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.

- **Purpose:**
  - Improve the quality of care delivery to Medicare beneficiaries
  - Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and goods that are:
    - Reasonable and medically necessary
    - Provided in the most appropriate setting
  - Protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals
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.
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
In the following slides, let’s take a look at the paperwork you will receive with the medical record.
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.

- You will find the patient details in the case summary
  - The beneficiary complaint/concern
  - The reason for the Health Care Encounter
  - Acute diagnosis, history, and diagnosis codes
  - On the second page of the case summary, you will find names of the facilities and the practitioners involved
The QRD form includes patient demographics, a case summary, and diagnostic information.

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 section entitled Relevant Standard of Care is used by the Peer Reviewer if they determine that the standard(s) identified by the Nurse Reviewer for a specific concern(s) is incorrect or not thorough. In that case, the Peer Reviewer should then identify the correct standard(s).
- Please cut and paste or highlight the specific section of the standard of care referenced for the review decision(s), as the Nurse Reviewer will summarize this to the provider, practitioner, and/or beneficiary.
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.
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.
- 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**

**Initial Determination Peer Review**

**Patient Details**

<table>
<thead>
<tr>
<th>Data</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Start: 07/15/2015 End: 07/18/2015</td>
</tr>
<tr>
<td>Concern ID</td>
<td>1234</td>
</tr>
<tr>
<td>Provider/Practitioner Name</td>
<td>Pumplin-Pa Behavioral Health Dr. Samuel Smith</td>
</tr>
</tbody>
</table>

**Concern**

There is a concern that the beneficiary was inappropriately admitted to an inpatient Psychiatry at Pumplin-Pa Behavioral Health facility.

**C-Category**

DID: Apparently did not establish or develop an appropriate treatment plan for a defined problem which prompted the episode of care.

**Nurse Reviewer Notes**

46 year old female presented to Pumplin-Pa Behavioral Health on 06/29/2015. The beneficiary was admitted to the facility with a diagnosis of suspected bipolar mood disorder (characterized bymania and anxiety). The beneficiary's brother had brought the beneficiary to the facility due to noting "increased manic 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 beneficary was admitted for safety. The beneficary had her medications managed/adjusted and was discharged 07/19/2015.
On this form you will find the statement of the quality of care concern.

- There will also be an area that states: Concurrence with Identified Standard of Care
- Please note that when you check concur, do not concur, or not applicable, this is referring to whether or not you agree with the standard of care selected and not your opinion on if you concur with the quality of care concern identified
- If you do not agree with the standard of care selected, please identify the standard of care that should be used and reference the supporting literature

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.
The arrows point to the sections discussed on the previous slides.
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.
C-Categories

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 the episode of care (includes 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 and/or 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.
C19. Apparently did not follow-up on patient's noncompliance.
C20. Other quality concern not elsewhere classified.
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
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.

- Here you will choose if the standard of care was met or not met
  - If the standard of care is met, check the box. Go to bottom of 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.
  - Read the Conflict of Interest statement.
  - Sign, date, and add the time spent on the case.
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

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.
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
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.
Re-Review Peer Review (Recon) – “Third Level”

- Choose who you feel is responsible for the concern

Concern #1: Question: Do you agree with this concern? Please provide the rationale for your concerns and/or the absence of concern as it relates to the quality of care provided in regard to this concern.

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

Analysis/Justification/Rationale:
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

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard of Care Not Met</td>
</tr>
<tr>
<td>Standard of Care Met</td>
</tr>
<tr>
<td>Standard of Care Not Met (with a note of concern)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledge that the provider/practitioner completed a Root Cause Analysis, review and implement a quality improvement plan with ongoing monitoring by the QIO/DO. Issue a letter summarizing recommendation and actions.</td>
</tr>
<tr>
<td>Acknowledge a practice deviation situation or consider an alternate approach to future care and inform within the care provider’s network through a letter from the QIO/DO. Issue a letter summarizing recommendation and actions.</td>
</tr>
</tbody>
</table>

Initial Determination Peer Review Signature: __________________________

Signature: __________________________ Date: __________________________
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.
§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
§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