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
11		Table of Contents	
11		11000 - 11030	

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 29, 2003

Throughout Chapter 11, 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).

Section 11000 - Introduction has minor changes to improve clarity.

Section 11005 - Review Responsibilities to Handle Clinical Data Abstraction Center (CDAC) Referrals has minor corrections.

Section 11010 - Monitoring Hospital Payment Patterns and Developing the Interventions Necessary to Reduce or Eliminate Errors has minor clarifying changes throughout and has an added note regarding confidentiality.

Section 11020 - Developing, Applying, and Assessing the Effect of Interventions has minor clarifying changes throughout.

Section 11025 - Collaborating With Provider and Practitioner Groups has added language regarding existing obligations.

Section 11030 - Collaborating Efforts With Federal and State Agencies and Other Medicare Contractors has minor clarifying changes made throughout and has added language regarding confidential information.

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 11 - Hospital Payment Monitoring Program (HPMP)

TABLE OF CONTENTS (Rev. 8, 08-29-03)

11000 – Introduction

(Rev. 8, 08-29-03)

Section 1154(a)(2) of the Social Security Act (the Act) requires you to determine, based on your review of services furnished by health care practitioners and providers, whether payment should be made by Medicare. This requirement is fulfilled through a variety of activities, all of which are designed to reduce the percentage of Medicare dollars paid improperly for:

- Medically unnecessary or unreasonable care (see §1154(a)(1)(A));
- Inpatient care that could have been provided in a more economical setting (see §1154(a)(1)(C));
- Hospital actions that circumvent Medicare payment rules (see §1886(f)(2)); and
- Incorrect diagnostic information and/or inadequate documentation (see §§1154(a)(6) and 1866(a)(1)(F)).

Centers for Medicare & Medicaid Services (CMS) will determine the inpatient payment error rate for each State. The Clinical Data Abstraction Centers (CDACs) will be responsible for initially requesting and screening the medical records for the Hospital Payment Monitoring Program (HPMP) surveillance sample.

11005 - Review Responsibilities to Handle Clinical Data Abstraction Center (CDAC) Referrals

(Rev. 8, 08-29-03)

As part of their surveillance activities, the CDACs screen medical records for Diagnosis Related Groups (DRG) validation and medical necessity. The initial screening will be conducted by a non-physician reviewer using screening criteria. As a result of this screening, cases are selected and forwarded to you for case review. Upon receipt of cases from the CDAC, review these cases using the review procedures specified at Chapter 4 of the Quality Improvement Organization (QIO) Manual.

NOTE: The HPMP QIO Support Center (QIOSC) works with the CDACs to develop and refine medical review criteria applied by the CDACs to screen medical records. The purpose of this collaboration is to create consistent and reliable screening review criteria in order to make the review process consistent.

A. Medical Review -- You are required to make a full determination for each case (see Chapter 4.) Forward payment adjustments to the intermediary(ies) for processing. Process any identified quality of care concerns following the review instructions at Chapter 4. Report the results of your review into the Case Review Information System (CRIS) under the Standard Data Processing System (SDPS).

B. DRG Validation -- Conduct a DRG validation on all records forwarded to you by the CDAC. It will be your responsibility to forward adjustments to the intermediary for processing. Report the results of your review into CRIS.

C. Failure to Submit Medical Records -- Hospitals are expected to deliver the requested medical records within 30 days (whether for purposes of fulfilling your mandatory review requirements or for HPMP). The CDACs will generate a reminder within this 30-day period. For the medical records that were requested from hospitals but not received within 30 calendar days of the date of the initial request, the CDACs will mark those records as canceled (not received) using the QIO Abstraction Tracking System (PATS). You must use the PATS to identify overdue records and issue a technical denial in accordance with the procedures outlined in Chapter 7.

11010 - Monitoring Hospital Payment Patterns and Developing the Interventions Necessary to Reduce or Eliminate Errors

(Rev. 8, 08-29-03)

CMS will continue to estimate the State and national payment error rates utilizing the surveillance sample. In accordance with §4550 of the QIO Manual, you are expected to monitor case review data for your review area for trends and/or patterns of inappropriate billing. Your monitoring and assessment strategies must reflect changes in billing practices and be responsive to information that may indicate changes in error patterns resulting from genuine confusion, deliberate abuse, or fraud.

