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9215. CERTIFICATION

Certification is the process by which a physician who has knowledge of the case attests to an individual’s need for a specific type or level of institutional care. This certification must be provided by the physician on or not more than 30 days prior to an individual’s admission to an institution. If an individual makes an application for assistance while in an institution, the certification must be signed at that time or, if the certification was made earlier, not more than 30 days prior to authorization of Medicaid payment. When the preceding time limitation for certification is exceeded, a new certification must be obtained.

Also, a transfer of a patient from one level of care to another is considered as a new admission. Therefore, the patient must be certified for the new level of care on or before the patient is admitted to the new facility. This would include a transfer from an acute care hospital to long-term care facility even if the patient had previously been a resident in the facility to which he or she is being transferred, when the transfer is from one level of care to another level within the same facility, or when the patient is transferred from one long-term care facility to another facility at the same level of care.

The following conditions must be met in order for the certification to be considered valid:

1. The certification must be in writing.

2. The certification must be signed or initialed by an individual clearly identified as a physician. A physician means a doctor of medicine or osteopathy licensed under State law to practice. The signature or initials are not acceptable if they are rubber stamped, unless the physician has initialed the stamp. The physician must date the certification on the same date he or she signs it.

3. The certification must demonstrate the need for the level of care that the individual will receive or is receiving.

4. The certification must be no later than the date of admission.

5. The facility must be certified to furnish the level of care that the individual is certified as needing to receive.

6. The Medicaid agency must describe in its written methods and procedures for utilization control (UC) what type of documentation it will require for

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certification. The documentation must conform with Federal requirements as specified in paragraphs one through five. A certification will be acceptable only if it meets these requirements. Some examples of acceptable certification documentation (with State agency approval) are:

a. A statement signed and dated by the attending, staff physician and/or consultant physician who has knowledge of the case that the individual is in need of a particular level or type of care (i.e., hospital, mental hospital, skilled nursing facility, and intermediate care facility).

b. Physician orders, which clearly specify the need for a particular level of care, which are signed and dated on or not more than 60 days before the date of admission or authorization for payment.

c. A medical evaluation acceptable to the State agency which designates the level of care signed and dated by a physician who has knowledge of the case not more than 60 days prior to admission or authorization for payment.

d. A referral or transfer form indicating the level of care to which the patient is being transferred and other necessary data (e.g., patient’s name, transferring facility), signed and dated by a physician who has knowledge of the case.

e. An admission review form signed and dated by an attending or staff physician who has knowledge of the case and forwarded to the State agency.

The certifications for all title XIX patients must be maintained in the patient’s/resident’s medical record, a central file in the facility where the patient/resident is residing, or a central file in the medical administration unit of the single State agency. The State’s written methods and procedures for UC must specify the location of such information.

9216. PLAN OF CARE REQUIREMENTS

A plan of care must be established by an individual clearly identified as a physician. "M.D." (medical doctor) or "D.O." (doctor of osteopathy) written after the signature or initials are the only acceptable acronyms. "P.A." (physician’s assistant), "R.N." (registered nurse), etc., are not acceptable. The signature or initials are not acceptable if they are rubber stamped unless the physician has initialed the stamp. The plan of care must be established on or not more than 30 days, whichever is applicable, prior to an individual’s admission to an institution. For an individual who makes applications for assistance while in an institution, the plan of care must be established not more than 30 days (whichever is applicable) prior to authorization of Medicaid payment. The plan of care must be reviewed, evaluated, and updated at least every 60 or 90 days (whichever is applicable). A plan of care loses its validity after the required 60 or 90-day period.

The physician’s plan of care must be maintained in the individual’s medical record and include all of the plan of care requirements, as specified in

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456.80, 456.180, 456.280, 456.380 and 456.481. All plan of care orders and patient activities and services must be reviewed and revised as appropriate by the physician and other personnel involved in the recipient’s care. Each new plan of care must be signed and dated by a physician who is responsible for the patient’s care.

Some examples of how a physician might establish a plan of care are by:

1. signing his/her name and title and dating the orders which meet the requirements for a plan of care;

2. writing his/her initials and title and dating orders which meet the requirements for a plan of care;

3. using a rubber stamp, initials and title and dating orders which meet the requirements for a plan of care; and

4. phoning or verbally giving orders to a physician assistant or nurse who records them, and the physician signs and dates the orders later on the day of admission or authorization of Medicaid payment, or sometime during the 60 or 90-day period when updating a plan of care. These orders must also meet all plan of care requirements for the specific level of care involved.

