CMS Manual System

Pub. 100-10 Medicare Quality Improvement Organizations

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

Transmittal 16 **Date: JUNE 30, 2006**

SUBJECT: Revisions to Chapter 1, "Background and Responsibilities"

I. SUMMARY OF CHANGES: The changes included in this transmittal update Chapter 1 of the QIO Manual to reflect the 8th QIO Statement of Work contract. These updates reflect the current purpose, authority, and responsibilities of the QIO Program and its contractors, including improving quality of care for beneficiaries and protecting beneficiaries and the Medicare Trust Fund. Also, these changes define the role of the QIO Support Centers (QIOSCs) in the QIO Program.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 30, 2006
IMPLEMENTATION DATE: June 30, 2006

The revision date and transmittal number apply to red italicized material only. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/1000/Authority
R	1/1005/Purpose of QIO Review
R	1/1010/QIO Responsibilities
R	1/1020/Health Care Quality Improvement Program (HCQIP)
R	1/1025/Hospital Payment Monitoring Program (HPMP)
N	1/1030/QIO Support Center (QIOSC)

III. FUNDING: No additional funding will be provided by CMS.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

Quality Improvement Organization Manual

Chapter 1 - Background and Responsibilities

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(Rev.16, 06-30-06)

1000 - Authority

(Rev.16, Issued: 06-30-06, Effective: 06-30-06, Implementation: 06-30-06)

Part B of title XI of the Social Security Act (the Act), as amended by the Peer Review Improvement Act of 1982, established the Utilization and Quality Control Peer Review Organization Program -- the Quality Improvement Organization (QIO) Program. The QIO program activities are further governed by title XVIII of 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 *475* -- Definition of eligible organizations and area designation;
- 42 CFR *476* -- Assumption and conduct of review;
- 42 CFR *478* -- QIO reconsiderations and appeals;
- 42 CFR *480* -- Disclosure of information;
- 42 CFR 482 -- Hospital Conditions of Participation; and
- 42 CFR 1004 -- Sanctions.

1005 - Purpose of QIO Review

(Rev.16, Issued: 06-30-06, Effective: 06-30-06, Implementation: 06-30-06)

As a result of legislative mandates and the Centers for Medicare & Medicaid Services' (CMS) experience in administrating the program, CMS has identified the following requirements of the QIO program:

- *Improve quality of care for beneficiaries;*
- *Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and medically necessary and that are provided in the most appropriate setting; and*
- *Protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals, such as beneficiary complaints; provider-issued notices of non-coverage (Hospital-Issued Notice of Non-coverage [HINN], Notice of Discharge and Medicare Appeal Rights [NODMAR], and Medicare Advantage appeal);*

Emergency Medical Treatment and Labor Act (EMTALA) violations; and other related statutory QIO responsibilities. Also, protect beneficiaries by implementing a fast-track appeals process that limits the beneficiaries' financial liability when a Notice of Medicare Non-coverage has been issued from a provider (i.e., Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice, Comprehensive Outpatient Rehabilitation Facility (CORF)).

Moreover, you review items or services provided to Medicare beneficiaries as instructed in the QIO Manual, Chapters 4, 5, 7, and 9.

1010 - QIO Responsibilities

(Rev.16, Issued: 06-30-06, Effective: 06-30-06, Implementation: 06-30-06)

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

- Obtaining written Memorandums of Agreement (MOAs) (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., *HINN* and *NODMAR*).

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*, but is subject to confidentiality rules in §1160 of the Act and regulations at 42 CFR Part 480. It* 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. The SOW includes your requirements for*

improving quality of care for beneficiaries and protecting beneficiaries and the Medicare program.

1020 - Health Care Quality Improvement Program (HCQIP)

(Rev.16, Issued: 06-30-06, Effective: 06-30-06, Implementation: 06-30-06)

The Health Care Quality Improvement Program (HCQIP) had its conceptual foundations in the health care variations research of the 1980s that examined variability in care and outcomes among providers and geographic areas. Under HCQIP, you conduct Quality Improvement Projects (QIPs) using statistical information to examine medical processes and outcomes of health care, and provide feedback to providers and practitioners so that this information can be used to benchmark progress toward improved practices and outcomes. CMS designed 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, *Medicare Advantage Organizations*, hospitals, nursing homes). Your SOW sets specific quality *measures* for national health improvement priorities that reflect the current state of QIO program experience, measurement systems, and data sources. These quality *measures* do not address the entire spectrum of health care, nor do they reflect fully the unique circumstances of each state *(see Chapter 16)*.

1025 - Hospital Payment Monitoring Program (HPMP)

(Rev.16, Issued: 06-30-06, Effective: 06-30-06, Implementation: 06-30-06)

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 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.

CMS has developed the Comprehensive Plan for Program Integrity (Plan) to serve as the road map for reducing payment errors in the Medicare program. The Hospital Payment Monitoring Program (HPMP, formerly the Payment Error Prevention Program or PEPP) is one of ten initiatives included in this Plan.

This ongoing surveillance allows CMS to continue to produce accurate and reliable estimates of payment errors at the State and national level for inpatient acute care hospital PPS services. In addition, highly targeted, narrowly focused projects will be undertaken by some QIOs in an effort to reduce known sources of payment error.

1030 - QIO Support Center (QIOSC)

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For certain topics, settings, populations, and project processes, CMS is contracting with designated QIOs to provide support for CMS and the QIO community for the particular areas of interest. These QIO Support Centers (QIOSCs) will work in conjunction with corresponding Topic Area Teams (TATs) established by CMS. The QIOSC will serve as a clearinghouse of topic-specific information and provide technical assistance to QIOs as necessary.