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

WCDSC-R8-RB

March 26, 2008

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 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, 2010.

If you decide to renew the Superior Waiver after January 31, 2010, please send your request and supporting documentation 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
Aviva Walker-Sicard, CMS, CMSO, Survey and Certification Group
Gregory Watson, CMS, Division of Financial Management, Denver Regional Office
Betty Strecker, CMS, Program Management Branch, Denver Regional Office

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
SCB	Bailey	3/26/2008			
SC	Lord	3/26/08			

FILE COPY

State of Utah
JON M. HUNTSMAN, JR.
Governor
GARY R. HERBERT
Lieutenant Governor

Utah Department of Health
David N. Sundwall, M.D.
Executive Director
A. Richard Melton, Dr. P.H.
Deputy Director
Allen Korhonen
Deputy Director
Health Care Financing
Michael T. Hales
Division Director

CRP-793-07

December 17, 2007

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

Dear Ms. Strecker:

Enclosed are two copies of the updated Superior Systems Waiver.

If you have questions or wish to discuss this information further, please contact Alex Yei at (801) 538-6455.

Sincerely,

Michael T. Hales, Director
Division of Health Care Financing

Enclosures (2)

2007 DEC 28 PM 55

Utah Department of Health
Promote Prevent Protect

Bureau of Coverage & Reimbursement Policy
288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143102 • Salt Lake City, UT 84114-3102
Telephone (801) 538-6149

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

December 2007

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, 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 the division reimbursement policy, Medicaid 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 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 Health Care Financing, (hereafter called Division) has assigned the Bureau of Coverage & Reimbursement Policy, Program Integrity 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 Division assigned to 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 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 Bureau 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 Superior Systems Waiver 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 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 related to hospital utilization review and is only informational.

Prior Authorization Program. The Program Integrity/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 and 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 or staff that has been assigned by 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 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 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 bureau 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 Bureau Director 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 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, as 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, 2006, 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 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:

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 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

March 13, 2008

Ruth Bailey
Centers for Medicare & Medicaid Services
Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967

Dear Ms. Bailey:

Enclosed with this letter is the updated Utilization Review Superior Systems Waiver for the State of Utah. One of the exceptions to meeting the Medicare requirement for utilization review at 42 CFR §482.30 is if the State in which the hospital resides has a CMS-approved Superior Systems Waiver. Therefore, please copy Central Office on the final decision regarding the waiver. If you have any questions or concerns, please do not hesitate to contact me at (410) 786-8648 or via email at Aviva.walker-sicard@cms.hhs.gov.

Sincerely,

Aviva Walker-Sicard
Health Insurance Specialist

2008 MAR 18 AM 9 46

ıl of FFP for failure to have ıtilization review procedures. 03(i)(4) provides that FFP is ble in a State's expenditures ıl or mental hospital services : institution has in effect a ı review plan that meets requirements. However, the may waive this requirement icaid agency demonstrates to ction that it has utilization ocedures superior in effective- e Medicare procedures.

: *health agency guidance on d appropriateness of care and* ection 1902(a)(33)(A) requires plan provide that the State other appropriate medical tablish a plan for review, by al health personnel, of the eness and quality of Med- ices to provide guidance to aid agency and the State li- gency in administering the program.

' use review program. Section the Act provides that, for to be made under section 1903 Act for covered outpatient e State must have in oper- not later than January 1, ıg use review (DUR) program. quires that each State pro- er directly or through a con- ı a private organization, for ishment of a DUR Board.

TABLE 1

ates the regulations in this part to the sections the Act on which they are based.]

neral	1902(a)(30) 1902(a)(33)(A)
tilization Control: All vices.	1902(a)(30)
ilization Control: Hos-	
n of need for care	1903(g)(1)(A)
e	1903(g)(1)(B)
review plan (including in review).	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)
lization Control: Mental	
n of need for care	1903(g)(1)(A)
aluation and admission	1902(a)(26)(A) 1903(g)(1)(C)
e	1902(a)(26)(A) 1903(g)(1)(B)
and plan of care re- nts for individuals l.	1902(a)(26)(A) 1903(g)(1) (B), (C)
review plan	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)

TABLE 1—Continued

[This table relates the regulations in this part to the secti[ons] of the Act on which they are based.]

