Sec. 17-134d-80. Title XIX utilization review requirements for medicaid services in general hospitals

(a) **Definitions**

For purposes of this regulation, the following definitions apply:

(1) Acute Care means the medical care needed for an illness, episode, or injury which requires short term, intense care and hospitalization for a short period of time.

(2) Admission means the formal acceptance by a hospita1 of a patient who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services.

(3) Adverse Determination means the initial negative decision by a reviewing body regarding the medical necessity, quality, or appropriateness of health care services provided or proposed to be provided to a patient.

(4) Appropriateness of Setting Review means the review of services provided or proposed to be provided to determine if the services could have been delivered safely, effectively and more economically in another setting.

(5) Criteria means the pre-determined measurement variables on which judgment or comparison of necessity, appropriateness or quality of health services may be made.

(6) Department means the State of Connecticut Department of Income Maintenance or its agent.

(7) Department's Manual means the Department's Connecticut Medical Assistance Provider Manual, which contains the Medical Services Policy, as amended from time to time.

(8) Diagnosis

(A) Admitting Diagnosis means the patient's condition which necessitated or prompted the admission to the hospital, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(B) Principal Diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care and coded using International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(9) Emergency means a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(10) Evaluation means an assessment or examination in which actions and their results are measured against predetermined criteria in order to verify medical necessity, appropriateness, and quality.

(11) Free Standing Clinic means a facility providing medical or medically related clinic outpatient services or clinic off-site services by or under the direction of a physician or dentist and the facility is not part of, or related to, a hospital. Such facilities provide mental health, rehabilitation, dental and medical services and are subject to Sections 171 through 171.4 of the Department's Manual, as may be amended from time to time.

(12) General Hospital for purposes of this regulation means a short-term hospital having

facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries, and shall include a children's general hospital which means a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries. It shall also include a border hospital as defined in Section 150.1 of the Department's Manual, as may be amended from time to time.

(13) Inpatient means a recipient who has been admitted to a general hospital for the purpose of receiving medically necessary, appropriate, and quality medical, dental or other health related services and is present at midnight for the census count.

(14) Medical Appropriateness means medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting.

(15) Medical Necessity means medical care provided to:

(A) Correct or diminish the adverse effects of a medical condition;

(B) Assist an individual in attaining or maintaining an optimal level of well being;

(C) Diagnose a condition; or

(D) Prevent a medical condition from occurring.

(16) Override Option means a decision, used in utilization review, when "overriding" circumstances of clinical significance justify changing the conclusion of the objective criteria.

(17) Patient means an individual who receives a health care service from a provider and is also a Medicaid recipient.

(18) Preadmission Review means a review prior to or in the case of an emergency admission, immediately thereafter, a patient's admission to a hospital to determine the medical necessity, appropriateness, and quality of the health care services proposed to be delivered, or in the case of an emergency, delivered in the hospital.

(19) Principal Procedure means the procedure most closely related to the principal diagnosis, that is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes and/or was necessary to care for a complication, and coded according to International Classification of Diseases, 9th Revision, Clinical Modification, and as amended from time to time.

(20) Prior Authorization means approval for a service from the Department or the Department's agent before the provider actually provides the service. In order to receive reimbursement from the Department a provider must comply with all prior authorization requirements. The Department in its sole discretion determines what information is necessary in order to approve a prior authorization request.

In the case of an emergency admission to a general hospital, prior authorization means approval obtained within two business days of admission.

(21) Quality of Care means the evaluation of medical care to determine if it meets the professionally recognized standard(s) of acceptable medical care for the condition and the patient under treatment.

(22) Recipient means an individual who has been determined eligible for Medicaid.

(23) Reliability means a measure of the consistency of a method in producing results. A reliable test gives the same results when applied more than once under the same conditions.

(24) Retrospective Review means the review conducted after services are provided to a patient, to determine the medical necessity, appropriateness, and quality of the services provided.

(25) Utilization Review means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures and facilities. Utilization review evaluates the medical necessity, and medical appropriateness of admissions, the services performed or to be performed, the length of stay and the discharge practices. It is conducted on a prospective and/or retrospective basis.

(26) Validity means a measure of the extent to which an observed situation reflects the true situation or an indication of medical quality measures what it purports to measure.

(b) **Utilization Review Program in General Hospitals**

(1) The Department's Utilization Review Program conducts utilization review activities for services delivered to general hospital inpatients, where Medicaid has been determined to be the appropriate payer.

(2) The Department's objectives for performing utilization review include:

(A) To determine the medical necessity and appropriateness of general hospital inpatient services;

(B) To assure that the quality of service meets accepted and established standards;

(C) To safeguard against unnecessary and inappropriate utilization;

(D) To effectively monitor provider patterns of utilization; and

(E) To identify inappropriate patterns and services.

(3) To evaluate services the Department through its staff or its agent, uses utilization review techniques that have withstood tests for validity and reliability. For example: Professional Activity Study (PAS) Norms, Appropriateness Evaluation Protocol (AEP), InterQual ISD Review System (Intensity of service, severity of illness discharge screens).

