Annual Report of Medicare Case Reviews for Minnesota

August 1, 2013 – April 30, 2014

This annual report provides data regarding case reviews that Stratis Health has completed on behalf of Medicare beneficiaries.

Across the nation, Medicare Quality Improvement Organizations (QIOs) in every state and territory publish an annual report of their case review activities. General requirements for these reports are outlined by Centers for Medicare & Medicaid Services (CMS). Unless noted otherwise, the information in this report reflects the period August 1, 2013, to April 30, 2014.

Information for Medicare consumers on concerns about clinical quality of care or appealing a discharge or denial of coverage is available at www.stratishealth.org/consumers/medicare/index.html.

Improving Quality of Care for Medicare Beneficiaries

Stratis Health is Minnesota's federally-designated Medicare Quality Improvement Organization. As a trusted partner to CMS, we work every day to support the agency's three part aim: better care, better health, and lower costs. QIOs ensure the quality, effectiveness, efficiency, and economy of health care services provided to people with Medicare. Stratis Health is a change agent and convener for widespread, significant improvements in health quality. We freely share knowledge and tools, bringing evidence-based best practices to the bedside through both rapid-cycle projects for collaborative learning and individual assistance as needed. Patients are at the center of everything we do.

To support our patient-centered approach, we are authorized by the Medicare program to review medical care provided to beneficiaries to determine whether it meets medically-acceptable standards of care, is medically necessary, and is delivered in the most appropriate setting.

Linking Case Review to Quality Improvement

Stratis Health is increasing efforts to link case review activities to improvements in the delivery of care by developing quality improvement activities focused on system-wide changes. Stratis Health uses data from case review activities to identify problems related to the quality of care and to design quality improvement activities to help providers correct these problems.

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Review Types

Under our current improvement efforts with Medicare, Stratis Health carries out a number of activities related to Medicare beneficiary review.

Stratis Health carries out statutorily-mandated review activities including the following:

- Reviews the quality of care provided to beneficiaries – quality of care reviews
- Reviews requests for service termination and/or discharge – notice of non-coverage
- Reviews potential Emergency Medical Treatment and Active Labor Act violations (anti-dumping cases) – EMTALA
- Reviews CMS-selected cases for appropriate admission status and higher-weighted diagnosis related group (HWDRG) assignment – coding validations, utilization

Medicare Beneficiaries in Minnesota

The table below shows gender and race make up of the state's Medicare population. For more information on Medicare in the state, see Stratis Health's *Profile of Medicare in Minnesota*, http://www.stratishealth.org/documents/MedicareProfile.pdf.

Table 1. Beneficiary demographics in Minnesota

Demographics	Overall Beneficiaries[1]		Beneficiaries Initiating Case Review	
	Number	Percent	Number	Percent
Sex/Gender				
Female	433,181	54.8%	547	61.39%
Male	356,082	45.1%	344	38.61%
Total	789,263		891	100.00%
Race				
Asian	8,565	1.1%	3	0.34%
Black	18,558	2.4%	28	3.14%
Hispanic	2,291	0.3%	2	0.22%
North American Native	5,684	0.7%	8	0.90%
Other	7,591	1.0%	4	0.45%
Unknown	2,282	0.3%	4	0.45%
White	744,286	94.3%	842	94.50%
Total	789,263		891	100.00%

1. Medicare enrollment database (2010), excluded death prior to 12/31/2010

Summary of Stratis Health Review Activities on Behalf of Medicare

Stratis Health completed a total of 1,189 reviews on behalf of Medicare beneficiaries receiving care in Minnesota. The table below shows the different types of reviews we conducted. For more detailed data on types of reviews, see Table I in the Appendix. Details on expedited appeals are in Table II.

Table 2. Total number of completed reviews

Review Type	Number of Reviews	Percent of Reviews
Quality of Care Review[1]	97	8.2%
Immediate Advocacy[2]	4	0.34%
Notice of Non-coverage/ Expedited Appeals[3]	781	66%
Coding Validations[4]	99	8.3%
Utilization Reviews[4]	206	17%
EMTALA Reviews[5]	2	0.16%
Total	1,189	

1. **Quality of Care Reviews:** If a Medicare beneficiary is not satisfied with the quality of care they receive, they can call the Medicare Beneficiary Help Line to discuss the situation with a trained professional. We ask them questions to better understand their concerns. If the beneficiary wants to make a formal complaint, we ask them to send us their concerns in writing. Once we receive the written complaint, a Review Specialist and an independent Physician Reviewer review the case.

