Annual Medical Services Review Report
New York
IPRO

Time Frame: 8/1/08 through 6/30/09

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 complaint cases reviewed.

Beneficiary Complaint Cases: Number and Review Results

Number and Rate	Review Results
Total cases reviewed by the QIO: 357	Cases with confirmed quality concern: 126
Resolved by MRR: 255	
Resolved by Mediation: 0	
Resolved by Facilitated Resolution (ADR): 102	
Resolved by External Resolution: 0	
*Total cases Abandoned or Withdrawn by Beneficiary or representative: 256	
Cases per 10,000 Part A Medicare Beneficiaries: 1.24	Cases without confirmed quality concern: 231
Total Part A Medicare Beneficiaries in the State: 2,873,105	Cases in process (without completion date): 143

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	1,221	171	14.00%
Skilled Nursing Facility (SNF) (includes SNF, swing, and critical access)	350	53	15.14%
Home Health Agency	90	17	18.89%
Medicare Advantage	0	0	0.00%
Physician	281	26	9.25%
Other Provider	77	11	14.29%

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	1	0	0.00%
Inappropriate setting	17	1	5.88%
Cases with a quality concern	2,001	277	13.84%

B. Beneficiary Notice Reviews

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-For-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.[1] Once a patient or their representative asks the QIO to review a provider issued notice, the QIO conducts a review and issues either a denial notice or a notice explaining that the care would be, or is, covered. 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.

Beneficiary Notice Reviews

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	101	88	13
Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	7	4	3
Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	177	129	48
Notice of Non-coverage FFS Admission Notice Non-immediate Review	17	12	5
Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	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	1	0	1
Notice of Non-coverage Continued Stay Retrospective	0	0	0
Notice of Non-coverage Retrospective Monitoring Review	5	5	0
NODMAR Immediate Review MA	0	0	0
MA Appeal Review (CORF, HHA,			

SNF)	1,319	855	464
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	1,301	1,171	130
FFS Notice of Non-coverage Continued Stay Notice Immediate Review – Attending Physician Concurs	907	814	93
FFS Notice of Non-coverage Continued Stay Notice Concurrent Non-immediate Review	70	61	9
FFS Notice of Non-coverage Continued Stay Retrospective	6	6	0
MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	270	211	59

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
HHA - Home Health Agency

[1]Overview Beneficiary Notices Initiative (BNI) http://www.cms.hhs.gov/BNI/

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy.

9SOW-NY-THM6.1-09-23