



Refer to: WCDSC-R8-RB

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Consortium for Quality Improvement and Survey & Certification Operations
Western Division of Survey and Certification

November 22, 2011

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing
288 North 1460 West
Post Office Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Hales:

The Centers for Medicare and Medicaid Services has approved the request for a two-year extension of the Inpatient Hospital Utilization Review Waiver (Title 42 of the Code of Federal Regulations, Part 456 Subpart C, Section 456.50 through 456.137). This current two-year extension is granted through January 31, 2014.

If the Utah Department of Health, Division of Medicaid and Health Financing chooses to renew the Hospital Utilization Review Program Superior Waiver after January 31, 2014, please send the request and supporting documentation to this office at least 90 days prior to the expiration date of the waiver.

Please address the request for an additional two-year renewal of the Superior Waiver to Ruth Bailey, Health Insurance Specialist, Centers for Medicare and Medicaid Services, 1600 Broadway, Suite 700, Denver, Colorado 80202-4967.

If you or staff have questions, please contact Ruth Bailey at 303-844-7031, or e-mail her at ruth.bailey@cms.hhs.gov.

Sincerely,

Bernard S. Fellner, Manager
Certification and Enforcement Branch

Copies to:

Utah Department of Health, Division of Health Care Financing, F. Blake Anderson
Utah Department of Health, Division of Health Care Financing, Alex Yei (via e-mail)
Utah Department of Health, Division of Health Care Financing, Craig Devashrayee (via e-mail)
CMS, CMSO, Survey and Certification Group, Aviva Walker-Sicard (via e-mail)
CMS, Financial Management Branch, Denver Regional Office, Stephen Nose (via e-mail)
CMS, Program Management Branch, Denver Regional Office, Betty Strecker (via e-mail)

UTAH DEPARTMENT OF HEALTH
DIVISION OF MEDICAID and HEALTH FINANCING
IN CONJUNCTION WITH THE
**OFFICE OF INSPECTOR GENERAL OF MEDICAID
SERVICES**

**HOSPITAL UTILIZATION REVIEW PROGRAM
SUPERIOR SYSTEM WAIVER**

Salt Lake City, Utah

November 2011

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SUPERIOR SYSTEM WAIVER

SECTION I BACKGROUND AND AUTHORITY

1.1 Authority

The authority to evaluate the need for admissions and continued stays in an acute care general hospital, and of the quality of the care provided, are defined in the Utah State Plan, Attachment 4.19-A and 42 Code of Federal Regulations 456.121 through 456.137. In addition, the authority for this waiver request is defined under 42 CFR, Part 456, Subpart H. This waiver will also include utilization review for the Utah State Hospital as defined under 42 CFR 456, Subpart D.

1.2 Provisions Governing the Program

The provisions of Utah's Hospital Utilization Review Program shall be governed by Title XIX of the Social Security Act, the laws of the State of Utah, under authority as granted by regulations set forth in Title 42 of the Code of Federal Regulations, the Utah State Plan and Utah Administrative Rules. The Division of Medicaid and Health Financing (DMHF) and the Office of Inspector General (OIG) for Medicaid Services in Utah ensure compliance with these statutes and regulations cited above.

1.3 Review Policy and Reimbursement

As of this date, the Hospital Utilization Review Policy and reimbursement for inpatient hospital services are described in Attachment 4.19-A of the Utah State Plan under Title XIX, as periodically amended. This policy establishes a prospective payment Diagnostic Related Group (DRG) reimbursement program for all hospitals except the Utah State Hospital and rural hospitals as defined in the Utah State Plan.

1.4 Office of Inspector General for Medicaid Services

In order to meet the requirements of the Hospital Utilization Review Program and also meet the requirements for a statewide surveillance and utilization control program, DMHF has entered into a memorandum of understanding with the newly created Office of Inspector General for Medicaid Services, which by state statute is empowered to perform these functions.