   The purpose of the quality of care review is to find the reason things happened to cause the concern and to determine the likelihood that it will happen again. The purpose of the review is not to punish the physician or health care provider, but to help improve care delivery for future patients.

2. **Immediate Advocacy**: In some situations a less formal approach is better to help address a beneficiary's concern. Through immediate advocacy the QIO makes immediate and direct contact with the provider of Medicare services for the beneficiary to resolve the concern as quickly as possible.

3. **Notice of Non-coverage Reviews/Expedited Appeals:** Medicare beneficiaries receive a Notice of Medicare Non-Coverage prior to the termination of Medicare-covered items and/or services for skilled nursing facility (SNF), home health care (HHC), hospice and comprehensive outpatient rehabilitation facility (CORF) services. This notice informs the beneficiaries of their right to request an expedited review from the QIO for the proposed discontinuation of covered services. A Detailed Notice of Non-coverage is provided to the beneficiary when they request a QIO review in order to provide more explanation on why the coverage is ending.

   Hospitals must deliver the Important Message from Medicare (IM) to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. The IM informs the beneficiaries of their right to request an expedited review from the QIO for the proposed discontinuation of covered services. Beneficiaries who choose to appeal a discharge decision receive a Detailed Notice of Non-coverage to provide more explanation on why the coverage is ending.

4. **Coding Validations and Utilization Reviews:** Certain hospital claims submitted as part of hospital billing trigger review by the QIO, since the proposed changes to billing codes would allow the hospital to receive more money for the care delivered. The organization that processes

hospital claims for Medicare patients refers all claims of this type to the QIO. The QIO ensures that the care provided accurately matches the provider's claim for payment, and was coded correctly for billing purposes. The QIO also confirms that all services and items provided were reasonable and medically necessary.

5. **EMTALA Reviews:** Stratis Health reviews cases that may be in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA is a federal regulation requiring that patients who need stabilization for an emergency medical condition receive that care, regardless of their ability to pay. CMS refers cases of this kind to the QIO. The QIO determines whether the medical screening was adequate; whether an emergency medical condition existed and, if so, was stabilized; and whether there are concerns with the quality of care provided.

Geography of Providers – Urban and Rural

The table below shows how many urban and rural providers are represented among our completed case reviews.

Table 3. Provider reviews geographics

Geographic Area	Number of Providers	Percent of Providers
Rural	98	37.26%
Urban	165	62.74%
Total	263	100.00%

Types of Health Care Providers Reviewed

As the Medicare QIO, Stratis Health reviews care provided by many different types of health care providers. The table below shows, for the cases reviewed, how many reflected care delivered by particular kinds of facilities. For more detailed data on types of health care providers we reviewed, see Table III in the Appendix.

Table 4. Types of health care settings providers reviewed

Setting	Number of Providers	Percent of Providers
Skilled Nursing Facility	182	69.20%
Hospital (acute care unit of an inpatient facility)	43	16.35%
Home Health Agency	11	4.18%
Critical Access Hospital	10	3.80%
Hospice	8	3.04%
Swing Bed Designation for Critical Access Hospitals	7	2.67%
Long Term Care Facility	2	0.76%
Total	263	100.00%

Quality of Care Concerns Confirmed

When we start a review, Stratis Health categorizes each concern raised in the complaint. The table below shows the types of concerns voiced by beneficiaries and the number of concerns that we confirmed among all quality of care reviews that we completed. A complaint case often has multiple concerns, each of which we address through the review process. In Minnesota, we completed 97 quality of care reviews with 304 identified concerns.

