PART NINE

UTILIZATION CONTROL

GENERAL PROVISIONS

UTILIZATION CONTROL

PHYSICIAN CERTIFICATION/RECERTIFICATION

SUPERIOR UR SYSTEMS

9100. LEGAL BACKGROUND AND AUTHORITY FOR THE UTILIZATION CONTROL PROGRAM

Section 1903(g) of the Act mandates a reduction in a State's Federal financial participation (FFP) unless the State has an effective program of control over health care services provided to Medicaid recipients receiving inpatient care after:

- 60 days in a hospital or intermediate care facility (ICF) or ICF for the mentally retarded (ICF/MR),
- 30 days in a skilled nursing facility (SNF),
- 90 days in an institution for mental diseases (IMD).

All participating States must make quarterly showings (QS) demonstrating to the Secretary that they have an effective utilization control (UC) program which meets all of the requirements of §1903(g).

To assure compliance, §1903(g) of the Act requires the Secretary, who has delegated this authority to the Administrator of the Health Care Financing Administration (HCFA), to validate the States' QS through onsite surveys at SAs administering medical assistance programs and at institutions providing long-term care services to Medicaid recipients. Section 1903(g)(5) requires a reduction of 33 1/3 percent of a State's FFP for a given level of care for each quarter in which it does not make a satisfactory showing.

9102. SCOPE OF THE UC QUALITY REVIEW SYSTEM

The primary objective of the UC quality review system is to monitor the States' quarterly compliance with the regulatory requirements of 42 CFR, part 456, and with policies established to satisfy the UC requirements of §1903(g) of the Act. The review enables HCFA to determine if a State has satisfactorily demonstrated that it has an effective program of control over the utilization of inpatient institutional services. If the determination (through a review of the State's QS and the validation survey at the SA or institution) indicates that a State's performance is unsatisfactory, a reduction is made in Federal matching payments for the costs of inpatient institutional services under Medicaid in every quarter for which a State fails to make a satisfactory showing.

A single SA which contracts its medical review function to another SA, local public agency or private professional group other than an HCFA approved peer review organization (PRO) or a health maintenance organization (HMO) continues to be responsible for meeting all UC requirements.

9105. REQUIREMENTS FOR CONTENT OF QUARTERLY SHOWINGS

Submit the following documents in the showing for each quarter in which you participate in the Medicaid program.

9105.1 Certification by Director of the Single SA.--Submit a certification by the Single SA that the requirements for an effective UC program were met for each level of care or, if applicable, submit a certification of the reasons the annual onsite review requirements were not met in any facility. (See §9120.) The certification must be on SA letterhead for each level of care (SNF, ICF, and IMD) for which an annual review is required, and it must be signed and dated by the Director of the Single SA. For any level of care where 100 percent of the facilities in the State are under review by a PRO, the medical review requirements are deemed met. Therefore the State is relieved of UC QS requirements and validation surveys. However, a certification for each level of care under PRO review must be submitted for those levels of care until further instructions are issued. Annotate "PRO Review" in the upper right hand corner of the certification. Ensure that the face of each certification identifies the name of the State and the quarter for which the certification is made. (See Exhibits 1, 2, 3, and 4 for samples of certifications.)

9105.2 List of Participating Facilities.--Submit, as part of your QS, a list of IMDs, SNFs, and ICFs which participated in Medicaid anytime during the 12-month period ending on the last day of the showing quarter. Indicate which facilities had an annual medical review (also referred to as an inspection of care (IOC) review) performed during the showing quarter. The review is considered timely if it is completed by the end of the anniversary quarter of the facility's entry into the program or by the end of the quarter in which the previous year's review was performed, whichever is applicable. (Facilities reviewed untimely must revert to the original review quarter for subsequent reviews.)

Example: If a facility entered into the Medicaid program or performed its last prior review on May 23, 1987, the annual IOC review is required to be performed not later than the anniversary quarter ending June 30, 1988 (anytime between April 1 and June 30).

The QS format (Exhibit 5) provides a column to list the date on which an annual onsite review was performed in the 12-month period preceding the last day of the showing quarter. For any level of care where 100 percent of the facilities are under binding review by a PRO, you need not submit a list of participating facilities. (You must however, assure that your contract with the PRO satisfies UC requirements.)

9105.3 Facility Payment Data.--Submit a listing showing all facilities for which Medicaid payments were made during the quarter or for which Medicaid payments were requested. Identify the facility, address, provider number, and payments by level of care.

9110. COMPLETING FACILITY LISTS

9110.1 General.--Submit three facility lists for each showing quarter:

- SNFs and ICFs (including those dually certified) on the same listing. Include those hospitals, located in a rural area and having less than 50 beds, which have a "swing bed" agreement where they can designate a number of their beds between acute and long term levels of care on an as needed basis. (Part 4 describes your option to enter into such an agreement.)

- ICFs/MR (although a part of the ICF level of care) separately.

- IMDs (include mental hospitals, psychiatric facilities, and SNFs and ICFs designated as IMDs). A psychiatric facility includes a facility or program that provides inpatient psychiatric services for individuals under 21. It does not include psychiatric wards in acute care hospitals. An institution for mental diseases is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services. For classifying facilities into the IMD subgroup, use the designations made by HCFA's Health Standards and Quality Office which appear on the facility's provider agreement. Note that an institution for the mentally retarded is not an institution for mental diseases.

To reduce the possibility of a QS erroneously being found unsatisfactory and to make the facility listing easier for HCFA to analyze:

- Type all information or write or print legibly.

- Leave enough space between information for each facility so that it is clear as to which facility the information applies.

- Indicate the name and degree of the team leader of each facility's IOC review. For IMDs, list the name of the physician who is knowledgeable about mental diseases and institutions and who served as the team leader (supervised) of the IOC team. For ICFs, ICFs/MR, and SNFs indicate the name and degree of the registered nurse who participated in the annual IOC review and served in the capacity of the team's leader (supervised) during the IOC review.

- Make sure all required information is included. Omissions may make the showing unsatisfactory on its face.

- IF ANY REVIEWS DUE IN THE QUARTER WERE NOT PERFORMED BECAUSE THERE WERE NO TITLE XIX RECIPIENTS PRESENT IN THE FACILITY OR NO TITLE XIX RECIPIENTS AT A GIVEN LEVEL IN A DUALLY-CERTIFIED FACILITY, INDICATE THIS ON THE FACILITY LISTING AND ATTACH A STATEMENT TO THIS EFFECT SIGNED BY THE DIRECTOR OF THE SINGLE SA.

9110.2 Specific.--Include the following detailed information. All facilities participating in the Medicaid program must be shown.

o Heading.--Put at the top of each page of the facility listing for each level of care: Name of State, level of care, ending date of the quarter, page number, and total number of pages in the listing for that level of care.

o Column I - Facility Name, Address, and Title XIX Provider Number.--List the complete name of the facility as the first line. Show the complete address (street and/or post office box, city, and ZIP code) directly under the name. Follow the address with the provider number(s). It is preferred that facility names be listed in alphabetical order. They may be listed in alphabetical order by county, city, or other geographic area; and within each geographic area, in alphabetical order by name of facility. However, provide a key explaining the listing. If a facility changes name, address, or provider number within the showing quarter, list the facility under both names and show a cross-reference. Complete data in columns II through VII only under the new name. Line through columns II through VII after the former name and omit the former facility's name from future listings.

o Column II - Certification Status Change.--Indicate any change in provider status which occurred at any time during the 12-month period ending on the last day of the showing quarter. Include provider agreement information for facilities newly certified or recertified for participation in the Medicaid program, terminations or suspensions, change of ownership or address, and the addition or deletion of a level of care in dually-certified facilities.

