Medicare
Peer Review Organization Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 88 **Date: JUNE 5, 2002**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Part 3 - Table of Contents	3-1 (1 p.)	3-1 (1 p.)
3005 - 3020 (Cont.)	3-5 - 3-9 (5 pp.)	3-5 -3-9 (5 pp.)
Exhibits 3-1 - 3-3	3-41 - 3-52 (12 pp.)	3-51 - 3-54 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:*

CLARIFICATION - *EFFECTIVE DATE: Not applicable*

Section 3000, Background, is revised to clarify that Quality Improvement Organizations (QIOs) (formerly Peer Review Organizations (PRO)) are required to develop a Memorandum of Agreement (MOA) with certain providers (i.e., hospitals, critical access hospitals, home health agencies, skilled nursing facilities, and Medicare+Choice Organizations) who wish to participate, or continue to participate in the Medicare program. It is the providers' responsibility to sign and return the MOA to the QIO. All references to peer review organizations have been changed to quality improvement organizations.

Section 3005, Statutory Authority for MOAs, is revised to add §§1154 (a)(4)(A), 1154 (a)(14) and §1866(a)(3)(A) of the Social Security Act to the statutory authority citations for providers who have MOAs with QIOs. This section also corrects the statutory reference for Medicare+Choice Organizations.

Section 3010, Scope, is revised to clarify that MOAs with hospitals, home health agencies, skilled nursing facilities, M+C organizations and critical access hospitals should reflect specific review responsibilities referenced in §§1866 (a)(3)(A), 1154 (a)(4)(A), and 1154 (a)(14) of the Social Security Act. In addition, MOAs with the above providers should reflect the broad responsibilities of you and the provider regarding SOW activities (See §3020, MOAs with Specific providers). This section deletes reference to Payment Error Prevention Program.

Section 3015, Provider MOA Specifications, is revised to clarify that providers are responsible for maintaining MOAs with QIOs. QIOs must forward MOAs to providers with a return due date using certified mail or an equivalent delivery service, which provides proof of delivery and a signed receipt to providers. A description of health care quality improvement activities was incorporated under the Provisions section. This section also clarifies that failure to sign, return or honor the provisions of a MOA violates the provision for certification for Medicare payment under 42 CFR 489.53 (a)(1).

Section 3020, MOAs With Specific Providers, is revised to clarify specific review responsibilities referenced in the statute that must be mentioned in MOAs with hospitals, home health agencies, skilled nursing facilities, Medicare+Choice Organizations and assistants at cataract surgery. MOAs with providers must also include broad review responsibilities mentioned in the current Scope of Work.

Exhibit 3-1, Memorandum of Agreement Cover Letter for Providers, is added and should be used when forwarding new/revised MOAs to providers.

Exhibit 3-2, Model Memorandum of Agreement For Providers, is added and can be used as a guide when preparing MOAs for providers.

Exhibit 3-3, Model Memorandum of Agreement for State Licensing\Certification Agency, was previously numbered as Exhibit 3-1. References to Peer Review Organizations have been changed to Quality Improvement Organizations, and references to the Health Care Financing Administration have been changed to the Centers for Medicare and Medicaid Services.

Workload and Costs

These instructions do not represent any increase in workload or costs.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

PART 3

AGREEMENTS

Memorandum of Agreement With Providers of Health Care Services

3000. BACKGROUND

The Memorandum of Agreement (MOA) is a written document which outlines your administrative and review responsibilities and the responsibilities of providers, necessary to accomplish certain review requirements under your contract. (See §3005 for statutory authority applicable to MOAs.) The responsibilities of both parties should be clearly outlined in the MOA.

Quality Improvement OrganizationI (QIOs) are required to develop, implement, and revise MOAs, acceptable to CMS, with certain providers of health services (i.e., Hospitals, Critical Access Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Medicare + Choice Organizations) who wish to participate, or continue to participate in the Medicare program, as specified in the contract with the Secretary. It is the provider's responsibility to sign and return the MOA. In all instances, both the QIO and the provider are expected to honor the terms of the agreement. QIOs are not required to develop MOAs with individual practitioners.

NOTE: QIOs are not required to develop MOAs with individual physicians pertaining to physician services rendered in freestanding physician offices or physician offices related to Medicare +Choice (M+C) organization reviews.

