

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Region VIII
1600 Broadway, Suite 700
Denver, CO 80202-4967

January 22, 2001

Michael Deily, Director
Division of Health Care Financing
Utah Department of Health
288 North 1460 West
Post Office Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Deily:

This letter acknowledges receipt of your correspondence dated November 20, 2000, in which you request an amendment to the Utah Medicaid Hospital Utilization Review Program, Superior Systems Waiver.

We have approved your proposal to amend the Superior Systems Waiver. It will facilitate payment of the entire hospital claim upon receipt, followed at least once each year, by a review of claims from each hospital based on a random sample. Additionally, the amendment will result in more timely reimbursements to hospitals, maintain the integrity of the review process, and reduce the number of claims requiring review.

Please incorporate the amendment into your Superior Systems Waiver and send two copies of the amended waiver to this office, attention Ruth Bailey.

The two year extension of the Inpatient Hospital Utilization Review Program Superior Systems Waiver (Title 42 Code of Federal Regulations, Part 456, Subpart C, Section 456.50 through 456.137) was granted through January 31, 2002.

If you wish to renew the Superior Systems Waiver, please send your request to this office at least 90 days prior to the expiration date of the waiver (January 31, 2002). Please address your renewal request to Ruth Bailey, Health Insurance Specialist, Health Care Financing Administration, 1600 Broadway, Suite 700, Denver, CO, 80202.

If you have any questions, please contact Ruth Bailey at 303-844-7031.

Sincerely yours,



Dave Selleck
Acting Associate Regional Administrator
Division of Medicaid & State Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

**Region VIII
1600 Broadway, Suite 700
Denver, CO 80202-4967**

March 2, 2000

Michael Deily, Director
Division of Health Care Financing
Utah Department of Health
288 North 1460 West
Post Office Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Deily:

The Health Care Financing Administration has reviewed the Utah Department of Health, Division of Health Care Financing's 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).

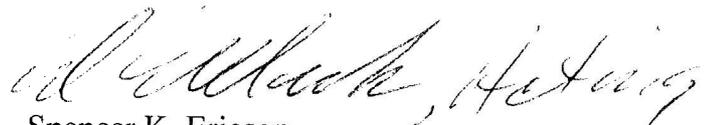
This waiver was originally granted in October 1982, and has since been renewed several times. Your narrative report for the past two years reflects substantial savings that total \$2,518,982.00. The sum includes savings to hospital utilization post payment review, prepayment outlier review savings, and savings in the review of all hospital claims when patients are readmitted within 30 days with the same or a similar diagnostic related group.

The Health Care Financing Administration has approved your request for a two-year extension of the Inpatient Hospital Utilization Review Waiver. This current two-year extension is granted through January 31, 2002.

If you decide to renew the Superior Waiver after January 31, 2002, please send your request to this office at least 90 days prior to the expiration date of the waiver. Please address your request for an additional renewal of the Superior Waiver to Ruth Bailey, Health Insurance Specialist, Health Care Financing Administration, 1600 Broadway, Suite 700, Denver, CO, 80202.

If you have any questions, please contact Ruth Bailey at 303-844-7031.

Sincerely yours,



Spencer K. Ericson
Associate Regional Administrator
Division of Medicaid & State Operations

Copies to:

F. Blake Anderson, Utah Department of Health, Division of Health Care Financing
Rachael Weinstein, HCFA, Office of Clinical Standards and Quality
Greg Watson, HCFA, Denver Regional Office
Sandy White, HCFA, Denver Regional Office
Tilly Rollin, HCFA, Denver Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

**Region VIII
1600 Broadway, Suite 700
Denver, CO 80202-4967**

March 2, 2000

Michael Deily, Director
Division of Health Care Financing
Utah Department of Health
288 North 1460 West
Post Office Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Deily:

The Health Care Financing Administration has reviewed the Utah Department of Health, Division of Health Care Financing's 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 waiver was originally granted in October 1982, and has since been renewed several times. Your narrative report for the past two years reflects substantial savings that total \$2,518,982.00. The sum includes savings to hospital utilization post payment review, prepayment outlier review savings, and savings in the review of all hospital claims when patients are readmitted within 30 days with the same or a similar diagnostic related group.

The Health Care Financing Administration has approved your request for a two-year extension of the Inpatient Hospital Utilization Review Waiver. This current two-year extension is granted through January 31, 2002.

If you decide to renew the Superior Waiver after January 31, 2002, please send your request to this office at least 90 days prior to the expiration date of the waiver. Please address your request for an additional renewal of the Superior Waiver to Ruth Bailey, Health Insurance Specialist, Health Care Financing Administration, 1600 Broadway, Suite 700, Denver, CO, 80202.

If you have any questions, please contact Ruth Bailey at 303-844-7031.

Sincerely yours,

Spencer K. Ericson
Associate Regional Administrator
Division of Medicaid & State Operations

Spencer K. Ericson: Utah Superior Waiver 2/29.doc

Copies to:

F. Blake Anderson, Utah Department of Health, Division of Health Care Financing

Rachael Weinstein, HCFA, Office of ~~Central~~ Standards and Quality

Greg Watson, HCFA, Denver Regional Office

Sandy White, HCFA, Denver Regional Office

Tilly Rollin, HCFA, Denver Regional Office

Office	Surname	Date	Office	Surname	Date	Office	Surname	Date
ESB	Bailey	3/2/00	DMSO	Sellack	3/2			
SOSB	Walker	03/02/00						

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DIVISION OF HEALTH
CARE FINANCING

State of Utah

Michael O. Leavitt
Governor

Rod L. Betit
Executive Director

Michael J. Deily
Division Director

2001 FEB 21 2:31
North 1400 West
PO Box 133701
Salt Lake City, Utah 84114-3701
Telephone (801) 538-6406
Fax (801) 538-6099

CRP-07-01

2:31

February 13, 2001

Ruth Bailey
Health Insurance Specialist
HCFA, Region VIII
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967

Dear Ms. Bailey:

Enclosed are two copies of the amended Superior Systems Waiver covering the change in the Outlier review process.

If you have questions or wish to discuss this information further, please contact F. Blake Anderson (801) 538-6149 or Urla Jeane Maxfield at (801) 538-9144.

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Deily".

Michael Deily, Director
Division of Health Care Financing

Enclosures (2)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

**Region VIII
1600 Broadway, Suite 700
Denver, CO 80202-4967**

July 26, 2000

Michael Deily, Director
Division of Health Care Financing
Utah Department of Health
288 North 1460 West
Post Office Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Deily:

This letter acknowledges receipt of your correspondence dated June 26, 2000, in which you request an amendment to the extended Superior Systems Waiver, that was approved on March 2, 2000.

The two year extension of the Inpatient Hospital Utilization Review Program Superior Systems Waiver (Title 42 Code of Federal Regulations, Part 456, Subpart C, Section 456.50 through 456.137) was granted through January 31, 2002.

After reviewing the proposed amendment, we are approving the additional requirements for utilization review and oversight of the Utah State Hospital.

Please incorporate the amendment into your Superior Systems Waiver and send two copies of the amended waiver to this office, attention Ruth Bailey.

If you wish to renew the Superior Systems Waiver, please send your request to this office at least 90 days prior to the expiration date of the waiver (January 31, 2002). Please address your renewal request to Ruth Bailey, Health Insurance Specialist, Health Care Financing Administration, 1600 Broadway, Suite 700, Denver, CO, 80202.

If you have any questions, please contact Ruth Bailey at 303-844-7031.

Sincerely yours,



Paul R. Long, M.D.
Acting Associate Regional Administrator
Division of Medicaid & State Operations

Copies to:

F. Blake Anderson, Utah Department of Health, Division of Health Care Financing

Rachael Weinstein, HCFA, Office of Clinical Standards and Quality

Greg Watson, HCFA, Denver Regional Office

Sandy White, HCFA, Denver Regional Office

Tilly Rollin, HCFA, Denver Regional Office



DIVISION OF HEALTH
CARE FINANCING

State of Utah

Michael O. Leavitt
Governor

Rod L. Betit
Executive Director

Michael J. Deily
Division Director

288 North 1460 West
PO Box 143101
Salt Lake City, Utah 84114-3101
Telephone: (801) 538-6406
Fax: (801) 538-6099

June 26, 2000

CRP-405-00

Ruth Bailey
Health Insurance Specialist
HCFA, Region VIII
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967

Dear Ms. Baily:

The State of Utah is formally requesting an amendment to the two-year-extension of the Inpatient Hospital Utilization Review Program Superior Systems Waiver (Title 42 of the Code of Federal Regulations, Part 456, Subpart C, Section 456.50 through 456.137). A two-year extension was provided by Spencer K. Ericson, Acting Associate Regional Administrator, within the letter of March 2, 2000, granting an extension through January 31, 2002. Mr. Ericson requested that additional renewal requests of the Superior Waiver, prior to January 31, 2002, be directed to Ruth Bailey.

Further review of the Superior Waiver has identified the need for an amendment providing utilization review and oversight for the Utah State Hospital. The attached amendment addresses the requirement for quarterly clinical utilization review of patients at the Utah State Hospital, a review of the Utah State Hospital's Quality Assurance Program and Utilization Review Program, and describes the intention of the state Medicaid agency to provide technical assistant and/or education to the Utah State Hospital to address issues identified during the utilization review process. (See attachment).

If you have questions or wish to discuss this information further, please contact F. Blake Anderson (801) 538-6149 or Marilyn Tucker at (801)538-6582.

Sincerely,

Michael Deily, Director
Division of Health Care Financing

2000 JUL 9 - 9 3 31

Enclosure

Amendment to Superior Systems Waiver Regarding Oversight of the Utah State Hospital

To ensure Medicaid funds are expended appropriately and to ensure services provided to Medicaid recipients at the Utah State Hospital are of high quality, the Medicaid agency shall conduct utilization review activities at the Utah State Hospital. These reviews will be conducted by a utilization review group under contract with the Medicaid agency. The reviews will include:

I. Quarterly Clinical Utilization Reviews

On a quarterly basis, a review of patient records will be conducted for a selected sample of patients hospitalized during the previous quarter. These reviews will be conducted for a 10% sample of patients under age 21 and for a 10% sample of adults ages 65 and older. If a 10% sample is equal to less than five patients, then a minimum of five patients must be reviewed.

