



Information for Healthcare Improvement



# Case Review Connection

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## *PEPPER Distribution*



PEPPERresources.org is the official site for information, training, and support related to the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The next scheduled release of PEPPER is on or around August 24, 2010. The PEPPER files will be sent to your hospital's QualityNet Administrators and to My QualityNet user accounts with the PEPPER recipient role. PEPPER provides hospital-specific data statistics for Medicare severity diagnosis-related groups (MS-DRGs) and discharges at high risk for payment errors.

## *Utilization Reviews*

FMQAI would like to remind all Quality Improvement Organization (QIO) Liaisons that hospital billing departments need to be incorporated into the loop of communications for all final QIO utilization determinations (e.g., DRG changes, admission denials, technical denials, and billing errors). We have noted an increase in the number of calls from hospital billing departments inquiring why claims have a QIO denial. While the utilization review team has provided billing departments with vital information, these types of calls should be directed to your facility's QIO Liaison. The billing department plays a very important role in the process and needs the information to complete the billing cycle. We suggest that your facility's QIO Liaison make a copy of the final utilization letter for the billing department, as this would help close the communication loop.



## *Utilization Reviews (cont.)*

The utilization team will soon begin to provide information to the fiscal intermediary (FI)/ Medicare Administrative Contractor (MAC) regarding Medicare Secondary Payers. There has been a noted increase in the number of these types of reviews in the monthly higher-weighted DRG selection. For more information on these types of reviews, please visit the Centers for Medicare & Medicaid Services (CMS) website, look under Manuals - Internet Only Manuals - Claims Processing Manual. When the utilization review team reviews a case that should be billed as a Medicare Secondary payer, correspondence will be sent to the appropriate FI/MAC notifying it of this finding.

The 2010 Federal Inpatient Only List is available at:

[http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS\\_1414\\_FC\\_Addenda.zip](http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS_1414_FC_Addenda.zip)

Inpatient Only List file: CMS\_1414\_FC\_2010\_OPPO\_FR\_AddE.xls

## *Quality Improvement Activities*

Improving the quality of health care for Medicare beneficiaries provides a means for not only getting better, but staying better. Providers may look to Quality Improvement Organizations, such as FMQAI, to help guide them in this activity. Not only does FMQAI provide a resource for beneficiaries to state their concerns, but it also allows organizations and providers to improve their processes and seek out evidence-based resources to improve the quality of care for their patients.

## *Quality Improvement Activities (cont.)*

The development of a Quality Improvement Activity starts with the cooperation of the organization. Once established, an organization can review the patient concerns and collaborate with a quality improvement project coordinator who specializes in quality improvement planning. The coordinator can help establish and encourage a critical thinking process that can ultimately affect all beneficiaries who seek out health care with the organization or provider.

The focus of most of the quality improvement activities is to benefit the most beneficiaries as possible by improving patient outcomes. For example, system-wide change can impact an entire network of facilities, improve processes, and enhance outcomes. Once a concern is noted for a facility, coordinators make every effort to understand the facility, its current processes, and help the facility develop a positive change towards better outcomes. A few of the current quality improvement activities for hospitals and hospital systems include timeliness of patient care to reduce potential mortality and morbidity, physician order follow through, accurate medical record documentation, and ensuring patient safety through a safe environment of care. As the coordinators continue to develop positive rapport with facility representatives, collaboration provides a better medium for outcomes and process improvement.

## *ADR*

In the April 2010 issue of Case Review Connection, we introduced examples of cases that would not benefit from the services offered by the Alternative Dispute Resolution Program. Such cases include those wherein a beneficiary's goal is to gain financial damages, there is an existence of legal action, some identifiable adversarial event has occurred in the past that prevents collaborative discussion of the concerns, or the parties involved are clearly at an impasse.

## *ADR (cont.)*

Not addressed in the last newsletter is that fact that many beneficiaries share concerns that fall outside of the scope of the QIO process. These concerns address issues that are not found in the medical record. They do, however, have a great impact on the perception of the care and, ultimately, the overall quality of care provided. Although the QIO recognizes that these cases do not fall within the guidelines of ADR nor the medical record review process, we remain committed to assisting these beneficiaries in coming to resolution as we are able within our scope.

FMQAI has examined these issues at length, and, as a result, we have found that many beneficiaries are simply seeking to be heard by their providers and to have some positive impact on future patients. As such, we have begun to utilize a letter of advocacy written on the beneficiary's behalf to the involved provider that gives them a "voice." With the beneficiary's consent, FMQAI is able to share their concerns in detail, along with possible insights regarding these concerns based on both our verbal and written contact with them, through this letter of advocacy. Although the QIO does not hold any expectations regarding providers' responses or actions addressing the issues raised in the letter of advocacy, we do feel that, by sharing such concerns, we can offer a more comprehensive approach to quality improvement and beneficiary customer service.

It is our hope that providers will be able to see the full picture of what occurred during the dissatisfactory episode of care, so that productive root cause analysis can be conducted, and appropriate and effective areas of improvement can be identified and addressed. Furthermore, we intend for the letter of advocacy to empower the beneficiary to be an active participant in his/her own care and lead to the repair of the patient-provider relationship.

## *FAQs*

- Q.** Two different hospitals have different Medicare ID (provider) numbers. Patients are transferred from one facility to the other for inpatient care. Does the sending hospital need to issue a follow-up copy of the Important Message from Medicare (IM)? Does the receiving facility need to issue a new IM?
- A.** The receiving hospital would provide a new IM if the transfer involves different Medicare ID (provider) numbers. However, no follow-up copy is needed prior to leaving the sending hospital if the transfer is an inpatient to inpatient hospital level of care



*For more information about this newsletter  
or for questions about case review, please  
contact: Marie Munsch - Case Review  
813-865-3536 - [mmunsch@flqio.sdps.org](mailto:mmunsch@flqio.sdps.org)*

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