3005. STATUTORY AUTHORITY FOR MOAs

The Social Security Act (the Act) contains statutory provisions applicable to MOAs:

- Section 1154(a)(1) of the Act gives QIOs the authority to review services furnished by physicians, other health care practitioners, and institutional and noninstitutional providers of health care services for which payment may be made under Medicare, as specified in the QIO's contract with the Secretary.

- Section 1154 (a)(4)(A) of the Act requires QIOs to provide that a reasonable proportion of the QIOs' activities are involved in reviewing, under paragraph (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

- Section 1154(a)(7)(C) of the Act requires QIOs to examine the pertinent records of any practitioner or provider of health care services that the QIOs have responsibility for reviewing.

- Section 1154 (a)(14) of the Act requires QIOs to conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

- Section 1852 (e)(3)(A) of the Act requires each M+C organization to maintain a written agreement with a QIO or some other independent quality review and improvement organization to review M+C organization services for purposes of, among other things, quality review and beneficiary complaints.

- Section 1866 (a)(1)(E) of the Act requires providers of services to have an agreement with QIOs to release data related to patients when a QIO requests it.

- Section 1866(a)(1)(F)(i) of the Act requires hospitals which provide inpatient hospital services paid under the prospective payment system (PPS) to maintain an agreement with QIOs to review the validity of diagnostic information provided by such hospitals, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought.

o Section 1866(a)(1)(F)(ii) of the Act requires hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), and home health agencies (HHAs) to maintain an agreement with the QIO to perform certain functions listed in §1866 (a)(3)(A).

o Section 1866(a)(3)(A) of the Act requires QIOs, under MOAs with SNFs, HHAs, CAHs and hospitals, to perform functions described under the third sentence in §1154 (a)(4)(A) related to quality and under §1154 (a)(14) related to beneficiary complaints.

3010. SCOPE

MOAs specify your administrative and review responsibilities and the providers' administrative and review responsibilities necessary to accomplish certain review requirements under your contract. MOAs are intended to be informational in order to facilitate the review process and to avoid any misunderstandings between you and the provider.

Your MOA with hospitals, home health agencies, skilled nursing facilities, M+C organizations and critical access hospitals should reflect your specific review responsibilities referenced in §1866 (a)(3)(A), § 1154 (a)(4)(A) and §1154 (a)(14) of the Act concerning these providers.

In addition, your MOA should reflect the specific responsibilities of you and the provider regarding Scope of Work (SOW) activities that fulfill the responsibilities in the MOA. (See §3020, MOAs with Specific Providers.) Expectations regarding activities under the current SOW applicable to each provider type should be outlined in your MOA such as:

A. Mandatory Case Review.--You are responsible for reviewing specific types of cases, including beneficiary complaints, hospital and M+C organization notices of noncoverage (e.g., Hospital Issued Notice of Noncoverage and Notice of Discharge and Medicare Appeal Rights), assistants at cataract surgery, diagnosis related group (DRG) changes, anti-dumping cases, CAH and/or utilization (payment) determinations by evaluating quality of care, the appropriateness of admission/discharge, Medicare coverage issues, accuracy of coding or appropriateness of medical services. This is accomplished by the review procedures specified in Parts 4 and 5. The provider must provide you with the medical record in order for you to conduct these reviews. The results of these reviews may include denial of payment for admission, DRG changes, or confirmed quality of care concerns.

B. Health Care Quality Improvement.--Health Care Quality Improvement Projects are collaborative efforts with entities and individuals such as health care providers, CMS, practitioners, M+C organizations, advocacy groups, specialty societies and beneficiaries, which promote measurable improvement of processes and outcomes of care for Medicare beneficiaries. The goal is to make measurable improvements in Medicare beneficiary health status or satisfaction. You are required to conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers and others to improve the processes of care by further reducing the variations and enhancing the results. You use information abstracted from medical records to accomplish this work. The provider is expected to provide all pertinent materials from the medical record for these efforts. (See Part 4.)

3015. PROVIDER MOA SPECIFICATIONS

Hospitals, CAHs, SNFs, HHAs, and M+C Organizations providers are required to maintain an agreement with you if they wish to continue to participate in the Medicare program. Examine all agreements currently in use in your review area and modify them to incorporate activities mentioned in the statute and current SOW.