From the total patient population during the previous quarter for the aforementioned age groups, samples may be randomly selected or based on the following:

- (1) referring community mental health center
- (2) custody status for patients under age 21, (i.e., parental or state custody)
- (3) other human services agency involvement
- (4) diagnosis
- (5) referrals from Medicaid agency psychiatric consultants due to concerns/issues raised as a result of their hospital admission certifications or disability determinations

Based on the initial findings, a minimum of three additional patients must be selected for review if a more in-depth review is needed.

II. Review of Utah State Hospital Quality Assurance and Utilization Review Programs

Reviews of the Utah State Hospital's Quality Assurance Program and Utilization Review Program shall also be conducted to determine whether (1) the programs have been implemented in accordance with written hospital policy, (2) the programs are effective in meeting their stated goals, and (3) modifications in the programs need to be made to improve their effectiveness.

III. Technical Assistance

Based on these reviews, the Medicaid agency may provide technical assistance and education to assist the Utah State Hospital to improve patient record keeping, quality of care, and the Quality Assurance and Utilization Review programs.

Region VIII
1600 Broadway, Suite 700
Denver, CO 80202-4967

January 22, 2001

Michael Deily, Director
Division of Health Care Financing
Utah Department of Health
288 North 1460 West
Post Office Box 143101
Salt Lake City, Utah 84114-3101

Dear Mr. Deily:

This letter acknowledges receipt of your correspondence dated November 20, 2000, in which you request an amendment to the Utah Medicaid Hospital Utilization Review Program, Superior Systems Waiver.

We have approved your proposal to amend the Superior Systems Waiver. It will facilitate payment of the entire hospital claim upon receipt, followed at least once each year, by a review of claims from each hospital based on a random sample. Additionally, the amendment will result in more timely reimbursements to hospitals, maintain the integrity of the review process, and reduce the number of claims requiring review.

Please incorporate the amendment into your Superior Systems Waiver and send two copies of the amended waiver to this office, attention Ruth Bailey.

The two year extension of the Inpatient Hospital Utilization Review Program Superior Systems Waiver (Title 42 Code of Federal Regulations, Part 456, Subpart C, Section 456.50 through 456.137) was granted through January 31, 2002.

If you wish to renew the Superior Systems Waiver, please send your request to this office at least 90 days prior to the expiration date of the waiver (January 31, 2002). Please address your renewal request to Ruth Bailey, Health Insurance Specialist, Health Care Financing Administration, 1600 Broadway, Suite 700, Denver, CO, 80202.

If you have any questions, please contact Ruth Bailey at 303-844-7031.

Sincerely yours,

Dave Selleck
Acting Associate Regional Administrator
Division of Medicaid & State Operations

Copies to:

F. Blake Anderson, Utah Department of Health, Division of Health Care Financing

Rachael Weinstein, HCFA, Office of Clinical Standards and Quality

Greg Watson, HCFA, Denver Regional Office

Diana Friedli, HCFA, Denver Regional Office

Office	Surname	Date	Office	Surname	Date	Office	Surname	Date
SSSB	Bailey	1/22/01	DWFD	Selleck	1/22			
SSSB	LEIKER	1/22/01						

FILE COPY



DIVISION OF HEALTH CARE FINANCING

State of Utah

Michael O. Leavitt
Governor
Rod L. Betit
Executive Director
Michael J. Deily
Division Director

288 North 1400 West
PO Box 143101
Salt Lake City, Utah 84110-3101
Telephone: (801) 538-6106
(801) 538-6000

CRP 691-00

2000 NOV 21 P 2:09

November 20, 2000

Ruth Bailey, Health Insurance Specialist
Health Care Financing Administration
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967

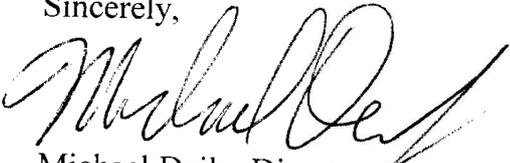
Dear Ms. Bailey:

Enclosed is a proposal to amend the Utah Medicaid Hospital Utilization Review Program, Superior System Waiver, Amended, November 1999. The proposed amendment addresses a change in the outlier review process from pre-payment review of all claims where the stay exceeds the DRG payment threshold to post-payment review based on a random sample.

Outlier Review is a Utilization Management Program associated with the Superior System Waiver program. The program involves review of claims and limitation of payment where the length of stay has exceeded the outlier trim point, and continued stay in an acute care setting is no longer appropriate. This proposed change would facilitate payment of the entire hospital claim upon receipt, followed, at least once each year, by a review of claims from each hospital based on a random sample. This change would result in more timely reimbursement to the hospital, maintain the integrity of the review process, and reduce the number of claims requiring review.

This amendment is proposed in response to discussion with providers and efforts to be sensitive to their needs. Over the last few years, a number of hospitals have adopted the same InterQual criteria in their Utilization Management programs as used by Medicaid. This has resulted in significantly fewer disallowances, but outliers are still generated.

If you have questions or wish to discuss this information further, please call F. Blake Anderson at (801) 538-6149 or Urla Jeane Maxfield at (801) 538-9144.

Sincerely,

Michael Deily, Director
Division of Health Care Financing

Enclosure

Amendment to "Hospital Utilization Review Program, Superior System Waiver, November 1999. (Amended)

Page 4 and 5, Pre-Payment Outlier Review is amended by striking the existing wording of this section and replacing it with the following:

Outlier Review. The purpose of outlier review is to assure Medicaid payment only for those days beyond the outlier trim point where continued stay in an acute care setting is appropriate. Full payment will initially be made on all claims received. Any claim which exceeds the outlier threshold will be part of the universe to be evaluated. At least once each year, hospitals with documented claims which reached the outlier payment trim point will have a statistically valid sample of claims selected for audit. Documentation supporting the selected claims will be evaluated for appropriateness of admission and continued stay, accuracy of diagnosis and DRG assignment, relevant discharge planning, and appropriateness of transfers to other facilities/units. InterQual criteria will be used to validate the findings. A decision on appropriateness of payment will be made based on review and findings.

After the audit of outlier claims for a facility is completed, the payment made for days found not to be appropriate will be divided by the total expenditures in the sample selected. The resulting proportion of inappropriate payments will then be applied to the total amount paid to the facility for outlier days for the period reviewed. The facility will be notified of the projected amount of overpayment along with the reasons payment for the outlier days was determined to be inappropriate. A request for recovery of the overpayment will be made. The facility will have an opportunity to challenge the findings of the audit with clarifying information. However, once the sample has been selected and the submitted documentation reviewed, the record will be considered closed.

UTAH DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING
BUREAU OF COVERAGE & REIMBURSEMENT POLICY

HOSPITAL UTILIZATION REVIEW PROGRAM
SUPERIOR SYSTEM WAIVER (AMENDED, 2-13-01)

Salt Lake City, Utah

November 1999

SUPERIOR SYSTEM WAIVER

AUTHORITY

The authority for the evaluation of each Medicaid recipient's or applicant's need for admission and continued stay in an acute care general hospital and of the quality of the care provided is defined in the Utah State Plan, Attachment 4.19-A and 42 Code of Federal Regulations 456.121 through 456.127. The waiver of utilization review requirements, as applied for, is defined under 42 CFR, Part 456, Subpart H. This waiver will include utilization review for the Utah State Hospital.

The provisions of the Hospital Utilization Review Program shall be governed by the Social Security Act, the laws of the State of Utah, under authority as granted by regulation set forth in the 42 Code of Federal Regulations and Utah State Plan under Title XIX, with which the Division of Health Care Financing ensures compliance.

As of the date of this Hospital Utilization Review Policy, reimbursement for inpatient hospital services is described in Attachment 4.19-A of the Utah State Plan under Title XIX, effective July 1, 1989, and incorporated as periodically amended. This policy establishes a prospective payment diagnosis related group (DRG) based reimbursement program for all hospitals except the Utah State Hospital and rural hospitals which are defined in the Utah State Plan.

Although Utah pays a per diem for day outliers, additional per diem reimbursement for cost outliers is not provided. The methods of utilization review reflect this policy in that appropriateness of payment for outlier days is reviewed for claims as they appear as cases in the sample. This review does not take the place of pre-payment outlier review, described in this document under Related Programs.

In order to meet the requirements of the Hospital Utilization Review Program, the Division of Health Care Financing, (hereafter called Division) has assigned the Bureau of Coverage & Reimbursement Policy, Utilization Management Unit (hereafter referred to as Bureau and Unit respectively) responsibility for utilization review. The Bureau has the authority to develop and implement procedures and protocols to achieve the stated purposes of the program.

PURPOSE

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

1. Admission to a hospital or a designated distinct part unit within a hospital,
2. Transfer 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. Transfer from an acute care setting to a distinct part rehabilitation or psychiatric unit within the same facility (intra-facility transfer),
4. Continued stay:
 - a. Beyond the outlier cutoff or trim point for urban hospitals, and
 - b. For each day of continued stay for rural hospitals.
5. Surgical and invasive diagnostic procedures.

The Hospital Utilization Review program will also perform reviews to:

1. Validate the principal diagnosis and/or principal operative procedure on the paid claim are accurate, consistent with the attending physician's determination and documentation as found in the patient's medical record,
2. Validate the presence of comorbidity, as found on the claim, is accurate and correct, consistent with the attending physician's determination and 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. Assure provider compliance with state and federal regulation.

UTILIZATION REVIEW COMMITTEE

A Utilization Review Committee (hereafter referred to as Committee) shall be established and maintained within the Bureau. The chairperson of the Committee shall be a physician licensed to practice in the State of Utah and an employee of, or contracted by, the Department of Health.

Membership

Members of the Committee authorized to vote on Committee actions shall be physicians licensed to practice in the State of Utah, who are members of the consultant panel for Health Care Financing or employees of the Department of Health; registered nurses licensed to practice in the State of Utah, employed by the Department of Health, and considered to be capable of performing utilization review; and other professional Division of Health Care Financing 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 would not be voting members of the Committee.

The Committee shall not include any member who is responsible for the care of a patient, whose care is being reviewed, or who has financial interest in any hospital or nursing care facility.