Subpart F—Utilization Control: Intermediate Care Facilities	
Certification of need for care	1903(g)(1)(A)
Medical evaluation and admission review.	1902(a)(31)(A) 1903(g)(1)(C)
Plan of care	1902(a)(31)(A) 1903(g)(1)(B)
Utilization review plan	1902(a)(30) 1903(g)(1)(C) 1903(i)(4)
Subpart G—Inpatient Psychiatric Services for Individuals Under Age 21: Admission and Plan of Care Requirements.	1905 (a)(16) and
Subpart H—Utilization Review Plans: FFP, Waivers, and Variances for Hospitals and Mental Hospitals.	
Subpart I—Inspections of Care in Intermediate Care Facilities and Institutions for Mental Diseases.	
Subpart J—Penalty for Failure To Make a Satisfactory Showing of An Effective Institutional Utilization Control Program.	1903(g)
Subpart K—Drug Use Review (DUR) Program and Electronic Claims Management System for Outpatient Drug Claims.	1927(g) and

[43 FR 45266, Sept. 29, 1978, as amended FR 48561, Oct. 1, 1981; 57 FR 49408, 1992; 61 FR 38398, July 24, 1996]

§ 456.2 State plan requirements.

(a) A State plan must provide the requirements of this part are

(b) These requirements may be by the agency by:

(1) Assuming direct responsibility assuring that the requirements of part are met; or

(2) Deeming of medical and tion review requirements if the contracts with a QIO to perform review, which in the case of acute care review will also serve initial determination for QIO necessity and appropriateness for patients who are dually enti benefits under Medicare and Med

(c) In accordance with § 431.15 of subchapter, FFP will be availabl expenses incurred in meeting quirements of this part.

[46 FR 48566, Oct. 1, 1981, as amended 15327, Apr. 17, 1985; 51 FR 43198, Dec.

§ 456.3 Statewide surveillance lization control program.

The Medicaid agency must ment a statewide surveillance and lization control program that—

appropriate use of Medicaid serv- and against excess payments;

Assesses the quality of those serv-

Provides for the control of the ation of all services provided the plan in accordance with sub- B of this part; and

Provides for the control of the ation of inpatient services in ac- nce with subparts C through I of part.

4 Responsibility for monitoring the utilization control program.

The agency must—

Monitor the statewide utilization ol program;

Take all necessary corrective ac- to ensure the effectiveness of the ram;

Establish methods and procedures plement this section;

Keep copies of these methods and dures on file; and

Give copies of these methods and dures to all staff involved in car- out the utilization control pro- am.

5 Evaluation criteria.

agency must establish and use criteria for evaluating the ap- riateness and quality of Medicaid ices. This section does not apply to es in hospitals and mental hos- s. For these facilities, see the fol- g sections: §§ 456.122 and 456.132 of art C; and § 456.232 of subpart D.

45266, Sept. 29, 1978, as amended at 61 , July 24, 1996]

6 Review by State medical agency of appropriateness and quality of services.

The Medicaid agency must have greement with the State health cy or other appropriate State med- agency, under which the health or al agency is responsible for es- shing a plan for the review by pro- onal health personnel of the appro- eness and quality of Medicaid ices.

The purpose of this review plan is provide guidance to the Medicaid cy in the administration of the e plan and, where applicable, to

§ 431.610.

Subpart B—Utilization Control: All Medicaid Services

§ 456.21 Scope.

This subpart prescribes utilization control requirements applicable to all services provided under a State plan.

§ 456.22 Sample basis evaluation of services.

To promote the most effective and appropriate use of available services and facilities the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

§ 456.23 Post-payment review process.

The agency must have a post-payment review process that—

(a) Allows State personnel to develop and review—

(1) Recipient utilization profiles;

(2) Provider service profiles; and

(3) Exceptions criteria; and

(b) Identifies exceptions so that the agency can correct misutilization practices of recipients and providers.

Subpart C—Utilization Control: Hospitals

§ 456.50 Scope.

This subpart prescribes requirements for control of utilization of inpatient hospital services, including requirements concerning—

(a) Certification of need for care;

(b) Plan of care; and

(c) Utilization review plans.

