
Medical Record Review: Ensuring Quality of Care

Andrew Miller, MD, MPH

The Centers for Medicare and Medicaid Services (CMS), an agency of the US Department of Health and Human Services, has established definitions and requirements for medical record review under the Medicare program. Reviews are conducted to protect beneficiaries and the program itself. The reviews can be generated by the Medicare beneficiary or be referred to a Quality Improvement Organization (QIO) by CMS. QIOs conduct medical record reviews following CMS requirements as part of the 8th Scope of Work (8th SOW), a 3-year contract with the agency. Other components of the contract involve working on quality improvement initiatives with hospitals, nursing homes, home health agencies, and physician offices.

CMS Review Objectives

The purpose of case review is to ensure that services provided to Medicare beneficiaries are:

- Medically necessary
- Provided in the most appropriate setting
- Of a quality that meets professionally recognized standards of care

Reviews can be conducted concurrently (while the patient is still receiving services) or retrospectively.

QIOs review cases within their review authority, including random samples of cases referred by CMS or its contractors. If QIO reviewers raise questions regarding the care or services under review, all appropriate parties (eg, provider and physicians) are notified and given the opportunity to respond. This information and the complete medical record are used by the physician reviewer to make a final determination. If, for example, a QIO

finds that services were not medically necessary or that the setting in which the services were rendered was not appropriate, Medicare payment to hospitals or other facilities for the days of hospitalization

or services provided will be denied. The beneficiary, physician, and provider are notified of this determination and are advised of the process to follow if they disagree with the QIO determination (see *Case Study: Utilization Review*).

Quality-of-care complaints allege that services received do not meet professionally recognized standards of care. Examples of quality-of-care complaints include medication issues, such as wrong medication or missed dose; unnecessary surgery or diagnostic testing; misdiagnosis; and inadequate discharge instructions. If quality of care does not meet standards and triggers “a quality-of-care concern,” the physician or health-care provider may be required to develop and implement a quality im-

■ Case Study: Utilization Review*

Mrs. Hilliard, a 77-year-old woman with a history of moderate congestive heart failure, presented to the emergency department (ED) with diarrhea of 3 days' duration. She was afebrile, with a pulse of 100 beats/minute; respirations, 21 breaths/minute; and blood pressure, 110/60 mm Hg. Her mucous membranes were noted to be moist, but her skin was dry. A stool culture was obtained, she was given IV fluids at 40 mL/hour and loperamide PO, and she was admitted as an inpatient. Her diarrhea resolved by the next day, her cultures were negative, and she was discharged on Day 2. The case was randomly referred to the QIO for a determination of appropriateness.

The QIO physician reviewer determined that the ED physician had noted rales in the lower third of the lungs bilaterally and chose to admit Mrs. Hilliard so that she could be rehydrated without exacerbating her heart failure, which was also treated during admission. The appropriateness of the admission was upheld.

*Hypothetical case using fictitious names

provement plan or be subject to ongoing review see *Case Study: Quality of Care*.

The Roles of QIO Reviewers

QIOs use practicing physicians to conduct medical reviews with the goal of having peers provide objective review. Initially, nonphysician reviewers (nurses or coding experts) examine each case using medical screening criteria. Cases are referred to a physician when criteria fail to be met or questions are raised regarding utilization, diagnosis-related group (DRG) assignment, or quality of care.

QIO physician reviewers must meet the following requirements:

- Have an active, unrestricted license to practice medicine in the QIO geographic area of authority. (Military physicians who actively practice in a military or Department of Veterans Affairs healthcare facility in the QIO geographic area of authority are eligible to serve as physician reviewers, even though their licenses to practice have been issued by a different state.)
- Be board certified in their stated specialty, whenever possible
- Be in active practice in the QIO geographic area of authority at least 20 hours per week
- Have active admitting privileges to at least 1 healthcare facility in the QIO geographic area of authority
- Routinely admit and treat Medicare patients

Protecting the Integrity of the Medicare System

Medical record review is an important component of the Medicare program. This component supports

CMS' primary mission to promote the timely delivery of appropriate quality health care to beneficiaries, ensure that beneficiaries are aware of the services for which they are eligible, ensure that those services are accessible and of high quality, and promote efficiency and quality within the total healthcare delivery system. QIOs are authorized by CMS to review medical services in their geographic area of authority. QIOs also recognize their responsibility to improve quality of care for beneficiaries; protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services

and goods that are reasonable, medically necessary, and provided in the most appropriate setting; and protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals. **MPM**

Andrew Miller, MD, MPH, is the Director of Physician Services at Healthcare Quality Strategies, Inc. (HQSI). HQSI is the federally designated Quality Improvement Organization (QIO) for New Jersey.

This material was prepared by Healthcare Quality Strategies, Inc., (HQSI), the Medicare Quality Improvement Organization for New Jersey, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-NJ-GEN-07-11

Case Study: Quality of Care*

Mr. Tyler is a 66-year-old Medicare beneficiary with non-insulin-dependent diabetes mellitus. He has been treated since 2002 by Dr. Jones, his family doctor, with oral hypoglycemics and hydrochlorothiazide for hypertension. He was seen by Dr. Jones complaining of intermittent pain in his left hamstring after helping his daughter move. His blood glucose level was 223 mg/dL, and his blood pressure was 165/110 mm Hg, up from his usual reading of 140/85 mm Hg. Dr. Jones prescribed rest, gentle stretching, and ibuprofen, and reviewed the need for Mr. Tyler to take his oral hypoglycemic medication and follow his diet. Mr. Tyler was scheduled for a follow-up visit in 1 month.

Three weeks later, Mr. Tyler called Dr. Jones complaining of headaches for the past 2 weeks. When he was told that Dr. Jones was away and that he should see the doctor who was covering for him, Mr. Tyler went to the local hospital emergency department (ED). His blood pressure was 178/114 mm Hg. He did not have papilledema, and a CAT scan of the head was negative. Enalapril maleate was prescribed, and Mr. Tyler was told to follow up with Dr. Jones. Mr. Tyler called the QIO to complain that Dr. Jones had not treated his hypertension.

The QIO requested the medical records from Dr. Jones and the ED. The QIO's physician reviewer reviewed the records and determined that the care provided by Dr. Jones could reasonably be expected to have been better (by addressing Mr. Tyler's increased blood pressure and/or scheduling a follow-up visit sooner). A letter was sent to Dr. Jones explaining the QIO's decision and recommending that Dr. Jones should have scheduled a follow-up visit sooner (ie, within 2 weeks). Permission to release the results of the QIO's review was given by Dr. Jones, and this information was shared with the beneficiary, Mr. Tyler.

*Hypothetical case using fictitious names