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 includes, but is not limited to:

1. Recommending and approving adoption of review protocols, criteria, guidelines, and standards to support the purpose of Hospital Utilization Review.
2. Making medical determinations, including appropriateness of care and services,
3. Recommending one or more areas of focus for a particular review sample,
4. Recommending further study of individual hospitals, physicians, or patients, and of specific diagnoses, procedures, or other issues,
5. Intervening on a professional basis with hospitals, hospital professional committees, and physicians,
6. Seeking additional consultation as needed,
7. Recommending and approving written criteria defining similar principal diagnoses and similar principal procedures,
8. Recommending initiation of remedial actions.

At least two physician members, including the chairperson, and two other committee members must be present at a regularly scheduled meeting before a remedial action against a provider can be recommended.

Meetings

The Committee will meet bimonthly on a regularly scheduled basis when there is Superior Waiver business to conduct. Unscheduled meetings may be called on a more frequent basis to meet the needs of the program.

Emergency Meetings

An unscheduled, or emergency meeting of the Committee may be held with attendees present, or may be conducted as a telephone conference. At least three members of the

Committee, two of whom must be physician members, must be included. All remedial actions require the signatures of at least two physicians who participated in the decision. The following actions may be taken during an emergency meeting:

1. Recommendation for adoption of review protocols, criteria, and other review standards,
2. Recommendation, approval, and scheduling of remedial actions.

When review protocols, criteria, guidelines, and standards are recommended for adoption, at times other than regularly scheduled meetings of the Committee as described above, they will be presented to the full Committee for approval and voting at the next regularly scheduled Committee meeting.

When any decision is made on recommended remedial action(s) during an emergency meeting as described above, the decision is final and requires no further review or other action by the full Committee.

RELATED PROGRAMS

The Hospital Utilization Review Program will develop and sustain cooperative relationships with other units, sections, and bureaus, within the Division of Health Care Financing, the Utah Department of Health, and with other state agencies as necessary and appropriate. This waiver does not specify the scope of related programs which are governed by the State Plan under Title XIX and independent state rule-making. The following are brief descriptions of some of the programs most closely related to hospital utilization review and is provided for information only.

Prior Authorization Program. The Utilization Management Unit staff process prior authorization requests for specific surgical, medical, dental, drug, medical supplies, or other services. Any inpatient hospital claims for service which were prior authorized are included in the universe for sample selection, and may also be subjected to outlier review. If any inpatient hospital claim with prior authorized service is selected as part of the sample, it will be subject to the same review procedures and remedial actions as any other claim included in the sample.

Outlier Review. The purpose of outlier review is to assure Medicaid payment only for those days beyond the outlier trim point where continued stay in an acute care setting is appropriate. Full payment will initially be made on all claims received. Any claim which exceeds the outlier threshold will be part of the universe to be evaluated. At least once each year, hospitals with documented claims which reached the outlier payment trim point will have a statistically valid sample of claims selected for audit. Documentation supporting the selected claims will be evaluated for appropriateness of admission and continued stay, accuracy of diagnosis and DRG assignment, relevant discharge planning, and appropriateness of transfers to other facilities/units. InterQual criteria will be used to validate the findings. A decision on appropriateness of payment will be made based on review and findings.

After the audit of outlier claims for a facility is completed, the payment made for days found not to be appropriate will be divided by the total expenditures in the sample selected. The resulting proportion of inappropriate payments will then be applied to the total amount paid to the facility for outlier days for the period reviewed. The facility will be notified of the projected amount of overpayment along with the reasons payment for the outlier days was determined to be inappropriate. A request for recovery of the overpayment will be made. The facility will have an opportunity to challenge the findings of the audit with clarifying information. However, once the sample has been selected and the submitted documentation reviewed, the record will be considered closed.

Utah State Hospital Utilization Review. To ensure Medicaid funds are appropriately expended and health care services are of high quality, the Utilization Management Unit in Medicaid will contract with a utilization review group to complete:

1. **Quarterly Clinical Utilization Reviews**

A patient random sample of patients under 21 years of age (10%) and adults 65 and over (10%) will be pulled from patients receiving care over the previous quarter. If the sample size is less than 10% within each grouping, a minimum of five patients must be reviewed. The total patient random sample groups may be based on the following:

- a. Referring community mental health center
- b. Custody status for patients under age 21 (i.e., parental or state custody)
- c. Other human services agency involvement
- d. Diagnosis
- e. Referrals from Medicaid agency psychiatric consultants due to concerns/issues raised as a result of their hospital admission certifications or disability determinations

Based on the initial findings, a minimum of three additional patients must be selected for review if a more in-depth review is needed.

2. **Review of the Utah State Hospital's Quality Assurance Program and Utilization Review Program shall also be conducted to determine whether:**

- The programs have been implemented in accordance with written hospital policy,
- The programs are effective in meeting their stated goals, and
- The programs require modifications to improve their effectiveness.

3. **Based on these reviews, the Medicaid agency may provide technical assistance and education to assist the Utah State Hospital to improve patient record keeping, quality of care, and the Quality Assurance and Utilization Review Programs.**

Utilization Control. The utilization control process, as defined under 42 Code of Federal Regulations, 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 also perform utilization control functions as outlined in this subpart.

Identification of Possible Fraud and Abuse. Referral to the Medicaid Agency Fraud Detection and Investigation Program is implemented consistent with 42 CFR 455.12 through 42 CFR 455.23.

ACCESS TO MEDICAL RECORDS

The Utilization Management staff may request that the 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 provided during the admission may be recovered. The Committee will make recommendations on the proper course of action in these cases.

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 on written consent of the applicant/recipient, his attorney, or his responsible parent or guardian (42 CFR 431, Subpart F).

FREE CHOICE OF PROVIDERS

A recipient may request service from any certified hospital provider subject to 42 CFR 431.51, and provisions of the Utah Freedom of Choice Waiver under Sections 1915 (b)(1) and (b)(2) of the Omnibus Reconciliation Act of 1981.

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.

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.

REMEDIAL ACTIONS

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 recommend appropriate remedial action to the Committee. Remedial action may include, but is not limited to, adjustment or correction of a claim, denial or recoupment of payment, or education and assistance with billing problems.

Failure on the part of a provider to correct any claim, when notified of the error, may result in loss of payment for the claim or claims affected.

NOTIFICATION

The Utilization Unit Manager or her designee, shall at the recommendation of the Committee, issue written notification of remedial action to the hospital and physician providers. Such notice will be issued in accordance with 42 Code of Federal Regulations, Part 431, Subpart E, and state administrative rules and regulations governing rights of providers to hearings.

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. Remedial action that will be taken,
4. Hearing rights, if the remedy involves a loss or restriction of benefits to the provider or the recipient,
5. Procedures for requesting a hearing.

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 Division hearing policies. A pre-hearing conference will provide an opportunity to discuss the action, resolve questions, and clarify issues prior to proceeding with the formal hearing.

READMISSION REVIEW ACTIVITIES

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

1. Any readmission for the same or a similar diagnosis to the same hospital, or to a different hospital,
2. Appropriateness of inter-facility transfers,
3. Appropriateness of intra-facility transfers.

A similar diagnosis is defined as:

1. Any diagnosis code using the same integer (the whole number after truncating from the entire decimal),
2. Any exchange or combination of principal and secondary diagnosis,
3. Any other sets of principal diagnoses established to be similar by the Committee in written criteria and published to the hospitals prior to service dates,
4. 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 hospital utilization post-payment review.

SAMPLING REVIEW ACTIVITIES

Each month five percent of a selected universe of claims adjudicated the previous month will be reviewed. A minimum of 2.5 percent of the claims to be reviewed will be a random sample. Up to 2.5 percent may be a focused review on a specific service, as determined by the Committee. A Committee decision to focus on a specific service will be made no later than the 15th day of the month prior to the beginning of the sample cycle so that, if necessary, the universe of claims may be modified. However, at the discretion of administrative staff, a focused sample may be selected from a universe at the time the sample is pulled.

The universe will be electronically selected from the Surveillance and Utilization Review System (S/URS) history of paid inpatient claims, and will automatically be generated at the beginning of each month. The universe from which the random sample is selected is defined as all inpatient hospital claims adjudicated within the month prior to the beginning of the review cycle, except:

1. Claims with first date of service prior to July 1, 1997, adjusted claims, crossover claims, and claims submitted by out-of-state hospitals,
2. 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 DRGs as specified by policy or administrative decision,
3. Claims which show an aide category of: "D" (Utah Medical Assistance Program),
4. Claims which show \$00.00 payment by Medicaid,
5. Interim bills.

Herbert Arkin's Table of 120,000 Random Decimal Digits is used for random sample selection.

The sample cycle shall begin on the first work day of each month and reflect claims paid in the prior month. An exception to this may occur when the MMIS system is unable to provide an electronically selected universe of a S/URS history of adjudicated claims in a timely manner. If an exception occurs, sampling of a minimum of five percent of claims adjudicated during the period of exception must be assured.

The schedule for the sample will proceed as follows:

Activities	Ending Date
Sample selection	15 th working day
Request records	20 th working day
Nurse review	85 th working day
Committee 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 recommended and approved by the Committee; (2) diagnostic and procedural coding review; (3) review of appropriateness of continued stay through outlier review.

STATISTICAL REPORTS

At the end of each quarter and again at the end of each waiver year, summary reports of all review activities will be generated. These reports will include a measure of the cost effectiveness of the review process. The report shall include the number of cases in the sample, amount denied, days denied, and reasons for denials. The report shall also include major findings/problems identified in the reviews, and a report of any activities or developments which impact the review process.



DIVISION OF HEALTH
CARE FINANCING

State of Utah

Michael O. Leavitt
Governor

Rod L. Betit
Executive Director

Michael J. Deily
Division Director

2000 AUG 28 P 2:49

288 North 1460 West
PO Box 143101
Salt Lake City, Utah 84114-3101
Telephone: (801) 538-6406
Fax: (801) 538-6099

CRP-512-00

August 22, 2000

Ruth Bailey
Health Insurance Specialist
HCFA, Region VIII
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967

Dear Ms. Bailey:

Enclosed are two copies of the amended Superior Systems Waiver covering the additional requirements for utilization review and oversight of the Utah State Hospital.

If you have questions or wish to discuss this information further, please contact F. Blake Anderson (801) 538-6149 or Linda Morris at (801) 538-6731.