§ 456.51 Definitions.

As used in this subpart:

Inpatient hospital services—

(a) Include—

(1) Services provided in an institution other than an institution for mental disease, as defined in § 440.10;

(2) [Reserved]

(3) Services provided in specialty hospitals and

(2) Associated with the frequent furnishing of excessive services; or

(3) Attended by physicians whose patterns of care are frequently found to be questionable.

§ 456.123 Admission review process.

The UR plan must provide that—

(a) Admission review is conducted by—

(1) The UR committee;

(2) A subgroup of the UR committee; or

(3) A designee of the UR committee;

(b) The committee, subgroup, or designee evaluates the admission against the criteria developed under § 456.122 and applies close professional scrutiny to cases selected under § 456.129(b);

(c) If the committee, subgroup, or designee finds that the admission is needed, the committee assigns an initial continued stay review date in accordance with § 456.128;

(d) If the committee, subgroup, or designee finds that the admission does not meet the criteria, the committee or a subgroup that includes at least one physician reviews the case to decide the need for admission;

(e) If the committee or subgroup making the review under paragraph (d) of this section finds that the admission is not needed, it notifies the recipient's attending physician and gives him an opportunity to present his views before it makes a final decision on the need for the continued stay;

(f) If the attending physician does not present additional information or clarification of the need for the admission, the decision of the committee or subgroup is final; and

(g) If the attending physician presents additional information or clarification, at least two physician members of the committee review the need for the admission. If they find that the admission is not needed, their decision if final.

§ 456.124 Notification of adverse decision.

The UR plan must provide that written notice of any adverse final decision on the need for admission under § 456.123 (e) through (g) is sent to—

(a) The hospital administrator;

(b) The attending physician;

(c) The Medicaid agency;

(d) The recipient; and

(e) If possible, the next of kin [illegible] sponsor.

§ 456.125 Time limits for admission review.

Except as required under § 456.127, [illegible] UR plan must provide that review [illegible] each recipient's admission to the hospital is conducted—

(a) Within one working day after [illegible] mission, for an individual who is [illegible] ceiving Medicaid at that time; or

(b) Within one working day after [illegible] hospital is notified of the application [illegible] for Medicaid, for an individual who [illegible] plies while in the hospital.

§ 456.126 Time limits for final decision and notification of adverse decision.

Except as required under § 456.127, [illegible] UR plan must provide that the committee makes a final decision on [illegible] cipient's need for admission and [illegible] notice of an adverse final decision—

(a) Within two working days after [illegible] mission, for an individual who is [illegible] ceiving Medicaid at that time; or

(b) Within two working days [illegible] the hospital is notified of the application for Medicaid, for an individual who applies while in the hospital.

§ 456.127 Pre-admission review.

The UR plan must provide for [illegible] and final decision prior to admission for certain providers or categories of admissions that the UR committee designates under § 456.142(b) (4)(iii) [illegible] ceive pre-admission review.

§ 456.128 Initial continued stay review date.

The UR plan must provide that—

(a) When a recipient is admitted to the hospital under the admission review requirements of this subpart, the committee assigns a specified date on which the need for his continued stay will be reviewed;

(b) The committee bases its assignment of the initial continued stay review date on—

(1) The methods and criteria required to be described under § 456.129;

(2) The individual's condition; and

(3) The individual's projected discharge date;

(c)(1) The committee uses any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third party payors, to assign the initial continued stay review date;

(2) These regional norms are based on current and statistically valid data on duration of stay in hospitals for patients whose characteristics, such as age and diagnosis, are similar to those of the individual whose case is being reviewed;

(3) If the committee uses norms to assign the initial continued stay review date, the number of days between the individual's admission and the initial continued stay review date is no greater than the number of days reported in the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate; and

(d) The committee ensures that the initial continued stay review date is recorded in the individual's record.

§ 456.129 Description of methods and criteria: Initial continued stay review date; close professional scrutiny; length of stay modification.

The UR plan must describe—

(a) The methods and criteria, including norms if used, that the committee uses to assign the initial continued stay review date under § 456.128.

