DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services
Western Consortium
Division of Survey and Certification

January 18, 2006

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

Dear Mr. Hales:

The Centers for Medicare and Medicaid Services has approved your request for a two-year extension of the Inpatient Hospital Utilization Review Waiver (Title 42 of the Code of Federal Regulations, Part 456 Subpart C, Section 456.50 through 456.137). This current two-year extension is granted through January 31, 2008.

If you decide to renew the Superior Waiver after January 31, 2008, 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, Centers for Medicare and Medicaid Services, 1600 Broadway, Suite 700, Denver, Colorado 80202-4967.

Sincerely,

Paul R. Long, MD
Regional Program Manager
Denver Regional Office

Copies to:
F. Blake Anderson, Utah Department of Health, Division of Health Care Financing
Rachael Weinstein, CMS, Office of Clinical Standards and Quality
Greg Watson, CMS, Denver Regional Office
Diana Friedli, CMS, Denver Regional Office

Office	Surname	Date	Office	Surname	Date	Office	Surname	Date
SCB	Bailey	1/18/06						
SC	Long	1/18/06						

FILE COPY

Utah Department of Health
Executive Director's Office

David N. Sundwall, M.D.
Executive Director

A. Richard Melton, Dr. P.H.
Deputy Director

Allen Korhonen
Deputy Director

Health Care Financing

Michael J. Deily
Division Director

State of Utah

JON M. HUNTSMAN, JR.
Governor

GARY R. HERBERT
Lieutenant Governor

September 20, 2005

CRP-530-05

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

Dear Ms. Bailey:

Enclosed are two copies of the updated Superior Systems Waiver.

If you have questions or wish to discuss this information further, please contact F. Blake Anderson (801) 538-6149 or Pat Smith at (801) 962-8199.

Sincerely,

Michael Deily, Director
Division of Health Care Financing

Enclosures (2)

2005 SEP 28 AM 10 04

Utah Department of Health
Promote Prevent Protect

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6406 • Facsimile (801) 538-6099 • *www.health.utah.gov*

UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

BUREAU OF COVERAGE & REIMBURSEMENT POLICY

HOSPITAL UTILIZATION REVIEW PROGRAM
SUPERIOR SYSTEM WAIVER

Salt Lake City, Utah

September 2005

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.

After changes in our reimbursement policy, Medicaid has found that outlier review program has proven **not** to be cost effective. The process has resulted in very few recoveries and use of significant staff time. Therefore, the outlier review program will no longer be done by Medicaid.

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. Hospital review of the mental health programs for the Medicaid program will be the responsibility of the Bureau of Managed Health Care.

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 co-morbidity, 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.

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

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 include, but are 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 adoption of 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,

3. Emergency Care review.

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 maintain 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 processes prior authorization requests for specific surgical, medical, dental, drug, medical supplies, or other services. Any inpatient hospital claims for services 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. Since changes in our reimbursement, significant increase of staff time, and little or no recoveries over the past two years have occurred, this program has been eliminated due to decreased cost effectiveness.

Utah State Hospital Utilization Review. To ensure Medicaid funds are expended appropriately and to ensure services provided to Medicaid recipients at the Utah State Hospital (USH) are of high quality, the Medicaid agency shall conduct oversight activities at the Utah State Hospital. Responsibilities for ensuring compliance with this hospital utilization review

component will rest with the Bureau of Managed Health Care.

1. Quarterly Clinical Utilization Reviews

   On a quarterly basis, psychiatric consultants under contract with the Bureau of Managed Health Care will review a sample of patients under age 21 and over age 64 who were reviewed by the USH's utilization review (UR) staff during a previous quarter. Reviews will be performed to: (1) evaluate the USH's UR process, and (2) address the clinical topic selected for that quarter's review.

2. Review of Utah State Hospital Quality Assurance, Quality Improvement and Utilization Review Programs

   Reviews of the Utah State Hospital's Quality Assurance, Quality Improvement and Utilization Review programs shall also be conducted to determine if (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.

3. Technical Assistance

   Psychiatric consultants may provide technical assistance and education to assist the Utah State Hospital to improve patient record keeping, clinical protocols and processes, quality of care, and the Quality Assurance, Quality Improvement and Utilization Review programs. Compliance with federal and state record keeping requirements will be evaluated. This review may also be completed by other medically trained staff.