Sincerely,

Michael Deily, Director
Division of Health Care Financing

Enclosure (2)

UTAH DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING
BUREAU OF COVERAGE & REIMBURSEMENT POLICY

HOSPITAL UTILIZATION REVIEW PROGRAM
SUPERIOR SYSTEM WAIVER (AMENDED)

Salt Lake City, Utah

November 1999

SUPERIOR SYSTEM WAIVER

AUTHORITY

The authority for the evaluation of each Medicaid recipient's or applicant's need for admission and continued stay in an acute care general hospital and of the quality of the care provided is defined in the Utah State Plan, Attachment 4.19-A and 42 Code of Federal Regulations 456.121 through 456.127. The waiver of utilization review requirements, as applied for, is defined under 42 CFR, Part 456, Subpart H. This waiver will include utilization review for the Utah State Hospital.

The provisions of the Hospital Utilization Review Program shall be governed by the Social Security Act, the laws of the State of Utah, under authority as granted by regulation set forth in the 42 Code of Federal Regulations and Utah State Plan under Title XIX, with which the Division of Health Care Financing ensures compliance.

As of the date of this Hospital Utilization Review Policy, reimbursement for inpatient hospital services is described in Attachment 4.19-A of the Utah State Plan under Title XIX, effective July 1, 1989, and incorporated as periodically amended. This policy establishes a prospective payment diagnosis related group (DRG) based reimbursement program for all hospitals except the Utah State Hospital and rural hospitals which are defined in the Utah State Plan.

Although Utah pays a per diem for day outliers, additional per diem reimbursement for cost outliers is not provided. The methods of utilization review reflect this policy in that appropriateness of payment for outlier days is reviewed for claims as they appear as cases in the sample. This review does not take the place of pre-payment outlier review, described in this document under Related Programs.

In order to meet the requirements of the Hospital Utilization Review Program, the Division of Health Care Financing, (hereafter called Division) has assigned the Bureau of Coverage & Reimbursement Policy, Utilization Management Unit (hereafter referred to as Bureau and Unit respectively) responsibility for utilization review. The Bureau has the authority to develop and implement procedures and protocols to achieve the stated purposes of the program.

PURPOSE

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

1. Admission to a hospital or a designated distinct part unit within a hospital,
2. Transfer 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. Transfer from an acute care setting to a distinct part rehabilitation or psychiatric unit within the same facility (intra-facility transfer),
4. Continued stay:
 - a. Beyond the outlier cutoff or trim point for urban hospitals, and
 - b. For each day of continued stay for rural hospitals.
5. Surgical and invasive diagnostic procedures.

The Hospital Utilization Review program will also perform reviews to:

1. Validate the principal diagnosis and/or principal operative procedure on the paid claim are accurate, consistent with the attending physician's determination and documentation as found in the patient's medical record,
2. Validate the presence of comorbidity, as found on the claim, is accurate and correct, consistent with the attending physician's determination and 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. Assure provider compliance with state and federal regulation.

UTILIZATION REVIEW COMMITTEE

A Utilization Review Committee (hereafter referred to as Committee) shall be established and maintained within the Bureau. The chairperson of the Committee shall be a physician licensed to practice in the State of Utah and an employee of, or contracted by, the Department of Health.

Membership

Members of the Committee authorized to vote on Committee actions shall be physicians licensed to practice in the State of Utah, who are members of the consultant panel for Health Care Financing or employees of the Department of Health; registered nurses licensed to practice in the State of Utah, employed by the Department of Health, and considered to be capable of performing utilization review; and other professional Division of Health Care Financing 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 would not be voting members of the Committee.

The Committee shall not include any member who is responsible for the care of a patient, whose care is being reviewed, or who has financial interest in any hospital or nursing care facility.

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 includes, but is not limited to:

1. Recommending and approving adoption of review protocols, criteria, guidelines, and standards to support the purpose of Hospital Utilization Review.
2. Making medical determinations, including appropriateness of care and services,
3. Recommending one or more areas of focus for a particular review sample,
4. Recommending further study of individual hospitals, physicians, or patients, and of specific diagnoses, procedures, or other issues,
5. Intervening on a professional basis with hospitals, hospital professional committees, and physicians,
6. Seeking additional consultation as needed,
7. Recommending and approving written criteria defining similar principal diagnoses and similar principal procedures,
8. Recommending initiation of remedial actions.

At least two physician members, including the chairperson, and two other committee members must be present at a regularly scheduled meeting before a remedial action against a provider can be recommended.

Meetings

The Committee will meet bimonthly on a regularly scheduled basis when there is Superior Waiver business to conduct. Unscheduled meetings may be called on a more frequent basis to meet the needs of the program.

Emergency Meetings

An unscheduled, or emergency meeting of the Committee may be held with attendees present, or may be conducted as a telephone conference. At least three members of the Committee, two of whom must be physician members, must be included. All remedial actions require the signatures of at least two physicians who participated in the decision. The following actions may be taken during an emergency meeting:

1. Recommendation for adoption of review protocols, criteria, and other review standards,
2. Recommendation, approval, and scheduling of remedial actions.

When review protocols, criteria, guidelines, and standards are recommended for adoption, at times other than regularly scheduled meetings of the Committee as described above, they will be presented to the full Committee for approval and voting at the next regularly scheduled Committee meeting.

When any decision is made on recommended remedial action(s) during an emergency meeting as described above, the decision is final and requires no further review or other action by the full Committee.

RELATED PROGRAMS

The Hospital Utilization Review Program will develop and sustain cooperative relationships with other units, sections, and bureaus, within the Division of Health Care Financing, the Utah Department of Health, and with other state agencies as necessary and appropriate. This waiver does not specify the scope of related programs which are governed by the State Plan under Title XIX and independent state rule-making. The following are brief descriptions of some of the programs most closely related to hospital utilization review and is provided for information only.

Prior Authorization Program. The Utilization Management Unit staff process prior authorization requests for specific surgical, medical, dental, drug, medical supplies, or other services. Any inpatient hospital claims for service which were prior authorized are included in the universe for sample selection, and may also be subjected to outlier review. If any inpatient hospital claim with prior authorized service is selected as part of the sample, it will be subject to the same review procedures and remedial actions as any other claim included in the sample.

Pre-Payment Outlier Review. The purpose of pre-payment outlier review is to assure Medicaid payment only for those days where continued stay in an acute care setting beyond the outlier trim point is appropriate. Since July 1988, hospitals have initiated outlier review by submitting an Outlier Transmittal Form and supporting documentation from the appropriate medical records. The documentation is reviewed

for appropriateness of admission and of continued stay, correctness of diagnoses and DRG assignment, discharge planning, and appropriateness of transfers to other facilities/units. A decision to pay all or part of the outlier days is made based on review and findings.

The on-site outlier review project implemented as part of the Waiver program with the previous renewal of this Waiver has been expanded to include all of the tertiary care facilities and is a permanent part of the pre-payment outlier review program.

The number of outlier days approved for payment are recorded on the Transmittal Form and sent to Medicaid Operations. A copy of the completed form is returned to the provider. In addition, providers are notified in writing when payment is not approved for any days. The written notice includes the number of days approved for payment, the number of days denied for payment, and reasons for denial of payment.

Information from each Transmittal Form processed is entered into a computerized database, making it possible to perform statistical analysis of the outlier data, or for information retrieval.

Utah State Hospital Utilization Review. To ensure Medicaid funds are appropriately expended and health care services are of high quality, the Utilization Management Unit in Medicaid will contract with a utilization review group to complete:

1. Quarterly Clinical Utilization Reviews

A patient random sample of patients under 21 years of age (10%) and adults 65 and over (10%) will be pulled from patients receiving care over the previous quarter. If the sample size is less than 10% within each grouping, a minimum of five patients must be reviewed. The total patient random sample groups may be based on the following:

- a. Referring community mental health center
- b. Custody status for patients under age 21 (i.e., parental or state custody)
- c. Other human services agency involvement
- d. Diagnosis
- e. Referrals from Medicaid agency psychiatric consultants due to concerns/issues raised as a result of their hospital admission certifications or disability determinations

Based on the initial findings, a minimum of three additional patients must be selected for review if a more in-depth review is needed.

2. Review of the Utah State Hospital's Quality Assurance Program and Utilization Review Program shall also be conducted to determine whether:
- The programs have been implemented in accordance with written hospital policy,
 - The programs are effective in meeting their stated goals, and
 - The programs require modifications to improve their effectiveness.

3. Based on these reviews, the Medicaid agency may provide technical assistance and education to assist the Utah State Hospital to improve patient record keeping, quality of care, and the Quality Assurance and Utilization Review Programs.

Utilization Control. The utilization control process, as defined under 42 Code of Federal Regulations, 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 also perform utilization control functions as outlined in this subpart.

Identification of Possible Fraud and Abuse. Referral to the Medicaid Agency Fraud Detection and Investigation Program is implemented consistent with 42 CFR 455.12 through 42 CFR 455.23.

ACCESS TO MEDICAL RECORDS

The Utilization Management staff may request that the 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 provided during the admission may be recovered. The Committee will make recommendations on the proper course of action in these cases.

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 on written consent of the applicant/recipient, his attorney, or his responsible parent or guardian (42 CFR 431, Subpart F).

FREE CHOICE OF PROVIDERS

A recipient may request service from any certified hospital provider subject to 42 CFR 431.51, and provisions of the Utah Freedom of Choice Waiver under Sections 1915 (b)(1) and (b)(2) of the Omnibus Reconciliation Act of 1981.

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.

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.

REMEDIAL ACTIONS

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 recommend appropriate remedial action to the Committee. Remedial action may include, but is not limited to, adjustment or correction of a claim, denial or recoupment of payment, or education and assistance with billing problems.

Failure on the part of a provider to correct any claim, when notified of the error, may result in loss of payment for the claim or claims affected.

NOTIFICATION

The Utilization Unit Manager or her designee, shall at the recommendation of the Committee, issue written notification of remedial action to the hospital and physician providers. Such notice will be issued in accordance with 42 Code of Federal Regulations, Part 431, Subpart E, and state administrative rules and regulations governing rights of providers to hearings.

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. Remedial action that will be taken,
4. Hearing rights, if the remedy involves a loss or restriction of benefits to the provider or the recipient,
5. Procedures for requesting a hearing.