(b) The methods that the committee uses to select categories of admission to receive close professional scrutiny under § 456.123(b); and

(c) The methods that the committee uses to modify an approved length of stay when the recipient's condition or treatment schedule changes.

UR Plan: Review of Need for Continued Stay

§ 456.131 Continued stay review required.

The UR plan must provide for a review of each recipient's continued stay in the hospital to decide whether it is needed, in accordance with the requirements of §§ 456.132 through 456.137.

§ 456.132 Evaluation criteria for continued stay.

The UR plan must provide that—

(a) The committee develops written medical care criteria to assess the need for continued stay.

(b) The committee develops more extensive written criteria for cases that its experience shows are—

(1) Associated with high costs;

(2) Associated with the frequent furnishing of excessive services; or

(3) Attended by physicians whose patterns of care are frequently found to be questionable.

§ 456.133 Subsequent continued stay review dates.

The UR plan must provide that—

(a) The committee assigns subsequent continued stay review dates in accordance with §§ 456.128 and 456.134(a);

(b) The committee assigns a subsequent review date each time it decides under § 456.135 that the continued stay is needed; and

(c) The committee ensures that each continued stay review date it assigns is recorded in the recipient's record.

§ 456.134 Description of methods and criteria: Subsequent continued stay review dates; length of stay modification.

The UR plan must describe—

(a) The methods and criteria, including norms if used, that the committee uses to assign subsequent continued stay review dates under § 456.133; and

(b) The methods that the committee uses to modify an approved length of stay when the recipient's condition or treatment schedule changes.

§ 456.135 Continued stay review process.

The UR plan must provide that—

(a) Review of continued stay cases is conducted by—

(1) The UR committee;

(2) A subgroup of the UR committee; or

(3) A designee of the UR committee;

(b) The committee, subgroup or designee reviews a recipient's continued stay on or before the expiration of each assigned continued stay review date;

(c) For each continued stay of a recipient in the hospital, the committee,

subgroup or designee reviews and evaluates the documentation described under § 456.111 against the criteria developed under § 456.132 and applies close professional scrutiny to cases selected under § 456.129(b);

(d) If the committee, subgroup, or designee finds that a recipient's continued stay in the hospital is needed, the committee assigns a new continued stay review date in accordance with § 456.133;

(e) If the committee, subgroup, or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one physician reviews the case to decide the need for continued stay;

(f) If the committee or subgroup making the review under paragraph (e) of this section finds that a continued stay is not needed, it notifies the recipient's attending physician and gives him an opportunity to present his reviews before it makes a final decision on the need for the continued stay;

(g) If the attending physician does not present additional information or clarification of the need for the continued stay, the decision of the committee or subgroup is final; and

(h) If the attending physician presents additional information or clarification, at least two physician members of the committee review the need for the continued stay. If they find that the recipient no longer needs inpatient hospital services, their decision is final.

§ 456.136 Notification of adverse decision.

The UR plan must provide that written notice of any adverse final decision on the need for continued stay under § 456.135 (f) through (h) is sent to—

(a) The hospital administrator;

(b) The attending physician;

(c) The Medicaid agency;

(d) The recipient; and

(e) If possible, the next of kin or sponsor.

§ 456.137 Time limits for final decision and notification of adverse decision.

The UR plan must provide that—

(a) The committee makes a final decision on a recipient's need for continued stay and gives notice under § 456.[illegible] of an adverse final decision within [illegible] working days after the assigned continued stay review dates, except as required under paragraph (b) of this section.

(b) If the committee makes an adverse final decision on a recipient's need for continued stay before the assigned review date, the committee gives notice under § 456.136 within [illegible] working days after the date of the final decision.

UR Plan: Medical Care Evaluation Studies

§ 456.141 Purpose and general description.

(a) The purpose of medical care evaluation studies is to promote the [illegible] effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

(b) Medical care evaluation studies—

(1) Emphasize identification and analysis of patterns of patient care; and

(2) Suggest appropriate changes needed to maintain consistently high quality patient care and effective and efficient use of services.

§ 456.142 UR plan requirements for medical care evaluation studies.

(a) The UR plan must describe the methods that the committee uses to select and conduct medical care evaluation studies under paragraph (b) of this section.