SECTION II PURPOSE AND PROGRAM:

2.1 Purpose

The purpose of the Hospital Utilization Review Program is to ensure the appropriateness and medical necessity of:

1. Admissions to a hospital or a designated distinct-part unit within a hospital,
2. Transfers from one acute care hospital to another acute care hospital or to a distinct-part rehabilitation unit or psychiatric unit in another acute care hospital (inter-facility transfer),
3. Transfers from an acute care setting to a distinct-part rehabilitation or psychiatric unit within the same facility (intra-facility transfer),
4. Continued stays:
 - a. For urban hospitals, the charges above the specific DRG outlier threshold are reviewed,
 - b. For rural hospitals, the charges for each additional day above the average length of stay are reviewed, and
5. Surgical services and invasive diagnostic procedures.

2.2 Additional Reviews

The Hospital Utilization Review program will also perform reviews to:

1. Validate the principal diagnosis and/or principal surgical procedure reflected on paid claims to ensure consistency with the attending physician's determination and documentation as found in the patient's medical record,
2. Validate the presence of co-morbidity, as found on the claim; determine if it is correct; if it is consistent with the attending physician's determination and compatible with documentation found in the patient's medical record,
3. Assure timeliness and quality of care received,
4. Safeguard against inappropriate utilization and non-covered care,
5. Ensure provider compliance with state and federal regulations,

6. Assure that documentation meets state and federal requirements and sufficiently describes the status of and services provided to the patient.

SECTION III UTILIZATION REVIEW COMMITTEE

3.1 Introduction

A Utilization Review (UR) Committee functions within the Division. The chairperson of the Committee is a physician licensed to practice in the State of Utah and an employee of, or contracted by DMHF.

Although the Committee resides within the Division, the OIG has access to and can use the committee as a resource for professional evaluations and recommendations during the course of investigations, audits and reviews.

3.2 Voting Membership

Voting members of the committee are physicians licensed to practice in the State of Utah, who are members of the consultant panel for the Division or employees of the Department of Health. In addition, other voting Committee members include registered nurses licensed to practice in the State of Utah, employed by the Department of Health, and capable of performing utilization review, and other professional staff determined by the Division Director to be appropriate for the Committee. Other professionals or Department staff may be invited to specific Committee meetings, as needed, for consultation and discussion in areas of their expertise, but shall not be voting members of the Committee.

3.3 Conflict of Interest

In making determinations and decisions, the Committee insulates itself from any conflict of interest through members disqualifying themselves from voting when they are responsible for the direct care of a patient whose care is being reviewed, or when they have a financial interest in any entity directly benefitting from the decision.

3.4 Scope of Committee Activities

This Committee is advisory to the Division. All decisions of the Committee are subject to

the review and approval of the Division Director or his/her designee. The scope and authority of the Committee include, but are not limited to:

1. Responding to inquiries from the OIG relating to the adoption of review protocols, criteria, guidelines, and standards to support the purpose of Hospital Utilization Review.
2. Making medical recommendations in the context of reimbursement, including appropriateness of care and services,
3. Making recommendations to the OIG for one or more areas of focus for a particular review sample,
4. Recommending additional studies, reviews and audits of individual hospitals, physicians, or patients, and of specific diagnoses, procedures, or other issues to the OIG,
5. Seeking additional consultation as needed,
6. Providing consultation on written criteria sets to the Policy Committee,
7. Recommending possible remedial actions against a provider to the OIG, and
8. Intervening on a professional basis with hospitals, hospital professional committees, and physicians.

3.5 Committee Meetings

The Committee will meet weekly on a regularly scheduled basis when there is review business to conduct. Unscheduled meetings may be called on a more frequent basis to meet the needs of the program. Emergency meetings of the Committee may be held with attendees present, or may be conducted as a telephone conference. The emergency meeting shall consist of two staff physicians and two staff nurses with at least two members of the Committee participating. Further, all remedial recommendations require the signatures of at least two physicians. The following actions may be taken during an emergency meeting:

1. Recommend remedial actions, and
2. Approve or deny reimbursement for emergency care where applicable.

When any decision is made during an emergency meeting as described above, the recommendation represents a final decision by a full Committee.

SECTION IV RELATED PROGRAMS

The Hospital Utilization Review Program within the OIG maintains cooperative relationships with other offices, units, sections, programs and bureaus within the DMHF, the Utah Department of Health, and with other state agencies as necessary and appropriate. This waiver does not specify all of the related programs and their scopes which are governed by the State Plan under Title XIX. However, the following are brief descriptions of some of the programs related to hospital utilization review.