A. Purposes -- You are to conduct this monitoring for the purposes of:

- Identifying potential problem areas in admissions patterns or coding practices and developing project plans that assess and intervene to rectify these problem areas. Project plans will be submitted to CMS for approval. No project will be initiated without prior CMS approval. Requirements for project plans are in §11020.C. When you submit the

project plan for approval, you must also submit as a separate document a detailed budget for the project, including both a total cost and a specific breakdown of costs for the project;

- Meeting your statutory requirements to review specific categories of services, such as unnecessary admissions and up-coded DRG assignments; and

- Developing a profile of Medicare services in your State. You have full discretion to structure your analysis to best characterize your State's Medicare population, your local environment, and its unique blend of providers, physicians, and practitioners.

B. Analyses -- Develop appropriate interventions based on the results of your monitoring in conjunction with review and analysis of hospital-specific administrative reports provided by the HPMP QIOSC.

- General Analysis -- Conduct this analysis to identify trends and patterns suggestive of:

    - Inappropriate setting, unreasonable or medically unnecessary care;

    - Incorrect DRG assignments;

    - Premature discharges;

    - Inappropriate transfers; and

    - Insufficient or poor care.

A good deal of work has been done that allows you to make certain assumptions about the relationship between types of discharges and the occurrence of payment errors. For instance, the Office of the Inspector General (OIG) has demonstrated that one-day stays have a higher incidence of unnecessary admissions when compared to discharges that occur after just one day. Therefore, it is reasonable to assume that a facility exhibiting a high proportion of one-day stays may also have a high proportion of unnecessary admissions.

You cannot determine that any one discharge is medically necessary and/or appropriate or not unless you review the medical record. In addition, an analysis of a number of one-day stays may help to determine whether there is a systemic problem with unnecessary admission. Further work in conjunction with the facility may determine the underlying cause.

This type of analysis will allow you to decide if an intervention is warranted and, if so, what type and to whom it should apply. It may be difficult to know at this stage whether significant trends or patterns exposed by your analysis represent unnecessary services, poor quality of care, fiscal impropriety, inadequate access to services, or evolving standards of acceptable health care practice. For this reason, treat this analysis and all reports and work plans based on it in a manner appropriate from all perspectives.

NOTE: Any information the QIO receives, maintains, or generates as part of its analysis of hospital information when performing under its Part B, Title XI contract with CMS is subject to

certain confidentiality requirements. These requirements will vary somewhat depending upon the type of information. Please see Chapter 10, Confidentiality and Disclosure.

- Areas for Analyses -- It is expected that payment errors for inpatient services will occur in areas including unnecessary admissions and DRG miscoding. You have discretion to identify these areas and propose to CMS special projects to address problems. For approved projects, you must document the impact of your intervention(s) in PARTner.

    - Tables Supplied by CMS -- CMS will supply to the QIO, through the QIOSC, summary tables of utilization statistics for facilities in each State. These tables will display the results of data processing of the Medicare administrative data by hospital. The tables will cover specific topics (i.e., the proportion of one-day stays or the ratio of the frequency of one DRG to another, and be in sufficient detail to identify a facility's separate activity). The tables will also include statistics that will allow the QIO to determine the outlier status of any provider.

        - The topics of each table will be initially determined by CMS. Over the course of the contract, data from the HPMP surveillance sample will be analyzed to identify any new topics that should be included in future tables. Topics may be removed as a result of these analyses as well. The QIO is encouraged to suggest topics to be included on the tables generated by CMS.

    - Descriptive Statistics and Local Highlights -- Information about other areas with a potential for payment errors, or to supplement the tables provided, can be obtained from published sources and generally, publicly available summary data.

    - External Perspectives -- Outside agencies can provide information as a result of their own activities. In particular, OIG and General Accounting Office (GAO) produce reports every year that review and analyze aspects of Medicare payments. These reports, and the analytical approaches presented, can provide good insight into other areas that may be productive to review. In some cases, reproducing their analyses may uncover admission types with a high potential for masking unnecessary admissions, potentially inappropriate DRGs, or other areas with potential payment errors.

