(iii) A summary of the specific facts that the QIO determines are pertinent to its findings; and
(iv) A statement that the letter represents the QIO’s final determination and that there is no right to further appeal.

(2) The QIO may provide information to the beneficiary, practitioner, and provider regarding opportunities for improving the care given to patients based on the specific findings of its review and the development of quality improvement initiatives.

[77 FR 68561, Nov. 15, 2012]

§ 476.150 Abandoned complaints and reopening rights.

(a) Abandoned complaints. If a Medicare beneficiary fails to participate or otherwise comply with the requirements of the beneficiary complaint review process and the QIO does not have sufficient information to complete its review, the QIO may determine that the complaint has been abandoned and—

(1) Inform the parties that its complaint review will be discontinued; and

(2) Inform the beneficiary of his or her right to resubmit a written complaint in accordance with the procedures in § 476.120.

(b) Reopening complaint reviews. A QIO may reopen a Medicare beneficiary complaint review using the same procedures that the QIO would use for reopening initial denial determinations and changes as a result of DRG validation, as described in § 476.96.

[77 FR 68561, Nov. 15, 2012]

§ 476.160 General quality of care review procedures.

(a) Scope of the QIO review. A QIO may conduct a general quality of care review in accordance with section 1154(a)(1)(B) of the Act.

(1) A QIO may conduct general quality of care reviews based on—

(i) Concerns identified during the course of other QIO review activities;

(ii) Referrals from other sources, including but not limited to individuals, contractors, other Federal or State agencies; or

(iii) Analysis of data.

(2) The QIO’s review will focus on all concerns identified by the QIO and/or identified by those who have referred or reported the concerns, with consideration being given to the episode of care related to the concerns.

(3) The QIO will use evidence-based standards of care to the maximum extent practicable. If no standard of care exists, the QIO must use available norms, best practices, and established guidelines to establish the standard that will be used in completing the review. The QIO’s determination regarding the standard used is not subject to appeal.

(b) Medical information requests. Upon request by the QIO, a provider or practitioner must deliver all medical information requested within 14 calendar days of the request. A QIO is authorized to require the receipt of the medical information sooner if the QIO makes a preliminary determination that the review involves a potential gross and flagrant or substantial quality of care concern and circumstances warrant earlier receipt of the medical information. A practitioner’s or provider’s failure to comply with the request for medical information within the established timeframe may result in the QIO taking action in accordance with § 476.90.

(c) Initial determination. The QIO peer reviewer will complete the review and the practitioner and/or provider will be notified of the initial determination in writing within 10 calendar days of the receipt of all medical information.

[77 FR 68561, Nov. 15, 2012]

§ 476.170 General quality of care reconsideration procedures.

(a) Right to request a reconsideration. Beginning with reviews initiated after July 31, 2014, a provider or practitioner who is dissatisfied with a QIO’s initial determination may request a reconsideration by the QIO.

(1) The reconsideration request must be received by the QIO, in writing or by telephone, by no later than 3 calendar days following receipt of the QIO’s initial determination. If the QIO is unable to accept the request, the request must be submitted by noon of the next day the QIO is available to accept a request.
Centers for Medicare & Medicaid Services, HHS § 478.10

(2) The practitioner or provider must be available to answer any questions or supply any information that the QIO requests in order to conduct its reconsideration.

(3) The QIO must offer the practitioner or provider an opportunity to provide further information. A practitioner or provider may, but is not required to, submit evidence to be considered by the QIO in making its reconsideration decision.

(b) Issuance of the QIO's final decision. No later than 5 calendar days after receipt of the request for a reconsideration, or, if later, 5 calendar days after receiving any medical or other records needed for such reconsideration, the QIO must complete the review and notify the practitioner or provider of its decision.

(1) The QIO's initial notification may be done by telephone, followed by the mailing of a written notice by noon the next calendar day that includes:

(i) A statement for each concern that care did or did not meet the standard of care;
(ii) The standard identified by the QIO for each of the concerns;
(iii) A summary of the specific facts that the QIO determines are pertinent to its findings; and
(iv) A statement that the letter represents the QIO's final determination and that there is no right to further appeal.

(2) The QIO may provide information regarding opportunities for improving the care given to patients based on the specific findings of its review.

PART 478—RECONSIDERATIONS AND APPEALS

Subpart A [Reserved]

Subpart B—Utilization and Quality Control Quality Improvement Organization (QIO) Reconsiderations and Appeals

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478.46 Departmental Appeals Board and judicial review.
478.48 Reopening and revision of a reconsidered determination or a hearing decision.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 50 FR 15372, Apr. 17, 1985, unless otherwise noted. Redesignated at 64 FR 66279, Nov. 24, 1999.

§ 478.10 Scope.

This subpart establishes the requirements and procedures for—
(a) Reconsiderations conducted by a Utilization and Quality Control Quality Improvement Organization (QIO) or its subcontractor of initial denial determinations concerning services furnished or proposed to be furnished under Medicare;
(b) Hearings and judicial review of reconsidered determinations; and
(c) QIO review of a change in diagnostic and procedural coding information.