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

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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

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(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;

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(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).

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(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.

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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

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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.

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