

**Annual Medical Services Review Report
Oregon
Acumentra Health**

Time Frame: From August 1, 2008 through June 30, 2009

A. Beneficiary Complaints

Under Medicare law, Quality Improvement Organizations (QIOs) review complaints about the quality of care that Medicare patients receive. The complaints come from Medicare patients and/or their representatives. In reviewing a complaint, the QIO looks at the services a patient received and decides whether those services met standards of health care that are commonly accepted by physicians and others in the medical community.

Quality of care complaints may involve more than one concern, due to the following: (1) more than one quality of care concern in a single setting; (2) the same quality of care complaint for a single patient episode of illness involving multiple settings and/or providers; (3) or more than one quality of care concern involving more than one setting and/or provider. For example, a Medicare beneficiary complaint related to a hospital stay might include several different quality-of-care concerns or a beneficiary who was hospitalized and then moved into a skilled nursing facility or other outpatient hospital setting might have the same quality of care concern occur in each type of setting. Consequently, for a specific Setting or Provider type, the number of quality of care concerns confirmed by the QIO may exceed the number of beneficiary cases reviewed.

Beneficiary Complaint Cases: Number and Review Results

Number and Rate	Review Results
Total cases reviewed by the QIO: 23	Cases with confirmed quality concern: 3
Resolved by MRR: 21	
Resolved by Mediation: 2	
Resolved by Facilitated Resolution (ADR): 0	
Resolved by External Resolution: 0	
*Total cases Abandoned or Withdrawn by Beneficiary or representative: 31	
Cases per 10,000 Part A Medicare Beneficiaries: 0.4	Cases without confirmed quality concern: 20
Total Part A Medicare Beneficiaries in the State: 580,425	Cases in process (without completion date): 63

Note: Individual cases may involve more than one setting and/or provider.

Complaint Cases by Setting or Provider

Care Setting or Care Provider	Total Number of Concerns	Number and Percent of Confirmed Concerns for the State	
		Number	Percent
Hospital	28	2	7.14%
Skilled Nursing Facility (SNF) (includes SNF, swing, and swing critical access)	28	0	0.00%
Home Health Agency	0	0	0.00%
Medicare Advantage	0	0	0.00%
Physician	36	1	2.78%
Other Provider	14	0	0.00%

Note: Individual cases may involve more than one setting and/or provider.

Complaint Cases by Type of Problem

The numbers below represent only complaints by beneficiaries or their representatives. They do not include any other QIO reviews of medical services.

Type of Problem	Number and Percent of Confirmed Concerns for the State		
	Total Number of Concerns	Number of Confirmed Concerns	Percent (%) of Total Confirmed Concerns
Inappropriate or unnecessary services	0	0	0.00%
Inappropriate setting	0	0	0.00%
Cases with a quality concern	106	3	2.83%

B. Hospital Admission and Continued Stay Concerns

Under Medicare law, QIOs review the need for inpatient hospital care and certain on-going outpatient treatments. They help determine whether a patient received care in the proper place or “care setting.” This review may take place either before, during or after a hospitalization or treatment. Once a patient or their representative asks the QIO to review a “Hospital Issued Notice of Non-Coverage,” or HINN, the QIO conducts a review and issues either a denial notice or a notice explaining that the care would be, or is, covered. If a hospital issues a HINN and the beneficiary has financial liability for care rendered but the patient does not request a review, the QIO automatically reviews the case after the fact in what is called “retrospective review.” In all reviews, the QIO staff looks carefully at the patient’s medical record to decide if an admission or continued stay or care is/was needed.

Reviews of Hospital Issued Notice of Non-coverage (HINN) and Notice of Discharge and Medicare Appeal Rights (NODMAR)

Type/Timing of Review	Number of Cases	Review Results	
		Appropriate Cases (Agree with notice)	Inappropriate Cases (Disagree with notice)
Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0	0
Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0	0
Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	0	0	0
Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0	0
Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concur	0	0	0
Notice of Non-coverage Continued Stay Notice Concurrent Non-immediate Review	0	0	0
Notice of Non-coverage Continued Stay Notice - Attending Physician Does not Concur	0	0	0
Notice of Non-coverage Continued Stay Retrospective	0	0	0
Notice of Non-coverage Retrospective Monitoring Review	0	0	0

NODMAR Immediate Review MA	0	0	0
MA Appeal Review (CORF, HHA, SNF)	334	286	48
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	66	63	3
FFS Notice of Non-coverage Continued Stay Notice Immediate Review – Attending Physician Concur	38	38	0
FFS Notice of Non-coverage Continued Stay Notice Concurrent Non-immediate Review	5	5	0
FFS Notice of Non-coverage Continued Stay Retrospective	0	0	0
MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concur	28	24	4

Glossary of Terms

BIPA- Benefits Improvement and Protection Act

CORF- Comprehensive Outpatient Rehabilitation Facility

FFS- Fee For Service

HINN- Hospital Issued Notice of Noncoverage

MA- Medicare Advantage (aka Medicare Plus Choice, Health Maintenance Organization [HMO])

NODMAR- Notice of Discharge and Medicare Appeal Rights

Q of C- Quality of Care

QIO- Quality Improvement Organization (formerly Peer Review Organization [PRO])

SNF- Skilled Nursing Facility