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 Program Integrity Unit 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 will 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 Utah Medicaid provider subject to 42 CFR 431.51, the provisions of the Utah Freedom of Choice Waiver under Sections 1915 (b)(1) and (b)(2) of the Omnibus Reconciliation Act of 1981, and any other related waivers granted by the Center for Medicare and Medicaid Services (CMS).

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

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 his/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. Appropriate laws, rules, program memorandums, and provider manuals,

4. Remedial action that will be taken,

5. Hearing rights, if the remedy involves a loss or restriction of benefits to the provider or the recipient,

6. 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,

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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 a minimum of 5 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, 2004, 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 $00.00 payment by Medicaid,

4. Interim bills,

5. Claims with other codes or diagnosis determined by the state to be inappropriate for this review.

A computer generated random sample (1-20 for 100 months) is used.

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 5 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	15th working day
Request records	20th working day
Nurse review	85th working day
Committee review	next scheduled meeting
Statistical summary	90th 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.

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 and the denied days. 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.

UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

BUREAU OF COVERAGE & REIMBURSEMENT POLICY

HOSPITAL UTILIZATION REVIEW PROGRAM
SUPERIOR SYSTEM WAIVER

Salt Lake City, Utah

September 2005

SUPERIOR SYSTEM WAIVER

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NOTIFICATION

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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,

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4. Any psychiatric diagnosis within the ICD-9-CM diagnosis code range 290 to 319.

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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, 2004, 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 $00.00 payment by Medicaid,

4. Interim bills,

5. Claims with other codes or diagnosis determined by the state to be inappropriate for this review.

A computer generated random sample (1-20 for 100 months) is used.

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 5 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	15th working day
Request records	20th working day
Nurse review	85th working day
Committee review	next scheduled meeting
Statistical summary	90th 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.

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 and the denied days. 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.

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

September 2005

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EXECUTIVE SUMMARY

Review activities conducted under the conditions set forth in the Superior System Waiver, for the time period January 1, 2004 to January1, 2006 are presented in this report. Review activities accounted for a total savings of $1,396,033.00.

Of the savings identified, hospital utilization post payment review represented $179,688, showing 635 cases with days denied. A 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 $1,216,345. (Activity is only shown through February 2005 due to the fact that some cases are still being processed).

In addition to review activities, staff was 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 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 January 1, 2004. Statistics are provided through February 2005. Hearing negotiations are still ongoing for some of the cases reviewed through this period of time, and 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 dates 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 show no dollars paid by Medicaid,

4. Interim billings,

5. 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 computerized list is generated each month. 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 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 assigns 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 30 days from date of letter. 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 is 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. Certain codes or diagnoses may be eliminated from this review if the staff feels re-admissions under those codes or diagnosis within 30 days is essential.

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 are 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, chemotherapy, revision of shunts, and hyperbilirubenemia are exempt from this process.

InterQual Criteria and protocols approved by the Utilization Review Committee are used to review 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 may be 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 a continued stay, where applicable,

6. Medical necessity and quality of the care provided,

7. InterQual Discharge Criteria,

8. Compliance with state and federal requirements,

9. Cost effectiveness of combining admissions.

Cases are closed by the nurse reviewer when no problems are found and the admission and continued stay are appropriate. When coding or billing errors are 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 suggestion 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 30 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. All denials are referred for physician review.

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. Cases for which records are not received within the specified time frame are not presented to the Utilization Review Committee. An emergency committee meeting may be held if need is urgent. 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 arises 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. 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.

Recovery Process

When recovery has been determined to be an appropriate remedial action, the provider is notified in writing. 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.

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 is ongoing in the use of the InterQual Criteria System for staff. Due to significant staff turnover there continues to be several new staff who need InterQual training. The InterQual Criteria is used by nurse reviewers and physicians when performing the review of patient records, and they are trained as necessary.

Hearings

The hearing process includes a Hearing Coordination Committee. The Committee includes at least two physicians, the Utilization Management Health Program Manager, the Program Integrity Health Program Manager, a representative from the attorney general's office , a paralegal and any other involved staff as deemed appropriate. 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 policies. Each nurse reviewer responsible for the specific case provides information 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. The hearing coordination process is considered an integral part of the administrative hearing process.