If the facility's title XIX participation began or ended during the period, show the beginning or ending provider agreement date. Report the facility's beginning provider agreement date in this column only if:

o The beginning date of the provider agreement for that level of care falls within the quarter or less than 12 months earlier than the ending date of the quarter; or

o The facility began participating as a title XIX provider at a different level of care.

For any facility entering the program during the showing quarter, submit a copy of the provider agreement with the QS. (FFP is not available for Medicaid services in any facility prior to a valid provider agreement being executed.) For any facility that is terminated during the showing quarter, or which withdraws from the program, submit a copy of the termination or withdrawal notice. Be sure to include terminated facilities on the current listing and include them in the facility count. They may be deleted from future QS listings unless the facility continues to provide services and requests payment for Medicaid recipients after the expiration or termination of the facility's provider agreement. Once all Medicaid recipients have been placed elsewhere or payments stopped, the facility may be deleted.

Submit documentation to substantiate suspensions, change of ownership or address, and the addition or deletion of a level of care.

D. Column III - Reviews Completed in Prior 12 Months.--Give the dates on which onsite reviews were completed in the 12 months prior to the end of the showing quarter. Where an IOC took more than 1 day to complete, use the last day of the review as the facility's IOC date. If multiple reviews were performed during the year, list the dates each review was performed, the number or percentage of patients reviewed if the review was not a 100-percent review, and identify the facility's anniversary quarter. (Indicate 100-percent after the last review date.) Example: 10/13/87-10% 11/17/87-35% 12/15/87-100% (anniversary qtr.) However, list only the most recent review date if 100 percent of the Medicaid recipients are reviewed each time and designate the facility's anniversary quarter. Example: 06/13/86 (anniversary Qtr. 12/30/86). If a facility is participating at both the SNF and ICF levels of care and a separate IOC review is performed at each level, indicate both dates and the appropriate level of care in brackets. Example: 6/13/88 (SNF) 6/27/88 (ICF).

If a facility was due for review during the showing quarter but was not reviewed because there were no title XIX recipients residing in the facility during the showing quarter or on the date of the scheduled review, indicate this. For example: "No title XIX patients in the facility since (date)"; "No title XIX recipients in the facility on date of scheduled review (date)." If the review included only title XIX recipients at one level of care in a dually-certified facility during the showing quarter or on the date of the scheduled review, indicate this. For example: "No title XIX (level of care) recipients in the facility since (date)"; "No title XIX (level of care) recipients in the facility on date of scheduled review (date)."

In each case, attach a statement signed by the Director of the Single SA with the QS containing the following information:

- facility name and address,
- provider number(s),
- level(s) of care in each facility not reviewed,
- date on which you attempted to schedule or to perform the review, and
- a statement that at such time there were no title XIX recipients in the facility or none at a given level of care. (See Exhibit 6.)

Check with the facility and the component which certifies recipients as eligible for Medicaid institutional payments each subsequent quarter to determine if any recipients had been admitted to the facility. If a recipient has been admitted to the facility, the IOC team must make arrangements before the end of the quarter to conduct an annual review of the recipient's care. The new IOC annual review quarter becomes the anniversary quarter in which the recipient is reviewed. No additional reviews are required until the anniversary quarter 1 year later. This is applicable only to facilities which have been in the program at least 1 year.

For facilities participating in the program for less than 1 year, there is no need to check each quarter. Any Medicaid recipient entering the facility during the period between the facility's entry into the program and the last day of the facility's anniversary quarter (1 year later) must be reviewed by that date. The review date for the subsequent year remains the same unless there are no Medicaid recipients in the facility at the time of the second anniversary review period.

E. Column IV - PRO Assumption Date/Area.--Show the date (or area if other than entire State) on which UC review responsibilities were assumed by a PRO. If a PRO assumed responsibility for a level of care, continue to show this date, along with the necessary identifying information for the facility in column I, until all facilities in the State at this level of care are under PRO review. Once the PRO has assumed total review responsibility for a level of care, line through the facilities on the QS in which the review responsibility was completed and delete them from future showings. Continue to submit a certification for the level of care until further instructions are provided. However there is no need to submit a facility listing for that level of care. In the case of a dually-certified facility where the PRO is responsible for only one level of care, continue to report the other level of care. Indicate the particular level of care in the dually-certified facility which was relieved. Example: 7/30/86 (SNF).

If a PRO assumed UC review responsibility on an individual facility basis, line through the facility on the State's showing once actual PRO assumption/implementation has begun (the effective date) during the reporting quarter and delete it from future showings. Submit appropriate documentation supporting all PRO assumption of UC review responsibilities with the QS.

F. Column V - PRO Relieved Date/Area.--Show the date (or area if other than entire State) on which a PRO was defunded or its contract terminated and you became responsible for UC review activities. Submit a QS with the first full quarter of State review responsibility and every quarter thereafter. Submit appropriate documentation verifying PRO relief with QS. You must perform an onsite review within one year of the date the PRO was defunded or its contract terminated. (This means by the end of the anniversary quarter of PRO defunding.) A proposed schedule of review for facilities which were deemed met under PRO must be submitted with the first QS.

G. Column VI - Name and Degree of Physician (If Required) or Nurse.--For each onsite review in a facility, list the name and medical qualifications of the physician or nurse on the inspection team. List the name of the physician or nurse who supervised the most recent IOC review corresponding with the last date shown in column III. Do not use ditto marks since a mark may be inadvertently omitted and cause the showing to be unsatisfactory on its face.

For SNFs, ICFs and ICFs/MR there must be a physician or nurse and other appropriate health and social services personnel on the IOC team who know the problems and needs of the individuals at the level of institutional care. For IMDs (including MHs, psychiatric units or facilities, and SNFs or ICFs that primarily care for mental patients) the inspection team must include a psychiatrist or physician knowledgeable about mental diseases who actively participated onsite in the IOC review, as well as other appropriate health and social services personnel. The intent is that a physician must have input rather than merely review or approve the findings of other IOC team members. All team members must be physically present at the facility during the entire IOC review and must actively participate. (The absence of a team member during the course of a review may render the review invalid.) The purpose of the team process is to provide team members with the opportunity to review and discuss face-to-face information relating to the needs of each recipient.

Where a physician is not required to be on the IOC team, insure that a physician is available to provide consultation. If a team has one or more physicians, it must be supervised by one of them.

H. Column VII - Level of Care.--Designate whether a facility is a SNF only, an ICF only, dually-certified as both, or is an ICF/MR or an IMD.

9110.3 Reporting A Multiple Building Facility.--Use the following procedure to report a multiple building facility such as campus arrangements, cottages, State schools, etc.

o For a multiple building facility operating under a single provider number, list the name of the facility, the address, and provider number. Identify each building or cottage that is a part of the provider agreement directly under the provider number. If all buildings in the complex were reviewed within the same calendar quarter, indicate the review date or period (if more than one day) opposite of the facility in column III. (The IOC review is not considered complete until all buildings are reviewed.)

o For a multiple building facility having separate provider numbers, for each cottage or building identify each building separately on the appropriate facility list and show the date the recipients in that building were reviewed if the dates of all the building reviews are not in the same calendar quarter.