Forward the MOA/modified MOA to the provider for signature and include a return due date in your correspondence to the provider. (See Exhibit 3-1.) Forward the MOA using certified mail or an equivalent delivery service. Provide an informational copy of the agreement to each provider that signed an MOA.

A. Provisions of Agreement.--MOAs with providers, should address certain required activities referenced in the Statute (i.e., §1154(a)(4)(A), §1154(a)(14), §1866(a)(F)(i) and §1866(a)(3)(A) of the Act, as well as those activities in the SOW. At a minimum, include your responsibilities and the responsibilities of the provider regarding the following, if applicable:

1. Health Care Quality Improvement Project Activities.--Conduct quality improvementefforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research), and to work collaboratively with providers to improve the processes of care by further developing the variations and enhancing the results.

2. Medical Review.--Review of medical services to determine whether the services were reasonable and medically necessary, were furnished in the appropriate setting, and were of a quality that meets professionally recognized standards of care.

NOTE: In hospitals and M+C organization MOAs, include review requirements regarding notices of noncoverage. (See Part 7.) In hospital MOAs, include the preadmission and preprocedure review requirements (e.g., assistants-at-cataract surgery). For additional information concerning assistants-at-cataract surgery see §3110 A.3 and §3110 A.4.

3. Data Analysis.--Review of individual patient care data furnished by providers to ensure the validity of all diagnostic and procedural information. Identify requirements that the provider agrees to comply with in providing necessary data and information.

4. Claims Analysis.--Review of payment data to determine whether payment may be made for services furnished (as appropriate).

5. Complaint Analysis.--Review of cases in response to written beneficiary complaints about the quality of services.

6. Confidentiality and Disclosure.--Include Confidentiality and Disclosure Requirements in accordance with §1160 of the Act and 42 CFR Part 480.

7. Beneficiary Rights Outreach & Education Activities.--Conduct programs to inform Medicare enrollees about QIO review programs, the role of the QIO, grievance and complaint procedures.

8. Timing of Review.--Conduct of review within the time frames specified in the contract.

9. Location of Review.--Specify all locations where QIO review of cases may take place (e.g., at the QIO or facility);

10. Work Space for Review Activities.--Address provisions of space for staff to conduct onsite review;

11. Corrective Action.--Develop, implement, and complete corrective action plans to address confirmed quality concerns or patterns of quality problems.

12. Miscellaneous.--Identify additional review activities and procedures as prescribed by CMS.

B. Signatures.--MOAs must be signed by representatives of your organization and appropriate provider representatives. If a provider refuses to sign the MOA, inform the CMS Project Officer (PO) of this matter.

C. Modifying MOAs.--Modify MOAs when changes in the requirements of the SOW necessitate additional understandings between you and the provider. Representatives of your organization and a representative of the provider organization must sign the revised MOA.

D. Failure to Return, Sign or Honor the Terms of an MOA.--If a provider fails to return the MOA by the requested due date, or refuses to sign the MOA, or fails to honor the provisions of a MOA, document your efforts and refer the circumstances to your PO for resolution. It is the provider's responsibility to return the signed MOA by the requested due date.

If the provider continues to act outside the provisions of the MOA, the PO should contact the staff in the Regional Division of Medicaid and State Operations (DMSO), Survey and Certification Branch. DMSO will initiate action to terminate the provider agreement based on failure to comply with 42 CFR 489.53(a)(1). If the institution is dissatisfied with a determination that its provider agreement is proposed to be terminated, it is entitled to a hearing and judicial review of that hearing under 42 CFR 498.

3020. MOAs WITH SPECIFIC PROVIDERS

Your MOA with hospitals, home health agencies, skilled nursing facilities, M+C organizations and critical access hospitals should reflect your specific review responsibilities referenced in §1866 (a)(3)(A), §1154 (a)(4)(A) and §1154 (a)(14) of the Act as well as the responsibilities of the provider regarding SOW activities. Your MOA with the providers listed below should include the following specific activities.

