discussed on the previous slides.

Interim Initial Determination Peer Review Form

- **Choose if the standard of care was met or not met.**
- **If the standard of care was not met, please check that box. Then choose a sub-category of concern that you feel most closely matches your level of concern.**
- **Sign, date, and add the time spent on the case.**
- **Read the Conflict of Interest statement.**



Conclusion:

☐ Standard of Care Met

☐ Standard of Care Not Met

☐ Grossly and flagrantly violated the obligation in §1156(a)(2) of the Act, in one or more instances, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)

Definition: A violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety, or well-being of a beneficiary or unnecessarily places the beneficiary in a high-risk situation

☐ Failed in a substantial number of cases (four or more) to substantially comply with the obligation in §1156(a)(2) of the Act, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)

Definition: A pattern of providing care that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the QIO.

☐ Substantial failure (four or less cases) to comply with the obligation in §1156 (a) (2) of the Act to provide care that is of a quality that meets professionally recognized standards (Quality Improvement Initiative Required)

☐ Significant concern (Quality Improvement Initiative Required)

Definition: The quality of care provided represents a substantial departure from the standard that could reasonably be expected to have a negative impact on the health of a beneficiary

☐ Non-significant concern (Quality Improvement Initiative Required)

Initial Determination Peer Reviewer Signature: _____

Print Name: _____

Date: _____

Minutes Spent on Case: _____

Conflict of Interest Statement: I do not have a material, professional, familial, or financial conflict of interest regarding any parties associated with this case including any referring entity, any health benefits plan, the patient or his/her family, the care providers, the facility, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended/prescribed or provided, nor have I accepted compensation for my independent review activities that is dependent in any way on the specific outcome of the case or had involvement with the case prior to its referral to independent review.

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The definitions for each sub-category that can be selected when the standard of care is not met are noted on the next slide.

The Peer Reviewer must use their clinical judgment to determine the sub-category if the standard of care was not met. Please note that a pattern of care can only be identified when reviewing different episodes of care involving the same provider or practitioner. A pattern of care can not be assigned when there are multiple mistakes involving one case. An example of substantial violation in a substantial number of cases is:

A Medicare contractor submits a case to the QIO with potential QOC concerns regarding a facility, involving multiple beneficiaries. Each case (at least 4) shows a pattern of substantial violations.

Quality of Care Concern or "C" Categories

C01- Apparently did not obtain pertinent history and/or findings from Examination

C02- Apparently did not make appropriate diagnoses and/or assessments

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])

C04- Apparently did not carry out an established plan in a competent and/or timely fashion (e.g. omissions, errors of technique, unsafe environment).

C05- Apparently did not appropriately assess and/or act on changes in clinical/ other status results.

C06- Apparently did not appropriately assess and/or act on laboratory tests or imaging study results.

C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed.

C08- Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09).

C09- Apparently did not obtain appropriate laboratory tests and/ or imaging studies.

C10- Apparently did not develop and initiate appropriate discharge, follow-up, and/ or rehabilitation plans.

C11- Apparently did not demonstrate that the patient was ready for discharge.

C12- Apparently did not provide appropriate personnel and/ or resources.

C13- Apparently did not order appropriate specialty consultation.

C14- Apparently specialty consultation process was not completed in a timely manner.

C15- Apparently did not effectively coordinate across disciplines.

C16- Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infections, etc.).

C17- Apparently did not order/follow evidence-based practices.

C18- Apparently did not provide medical record documentation that impacts patient care.

C40- Apparently did not follow-up on patient's noncompliance.

C99- Other quality concern not elsewhere classified.

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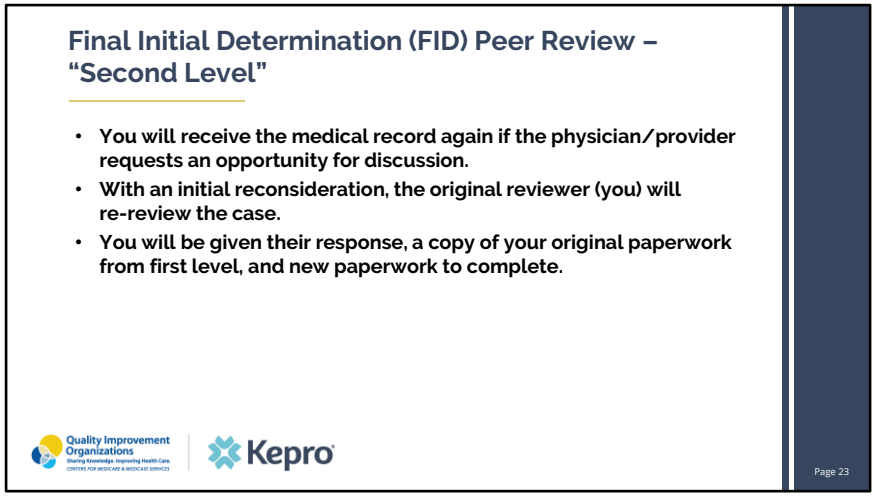
Quality of Care Concern or "C" Categories

- You will get a list of "C" categories with each case. Please review the categories in order to ensure that the best category has been selected for each quality of care concern.
- The "C" categories are used to standardize data reporting that can be used for pattern analysis, feedback, and improving care.