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 Division hearing policies. A pre-hearing conference will provide an opportunity to discuss the action, resolve questions, and clarify issues prior to proceeding with the formal hearing.

READMISSION REVIEW ACTIVITIES

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

1. Any readmission for the same or a similar diagnosis to the same hospital, or to a different hospital,
2. Appropriateness of inter-facility transfers,
3. Appropriateness of intra-facility transfers.

A similar diagnosis is defined as:

1. Any diagnosis code using the same integer (the whole number after truncating from the entire decimal),
2. Any exchange or combination of principal and secondary diagnosis,
3. Any other sets of principal diagnoses established to be similar by the Committee in written criteria and published to the hospitals prior to service dates,
4. 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 hospital utilization post-payment review.

SAMPLING REVIEW ACTIVITIES

Each month five percent of a selected universe of claims adjudicated the previous month will be reviewed. A minimum of 2.5 percent of the claims to be reviewed will be a random sample. Up to 2.5 percent may be a focused review on a specific service, as determined by the Committee. A Committee decision to focus on a specific service will be made no later than the 15th day of the month prior to the beginning of the sample cycle so that, if necessary, the universe of claims may be modified. However, at the discretion of administrative staff, a focused sample may be selected from a universe at the time the sample is pulled.

The universe will be electronically selected from the Surveillance and Utilization Review System (S/URS) history of paid inpatient claims, and will automatically be generated at the beginning of each month. The universe from which the random sample is selected is defined as all inpatient hospital claims adjudicated within the month prior to the beginning of the review cycle, except:

1. Claims with first date of service prior to July 1, 1997, adjusted claims, crossover claims, and claims submitted by out-of-state hospitals,
2. 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 DRGs as specified by policy or administrative decision,

3. Claims which show an aide category of: "D" (Utah Medical Assistance Program),
4. Claims which show \$00.00 payment by Medicaid,
5. Interim bills.

Herbert Arkin's Table of 120,000 Random Decimal Digits is used for random sample selection.

The sample cycle shall begin on the first work day of each month and reflect claims paid in the prior month. An exception to this may occur when the MMIS system is unable to provide an electronically selected universe of a S/URS history of adjudicated claims in a timely manner. If an exception occurs, sampling of a minimum of five percent of claims adjudicated during the period of exception must be assured.

The schedule for the sample will proceed as follows:

Activities	Ending Date
Sample selection	15 th working day
Request records	20 th working day
Nurse review	85 th working day
Committee 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 recommended and approved by the Committee; (2) diagnostic and procedural coding review; (3) review of appropriateness of continued stay through outlier review.

STATISTICAL REPORTS

At the end of each quarter and again at the end of each waiver year, summary reports of all review activities will be generated. These reports will include a measure of the cost effectiveness of the review process. The report shall include the number of cases in the sample, amount denied, days denied, and reasons for denials. The report shall also include major findings/problems identified in the reviews, and a report of any activities or developments which impact the review process.



DIVISION OF HEALTH
CARE FINANCING

State of Utah

1998 NOV 5 AM 9 01

Michael O. Leavitt
Governor

Rod L. Betit
Executive Director

Michael J. Deily
Division Director

288 North 1460 West
PO Box 143101
Salt Lake City, Utah 84114-3101
Telephone: (801) 538-6406
Fax: (801) 538-6099

CRP-702-99

October 28, 1999

Spencer K. Ericson
Associate Regional Administrator
Health Care Financing Administration, Region VIII
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

Dear Mr. Erickson:

The State of Utah is formally requesting a two-year extension of the Inpatient Hospital Utilization Review Waiver, which was originally granted in October 1982, and extended through January 31, 1998.

This request for an extension of the waiver of utilization review requirements in Title 42 Code of Federal Regulations, Part 456, subpart C, sections 456.50 through 456.137, is based on a belief in the continued superiority of this program. In the past two years of the waiver, inpatient hospital utilization review has included post-payment review of inpatient hospital claims, prepayment review of continued stay beyond the outlier trim point for providers reimbursed under the DRG prospective payment system, preadmission certification of psychiatric and rehabilitation hospitalizations, and review of readmission within 30 days.

Nurse reviewers continue to validate the principal diagnosis and principal operative procedure are consistent with the attending physician's determination and documentation found in the medical record; review for appropriateness of admission and continued stay; monitor for compliance with state and federal requirements; and review for appropriateness and quality of care provided to the patient.

The Hospital Utilization Review Program continues to be cost effective through recoupment of payment made for inappropriate admissions and length of stay. In addition, the review process identifies areas where changes in policy or reimbursement methodology can save Medicaid resources.

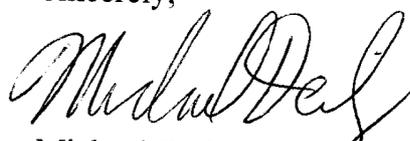
With this request for a two-year extension of the inpatient hospital utilization review

Spencer K. Ericson
October 28, 1999
Page 2

waiver, a narrative report of the activities, impact and projected cost savings of the review program for the years 1998 and 1999 is included for your review, along with a copy of the Hospital Utilization Review Superior System Waiver.

If you have questions or wish to discuss this information further, please contact F. Blake Anderson or Ann Petersen at (801) 538-9127.

Sincerely,

A handwritten signature in cursive script, appearing to read "Michael Deily".

Michael Deily, Director
Division of Health Care Financing

Enclosure

UTAH DEPARTMENT OF HEALTH

A REPORT OF THE ACTIVITIES AND IMPACT OF
THE HOSPITAL UTILIZATION REVIEW PROGRAM

DIVISION OF HEALTH CARE FINANCING
MICHAEL DEILY, DIRECTOR

Salt Lake City, Utah
November 1999

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EXECUTIVE SUMMARY

Review activities conducted under the conditions set forth in the Superior System Waiver, for the time period July 1, 1997 to September 30, 1999, are presented in this report. Review activities accounted for a total savings of \$2,518,982.00.

Of the savings identified, hospital utilization post payment review represented \$778,081.00, showing 132 cases with days denied. Prepayment outlier reviews resulted in a savings of \$1,122,025.00 with 814 days denied. A new program was initiated in February 1998 to review all hospital claims when the patient has been readmitted within 30 days with the same or a similar DRG. The total savings from this review was \$618,876.00.

The on-site review program was expanded to include all five tertiary care facilities. The original pilot program for on-site review was initiated with three hospitals operated under one management structure. The expansion to the additional facilities has proved to be very successful and productive, providing an opportunity for personal interaction with hospital staff to discuss issues, resolve problems, and complete reviews in a more timely manner. An additional benefit of this program is the reduction in operational costs to both the hospitals and the state due to a decreased need to duplicate, mail and provide storage for the completed records. The on-site program will continue with the current facilities. Evaluation was done to determine whether the on-site program would be economically feasible for the state in the other urban facilities. Due to the number of Medicaid clients enrolled in HMOs, the number of on-site outlier reviews in some urban hospitals has declined.

In addition to review activities, staff were involved in providing technical assistance to providers. Provider education, in-service, and telephone assistance gave needed guidance. This customer service method decreased the number of errors in the program.

INTRODUCTION

A Superior System Waiver for inpatient hospital utilization review has been in place since October 6, 1982. The program operated with one-year extensions through January 31, 1986. Since then, two-year extensions have been granted. The current waiver will expire on January 31, 2000.

The original waiver was rewritten in 1983 to support implementation of the prospective payment system of reimbursement based on Diagnosis Related Group (DRG) categories. Modifications have been made over time to reflect procedural changes, State Plan changes, and health care delivery system changes. Beginning in 1983, utilization of inpatient hospital services has been monitored through post-payment review of samples of paid claims. In July 1988, staff also became responsible for prepayment review and authorization of payment for outlier days.

This report describes the responsibilities and functions of the Hospital Utilization Review Program, and summarizes the impact of the program during the waiver period beginning February 1998. Statistics are provided through September 1999. Hearing negotiations are still ongoing for some of the cases reviewed through this period of time, and one final sample is being worked, but the review will not be completed in time to include the final statistics in this report.

REVIEW PROCESSES

Hospital Utilization Post-Payment Review

Post-payment review of adjudicated claims to monitor appropriateness of admission and continued stay applies to all Utah acute care hospitals. Paid claims for all admissions are included in post-payment review samples.

A review cycle begins on the first working day of each month. The reviews are completed within the 90-day review cycle. Specific time frames have been established for completion of each phase of the cycle.

A history of electronically selected claims, adjudicated during the preceding month, is obtained at the beginning of each review cycle. The electronic selection process automatically excludes the following:

1. Claims with first date of service prior to the waiver report period, adjusted claims, Medicare crossover claims, and claims submitted by out-of-state hospitals;
2. Claims with principal diagnosis of any ICD-9-CM delivery code in the range 640 through 669.9, with a fifth digit of 1 or 2; including 650; any claims which include a diagnosis code of V27.0 through V27.9; any claim for a live-born infant with a diagnosis code of V30.0 through V39.9; and other ICD-9-CM diagnosis codes or DRGs specified by policy or administrative decision;
3. Claims which are related to the Utah Medical Assistance Program (UMAP);
4. Claims which show no dollars paid by Medicaid;
5. Interim billings;
6. HMO Clients.

By electronically eliminating the claims described above, a universe of claims appropriate for review is established. This process significantly shortens the time the nurse reviewer must spend in establishing a universe of "clean claims." It does, however, have the disadvantage of eliminating the "trail" when claims are denied or adjusted. The reviewer can no longer identify changes in diagnoses and procedures

made by providers so that previously denied claims will pay. The number of instances where this has occurred has been minimal and the advantage of making the sampling process move more efficiently far outweigh the disadvantages.

From the more appropriate universe, a 5 percent sample of paid claims is selected for review. A minimum of 2.5 percent of the claims reviewed must be selected by random sampling. The remainder of the sample must include, at a minimum, the same number of claims as selected in the 2.5 percent random sample and may be focused on a specific area. This focused sample may be selected through the recommendations of the Utilization Review Committee of the Bureau of Coverage and Reimbursement Policy or by administrative decision.

Each selected claim in the universe is numbered sequentially. A random number is then selected from Herbert Arkin's Table of 120,000 Random Decimal Digits. For a random sample the random number must be less than 20, and every 20th claim in the universe is included in the sample. When a focused review is included, the random number must be less than 40, and every 40th claim is included in the sample. When a focused sample is included for review, the total number of claims selected for both samples must be at least 5 percent of the total claims in the universe from which the random sample was selected.

