CMS Manual System

Pub. 100-10 Medicare Quality Improvement Organizations

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
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1		1000 - 1025	

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 5, 2003

Throughout Chapter 1, all references to Health Care Financing Administration (HCFA) are changed to Centers for Medicare & Medicaid Services (CMS), and all references to Peer Review Organization (PRO) are changed to Quality Improvement Organization (QIO). All references to Payment Error Prevention Program (PEPP) are changed to Hospital Payment Monitoring Program (HPMP).

Workload and Costs: These instructions do not represent an increase in workloads or costs.

NOTE: Normally red, italic font identifies new material. However, because this release is a new manual, normal text font is used for the initial release.

Quality Improvement Organization Manual

Chapter 1 - Background and Responsibilities

TABLE OF CONTENTS (Rev.)

1000 – Authority

(Rev. 10, 09-05-03)

Quality Improvement Organization (QIO) review is governed by titles XI and XVIII of the Social Security Act (the Act) as amended, and by regulations contained in:

- 42 CFR 405, 411 -- Limitation on liability;
- 42 CFR 412 -- Outlier review, Diagnosis Related Group (DRG) validation, and hospital notices of non-coverage;
- 42 CFR 462 -- Definition of eligible organizations and area designation;
- 42 CFR 466 -- Assumption and conduct of review;
- 42 CFR 473 -- QIO reconsideration and appeals;
- 42 CFR 476 -- Disclosure of information;
- 42 CFR 482 -- Hospital Conditions of Participation; and
- 42 CFR 1004 -- Sanctions.

1005 - Purpose of QIO Review

(Rev. 10, 09-05-03)

You review items or services provided to Medicare beneficiaries to determine:

- Whether services provided or proposed to be provided are reasonable and medically necessary for the diagnosis and treatment of illness or injury, or to improve functioning of a malformed body member, or (with respect to pneumococcal vaccine and mammograms) for prevention of an illness, or (in the case of hospice care) for the palliation and management of terminal illness;

- Whether those services furnished or proposed to be furnished on an inpatient basis could be effectively furnished on an outpatient basis, or in an inpatient health care facility of a different type;

- The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of the Prospective Payment System (PPS);

- Whether a hospital has misrepresented admission or discharge information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries, or billing for services furnished to beneficiaries;

- The validity of diagnostic and procedural information supplied by the provider to the intermediary for payment purposes;

- The completeness and adequacy of hospital care provided; and

- Whether the quality of services meets professionally recognized standards of health care.

These activities enable you to determine whether Medicare payment may be made for the services claimed and to identify and initiate corrective action where appropriate.

1010 - QIO Responsibilities

(Rev. 10, 09-05-03)

A. Responsibilities Prior to Review -- You are responsible for:

- Obtaining written Memorandums of Agreement (MOAs) with all hospitals, Critical Access Hospitals (CAHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), assistants-at-cataract surgery, Medicare + Choice Organizations (M+COs), Clinical Data Abstraction Centers (CDACs), Medicare intermediaries and carriers, State agencies responsible for the licensing and certification of providers and practitioners in your jurisdiction, and other entities as directed by Centers for Medicare & Medicaid Services (CMS) (See Chapter 3);

- Specifying in your review plan and instructions to practitioners and providers the type of evidence you require to document that the care ordered or furnished was medically necessary, reasonable, and appropriate, and that the quality of services met professionally recognized standards of health care; and

- Applying professionally developed criteria for providing care, diagnosis, and treatment based upon typical patterns of practice within your geographic area to evaluate the medical necessity, quality, or appropriateness of services ordered or furnished.

B. Ongoing Review Activities -- As a part of your ongoing review activities, you must:

- Notify the appropriate agency of the State or Federal government when you become aware of situations which appear to be improper, but which do not fall within your review responsibilities (e.g., poor quality care in a renal dialysis center);

- Use your authority or influence to enlist the support of other professional or government agencies to ensure that all providers and practitioners for which you have review responsibilities comply with their obligations (See §1156 of the Act.); and

- Conduct beneficiary outreach and education activities for the express purpose of informing beneficiaries about:

    - The QIO program and how to contact the QIO;

    - Beneficiary rights as outlined at §1154(a)(4)(B) of the Act; and

    - How to exercise those rights, including what to expect when they do contact the QIO (e.g., length of time to obtain a response, form the response will take). This information must include the processes regarding beneficiary complaints and notices of non-coverage (e.g., Hospital-Issued Notice of Non-coverage and Notice of Discharge and Medicare Appeal Rights).

C. Responsibilities as a Result of Your Review -- To act upon information you obtain as a result of your review activities, you must:

- At least annually, publish and distribute to providers and practitioners, whose services you review, a report of your activities and findings as required in §1154(a)(6)(B) of the Act. It must include:

    - A description of the types of cases where you have found inappropriate or unnecessary care, services that were rendered in an inappropriate setting,

and/or services that did not meet professionally recognized standards of care; and

- A description of your Health Care Quality Improvement Program (HCQIP) activities.