Table 5. Quality of care concerns reviewed and confirmed

Quality of Care Concern Apparently did not…	Number of Concerns Raised	Number of Concerns Confirmed	Percent of these Concerns Confirmed
Obtain pertinent history and/or findings from examination	4	1	25.00%
Make appropriate diagnoses and/or assessments	37	8	21.62%
Establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care	48	5	10.42%
Carry out an established plan in a competent and/or timely fashion	16	1	6.25%
Appropriately assess and/or act on changes in clinical/other status results	23	7	30.43%
Appropriately assess and/or act on laboratory tests or imaging study results	6	1	16.67%
Establish adequate clinical justification for a procedure which carries patient risk and was performed	6	0	0.00%
Perform a procedure that was indicated (other than lab and imaging, see C09)	3	0	0.00%
Obtain appropriate laboratory tests and/or imaging studies	10	1	10.00%
Develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	8	0	0.00%
Demonstrate that the patient was ready for discharge	14	3	21.43%
Provide appropriate personnel and/or resources	2	0	0.00%
Order appropriate specialty consultation	7	0	0.00%
Complete specialty consultation in a timely manner	1	0	0.00%
Effectively coordinate across disciplines	5	0	0.00%
Ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	17	3	17.65%
Order/follow evidence-based practices	9	1	11.11%

Quality of Care Concern Apparently did not…	Number of Concerns Raised	Number of Concerns Confirmed	Percent of these Concerns Confirmed
Provide medical record documentation that impacts patient care	12	2	16.67%
Other quality concern not elsewhere classified	76	2	2.63%
Total	304	35	11.51%

See Table IV for the complete list of concern types (Quality of Care Physician Reviewer Assessment Form (PRAF) codes) identified by Medicare.

Evidence Used When Reviewing Quality Concerns

In general, for quality of care cases, Stratis Health uses evidence-based guidelines and the medical literature to identify standards of care, where such a standard exists. Many aspects of care are not clearly addressed by evidence-based guidelines. In these cases, we default to either a principle of professional practice or knowledge of local practice patterns. Examples of evidence-based guidelines can be found by clinical topic in Table V in the Appendix. For information on the top 10 medical diagnoses in Minnesota for hospital claims billed to Medicare, see Table VI in the Appendix.

Example of evidence used/standards of care

Concern: A beneficiary developed pressure ulcers on both heels following admission to a nursing home.

Findings: Using root cause analysis, the nursing home identified the following opportunities for improvement in its preventative skin care process: daily skin inspection did not include all skin surfaces and as a result did not detect early signs of breakdown; tissue tolerance testing was being completed within the first week, which was not early enough in the stay to help prevent a high risk beneficiary from developing a new skin problem; and communication between nursing assistants and licensed staff, as well as other disciplines, did not consistently include information regarding skin risk.

Evidence and Technical Assistance: Evidence considered for this case included *Guideline for prevention and management of pressure ulcers*. 2003 (updated 2010 June 1) NGC: 007973 Wound, Ostomy, and Continence Nurses Society. Other evidence sited included considered *Pressure Ulcer Treatment Strategies: Comparative Effectiveness Review No. 90*. Released May 8, 2013. Agency for Healthcare Research & Quality. Stratis Health provided information and coaching on conducting root cause analysis to identify all of the factors that may have led to the beneficiary's skin breakdown. Once the process breakdowns were identified, the nursing home was able to draw from the evidence and develop effective interventions to prevent similar breakdowns in the future. Examples of the interventions developed include updating its tissue tolerance testing policy so that the testing is completed the first day after admission to assure beneficiaries at high risk for skin breakdown are identified early in their admission to the home. The home identified features of its electronic medical record system that prompt nursing assistants to examine all skin areas during care activities in support of daily living and document their findings. Any new concern areas found and documented in the system trigger a note to the licensed staff to assess the resident's skin. At the request of the nursing home, Stratis Health developed an audit tool to allow the home to know if its

improvement plan was happening as expected and having the intended effect. Stratis Health designed the tool so that the staff at the nursing home could use as is or modify for future needs. The home's first two quarters of monitoring demonstrated positive results, ranging from 95 to 98 percent compliance with expected performance.

Quality Improvement Activities Initiated

Whenever Stratis Health confirms a quality of care concern, we work with the health care provider to uncover the cause of the problem, assure an understanding of evidence-based care, and prevent the problem from happening again by addressing any concerns about policies, procedures, and systems of care. We assist providers and practitioners in developing and carrying out plans or activities—called Quality Improvement Activities (QIAs)—to improve identified quality of care concerns. During this period, we initiated 19 QIAs.

