



WCDSC-R8-RB

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

February 12, 2010

Michael Hales, 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 the request for a two-year extension of the Inpatient Hospital Utilization Review Waiver (Title 42 of the Code of Federal Regulations, Part 456 Subpart C, Section 456.50 through 456.137). This current two-year extension is granted through January 31, 2012.

If the Utah Department of Health, Division of Medicaid and Health Financing chooses to renew the Hospital Utilization Review Program Superior Waiver after January 31, 2012, please send the request and supporting documentation to this office at least 90 days prior to the expiration date of the waiver.

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

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

Sincerely,

Bernard S. Fellner, Manager
Certification and Enforcement Branch

Copies to:

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

UTAH DEPARTMENT OF HEALTH
DIVISION OF MEDICAID and HEALTH FINANCING
Through
The Office of Internal Audit Services
Program Integrity Unit

HOSPITAL UTILIZATION REVIEW PROGRAM
SUPERIOR SYSTEM WAIVER

Salt Lake City, Utah

December 2009

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 456.137. 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 as defined under 42 CFR 456, Subpart D.

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 and Utah Administrative Rules, with which the Division of Medicaid and Health Financing and the Office of Internal Audit Services 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 the division reimbursement policy, The Division of Medicaid and Health Financing and the Office of Internal Audit Services has currently found the outlier review program has proven not to be cost effective, produced few recoveries and utilized significant staff resources. However the Department and the Office of Internal Audit Services will conduct periodic outlier reviews to ensure our current reimbursement policies remain efficacious.

In order to meet the requirements of the Hospital Utilization Review Program, the Division of Medicaid and Health Financing, (hereafter called Division) has assigned the Office of Internal Audit Services and the Program Integrity Unit (hereafter referred to as OIAS and Unit respectively) responsibility for utilization review. The Office 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 Office and Unit along with 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 the Committee) shall be established and maintained within the Division. 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, Office or Unit staff determined by

the Director to be appropriate for the Committee. Other professionals or department staff may be invited to specific Committee meetings, as needed, for consultation and discussion in areas of their expertise, but shall not be voting members of the Committee.

The Committee shall not include any member who is responsible for the direct 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 the adoption of review protocols, criteria, guidelines, and standards to support the purpose of Hospital Utilization Review.
2. Making medical recommendations, including appropriateness of care and services,
3. Making recommendations of one or more areas of focus for a particular review sample,
4. Recommending additional studies of individual hospitals, physicians, or patients, and of specific diagnoses, procedures, or other issues,
5. Seeking additional consultation as needed,
6. Recommending the approval of written criteria defining similar principal diagnoses and similar principal procedures,
7. Recommending the initiation of possible remedial actions against a provider.
8. Intervening on a professional basis with hospitals, hospital professional committees, and physicians,

Meetings

The Committee will meet bimonthly on a regularly scheduled basis when there is review business to conduct. Unscheduled meetings may be called on a more frequent basis to meet the needs of the program. Emergency meetings of the Committee may be held with attendees present, or may be conducted as a telephone conference. At least three members of the Committee, two of whom must be physician members, must be present during an emergency meeting. All remedial recommendations require the signatures of at least two physicians. The following actions may be taken during an emergency meeting:

1. Recommendation the adoption of review protocols, criteria, and other review standards where applicable,
2. Recommendation and scheduling of remedial actions,
3. Emergency Care review where applicable.

When review protocols, criteria, guidelines, and standards are recommended for adoption, at times other than regularly scheduled meetings of the Committee as described above, recommendations shall be recommended to a full Committee for review and voting at a regularly scheduled Committee meeting.

When any decision is made on recommended remedial action(s) during an emergency meeting as described above, the recommendation represents a final decision by a full Committee.

RELATED PROGRAMS

The Hospital Utilization Review Program will maintain and sustain cooperative relationships with other offices, units, sections, and bureaus, within the Division of Medicaid and Health 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 related to hospital utilization review and is only informational.

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 previously authorized by the division may be included in the universe for sample selection, and may be subjected to outlier review where applicable and appropriate. If any previously authorized inpatient hospital claim service is selected as part of the sample, it shall be subject to the same review procedures and remedial actions as any other claim included in the sample.

Outlier Review. Due to changes in the Department's reimbursement policy, significant increase of staff time, and few recoveries, the department will conduct ongoing periodic reviews to ensure current reimbursement methodology remains efficacious.

Utah State Hospital Utilization Review. To ensure Medicaid funds, as defined under 42 CFR 456, Subpart D, are expended appropriately and 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. Ensuring compliance with the hospital utilization control components shall be the responsibility of the Department, OIAS, Program Integrity Unit and the Bureau of Managed Health Care.

1. Quarterly Clinical Utilization Reviews

On a quarterly basis, psychiatric staff under the Program Integrity Unit 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 or staff that has been assigned by the Office of Internal Audit Services, Program Integrity Unit or the Department.

Notes

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 may also perform utilization control functions as outlined in this subpart.

Identification of Possible Fraud and Abuse. Referral to the Medicaid Agency, Office of Internal Audit Services, 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 may 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 by 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.

READMISSION REVIEW

Whenever information available to the reviewer indicates the possibility of readmission to acute care within 30 days of the previous discharge, the Program Integrity 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.

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

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 Program Integrity staff or Office designee, may 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 which shall be taken,
5. Hearing rights, if the remedy involves a reduction, a denial or restriction of benefits to the provider and/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.

SAMPLING

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 shall be a random sample. Up to 2.5 percent may be a focused review on a specific service, if recommended by the Committee. A Committee decision to focus on a specific service shall be made no later than the 15th day of the month prior to the beginning of the sample cycle, if necessary, the universe of claims may be modified. However, at the discretion of administrative staff focused samples may be selected from a universe at the time the sample is selected.

The universe will be electronically selected from the Surveillance and Utilization Review System (SURS) in MMIS and consist of historical paid inpatient claims or from selected reports within the Department's Data Warehouse, herein called the 'Warehouse', and may 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, 2008, 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 DRG's 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 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 SURS or Warehouse 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:

<u>Activities</u>	<u>Ending Date</u>
Sample selection	15 th working day
Request records	20 th working day
Nurse review	85 th working day
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 approved by the Department and listed in the State Plan or recommended 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 and may include inter rater reliability standards as set forth by the Department.