



The Medicare Disproportionate Share Hospital Fact Sheet (revised April 2008) is now available in print format. This fact sheet provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005; number of beds in hospital determination; and Medicare DSH payment adjustment formulas. To place your order, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html> scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

MLN Matters Number: MM5849

Related Change Request (CR) #: 5849

Related CR Release Date: August 7, 2008

Effective Date: August 1, 2008

Related CR Transmittal #: R264PI and R1571CP

Implementation Date: No later than August 15, 2008

Transition of Responsibility for Medical Review from Quality Improvement Organizations (QIOs)

Note: This article was updated on July 6, 2013, to reflect current Web addresses. This article was previously changed on August 19, 2008, to correct the effective date, which should have been stated as August 1, 2008, NOT April 1, 2008. All other information remains unchanged.

Provider Types Affected

Hospitals paid under the Inpatient Prospective Payment System (IPPS) and long term care hospitals (LTCH).

What You Need to Know

CMS has shifted the majority of utilization review of inpatient hospital claims (including acute inpatient prospective payment system (IPPS) hospital and long-term care hospital (LTCH) claims) from the Quality Improvement Organizations (QIOs) to Medicare Fiscal Intermediaries (FIs) and Part A and B Medicare Administrative Contractors (A/B MACs). FIs and MACs will begin performing reviews on IPPS hospital and LTCH claims for improper payment reduction

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purposes in August 2008. FIs and MACs will be allowed to review claims submitted January 1, 2008 forward.

Responsibility for IPPS hospital and LTCH error rate measurement has been shifted from the QIOs to the Comprehensive Error Rate Testing (CERT) contractor. The CERT contractor began reviewing acute care hospital claims for improper payment measurement beginning April 1, 2008.

Background

This article is based on Change Request (CR) 5849. CR5849 makes modifications to the Medicare Program Integrity Manual. The key points are:

- FIs or MACs may still make referrals to the QIO for quality of care issues of claims when their review of outpatient claims or inpatient claims data reveal a problem provider.
- FIs and MACs will perform most utilization reviews, for improper payment reduction purposes, of acute care inpatient hospital claims, and the CERT contractor will measure the inpatient hospital paid claims error rate.
- QIOs will no longer conduct the HPMP program and will instead focus their efforts on quality improvement, continuing to perform quality reviews, expedited determinations, and certain utilization reviews, such as provider-requested higher-weighted Diagnosis Related Group (DRG) reviews and referrals.

Additional Information

The official instruction (CR5849) was issued to your Medicare FI or A/B MAC in two transmittals, one related to the *Medicare Program Integrity Manual* and one for the *Medicare Claims Processing Manual*. These transmittals are available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R264PI.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1571CP.pdf> respectively on the CMS website.

CMS has posted a Fact Sheet and Power Point Slides to the CMS website. These documents can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/InpatientReviewFactSheet.pdf> and http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/Inpatient_Hospital_Review_Transition.zip on the CMS website.

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