Once the sample has been selected, a case file is prepared for each claim. Support staff assign sequential case file numbers and corresponding sample numbers. Photocopies of closed medical records for each claim selected in the sample are requested from the providers. Reimbursement for photocopying is made at a rate of ten cents per page when more than 20 pages are copied. The first 20 pages are the responsibility of the provider. If the number of records to be reviewed is excessive, on-site reviews can be arranged providing there is adequate staff coverage for the remaining in-house utilization management responsibilities.

Providers are notified the documents requested must be mailed or hand delivered within 20 working days after receiving the request. All requests for records are sent by certified mail. The date on the returned signature card determines compliance. When records are not received within the designated time frame, payment for the admission may be recovered. Providers are notified each time records are requested. Recovery of funds will occur if the records are not received within the time frame specified.

Review of Re-admissions

According to current policy, a re-admission occurs when a patient is readmitted for the same or similar diagnoses within 30 days of a previous discharge.

Principal diagnoses are considered to be similar or related when:

1. Any principal diagnosis or principal surgical procedure falls in the same DRG;
or

2. Any principal diagnosis or principal surgical procedure would fall in the same DRG but for variations in operating room or other procedures, complications, co-morbidity, or age; or
3. Any exchange or recombination of principal or other diagnoses and principal or other surgical procedures is found; or
4. Any principal diagnosis falls into the same three digit rubric or its subdivisions as found in Volume 1, Diagnosis - Tabular List, of the ICD-9-CM or any principal surgical procedure falls into the same two digit rubric or its subdivisions as found in Volume 3, Procedures, of the ICD-9-CM; or
5. Any other sets of principal diagnoses are established to be similar by the Committee in written criteria.

When a universe of paid claims clearly identifies a patient as having had one or more re-admissions, as defined above, and one of the claims is selected in either a random or a focused sample, photocopies of the medical records for all admissions are requested for a review. The medical records are reviewed for all post-payment review elements, with special attention to the patient's condition on admission and at discharge, treatment provided during the hospital stay, and the quality/appropriateness of discharge planning.

In addition to the above mechanism of identifying re-admissions, a new weekly report is generated for all re-admissions within 30 days with the **same** diagnosis. This process was started in February 1998. The cases identified through the report are reviewed in the same manner as those identified through the regular hospital utilization review process. Close coordination between the two systems of identifying re-admissions is ongoing. All cases identified with the **same** diagnosis are reviewed to determine the most cost effective way to reimburse the hospital. A determination is made by evaluating the cost to the Medicaid program of combining the stays and paying outlier days if appropriate **or** maintaining the reimbursement as separate for each admission. The state has the option of applying this logic to all **similar** re-admissions within 30 days, but currently lacks the computer resources to match on a similar diagnosis. Clients admitted for pregnancy related problems and those admitted for chemotherapy and revision of shunts are exempt from this process.

InterQual Criteria and protocols approved by the Utilization Review Committee are used to review all re-admission cases. Documentation found in the admission notes, physician progress notes, nursing notes, lab and X-ray or other appropriate diagnostic tests or examinations, and/or the discharge summary in each closed medical record is reviewed for the following review elements:

1. Validation of the principal diagnosis as claimed;

2. Validation of any secondary diagnoses as claimed;
3. Validation of the principal surgical procedure and other operative or diagnostic procedures as claimed;
4. Appropriateness of admission;
5. Appropriateness of continued stay, where applicable;
6. Medical necessity and quality of the care provided;
7. InterQual Discharge Criteria;
8. Compliance with state and federal requirements.

Cases are closed by the nurse reviewer when no problems are found and the admission and continued stay are appropriate. When a coding or billing error is identified, the reviewer prepares a letter outlining the findings for the provider. The letter includes the diagnosis or procedure code(s) which the reviewer believes to be correct, or suggestions on how to claim for the services if other billing errors are identified. Effort is made to provide a consultive, educational opportunity, by asking the provider to contact the reviewer within 10 working days to discuss the issues. Providers are told failure to respond may result in loss of the entire amount of payment. Once an agreement is reached on resolution of the dispute, documentation is submitted to the Bureau of Medicaid Operations to correct the error, or the case is closed if the error is not confirmed.

At any time in the review cycle, the nurse reviewer may request physician review and consultation to discuss issues pertaining to the medical record, a review element, service provision, or to provide peer review of the attending physician's documentation or quality of care.

The full Utilization Review Committee is used as a resource at any time during the review cycle when direction is needed about a particular case or individual issue. In the final analysis, when an adverse action is recommended on recovery of all or part of the reimbursement, the case is presented to the Utilization Review Committee for review and action. Cases for which records are not received within the specified time frame are not presented to the Utilization Review Committee. At the conclusion of the specified time frame the agency is notified recovery will be initiated for the full amount of the reimbursement they received.

Quality of care issues occasionally arise and must be assessed for their impact on the outcome and costs of service provided. The provider is notified of the concern, and a request is made to have the medical record reviewed by the hospital Quality Assurance Committee. The hospital Quality Assurance Committee is asked to submit a report of their review with a plan of corrective action, when appropriate. The Division

Utilization Committee reviews the report and corrective action plan and takes final action for disposition of the case subject to administrative review and approval.

Physician Review

A panel of physician consultants is available to assist the nurse reviewers. When there is a question about diagnosis, appropriateness of admission or continued stay, or questions about the appropriateness or quality of care or treatment provided to the patient, the case is referred to one of the physician consultants for review.

The physician independently reviews the record. If the physician finds the admission, and/or continued stay, was appropriate, or determines there was sufficient documentation to support the necessity of admission or continued stay, the case may be closed without further review. If the physician review does not support the medical necessity or appropriateness of the admission, or if recovery is recommended, the case is presented to the Utilization Review Committee for a final determination and action.

Utilization Review Committee

The Utilization Review Committee of the Bureau of Coverage and Reimbursement Policy is made up of physician consultants, nurse reviewers, and other health care professionals working in the Bureau. Other professionals or consultants attend as needed, and as appropriate. When remedial action is appropriate, other than adjusting a claim for a billing or coding error or for recovery of payment for failure to properly document, the members of the Committee determine the remedial action to be taken.

Based on the facts presented by the nurse reviewer or physician, Committee members can make a decision to close a case, recover all or part of the reimbursement, or specify other remedial actions, including provider education. If the issues are not clear, additional investigation is usually recommended.

The nurse reviewer is responsible for initiating and completing all actions for the cases which the reviewer presents to the Committee for a decision. Included in this responsibility is the preparation of correspondence to notify the provider of the action recommended, provider education regarding the deficiencies found in the review, requesting reports on quality of care issues and plans of corrective action, and initiating any recovery or adjustment of payment. The nurse reviewers also have the responsibility to defend their decisions in hearings requested by providers. Physician consultants serve as expert medical witnesses at hearings.

Recovery Process

When recovery has been determined to be an appropriate remedial action, the provider is notified in writing within ten working days of the Committee's decision. All notices are sent by certified mail.

Notification letters include the action to be taken, the reasons for the action, the federal and state regulations or policies that support the action, and the provider's rights to the appeal process. A provider has 30 calendar days from the date of the letter of notification in which to request a hearing or submit additional documentation for consideration. If a hearing has not been requested by the end of the 30-day period or the additional documentation does not change the initial decision, the reviewer begins the recovery process.

Outlier Review

For discharges after July 1, 1988, appropriateness of additional payment for continued stay beyond the outlier trim point is determined on a prepayment basis. To request payment for outlier days for an admission, hospitals not on the on-site review program complete and submit an Outlier Transmittal Form along with photocopies of the medical record. On-site hospitals submit a list of clients for which outlier days are being requested. The accuracy of the list is verified by Medicaid claims staff prior to Utilization Management staff conducting the on-site review. A transmittal form is completed by the hospital for each record to be reviewed.

Each Transmittal Form received is assigned the same document control number as that assigned to the claim. The Transmittal form and the attached documentation are routed to the nurse reviewer for review and processing. The nurse reviews the appropriateness of admission, service during the hospital stay, discharge planning, and the outlier portion of the hospital stay. Based on review of the documentation, the nurse reviewer can approve or deny payment for the admission as well as all or part of the requested outlier days. The physician consultant can be brought into the review at any point in time to help with decisions about disposition of a case. When insufficient or incorrect documentation is submitted, the nurse reviewer notifies the provider payment cannot be made and requests additional or correct documentation.

When a denial of payment is made, the nurse reviewer completes a provider notification letter outlining the reasons payment was denied. The provider's right to a hearing and information about how to secure a hearing are included in the denial notice. The denial letter and a copy of the Transmittal Form are sent to the provider. A copy of the denial letter and the completed Transmittal Form remains with the medical records and is filed. A second copy of the denial letter is attached to the original Transmittal Form and routed to the Bureau of Medicaid Operations for processing.

When a provider disagrees with denial of payment, a Payment Adjustment Request (PAR) can be submitted with any additional supporting information and a request that the decision be reconsidered. If the additional information supports the continued stay as appropriate, payment for the appropriate number of outlier days can be approved and the necessary corrections made to a copy of the Transmittal Form as originally processed. The PAR and the corrected Transmittal Forms are sent to the Bureau of Medicaid Operations for reprocessing. One copy of each form is retained with the documentation and one copy is returned to the provider. If justification still has not been

provided or only part of the days can be approved, the provider is notified as above. If no agreement can be reached, the provider may ask for an administrative hearing.

When payment for outlier days is requested for a psychiatric or rehabilitation admission, in addition to the above review process, the nurse reviewer will also look at the prior authorization paperwork to see if any days were denied at the time authorization for admission was given. The prior authorization is also reviewed for other programs (e.g., hysterectomies, back surgery, transplants) affecting inpatient care. If, for example, payment had been denied for two days for a late telephone contact, the number of outlier days approved would be adjusted to show this action.

ADDITIONAL ACTIVITIES

Each of the following activities involved one or more of the nurse reviewers. These are assignments which are not part of the review process, but impact Medicaid policy and review staff.