A. Hospitals.--Hospitals which provide inpatient hospital services paid under the prospective payment system (PPS) are required to maintain an agreement with you to review the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided with respect to services for which payment may be made under Part A of Medicare.

The MOA must stipulate that a reasonable proportion of your activities are involved in reviewing, under §1154 (a)(1)(B) of the Act, the quality of services and that a reasonable allocation of these activities be made among different settings. In addition, § 1154 (a)(14) of the Act requires that you conduct an appropriate review of written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

B. Home Health Agenices and Skilled Nursing Facilities.--Your MOA with HHAs and SNFs must stipulate that a reasonable proportion of your activities are involved in reviewing, under §1154 (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

Also, include language in your MOA that specifies that you conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care (§1154 (a)(14)). Review beneficiary complaints utilizing the review procedures specified in Part 5 of the QIO Manual. The provider must provide you with the medical record in order for you to conduct these reviews. The results of the review may include a denial of payment for admission, DRG changes or confirmed quality of care concerns. Utilize the review procedures specified in Part 4 of the QIO Manual when reviewing beneficiary complaints. The provider must provide you with the medical record in order for you to conduct these reviews. The results of the review may include a denial of payment for admission, DRG changes or confirmed quality of care concerns.

You may also want to include language to address FI, Carrier, CDAC, CMS, OIG, and State Agency referrals in your MOA

Also include language to address Health Care Quality Improvement Projects. Health Care Quality Improvement Projects are collaborative efforts with health care providers and/or beneficiaries, which promote measurable improvement of processes and outcomes of care for Medicare beneficiaries. The goal is to make measurable improvements in Medicare beneficiary health status or satisfaction. You are required to conduct quality improvement efforts to determine an opportunity to improve care based upon variation from accepted medical practice (derived from scientific research) and to work collaboratively with providers to improve the processes of care by further developing the variations and enhancing the results. QIO quality improvement projects typically focus on specific preventative services and care processes known to improve patient outcomes. Quality interventions are measures of how often these critical processes or services are performed, or how often desired outcomes are achieved. You use information abstracted from medical records to accomplish this work. The provider is expected to provide all pertinent materials from the medical record for these efforts. (See Part 4.)

Include appropriate specifications in §3015 and refer to the model agreement (see Exhibit 3-1) when preparing the MOA.

NOTE: You may develop one MOA with a parent HHA operating in a state that has branches located in the same state as the parent agency. Ensure that the name and address of all branch office locations are listed in the MOA with the parent agency. Separate MOAs with the respective State QIO are required for subunits of a parent HHA that serves patients in geographic areas different from that of the parent HHA because these subunits have their own agreement number. HHA subunits are considered to be semi-autonomous organizations and must independently meet the conditions of participation for HHAs. (See 42 CFR 484.2.)

C. Medicare + Choice Organizations.--For purposes of NODMARs immediate review, you are not required to have an agreement (to perform this review) with the M+C organization(s) in another state or in your state if you do not have the Medicare contract with the M+C organization. Your MOAs with the hospitals in your review area will suffice. The QIO that has an agreement with the hospital treating the beneficiary will review the beneficiary's immediate review request.

D. Assistants at Cataract Surgery.--In accordance with 42 CFR 476.78(a), hospitals in the state are required to maintain MOAs with you. The MOA must provide for review of assistants-at-cataract surgery prior to service and for monitoring of the services billed on a postpayment basis. (See §3110 A.3., and §3110 A.4.)

Exhibit 3-1

Memorandum of Agreement Cover Letter for Providers

Your Letterhead

Dear (Name of Provider):

The **(QIO Name)** is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare beneficiaries in the state of_(_____). As you may already know, we review medical records to determine whether services delivered to these beneficiaries meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. In addition, we review written complaints from Medicare beneficiaries about the quality of Medicare services they have received and conduct quality improvement projects to make measurable improvements in beneficiary health status or satisfaction.

