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# 42 C.F.R. § 476.1

## Definitions.

As used in this part, unless the context indicates otherwise:

*Admission review* means a review and determination by a QIO of the medical necessity and appropriateness of a patient's admission to a specific facility.

*Appointed representative* means an individual appointed by a Medicare beneficiary to represent the beneficiary in the beneficiary complaint review process.

*Authorized representative* means an individual authorized, under State or other applicable law, to act on behalf of a Medicare beneficiary. An authorized representative has all of the rights and responsibilities of a Medicare beneficiary throughout the processing of a beneficiary complaint.

*Beneficiary complaint* means a complaint by a Medicare beneficiary or a Medicare beneficiary's representative alleging that the quality of Medicare covered services received by the beneficiary did not meet professionally recognized standards of care. A complaint may consist of one or more quality of care concerns.

*Beneficiary complaint review* means a review conducted by a QIO in response to the receipt of a written beneficiary complaint to determine whether the quality of Medicare covered services provided to the beneficiary was consistent with professionally recognized standards of health care.

*Beneficiary representative* means an individual identified as an authorized or appointed representative of a Medicare beneficiary.

*Continued stay review* means QIO review that is performed after admission review and during a patient's hospitalization to determine the medical necessity and appropriateness of continuing the patient's stay at a hospital level of care.

*Criteria* means predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of a health care service may be compared.

*Diagnosis related group (DRG)* means a system for classifying inpatient hospital discharges. DRGs are used for purposes of determining payment to hospitals for inpatient hospital services under the Medicare prospective payment system.

*DRG validation* means a part of the prospective payment system in which a QIO validates that DRG assignments are based on the correct diagnostic and procedural information.

*Elective,* when applied to admission or to a health care service, means an admission or a service that can be delayed without substantial risk to the health of the individual.