

§ 476.73 Notification of QIO designation and implementation of review.

(a) *Notice of CMS's decision.* CMS sends written notification of a QIO contract award to the State survey agency and Medicare fiscal intermediaries and carriers. The notification includes the effective dates of the QIO contract and specifies the area and types of health care facilities to be reviewed by the QIO. The QIO must make a similar notification when review responsibilities are subcontracted.

(b) *Notification to health care facilities and the public.* As specified in its contract with CMS, the QIO must—

(1) Provide, to each health care facility scheduled to come under review, a timely written notice that specifies the date and manner in which the QIO proposes to implement review, and the information to be furnished by the facility to each Medicare beneficiary upon admission as specified in § 466.78(b)(3) of this part.

(2) Publish, in at least one local newspaper of general circulation in the QIO area, a notice that states the date the QIO will assume review responsibilities and lists each area health care facility to be under review. The QIO must indicate that its plan for the review of health care services as approved in its contract with CMS is available for public inspection in the QIO's business office and give the address, telephone number and usual hours of business.

[50 FR 15330, Apr. 17, 1985. Redesignated at 52 FR 37457, Oct. 7, 1987, and further redesignated at 64 FR 66279, Nov. 24, 1999]

§ 476.74 General requirements for the assumption of review.

(a) A QIO must assume review responsibility in accordance with the schedule, functions and negotiated objectives specified in its contract with CMS.

(b) A QIO must notify the appropriate Medicare fiscal intermediary or carrier of its assumption of review in specific health care facilities no later than five working days after the day that review is assumed in the facility.

(c) A QIO must maintain and make available for public inspection at its principal business office—

(1) A copy of each agreement with Medicare fiscal intermediaries and carriers;

(2) A copy of its currently approved review plan that includes the QIO's method for implementing review; and

(3) Copies of all subcontracts for the conduct of review.

(d) A QIO must not subcontract with a facility to conduct any review activities except for the review of the quality of care. The QIO may subcontract with a non-facility organization to conduct review in a facility.

(e) If required by CMS, a QIO is responsible for compiling statistics based on the criteria contained in § 405.332 of this chapter and making limitation of liability determinations on excluded coverage of certain services that are made under section 1879 of the Act. If required by CMS, QIOs must also notify a provider of these determinations. These determinations and further appeals are governed by the reconsideration and appeals procedures in part 405, subpart G of this chapter for Medicare Part A related determinations and part 405, subpart H of this chapter for Medicare Part B related determinations.

(f) A QIO must make its responsibilities under its contract with CMS, primary to all other interests and activities that the QIO undertakes.

§ 476.76 Cooperation with health care facilities.

Before implementation of review, a QIO must make a good faith effort to discuss the QIO's administrative and review procedures with each involved health care facility.

§ 476.78 Responsibilities of health care facilities.

(a) Every hospital seeking payment for services furnished to Medicare beneficiaries must maintain a written agreement with a QIO operating in the area in which the hospital is located. These agreements must provide for the QIO review specified in § 466.71.

(b) *Cooperation with QIOs.* Health care facilities that submit Medicare claims must cooperate in the assumption and conduct of QIO review. Facilities must—

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(1) Allocate adequate space to the QIO for its conduct of review at the times the QIO is conducting review.

(2) Provide patient care data and other pertinent data to the QIO at the time the QIO is collecting review information that is required for the QIO to make its determinations. The facility must photocopy and deliver to the QIO all required information within 30 days of a request. QIOs pay hospitals paid under the prospective payment system for the costs of photocopying records requested by the QIO in accordance with the payment rate determined under the methodology described in paragraph (c) of this section and for first class postage for mailing the records to the QIO. When the QIO does post-admission, preprocedure review, the facility must provide the necessary information before the procedure is performed, unless it must be performed on an emergency basis.

(3) Inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to QIO review and indicate the potential outcomes of that review. Furnishing this information to the patient does not constitute notice, under § 405.332(a) of this chapter, that can support a finding that the beneficiary knew the services were not covered.

(4) When the facility has issued a written determination in accordance with § 412.42(c)(3) of this chapter that a beneficiary no longer requires inpatient hospital care, it must submit a copy of its determination to the QIO within 3 working days.

(5) Assure, in accordance with the provisions of its agreement with the QIO, that each case subject to preadmission review has been reviewed and approved by the QIO before admission to the hospital or a timely request has been made for QIO review.

(6)(i) Agree to accept financial liability for any admission subject to preadmission review that was not reviewed by the QIO and is subsequently determined to be inappropriate or not medically necessary.

(ii) The provisions of paragraph (b)(6)(i) of this section do not apply if a facility, in accordance with its agreement with a QIO, makes a timely re-

quest for preadmission review and the QIO does not review the case timely. Cases of this type are subject to retrospective prepayment review under paragraph (b)(7) of this section.

(7) Agree that, if the hospital admits a case subject to preadmission review without certification, the case must receive retrospective prepayment review, according to the review priority established by the QIO.

(c) *Photocopying reimbursement methodology for prospective payment system hospitals.* Hospitals subject to the prospective payment system are paid for the photocopying costs that are directly attributable to the hospitals' responsibility to the QIOs to provide photocopies of requested hospital records. The payment is in addition to payment already provided for these costs under other provisions of the Social Security Act and is based on a fixed amount per page as determined by CMS as follows:

(1) *Step one.* CMS adds the annual salary of a photocopy machine operator and the costs of fringe benefits as determined in accordance with the principles set forth in OMB Circular A-76.

(2) *Step two.* CMS divides the amount determined in paragraph (c)(1) of this section by the number of pages that can be reasonably expected to be made annually by the photocopy machine operator to establish the labor cost per page.

(3) CMS adds to the per-page labor cost determined in paragraph (c)(2) of this section the per-page costs of supplies.

(d) *Appeals.* Reimbursement for the costs of photocopying and mailing records for QIO review is an additional payment to hospitals under the prospective system, as specified in § 412.115 of this chapter. Thus, appeals concerning these costs are subject to the review process specified in part 405, subpart R of this chapter.

[50 FR 15330, Apr. 17, 1985, as amended at 57 FR 47787, Oct. 20, 1992; 59 FR 45402, Sept. 1, 1994. Redesignated at 64 FR 66279, Nov. 24, 1999]

§ 476.80 Coordination with Medicare fiscal intermediaries and carriers.

(a) *Procedures for agreements.* The Medicare fiscal intermediary or carrier must have a written agreement with