

(3) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type;

(4) Through DRG validation, the validity of diagnostic and procedural information supplied by the hospital;

(5) The completeness, adequacy and quality of hospital care provided;

(6) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges;

(7) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.82 and 412.84 of this chapter; and

(8) Whether a hospital has misrepresented admission or discharge information or has taken an action that results in—

(i) The unnecessary admission of an individual entitled to benefits under part A;

(ii) Unnecessary multiple admissions of an individual; or

(iii) Other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(b) *Payment determinations.* On the basis of the review specified under paragraphs (a) (1), (3), (6), (7), and (8) of this section, the QIO must determine whether payment may be made for these services. A QIO may grant a period of not more than two days (grace days) for the purpose of arranging post discharge care when the provider did not know or could not reasonably be expected to have known that payment for the service(s) would not be made under the Medicare program as specified in § 405.330(b).

(c) *Other duties and functions.* (1) The QIO must review at least a random sample of hospital discharges each quarter and submit new diagnostic and procedural information to the Medicare fiscal intermediary or carrier if it determines that the information submitted by the hospital was incorrect.

(2) As directed by CMS, the QIO must review changes in DRG and LTC-DRG

assignments made by the intermediary under the provisions of §§ 412.60(d) and 412.513(c) of this chapter that result in the assignment of a higher-weighted DRG or a different LTC-DRG. The QIO's review must verify that the diagnostic and procedural information supplied by the hospital is substantiated by the information in the medical record.

(d) *Coordination of sanction activities.* The QIO must carry out the responsibilities specified in subpart C of part 1004 of this title regarding imposition of sanctions on providers and practitioners who violate their statutory obligations under section 1156 of the Act.

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§ 476.72 Review of the quality of care of risk-basis health maintenance organizations and competitive medical plans.

(a) (1) For purposes of a review under section 1154(a)(4) of the Act, a QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by an HMO or CMP meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.

(2) Paragraph (a)(1) of this section will not apply with respect to a contract year if another entity has been awarded a contract to perform those reviews under section 1154(a)(4)(C) of the Act.

(b) For purposes of reviews under this section, non-QIO entities selected to perform these reviews under section 1154(a)(4)(C) of the Act are subject to the requirements of paragraph (a)(1) of this section and—

(1) Part 476 of this chapter regarding acquisition, protection, and disclosure of peer review information; and

(2) Part 1004 of Chapter V regarding a QIO's responsibilities, and sanctions on health care practitioners and providers.

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