

the QIO. The QIO must take the initiative with the fiscal intermediary or carrier in developing the agreement. The following steps must be taken in developing the agreement.

(1) The QIO and the fiscal intermediary or carrier must negotiate in good faith in an effort to reach written agreement. If they cannot reach agreement, CMS will assist them in resolving matters in dispute.

(2) The QIO must incorporate its administrative procedures into an agreement with the fiscal intermediary or carrier and obtain approval from CMS, before it makes conclusive determinations for the Medicare program, unless CMS finds that the fiscal intermediary or carrier has—

(i) Refused to negotiate in good faith or in a timely manner, or

(ii) Insisted on including in the agreement, provisions that are outside the scope of its authority under the Act.

(b) *Content of agreement.* The agreement must include procedures for—

(1) Informing the appropriate Medicare fiscal intermediaries and carriers of—

(i) Changes as a result of DRG validations and revisions as a result of the review of these changes; and

(ii) Initial denial determinations and revisions of these determinations as a result of reconsideration, or reopening all approvals and denials with respect to cases subject to preadmission review, and outlier claims in hospitals under a prospective payment system for health care services and items;

(2) Exchanging data or information;

(3) Modifying the procedures when additional review responsibility is authorized by CMS; and

(4) Any other matters that are necessary for the coordination of functions.

(c) *Action by CMS.* (1) Within the time specified in its contract, the QIO must submit to CMS for approval its agreement with the Medicare fiscal intermediaries and carriers, or if an agreement has not been established, the QIO's proposed administrative procedures, including any comments by the Medicare fiscal intermediaries and carriers.

(2) If CMS approves the agreement or the administrative procedures (after a finding by CMS as specified in paragraph (a)(2) of this section), the QIO may begin to make determinations under its contract with CMS.

(3) If CMS disapproves the agreement or procedures, it will—

(i) Notify the QIO and the appropriate fiscal agents in writing, stating the reasons for disapproval; and

(ii) Require the QIO and fiscal intermediary or carrier to revise its agreements or procedures.

(d) *Modification of agreements.* Agreements or procedures may be modified, with CMS's approval—

(1) Through a revised agreement with the fiscal intermediary or carrier, or

(2) In the case of procedures, by the QIO, after providing opportunity for comment by the fiscal intermediary or carrier.

(e) *Role of the fiscal intermediary.* (1) The fiscal intermediary will not pay any claims for those cases which are subject to preadmission review by the QIO, until it receives notice that the QIO has approved the admission after preadmission or retrospective review.

(2) A QIO's determination that an admission is medically necessary is not a guarantee of payment by the fiscal intermediary. Medicare coverage requirements must also be applied.

[50 FR 15330, Apr. 17, 1985; 50 FR 41886, Oct. 16, 1985. Redesignated at 64 FR 66279, Nov. 24, 1999]

§ 476.82 Continuation of functions not assumed by QIOs.

Any of the duties and functions under Part B of Title XI of the Act for which a QIO has not assumed responsibility under its contract with CMS must be performed in the manner and to the extent otherwise provided for under the Act or in regulations.

QIO REVIEW FUNCTIONS

§ 476.83 Initial denial determinations.

A determination by a QIO that the health care services furnished or proposed to be furnished to a patient are not medically necessary, are not reasonable, or are not at the appropriate