In order to participate in the Medicare program, hospitals, critical access hospitals, skilled nursing facilities, and home health agencies are required to have a Memorandum of Agreement (MOA) with a QIO under Federal law1. M+C Organizations must have a MOA with a QIO or an independent quality review organization. MOAs are intended to facilitate the review process by outlining the QIO's administrative and review responsibilities and the provider's responsibility in assisting us in accomplishing our review requirements. MOAs are also intended to be informational. **(QIO Name)** wants to inform **(Name of State)** hospitals, critical access hospitals, M+C organizations, skilled nursing facilities and home health agencies of (a) **(QIO Name)** procedures with respect to certain contract obligations, (b) review and appeal rights which providers have with respect to these obligations, and (c) opportunities providers have to partner with **(QIO Name)** in local and national quality improvement projects.

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1 §1866 (a)(1)(E) of the Act requires providers of services to have an agreement with a QIO to release data related to patients.

§1866 (a)(1)(F)(I) of the Act requires hospitals which provide inpatient hospital services paid under the prospective payment system (PPS) to maintain an agreement with a QIO to review the validity of diagnostic information provided by such hospital, the completeness, adequacy and quality of care provided, the appropriateness of admissions and discharges and the appropriateness of care provided.

§1866 (a)(1)(F)(ii) of the Act requires hospitals, critical access hospitals, skilled nursing facilities, and home health agencies to maintain an agreement with a QIO to perform certain functions.

§1852 (a)(3)(A) of the Act requires that each M+C organization, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization to perform functions of the type described in §§ 1154(a)(4)(A) and 1154(a) (14).

Exhibit 3-1 (Cont.)

Memorandum of Agreement Cover Letter For Providers

Please review and sign the enclosed MOA and return it to the office listed below by the due date indicated.

(Address of QIO)_

If you have questions, please contact us at:

(QIO Contact Person)
(QIO Telephone Number)

Sincerely yours,

Enclosure: (See Exhibit 3-2.)

Exhibit 3-2

Model Memorandum of Agreement for Providers

MEMORANDUM OF AGREEMENT
BETWEEN
(NAME OF QIO)
AND
(NAME OF PROVIDER)

I. Agreement

A. Parties

The parties to this agreement are the (Name of QIO) hereinafter referred to as_____ and (Name of provider) hereinafter referred to as hospital, critical access hospital, skilled nursing facility, home health agency, or Medicare+Choice organization.

B. Statutory Specifications

Section 1154 (a)(1) of the Social Security Act (the Act) requires QIOs to review services furnished to Medicare beneficiaries by physicians, other health care professionals, providers and suppliers as specified in the contract with the Secretary.

Section 1154 (a)(4)(A) of the Act requires that a reasonable proportion of the QIOs activities are involved in reviewing, under paragraph (a)(1)(B), the quality of services and that a reasonable allocation of these activities be made among different settings.

Section 1154 (a)(14) of the Act requires that a QIO conduct an appropriate review of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

Section 1852 (e)(3)(A) of the Act requires that each M+C organization, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization to perform functions of the type described in §§ 1154(a)(4)(B) and 1154 (a)(14).

Section 1866 (a)(1)(F)(i) of the Act requires hospitals which provide inpatient hospital services paid under the prospective payment system (PPS) to maintain an agreement with a QIO to review the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which the hospital is seeking additional payments.

Section 1866 (a)(1)(F)(ii) of the Act requires hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), and home health agencies (HHAs) to maintain an agreement with the QIO to perform certain functions listed in §1866 (a)(3)(A).

Section 1866 (a)(3)(A) of the Act requires QIOs, under the MOA, to perform functions described under the third sentence in §1154 (a)(4)(A) related to quality of services and under §1154 (a)(14) related to beneficiary complaints.

II. QIO Program

In 1982, Congress established Utilization and Quality Control Peer Review Organizations (PROs) (now known as QIOs) to perform two broad functions: (a) promote quality health care services for Medicare beneficiaries, and (b) determine whether services rendered are medically necessary, appropriate, and meet professionally recognized standards of care. CMS also contracts with QIOs

to validate provider-coding assignments, which affect reimbursement. The goal of the QIO program is to improve the processes and outcomes of care for Medicare beneficiaries. The QIO is to achieve this goal through performance of various directives promulgated by CMS in the QIO Contract, as discussed below.