The following table shows the number and types of improvement activities we initiated for reviews with one or more confirmed Quality of Care concerns. This table reflects the first intervention pursued; in some cases multiple interventions were applied.

Table 6. Quality improvement activities

Initial Quality Improvement Activity (QIA)		Interventions with this QIA	
		Number	Percent
1	Send educational/alternative approach letter	4	21.05%
2	Perform intensified review	3	15.79%
3	Require continuing education	0	NA
4	Request/review policy/procedure	1	5.26%
5	Request development of quality improvement plan	6	31.58%
6	Accept provider-initiated quality improvement plan	0	NA
7	Conduct informal meeting or teleconference	5	26.32%
8	Refer to licensing board	0	NA
9	Initiate sanction activity	0	NA
10	Other	0	NA
	Total	19	100.00%

In Minnesota, 19 QIAs were initiated with health care providers identified in case reviews related to quality of care concerns. None were for Serious Reportable Events.

Table 7. Serious reportable events

Number of QIAs Initiated	Number of QIAs Initiated for Serious Reportable Events	Percent of QIAs Initiated for Serious Reportable Events
19	0	NA

Quality Improvement Activities Initiated

Below are three case studies of how QIAs were determined and implemented as a result of confirmed Quality of Care concerns. The goal of QIAs is to assure safe, appropriate care for future patients.

Providing assessment and or acting on changes in clinical or other status results

Through review of medical documentation, Stratis Health identified a breakdown in interdisciplinary communication at a nursing home regarding pain. The beneficiary, a resident of the nursing home, had been reporting pain during the occupational therapy treatment of her upper extremity, limiting her ability to fully participate. This information had not been communicated to nursing so that the beneficiary could be assessed and an update provided to her physician regarding possible changes to her treatment plan. Following a root cause analysis, the nursing home found an opportunity to improve systems that support interdisciplinary communication.

Regular interdisciplinary meetings were scheduled that focused on sharing information on resident progress, concerns, or other updates. This was an expansion of a process the nursing home already used successfully within its nursing department. The process now includes all disciplines so that effective and timely updates can be shared with physicians and nurse practitioners regarding their resident's status for any component of their care and treatment. In addition, the initial interdisciplinary care conference that includes the beneficiary and their family, was changed to occur earlier, within the first week of admission to engage the beneficiary and family in their plan of care.

Ensuring a safe environment

After a beneficiary's fall in the bathroom while being assisted by a nursing assistant, a hospital identified a breakdown in care team communication regarding patient level of risk for falls. At times, nursing assistants were not always invited to participate in the change of shift verbal report and, as a result, may not have had the most current information regarding a patient's fall risk or most recent level of assistance needs. The change of shift verbal report was modified to include all nursing assistants on that shift in the report process. Team members also were reminded about the visual prompts that signal fall risk such as red slippers, door magnets indicating fall risk, and notation on the patient's white board in their room. The hospitals implemented staying "within arm's reach", where at all times when the patient is up and in the bathroom, patients at high risk must stay within arm's reach of staff who are assisting them.

Developing appropriate hospital discharge and follow up plans

Transitions of care from one provider setting to another or to home can pose risks for beneficiaries when all pertinent information does not get conveyed to the next provider of care. Stratis Health's review of a hospital stay detected an antibiotic indicated on the beneficiary's discharge medication list was not indicated on the physician's patient discharge summary when it should have been. The discharge summary served as a communication to the patient's primary care provider about the course of treatment during the hospital stay and after. The hospital identified the system breakdown that led to the omission. It implemented a new process to allow for an electronic transfer of all of a patient's medication ordered on discharge to be incorporated into the physician's discharge summary for the patient, thus protecting against the potential inadvertent omission of information.

Conclusion

As described in the examples above, when a potential quality of care concern is confirmed, Stratis Health assesses the root cause of the confirmed concern and then, if appropriate, pursues interventions that will have a system-wide impact. The QIA process assures that no other Medicare beneficiary has the same experience, and often leads to improvements in facility policies, processes, and infrastructure that will benefit large groups of patients, regardless of diagnosis or insurance status.