4.1 Prior Authorization Program

The Bureau of Authorization and Community Based Services processes prior authorization requests for specific surgical, medical, dental, pharmaceutical, medical supplies, and other services. Any inpatient hospital claims which were previously authorized by the Division may be included in the universe for sample selection and would be subjected to review where applicable and appropriate. If any previously authorized inpatient hospital claim is selected as part of the sample, it shall be subject to the same review procedures and remedial actions as any other claim included in the sample.

4.2 Outlier Review

The OIG will conduct ongoing periodic reviews to ensure the current reimbursement methodology remains efficacious.

4.3 Utah State Hospital Utilization Review

To ensure that Medicaid funds, as defined under 42 CFR 456, Subpart D, are expended appropriately and to make sure services provided to Medicaid recipients at the Utah State Hospital (USH) are necessary and of high quality, the OIG shall conduct oversight activities at the Utah State Hospital. Oversight activities included, but are not limited to:

a. *Quarterly Clinical Utilization Reviews*

On a quarterly basis, psychiatric staff in the OIG will review a sample of patients under age 21 and over age 64 who were reviewed by the USH utilization review staff during a previous quarter. Reviews will be performed to: (a) evaluate the USH utilization process, and (b) address the clinical topic selected for that quarter's review.

b. *Evaluations of USH Quality Assurance and Quality Improvement Programs*

Reviews of the USH Quality Improvement and Quality Assurance programs are

conducted to determine if: (a) the programs have been implemented in accordance with written hospital policy, (b) the programs are effective in meeting their stated goals, and (c) improvements or modifications are made to improve program design.

c. **Technical Assistance Assessments**

Psychiatric consultants may provide technical assistance and education to improve patient record keeping, clinical protocols and processes, quality of care, and utilization review programs. This review may be completed by other medically trained staff or staff that has been assigned by the OIG.

SECTION V ACCESS TO MEDICAL RECORDS

The OIG may request that any hospital send a photocopy of all or part of the medical record to the Department for in-house review, or may review the entire medical record on-site in the hospital.

If a hospital is non-compliant with the request for access to medical records, payment for care and services will be recovered.

SECTION VI SAFEGUARDING OF CLIENT INFORMATION

The use or dissemination of any information concerning an applicant/recipient for any purpose not directly connected with administration of the Medicaid Program is prohibited except by written consent of the applicant/recipient, his attorney, or his responsible parent or guardian (42 CFR 431, Subpart F).

SECTION VII FREE CHOICE OF PROVIDERS

7.1 Exception to Free Choice of Providers

A recipient may request service from any certified Utah Medicaid hospital provider subject to 42 CFR 431.51, the provisions of the Utah Freedom of Choice Waiver under Sections 1915 (b)(1) and (b)(2) of the Omnibus Reconciliation Act of 1981, and any other related waivers granted by the Center for Medicare and Medicaid Services (CMS).

A recipient who believes his freedom of choice of provider has been denied or impaired may request a fair hearing pursuant to 42 CFR 431.200.

7.2 Free Choice of Providers and Non-Covered Services

A recipient's participation in the Medicaid program does not preclude the recipient's right to seek and pay for services not covered by Medicaid.

SECTION VIII READMISSION REVIEW

8.1 Readmission Review

Whenever information available to the reviewer indicates the possibility of readmission to acute care within 30 days of the previous discharge, the OIG staff may review any claim which appears in the sample for:

- a. Readmission for the same or a similar diagnosis to the same hospital, or to a different hospital,
- b. Appropriateness of inter-facility transfers,
- c. Appropriateness of intra-facility transfers.

8.2 Similar Diagnosis

When applying this waiver provision, a similar diagnosis is defined as:

- a. Any diagnosis code using the same integer (the whole number after truncating from the entire decimal),
- b. Any exchange or combination of principal and secondary diagnosis,
- c. Any other sets of principal diagnoses established to be similar by Utah Medicaid policy in written criteria and published to the hospitals prior to service dates,
- d. Any psychiatric diagnosis within the ICD-9-CM diagnosis code range 290 to 319.

Appropriate, remedial action will be initiated for any of the above, when identified through the hospital utilization post-payment review process.