InterQual Criteria System Implementation and Training

Additional training was provided in the use of the InterQual Criteria System for staff who had previously had the initial training. Due to significant staff turnover there were several new staff who needed the InterQual training. The training was completed in early April 1999. The training included both use of the paper system and the Auto Book [computerized criteria]. All Utilization Management nurse reviewers, one new policy staff person and all physician staff completed the three day training satisfactorily. The InterQual Criteria is used by all nurse reviewers and physicians when performing the review of patient records.

Hearings

The hearing process has been reorganized to add a hearing coordination committee. The committee includes two physicians, the Utilization Management Health Program Manager, the Program Integrity Health Program Manager, the staff attorney and the paralegal. Each case is discussed prior to the date of the pre-hearing. The details of each case are described and evaluated in terms of the appropriate administrative rules and/or specific Medicaid policy(ies). Each nurse reviewer responsible for the specific case attends when their particular cases are discussed. Decisions are made regarding the merits of the case and on what basis the case will be defended. Discussions also include any areas of potential negotiation in regard to the facts of the case.

IMPACT OF HOSPITAL UTILIZATION REVIEW

Program Activities

The number of cases for review has increased during this waiver period. At the

present time, the review covers an average of 32 cases per month. There are approximately 43,500 Medicaid clients covered by the fee for service program which are subject to hospital utilization review. HMO clients are not included in the review. The Bureau of Managed Care is responsible for oversight of HMO client hospital admissions.

Utilization Management staff work closely with providers to influence change for more effective outcomes through education and negotiation. The emphasis of utilization review continues to be on medical necessity and appropriateness of admission and services as evidenced by documentation and content of the full medical record. Provider satisfaction with this process continues to be positive.

Specific surgical procedures are manually excluded from the sample. These procedures include hysterectomy, hernia repair, cholecystectomy, appendectomy, discectomy, spinal fusion, and sterilization. With the exception of appendectomy, most hernia repairs, and cholecystectomy, these procedures require prior authorization, which in itself, provides a safeguard to utilization control.

The nurse reviewer selecting cases for the sample may include some of the excluded claims for review. The decision to include such claims is based on diagnoses, complications coded, procedures, age of the patient, length of the hospital stay, and charges submitted. If a preliminary review identifies a potential problem, the claim is included in the universe and is flagged as a "problem" claim. A record is kept of those claims not included in the universe. A small focused sample is then pulled from the problem claims to assure that the 5 percent minimum requirement is met.

Program Statistics

Program statistics will be reported beginning with July 1997. The data for July 1997 through December 1997 could not be completed in time to be reported in the previous report. This is due to the time requirements imposed by the sampling system used to select cases for review.

July 1997 through December 1997. A total of 223 cases were opened for review. Of these cases, 65 were focused reviews of which 15 were on one facility and 165 were random. No action was determined to be necessary in 195 cases. Payment was denied in 28 cases for policy or clinical reasons. A total of 23 hospital days were denied. The amount identified for recovery was \$171,057.35. This amount averages \$6,109.19 per case. No cases were closed without review. Remedial action in the form of provider education and guidance on billing issues or use of diagnostic procedure codes was provided as indicated.

January 1998 through June 1998. A total of 195 cases were opened for review. Of these cases, 57 were focused reviews. Nine were identified as being re-admitted within 30 days and 125 were random. No action was determined to be necessary in 162 cases. Payment was denied in 33 cases for policy or clinical reasons. A total of 155 hospital days were denied. The amount identified for recovery was \$150,531.32. This

averages \$4,561.56 per case. No cases were closed without review. Remedial action and assistance were provided as indicated.

July 1998 through December 1998. A total of 195 cases was opened for review. Of these cases, 57 were included for focused review, 9 were identified as being re-admitted within 30 days and 125 were random. No action was determined to be necessary in 166 cases. Payment was denied in 15 cases for policy or clinical reasons. The amount identified for recovery during this period was \$111,574.53. This amount averages \$1,957.45 per case. No cases were closed without review. Remedial action and assistance were provided as indicated.

January 1999 through June 1999. A total of 192 cases were opened for review. Of these cases 41 were focus reviews and 151 were random. No action was determined to be necessary in 150 cases. Payment was denied in 42 cases for policy or clinical reasons. The amount identified for recovery during this period was \$314,888.00 This amount averages \$7,680.00 per case. No cases were closed without review. Remedial action and assistance were provided as indicated.

When providers are notified of denials they are given 30 days in which to request a hearing to challenge the decision. Some of the cases identified for denial could still be in the hearing/legal review process and could result in some adjustments at a later time.

IMPACT OF OUTLIER REVIEW

Program Activities

Under the prospective payment system, the appropriateness of additional payment for continued stay beyond the outlier trim point must be determined on a prepayment bases. For all discharges after July 1, 1988, hospitals have requested this review by submitting an Outlier Transmittal Form along with photocopies of the medical record. Review of the record includes appropriateness of admission, service during the hospital stay, discharge planning, the outlier portion of the hospital stay, and is completed within a 60-day period of being received. The Utilization Review Committee can be involved in the review process as necessary. Hearings are offered on all denials.

The on-site outlier review program started in March of 1996, with three hospitals (one tertiary care facility and two community hospitals) under the same management system was expanded during this waiver period to include the additional four tertiary care facilities. The intent is to improve the efficiency of the program and reduce operational costs for both the hospitals and the Division of Health Care Financing. The on-site program eliminates the need to duplicate, mail or deliver records, exchange letters, and to correct problems. Being on-site with the ability to address questions, seek out physicians or other hospital staff to address issues, and finally to be able to resolve, negotiate and settle a case provides immediate closure and speeds payment to the facility. Most of the cases contested by the hospitals are ones in which the total hospital admission is denied because it does not meet InterQual Criteria or the agency failed to

obtain a prior authorization for services such as acute inpatient rehabilitation admissions.

Program Statistics

July 1997 through December 1997. The number of DRG days for this period totaled 9,819. The number of outlier cases received for review was 312. There were a total of 345 hospital days, including outlier days, not approved. Savings identified for the hospital days not approved was \$629,528.53 for this period.

January 1998 through July 1998. The number of DRG days for this period totaled 6130. The number of outlier cases received for review was 208. There were a total of 236 hospital days, including outlier days, not approved. Savings identified for the hospital days, including outlier days, not approved was \$381,565.03.

July 1998 through December 1998. The number of DRG days for this period totaled 8,633. The number of outlier cases received for review was 259. There were a total of 236 hospital days not approved. Savings identified for the outlier days not approved was \$60,769.46.

January 1999 through June 1999. The number of DRG days for this period totaled 7,156. The number of outlier cases received for review was 233. There were a total of 40 hospital days, including outlier days, not approved. Savings identified for the hospital days not approved was \$10,115.71.

July 1999 through September 1999. The number of DRG days for this period totaled 4,194. The number of outlier cases received for review was 151. There were a total of 73 hospital, including outlier days not approved. Savings identified for the hospital days not approved was \$40,046.00.

As this time period for the waiver has progressed the number of outliers being reviewed has evolved to be 60-70% newborn premature infants or high risk pregnancy patients at all of the tertiary care facilities with Newborn Intensive Care Units. It is unusual to have to deny outlier days for this group of patients. As a result of this shift in the type of clients we are reviewing for outlier days has occurred, we are seeing a decrease in the number of days denied and the amount of money recovered from the review of outliers. Several of the facilities are using the InterQual Criteria internally which may also be influencing the number of requests for the review of outlier days.

30 DAY RE-ADMISSION WITH THE SAME DRG REVIEW PROGRAM

This program was started in February of 1998. An agreement was reached with the Utah Hospital Association that evaluation would be made of all re-admission cases with the standard for reimbursement being the lowest cost for the Medicaid program. Decisions are made about reimbursing for both admissions or combining the admission and paying outlier days if appropriate. Disorders related to pregnancy and

chemotherapy are exempt from this review process.

February 1998 through June 1998. A total of 24 patients with re-admissions within 30 days with the same DRG were reviewed. A total of \$126,975.00 was recovered during this time period.

July 1998 through December 1998. A total of 17 patients with re-admission within 30 days with the same DRG were reviewed. A total of \$124,419.00 was recovered during this time period.

January 1999 through June 1999. A total of 19 patients with re-admissions within 30 days with the same DRG were reviewed. A total of \$116,301.00 was recovered during this time period.

July 1999 through September 1999. A total of 15 patients with re-admissions within 30 days with the same DRG were reviewed. A total of \$222,100.00 was recovered during this time period.

QUALITY ASSURANCE

Quality is the right and ethical expectation of patients seeking to achieve optimal care. It is the commitment of Health Care Financing to continue to operate an effective, well organized utilization management program that will sustain provider and patient satisfaction by:

1. Approaching review of the medical record from the perspective of standards and criteria (InterQual) that are objective and non-judgmental and emphasize outcome of care and benefit to the patient.
2. Structuring findings of medical case review to emphasize education change or systematic process improvement rather than individual or punitive discipline.
3. Considering patient grievance and complaints about care and service from the perspective of satisfaction with outcome and benefit.
4. Maintaining use of the clinically based patient focused InterQual Criteria and System and securing basic preparation for new staff members.
5. Monitoring performance of staff through job descriptions, orientation, and providing in-service and opportunity to participate in community education programs to improve skills and network with providers.
6. Encouraging those staff members interested in pursuing the National Quality Assurance Certification program. Expanding credentials of staff will promote the philosophy of Continuous Quality Improvement.

7. Looking at data and data entry programs and improving systems to monitor and tract effectiveness of outcomes.
8. Providing cross training of staff to understand these processes in order to minimize disruption of programs as a result of staff turnover.

2245. TITLE XIX SUPERIOR UTILIZATION REVIEW (UR) SYSTEM WAIVER

Section 1903(i)(4) of the Act provides that to participate in Medicaid a hospital or SNF must have in effect a UR plan meeting requirements specified in section 1861(k) of the Act. Section 1903(i)(4) also provides that the Secretary may waive these requirements when a State Medicaid agency demonstrates that it has in operation a superior UR system. A superior UR system is one that is more effective than the review required by section 1861(k) of the Act and related regulations. Superior system waivers are addressed in 42 CFR 456.505-.508.

Superior system waivers may be granted for a period of 2 years, and are renewable for periods of 2 years. Conduct a Federal assessment before each renewal.