9220. RECERTIFICATION

Recertification is the process by which a physician, nurse practitioner or physician assistant who has knowledge of the case attests to an individual’s continued need for a specific type or level of care. Except as provided below, this recertification must be provided at least every 60 days after the initial certification.

Section 2183 of Public Law 97-35 (the Omnibus Budget Reconciliation Act of 1981), amends section 1903(g)(1)(A) of the Act to allow physician assistants and nurse practitioners, under the supervision of a physician, to recertify the continued need for inpatient services. It also extends the period of time for recertification of care for patients receiving intermediate care facility services in an institution for the mentally retarded from once every 60 days to once every 12 months ("every 12 months" means by the 365th day). The recertification period was extended because patients’ conditions in such institutions may be expected to change slowly over an extended period of time.

The following conditions must be met in order for the recertification to be considered valid:

1. The recertification is in writing.

2. The recertification is signed or initialed by a physician, nurse practitioner or physician assistant (nurse practitioners and physician assistants under the supervision of a physician may only recertify to the need for inpatient services which are within the scope of their practice as defined

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under State law) who has knowledge of the case using his or her own signature or initials. The signature or initials are not acceptable if they are rubber stamped, unless the physician, nurse practitioner or physician assistant has initialed the stamp. The physician, nurse practitioner or physician assistant must date the recertification on the same date he or she signs it.

3. The recertification must demonstrate the need for the level of care that the individual is receiving.

4. The recertification must be no later than the 60th day after the previous certification or recertification.

5. The facility must be certified to furnish the level of care that the individual is recertified as needing.

6. The Medicaid agency must describe in its written methods and procedures for utilization control what type of documentation it will require for recertification. The documentation must conform with Federal requirements as specified in paragraphs one through five. A recertification will be acceptable only if it meets these requirements. Some examples of acceptable recertification documentation (with State agency approval) are:

a. Signed and dated statement by the physician, nurse practitioner or physician assistant who has knowledge of the case that continued care of a particular level or type is needed.

b. Signed and dated orders by the physician, nurse practitioner or physician assistant who has knowledge of the case clearly indicating that continued care of a particular level or type is needed.

c. Signed and dated progress notes by the physician, nurse practitioner or physician assistant who has knowledge of the case clearly indicating that continued care of a particular level or type is needed.

d. Signed and dated reports that a physician, nurse practitioner or physician might use in caring for the patient clearly indicating that continued care of a particular level or type is needed.

e. URC minutes or forms indicating that the patient’s care was reviewed by a physician, nurse practitioner or physician assistant who has knowledge of the case and that continued care of a particular level or type was needed along with the committee physician’s signature and date.

7. The recertifications for all title XIX patients must be maintained in the patient’s/resident’s medical record, a central file in the facility where the patient/resident is residing, or a central file in the medical assistance unit of the single State agency. The State’s written methods and procedures for utilization control must specify the location of such information.

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9220.1 Recertification by physician assistants and nurse practitioners under the supervision of a physician.--While the physician may choose to provide direct, on-the-premises or over-the-shoulder supervision of the physician assistant or nurse practitioner who recertified the need for inpatient care, general supervision will suffice for Medicaid recertification purposes.

In situations where the attending physician is not the supervising physician, if the physician assistant’s or nurse practitioner’s recommendation as to the need for continued care differs from that of the attending physician, the attending physician’s judgment prevails since he or she is legally responsible for the treatment of the patient.

NOTE: The visit of a physician assistant or nurse practitioner to an inpatient to recertify the need for continued care would not obviate the need for physician visits to the patient in a hospital as required in section 42 CFR 440.l0(3)(iii), or physician visits to the patient in a skilled nursing facility in accordance with 42 CFR 405.ll23(b) at least once every 30 days for the first 90 days following admission or physician visits to the patient in a intermediate care facility once every 60 days in accordance with the regulation at 42 CFR 442.346.