- CMS-selected Analyses -- CMS may direct you to conduct an analysis in one or more focus areas in your State. These focus areas may be broadly defined, allowing you to choose the data sources, time periods and statistical techniques, or CMS may prescribe some or all details of the process. CMS will use these analyses primarily either to build national profiles of significant issues and to explore local variations or to develop CMS-directed projects.

11020 - Developing, Applying, and Assessing the Effect of Interventions

(Rev. 8, 08-29-03)

A. Developing and Applying Improvement Methodologies as Interventions -- The same concepts and techniques that you use in conducting quality improvement projects are applicable to the use of interventions, with minor modifications. Improvement methodologies are appropriate where a substantial component of inappropriate provider activity arises from apparent lack of knowledge about acceptable practice standards, proper coding, or correct billing procedures.

Improvement methods may be highly effective in provider groups with a solid history of good faith efforts to self-regulate. This approach may be less effective in providers with a history of compliance problems. Thus, the responsiveness to education of providers and practitioners you are dealing with will substantially influence the extent to which you can rely on educational feedback instead of reporting the violation to OIG under your authority, as specified at 42 CFR 1004.30.

NOTE: Evidence of fraud precludes use of improvement methodologies with involved providers or physicians. Do not proceed with any improvement process where fraud is implicated without consulting with both CMS (through your Project Officer) and your intermediary.

- Health Care Quality Improvement Program (HCQIP) Projects Versus Hospital Payment Monitoring Program (HPMP) Projects -- There are distinctive differences between HCQIP projects and the use of improvement methodologies in HPMP.

    - Health Care Quality Improvement Program (HCQIP) - Providers collaborate in the HCQIP on a voluntary basis. If a provider has more pressing internal issues, it may decline to participate in a specific HCQIP without penalty. If it participates but fails to demonstrate improvement on re-measurement, there are no consequences.

    - Hospital Payment Monitoring Program (HPMP) Projects -- HPMP involves issues of unacceptable claims for reimbursement. A provider may not decline interest in conforming to standards of appropriate, reasonable, and medically necessary care. Claims must accurately report the diagnosis, procedures and services rendered, and beneficiary eligibility for coverage. The provider may accept your assistance or it may prefer to solve its own problems. However, your re-measurement is not optional for the providers/practitioners and failure to improve may have negative consequences in the form of denials/adjustments, imposition of corrective action plans, sanction recommendations, or referral to the appropriate State agency, OIG, State licensing authorities, the intermediary, or a carrier.

        - Improvement methodologies applied to HPMP are based on monitoring and enforcing compliance with established standards, as opposed to testing intervention methods to encourage optimal or benchmark performance on scientifically proven indicators. You are encouraged to consider all possible avenues to enhance compliance.

NOTE: All HPMP projects must be submitted to CMS and formally approved before project activity begins.

- Project Data Collection versus Case Review -- You may request medical records from a provider either for case review or for data collection. The processes have different implications; thus, it is crucial that you know for which process you are requesting a record. You may issue a technical denial for failure to provide the record in either case.

    - Data Collection -- Data collection differs from case review in that only specific pieces of data are abstracted. No determinations are made because the record is not evaluated using the full case review process. Consequently, the provider/practitioner does not have reconsideration or appeal rights to your data findings, nor is there a requirement for physician review of the record in order to abstract data.

    - Case Review -- When a medical record is subjected to case review, you may still elect to abstract data from it. You must follow the review procedures described in Chapter 4. You render a determination and, where necessary, you must issue denials and adjustments (see Chapter 7).

Data collection does not allow for denials or adjustments, making it less persuasive to reluctant providers and less certain in demonstrating measurable impact. Case review may be the only reasonable option where the number of cases is too small to legitimately document improvement on re-measurement. Both techniques have uses in HPMP.

NOTE: You are not restricted regarding your choice of data collection or case review by your initial analysis. You may elect to conduct data collection as a baseline, and later institute case review for non-responsive providers. Likewise, you might initially choose case review to address an issue, but change to data collection later to more efficiently monitor continued compliance.

- Use of Existing Intervention Materials -- QIOs implementing interventions may develop certain tools, educational materials, or other resources for use in addressing specific problems. Those resources will be collected and made available to other QIOs by the HPMP QIOSC. QIOs are encouraged to evaluate those resources prior to developing new resources.