(4) As part of the Utilization Review process, reviewers may use an override option. The purpose of the override option is to:

(A) Allow the reviewer to indicate that the criteria are not sufficiently comprehensive to meet non-criteria circumstances or factors necessitating admission and/or hospitalization; or

(B) Conversely, to judge that the service which meets the criteria are not justified on clinical grounds.

(5) When the Hospital Utilization Review Program makes an adverse determination on a preadmission review, the provider is notified by telephone and in writing and is given the opportunity to request a second review. The second review to present additional information, can be requested by telephone or in writing within ten (10) calendar days of the adverse determination, unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider by telephone and in writing.

(6) When the Hospital Utilization Review Program makes an adverse determination on a retrospective review providers are sent a written summary of findings by the Department. The provider is given an opportunity to request a second review and present additional

information in writing, provided said request is submitted in writing to the Department within twenty (20) calendar days of the date of receipt of notice of adverse determination unless, for good cause shown in the discretion of the Commissioner, the time for submission is extended. The date of receipt is presumed to be five (5) days after the date on the notice, unless there is a reasonable showing to the contrary. The provider sends the information to Director, Medical Care Administration, or his/her designee. Following receipt of said additional documentation, the Department shall make its final determination and shall notify the provider in writing.

(c) **Payment for Medicaid Services**

(1) Payment by Connecticut Medicaid is only for definitive medical care, treatment and services that are judged to be medically necessary. The Department will not pay for any principal procedure or other procedures or service of an unproven, experimental, social, educational or research nature or for service(s) in excess of those deemed medically necessary by the Department to treat the patient's condition or for services not directly related to the patient's diagnosis, symptoms or medical history.

(2) Medical care, treatment and services must be provided to eligible Medicaid recipients in accordance with the Department's policies, procedures, conditions and limitations and billed for in accordance with the billing section of the Department's Manual.

(3) Payment will be denied for hospital inpatient services, and also for physicians (including physicians in free-standing clinics), dentists, and podiatrists services provided to hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions, and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided which the Department finds not to meet the medically necessary or utilization review standard.

(d) **Requirements for Establishment of Medical Necessity**

(1) To determine that inpatient general hospital services or admissions are medically necessary, the Department or its agent:

(A) Shall require prior authorization of each general hospital inpatient admission including emergency admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such prior authorization. In addition the Department, in its discretion, may perform preadmission review and/or reviews of any or all general hospital inpatient admissions unless the Department notifies the providers that a specific diagnosis or procedure does not require such review.

(B) Shall perform retrospective reviews in the Department's discretion which may be of a random or targeted sample of general hospital admissions and services delivered. The review may be focused on the appropriateness, necessity, and quality of the health care services provided.

(2) If the Department decides to reimpose prior authorization or preadmission review

requirements which it has previously notified providers it will no longer require, the Department shall notify all affected providers at least thirty (30) days in advance of the imposition of preadmission review or prior authorization requirements.

(3) All claims for payment for admission and all days of stay and services provided must be documented with the medical records required by section 150.1F.V. of the Department's Manual. Lack of said documentation itself may be adequate ground for the Department, in its discretion, to deny payment for the admission of some or all of the days of stay or services provided.

(e) **Special Requirements for Retrospective Review of Emergency Admissions When Prior Authorization Had Not Been Obtained On A Timely Basis.**

Payment for an emergency admission where prior authorization was not obtained may be made pursuant to the following:

(1) The hospital shall request retrospective review within thirty (30) calendar days of the date the patient was admitted to the hospital. The hospital may request that the Department waive the thirty (30) calendar day time limit if the hospital proves to the satisfaction of the Department that: (a) the failure to make the request within the thirty (30) day time limit was caused by reasons beyond the control of the hospital; and (b) the hospital neither knew nor had any reason to check the eligibility of the individual within the thirty (30) day time period or checked with the Department's eligibility verification unit and was given erroneous information (the "Good Cause Exception"). The total number of Good Cause Exceptions, per hospital fiscal year, shall not exceed the greater of one, or.125% (.00125) of such hospital's Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS);

(2) The retrospective review will be done at the hospital's expense at the standard charge of the department's contractor to hospitals;

(3) For each fiscal year commencing October 1, the hospital may request, in total, retrospective reviews up to the maximum number for which it has received authorization pursuant to subsection six (6) below;

(4) The patient for whom the retrospective review is requested was an emergency admission (i.e. admitted through the emergency room or transferred from another hospital on an emergency basis due to the original hospital's inability to treat the patient due to the severity or complexity of the illness or injury). No request may be made for consideration of patients admitted directly or via transfer if the admission was not an emergency admission;

(5) The retrospective review reveals that all requirements for payment are met except for the failure to obtain prior authorization.

(6) In July of each year, the Department shall notify each hospital of the maximum number of retrospective reviews. Said number shall be one percent (1%) of its Medicaid discharges for the most recent fiscal year documented in the most recent "Cost Settlement Summary-Inpatient Fiscal Year" in the Department's possession on July 1, from the Department's Medicaid Management and Information System (MMIS).

(Effective February 24, 1993)