III. Purpose of Agreement

The purpose of this Agreement is to define the administrative relationship that will exist between parties in the exchange of data and information. This Memorandum of Agreement is required by the Medicare statute and regulations as well as the QIO manual and certain QIO contract directives. It is also intended to be informational. **(Name of QIO)** wants to inform **(Name of state)** hospitals, M+C Organizations, SNFs and HHAs of (a) **(Name of QIO)** procedures with respect to certain contract obligations, (B) review and appeal rights which providers have with respect to these obligations, and (c) opportunities providers have to collaborate with **(Name of QIO)** in local and national quality improvement projects.

IV. Effective Date

This Agreement shall be effective upon execution and shall remain in effect so long as **(Name of QIO)** is the Quality Improvement Organization, under contract with CMS, for the area in which the provider is located, or is terminated in accordance with Section VIII of this Agreement or the provider withdraws or is terminated from the Medicare program.

V. Responsibilities of Parties

MOAs with hospitals, home health agencies, skilled nursing facilities, M+C organizations and critical access hospitals reflect the specific QIO review responsibilities referenced in §1866 (a)(3)(A), § 1154 (a)(4)(A) and §1154 (a)(14) of the Act as well as the responsibilities of each provider regarding SOW activities. (See sections 3015 and 3020 of the QIO Manual.)

At a minimum, the MOA stipulates that a reasonable proportion of QIO activities are involved in reviewing, under §1154 (a)(1)(B) of the Act, the quality of services and that a reasonable allocation of these activities be made among different settings. In addition, §1154 (a)(14) of the Act requires that QIOs conduct an appropriate review of written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of care.

In addition, (**Name of QIO**) agrees that it will assume responsibility for performing the following activities mentioned in the SOW for Medicare:

A. QIO Responsibilities

The list of QIO Responsibilities in the areas below are not all inclusive. Many of the QIO's activities are provided in the SOW, which change with each 3 year QIO/CMS contract period.

(Name of QIO) shall assume the Federally mandated responsibility for performing the following activities for Title XVII (Medicare):

- Mandatory Case Review which involves nonphysician screening and physician review of medical records which require review under the SOW. Mandatory case review categories include certain anti-dumping violations, assistant surgeon at cataract surgery, beneficiary complaints, hospital notices of non-coverage, notice of discharge and Medicare appeal rights, hospital requested higher-weighted DRG adjustments, potential concerns identified during project data collections and referrals made by the OIG, FI and CMS.

- Health Care Quality Improvement projects which are collaborative efforts with health care providers and other groups which result in measurable improvement of processes and outcomes related to health care; and

- Communication Activities which result in providing information for education of health care providers, beneficiaries, and others to improve quality of care and to promote early detection and prevention of disease.

B. Provider Responsibilities

The list of Provider Responsibilities in the areas below is not all inclusive. Many of the provider activities in the SOW change with each three-year QIO/CMS contract period.

The **(provider type)** shall submit medical records and other information to the QIO which are needed for conducting of off-site review and cooperative project activities.

The **(provider type)** shall allocate adequate space to QIO staff for conducting on-site review and cooperative project activities, and shall provide medical records and other related information at the time of the QIOs visit.

The **(provider type)** will adhere to applicable Federal laws, regulations and guidelines that protect the confidentiality of medical review information, as well as applicable State laws and regulations.

The **(provider type)** may, as part of a participating in health care quality improvement projects, request technical assistance from the QIO or accept technical assistance offered by the QIO.

VI. Confidentiality of Records and Other Data

(Name of QIO) will abide by the applicable Federal confidentiality laws and regulations in § 1160 of the Act and 42 CFR Part 480. **(Name of QIO)** recognizes the inherent right of the individual to privacy and at the same time acknowledges the medical profession's need for adequate information in order to carry out its activities under this Agreement. To protect the confidentiality of data acquired by **(Name of QIO)** in carrying out its responsibilities under this contract, **(Name of QIO)** shall be bound by §1160 of the Act and applicable regulations. **(Name of QIO)** shall ensure the confidentiality and security of the (**Provider type**) medical records and data from the time the medical records/data are acquired by **(Name of QIO)** until their destruction in accordance with the statute and regulations.

The **(Provider Type)** shall adhere to the applicable State and Federal laws which protect the confidentiality of medical review information.

