(2) A QIO’s determination that an admission is medically necessary is not a guarantee of payment by the fiscal intermediary. Medicare coverage requirements must also be applied.

§ 476.82 Continuation of functions not assumed by QIOs.

Any of the duties and functions under Part B of Title XI of the Act for which a QIO has not assumed responsibility under its contract with CMS must be performed in the manner and to the extent otherwise provided for under the Act or in regulations.

QIO REVIEW FUNCTIONS

§ 476.83 Initial denial determinations.

A determination by a QIO that the health care services furnished or proposed to be furnished to a patient are not medically necessary, are not reasonable, or are not at the appropriate level of care, is an initial denial determination and is appealable under part 473 of this chapter.

§ 476.84 Changes as a result of DRG validation.

A provider or practitioner may obtain a review by a QIO under part 473 of this chapter for changes in diagnostic and procedural coding that resulted in a change in DRG assignment as a result of QIO validation activities.

§ 476.85 Conclusive effect of QIO initial denial determinations and changes as a result of DRG validations.

A QIO initial denial determination or change as a result of DRG validation is final and binding unless, in accordance with the procedures in part 473—

(a) The initial denial determination is reconsidered and revised; or

(b) The change as a result of DRG validation is reviewed and revised.

§ 476.86 Correlation of Title XI functions with Title XVIII functions.

(a) Payment determinations. (1) QIO initial denial determinations under this part with regard to the reasonableness, medical necessity, and appropriateness of placement at an acute level of patient care as are also conclusive for payment purposes with regard to the following medical issues:

(i) Whether inpatient care furnished in a psychiatric hospital meets the requirements of §424.14 of this chapter.

(ii) Whether payment for inpatient hospital or SNF care beyond 20 consecutive days is precluded under §489.50 of this chapter because of failure to perform review of long-stay cases.

(iii) Whether the care furnished was custodial care or care not reasonable and necessary and, as such, excluded under §405.310(g) or §405.310(k) of this chapter.

(iv) Whether the care was appropriately furnished in the inpatient or outpatient setting.

(2) Reviews with respect to determinations listed in paragraph (a)(1) of this section must not be conducted, for purposes of payment, by Medicare fiscal intermediaries or carriers except as outlined in paragraph (c) of this section.

(3) QIOs make determinations as to the appropriateness of the location in which procedures are performed. A procedure may be medically necessary but denied if the QIO determines that it could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.

(4) QIO determinations as to whether the provider and the beneficiary knew or could reasonably be expected to have known that the services described in paragraph (a)(1) of this section were excluded are also conclusive for payment purposes.

(b) Utilization review activities. QIO review activities to determine whether inpatient hospital or SNF care services are reasonable and medically necessary and are furnished at the appropriate level of care fulfill the utilization review requirements set forth in §§405.1035, 405.1042, and 405.1137 of this chapter.

(c) Coverage. Nothing in paragraphs (a) (1) and (3) of this section will be construed as precluding CMS or a Medicare fiscal intermediary or carrier, in the proper exercise of its duties.
§ 476.88 Examination of the operations and records of health care facilities and practitioners.

(a) Authorization to examine records. A facility claiming Medicare payment must permit a QIO or its subcontractor to examine its operation and records (including information on charges) that are pertinent to health care services furnished to Medicare beneficiaries and are necessary for the QIO or its subcontractor to—

(1) Perform review functions including, but not limited to—

(i) DRG validation; and

(ii) Outlier review in facilities under a prospective payment system; and

(iii) Implementation of corrective action and fraud and abuse prevention activities; (2) Evaluate cases that have been identified as deviating from the QIO norms and criteria, or standards; and (3) Evaluate the capability of the facility to perform quality review functions under a subcontract with the QIO.

(b) Limitations on access to records. A QIO has access to the records of non-Medicare patients if—

(1) The records relate to review performed under a non-Medicare QIO contract and if authorized by those patients in accordance with State law; or (2) The QIO needs the records to perform its quality review responsibilities under the Act and receives authorization from the facility or practitioner.

(c) Conditions of examination. When examining a facility’s operation or records the QIO must—

(1) Examine only those operations and records (including information on charges) required to fulfill the purposes of paragraph (a) of this section; (2) Cooperate with agencies responsible for other examination functions under Federal or Federally assisted programs in order to minimize duplication of effort; (3) Conduct the examinations during reasonable hours; and (4) Maintain in its principal office written records of the results of the examination of the facility.

§ 476.90 Lack of cooperation by a health care facility or practitioner.

(a) If a health care facility or practitioner refuses to allow a QIO to enter and perform the duties and functions required under its contract with CMS, the QIO may—

(1) Determine that the health care facility or practitioner has failed to comply with the requirements of § 474.30(c)