

§ 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 providers that submit Medicare claims must cooperate in the assumption and conduct of QIO review. Providers must—

(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 provider must photocopy and deliver to the QIO all required information within 30 days of a request. QIOs pay providers 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 postadmission, 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 providers.* Providers subject to the prospective payment system are paid for the photocopying costs that are directly attributable to the providers' responsibility to the QIOs to provide photocopies of requested provider 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.

(4) CMS will periodically review the photocopy reimbursement rate to ensure that it still accurately reflects provider costs. CMS will publish any changes to the rate in a FEDERAL REGISTER notice.

(d) *Appeals.* Reimbursement for the costs of photocopying and mailing records for QIO review is an additional payment to providers under the prospective payment system, as specified in §412.115, §413.355, and §484.265 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; 68 FR 67960, Dec. 5, 2003]

§ 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 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