The Peer Review Process
Quality Improvement Organization Program

- **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.
Ethics Manual 6th addition

- Professionalism entails membership in a self-correcting moral community
- Professional Peer Review is critical in assuring fair assessment of physician performance for the benefit of patients
- All physicians have a duty to participate in peer review
- Society looks to physicians to establish and enforce professional standards of practice, and this obligation can be met only when all physicians participate in the process
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.
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.
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.

<table>
<thead>
<tr>
<th>Case Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ID:</strong> (enter BC Key or Claim Key for referrals)</td>
</tr>
<tr>
<td><strong>DOS:</strong></td>
</tr>
<tr>
<td><strong>Provider/Practitioner Name:</strong></td>
</tr>
<tr>
<td><strong>Clinical Reviewer:</strong></td>
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</tbody>
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**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.
This will give you a quick reference of the facility and the physician information.
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 section entitled Analysis/Justification/ Rationale is where the Peer Reviewer evaluates the medical information based on the standard(s) as identified.

The Peer Reviewer must evaluate whether the quality of care standard for each of the identified concerns is met based on the facts of the case and directly link his/her decisions to elements contained in the evidence-based standard(s).
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
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
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.

Relevant Standard of Care:
Clinical manifestations, differential diagnosis, and initial management of psychosis in adults (Up To Date)

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 IDPR)

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.

Concern (enter #1, #2, etc.): 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:

If you do agree with the concern, please list who you feel the responsible party/parties are for the concern.
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
Sub-Categories when the Standard of Care is Not Met

- **Gross and Flagrant Violation:**
  - 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 high-risk situations

- **Substantial Violation in a Substantial (4 or more) Number of Cases:**
  - A pattern of providing care that violates the obligation to provide health care only when it is economical and medically necessary, of a quality that meets professionally recognized standards of health care, and supported by evidence of medical necessity and quality
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/others 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.
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.
- You will receive the medical record again if the physician/provider requests an opportunity for discussion
- With an initial reconsideration, the original reviewer (you) will re-review the case
- You will be given their response, a copy of your original paperwork from first level, and new paperwork to complete
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.
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:
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
“Third Level” or Reconsideration means the provider/practitioner or the beneficiary has appealed the initial Peer Reviewer’s decision.

As the second Peer Reviewer, you will receive the following with the case:

- The medical record
- A copy of the First and Second Level Peer Reviewers’ response determinations (the physician’s name will be blackened out for anonymity)
- A copy of the correspondence received from the physician or provider from the opportunity for discussion and the request for re-review
- New paperwork to complete
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.
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:**
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.
Statutory Authority

- §1862(g) of the Social Security Act (the Act) requires that the Secretary enter into contracts with Quality Improvement Organizations for the purpose of promoting the effective, efficient, and economical delivery of health care services and of promoting the quality of services of the type for which payment may be made under Title XVIII

- §1154(a)(1)(B) of the Act requires that a Quality Improvement Organization 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).
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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