9110.4 Reporting Facilities Approved Under the Swing Bed Provision.--Include acute care facilities which have received approval for the swing bed provision for title XIX recipients in the QS report beginning with the quarter under which the agreement became effective. SNF and ICF type services in swing bed hospitals are subject to the same requirements applicable to such services when furnished by a certified SNF or ICF. States that have hospitals approved under this provision must meet all UC requirements provided for in regulation 42 CFR 456.652. The following requirements in completing the QS must be met:

o Include in column I of the SNF/ICF Facility Listing the name of the acute care facility, the address, and the provider agreement number.

o Indicate the date the facility was approved for swing bed participation in column II if the beginning date of the agreement falls within the quarter or less than 12 months earlier than the ending date of the quarter.

o Designate in column VII that the facility is a swing bed participant and the level(s) of care approved under the swing bed provision. Example: Swing Bed-SNF/ICF.

o Include a copy of the swing bed provision agreement along with your QS for the first quarter it is included on the showing.

o Complete all other columns according to the instructions previously detailed.

9111. FACILITIES FOR WHICH NO REVIEWS WERE PERFORMED

In addition to the regular facility listings, include a list of all facilities, by level of care, that were due for an annual review by the close of the quarter but did not receive it. Include facilities that were reviewed in the 30-day period after the close of the quarter. Do not include facilities not reviewed because there were no title XIX recipients in them or dually-certified facilities for which there were no title XIX recipients at a given level of care. Make a separate list for each level of care, and list in alphabetical order the facility name, address, provider number, the number of certified title XIX beds and date of the last review. Attach a statement, signed and dated by the Director of the Single SA, explaining the reason(s) for the missed reviews. Include a copy of the original review team's schedule showing the planned dates of the review.

If there are facilities in which you knowingly missed some of the individual recipients during the IOC review, attach a list of the facilities. Include identifying facility information, the recipient(s) name, level of care and the reason for the missed review. Include this list with the QS.

9115. SUBMISSION OF QUARTERLY SHOWINGS

Submit your showing to the HCFA RO no later than 30 days after the close of the quarter. Section 1903(g)(4)(A) of the Act provides that:

> "The Secretary may not find the showing of a State . . . to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline."

If, due to circumstances beyond your control, a showing is submitted late, attach a statement of the reason(s) signed by the Single SA Director and submit the showing within 45 days after the close of the quarter. Note, however, that the Department does not routinely excuse late submittals of a QS (which could result in a penalty being imposed upon the State).

You may use the regular mail or hand deliver the QS to the HCFA RO. We recommend that you use either registered or certified mail to ensure timely receipt and proof of the date the QS was received.

9120. ACCEPTABLE REASONS FOR NOT MEETING ANNUAL REVIEW REQUIREMENTS OF THE QUARTERLY SHOWING

Two provisions exempt you from a reduction in your Federal matching payments when you have failed to complete the required annual onsite review(s) in any facility for the showing quarter. (See 42 CFR 456.653.)

9120.1 Good Faith and Due Diligence Exception.--Under this exception, the Administrator finds a State's showing satisfactory if it has performed reviews in at least 98 percent of all facilities and in all facilities with 200 or more certified beds which require a review by the end of the showing quarter, and if you attempted, in good faith and with due diligence, to review the remaining facilities but failed because of extreme circumstances clearly beyond your control. These circumstances could not have been reasonably anticipated.

Examples of circumstances which would allow an exception include the following. They are not all-inclusive.

- The review team is prevented from entering a facility because it was quarantined on the review date.

- The administrator of the facility to be reviewed refused to allow the State review team to observe patients or examine patient records without a court order.

- Records needed to make or maintain accurate decisions or determinations were destroyed.

- Strikes by State employees that resulted in the disruption of State staff or other government or private personnel normally assigned to the IOC teams for medical emergencies.

- Declared State disasters or civil disorders that required the diversion of significant personnel normally assigned to the IOC teams for medical emergencies.

o The review team could not reach the facility on the date of the scheduled review because of fire or severe and unpredictable weather disturbances such as floods, earthquakes, tornadoes, hurricanes, or snowstorms. (This does not include failures to perform timely reviews because the review team fell behind schedule due to difficult weather conditions of a recurring and predictable nature.)

o There were no title XIX recipients in the facility on the date of the scheduled review.

o State actions resulting from incorrect written policy interpretation to you by a Federal official reasonably assumed to be in a position to provide such interpretation.

Failure by you to act upon necessary legislative changes or to obtain budget authorization for needed resources does not constitute a factor beyond your control and is therefore unacceptable. You cannot have deliberately failed to review a facility or have merely forgotten to review it. While your showing would be excused in the situations illustrated by the above examples (if properly documented), promptly reschedule the IOC review as soon as it is feasible to do so. Forward a copy of the new review schedule to the RO. A facility that has not been reviewed in the quarter in which it is required to be reviewed continues to require a review in each subsequent quarter until the review is performed.

9120.2 Technical Failings Exception.--Under this exception, the Administrator finds a State's showing satisfactory if it has performed reviews no later than 30 days after the close of the quarter in at least 98 percent of all participating facilities and in all those facilities with 200 or more certified beds requiring a review by the end of the showing quarter and there were technical reasons which prevented the reviews from taking place within the quarter. Technical reasons are those unusual circumstances which you (with difficulty) could have controlled by using alternative solutions. Such circumstances include:

o Delaying a review because of a need to replace a member of the IOC team due to unanticipated absences of a member.

o Unusual delayed access to significant records needed to make or maintain accurate decisions or determinations.

o Sudden and unanticipated workload changes which resulted from changes in Federal law and regulation.

o Sudden withdrawal or termination of a large number of Medicaid providers which required active participation of IOC review staff in the placement of recipients.

These criteria are not all-inclusive. Failure to perform reviews caused by poor administration, disorderly recordkeeping, omission due to typographical error, unrealistic scheduling of reviews, inadequate staffing of review teams, or untimely reviews because the team fell behind schedule due to difficult weather conditions of a recurring and predictable nature are not acceptable. Establish your review schedules considering periods when you knowingly have bad weather. You cannot intentionally continue to miss reviews initially determined satisfactory under the technical failings standard in subsequent quarters.

For subsequent reviews, facilities reviewed within 30 days of the close of the quarter in which they were due for an annual review retain their original anniversary quarter due date (the quarter prior to the actual late review).

9125. PROCEDURES WHEN A STATE CLAIMS AN EXCEPTION CLAUSE

When claiming one of the "exception clauses" of §1903(g)(4)(B) of the Act, include the following with the QS:

- An explanation of the attempt(s) made to perform the reviews.
- A full explanation of the circumstances and documentation substantiating the circumstances which caused the facility or facilities not to be reviewed on time.
- A copy of your original review team's schedule showing the planned dates of the review(s).
- A copy of the proposed make-up schedule(s).

HCFA evaluates the situation and makes a judgement about the acceptability of the exception.