- Identify and seek correction of situations that, if continued, would result in violations under §1156 of the Act. This includes referring certain cases to State licensing boards (See §1154(a)(9)(B) of the Act);

- Submit reports to the Office of the Inspector General (OIG) on providers and practitioners found to have substantially violated an obligation in a substantial number of cases, or to have grossly and flagrantly violated an obligation in one or more instances; and

- Coordinate your activities, including information exchanges, in order to promote the efficient and economical operation of programs among appropriate public and private agencies. This fulfills §1154(a)(10) of the Act and includes, at a minimum:

    - Meeting with the State agencies; and

    - Communicating with accrediting bodies, quality organizations, and any other agencies as necessary to carry out QIO activities.

D. Additional Responsibilities -- Perform all other activities specified in the Statement of Work (SOW) of your CMS contract, including any modifications, CMS regulations and instructions, and relevant statutory provisions that include:

- Mandatory review activities (i.e., beneficiary complaints, violations of the Emergency Medical Treatment and Active Labor Act (EMTALA), assistants-at-cataract surgery, hospital-requested higher-weighted DRG validation, hospital and M+CO issued notices of non-coverage (e.g., Hospital-Issued Notice of Non-coverage and Notice of Discharge and Medicare Appeal Rights), potential gross and flagrant violations, and referrals from CMS, OIG, the M+C appeals contractor, intermediaries, carriers, CDACs, or other designated CMS contractors); and

- Other legislatively-mandated activities that include:

    - Regional meetings with medical and administrative staff of the hospitals that you review;

    - Onsite review activities at provider facilities that include 20 percent of the rural hospitals in your jurisdiction; and

- Additional activities approved by CMS such as a special study (i.e., any effort within the scope of the services to be provided by a QIO in accordance with §1154 of the Act, which is not otherwise defined in the contract).

1015 - Centers for Medicare & Medicaid Services (CMS) Role

(Rev. 10, 09-05-03)

CMS was established in March 1977, to combine health care financing and quality assurance programs into a single agency. CMS is responsible for the Medicare program, Federal participation in the Medicaid program, the Quality Improvement Organization (QIO) program, and a variety of other health care quality assurance programs.

A. The Primary Mission -- CMS' primary mission is to administer its programs in a manner that:

- Promotes the timely delivery of appropriate, quality health care to beneficiaries;
- Ensures that beneficiaries are aware of the services for which they are eligible;
- Ensures that those services are accessible and of high quality; and
- Promotes efficiency and quality within the total health care delivery system.

B. Central Office Policy-making Responsibility -- Overall policy-making responsibility for administration of the QIO program is centralized in CMS' Office of Clinical Standards and Quality (OCSQ). OCSQ is responsible for:

- Monitoring and overall administrative control of the QIO program, including coordinating with CMS' Office of Internal Customer Support on contracts and financial aspects;
- Establishing operational policy for the QIO program; and
- Developing operational instructions and official interpretations of policy for QIOs and CMS Regional Offices (ROs).

C. Regional Office Assistance to QIOs -- The ROs are responsible for assuring that QIOs meet applicable Federal requirements under the provisions of their contracts. The ROs:

- Provide liaison, direction, and technical assistance to QIOs in the day-to-day management of their operations;
- Interpret CMS guidelines, policies, and procedures applicable to QIO activities;

- Analyze QIO budgets and spending patterns to assure that funds are economically and appropriately utilized;

- Recommend the allocation of funds for conducting additional activities;

- Conduct assessments of QIO operations;

- Review QIO actions; and

- Provide feedback to each QIO.

1020 - Health Care Quality Improvement Program (HCQIP)

(Rev. 10, 09-05-03)

CMS designed the Health Care Quality Improvement Program (HCQIP) to improve health outcomes of all Medicare beneficiaries regardless of personal characteristics (e.g., socio-economic status, health status, ethnic group), physical location (urban or rural), or setting (e.g., physicians' offices, M+COs, hospitals, nursing homes). Your Statement of Work (SOW) sets forth specific quality indicators for national health improvement priorities, which reflect the current state of QIO program experience, measurement systems, and data sources. These quality indicators do not address the entire spectrum of health care, nor do they reflect fully the unique circumstances of each State.

CMS therefore requires you to conduct the following:

- For Medicare beneficiaries in your State, implement quality improvement projects on a standardized set of quality indicators in each of the following six clinical topics: acute myocardial infarction, pneumonia, diabetes, breast cancer, stroke/transient ischemic attack/atrial fibrillation and congestive heart failure;

- Initiate local projects within your State in the following three areas:

    - Quality improvement projects in alternate settings;

    - Projects designed to reduce the disparity of care received by members of disadvantaged groups and all other beneficiaries in the QIO's State; and

    - Projects in response to local interests and needs.

- For M+COs in your State, offer technical assistance services and encourage the M+COs to collaborate with you in any or all of its health improvement projects. This specifically includes the diabetes and influenza immunization projects that the M+COs are required to conduct under their Quality Improvement System for Managed Care (QISMC) regulations.

1025 - Hospital Payment Monitoring Program (HPMP)

(Rev. 10, 09-05-03)

Office of the Inspector General (OIG) Audit Opinion of CMS' 1997 Financial Statement found that approximately $4 billion in improper payments were made for inpatient services under the Prospective Payment System (PPS). In order to reduce this payment error rate, you must initiate a program of Hospital Payment Monitoring Projects. CMS defines the payment error rate as the number of dollars found to be paid in error out of the total of all dollars paid for inpatient PPS services. CMS will implement a surveillance system to provide State-specific estimates of the payment error rate. These estimates will be used as performance indicators on which to evaluate your performance.