2246. PROVISIONS OF SUPERIOR UR SYSTEMS

A. Provisions Which Cannot Be Waived.--Superior system waivers apply only to certain UR plan requirements for hospitals and SNFs. Do not approve or renew a waiver request if any of the following factors are part of the waiver request:

1. Certification or recertification of need for care;
2. Plan of care;
3. Discharge plan;
4. UR plan requirement provisions relating to disqualification of UR committee members; or
5. UR in ICFs. Note, however, that Medicaid regulations provide flexibility for States to determine the most effective manner for conducting UR in ICFs. For example, the State plan may require that UR be conducted by the facility or by individuals employed by (or under contract to) the State Medicaid agency. 42 CFR 456.401(b).

B. Provisions That Can Be Waived.--A more effective review system means one that can produce and maintain better results, such as:

- o Patients are more often or more dependably placed at a level of care or in a setting that will best meet the medical needs of the patient;
- o Care provided is more often medically necessary; or
- o Quality of patient care is more often consistent with current standards of medical practice.

To determine whether the proposed system yields superior results, evaluate the results of the review process elements pertaining to:

- o Admission review;
- o Continued stay review;
- o Timeliness of decision-making and notification; and
- o Quality review.

2247. CONTENT OF NEW UR WAIVER REQUESTS

A. Justification of Effectiveness Based on Results of Performance.—To justify an initial waiver request on the basis of demonstrated performance, a State must include documentation that:

- o The proposed waived system is and has been in operation for a minimum of 6 months in at least 10 percent of the institutions or facilities represented in the given level of care;
- o Medically necessary care is more often provided in the appropriate setting than under a review system conforming to section 1861(k) and related regulations; and
- o The activities maintain or improve the quality of care provided to Medicaid patients.

B. Justification Based on Superiority of Mechanism.—Although the State system must have been in use for six months, frequently an initial waiver can be assessed more directly in terms of the way the State has described the system's mechanisms for identifying questionable medical care practices, including the following aspects:

1. Admission Review.—Federal Medicaid UR regulations do not require admission review in mental hospitals or SNFs. Therefore, a superior UR system for mental hospitals or SNFs might provide an admission or pre-admission mechanism for reviewing medical necessity and determining the appropriate level of care. This monitoring approach can contribute to improving the utilization of long-term care facilities by eliminating inappropriate placements.

2. Continued Stay Review.—Federal Medicaid UR regulations for hospitals provide that continued stay reviews are set in accordance with criteria in the UR plan, and SNFs require a continued stay review (CSR) within 30 days of admission and subsequently at least every 90 days. When pre-admission or admission review is part of the proposed system, variations in the frequency of CSR may be acceptable, and even superior to those specified in regulations. For example, CSR could be intensified in the initial period of inpatient care and then, after the initial period, reduced.

Proposed systems that reduce the frequency of CSR in the initial period of a stay can result in payment for inappropriate care. Moreover, if initial CSR is delayed for several months or more during which the patient is in an inappropriate level of care, a patient may become totally dependent rather than maintaining more independence at a lower level of care through proper monitoring and placement.

3. Notification.—A superior UR system would include timely decision-making and written notification of denial to involved parties (e.g., patient, provider, and physician). Extended periods of time for decision-making or notification encourage inappropriate utilization of institutional resources. For example, the time between the denial decision and the written notification should generally be no more than 3 days.

4. Quality Review.—States seeking superior system waivers usually retain the Federal requirement for medical care evaluations. However, applicants should be encouraged to undertake quality review activity that addresses those patients who may be at greater risk of receiving poor quality care. Examples of such groups include (but are not limited to) long-stay patients with mental or cognitive problems in addition to physical limitations. Every quality review plan should include:

- a. Mechanisms for problem identification,
- b. Problem analysis,
- c. Intervention to resolve problem,
 - (1) Corrective action
 - (2) Follow-up to verify correction
- d. Monitoring to assure continued problem resolution.

C. Review Criteria.—The State plan should provide for the use of professionally established objective criteria to screen care proposed for or provided to Medicaid patients. The plan should also present evidence that the criteria set has been tested to assure inter-rater reliability. Any criteria set should:

- o Address those diagnoses and medical conditions typically found in patients admitted to the institution or facility;
- o Be accompanied by a set of clear, concise and easy to follow instructions;
- o Be sufficiently specific to prevent admission to or continued stay in a facility of a patient who does not require care in that facility;
- o Include the major reasons for admission or continued stay in an institution or facility; and
- o Contain elements for determining the quality of care provided.

D. Adherence to Mandatory UC Provisions (All New Waiver Requests).—To assure that none of the mandatory UC provisions are included in the proposed waived system, the State UR plan must contain the following information:

- o The process for conducting review activities and specifically how the State will meet its UC requirements.
- o Organizational structure and relationships (especially those related to potential conflicts of interest), including position descriptions and qualifications for involved personnel (e.g., educational requirements and clinical experience).

2248. UR WAIVER RENEWAL REQUESTS

The documentation for renewal must be submitted at least 90 days prior to the expiration of the current waiver to permit you to determine the appropriateness of renewal. The renewal documentation must include the specific improvements achieved by the State since the initiation of its superior system, such as:

- o Validation of improvements in appropriate patient placements in specific care settings;
- o Validation of reduced unnecessary admissions or days of unnecessary medical care; and
- o Validation of improvement in the quality of care.

2249. RO EVALUATION AND DECISION ON SUPERIOR UR SYSTEM WAIVER

A. Onsite Verification.—In considering any request for a superior UR system waiver that is based on process rather than results, conduct sufficient on-site monitoring to confirm that the procedures carried out in review are, in fact, the same as those described in the State plan. Review actual practices in sufficient detail to detect UR system changes not submitted or approved by HCFA, or changes to non-waiverable UC requirements.

B. Notification of Decision.—Within 90 days of receipt in your office of a request for waiver or renewal, send the requesting State formal notification of your decision to approve, deny, or renew the request. Use the model letters (Exhibits 4-154 - 4-156) as appropriate. Forward one copy of every letter to the Office of Survey and Certification, HSQB.

The 90-day limitation is mandated by section 1915(f) of the Act. Only a one-time RO request for additional information or documentation will interrupt and restart the 90-day period.

§ 456.505

plan requirements in Subpart C, D, or E of this part, which are equivalent to the Medicare UR plan requirements in §§ 405.1137, 482.30, and 482.60 of this chapter.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 22042, June 17, 1986]

UR PLAN: WAIVER OF REQUIREMENTS

§ 456.505 Applicability of waiver.

The Administrator may waive the UR plan requirements of Subparts C, D, or E of this part, except for provisions relating to disqualification of UR committee members under § 456.106 of Subpart C, § 456.206 of Subpart D, and § 456.306 of Subpart E, if the Medicaid agency—

- (a) Applies for a waiver; and
- (b) Demonstrates to the Administrator's satisfaction that it has in operation specific UR procedures that are superior in their effectiveness to the UR plan requirements under Subparts C, D, or E.

§ 456.506 Waiver options for Medicaid agency.

(a) The agency may apply for a waiver at any time it has the procedures referred to under § 456.505(b) in operation at least—

- (1) On a demonstration basis; or
 - (2) In any part of the State.
- (b) Any hospital, mental hospital, or SNF participating under the plan that is not covered by a waiver must continue to meet all the UR plan requirements under Subpart C, D, or E of this part.

§ 456.507 Review and granting of waiver requests.

(a) When the agency applies for a waiver, the Administrator will assess the agency's UR procedures and grant the waiver if he determines that the procedures meet criteria he establishes.

(b) The Administrator will review and evaluate each waiver between 1 and 2 years after he has granted it and between 1 and 2 years periodically thereafter.

§ 456.508 Withdrawal of waiver.

(a) The Administrator will withdraw a waiver if he determines that State

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procedures are no longer superior in their effectiveness to the procedures required for UR plans under Subparts C, D, or E.

(b) If a waiver is withdrawn by the Administrator, each hospital, mental hospital, or SNF covered by the waiver must meet all the UR plan requirements under Subparts C, D, or E of this part.

UR PLAN: REMOTE FACILITY VARIANCES FROM TIME REQUIREMENTS

§ 456.520 Definitions.

As used in §§ 456.521 through 456.525 of this subpart:

Available physician or other professional personnel means an individual who—

- (a) Is professionally qualified;
- (b) Is not precluded from participating in UR under § 456.107 of Subpart C; § 456.207 of Subpart D; or § 456.307 of Subpart E; and
- (c) Is not precluded from effective participation in UR because he requires more than approximately 1 hour to travel between the remote facility and his place of work.

Remote facility means a facility located in an area that does not have enough available physicians or other professional personnel to perform UR as required under Subparts C, D, or E of this part, and for which the State requests a variance.

Variance means permission granted by the Administrator to the Medicaid agency for a specific remote facility to use time periods different from those specified for the start and completion of reviews of all cases under the following sections: §§ 456.125, 456.126, 456.136, and 456.137 of Subpart C; § 456.238 of Subpart D; and §§ 456.333, 456.334, and 456.336 of Subpart E.

§ 456.521 Conditions for granting variance requests.

(a) Except as described under paragraph (b) of this section, the administrator may grant a variance for a specific remote facility if the agency submits concurrently—

- (1) A request for the variance that documents to his satisfaction that the facility is unable to meet the time re-

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requirements for which the requested; and

(2) A revised UR plan f

ty.
(b) The Administrator v a variance if the remote erating under a UR plan the Secretary has granted ering under §§ 456.5 456.508.

§ 456.522 Content of request.
The agency's request, f must include—

- (a) The name, location the remote facility;
- (b) The number of tot missions and the average census at the facility in preceding the request;
- (c) The number of Medicaid patient admis average daily Medicare patient census at the fa months preceding the re
- (d) The name and lo hospital, mental hospi ICF located within a 50 the facility;
- (e) The distance and time between the remo each facility listed in p this section;
- (f) Documentation by its attempts to obtain available physicians or sional personnel, or bot
- (g) The names of al the active staff, and t other professional pe staff whose availabilit the request;
- (h) The practice loc able physicians and number of available r sonnel whose availabil the request;
- (i) Documentation b its inability to perform time requirements for ance is requested and forts to comply with quirements of Subpar this part;
- (j) An assurance by it will continue its g to meet the UR plan Subpart C, D, or E of