9130. RECIPIENTS IN OUT-OF-STATE FACILITIES

Make reciprocal arrangements to monitor the care given to your recipients in out-of-State facilities. However, this review is not subject to the UC penalty for failure to make a satisfactory QS except where you own and operate a long-term care institution located in another State. In this case, the State owning the institution is required to report the institution or facility on its QS and to make appropriate onsite reviews.

9135. RECIPIENTS IN FACILITIES WITHOUT VALID PROVIDER AGREEMENTS

You are responsible for meeting UC requirements in facilities that do not have a valid provider agreement if you claim, or intend to claim, Medicaid payments made to them. This situation usually occurs when a facility continues to provide inpatient services to Medicaid recipients while appealing a denial or termination of its provider agreement and the State law provides for the continued validity of the agreement during the appeal or a State court has order you to continue payments to the facility pending action on administrative or judicial appeals. Continue to report the facility on the QS and keep the RO aware of the current appeal status each quarter for any facility in this category by submitting a statement with each QS. Report the appeal status of the facility until a final disposition is made.

9140. VALIDATION SURVEY IN THE STATE AGENCY

Periodically HCFA conducts a validation survey in all SAs administering medical assistance programs to determine the validity of QSs submitted.

9140.1 Description.--The survey is conducted for all levels of long-term care (SNF, ICF, ICF/MR, and IMD) for which you submitted a showing, regardless of whether the showing was found "facially" satisfactory.

During the survey, HCFA reviewers attempt to verify that every facility which had a continuous provider agreement for the 12-month period ending with the quarter of review (at one or more levels of care) received an appropriate onsite annual IOC review during the period. An appropriate review is one conducted timely (by the end of the anniversary quarter), by a properly constituted team, as defined in 42 CFR 456.602-604, and where 100 percent of the facility's Medicaid recipients are reviewed. (Note that an IOC team consists of more than one person collectively performing the review and present during the entire review.) Documentation must be available of the appropriateness of each IOC review as identified below. The documentation must specify the team members and their degrees (physician, registered nurse, social worker, or a qualified developmental disabilities specialist).

The Federal review can encompass any area specified in §1903(g) of the Act. Federal reviewers may visit each SA, Health Department, or any other location where the annual onsite review reports/documentation are maintained. Reviewers may not accept a document that is not clearly identified as an IOC report. (Utilization review minutes or reports, forms for continued stay reviews or admission review documents are not IOC reports and not acceptable as proof of individual recipient reviews.) The IOC report must be a full and complete report of the team's findings on recipient services as well as specific findings and recommendations with respect to individuals and contain the following:

- The name, address, provider number, level of care, and number of beds allocated or certified for care of Medicaid recipients.

- Number of Medicaid recipients under care at the time of the IOC.

- Identification data (in the IOC report summary, individual patient profile or patient care assessment) on each Medicaid recipient observed and medically reviewed.

- Date(s) the IOC was performed. If a review lasted more than 1 day, the beginning and ending dates.

- Date on which the IOC report was prepared.

- Signatures and degrees of team members.

Federal reviewers may request listings of Medicaid recipients who were reviewed, recipient census data for each facility reviewed, payment records, or turnaround documents listing the Medicaid recipients residing in the facilities as of the first day of the IOC review. They may also request documents concerning a recipient's application for institutional benefits, eligibility determination, client or facility notification of the determination, admissions, transfers, discharges, and deaths.

The RO generally notifies you in writing of the scheduled survey and the review date. However, there may be times when a review may be unannounced. If an announced review date presents a problem, discuss an alternate date with the Associate Regional Administrator, Division of Financial Operations.

9140.2 Procedures.--Provide a copy of your current UC plan and copies of methods, procedures and policy manual for conducting an IOC review and any evidence and/or documentation requested by Federal reviewers that may be necessary in validating a QS. If IOC reports are not kept on file at the SA, make arrangements with the Associate Regional Administrator, Division of Financial Operations, to consolidate the reports in one location. In addition, submit any data not available during the survey to the RO within 15 calendar days after the survey or exit conference.

If records cannot be produced to validate that the UC requirements were met during the quarter under review within the 15 days, HCFA must find you out of compliance with 1903(g) of the Act. A penalty must be assessed in accordance with 42 CFR 456.656(c).

9150. CONDITIONS FOR MEETING A 100-PERCENT RECIPIENT REVIEW

9150.1 Review of Medicaid Recipients.--Include all recipients/residents in the facility who have been determined Medicaid eligible; i.e., both eligible for Medicaid services and eligible for payments to the facility on their behalf anytime prior to the first day of the IOC review. This does not mean that a Medicaid payment must have been received by the facility for the patient to be considered for review. For clarification, a determination that an individual is financially eligible means a determination that, after deducting the individual's income from the cost of institutional care, some amount remains which you must pay for such care. This determination follows a determination that the individual is eligible for Medicaid as a categorically or medically needy individual who meets the general financial requirements. (Section 42 CFR 435.725.) Eligibility determinations may not exceed 60 days for applicants who apply for Medicaid on the basis of disability; and 45 days for all others except in unusual circumstances as specified in 42 CFR 435.91. You must provide acceptable documentation of the reason for excluding any recipient from the IOC review who has been determined eligible for Medicaid prior to the first day of the IOC review.

9150.2 Personal Contact.--There must be personal contact with, and observation of, each Medicaid recipient physically present in the facility at the time of the IOC team's visit. Each individual recipient report or profile must clearly assure that the recipient was visually observed by the team.

9150.3 Resident's Medical Record.--Review each Medicaid resident's medical record, including recipients who are absent at the time of the IOC review. This includes recipients admitted to an acute care hospital on a short-term basis for whom you have reserved a bed (hold bed policy), while the long-term care facility continues to receive payment on his/her behalf. This also includes residents on home leave and those absent because of outpatient, medical, rehabilitative, or educational services. Document the reason for the absence. Each recipient's individual report or profile must clearly assure that the medical record was reviewed by the IOC team.

IOC teams are not required to return to the facility to observe recipients absent during the IOC visit. However, for recipients who are not on leave, both the personal contact and medical record review must be performed concurrently or within 7 days of each other when the review lasts longer than 1 day. Do not include recipients who are Medicaid eligible for long-term care in the facility when Medicare reimburses any part of the cost. In addition, Medicaid recipients admitted to the facility, discharged, or transferred during the IOC review are not required to be included. (Only recipients present or listed as facility residents at the beginning of the IOC visit are required to be included in the review.)

9155. A REASONABLE STATE SYSTEM FOR IDENTIFYING RECIPIENTS FOR REVIEW

The law and regulations require an inspection of the care provided to each Medicaid recipient in every long-term care facility at least annually. To ensure compliance with this requirement, develop a system for keeping IOC teams apprised of eligibility determinations for institutionalized recipients. This assures that the inspection team is given an updated listing of all residents in the facility who had been determined eligible, providing their eligibility was determined no less than 7 calendar days prior to the start of the review on the day preceding its review of a facility. (You are responsible for identifying recipients for review, therefore do not rely solely on eligibility input from the facility.) In addition, the IOC team obtains a current list of recipients in the facility for whom payments are being made from the State component responsible for accounting for such payments and compare it with other resource documents (such as the facility's census or facility's request for payment) to ensure a 100-percent recipient review. Since claims for payment are often submitted late by a facility, nonpayment for services of a recipient who has been authorized for payment prior to the beginning of the IOC review, is not a valid reason for excluding that patient from the IOC review.

