Modifications to Quality Improvement Organization Quality of Care Review Process

Overview

The mission of the Centers for Medicare & Medicaid Services' Quality Improvement Organization (QIO) Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. One important component of serving and protecting people with Medicare is responding to quality of care concerns. Medicare fulfills this function through its arrangements with QIOs as they accept and review Medicare quality of care complaints. When QIOs confirm a quality of care concern, they work collaboratively with the involved healthcare provider(s) to uncover the cause of the problem, ensure an understanding of the appropriate evidence-based care, and work towards preventing the problem from happening again.

Modification to the Quality of Care Review Process

The process for responding to people with Medicare about their quality of care concerns has been modified as a result of new regulations published as part of the Calendar Year 2013 Outpatient Prospective Payment system (OPPS) final rule on November 15, 2012 – notice CMS-1589-FC at 77 FR 68209. The modified process is a significant change from the process QIOs previously used when addressing Medicare beneficiary complaints with the goal of fully realizing the objectivity of the QIO process as well as increasing its transparency.

How Does the Modification to the Quality of Care Review Process Impact Physicians?

Previously QIOs were required to obtain consent from physicians/practitioners to disclose details of beneficiary quality of care complaint review findings. As a result of the November 15, 2012 OPPS Final Rule, QIOs are no longer required to obtain consent from physicians/practitioners in order to divulge details of quality of care review findings of the beneficiary complaint review.

The OPPS Final Rule also removed the provider's and physician/practitioner's opportunity for discussion during the general quality of care review process. However, the physician/practitioner maintains the right to request a reconsideration review following the QIO's determination letter.

The issues addressed in the new regulations are an outgrowth of the decision in the case of *Public Citizen, Inc.* v. *U.S. Department of Health and Human Services (*332 F.3d 654, June 20, 2003*)* of the United States Court of Appeals for the District of Columbia Circuit.

What do the Modifications Mean for Medicare Beneficiaries?

The regulation allows QIOs to convey the initial decision by telephone followed by the mailing of a written notice. Content of written decisions given to beneficiaries will include a statement for: each concern on whether or not the care did or did not meet the standard of care; the standard identified by the QIO for each of the concern(s); and a summary of the specific facts that the QIO determines are pertinent to its decision(s).

Beginning with quality of care complaints that are filed after July 31, 2014, Medicare beneficiaries will be able to request a reconsideration review of their quality of care complaint review determination.

Additional Information

The regulation (Final Rule and comments) can be referenced in 42 CFR 476 in the Federal Register beginning on page 300. http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf.