

## APPENDIX E

### CODE OF FEDERAL REGULATIONS TITLE 42 PART 456 - UTILIZATION CONTROL Subpart C - Utilization Control: Hospitals

#### 42 CFR §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.

**.01 Source:**

As adopted, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

#### 42 CFR §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

(b) Exclude services provided in mental hospitals. Utilization control requirements for mental hospitals appear in subpart D.

"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.

**.01 Source:**

As adopted, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978), and amended at 51 F.R. 22010 (June 17, 1986).

**42 CFR §456.60 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 §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 hospital are needed.

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

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978), and amended at 46 F.R. 48556 (Oct. 1, 1981).

**42 CFR §456.80 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.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.100 Scope.**

Sections 456.101 through 456.145 of this subpart prescribe requirements for a written utilization review (UR) plan for each hospital providing Medicaid services. Sections 456.105 and 456.106 prescribe administrative requirements; §§456.111 through 456.113 prescribe informational requirements; §§456.121 through 456.129 prescribe requirements for admission review; §§456.131 through 456.137 prescribe requirements for continued stay review; and §§456.141 through 456.145 prescribe requirements for medical care evaluation studies.

**.01 Source:**

As adopted, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.101 UR plan required for inpatient hospital services.**

(a) A State plan must provide that each hospital furnishing inpatient services under the plan has in effect a written UR plan that provides for review of each recipient's need for the services that the hospital furnishes him.

(b) Each written hospital UR plan must meet the requirements under §§456.101 through 456.145.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.105 UR committee required.**

The UR plan must--

(a) Provide for a committee to perform UR required under this subpart;

(b) Describe the organization, composition, and functions of this committee; and

(c) Specify the frequency of meetings of the committee.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.106 Organization and composition of UR committee; disqualification from UR committee membership.**

(a) For the purpose of this subpart, "UR committee" includes any group organized under paragraphs (b) and (c) of this section.

(b) The UR committee must be composed of two or more physicians, and assisted by other professional personnel.

(c) The UR committee must be constituted as--

(1) A committee of the hospital staff;

(2) A group outside the hospital staff, established by the local medical or osteopathic society and at least some of the hospitals and SNF's in the locality;

(3) A group capable of performing utilization review, established and organized in a manner approved by the Secretary.

(d) The UR committee may not include any individual who--

(1) Is directly responsible for the care of the patient whose care is being reviewed; or

(2) Has a financial interest in any hospital.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.111 Recipient information required for UR.**

The UR plan must provide that each recipient's record includes information needed for the UR committee to perform UR required under this subpart. This information must include, at least, the following:

- (a) Identification of the recipient.
- (b) The name of the recipient's physician.
- (c) Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission.
- (d) The plan of care required under §456.70.
- (e) Initial and subsequent continued stay review dates described under §456.128 and §456.133.
- (f) Date of operating room reservation, if applicable.
- (g) Justification of emergency admission, if applicable.
- (h) Reasons and plan for continued stay, if the attending physician believes continued stay is necessary.
- (i) Other supporting material that the committee believes appropriate to be included in the record.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.112 Records and reports.**

The UR plan must describe--

- (a) The types of records that are kept by the committee; and
- (b) The type and frequency of committee reports and arrangements for their distribution to appropriate individuals.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.113 Confidentiality.**

The UR plan must provide that the identities of individual recipients in all UR records and reports are kept confidential.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.121 Admission review required.**

The UR plan must provide for a review of each recipient's admission to the hospital to decide whether it is needed, in accordance with the requirements of § 456.122 through 456.129.

**.01 Source:**

As redesignated, 43 F.R. 45175. (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.122 Evaluation criteria for admission review.**

The UR plan must provide that--

- (a) The committee develops written medical care criteria to assess the need for admission; and
- (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.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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 is final.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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 or sponsor.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.125 Time limits for admission review.**

Except as required under §456.127, the UR plan must provide that review of each recipient's admission to the hospital is conducted--

(a) Within one working day after admission, for an individual who is receiving Medicaid at that time; or

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

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

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

Except as required under §456.127, the UR plan must provide that the committee makes a final decision on a recipient's need for admission and gives notice of an adverse final decision--

(a) Within two working days after admission, for an individual who is receiving Medicaid at that time; or

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

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456-127 Pre-admission review.**

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

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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 by 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 reflected 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

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

*NOTE: HCFA has clarified that the initial and subsequent continued stay review dates must be documented in both the patient's UR record and the patient's medical record.*

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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

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

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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.

**.01 Source:**

As adopted, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

(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.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

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

The UR plan must provide that—

(a) The committee make a final decision on a recipient's need for continued stay and gives notice under §456.136 of an adverse final decision within 2 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 2 working days after the date of the final decision.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §456.141 Purpose and general description.**

(a) The purpose of medical care evaluation studies is to promote the most 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.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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)(1) 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 review process for admissions or continued stay cases;

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

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

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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, staff, the hospital, and the community.

**.01 Source:**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

**42 CFR §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) PROS;

(2) Fiscal agents;

(3) Other service providers; or

(4) Other appropriate agencies.

**.01 Source**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978), and amended at 51 F.R. 43197 (Dec. 1, 1986).

**42 CFR §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.

**.01 Source**

As redesignated, 43 F.R. 45175 (Sept. 29, 1978, effective Oct. 1, 1978).