(b) The UR plan must provide that the UR committee—

(1) Determines the methods to be used in selecting and conducting medical care evaluation studies in the hospital;

(2) Documents for each study—

(i) Its results; and

(ii) How the results have been used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services;

(3) Analyzes its findings for each study; and

(4) Takes action as needed to—

(i) Correct or investigate further any deficiencies or problems in the [illegible] process for admissions or continued stay cases;

(ii) Recommend more effective and efficient hospital care procedures; or

(iii) Designate certain providers or categories of admissions for review prior to admission.

§ 456.143 Content of medical care evaluation studies.

Each medical care evaluation study must—

(a) Identify and analyze medical or administrative factors related to the hospital's patient care;

(b) Include analysis of at least the following:

(1) Admissions;

(2) Durations of stay;

(3) Ancillary services furnished, including drugs and biologicals;

(4) Professional services performed in the hospital; and

(c) If indicated, contain recommendations for changes beneficial to patients, [illegible] the hospital, and the community.

§ 456.144 Data sources for studies.

Data that the committee uses to perform studies must be obtained from one or more of the following sources:

(a) Medical records or other appropriate hospital data;

(b) External organizations that compile statistics, design profiles, and produce other comparative data;

(c) Cooperative endeavors with—

(1) QIOs;

(2) Fiscal agents;

(3) Other service providers; or

(4) Other appropriate agencies.

[[illegible] 45266, Sept. 29, 1978, as amended at 51 [illegible]198, Dec. 1, 1986]

§ 456.145 Number of studies required to be performed.

The hospital must, at least, have one study in progress at any time and complete one study each calendar year.

Subpart D—Utilization Control: Mental Hospitals

§ 456.150 Scope.

This subpart prescribes requirements for control of utilization of inpatient services in mental hospitals, including requirements concerning—

(a) Certification of need for care;

(b) Review;

(c) Plan of care; and

(d) Utilization review plans.

§ 456.151 Definitions.

As used in this subpart:

Medical care appraisal norms or *norms* means numerical or statistical measures of usually observed performance.

Medical care criteria or *criteria* means predetermined elements against which aspects of the quality of a medical service may be compared. These criteria are developed by health professionals relying on their expertise and the professional health care literature.

Certification of Need for Care

§ 456.160 Certification and recertification of need for inpatient care.

(a) *Certification.* (1) A physician must certify for each applicant or recipient that inpatient services in a mental hospital are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a mental hospital, before the Medicaid agency authorizes payment.

(b) *Recertification.* (1) A physician, or physician assistant or nurse practitioner (as defined in § 491.2 of this chapter) acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or recipient that inpatient services in a mental hospital are needed.

(2) Recertification must be made at least every 60 days after certification.

[46 FR 48561, Oct. 1, 1981]

Medical, Psychiatric, and Social Evaluations and Admission Review

§ 456.170 Medical, psychiatric, and social evaluations.

(a) Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or recipient's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation.

ıe hospital must take the following
:tions:
(i) Promptly make at least three at-
mpts to notify the patient's attend-
g physician (that is, the physician of
cord) or the physician who ordered
e blood or blood product that poten-
ılly HIV infectious blood or blood
oducts were transfused to the pa-
ent.
ii) Ask the physician to immediately
tify the patient, or other individual
permitted under paragraph (c)(8) of
is section, of the need for HIV test-
; and counseling.
iii) If the physician is unavailable,
:lines to make the notification, or
er informs the hospital that he or
: was unable to notify the patient,
)mptly make at least three attempts
notify the patient, or other indi-
ual as permitted under paragraph
8) of this section, of the need for
V testing and counseling.
iv) Document in the patient's med-
l record the notification or attempts
give the required notification.
i) *Timeframe for notification.* The no-
cation effort begins when the blood
ık notifies the hospital that it re-
ved potentially HIV infectious blood
l blood products and continues for 8
:ks unless—
.) The patient is located and noti-
l; or
ii) The hospital is unable to locate
patient and documents in the pa-
nt's medical record the extenuating
:umstances beyond the hospital's
ıtrol that caused the notification
ıeframe to exceed 8 weeks.
i) *Content of notification.* The notifi-
ion given under paragraphs (c)(4) (ii)
(iii) of this section must include
following information:
) A basic explanation of the need for
V testing and counseling.
i) Enough oral or written informa-
ı so that the transfused patient can
ke an informed decision about
:ther to obtain HIV testing and
nseling.
ii) A list of programs or places
:re the patient can obtain HIV test-
and counseling, including any re-
rements or restrictions the program
y impose.
v) *Policies and procedures.* The hos-
al must establish policies and proce-
dures for notification and documenta-
tion that conform to Federal, State
and local laws, including requirements
for confidentiality and medical
records.