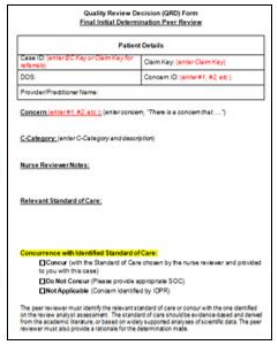


When the beneficiary initiates the complaint and if the Peer Reviewer determines that the standard of care is not met after the initial review, the QIO must offer the provider and/or practitioner that is the subject of the concern an opportunity for discussion of the concerns found. The practitioner and/or provider is afforded the opportunity to orally and/or in writing convey his/her disagreement with the conclusions rendered by the Peer Reviewer in the Interim Initial Determination. A summary of the facts provided by the practitioner and/or provider is sent back to the initial Peer Reviewer to see if the explanation satisfies the concern identified. The practitioner/provider may also choose to not respond to their opportunity to discuss the concerns found, and the case will proceed through the process.

For general quality of care concerns, the QIO is not required to offer the provider/practitioner with an opportunity for discussion if the Peer Reviewer determines that the standard of care was not met.

FID Peer Review – "Second Level"

- **Do you agree with the identified standard of care provided to you by the Nurse Reviewer?**
- **If you do not agree, please choose an appropriate response and write it here.**



Quality Review Decision (QRD) Form
Final Initial Determination Peer Review

Patient Details

Case ID: (enter ID Key or Claim Key for reference)
Claim Key: (enter Claim Key)
DOS:
Concern ID: (enter #1, #2, etc.)
Provider/Practitioner Name:

Concern (enter #1, #2, etc.): (enter concern, "There is a concern that…")

C-Category: (enter C-Category and description)

Nurse Reviewer Notes:

Relevant Standard of Care:

Concurrence with Identified Standard of Care:
☐ Concur (with the Standard of Care chosen by the nurse reviewer and provided to you with this case)
☐ Do Not Concur (Please provide appropriate SOC)
☐ Not Applicable (Concern Identified by ICPR)

The peer reviewer must identify the relevant standard of care or concur with the one identified on the review analyst assessment. The standard of care should be evidence-based and derived from the academic literature, or based on widely supported analyses of scientific data. The peer reviewer must also provide a rationale for the determination made.

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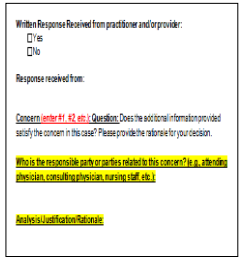
FID Peer Review – "Second Level"

- **Did you receive written information from the physician or provider to review? Please check yes or no**
- **Does the information from the physician/provider alleviate your concern? Please write yes or no**
- **Provide your justification/rationale**



Written Response Received from practitioner and/or provider:
☐Yes
☐No

Response received from:

Concern (enter #1, #2, etc.): Question: Does the additional information provided satisfy the concern in this case? Please provide the rationale for your decision.

Who is the responsible party or parties related to this concern? (e.g., attending physician, consulting physician, nursing staff, etc.)

Analysis/Justification/Rationale

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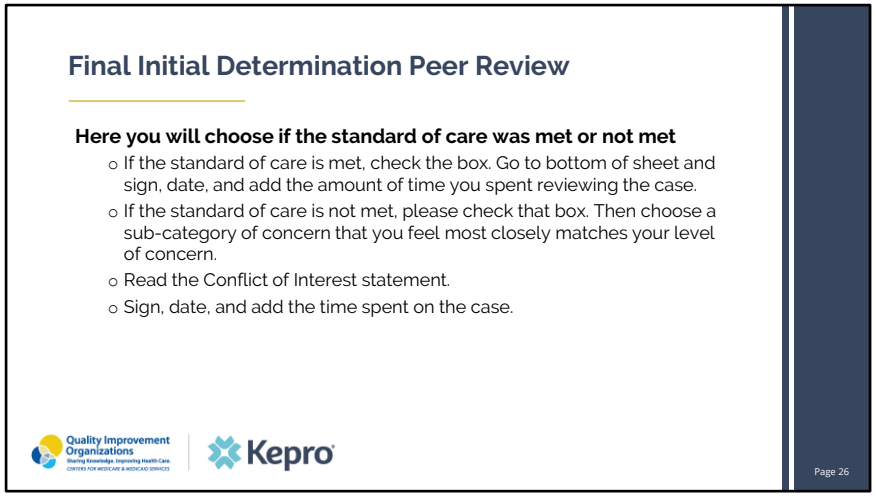
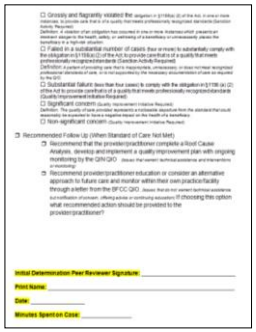
The initial Peer Reviewer must determine if the additional information satisfies the concern(s) that were raised and complete the Final Initial Determination form. The analysis and justification portion should be completed to convey the rationale for the decision.