QIOs are under contract with CMS "to support CMS in its efforts to seek to improve health and health care for all Medicare beneficiaries and promote quality of care to ensure the right care at the right time, every time." As highlighted in the preceding report, QIOs find broad themes that impact care including breakdown in health care team communication, deficits in written information during transitions of care, and departure from use of evidenced based practices. Use of the electronic health record or other health information technology can be a powerful tool in support of communication and conveying complete information to the health care team, and the beneficiary and family.

Highlighting a weakness in the care delivery system from a single patient's experience is motivating to providers. We see responsive and robust quality improvement activities initiated in the context of the root cause analysis of a single failed case that lead to changes that can impact all patients, or large groups of patients.

For more information about Stratis Health and the Medicare QIO Program, see www.stratishealth.org/expertise/quality/cmsqio.html.

Appendix: Supplementary Data

Table I. Total number of completed reviews

Review Type	Number of Reviews	Percent of Reviews
Coding Validation (120 - HWDRG)	99	0.09%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	65	0.06%
Quality of Care Review (All Other Selection Reasons)	32	0.03%
Immediate Advocacy	4	<0.01%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	206	0.19%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	2	<0.01%
Notice of Non-coverage (118 - BIPA)	442	0.41%
Notice of Non-coverage (117 - Grijalva)	204	0.19%
Notice of Non-coverage (121 through 124 -Weichardt)	132	0.12%
Notice of Non-coverage (111-Request for QIO Concurrence)	1	<0.01%
EMTALA 5 Day	2	<0.01%
EMTALA 60 Day	0	0.00%
Total	1,189	

Table II. Discharge location of beneficiaries associated with certain appeals

This table only includes Weichardt[1] reviews for which the hospital claim included the discharge location for a nine-month period. This represents a small portion of the 1,111 Notice of Non-coverage reviews/expedited appeals conducted during the year period for this annual report.

Discharge/service termination

	Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01	Discharged to home or self care (routine discharge)	15	25.86%
02	Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03	Discharged/transferred to skilled nursing facility (SNF)	29	50.00%
04	Discharged/transferred to intermediate care facility (ICF)	2	3.45%
05	Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06	Discharged/transferred to home under care of organized home health service organization	6	10.34%
07	Left against medical advice or discontinued care	0	0.00%
09	Admitted as an inpatient to this hospital	0	0.00%
20	Expired (or did not recover – Christian Science patient)	3	5.17%
21	Discharged/transferred to court/law enforcement	0	0.00%
30	Still a patient	0	0.00%
40	Expired at home (Hospice claims only)	0	0.00%

	Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
41	Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing Hospice)	0	0.00%
42	Expired – place unknown (Hospice claims only)	0	0.00%
43	Discharged/transferred to a Federal hospital	0	0.00%
50	Hospice – home	1	1.72%
51	Hospice – medical facility	1	1.72%
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	0	0.00%
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	0	0.00%
63	Discharged/transferred to a long term care hospital	0	0.00%
64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66	Discharged/transferred to a Critical Access Hospital	1	1.72%
70	Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
	Other	0	0.00%
	Total	58	100.00%

1. The Department of Health and Human Services made several changes to federal regulations in response to a lawsuit from three Medicare beneficiaries who alleged that they were forced to leave the hospital before they were medically ready. This lawsuit is called the Weichardt lawsuit. As a result, CMS established a new Medicare hospital discharge notice and appeals process, published in the federal regulations on November 27, 2006, with an effective date of July 1, 2007.This process assures that hospitalized beneficiaries receive the Important Message from Medicare (IM) both on admission and again at discharge, and gives the beneficiary the right to appeal the discharge to the QIO.

