CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 475	**Date: July 19, 2013**
	Change Request 8379

SUBJECT: PIM Chapter 6 MR Guidelines 6.54-6.5.7 Update

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update section 6.5.4 to include MAC referral to QIO of quality of (health) care concerns.

EFFECTIVE DATE: August 19, 2013
IMPLEMENTATION DATE: August 19, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/Table of Contents
R	6.5.4 - Review of Procedures Affecting the DRG
R	6.5.7 - Reserved for Future Use
R	6.5.8 - Reserved for Future Use
R	6.5.9 - Circumvention of PPS
N	6.6 - Referrals to the Quality Improvement Organization (QIO)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 475	Date: July 19, 2013	Change Request: 8379

SUBJECT: PIM Chapter 6 MR Guidelines 6.54-6.5.7 Update

EFFECTIVE DATE: August 19, 2013
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I. GENERAL INFORMATION

A. Background: The Contractor shall make appropriate referrals to the QIO for quality of (health) care concerns. A Quality of (Health) Care Concern is defined as a concern that care provided did not meet a professionally recognized standard of health care, IOM Pub. 100-04, IOM Pub. 100-10 and 42 CFR 476.80(b).

B. Policy: The Contractor shall refer Quality of (Health) Care Concerns **ONLY** to the QIOs.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8379.1	The MAC shall make appropriate referrals to the QIO for quality of (health) care concerns. A Quality of (Health) Care Concern is defined as a concern that care provided did not meet a professionally recognized standard of health care, IOM Pub. 100-04, IOM Pub. 100-10 and 42 CFR 476.80(b). The QIOs will retain their responsibility for performing expedited determinations, Hospital-Issued Notices of Non-Coverage (HINN) reviews, quality reviews, and provider-requested higher-weighted DRG reviews. All other initial payment determinations and claim adjustments are required to be performed by the MAC.	X											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Della Johnson, 410-786-8220 or della.johnson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual
Chapter 6 - Intermediary MR Guidelines for Specific Services

Table of Contents
(Rev.475, Issued: 07-19-13)

Transmittals for Chapter 6

6.5.4 – Review of Procedures Affecting the DRG

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

The contractor shall determine whether the performance of any procedure that affects, or has the potential to affect, the DRG was reasonable and medically necessary. If the admission and the procedure were medically necessary, but the procedure could have been performed on an outpatient basis if the beneficiary had not already been in the hospital, do not deny the procedure or the admission.

When a procedure was not medically necessary, the contractor shall follow these guidelines:

If the admission was for the sole purpose of the performance of the non-covered procedure, and the beneficiary never developed the need for a covered level of service, deny the admission;

If the admission was appropriate, and not for the sole purpose of performing the procedure, deny the procedure (i.e., remove from the DRG calculation), but approve the admission;

If performing a cost outlier review, in accordance with Pub. 100-10, chapter 4, §4210 B, and the beneficiary was in the hospital for any day(s) solely for the performance of the procedure or care related to the procedure, deny the costs for the day(s) and for the performance of the procedure; and

If performing a cost outlier review, and the beneficiary was receiving the appropriate level of covered care for all hospital days, deny the procedure or service.

See Pub. 100-02, *C*hapter 1, §10 for further detail on payment of inpatient claims containing non-covered services.

6.5.7 – *Reserved for Future Use*

((Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

6.5.8 – *Reserved for Future Use*

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

6.5.9 - Circumvention of PPS

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

If you suspect, during review of a claim associated with a transfer or readmission, that a provider of Medicare services took an action with the intent of circumventing PPS (as described in §1886(f)(2) of the Act) and that action resulted in unnecessary admissions, premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services, you shall make a referral to your *Zone Program Integrity Contractor (ZPIC).*

6.6 Referrals to the Quality Improvement Organization (QIO)

(Rev. 475, Issued: 07-19-13, Effective Date: 08-19-13; Implementation Date: 08-19-13)

The MACs shall only refer Quality of (Health) Care Concerns to the QIOs. A Quality of (Health) Care Concern is defined as "a concern that care provided did not meet a professionally recognized standard of health care." The Contractor shall follow the referral process as agreed upon in the QIO-MAC Joint Operating Agreement. The QIOs will retain their responsibility for performing expedited determinations, Hospital-Issued Notices of Non-Coverage (HINN) reviews, quality reviews, transfer reviews, readmission reviews and, provider-requested higher-weighted DRG reviews.

The Circumvention of PPS will continue to be reported to your Zoned Program Integrity Contactor (ZPIC). The quality initiatives associated with payment for performance are now the reporting source for Readmission Reviews and Transfer Review data to the QIOs. Non-covered benefits/services are not to be reported to the QIO.

All initial payment determinations and claim adjustments are required to be performed by the MAC.

All MACs are to turn off all automated edits/processes that generate a referral to the QIOs prior to a complex medical review of the claim. Referrals to the QIO shall be limited to Quality of Health Care issues as defined above and shall result from a clinician's complex medical review of a provider's medical documentation.

If during the complex medical review process, "a concern that care provided did not meet a professionally recognized standard of health care," the MAC shall issue a payment determination and/or adjustment for the claim, complete the QIO referral form, and forward the completed referral form and file(s) to the QIO. If the referral form is not complete, the QIO will return the file to the MAC and request that the MAC provide the missing information prior to the QIO performing a review.

A non-covered service and/or procedure shall not be automatically referred to the QIO. The MAC shall make the initial payment determination and/or claim adjustment for a non-covered service or procedure in accordance with the Medicare IOM 100-04, Claims Processing Manual and IOM 100-02, Benefit Policy Manual.

If during the complex medical review process, "a concern that care provided did not meet a professionally recognized standard of health care," such as a medically unnecessary procedure, the claim shall be referred to the QIO for quality review after payment determination and/or claim adjustment is made.

The MACs shall not instruct providers, suppliers, or beneficiaries to refer payment issues to the QIO. If the provider or supplier does not agree with the payment and/or claim adjustment decision, the MAC shall communicate their options to follow the current process in IOM 100-08, requesting a reopening or an appeal. If the beneficiary disagrees with the payment decision and makes a request for re-evaluation/redetermination, this will be considered a demand bill and is the responsibility of the MAC.