(8) *Notification to legal representative or relative.* If the patient has been adjudged incompetent by a State court, the physician or hospital must notify the legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or relative. If the patient is deceased, the physician or hospital must continue the notification process and inform the deceased patient's legal representative or relative.

[57 FR 7136, Feb. 28, 1992, as amended at 61 FR 47433, Sept. 9, 1996]

§482.28 Condition of participation: Food and dietetic services.

The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

(a) *Standard: Organization.* (1) The hospital must have a full-time employee who—

(i) Serves as director of the food and dietetic service;

(ii) Is responsible for the daily management of the dietary services; and

(iii) Is qualified by experience or training.

(2) There must be a qualified dietitian, full-time, part-time, or on a consultant basis.

(3) There must be administrative and technical personnel competent to perform respective duties.

(b) *Standard: Diets.* Menus must meet the needs of the patients.

(1) Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the patients.

(2) Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients.

(3) A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel.

§482.30 Condition of participation: Utilization review.

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

(a) *Applicability.* The provisions of this section apply except in either of the following circumstances:

(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.

(2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section and has required hospitals in that State to meet the UR plan requirements under §§456.50 through 456.245 of this chapter.

(b) *Standard: Composition of utilization review committee.* A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).

(1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following:

(i) A staff committee of the institution; or

(ii) A group outside the institution—

(A) Established by the local medical society and some or all of the hospitals in the locality; or

(B) Established in a manner approved by CMS.

(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

(3) The committee's or group's reviews may not be conducted by any individual who—

(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or

(ii) Was professionally involved in the care of the patient whose case is being reviewed.

(c) *Standard: Scope and frequency of review.* (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of—

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished, including drugs and biologicals.

(2) Review of admissions may be performed before, at, or after hospital admission.

(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.

(4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in Part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:

(i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in §412.80(a)(1)(i) of this chapter; and

(ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in §412.80(a)(1)(ii) of this chapter.

(d) *Standard: Determination regarding admissions or continued stays.* (1) The determination that an admission or continued stay is not medically necessary—

(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of

§ 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and

(ii) Must be made by at least two members of the UR committee in all other cases.

(2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

(3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);

(e) *Standard: Extended stay review.* (1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may—

(i) Be the same for all cases; or

(ii) Differ for different classes of cases.

(2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in § 412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.

(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.

(f) *Standard: Review of professional services.* The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

§ 482.41 Condition of participation: Physical environment.

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

(a) *Standard: Buildings.* The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

(1) There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.

(2) There must be facilities for emergency gas and water supply.

(b) *Standard: Life safety from fire.* (1) Except as otherwise provided in this section—

(i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the FEDERAL REGISTER to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.

(4) Beginning March 13, 2006, a hospital must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.

(6) The hospital must have procedures for the proper routine storage and prompt disposal of trash.

(7) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

(8) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.

(9) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospital may install alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any additional changes are made to this amendment, CMS will publish notice in the FEDERAL REGISTER to announce the changes.

(c) *Standard: Facilities.* The hospital must maintain adequate facilities for its services.

(1) Diagnostic and therapeutic facilities must be located for the safety of patients.

(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

(3) The extent and complexity of facilities must be determined by the services offered.