VII. Modification of Agreement

This Agreement may be amended by **(Name of QIO)** at any time as necessary to conform with any changes or modifications to relevant state or federal laws or applicable regulations, CMS transmittals, program directives, or instructions issued pursuant to applicable laws and regulations. In the event of such an amendment, **(Name of QIO)** shall provide the **(Provider type)** with notice of any such new or revised laws, regulations, CMS transmittals, program directives, or instructions, etc.

VIII. Termination of Agreement

This agreement may be terminated**,** upon advance written notice by one party to the other, as follows:

A. By the **(Provider Type)** without cause with 60 day prior written notice to **(name of QIO)** if the **(provider type)** determines that it is no longer required to be a party to this agreement as a condition of participation in the Medicare program.

B. In the event that the **(Name of QIO**) status as a QIO and/or the **(Provider Type)** status, as an institution qualified and eligible to receive reimbursement for services and items provided under the Medicare program, is terminated by CMS.

In the event that CMS terminates this agreement, **(Name of QIO)** shall notify **(Provider Type)** of termination.

C. In the event that the QIO and the provider cannot agree to a modification to the Agreement.

IX. Miscellaneous Provisions

A. Severability:

Should any clause, portion, or section of this Agreement be unenforceable or invalid, this shall not affect the enforceability or validity of the remainder of this Agreement. Should any particular provision (s) of this Agreement be held unreasonable or unenforceable for any reason, the provisions shall be given effect and enforced to whatever extent would be reasonable and enforceable.

B. Governing Law:

To the extent procedures for resolving any dispute under this Agreement are not available through the Department of Health and Human Services, this Agreement and any disputes arising under it shall be governed by laws of the State of **(Name of State of QIO).**

C. Resolution of Disputes:

If problems in the parties' relationship present themselves, or in the event a dispute arises between the parties, the parties shall attempt to resolve those differences in good faith. If a good faith dispute resolution should fail **(Name of QIO)** shall notify CMS, and CMS shall advise the parties concerning the matter in dispute.

D. Notices:

Notice from **(Name of QIO)** concerning this Agreement shall be directed to the party specified on the signature page below. Other notices from **(Name of QIO)** which are issued as a result ofactivities required by this Agreement shall be directed to an individual designated by the **(Provider (Type)**. **(Name of Provider)** is responsible for notifying **(Name of QIO)** about any change in the person designated to receive such communications.

Notices from the **(Provider type)** in response to **(Name of QIO)** notices shall be directed to the individual or department specified in **(Name of QIO)** communications.

E. Change of Ownership:

In the event of a change of ownership, the new owners will assume all obligations in the current MOA.

Agreement To Terms

The undersigned acknowledge that this Agreement is made pursuant to §1866 (a)(1)(F)(i), §1866(a)(1)(F)(ii) and §1852 (e)(3)(A) of the Act, 42 CFR Part 476; the QIO Manual and certain QIO contract directives, and agree to abide by the terms and conditions set forth.

Provider name:_____

Address:_____

_____

Signature:_____

Date:_____

Name, address and title of individual (QIO) executing Agreement:

_____

_____

_____

Signature:_____

Date:_____

Next Page is 3-49

Exhibit 3-3

Model Memorandum of Agreement for State Licensing\Certification Agency

MEMORANDUM OF AGREEMENT BETWEEN

(QIO NAME)

AND

(State Licensing Agency/Certification Body Name)

I. AGREEMENT

A. Parties to the Agreement:

The parties to this Memorandum of Agreement are the (State Licensing Agency/Certification Body Name and Address) (herein-after referred to as the (_____) and the (QIO Name).

B. Statutory/State Law Specifications:

Quality Improvement Organizations (QIOs) are authorized to perform Medicare peer review as defined in titles XI and XVIII of the Social Security Act (hereinafter referred to as the Act). This authorization is made effective through the QIO's contract with the Centers for Medicare and Medicaid Services (CMS). Section 1160(b)(1)(C) of the Act specifically authorizes QIOs to assist appropriate State agencies, recognized by the Secretary as having responsibility for licensing/certification, by providing data and information (at the request of such agency) insofar as such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law. State licensing agencies/certification bodies may provide data/information to QIOs in accordance with applicable State law.

C. Purpose of Agreement:

The purpose of this Agreement is to define the administrative relationship that will exist between the parties in the exchange of data and information that relates to promoting appropriate and professionally-recognized standards of care to Medicare beneficiaries.

