

PLAN OF CARE

§ 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 beneficiary.

(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 beneficiary's case must review each plan of care at least every 60 days.

UTILIZATION REVIEW (UR) PLAN:
GENERAL REQUIREMENT**§ 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.

§ 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 beneficiary'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.

UR PLAN: ADMINISTRATIVE
REQUIREMENTS**§ 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.

§ 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 SNFs 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.

§ 456.111

UR PLAN: INFORMATIONAL
REQUIREMENTS

**§ 456.111 Beneficiary information re-
quired for UR.**

The UR plan must provide that each beneficiary'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 beneficiary.
- (b) The name of the beneficiary'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.

§ 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.

§ 456.113 Confidentiality.

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

UR PLAN: REVIEW OF NEED FOR
ADMISSION¹

§ 456.121 Admission review required.

The UR plan must provide for a review of each beneficiary's admission to

¹The Department was enjoined in 1975 in the case of American Medical Assn. et al. v. Weinberger, 395 F. Supp. 515 (N.D. Ill., 1975),

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the hospital to decide whether it is needed, in accordance with the requirements of §§ 456.122 through 456.129.

§ 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.

§ 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 beneficiary'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;

aff'd., 522 F2d 921 (7th cir., 1975) from implementing the admission review requirements contained in §§ 456.121-456.127. This case was dismissed on the condition that these requirements be revised. They are presently being revised, and will not be in force until that revision is completed.

(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.

§ 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 beneficiary; and
- (e) If possible, the next of kin or sponsor.

§ 456.125 Time limits for admission review.

Except as required under § 456.127, the UR plan must provide that review of each beneficiary'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.

§ 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 beneficiary'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.

§ 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 UR committee designates under § 456.142(b) (4)(iii) to receive pre-admission review.

§ 456.128 Initial continued stay review date.

The UR plan must provide that—

(a) When a beneficiary 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

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

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

The UR plan must describe—

§ 456.131

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

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

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

UR PLAN: REVIEW OF NEED FOR
CONTINUED STAY

§ 456.131 Continued stay review required.

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

§ 456.132 Evaluation criteria for continued stay.

The UR plan must provide that—

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

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

(1) Associated with high costs;

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

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

§ 456.133 Subsequent continued stay review dates.

The UR plan must provide that—

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

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

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

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

The UR plan must describe—

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

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

§ 456.135 Continued stay review process.

The UR plan must provide that—

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

(1) The UR committee;

(2) A subgroup of the UR committee; or

(3) A designee of the UR committee;

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

(c) For each continued stay of a beneficiary in the hospital, the committee, subgroup or designee reviews and evaluates the documentation described under § 456.111 against the criteria developed under § 456.132 and applies close professional scrutiny to cases selected under § 456.129(b);

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

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

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

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

(h) If the attending physician presents additional information or clarification, at least two physician members of the committee review the need

for the continued stay. If they find that the beneficiary no longer needs inpatient hospital services, their decision is final.

§ 456.136 Notification of adverse decision.

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

- (a) The hospital administrator;
- (b) The attending physician;
- (c) The Medicaid agency;
- (d) The beneficiary; and
- (e) If possible, the next of kin or sponsor.

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

The UR plan must provide that—

(a) The committee makes a final decision on a beneficiary'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 beneficiary'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.

UR PLAN: MEDICAL CARE EVALUATION STUDIES

§ 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.

§ 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 admissions for review prior to admission.

§ 456.143 Content of medical care evaluation studies.

Each medical care evaluation study must—

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

(b) Include analysis of at least the following:

(1) Admissions;

(2) Durations of stay;

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

(4) Professional services performed in the hospital; and

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

§ 456.144 Data sources for studies.

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

(a) Medical records or other appropriate hospital data;

§ 456.145

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

(c) Cooperative endeavors with—

- (1) QIOs;
- (2) Fiscal agents;
- (3) Other service providers; or
- (4) Other appropriate agencies.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 43198, Dec. 1, 1986]

§ 456.145 Number of studies required to be performed.

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

Subpart D—Utilization Control: Mental Hospitals

§ 456.150 Scope.

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

- (a) Certification of need for care;
- (b) Medical evaluation and admission review;
- (c) Plan of care; and
- (d) Utilization review plans.

§ 456.151 Definitions.

As used in this subpart:

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

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

CERTIFICATION OF NEED FOR CARE

§ 456.160 Certification and recertification of need for inpatient care.

(a) *Certification.* (1) A physician must certify for each applicant or beneficiary 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 practi-

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tioner (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 beneficiary that inpatient services in a mental hospital are needed.

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

[46 FR 48561, Oct. 1, 1981]

MEDICAL, PSYCHIATRIC, AND SOCIAL EVALUATIONS AND ADMISSION REVIEW

§ 456.170 Medical, psychiatric, and social evaluations.

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

(b) Each medical evaluation must include—

- (1) Diagnoses;
- (2) Summary of present medical findings;
- (3) Medical history;
- (4) Mental and physical functional capacity;
- (5) Prognoses; and
- (6) A recommendation by a physician concerning—

(i) Admission to the mental hospital; or

(ii) Continued care in the mental hospital for individuals who apply for Medicaid while in the mental hospital.

§ 456.171 Medicaid agency review of need for admission.

Medical and other professional personnel of the Medicaid agency or its designees must evaluate each applicant's or beneficiary's need for admission by reviewing and assessing the evaluations required by § 456.170.

PLAN OF CARE

§ 456.180 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