Table III. Types of providers represented among the reviews competed

Setting	Number of Providers	Percent of Providers
0 - Acute Care Unit of an Inpatient Facility	43	16.35%
1 - Distinct Psychiatric Facility	0	0.00%
2 - Distinct Rehabilitation Facility	0	0.00%
3 - Distinct Skilled Nursing Facility	182	69.20%
5 - Clinic	0	0.00%
6 - Distinct Dialysis Center Facility	0	0.00%
7 - Dialysis Center Unit of Inpatient Facility	0	0.00%
8 - Independent Based RHC	0	0.00%
9 - Provider Based RHC	0	0.00%
C - Free Standing Ambulatory Surgery Center	0	0.00%
G - End Stage Renal Disease Unit	0	0.00%
H - Home Health Agency	11	4.18%
N - Critical Access Hospital	10	3.80%

Setting	Number of Providers	Percent of Providers
O - Setting does not fit into any other existing setting code	0	0.00%
Q - Long Term Care Facility	2	0.76%
R - Hospice	8	3.04%
S - Psychiatric Unit of an Inpatient Facility	0	0.00%
T - Rehabilitation Unit of an Inpatient Facility	0	0.00%
U - Swing Bed Hospital Designation for Short-Term, Long Term Care, and Rehabilitation Hospitals	0	0.00%
Y - Federally Qualified Health Centers	0	0.00%
Z - Swing Bed Designation for Critical Access Hospitals	7	2.66%
Other	0	0.00%
Total	263	100.00%

Table IV. Quality of care concerns confirmed

Quality of Care ("C" Category) PRAF Category Codes		Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01	Apparently did not obtain pertinent history and/or findings from examination	4	1	25.00%
C02	Apparently did not make appropriate diagnoses and/or assessments	37	8	21.62%
C03	Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14]	48	5	10.42%
C04	Apparently did not carry out an established plan in a competent and/or timely fashion	16	1	6.25%
C05	C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results	23	7	30.43%
C06	Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	6	1	16.67%
C07	Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	6	0	0.00%
C08	Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	3	0	0.00%
C09	Apparently did not obtain appropriate laboratory tests and/or imaging studies	10	1	10.00%
C10	Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	8	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes		Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C11	Apparently did not demonstrate that the patient was ready for discharge	14		
C12	Apparently did not provide appropriate personnel and/or resources	2		
C13	Apparently did not order appropriate specialty consultation	7		
C14	Apparently specialty consultation process was not completed in a timely manner	1		
C15	Apparently did not effectively coordinate across disciplines	5		
C16	Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	17		
C17	Apparently did not order/follow evidence-based practices	9		
C18	Apparently did not provide medical record documentation that impacts patient care	12		
C99	Other quality concern not elsewhere classified	0		
	Total	76		
		304		

Table V. Evidence/standards of care which could be used in conducting quality of care reviews

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
Quality of Care	Pneumonia	No reviews conducted in the category in the reporting period. Evidence/Standards that may be used if deemed relevant include: Infectious Diseases Society of America/American Thoracic Society Consensus guidelines on management of community acquired pneumonia in adults. 2007 Mar. NSC:005516 America Thoracic Society. The utility of an in-hospital observation period after discontinuing intravenous antibiotics. Am J Med. 1999 Jan;106(1):6-10.	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.

	Heart Failure	2012 ACCF/AHA/HRS Focused Update of the 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities. A Report of the American College of Cardiology/Foundation/ American Heart Association/ Task Force on Practice Guidelines. J Am Coll Cardiol. 2012;60(14):1297-1313. HFSA 2010 Comprehensive Heart Failure Practice Guideline. J Card Fail. 2010 Jun;16(6):e1-194. ACC and AHA Update on Chronic Heart Failure Guidelines. Am Fam Physician. 2010 Mar 1;81(5):654-665.	The case review had both utilization considerations as well as quality of care. Evidence selected for any case would be dependent on the specific concern related to heart failure that had been identified.
	Acute Myocardial Infarction	No reviews conducted in the category in the reporting period. Evidence/Standards that may be used if deemed relevant include: 2012 ACCF/AHA Focused Update of the Guideline for the Management of Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction (Updating the 2007 Guideline and Replacing the 2011 Focused Update). A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Circulation. 2012; 126: 875-910.	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.
	Pressure Ulcers	No reviews conducted in the category in the reporting period. Evidence/Standards	Evidence selected for any case would be dependent on the specific concern related