- Other Interventions:

    - Generalized Provider Education -- Educational efforts, whether narrowly focused on specific providers or widely broadcast, can have a dramatic impact on HPMP issues. It may be particularly popular with the health care community, and so you may experience considerable pressure to educate first and foremost in all focus areas. You must always consider whether education is appropriate before using this strategy. It is never appropriate to "educate" a potentially fraudulent provider without first consulting with your Project Officer and your intermediary.

        - Even where the suggestion of fraud is absent, billing must be dealt with in a suitable manner. It is imperative that you never create the misperception that it is acceptable for providers to continue improper practices until notified by your "education" that it is time to stop. It must remain clear that you are not the sole source of information on Medicare policy, and

that providers bear the full responsibility for learning and abiding by all the rules applicable to the services they provide.

- Equally important is that the general public views your educational efforts accurately as disseminating helpful information to honest providers, not warning unscrupulous ones to quietly move on to new abuses. Your status as a physician-sponsored or physician-access organization aids your credibility in the community, but it also requires that your choice of strategies be above reproach.

- Education and information dissemination are tools that should be used frequently. The paramount goal is to ensure that Medicare pays correctly for care that is reasonable and necessary, of high quality, provided in the most appropriate setting, and accurately reported. Raising the level of knowledge among providers and practitioners enhances claims accuracy in the most fundamental sense. Education will continue to be a core responsibility for the QIO program.

- Engage in a multi-level educational approach when developing interventions to prevent payment errors. At one level, and with providers at low risk for payment errors, you should consider promoting voluntary compliance plans. Another level would include generalized education on proper billing techniques, appropriate care, and proper coding directed at classes of providers or practitioners. A final level would direct educational efforts at specific providers or practitioners.

- Specific Topic Education -- As a result of an analysis of payment errors, you may determine that certain types of payment errors are not specific to individual providers or practitioners. For instance, proper coding for a specific DRG may not be well understood among a majority of providers in a State. It would be appropriate in this case to develop an intervention specific to the topic of proper DRG coding and directed at all providers or, at least, those in the majority previously identified. Similarly, all providers in a QIO area may benefit from a general education on proper billing in the Medicare program. You need to document and assess these generalized approaches.

- Specific Provider Education -- The identification of payment errors by a specific provider require an individual educational approach. Providers that represent outliers will need to be approached with individual interventions. The intent is to change behavior, and you should document and assess the intervention.

- Promoting Voluntary Compliance Plans -- The OIG has published the "OIG Compliance Program Guidance for Hospitals" (“Federal Register,” Vol. 63, No. 35, February 23, 1998, Pages 8987-8998). This publication responds to a desire on the part of many providers to protect their operations from fraud and abuse through the adoption of voluntary compliance programs. While directed at tailoring programs to avoid the occurrence of fraud and abuse, such programs can also assist providers in setting up the necessary internal controls to promote adherence to applicable billing guidelines. For those providers in your area that

are considered at low risk of billing errors, you should consider assistance in establishing a compliance program using OIG guidelines. You can then monitor the implementation of this plan by reviewing the recommended reports and verifying that the provider has implemented the plan.

- You are in a unique position to promote the effective use of voluntary compliance programs, another tool available to you in your graduated approach to proactive elimination of payment errors.

Each HPMP activity does not necessarily represent an element of a graded or stepped approach to education. Nor do these different levels represent a sequence you must follow. Rather, these levels of effort suggest an intervention approach to a class of provider or problem you may detect in your analysis. Lack of success with one approach may indicate a need to try a second approach. However, a provider's continued failure to change behavior does not require you to always try another approach. At some point you will have to develop a case on a non-responsive provider and make an appropriate intervention, such as a sanction referral to the OIG.

B. Estimating, Documenting, and Assessing Effect of Interventions -- The goal of the HPMP is to reduce the percentage of Medicare dollars that are improperly paid for inpatient services. Performance will be primarily evaluated against CMS' measurement of the inpatient payment error rate in each State. The inpatient payment error rate will not be so comprehensive as to allow determination of the error rate for specific services, diagnostic groups, or practitioners or providers within a single State. Therefore, you will have to develop separate indicators to estimate the impact of your intervention efforts, and you may choose to prioritize HPMP focus areas and strategies.

