

QIO-LIKE ENTITY

Under section 1902 (d), a State can contract with a QIO or QIO-like entity to perform medical and utilization review functions required by law. The contracts must be consistent with the QIO legislation. Section 1903 (a)(3)(C) of the Act specifies that 75% Federal Financial Participation is available for State expenditures for the performance of medical and utilization reviews or external quality reviews by a QIO, or by entity, which meets the requirements of section 1152 of the Act (i.e., "QIO-like entity").

The Office of Clinical Standards and Quality (OCSQ) within the CMC, reviews applications from prospective QIO-like organizations to determine whether the organization meets the requirements in section 1152 of the Act and 42 CFR Part 475 as specified below:

Physician-Sponsored Organization

To be eligible as a physician-sponsored organization, you must demonstrate to CMS that your organization meets the following requirements:

- Is composed (have physicians as owners or members) of at least 20% of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the State; (i.e., at least 20 percent of the practicing physicians in the State are owners of the QIO, or the QIO is owned by an entity which includes at least 20% of the practicing physicians in the State as members; or
- Is composed (have physicians as owners or members) of at least 10% of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the State, and demonstrate through means (e.g., letters of support from physicians and physician organizations) acceptable to CMS that the organization is representative of an additional 10% of the practicing physicians in the State
- Is not a healthcare facility, healthcare facility association, or healthcare facility affiliate; and
- It must have at least one individual who is representative of consumers on its governing body.

Physician-Access Organization

To be eligible as a physician-access organization, you must demonstrate to CMS that your organization meets the following requirements:

- Has arrangements with doctors of medicine or osteopathy, licensed in the State to conduct review for your organization;

- Has available at least one physician, licensed in the State from every generally recognized specialty (i.e., CMS has defined generally recognized specialties as follows: Cardiology, Gerontology, Gynecology, Immunology/Rheumatology/Endocrinology, Internal Medicine/Family Practice, Neurology, Oncology, Ophthalmology, Orthopedics/Podiatry, Psychiatry, Pulmonary Medicine, Radiology, Surgery (includes subspecialties), and Urology/Nephrology) who is in active practice in your review area (the pool of licensed physician reviewers must be practicing in the State where certification is requested);
- Is not health care facility, health care facility association, or health care facility affiliate; and
- It must have at least one individual who is representative of consumers on its governing body.
- and responding to complaints and appeals.

Ability To Perform Review Functions

In order to demonstrate that your organization has the ability to perform review activities set forth in Section 1154 of the Act, you must document and submit for CMS review and approval a brief explanation of your capability to perform the work by demonstrating past/current experience in this area, or absent this, offer a detailed plan as to how you would perform these activities. You must meet all the requirements listed below and provide a copy of your policy and procedures, with appropriate sections highlighted documenting:

- Medical record and review information must be maintained confidentially.
- Appropriate information must be collected in review of a case.
- Denial decisions must be made by a physician.
- Review decisions are made on the basis of written criteria.
- Review criteria can be provided to practitioners and providers when appropriate, and a process exists for modifying them in response to practitioner recommendations.
- Complaint and appeal process must include procedures for receiving and responding to complaints and appeals.

In order for OCSQ to make a determination as to whether your organization qualifies as a QIO-like entity, you must demonstrate to us that you meet the above requirements and provide information that describes your ability to review cases and analyze patterns of care related to medical necessity and quality of care.

Provide a copy of your organizational chart and listing of staff documenting:

- Physicians must be involved in the management of the program.
- Clinical staff must collect clinical information.

Provide evidence of your ability to analyze patterns of medical review information for purposes of reporting and conduct of subsequent reviews.

Provide evidence of your past and current experience in medical and quality review.

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Review of Applications

The Office of Clinical Standards and Quality (OCSQ) within the CMC, reviews applications from prospective QIO-like organizations to determine whether the organization meets the requirements in section 1152 of the Act and 42 CFR Part 475 as specified below:

- Organization must be physician-sponsored or physician-access;
- Organization must be able to perform review functions specified under section 1154 of the Act related to the performance of medical necessity and quality of care review. QIO-like entities must be able to review cases and analyze patterns of care related to medical necessity and quality review. (We do not determine if the organization meets the states' requirements for external quality review specified in sections 1902 (a)(30)(A), 1902 (a)(30)(C) and 1932 (c)(2) of the Act, nor have we evaluated the organization to perform the same functions as a QIO under contract with CMS);
- Must have at least one individual who is representative of consumers on its' governing body; and
- Must not be a health care facility, health care facility affiliate or health care association.

Definitions

A health care facility is defined as an entity that directly provides or supplies health care services for which payment may be made in whole or in part under Title XVIII of the Act. A "health care facility affiliate" is an organization which has a board on which more than 20 percent of the members are affiliated through management, ownership or common control with one or more facilities.

Consumer Representative is defined as a Medicare beneficiary (fee for service or managed care). The consumer representative must not be a practicing physician, or a governing board member, office, partner, owner of more than 5 percent interest in a health care facility, or managing employee of a health care facility or association of health care facilities.

Three-Year Certification

If your organization is approved as a QIO-like entity, QIO-like certification will be limited for a period of three years. You will be required to provide an annual assurance statement of your continued adherence to certification requirements within 30 days of the last month of the first certification year and within 30 days of the last month of the second certification year. In addition, you must notify this Office if there are changes in the name and address of the organization, pool of physician reviewers, etc., for a reevaluation of your certification.