SECTION IX REMEDIAL ACTIONS

9.1 Appropriate Action

Appropriate remedial actions shall be taken when incorrectly paid claims are identified by the utilization review process. The reviewer shall determine the nature of the error, and may recommend appropriate remedial action. Remedial action may include, but is not limited to, adjustment or correction of a claim, denial or recoup of payment, or provider education and/or assistance with billing problems.

9.2 Notification

The OIG will issue written notification of remedial action to the hospital and physician providers. Such notice will be issued in accordance with 42 CFR, Part 431, Subpart E, and state administrative rules and regulations governing rights of providers.

All notices will contain, at a minimum, the following information:

1. Review process by which the determination was reached,
2. Findings and conclusions of the review,
3. Appropriate laws, rules, program memorandums, and provider manuals,
4. Remedial action,
5. Hearing rights, if the remedy involves a reduction, a denial or provider restrictions,
6. Procedures for requesting a hearing.

9.3 Hearings

Providers and recipients, who disagree with a remedial action or are adversely affected by remedial actions, may request an administrative hearing in accordance with OIG hearing policies. As part of that process, there is a pre-hearing. A pre-hearing conference will provide an opportunity to discuss the action, resolve questions, and clarify issues prior to proceeding with the formal hearing, if necessary.

SECTION X SAMPLING

10.1 Sample Size

Each month a minimum of 5 percent of a selected universe of claims previously adjudicated will be reviewed. A minimum of 2.5 percent of the claims shall be a random sample. Up to 2.5 percent may be a focused review on a specific service. An OIG decision to focus on a specific service shall be made no later than the 15th day of the month prior to the beginning of the sample cycle. If necessary, the universe of claims may be modified. However, at the discretion of the OIG, focused samples may be selected from a universe at the time the sample is selected.

The universe will be electronically selected from the Surveillance and Utilization Review System (SURS) or extracted from the Data Warehouse. The claims will consist of paid inpatient claims or selected from reports within the Department's Data Warehouse. The universe from which the random sample is selected is defined as all inpatient hospital claims adjudicated prior to the beginning of the review cycle, except:

- a. Claims with the first date of service prior to July 1, 2006,
- b. Claims showing, as a principal diagnosis, any ICD-9-CM delivery code in the range of 640 through 669.9, with 1 or 2 as the fifth digit; including 650; any claim with a diagnosis code of V27.0 to V27.9; any claim for a live born infant showing a principal diagnosis ICD-9-CM code V30 through V39, and other ICD-9-CM codes or DRG or DRG's as specified by policy or administrative decision,
- c. Claims which show \$00.00 payment by Medicaid,
- d. Interim bills,
- e. Medicare crossover claims,
- f. Claims with other codes or diagnosis determined by the OIG to be inappropriate for review,

The sample cycle shall begin on the first working day of each month and reflect claims paid in prior months.

10.2 Schedule

The schedule for the sample will proceed as follows:

<u>Activities</u>	<u>Ending Date</u>
Sample selection	15 th working day
Request records	20 th working day
Nurse review	85 th working day
OIG review	next scheduled meeting
Statistical summary	90 th working day

Each claim selected for inclusion in a sample, regardless of how the claim is selected for review, will be subject to: (1) review of appropriateness of admission using review protocols, criteria, guidelines, and standards as approved by the Department and (2) diagnostic and procedural coding review.

SECTION XI STATISTICAL REPORT

At the end of each quarter and again at the end of each waiver year, summary reports of all review activities will be generated by the OIG. These reports will include a measure of the cost effectiveness of the review process. The reports shall also include the number of cases reviewed in the sample, recoveries identified and actual recoveries. Likewise, the report will have major findings, problems identified in the reviews, and a narrative regarding any activities or developments which impact the review process, plus any pertinent information relative to findings.

SECTION XII OTHER CLAIRIFING INFORMATION

11.1 Other Utilization Review Functions

The utilization control process, as defined in 42 CFR Part 456, Subpart B, is separate and apart from the conditions of this waiver. However, the reviewers who perform the responsibilities outlined in this waiver may also perform utilization control functions as outlined in this subpart.

11.2 Identification of Possible Fraud and Abuse

The OIG has implemented the provisions of 42 CFR 455.12 through 42 CFR 455.23, Program Integrity.