You need not use the same indicator of payment error rate that is to be used by CMS. Intermediate indicators may suffice. For example, if it is born out that a high proportion of one-day stays are associated with unnecessary admissions, especially in specific providers, then measuring this proportion subsequent to an intervention may suffice to demonstrate the effects of the intervention.

C. Information Requirements for the HPMP Project Plan and Project Results Narrative Documents -- Document each intervention effort to assess its effectiveness and to help determine, at a national level, those practices that are more or less effective than others.

CMS has identified the following three situations for reporting a HPMP project under one project number:

- Projects With Same Indicator -- If you are specifically focusing on, measuring on, and conducting interventions on the same indicator for different facilities, this constitutes one project.

- Replicated Projects -- If you take a previously completed project and duplicate the project steps with a new group of facilities at a later point in time, this constitutes a separate project.

- Projects With Same Intervention Plan (Same Component) -- If you are conducting the same intervention plan with all facilities, this constitutes one project.

HPMP Project Plan -- For each intervention effort, complete a HPMP Project Plan. The elements listed below represent minimal requirements. Include whatever additional information is necessary to fully describe your effort. Project Plans must be submitted to CMS and approved prior to initiating any activity.

- Background -- This is a description of how you arrived at the need for the project. Explain how the topic came to your attention and describe the issues. Provide general descriptive information such as external agency perspectives, literature reviews, and specific statistics (e.g., State performance versus national performance, provider performance versus State performance, etc.). If you extrapolate based on results of existing studies, describe the methods you used.

- Purpose -- Describe specifically what you hope to accomplish with the project. This should include both the process(es) that you intend to improve and the ultimate outcome that you plan to achieve. This should be quantifiable where possible.

- Hypothesis -- The hypothesis is a statement of the question(s) that the project you have designed is intended to answer regarding the causes and potential prevention of payment errors. Hypotheses typically contain both a predictor and an outcome variable. They should be stated as specifically as possible and be easy to comprehend. Multiple hypotheses should be broken out individually rather than combined. Although further exploration may be needed to define the types and extent of HPMP issues, you should, at a minimum, have formed hypotheses about the nature of problems in each focus area. Your description of each hypothesis should be supported by citations or descriptions of the relevant policy, regulations, statutes, or standards involved. If you have anecdotal information that suggests a hypothesis, you may include it here or refer to it from the background information.

- Methods for Assessing Performance -- Describe the methods by which you will monitor progress and estimate impact for each focus area.

    - Indicators and Performance Goals -- Specify which indicators you expect to impact and provide a detailed narrative description. Note that these may change in actual implementation due to shifting strategies or unforeseen developments.

    - Calculations and Goals -- Describe how you will calculate changes in the indicators, what the goals of the intervention effort are, and how you will measure success.

    - Data Sources and Collection Methods -- Describe each of the data sources that will be utilized (e.g., claims/administrative files, medical record review) in identifying the focus of the project and determining results. Indicate the specific data that will be obtained from each source. Describe how you will develop and pilot test data collection instruments, the methods used to assess data quality, and the methods for measuring data validity and reliability.

- Data Analysis Methods -- Describe in detail your methods for analyzing data to assess the project impact on performance of the indicators. Identify any data analysis software that you plan to use.

- Project Setting and Reach -- Define the parameters of the intervention. This may include specific diagnostic codes, particular providers, and/or entire provider categories. It may be bounded by geography or by rural versus urban setting. You may choose to address the entire universe of events (e.g., all unnecessary right heart catheterizations in the State) or a subset (e.g., unnecessary right heart catheterizations in the top 10 providers, based on the percentage of claims). It is entirely appropriate to approach some topics on a statewide basis and others in a tightly focused manner.

- Case Selection and Sampling -- Indicate the number of cases sampled and how they were selected for this project. Include a general description of the inclusion and exclusion criteria within the sample. Identify any special subgroups that were uniquely sampled. Specify the time period used to select cases, being sure to define the time period for the baseline and/or re-measurement sample. Describe any statewide sampling that was done and the relationship between the statewide and provider specific samples. Describe any geographic units (i.e., counties) that were used to restrict the sample (**NOTE:** Sampling does NOT refer only to projects involving review of medical records).

- Baseline Data Analysis -- Describe the results of baseline data analysis.

