

## Categories of Case Review Performed by QIOs

Quality Improvement Organizations (QIOs) perform several categories of medical review under contract to the Centers for Medicare & Medicaid Services (CMS). These review processes can be triggered by a Medicare beneficiary through a complaint or a request for appeal, by federal agencies, or as a routine review of care and billing patterns under the Medicare program. All of these functions are collectively referred to as “case review.” Following are short descriptions of the different types of case review.

**Medicare Beneficiary Complaint:** QIOs assess complaints received from Medicare beneficiaries to determine whether the health care services provided met professionally recognized standards for care. When care can be improved, both facilities and physicians are encouraged to participate in quality improvement activities that are monitored by QIO staff. Complaints that do not involve substandard medical care but do represent a patient satisfaction concern can be resolved through alternative dispute resolution methods such as mediation or other facilitated communication. Findings of egregious error or incompetence are handled through the sanction process and, if appropriate, are referred to regulatory authorities such as state licensing agencies.

**Grijalva Reviews** (Medicare Advantage only): QIOs review medical charts on an expedited basis to ensure that Medicare beneficiaries enrolled in MA plans are not prematurely discharged from comprehensive outpatient rehabilitation services (CORFs), home health agencies (HHAs), or skilled nursing facilities (SNFs).

**Clinical Data Abstraction Center (CDAC):** QIOs review hospital records when records submitted to the CDAC do not pass routine data validation methodologies.

### **Hospital Discharge Appeal Rights:**

These QIO reviews ensure that every Medicare hospital inpatient is informed of the available appeal process. If the patient thinks they are being discharged from the hospital too early, fee-for-service Medicare beneficiaries and Medicare Advantage (MA) plan enrollees can request an expedited review from the QIO. Beneficiaries are protected from liability during the expedited review process. For fee-for-service Medicare beneficiaries, hospitals can request an expedited QIO determination for medically unnecessary admissions or for QIO concurrence when the hospital thinks the beneficiary is ready to be discharged.

**Benefits Improvement and Protection Act (BIPA)** (Fee-For-Service Only): QIOs review medical charts on an expedited basis to ensure that Medicare beneficiaries receiving services under the traditional fee-for-service Medicare program are not prematurely discharged from CORFs, HHAs, hospices, or SNFs.

**Higher-Weighted Diagnosis Related Group (DRG):** QIOs review medical records for which hospitals have submitted requests for a higher-paying DRG to the fiscal intermediary. These reviews ensure appropriate payments to hospitals.

**Emergency Medical Treatment and Labor Act (EMTALA):** QIOs review medical records upon the request of CMS to determine whether a hospital emergency department failed to provide federally-mandated emergency medical care.

**Referral Reviews from CMS, Department of Justice, Health and Human Services Office of Inspector General, Program Safeguard Contractors (PSC):** Any of these entities can refer medical records to a QIO for review of medical necessity and quality of care on an ad hoc basis.

**Long-Term Care Hospital (LTCH):** QIOs routinely review long-term care hospital stays to ensure that the level of service intensity is appropriate and diagnostically valid. These reviews can include the entire breadth of the hospital billing claim and medical record.

**Sanction Activities (Post Review):** When care meets the threshold of grossly and flagrantly unacceptable or an unacceptable pattern of care is identified, QIOs initiate a sanction process. As part of the sanction process, a QIO may initiate a corrective action plan including education and quality improvement activities, after which QIO staff may review medical records for a period of time to monitor sustained and appropriate quality improvement. If a corrective action plan is not successful, it may result in a provider's exclusion from the Medicare program and/or civil monetary penalties.

*The American Health Quality Association represents the national network of Quality Improvement Organizations (QIOs) that work to encourage the spread of best clinical practices and improve systems of care delivery. Visit [www.abqa.org](http://www.abqa.org) for more details.*