The Final Initial Determination forms should be completed in the same manner previously described for the Interim Initial Determination forms.

Final Initial Determination Peer Review

- **Here you will choose if the standard of care was met or not met.**
- **Then choose a sub-category of concern that you feel most closely matches your level of concern.**
- **Next, choose a recommended follow-up (when standard of care was not met).**
- **Sign, date, and add the time you spent on the case.**



Initial Determination Peer Reviewer Signature: _____

Print Name: _____

Date: _____

Minutes Spent on Case: _____

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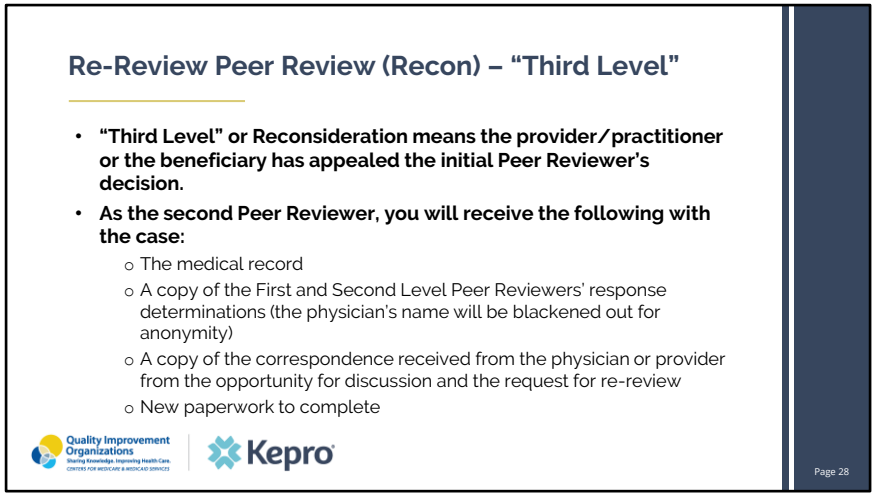
As you can see, the form is the same as the Interim Initial Determination form but does need to be completed again with consideration of the information given in the opportunity for discussion.



If the initial reviewer maintains that the standard of care is not met after the opportunity for discussion, then the practitioner and/or provider may request a Re-Review. The re-review Peer Reviewer must be different than the Peer Reviewer who conducted the Interim and Final Initial Determinations. In making his/her determination, the re-review Peer Reviewer shall review all information provided. The forms should be filled out as per the instructions given for the Interim Initial Determination.

Re-Review Peer Review (Recon) – "Third Level"

You will choose if you agree with the previous Peer Reviewer in that the standard of care was not met

- If the standard of care is met, check the box. Go to the bottom of the sheet and sign, date, and add the amount of time you spent reviewing the case.
- If the standard of care is not met, please check that box. Then choose a sub-category of concern that you feel most closely matches your level of concern.
- Then choose who you feel is responsible for the concern.
- Read the Conflict of Interest statement.
- Sign, date, and add the time spent on the case.

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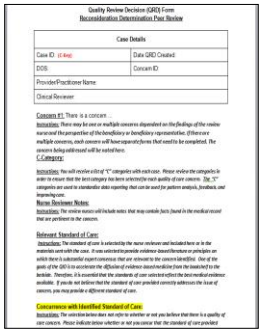
Re-Review Peer Review (Recon) – "Third Level"

- **Here you will find the beneficiary's concern and any Nurse Reviewer notes.**
- **Highlighted area: choose agreement with the standard of care provided by the Nurse Reviewer. If you do not agree, please choose the appropriate one, and write it on this sheet.**



Quality Review Decision (QRD) Form
Reconsideration Determination Peer Review

Case Details	
Case ID (C-Key)	Date QRD Created
DOS	Concern ID
Provider/Practitioner Name	
Clinical Reviewer	

Concern #1: There is a concern ...

Instructions: There may be one or multiple concerns dependent on the findings of the review nurse and the perspective of the beneficiary or beneficiary representative. If there are multiple concerns, each concern will have separate forms that need to be completed. The concern being addressed will be noted here.

C Category:

Instructions: You will receive a list of "C" categories with each case. Please review the categories in order to ensure that the term category has been selected for each quality of care concern. The "C" categories are used to standardize data reporting that can be used for pattern analysis, feedback, and improvement.

Nurse Reviewer Notes:

Instructions: The review nurse will include notes that may contain facts found in the medical record that are pertinent to the concern.

Relevant Standard of Care:

Instructions: The standard of care is selected by the nurse reviewer and included here or in the materials sent with the case. It was selected to provide evidence-based literature or principles on which there is substantial expert consensus that are relevant to the concern identified. One of the goals of the QIO is to accelerate the diffusion of evidence-based medicine from the knowledge to the bedside. Therefore, it is essential that the standards of care selected reflect the best medical evidence available. If you do not believe that the standard of care provided correctly addresses the issue of concern, you may provide a different standard of care.

Concurrence with Identified Standard of Care:

Instructions: The selection below does not refer to whether or not you believe that there is a quality of care concern. Please indicate below whether or not you concur that the standard of care provided

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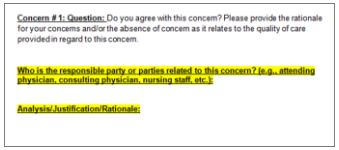
Re-Review Peer Review (Recon) – "Third Level"

Choose who you feel is responsible for the concern.



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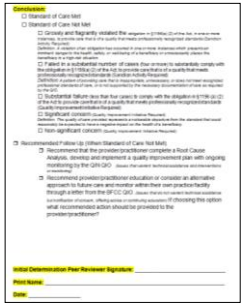
Re-Review Peer Review (Recon) – "Third Level"

- Here you will choose if the standard of care was met or not met.
- If the standard of care is not met, please check that box. Then choose a sub-category of concern that you feel most closely matches your level of concern.
- Read the Conflict of Interest statement.
- Sign, date, and add the time you spent on the case.



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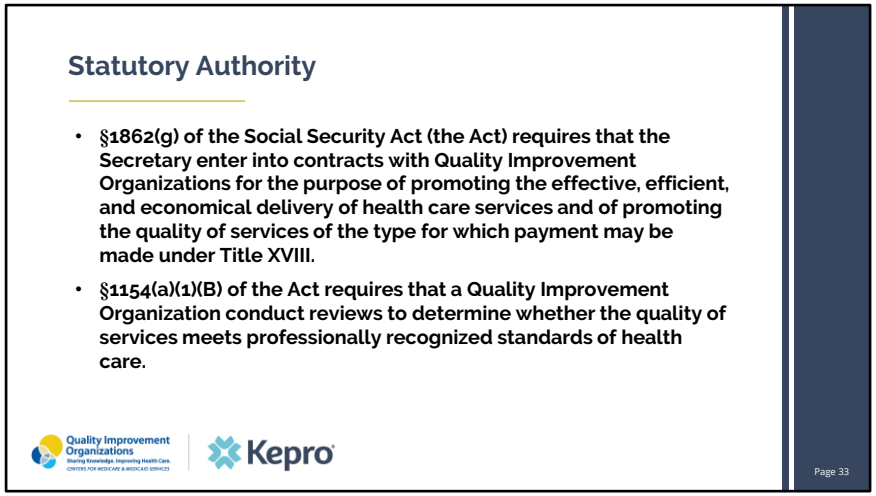

The statutory authority for the QIO Program is presented on the following slides for your review. QIOs are statutorily required to conduct reviews to determine whether the quality of services meets professionally recognized standards of health care.

Statutory Authority

§1154(a)(14) of the Act requires that Quality Improvement Organizations conduct appropriate reviews of all written complaints, submitted by beneficiaries or beneficiaries' representatives, about the quality of services not meeting professionally recognized standards of health care.

Title XVIII Social Security Act, sections 1154 and 1862

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Statutory Authority

§1154(a)(4)(A) of the Act requires that each Quality Improvement Organization provide that a reasonable proportion of its activities are involved with reviewing the quality of services, under paragraph (a)(1)(B), and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute care settings, ambulatory settings, and health maintenance organizations).

Statutory Authority

- **42 CFR 476.71(a)(2) requires a Quality Improvement Organization to determine whether the quality of services meets professionally recognized standards of health care.**
- **42 CFR 476.71(a)(5) requires the Quality Improvement Organization to determine the completeness, adequacy, and quality of hospital care.**

Title XVIII Social Security Act, section 1154; Code of Federal Regulations Title 42

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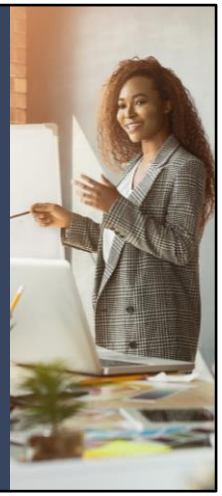

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