- QIO Interventions:

  - Development -- Describe your strategy and goals, the target audience, partners and collaborators, specific indicators (if different from project indicators), and your timelines. Specify targeted and statewide interventions. For those activities that involve collaboration with other partners, describe the specific activities that each partner will undertake. In your timelines establish a beginning, evaluation, and ending (if applicable) dates. If the intervention effort is continuous after a given start date, note this. To facilitate your work, you may include other dates such as case selection, case review, and improvement plan request dates.

  - Implementation -- Describe how you will implement the interventions (method of delivery), your communication strategy, and any pilot testing. Describe the communications strategy in detail, including what is being communicated (e.g., results of baseline data, compliance techniques), who is being targeted for the communications (e.g., compliance officer, financial officer, collaborator liaison), and how the messages will be conveyed (e.g., regional meetings, project workshops, newsletters).

  - Evaluation -- Describe your monitoring plan, how you will perform a process assessment to identify process changes occurring as a result of your intervention, and how you will modify your interventions based on results.

- Additional Information -- Include any other information needed to fully describe your plans for each intervention.

HPMP Project Results -- Report the results of your HPMP project, including the following:

- Data Collection/Case Review Findings and Analysis -- Describe the results of data collection activities and what your analysis revealed. This may include case review activities.

- Final Re-measurement Findings -- Provide your final re-measurement results by provider or provider group or a combination of these, whichever is appropriate, and compare the results to your baseline data. Report the degree of improvement, reduction in rate, etc.

- Developed Resources -- Provide any tools, educational materials, or other resources developed by you and used in your interventions to the HPMP QIOSC. The HPMP QIOSC will collect these resources and make them available to other QIOs for use in similar interventions.

11025 - Collaborating With Provider and Practitioner Groups

(Rev. 8, 08-29-03)

You are required to consult with the provider and practitioner community, as specified in §4510, when you are establishing or updating screening criteria used by non-physician reviewers when screening cases for physician referral. In addition, consult with them to design appropriate interventions for addressing HPMP issues.

11030 - Collaborating Effort With Federal and State Agencies and Other Medicare Contractors

(Rev. 8, 08-29-03)

Collaboration begins with communication. You must fully understand the jurisdictional authority, resource limitations, and routine work processes of each partner with which you will engage in HPMP efforts. Similarly, these partners must have realistic expectations of your abilities and limits.

The ability to work with different partners in a variety of ways does not create an automatic obligation to respond affirmatively to all requests (see §§9200ff.). Where you cannot resolve differences of opinion about your obligations as a QIO, the obligations of other agencies to you, or the best course of action on a specific issue, involve your Project Officer in the discussions. Collaboration with these other agencies will be important to their understanding of the nature of the HPMP.

You are not limited to collaborating with one agency at a time any more than you are obligated to involve any external partner where your own authority and resources are sufficient. Dialogue should occur early and continue as events unfold. Facilitating these discussions is one reason for forming a work plan.

You bring many potential contributions to the table, including the not-so-simple act of convening groups with different perspectives and responsibilities to examine common problems. You can

provide data to educate and inform participants, define major issues, and guide development of an efficient plan. You may even find it productive to serve as a temporary "base" for complex operations, where collaborators are dispersed. The ability to join forces for common work without confusing distinct jurisdictions will take careful and constant attention, but the synergistic impact will make coalitions attractive options for dealing with extensive or pervasive problems.

A. Collaborating with Office of the Inspector General (OIG):

- QIO Responsibilities:

  - The QIO Basic Responsibilities -- You are required by §1156(a) of the Social Security Act (the Act) to use your authority or influence to enlist the support of other professional or government agencies to ensure that each practitioner or other person complies with the obligations specified in §1156(a) (1), (2), and (3). These obligations are: the services are provided economically and only when and to the extent medically necessary, are of a quality that meets professionally recognized standards of health care, and are supported by evidence of medical necessity and quality in such form and fashion and at such time as you may reasonably require in the exercise of your duties and responsibilities.

  - Intent of the Collaborative Relationship -- As part of this responsibility, you should develop a collaborative relationship with OIG to facilitate not only the exchange of information, but also reciprocal understanding of each organization's roles in safeguarding the Medicare Program.