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Superior UR Systems

9300. SUBMITTING SUPERIOR UR SYSTEM WAIVER REQUEST TO HCFA

Section 1903(i)(4) of the Act provides that to participate in Medicaid, a hospital or a skilled nursing facility must have in effect a Utilization Review (UR) plan meeting requirements specified in section l86l(k) of the Act. Section 1903(i)(4) also provides that the Secretary may waive the requirements of section 1861(k) when a State Medicaid agency demonstrates that it has in operation UR procedures that are superior in their effectiveness to Federal requirements. Superior UR system waivers are addressed in 42 CFR 456.505-.508.

If you have a UR system in operation for which a waiver is necessary, submit the waiver request to the Regional Administrator, Health Care Financing Administration. If clarification or further information is needed to determine whether a waiver request is warranted, contact the Regional Administrator.

9310. UTILIZATION REVIEW FEATURES WHICH WILL NOT BE WAIVED

Superior system waivers apply only to certain UR plan requirements. A waiver request will not be approved or renewed if the following elements are part of the waiver request:

1. Certification or recertification of need for care;

2. Plan of care;

3. Discharge plan;

4. UR plan requirement provisions relating to disqualification of UR committee members; or

5. UR in ICFs.--Note, however, that Medicaid regulations provide flexibility for States to determine the most effective manner for conducting UR in ICFs. For example, the State plan may require that UR be conducted by the facility, or by individuals employed by (or under contract to) the State Medicaid agency.

9320. CONTENT OF INITIAL WAIVER REQUEST

Submit a complete description of the operating system, including at least the following items:

o Documentation that the system is in operation; date of initiation; whether statewide (if not statewide, describe specifically the geographic scope of operation); State agency responsible for administration of system; copies of any contracts or agreements if system is not conducted by the State Medicaid agency.

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o Goals of the system.

o Documentation of results of system to date in light of the goals stated above, e.g., reduction in length of stay, cost avoidances, documentation of provision of more appropriate care.

o Description of methodology for evaluating results.

o Justification of superior system and supportive documentation.

o Description of mechanisms whereby the State monitors the system, including a specific description of quality controls.

o Description of processes, methodology, numbers and types of personnel, and timing involved in:

- Admission Review (Admission or pre-admission mechanism for reviewing medical necessity and determining the appropriate level of care.)

- Continued Stay Review (Standards and criteria which determine the necessity for continued stay and a process for determining the duration of continued stays.)

(The above description must also include the processes of specifying the relevant parties and notifying such parties, and the timing of the notifications.)

- Quality review plan that addresses those patients who may be at greater risk of receiving poor quality care, e.g., long-stay patients with mental or cognitive problems in addition to physical limitations. A quality review plan should include:

-- Mechanisms for problem identification;

-- Problem analysis;

-- Intervention to resolve problem;

-- Corrective action;

-- Follow-up to verify correction;

-- Monitoring to assure continued problem resolution.

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9330. CONTENT OF RENEWAL OF WAIVER REQUEST

Submit documentation at least 90 days prior to the expiration of the current waiver. The renewal documentation must include the specific improvements achieved since the initiation of the superior system, in regard to:

o Necessity and appropriateness of patient placement in specific care settings.

o Reduction of unnecessary admissions or days of unnecessary medical care.

o Improvements in the quality of care provided to Medicaid patients (such as through results of quality review studies).

9340. DECISIONS AND NOTIFICATIONS BY HCFA

Superiority in initial waiver requests may be judged based on either the quality of the process or on the results demonstrated during use of the procedures before approval was requested.

Formal approval of waiver requests requires on-site review and written documentation of the operating system. Compliance is judged on such documentation. In considering any State request for a superior UR system waiver that is justified based on process rather than results, HCFA verifies that the procedures described in the request are, in fact, the same as those carried out by the Medicaid agency in its review. Within 90 days of receipt of a request for waiver or renewal, HCFA must make a final decision and send a formal written notification of the decision to approve or deny the request to the State Medicaid agency.

The 90-day limitation is mandated by section l9l5(f) of the Act. Only a one-time request by the HCFA Regional Office for additional information or documentation can interrupt and restart the 90-day period.

9350. WITHDRAWAL OF HCFA APPROVAL

At any time during the waiver period, if State procedures are determined to be no longer superior in their effectiveness, HCFA will withdraw the waiver. The Regional Administrator, Health Standards and Quality Bureau, will issue a letter to the Director of the State Medicaid agency informing him/her of the date by which the State must begin operating under the statutory UR system.

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