



CMA Weekly Alert – August 30, 2007

ADDRESSING CONCERNS ABOUT QUALITY OF CARE FOR MEDICARE BENEFICIARIES

When beneficiaries receive Medicare coverable healthcare, there is an expectation that the provider will listen to their concerns and assess and provide appropriate medical care. What can beneficiaries do if they believe that the prescribed medical care is inadequate or incorrect in some way? In Medicare, beneficiaries can request a “quality of care review” and question the level and appropriateness of the services provided.

The Quality Improvement Organization Program

The Centers for Medicare & Medicaid Services (CMS) oversees the Quality Improvement Organization (QIO) program, which is responsible for working with providers and beneficiaries to improve the quality of health care delivered to Medicare beneficiaries. The QIO program is implemented by a network of 41 contractors—some for-profit but most not-for-profit—with each contractor representing one or more of the 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico.¹

As part of its overall mission, the Social Security Act places the responsibility for investigating and resolving “quality of care” complaints from Medicare beneficiaries with QIOs.² A quality review is defined as “a review focused on determining whether the quality of the services meets professionally recognized standards of care.”³ Quality of care complaints triggering review may include concerns about the receipt of poor or inadequate treatment from health care workers, incorrect or inadequate medication, and inappropriate or failed surgeries and procedures.

QIOs are to review beneficiary quality of care complaints when all of the following conditions are met:

1. The complaint is in writing.
2. The service is furnished while the individual is a Medicare beneficiary.
3. The service is Medicare-covered.
4. The service is furnished by a health care provider that, at the time of the service, is qualified to receive Medicare payment.⁴

For complaints about quality received by telephone or in person, QIOs are instructed to advise the beneficiary or representative that the complaint must be submitted in writing. The QIO must also advise the beneficiary that, on request, it will provide assistance in preparing the written complaint, including sending the beneficiary the prepared complaint for his or her approval and signature, along with a pre-paid envelope for the beneficiary to use to mail the written complaint back to the QIO. For anonymous complaints or for complaints that are submitted orally, CMS instructs QIOs to investigate those that it believes are serious or urgent in nature.

A beneficiary may designate, in writing, a representative to file a complaint on his or her behalf. The QIO should provide the beneficiary with the appropriate form for this designation.⁵ Once the designation of a representative has been made, QIOs will send all future correspondence only to the representative and not to the beneficiary.

Beneficiary concerns about non-medical services are ancillary to the receipt of care and are reviewable by a Grievance procedure. They are not considered quality of care matters, and therefore are not reviewable by QIOs. For example, if a beneficiary, during a hospital stay, were to find the food bad, the staff rude, or the room temperature too cold or too hot, such concerns would not be considered “quality of care” complaints for purposes of QIO review. Rather, these matters should be addressed through the health care provider’s Grievance process.

The Beneficiary Quality of Care Complaint Review Process

Once a beneficiary (or designated representative) has submitted a written complaint about the quality of a Medicare service received, the QIO is required to conduct a review as follows:

1. Acknowledge Receipt of the Complaint

The initial acknowledgement may be oral, but QIOs are instructed to follow up in writing with an acknowledgement which details, among other items, the nature of the complaint and what the beneficiary can expect from the complaint process

2. Request and Receive Medical Records

The QIO will request the beneficiary’s medical records from the provider in question. If a provider fails to turn over the requested medical records, the QIO will contact the CMS Regional Office Project Officer. Failure to comply can lead to revocation of the Provider Agreement.

3. Complete Quality Review

The QIO will use the medical records to conduct a quality review. For beneficiaries in traditional Medicare and for beneficiaries enrolled in a Medicare Advantage (MA) plan, the focus of the review is to determine whether the services met “professionally recognized standards of health care.” For beneficiaries enrolled in an MA plan, the review should also determine whether appropriate services were absent or were provided in inappropriate settings.

4. Provide Re-review

If the QIO confirms a quality concern against a practitioner/provider, the QIO must offer the provider an opportunity for a re-review. The provider may present additional documentary information at this time.

5. Provide Notice of Disclosure

When the investigation is complete, the QIO will give the provider a notice of disclosure. The provider has an opportunity to comment on the final response to the complainant and to consent to or prohibit the disclosure of information that would explicitly or implicitly identify the provider in the final report. (Legislation recently introduced in the Senate would improve beneficiaries’ access to this information.⁶) The attending physician is also allowed an opportunity to provide an opinion as to whether it would be appropriate to disclose the final report to the beneficiary. In cases where the attending physician decides it would be harmful to disclose the final report to the beneficiary, it will be disclosed to a representative instead.

6. Respond to Complainant

The final letter to the complainant follows a set of guidelines which differ depending on whether the

provider consented to disclosure and whether the complainant consented to disclosure of his or her identity.⁷

If the provider consents to disclosure the letter will indicate whether the care met recognized standards of quality. If the care did not meet those standards, the letter will also detail what steps the QIO will take. The letter will instruct the beneficiary that information identifying the provider is confidential and cannot be further disclosed. The QIO will also attach any comments received from the involved practitioner or provider.

If the provider does not consent to disclosure, the letter will indicate that a complete review was conducted and that information about the provider cannot be given. If the review warrants action, the QIO will take it. The letter will also state that the provider's refusal to consent to disclosure does not necessarily mean that there was a problem with the care.

CMS also provides QIOs with a timetable for handling each step in the review process. This timetable is different depending on the type of review requested. If the beneficiary is no longer receiving the services in question or has been discharged from the facility in question, the review is retrospective. It can take anywhere from 85 to 165 days to complete, depending on whether a quality concern was identified and whether a re-review was requested. If the beneficiary is still receiving the services in question, the review is concurrent and can take anywhere from 38 to 83 days to complete, with the initial review coming within three days of filing the complaint.

Conclusion

Despite its shortcomings, the beneficiary complaint review process can still be a useful tool for addressing quality of care concerns. It can provide clarifying information about services and procedures and bring about a measure of provider/physician scrutiny and oversight, thus making providers generally more accountable. For a broader discussion of problems, concerns, and recommendations for change, please review the proceedings and recommendations from the recent Center for Medicare Advocacy conference on the QIO beneficiary complaint process. www.medicareadvocacy.org/Projects_QIOConference.htm.

For more information, please contact attorney Alfred Chiplin (achiplin@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028.

¹ For a complete listing of all of the QIOs, see <http://www.medqic.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings>.

² Social Security Act §1154(a)(14), 42 U.S.C. §1320c-3(a)(14). See also, 42 C.F.R. §475.70, *et seq.*

³ QIO Manual § 4410, CMS Publication No.100-10. Available at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

⁴ QIO Manual § 5005.

⁵ See the QIO Manual, Exhibit 5-16 – VII, for the model language to designate a representative.

⁶ See 110th Congress, S.1947 (August 2, 2007) <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s1947is.txt.pdf>.

⁷ See the QIO Manual, Exhibits 5-17 and 5-18, for two model letters of final response.