- OIG Components -- Three components within OIG are pertinent to HPMP, and you may find it useful to work with each on different occasions. These components include:

  - The Office of Investigations (OI) -- OI develops cases involving civil and criminal violations of Federal law. Its investigators generally focus on specific providers and practitioners, ranging from a single legal entity to large corporations with multi-State provider holdings. This is the office within OIG that will accept fraud referrals and sanction recommendations. Its offices often request medical review determinations (see Chapter 9 for information regarding Fraud & Abuse referrals).

    - OI may want QIO physicians to provide medical expertise for court presentation as well as case development. Both you and OI should be clear on whether this is a potential part of your contribution before you begin collaboration (see §9230). OI investigators are also an excellent source of information on investigative procedures and evidence gathering in general.

  - The Office of Audit Services (OAS) -- OAS conducts both audits of specific providers and large-scale audits focusing on specific program issues. This office has particular expertise in issues involving provider activity designed to defraud or abuse the Medicare program through cost reports.

- The Office of Evaluations and Inspections (OEI) -- OEI conducts studies on a variety of issues, often national in scope. They post these completed studies on OIG's Internet home page, which is an excellent information source.

- QIO Information Sharing with OIG -- There are several ways you can share information with OIG. Possible types of requests are addressed below.

  - QIO Case Referral to OIG -- Referral is required when you identify possible performance patterns of fraud or abuse during your regular review activity, regardless of whether these situations or issues are within your area of responsibility. You may make a referral if you suspect fraud or abuse but you do not discern a practice or performance pattern. Refer to §§9000-9070 for instructions and information regarding the sanction process. These sections, along with the fraud and abuse sections (§§9200-9240), clarify when you must or may refer a case to OIG or other agencies.

  - OIG Requests for Case Review -- QIO review may be necessary for the development of an OIG case. OIG referrals for fraud and abuse are addressed in §§9200-9240. You must follow the process specified in §9210 in order to provide this service.

  - OIG Requests for QIO Data -- The OIG may request data that you have collected under HPMP. If the OIG makes such a request, the following apply:

    - If the information is relative to a specific case or pattern involving possible fraud or abuse and it is requested in writing by a Federal or State agency charged with carrying out such investigations, you (the QIO) are required to provide the relevant information.

    - If you have specific concerns about the data, such as it is unconfirmed or data collection is incomplete, you should inform OIG of those concerns and the reasons for those concerns at the time you provide the data. In addition, you should educate the OIG as to the purpose of the data collection and your intended response to the data.

    - If the request for data is not relative to a specific situation involving possible fraud or abuse, refer the OIG to your Project Officer. Inform the OIG that you will be able to provide the requested data only upon being instructed to do so by your Project Officer.

- QIO Coordination with OIG:

  - Overlap of QIO Activities/OIG Investigation -- There are times when QIO and OIG activities could target the same data or cases within a hospital. In order to avoid interfering with or interrupting an OIG investigation, you must check with OIG before requesting medical records or initiating any corrective action. The process for you to obtain OIG clearance is outlined in 4.(b). If the provider is under OIG investigation, your ability to proceed will be determined on a case-by-case basis in consultation with OIG and your CMS Project Officer. This is an

opportunity for you to explain the focus of the project being proposing or implementing. In some cases, OIG may ask you to refrain from contacting the provider until the OIG investigation is complete. In general, the OIG makes the determination of whether or not you may proceed. However, if you are prohibited from contacting so many providers and/or from working on so many issues that you cannot conduct your HPMP activities in any meaningful way, you may, through your Project Officer, bring the matter to the attention of the CMS Central Office. Central Office, in turn may bring the matter to the attention of the OIG in Washington, D.C., so that a joint resolution can be worked out. You may follow the same process if you are prohibited from contacting a provider when the focus of the OIG investigation is completely unrelated to the focus of your proposed review or intervention.

- Obtaining OIG Clearance Before Beginning QIO Activity in a Hospital -- Before you begin any activity in a hospital, you must first check with the appropriate OIG regional office to ensure the facility(ies) in question are not under investigation. In order to obtain this clearance, you will:

    - Send a list of the hospitals in which you intend to begin activity to the appropriate OIG regional office.

    - If there are hospitals which are entirely prohibited, negiotiate with OIG to determine if there are topics which could be prohibited, but still allow you to perform activities within the facility to the extent they do not involve those prohibited topics.

    - If you encounter difficulty in obtaining a response or an agreement with OIG, contact your Project Officer and Central Office.