(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

[51 FR 22042, June 17, 1986, as amended at 53 FR 11509, Apr. 7, 1988; 68 FR 1386, Jan. 10, 2003; 69 FR 49267, Aug. 11, 2004; 70 FR 15238, Mar. 25, 2005]

EFFECTIVE DATE NOTE: At 71 FR 55340, Sept. 22, 2006, § 482.41 was amended by revising paragraph (b)(9)(iii), by removing the last sentence of paragraph (b)(9)(iv), by removing the period at the end of paragraph (b)(9)(iii) and adding in its place "; and", and adding paragraph (b)(9)(v), effective Oct. 23, 2006. For the convenience of the user, the added and revised text is set forth as follows:

§ 482.41 Condition of participation: Physical environment.

* * * * *

(b) * * *

(9) * * *

(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;

* * * * *

Bailey, Ruth R. (CMS/CQISCO)

From: Dahl, Marilyn M. (CMS/CMSO)
Sent: Wednesday, March 26, 2008 1:52 PM
To: Weinstein, Rachael B. (CMS/OCSQ); Bailey, Ruth R. (CMS/CQISCO)
Cc: Chmielewski, Patricia A. (CMS/CMSO); Walker-Sicard, Aviva J. (CMS/CMSO)
Subject: RE: Renewal of Two Year Superior Systems Waiver for the State of Utah

Copies of the RO decision documentation should be sent to Aviva Walker-Sicard within our Division

Marilyn Dahl
Director, Division of Acute Care Services
Survey and Certification Group
CMSO/CMS
Phone: 410-786-8665
Fax: 410-786-0194
marilyn.dahl@cms.hhs.gov

From: Weinstein, Rachael B. (CMS/OCSQ)
Sent: Wednesday, March 26, 2008 3:49 PM
To: Bailey, Ruth R. (CMS/CQISCO)
Cc: Dahl, Marilyn M. (CMS/CMSO); Chmielewski, Patricia A. (CMS/CMSO)
Subject: RE: Renewal of Two Year Superior Systems Waiver for the State of Utah

I have long been out of survey and certification, and likely these letters have been routed to CMSO.
I have copied Mailyn Dahl and Pat Chmielewski here. They should be able to give you the name of a contact.

From: Bailey, Ruth R. (CMS/CQISCO)
Sent: Wednesday, March 26, 2008 3:46 PM
To: Weinstein, Rachael B. (CMS/OCSQ)
Subject: Renewal of Two Year Superior Systems Waiver for the State of Utah

Rachael,

In the past I've sent copies to you of the subject approval letters. I am currently in the process of preparing a new two year approval letter for their Hospital Utilization Review Program. I would like to copy it to the correct person in Central Office. If someone else should be receiving this correspondence, please respond and send me their name and telephone number.

Thanks,

Ruth Bailey, Health Insurance Specialist
Denver Regional Office/CMS/WCDSC/SCB
1600 Broadway, Suite 700
Denver, Colorado 80202-4967
Telephone: 303-844-7031
Fax: 303-844-3753
E-Mail: Ruth.Bailey@cms.hhs.gov

Two –Year Extension of Inpatient Hospital Utilization Review Waiver Granted to the Utah Department of Health

The Utah Department of Health, Division of Health Care Financing, was granted a two-year extension of their Inpatient Hospital Utilization Review Waiver. The Superior Systems Waiver was originally granted in October 1982, and has since been renewed several times. This current two-year extension is granted through January 31, 2010.

Contact: Ruth Bailey – 303-844-7031.

Utah OPT/OSP Approved to Add Two New Extension Offices

Mountain Land Rehabilitation Agency, an outpatient physical therapy (OPT) facility located in Salt Lake City, Utah, was approved to add two new extension offices effective February 29, 2008 and March 5, 2008, at 5250 South Commerce Drive, Salt Lake City, Utah, and 3225 West Gordon Avenue, Layton, Utah. Mountain Land Rehabilitation Agency including the parent now has a total of twenty-four offices.

Contact: Ruth Bailey, 303-844-7031.

Utah Initial Certifications

A Step Forward Home Health Agency, located in Sandy, Utah, was found to meet CMS's requirements for participation in the Medicare/Medicaid program as a freestanding home health agency effective February 28, 2008.

Zion's Way Home Health Agency, located in American Fork, Utah was found to meet CMS's requirements for participation in the Medicare/Medicaid program as a freestanding home health agency effective March 5, 2008.

Contact: Ruth Bailey - 303-844-7031.