



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 May 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 announces a change in process regarding billing error letters related to incorrect dates of service. In the past, when we identified a billing error related to incorrectly billed dates of service, a letter was sent to the hospital and the FI/MAC informing them of the error.

As of May 1, 2010, FMQAI will only send a notice to the FI/MAC indicating that, after review of the medical record, incorrect dates were billed. Any adjustments made as a result of this notice will be processed by the FI/MAC. Questions related to these errors should be directed to the FI/MAC. FMQAI will continue to send billing error letters to Hospitals and FI/MACs for admission denials identified through the utilization management review process.



Discharge Appeals

When issuing the *Important Message from Medicare (IM)*, facilities should keep in mind that the IM must be given to a competent beneficiary. If there is doubt in the issuing person's mind regarding beneficiary competency, the issuer should ask his/herself, "Is this beneficiary able to exercise his/her right to an appeal?" Can the beneficiary understand the notice, dial the telephone, and explain his/her point of view in a cogent manner? If the answer to any of these questions is "maybe" or "no," then the issuer should choose an alternative method of valid delivery of the IM such as assisting the beneficiary in calling the QIO. If the beneficiary has a Health Care Surrogate or a Power of Attorney, that individual would be the person to receive the IM. However, this is only if the beneficiary is incompetent as noted above. If a beneficiary is competent, then the beneficiary should receive the notice regardless of Health Care Surrogacy/Power of Attorney.

If there is no Health Care Surrogate/Power of Attorney, the IM cannot be given to an incompetent beneficiary. In this instance, the issuer can, with the assistance of Risk Management, seek a neutral party to act on the beneficiary's behalf. If this cannot be done, the IM should not be issued.

In the instance where a Health Care Surrogate/Power of Attorney has been identified, only that person should be notified. The QIO will only speak with the person who calls for the appeal. In the instance where there is a Health Care Surrogate/Power of Attorney identified, that would be the individual with whom the QIO communicates. There can be instances where the family members are in dispute with the Power of Attorney. This is a social issues and not one with which the facility or the QIO need become involved. In fact, communication with individuals other than the Health Care Surrogate/Power of Attorney could lead to questions of HIPAA violations.

If you need to issue an IM and have questions concerning this process, please call the QIO and ask to speak to the Manager on Duty.

ADR

Over the past years, we have presented a comprehensive overview of the Alternative Dispute Resolution Program and the positive results that can be gained by both beneficiaries and providers through participating in its processes. However, there are situations where the ADR program is not appropriate or would most likely not have a successful result. It is important to acknowledge these situations so that when evaluating whether or not to utilize the program in a specific case, a wise decision can be made.

After the determination is made that there are no confirmed quality of care concerns through the medical record review process, there are three main factors to be considered in determining appropriateness of a case resolution through the ADR process. First and foremost is whether a case falls within the scope of the QIO and its focus on improving quality of care. This determination not only considers the complaint itself but also the beneficiary's goal in making the complaint. ADR cannot address complaints that involve a beneficiary who is seeking financial damages, punitive damages, or a forum to engage in an adversarial conversation with the provider.

The second main factor to be considered is the beneficiary. The QIO must make a determination as to whether a beneficiary displays competency to participate in the ADR process. It is important to differentiate that competency is not used in traditional terms, but indicates whether the beneficiary is able to fully understand the process, is able to participate meaningfully in the process, and has goals congruent with the QIO scope. Simply having a cognitive deficiency or mental illness does not prohibit a beneficiary from participating in the ADR process as long as he or she meets the QIO's standards for competency in the ADR process. The possible resolutions that can be provided through the ADR process are considered under the third factor.

ADR (cont.)

The QIO views the complaint in terms of potential resolutions that may result from the ADR process that will not only benefit the beneficiary but will also demonstrate enhancement of the quality of care provided in the future. This aspect of the determination process is sometimes the most difficult, although in the end it is the beneficiary's right to be offered the opportunity to participate in the ADR process if he/she is are competent to do so.

In truth, there are a number of cases each month that are determined to be inappropriate for the ADR process. The majority of these inappropriate cases are deemed so due to a beneficiary's goal of financial damages, the existence of legal action, or some identifiable adversarial event that demonstrates the parties involved would not be able to act collaboratively toward resolution of the concerns. For example, a case was recently deemed inappropriate for ADR that involved statements by the beneficiary that she would like to meet with the provider in criminal court. Clearly, the QIO recognizes that this beneficiary would not find satisfaction through our non-adversarial, proactive, and future focused process.

In addition to situations like this one, the QIO recognizes that there are many cases where parties are simply at an impasse and that further attempts at resolution would be a disservice to all involved. For example, in another recent case, the family of a deceased beneficiary had had numerous contacts with the provider, which despite appropriate interventions by the provider, had proven unsatisfactory to the family. The family also acknowledged that short of bringing their loved one back, there was nothing the provider could do to bring peace to the matter. Although at times this assessment of impasse is disheartening, it is a reality in the field of health care. As such, the QIO focuses its efforts on those cases with potential for positive resolution that improve future care for others.

FAQs

Q. Please clarify which HINNS still remain in use.

A. HINNS 1, 10, and 11 continue to be used.

Q. Is it necessary to obtain the patient's signature on the follow-up copy of the IM that is given at discharge?

A. CMS strongly recommends that the hospitals obtain the signature or initials of the patient when delivery of the follow-up copy is necessary. Although a signature is not required, we believe it constitutes the best method of documenting delivery of the follow-up copy of the IM. Other methods of documentation are acceptable (e.g., a discharge document checklist), provided that surveyors can ascertain that the notice was delivered.



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