9160. MULTIPLE IOC REVIEWS

The IOC requirements may be met by conducting reviews at a facility more than once during the appropriate 1-year period. Report each review date on the QS and the percentage or number of Medicaid recipients reviewed if it was not a 100-percent review. If multiple reviews are conducted throughout the year, all recipients who resided in the facility as of the last day of the facility's anniversary quarter or at the conclusion of the final review date denoting the 100-percent review must have been reviewed.

The annual IOC requirement requires a review of all recipients in a facility by that facility's anniversary quarter rather than at 12-month periods for each recipient. You are not required to track the length of time each individual recipient was in the facility as the IOC review date does not apply to the length of stay or eligibility of any individual recipient. Individual reviews performed outside of the designated annual period for the facility are not acceptable even if the recipients were reviewed within 1 year of their admission or the approved eligibility date. Include newly admitted or eligible Medicaid recipients in the IOC review even if an admission review (for level of care determination) was performed prior to the IOC review.

All States performing multiple IOC reviews must establish an anniversary quarter to determine the period in which a 100-percent IOC review must be completed. You may use the anniversary quarter of the facility's entry into the program or the quarter in which the previous year's last 100-percent review was performed. To prevent confusion, obtain approval from the RO before changing a facility's anniversary quarter.

Total rather than substantial compliance with IOC requirements is necessary. A failure to review any Medicaid recipient amounts to failure to review an entire facility. The penalty is the same for either review failure.

9165. ACCEPTABLE REASONS FOR NOT MEETING REQUIREMENTS FOR A 100-PERCENT RECIPIENT REVIEW

Since failure to review each Medicaid recipient is the same as a failure to review the facility, the two exempt provisions in §9120 are applicable. You must meet the good faith and due diligence exception (which represents circumstances clearly beyond your control) or the technical failings exception (unusual circumstances which you (with difficulty) could have controlled by using alternative solutions). Document these situations.

9170. ENTRANCE AND EXIT CONFERENCES

Federal reviewers will hold entrance and exit conferences with your staffs for all validation surveys. At the entrance conference they will explain the purpose of the review and identify the records they will review. At the exit conference they will explain the problems encountered and request additional documentation to establish compliance. (Statements; i.e., affidavits and travel logs, are unacceptable without supporting documentation from the IOC team's notes or recipient's records.) Failure to submit the requested documentation may result in the imposition of a penalty. Submit any additional data to the Associate Regional Administrator (ARA), Division of Financial Operations (DFO), within 15 calendar days of the exit conference.

Since a complete analysis takes several months before it is determined if the findings result in a penalty, the RO notifies the State administrator, in writing, of the preliminary survey findings. This provides detailed information about the deficiencies uncovered. An official written notification in the form of a penalty letter (and sometimes a telegram) is sent from HCFA's Central Office to States failing to meet UC requirements. (The official notification represents the final determination of deficiencies found and may differ from the preliminary findings.)

9180. REDUCTIONS IN FEDERAL FINANCIAL PARTICIPATION

When an agency does not meet the UC requirements, HCFA notifies the agency in writing prior to making a reduction in the FFP. If a QS is unsatisfactory on its face, in any quarter, a notification of the reduction is sent no later than 90 days after the close of the quarter for which the showing was made. This allows for preparation of a comprehensive assessment of findings for the quarter, and allows HCFA to resolve many issues prior to issuing penalty notices to States. If a showing is satisfactory at the time of submission but a validation survey determines that showing to be unsatisfactory, HCFA sends a notification of the reduction to you no later than the first day of the fourth quarter following the quarter for which the showing was made (9 months after the close of the quarter upon which the survey is based). Any reduction is made by amending or adjusting an agency's grant award. You may appeal HCFA's decision to the Departmental Grant Appeals Board (GAB) within 30 days of receipt of the penalty letter. Regulations covering the procedures for appealing to the GAB are found at 45 CFR , part 16.

9180.1 Computation of Reductions in Federal Financial Participation.--Reductions in FFP are made on a quarterly basis and only for the level of care (SNF, ICF, or IMD) for which you failed to comply with UC requirements. SNF penalties are based on all facilities providing SNF services including swing-bed facilities. ICF penalties are based on all facilities providing ICF services including swing-bed facilities and facilities which provide ICF services for the mentally retarded. IMD penalties are based on services provided by such facilities as mental hospitals, psychiatric facilities (which include a facility or program that provides inpatient psychiatric services for individuals under 21), and skilled nursing or intermediate care facilities that primarily care for mentally ill patients. For each level of care subject to reduction, the following steps are used:

Step 1: The expenditures (or the estimated expenditures) for the level of care subject to reduction for the quarter out of compliance is multiplied by the State's Federal Medical Assistance Percentage (FMAP). Lacking these expenditures, the expenditures available for the most recent calendar quarter prior to the quarter out of compliance is substituted. The expenditures represent the total Federal payments to you which is equal to the specific percent of FMAP allowed to you each quarter. (Individual State FMAP is in Part 2.) The amount of the expenditures is obtained from line 6 of Form HCFA 64.9, Statement of Medical Assistance Expenditures by Type of Service for the Medical Assistance Program. (Note that expenditures are not prorated or averaged when a State is issued a penalty covering more than one quarter and the State failed to provide expenditures on the HCFA 64-9 for one of the quarters.)

Step 2: The product obtained is multiplied by 33 1/3 percent.

Step 3: The product obtained is multiplied by a fraction, the numerator is the number of recipients in facilities for which a satisfactory showing was not made for the level of care and the denominator is the total number of recipients in all facilities for the level of care participating in the program at some time during the quarter out of compliance. This fraction is formed by using facility data from your QS when specific data on the number of recipients in individual facilities is not immediately available. You may supply exact recipient data on which to recalculate the reduction whether you chose to file a reconsideration or not. This necessitates your providing the number of Medicaid recipients residing in each facility at the specific level of care for which the penalty is being assessed regardless of the length of time (one day or 60 days) each patient resided in the facility at the time of the IOC review. Averages cannot be used and all data must be supported by documentation from your records. Monthly quarterly payment data in the form of a report generated from your payment system covering all facilities participating at the required level of care or individual facility payment lists may be used. You may use other acceptable resource data that clearly document the quarterly Medicaid population for each facility. The data submitted must be separated by facility with subtotals of Medicaid recipients by facility and must provide the name, address, and provider number for each facility.

Step 4: The product obtained is multiplied by a fraction, the numerator is the number of recipients residing in facilities participating at the level of care (SNF, ICF, or IMD) for 30, 60, or 90 days, whichever is applicable, (whether or not such days are consecutive) and the denominator is the total number of recipients receiving services in the State at the level of care for which UC requirements were not met. (This reflects that part of your expenditures related to long-stay services). Once an individual attains long-stay status in any fiscal year, he remains in that status during all future services.

The data used are obtained from the HCFA-2082 Form, Statistical Report of Medical Care: Recipients, Payments, and Services. In the absence of such data the fraction 1/1 is used. You may provide documented evidence on the exact number of recipients in facilities at the level of care in question as outlined above. The annual payment history of each recipient is one document that may be used to substantiate long-stay services. This documentation must include, by facility, the following:

- o Name, address and provider number.
- o Names of individual recipients.
- o Date of eligibility determination.
- o Type of service (level of care) provided.
- o Date(s) of service for which payment was made or claimed. Multiple entries for an individual recipient are listed together.
- o A "key" or procedure explaining the format used in the document and the name and telephone number of an individual to contact if clarification is needed.