		that may be used if deemed relevant include: Guideline for prevention and management of pressure ulcers. 2003 (updated 2010 June1) NGC:007973 Wound, Ostomy, and Continence Nurses Society. Pressure Ulcers in the long term care setting. 1009 (revised 2008) NGC:006410 American Medical Directors Association Pressure Ulcer Treatment Strategies: Comparative Effectiveness Review No. 90. Released May 8, 2013. Agency for Healthcare Research & Quality.	to the condition that had been identified.
	Urinary Tract Infection	Evidence/Standards that may be used if deemed relevant include: Guideline for the prevention of catheter-associated urinary tract infection (CAUTI), 2009 Guideline for Prevention of Catheter-Associated Urinary Tract Infection, 2009. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee.	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.
	Sepsis	No reviews conducted in the category in the reporting period. Evidence/Standards that may be used if deemed relevant include: Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2008. Intensive Care Med. 2008 January; 34(1): 17–60.	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.

	Adverse Drug Events	Evidence/Standards that may be used if deemed relevant include: Institute for Safe Medication Practices Acute Care Guidelines for Timely Administration of Scheduled Medications, 2011. The Patient Safety and Clinical Pharmacy Services Collaborative National Performance Report PSPC 3: October 2010 - September 2011. http://www.ahrq.gov/research/findings/evidence-based-reports/er201-abstract.html AHRQ Medication Management Guidelines, 2012. http://www.fda.gov/drugs/informationondrugs/ucm142438.htm Food and Drug Administration National Drug Code Directory, 2013	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.
	Falls	No reviews conducted in the category in the reporting period. Evidence/Standards that may be used if deemed relevant include: Falls and risk. 2003 (revised 2011). NGC:008494 American Medical Directors Association. Fall management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2007 Mar. 32 p.	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.
	Patient Trauma	No reviews conducted in the category in the reporting period. Evidence/Standards that may be used if deemed	Evidence selected for any case would be dependent on the specific concern related to the condition that had been

		relevant include: Guidelines for Essential Trauma Care. 2004 World Health Organization.	identified.
	Surgical Complications	No reviews conducted in the category in the reporting period. Evidence/Standards that may be used if deemed relevant include: Surgical site infection: prevention and treatment of surgical site infection. National Collaborating Centre for Women's and Children's Health. London (UK): National Institute for Health and Clinical Excellence (NICE); 2008 Oct. 142 p. Diagnosis and management of complicated intra-abdominal infection in adults and children: guidelines by the Surgical Infection Society and the Infectious Diseases Society of America. Clin Infect Dis. 2010 Jan 15;50(2):133-64.	Evidence selected for any case would be dependent on the specific concern related to the condition that had been identified.
Medical Necessity/ Utilization Review		InterQual criteria with supporting literature/evidence embedded. Includes Local Coverage Determinations, National Coverage Determinations, and Medicare Conditions for Coverage.	Evidence selected is based on the most applicable evidence or standard of care available. Interqual is maintained by McKesson as a standard, evidence-based criteria to assess when and how individual patients progress through the continuum of care.
Appeals		Appeals are reviewed on a case-by-case basis and default to physician judgment regarding whether discharge is appropriate from the current setting of care, taking into account Medicare's coverage/benefit criteria.	Evidence selected is based on the most applicable evidence or standard of care available. Medicare's coverage guidelines determine what is defined by skilled care at each setting of care, and what

		InterQual criteria with supporting literature/evidence embedded. Includes Medicare Conditions for Coverage.	can be covered.

Table VI. Top 10 medical diagnoses in Minnesota for hospital claims billed to Medicare

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. 486 - PNEUMONIA, ORGANISM NOS	6,397	16.67%
2. 71536 - LOC OSTEOARTH NOS-L/LEG	5,157	13.44%
3. 0389 - SEPTICEMIA NOS	4,607	12.01%
4. V5789 - REHABILITATION PROC NEC	3,698	9.64%
5. 42731 - ATRIAL FIBRILLATION	3,684	9.60%
6. 41401 - CRNRY ATHRSCL NATVE VSSL	3,252	8.48%
7. 5990 - URIN TRACT INFECTION NOS	3,089	8.05%
8. 5849 - ACUTE KIDNEY FAILURE NOS	2,864	7.46%
9. 41071 - SUBENDO INFARCT, INITIAL	2,832	7.38%
10. 49121 - OBS CHR BRONC W(AC) EXAC	2,790	7.27%
Total	38,370	100.00%

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