D. Acknowledgements:

The (QIO Name)

AND

(State Licensing Agency/Certification Body Name)

share a mutual interest in exchanging data and information that may be used to improve health care outcomes. Participants to this Agreement are expected to provide data/information as specified herein.

E. Term of Agreement:

This Agreement is effective on and after _____, 20____ and until such time as a new Agreement is deemed necessary by the parties.

F. Provisions of Agreement:

1. Applicable Law

This agreement shall, to the extent applicable, be governed by and construed in accordance with the provisions of titles XI and XVIII of the Act, and applicable Federal regulations.

2. Severability

If any provision of this Agreement is determined to be inconsistent with any Federal or State law or regulation, the Federal or State law or regulation shall control. (In cases where Federal and State law conflict, the Federal law shall prevail.) However, the remainder of this agreement shall remain valid.

3. Medicare Liability

This Agreement shall not be construed to increase either party's financial liability beyond that required by Medicare, i.e., the release or sharing of QIO data will be performed within the QIO's current operating budget.

II. QIO RESPONSIBILITIES

The (QIO Name) has the responsibility to provide (in accordance with the dates and timeframes set forth in this section) to the (State Licensing Agency/Certification Body Name) the data/information listed in this section.

(ENTER RESPONSIBILITIES)

III. LICENSING AGENCY/CERTIFICATION BODY RESPONSIBILITIES

The (State Licensing Agency/Certification Body Name) has the responsibility to provide (in accordance with the dates and timeframes set forth in this section) to the (QIO Name) the data/information listed in this section.

(ENTER RESPONSIBILITIES)

IV. CONFIDENTIALITY AND DISCLOSURE

The parties agree to comply with confidentiality requirements of section 1160 of the Act and regulations at Part 480 of Title 42 of the Code of Federal Regulations (42 CFR), issued thereunder as well as confidentiality requirements under all other applicable Federal statutes, Federal regulations and any applicable State law. None of the confidential information or any data derived from the information will be released by the recipient to any other organization or individual in confidential form without prior CMS approval. Appropriate administrative, technical, procedural, and physical safeguards shall be established by the recipient to protect the confidentiality of the data and to prevent unauthorized access to it. The safeguards shall provide a level of security that is at least comparable to the level of security described in Office of Management and Budget (OMB) Circular No. A-130, Appendix III -- Security of Federal Automated Systems which sets forth guidelines for security plans for automated information systems in Federal agencies. The (State Licensing Agency/Certification Body Name) will not redisclose QIO data to other parties within the limitations set forth in 42 CFR Part 480 unless otherwise approved by CMS. Data release agreements will be entered into by such other parties and CMS.

V. CHANNELS OF COMMUNICATION-QIO\STATE LICENSING AGENCY\ CERTIFICATION BODY CONTACTS

QIO and licensing agency/certification body contact persons for oral or written communication regarding this data/information exchange process shall be:

QIO:

(Name)

(Phone #)

Re Memorandum of Agreement

(Name)

(Phone #)

STATE LICENSING AGENCY/CERTIFICATION BODY:

(Name)

(Phone #)

Re Memorandum of Agreement

(Name)

(Phone #)

VI. AMENDMENT OF AGREEMENT

This Agreement may be amended in writing by mutual agreement of the parties when required by (1) the Department of Health and Human Services (DHHS) changes to the QIO contract; (2) QIO changes to operational requirements mandated by Federal law and CMS directives; (3) DHHS changes in instructions or regulations; or (4) mutual agreement by all parties.

VII. TERMINATION OF AGREEMENT

A. This agreement may be terminated for any reason, upon mutual written consent of the parties with 90 days written notice by either party to the other, subject to applicable law and regulation. Both parties must provide written notice to CMS of either party's decision to terminate the agreement.

B. This agreement shall be assigned automatically to the succeeding QIO for any state if, for any reason, the current QIO ceases to exercise QIO review authority.

IN WITNESS WHEREOF, The parties hereby execute this agreement:

QIO: _____

TITLE: _____ DATE: _____

STATE LICENSING AGENCY/
CERTIFICATION BODY: _____

TITLE: _____ DATE: _____