You may use other acceptable resource data which clearly identify the above requested information.

9180.2 Request for Reconsideration.--Under §1116(d) of the Act, you may request reconsideration of the fiscal reduction from the GAB. If reconsideration is requested:

- o State the disputed amount.
- o Briefly explain why you believe the penalty to be in error.
- o Indicate that a copy of the request was sent to HCFA.
- o Attach a copy of the penalty letter.

Send the original application for review and two copies by registered or certified mail, or by personal delivery, to the:

Executive Secretary
Departmental Grant Appeals Board
U.S. Department of Health and Human Services
451-F, Hubert H. Humphrey Bldg.
200 Independence Avenue, SW.
Washington, D.C. 20201.

It must be postmarked no later than 30 days after the date the penalty notification was received from HCFA.

Send HCFA's copy of the request to:

Health Care Financing Administration
Office of Quality Control Programs, BQC
Attention: Utilization Control Branch
233 East High Rise Bldg.
6325 Security Blvd.
Baltimore, MD 21207

Forward an additional copy to the Regional Administrator. Your application for review of the UC penalty will be processed pursuant to the regulations of the Departmental Grant Appeals Board which are found in 45 CFR, part 16.

9180.3 Retention of UC Penalty Funds.--Any UC penalty issued by HCFA is subject to the provisions of §1903(d)(5) of the Act. If you appeal the penalty under §1116(d) of the Act, you have the option of retaining the disallowed funds during the appeal process. You may exercise that option by notifying the Regional Administrator in writing no later than 30 days after the date the penalty letter is received. Send a copy of your decision to retain the disputed funds to the Office of Quality Control, BQC, at the address in §9180.2.

If your notice to retain funds is mailed after the expiration of the 30-day requirement, the option is revoked. The date you mail your option letter must be within 30 days of your receipt of the penalty letter to be valid. The option to retain funds cannot apply to a portion of the appeal but must be exercised for the entire amount in dispute.

If the GAB decision upholds the penalty and you elected to retain the funds, the proper amount of the penalty plus interest is offset in a subsequent grant award. The interest is charged on the amount upheld from the date of the original penalty to the date of the Board's decision.

If you withdraw an appeal, in whole or in part, or reverse your election to retain the disputed funds, interest is charged from the date of the original penalty to the date the appeal is withdrawn or reversal of the election to retain funds.

Where you and HCFA reach a settlement, prior to a decision by the Board, interest is charged on the agreed penalty amount from the date of the original penalty to the date that you inform the Board of the written agreement between you and HCFA.

If you do not exercise your option to retain the disputed funds within 30 days of the penalty or reverse your option at some future date, you have no further option to retain the disputed funds.

Detailed information regarding interest on disputed Medicaid claims is in part 2.

EXHIBIT 1

SAMPLE CERTIFICATION OF UTILIZATION CONTROL FOR INPATIENT HOSPITALS (TO BE TYPED ON STATE AGENCY LETTERHEAD)

QUARTERLY UTILIZATION CONTROL SHOWING FOR INPATIENT HOSPITALS

I hereby certify that during the calendar quarter _____ to _____, there were methods and procedures in the State to assure that:

a. A physician certified (and where inpatient hospital services were furnished over a period of time, recertified) to the necessity of inpatient hospital services for each title XIX recipient receiving such services, as mandated by sections 1902(a)(44) and 1903(g)(6) of the Social Security Act.

b. In the case of each title XIX recipient receiving inpatient hospital services, such services were furnished under a plan established and periodically reviewed and evaluated by a physician as mandated by section 1902(a)(44) of the Social Security Act.

c. There was in operation a continuous program of utilization review under which the admission of each title XIX recipient receiving inpatient hospital services was reviewed or screened in accordance with section 1902(a)(30) and 1903(i)(4) of the Social Security Act.

Date: _____

_____
Name:
Title:
Agency:
State:

EXHIBIT 2

SAMPLE CERTIFICATION OF UTILIZATION CONTROL IN INSTITUTIONS FOR MENTAL DISEASES (TO BE TYPED ON STATE AGENCY LETTERHEAD)

QUARTERLY UTILIZATION CONTROL SHOWING FOR INSTITUTIONS FOR MENTAL DISEASES

I hereby certify that during the calendar quarter _____ to _____, there were methods and procedures in the State to assure that:

a. A physician certified (and where inpatient IMD services were furnished over a period of time, recertified) to the necessity of inpatient IMD hospital services for each title XIX recipient receiving such services, as mandated by sections 1902(a)(44) and 1903(g)(6) of the Social Security Act and 42 CFR 456.160.

b. In the case of each title XIX recipient receiving inpatient IMD services, such services were furnished under a plan established and periodically reviewed and evaluated by a physician as mandated by section 1902(a)(44) of the Social Security Act.

c. There was a regular program of medical review (including medical evaluation) of the care of recipients in IMDs pursuant to section 1902(a)(26) and section 1903(g)(1) of the Social Security Act whereby the professional management of each case was reviewed and evaluated at least annually by a properly constituted medical review team in accordance with 42 CFR 456.601-613.

Date: _____

_____
Name:
Title:
Agency:
State:

EXHIBIT 3

SAMPLE CERTIFICATION OF UTILIZATION CONTROL IN SKILLED NURSING FACILITIES (TO BE TYPED ON STATE AGENCY LETTERHEAD)

QUARTERLY UTILIZATION CONTROL SHOWING FOR SKILLED NURSING FACILITIES

I hereby certify that during the calendar quarter _____ to _____, there were methods and procedures in the State to assure that:

a. A physician certified (and where inpatient SNF services were furnished over a period of time, recertified) to the necessity of inpatient SNF services for each title XIX recipient receiving such services, as mandated by sections 1902(a)(44) and 1903(g)(6) of the Social Security Act.

b. In the case of each title XIX recipient receiving SNF services, such services were furnished under a plan established and periodically reviewed and evaluated by a physician as mandated by section 1902(a)(44) of the Social Security Act.

c. There was a regular program of medical review (including medical evaluation) of the care of recipients in skilled nursing facilities pursuant to section 1902(a)(31) and section 1903(g)(1) of the Social Security Act whereby the professional management of each case was reviewed and evaluated at least annually by a properly constituted medical review team in accordance with 42 CFR 456.601-613.

Date: _____

_____
Name:
Title:
Agency:
State:

EXHIBIT 4

SAMPLE CERTIFICATION OF UTILIZATION CONTROL IN INTERMEDIATE CARE FACILITIES (TO BE TYPED ON STATE AGENCY LETTERHEAD)

QUARTERLY UTILIZATION CONTROL SHOWING FOR INTERMEDIATE CARE FACILITIES

I hereby certify that during the calendar quarter _____ to _____, there were methods and procedures in the State to assure that:

a. A physician certified (and where ICF services were furnished over a period of time, recertified) to the necessity of ICF services for each title XIX recipient receiving such services, as mandated by sections 1902(a)(44) and 1903(g)(6) of the Social Security Act.

b. In the case of each title XIX recipient receiving ICF services, such services were furnished under a plan established and periodically reviewed and evaluated by a physician as mandated by section 1902(a)(44) of the Social Security Act.

c. There was a regular program of independent professional review (including medical evaluation) of the care of recipients in intermediate care facilities pursuant to section 1902(a)(31) and section 1903(g)(1) of the Social Security Act whereby the professional management of each case was reviewed and evaluated at least annually by a properly constituted independent professional review team in accordance with 42 CFR 456.601-613.