- QIO Role as Educator -- If you identify, in the course of HPMP activities, payment errors and subsequently implement activities intended to correct the cause of the payment error (i.e., a HPMP project, individual provider educational efforts, general provider educational campaigns, etc.), you are expected to educate OIG regarding the corrective activities and the impact of those activities (i.e., any re-measurement that has been done or is anticipated) when OIG requests related data and you provide it, or when such data is under discussion with OIG. Whenever you refer a case to OIG, you are also expected to educate OIG regarding the corrective activities that have occurred and the results of those activities.

B. Collaborating With Other Agencies:

- State Agencies -- CMS contracts with State departments of health to conduct survey and certification of Medicare and Medicaid providers. Their authority in monitoring and enforcing quality of care in Medicare providers is complementary to yours, making it paramount that you coordinate your activities. The certification process and periodic onsite surveys provide State agencies with a wealth of data, both quantitative and qualitative. Certification files contain detailed information about provider characteristics, both self-reported by providers and recorded by State staff. Onsite surveys also create

detailed documentation based on the surveyor's observations of compliance with certification requirements. Surveyors, by virtue of their training and field observations, are an excellent source of information on current local practices, emerging problems, and proven solutions.

- Your ability to profile providers, provider types, or services using claims and other data can be invaluable in helping the State agency effectively target its resources. Where collaboration allows the agency to use its authority to monitor and enforce requirements that parallel your own requirements, it is in the best interests of both agencies.

- Licensure and Accreditation Bodies -- State governments license a variety of providers and health care practitioners. In addition, national accrediting bodies provide an essential component to overseeing health care services. Regulations at 42 CFR 480.133 and 480.137 require you to disclose specific information to these entities when appropriate. In addition to these requirements, you should look for opportunities to work with these agencies to further your HPMP goals.

- State Medicaid Agencies -- Although your statutory authority directs you to review Medicare services, Medicaid is another large purchaser of health care services. As such, it is a potential partner with interests and obligations similar to your own. Regulations at 42 CFR 480.133(a)(2)(ii)(A) and 480.137(b) allow you to provide confidential information to Medicaid regarding payment errors, including fraud and abuse.

  - Further, you may provide non-confidential summary information to Medicaid about quality or program integrity issues identified in your work that may be similarly problematic in the Medicaid population. You should become familiar with your State's program and identify common ground with Medicare requirements. To the extent that you can develop parallel efforts, you will greatly amplify the message to providers to improve their practices.

NOTE: You must follow the notice requirements in 42 CFR 480.104 for disclosure of non-confidential information. Information related to your quality improvement projects that identifies a particular provider is confidential information, even if in summary form, and must be handled accordingly (see 42 CFR 480.101(b) for the definition of confidential information). You must disclose confidential information relevant to an investigation of fraud and abuse of the Medicaid program when you receive a written request from the State enforcement agency responsible for the investigation or identification of fraud and abuse in the Medicaid program. See 42 CFR 480.137(9a).

- Intermediaries/Carriers/Regional Home Health Intermediaries (RHHIs)/Durable Medical Equipment Regional Contractors (DMERCs) -- Continue to report denials and adjustments based on individual case reviews to the intermediary in accordance with Chapters 3 and 4. Provide determinations on cases referred to you by CMS contractors, and report the results in a mutually acceptable manner. These are only the beginnings of the potential partnerships you may develop with these contractors. You may share data for joint analysis or provide summary analysis or case review data, which identify patterns of payment errors. Beyond identification of specific providers, this may be useful to payers for development or assessment of local medical policy, edits, pre-

payment review criteria, or other processes. You must refer medical review determinations or data collection on Part A services, which result in denials of payment, to carriers for consideration in reviewing corresponding Part B physician services.

- Become familiar with the organizational structure of payers, and recognize the ease or difficulty with which information flows between them. For example, intermediaries and carriers have fraud units, which may receive your referrals for development (see §§3953ff. of the Medicare Intermediary Manual, Chapter 3). These units are generally distinct from medical review units, which may collaborate with you on a variety of program integrity issues that do not constitute fraud. These units may be willing and able to engage in joint reviews where your combined authority is needed to fully address an issue. Some of these organizations have significant beneficiary or provider outreach and education departments that would also be willing to join forces on issues of mutual interest.