IMPACT OF HOSPITAL UTILIZATION REVIEW

Program Activities

The number of cases for review has increased during this waiver period. There are now approximately 178,000 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 works 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 January 2004.

January 2004 through June 2004. A total of 311 cases were opened for review. Of these cases, 35 were focused reviews and 276 were random. The amount identified for recovery was $111,620. No cases were closed without review. Remedial action and assistance were provided as needed.

July 2004 through December 2004. A total of 271 cases were opened for review. Of these cases, 143 were included for focused review, and 128 were random. The amount identified for

recovery during this period was $68,068.00. No cases were closed without review. Remedial action and assistance were provided as indicated.

January 2005 through February 2005. A total of 53 cases were opened for review. Of these cases 45 were focus reviews and 8 were random. The amount identified for recovery during this period has not been established due to the fact that most of the cases are still in process. 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.

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, hyperbilirubinemia, revision of shunts, and chemotherapy are exempt from this review process.

January 2004 through June 2004. A total of 53 patients with re-admission within 30 days with the same DRG were reviewed. A total of $761,818 was recovered during this time period.

July 2004 through December 2004. A total of 110 patients with re-admissions within 30 days with the same DRG were reviewed. A total of $362,628 was recovered during this time period.

January 2005 through February 2005. A total of 8 patients with re-admissions within 30 days with the same DRG were reviewed. A total of $91,899 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 the Division 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.

UTAH DEPARTMENT OF HEALTH

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Once the sample has been selected, a case file is prepared for each claim. Support staff assigns 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.

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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 are 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, chemotherapy, revision of shunts, and hyperbilirubenemia are exempt from this process.

InterQual Criteria and protocols approved by the Utilization Review Committee are used to review 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 may be 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 a continued stay, where applicable,

6. Medical necessity and quality of the care provided,

7. InterQual Discharge Criteria,

8. Compliance with state and federal requirements,

9. Cost effectiveness of combining admissions.

Cases are closed by the nurse reviewer when no problems are found and the admission and continued stay are appropriate. When coding or billing errors are 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 suggestion 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 30 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. All denials are referred for physician review.

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Quality of care issues occasionally arises 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.

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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. 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.

Recovery Process

When recovery has been determined to be an appropriate remedial action, the provider is notified in writing. 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.

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 is ongoing in the use of the InterQual Criteria System for staff. Due to significant staff turnover there continues to be several new staff who need InterQual training. The InterQual Criteria is used by nurse reviewers and physicians when performing the review of patient records, and they are trained as necessary.

Hearings

The hearing process includes a Hearing Coordination Committee. The Committee includes at least two physicians, the Utilization Management Health Program Manager, the Program Integrity Health Program Manager, a representative from the attorney general's office , a paralegal and any other involved staff as deemed appropriate. 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 policies. Each nurse reviewer responsible for the specific case provides information 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. The hearing coordination process is considered an integral part of the administrative hearing process.

IMPACT OF HOSPITAL UTILIZATION REVIEW

Program Activities

The number of cases for review has increased during this waiver period. There are now approximately 178,000 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 works 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 January 2004.

January 2004 through June 2004. A total of 311 cases were opened for review. Of these cases, 35 were focused reviews and 276 were random. The amount identified for recovery was $111,620. No cases were closed without review. Remedial action and assistance were provided as needed.

July 2004 through December 2004. A total of 271 cases were opened for review. Of these cases, 143 were included for focused review, and 128 were random. The amount identified for

recovery during this period was $68,068.00. No cases were closed without review. Remedial action and assistance were provided as indicated.

January 2005 through February 2005. A total of 53 cases were opened for review. Of these cases 45 were focus reviews and 8 were random. The amount identified for recovery during this period has not been established due to the fact that most of the cases are still in process. 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.

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, hyperbilirubinemia, revision of shunts, and chemotherapy are exempt from this review process.

January 2004 through June 2004. A total of 53 patients with re-admission within 30 days with the same DRG were reviewed. A total of $761,818 was recovered during this time period.

July 2004 through December 2004. A total of 110 patients with re-admissions within 30 days with the same DRG were reviewed. A total of $362,628 was recovered during this time period.

January 2005 through February 2005. A total of 8 patients with re-admissions within 30 days with the same DRG were reviewed. A total of $91,899 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 the Division 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.