Date: _____

_____
Name:
Title:
Agency:
State:

EXHIBIT 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

QUARTERLY SHOWING

Form Approved
OMB No. 66-R-0094

Quarter Ending _____ Facility Listing for _____ (Level of Care)

Page _____ of _____
State _____

COLUMN I	COLUMN II	COLUMN III	COLUMN IV	COLUMN V	COLUMN VI	COLUMN VII
Facility Name Address Provider Number	Certification Status Change	Reviews Completed in Prior 12 Months	PRO Assumption Date/Area	PRO Relieved Date/Area	Team Leader and Degree	Level of Care S=SNF, I=ICF SI=SNF/ICF, ICF/MR or IMD

Form HCFA-41 (6-79)

EXHIBIT 6

SAMPLE CERTIFICATION OF NO TITLE XIX PATIENTS
(TO BE TYPED ON STATE AGENCY LETTERHEAD)

ATTACHMENT

QUARTERLY UTILIZATION CONTROL SHOWING

I hereby certify that during the calendar quarter ending_____, the following facilities had no title XIX recipients on the scheduled date(s) of review.

Facility Name and Address	Provider Number	Level of Care	Scheduled Review Date
Johnson Area Hospital Route 1 Brown (City)	97601	IMD	10-15-87
East Co. Health Center 640 Rock Lane Scott	64158	ICF/MR	12-09-87
Overbrook Nursing Home 21 First Street Central	53701	SNF	10-08-87
Tyler Convalescent Center 399 Texas Drive Parkston	66224	ICF	11-29-87

Date: _____

_____
Name:
Title:
Agency:
State:

9214. LEGAL BACKGROUND AND AUTHORITY

Title XIX of the Social Security Act, specifically Section 1903(g)(1)(A) of Public Law 92-603, enacted October 30, 1972, and as amended by Section 2183 of Public Law 97-35, enacted August 13, 1981 and further amended by Section 137(b)12 of Public Law 97-248.

Public Law 97-35 - August 13, 1981

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Section 1903 Payment to States

Section 1903(g)(1)(A), requires that, in order for full Federal matching to be available for long-stay services for any quarter, a State must make a satisfactory showing that, in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies where such services are furnished over a period of time, in such cases, at least every 60 days or, in the case of services that are intermediate care facility services provided in an institution for the mentally retarded, every year) and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary, that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

CITATION OF REGULATION

42 CFR Public Health
Part 405, Federal Health Insurance for the Aged and Disabled

§405.1123 Condition of participation--physician services.

Patients in need of skilled nursing or rehabilitative care are admitted to the facility only upon the recommendation of, and remain under the care of, a physician. To the extent feasible, each patient or his sponsor designates a personal physician.

(a) Standard: Medical findings and physicians' orders at time of admission. There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the patient. Information about the rehabilitation potential of the patient and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.

(b) Standard: Patient supervision by physician. The facility has a policy that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of total patient care. Each attending physician is required to make

arrangements for the medical care of his patients in his absence. The medical evaluation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and he signs all his orders. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with §405.ll26(b). At no time may the alternate schedule exceed 60 days between visits. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient, (l) in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid agency of the change in schedule, including justification, and (2) the utilization review committee or the medical review team (see §405.ll21(d)) promptly reevaluates the patient's need for monthly physician visits as well as his continued need for skilled nursing facility services (see §405.1137(d)). If the utilization review committee or the medical review team does not concur in the schedule of visits at intervals of more than 30 days, the alternate schedule is not acceptable.

(c) Standard: Availability of physicians for emergency patient care. The facility has written procedures, available at each nurses station, that provide for having a physician available to furnish necessary medical care in case of emergency.

Part 440, Services: General Provisions

§440.l0 Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases.

(a) "Inpatient hosptial services" means services that--

(l) Are ordinarily furnished in a hospital for the care and treatment of inpatients;

(2) Except in the case of nurse-midwife services, as specified in §440.l65, are furnished under the direction of a physician or dentist; and

(3) Are furnished in an institution that--

(i) Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;

(ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

(iii) Except in the case of medical supervision of nurse-midwife services, as specified in §440.l65, meets the requirements for participation in Medicare; and

(iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of §405.l035 of this chapter, unless a waiver has been granted by the Secretary.

(b) Inpatient hospital services do not incude SNF and ICF services furnished by a hospital with a swing-bed approval.

Part 442, Standards for Payment for Skilled Nursing and Intermediate Care Facility Services

§442.346 Physician services.

(a) The ICF must have policies and procedures to insure that the health care of each resident is under the continuing supervision of a physician.

(b) The physician must see the resident whenever necessary but at least once every 60 days unless the physician decides that this frequency is unnecessary and records the reasons for that decision.

Part 456, Utilization Control

§456.60 Hospitals (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 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 hospital, before the Medicaid agency authorizes payment.

(b) Recertification. (1) A physician, or physician assistant or nurse practitioner (as defined in §481.2 of this chapter) acting within the scope of his/her 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 hosptial are needed.

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

§456.80 Hospitals (Individual written plan of care).

(a) Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the individual must establish a written plan of care for each applicant or recipient.

(b) The plan of care must include--

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Any orders for--

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Social services;

(vi) Diet;

(4) Plans for continuing care, as appropriate; and
(5) Plans for discharge, as appropriate.
(c) Orders and activities must be developed in accordance with physician's instructions.
(d) Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of an individual.
(e) A physician and other personnel involved in the recipient's case must review each plan of care at least every 60 days.

§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 §481.2 of this chapter) acting within the scope of his/her 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.

§456.180 Mental Hospitals (Individual written plan of care).

(a) Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or recipient.
(b) The plan of care must include--
(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
(2) A description of the functional level of the individual;
(3) Objectives;
(4) Any order for--
(i) Medications;
(ii) Treatments;
(iii) Restorative and rehabilitative services;
(iv)Activities;
(v)Therapies;
(vi)Social services;
(vii)Diet; and
(viii)Special procedures recommended for the health and safety of the patient;
(5)Plans for continuing care, including review and modification to the plan of care; and
(6)Plans for discharge
(c)The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

§456.260 Skilled Nursing Facilities (Certification and recertification of need for inpatient care).

(a) Certification. (1) A physician must certify for each applicant or recipient that SNF services are or were needed.

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

(b) Recertification. (1) A physician, or physician assistant or nurse practitioner (as defined in §481.2 of this chapter) acting within the scope of his/her practice as defined by State law and under the supervision of a physician, must recertify for each applicant or recipient that SNF services are needed.

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

§456.280 Skilled Nursing Facilities (Individual written plan of care).

(a) Before admission to a SNF or before authorization for payment, the attending physician must establish a written plan of care for each applicant or recipient in a SNF.

(b) The plan of care must include--

(1) Diagnoses, symptoms, complaints and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any orders for--

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Therapies;

(vi) Social Services;

(vii) Diet; and

(viii) Special procedures recommended for the health and safety of the patient;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(c) The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 60 days.

§456.360 Intermediate Care Facilities (Certification and recertification of need for inpatient care).

(a) Certification. (1) A physician must certify for each applicant or recipient that ICF services are or were needed.

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

(b) Recertification. (1) A physician, or physician assistant or nurse practitioner (as defined in §481.2 of this chapter) acting within the scope of his/her practice as defined by State Law and under the supervision of a physician, must recertify for each applicant or recipient that ICF services are needed.

Recertification must be made at least--

(i) Every 12 months after certification in an institution for the mentally retarded.

(ii) Every 60 days after certification in an ICF other than an institution for the mentally retarded or persons with related conditions.

§456.380 Intermediate Care Facilities (Individual written plan of care).

(a) Before admission to an ICF or before authorization for payment, a physician must establish a written plan of care for each applicant or recipient.

(b) The plan of care must include--

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any orders for--

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Therapies;

(vi) Social services;

(vii) Diet; and

(viii) Special procedures designed to meet the objectives of the plan of care;

(5) Plans for continuing care, including review and modification of the plan of care; and

(6) Plans for discharge

(c) The team must review each plan of care at least every 90 days.

§456.481 Inpatient Psychiatric Services for Individuals Under 21 (Admission certification and plan of care).

If a facility provides inpatient psychiatric services to a recipient under age 21--

(a) The admission certification by the review team required in §441.152 satisfies the requirement for physician certification of need for care in §456.60, §§456.160, 456.260, and 456.360; and

(b) The development and review of the plan of care required in §441.154 satisfies the requirement for physician recertification of need for care in the sections cited in paragraph (a) and the requirement for establishment and periodic review of the plan of care in §§456.80, 456.180, 456.280, and 456.380.

(c) The plan of care must be established by the team described in §441.156.

§456.652 Penalty for Failure to Make a Satisfactory Showing of an Effective Institutional Utilization Control Program (Requirements for an effective utilization control program).

(a) General requirements. In order to avoid a reduction in FFP, the

Medicaid agency must make a satisfactory showing to the Administrator, in each quarter, that it has met the following requirements for each recipient:

(1) Certification and recertification of the need for inpatient care, as specified in §§456.60, 456.160, 456.260, 456.360 and 456.481.

(2) A plan of care established and periodically reviewed and evaluated by a physician, as specified in §§456.80, 456.180, 456.280 456.380, 456.481.

PART 9

UTILIZATION CONTROL

TABLE OF CONTENTS FOR INTERIM MANUAL INSTRUCTIONS

IM 9215 CERTIFICATION OF THE NEED FOR INPATIENT SNF OR ICF CARE

A. Prior to July 1 1988.-Only a physician could previously certify for each applicant or recipient that inpatient SNF services are or were needed. The Same restrictions also applied to who could preform certifications of the need for inpatient ICF care.

B. July 1, 1988 through October 1, 1990.-Effective July 1, 1988, a physician, or nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, may certify that inpatient SNF serivces are or were needed, The same requirements apply to certification for the need for inaptient ICf care.

Authority §4218 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Public Law 100-203), which amended §1902 (a)(44) of the Act.

C. Guidance to States.-For porposes of applying the new definition in IM 9215B., the legislative history indicates that the term "in collaboration with" relates to a written agreement reflective a distribution of responsibilities between a nurse practitioner or a clinical nurse specialist and a physician rather than to supervision of a nurse practitioner or a clinical nurse specialist by a physician.

IM 9216. WHO MAY ESTABLISH A PLAN OF CARE FOR SNF OR ICF INPATIENTS

A. Prior to July 1, 1988.-Only a physician could previously establish and periodically review and evaluate a written plan of care for each applicant or recipient in a SNF or and ICF.

B. July 1, 1988 through October 1, 1990.-Effective July 1, 1988, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, may establish and periodically review and evaluate a written plan of care for each applicant or recipient in a SNF or an ICF.

Authority: §4218 or OBRA '87

C. Guidance to States.-For purposes of applying the new definition in IM 9216B., follow IM 9215C.

IM 9220. RECERTIFICATION OF THE NEED FOR INPATIENT SNF OR ICF CARE

A. Who Can Recertify as to the Need for SNF or ICF Care

1. Prior to July 1, 1988.--A physician, or a physician assistant or nurse practitioner acting within the scope of his/her practice as defined by State law and under the supervision of a physician, could recertify as to the need for inpatient SNF care or inpatient ICF care respectively.

2. July 1, 1988 to October 1, 1990.--Effective July 1, 1988, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, can recertify as to the need for inpatient SNF or inpatient ICF care respectively.

Authority: §4218 of OBRA '87.

3. Guidance to States.--For purposes of applying the new definition in IM 9220A.2., follow IM 9215C.

B. Schedule for SNF Recertifications

Admissions On or After October 1, 1984.--Recertifications of the need for inpatient SNF care are to be conducted at least:

- 30 days after the date of the initial certification
- 60 days after the date of the initial certification
- 90 days after the date of the initial certification, and
- every 60 days thereafter.

Authority: §1903(g)(6)(B) of the Act, as revised by §2363(a)(4) of the Deficit Reduction Act of 1984 (DRA 1984) (Public Law 98-369)).

C. Schedule for ICF (Other Than ICF/MR) Recertifications

1. On or After October 1, 1984.--Recertifications of the need for inpatient ICF care (other than ICF/MR) are to be conducted at least:

- 60 days after the date of the initial certification,
- 180 days after the date of the initial certification,
- 12 months after the date of the initial certification,

- o 18 months after the date of the initial certification,
- o 24 months after the date of the initial certification, and
- o every 12 months thereafter.

Authority: §1903(g)(6)(C) of the Act, as revised by §2363(a)(4) of the DRA 1984.

2. Guidance to States.--For purposes of applying the above ICF schedule of recertifications, "12 months" means 365 days, "18 months" means 548 days, and "24 months" means 730 days.

D. Application of Grace Period to SNF and ICF (Other Than ICF/MR) Recertifications Which do not Meet the Time Frames in Subsections B. and C.

1. General.--Effective October 1, 1984, recertification of the need for inpatient SNF or inpatient ICF care, respectively, is considered timely if the following requirements are met:

- o the recertification is made no later than 10 days after the date it is due under the above schedules, and
- o you establish good cause why the physician or other person making the recertification did not meet the schedule.

Authority: §1903(g)(6)(D) of the Act, as revised by §2363(a)(4) of the DRA 1984.

2. Guidance to States.--Since the effective date of the grace period provision, October 1, 1984, you have not had the benefit of a federal regulation defining what constitutes "good cause".

For purposes of establishing "good cause", it is suggested that you apply the following criteria:

Good cause exists if:

- o The physician or other person making the recertification has a set monthly visit schedule to the facility, e.g., always visits on the last day of the month or the third Thursday of the month, which causes the recertification due date to be missed by several days, or
- o There are circumstances beyond the control of the physician or other person making the recertification which cause the recertification to be missed by several days. These circumstances include, but are not limited to, natural disasters, hazardous weather, illness of the person making the recertification, or specific medical emergencies which preclude a timely recertification.