Manual for Diagnosis Related Group Review of Inpatient Hospital Services

Effective with Admissions August 1, 1992

OFFICE OF MEDICAL ASSISTANCE PROGRAMS

DEPARTMENT OF HUMAN SERVICES

Last Revision Date: June 18, 2018

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I. INTRODUCTION

The Department of Human Services is the Single State Agency mandated under Section 1902(a)(30) of the Federal Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, to perform utilization review of medical services rendered to medical assistance (MA) recipients and payment to providers. Also, regulations at 42 CFR Part 456 provide for utilization control requirements for hospitals and Medicaid State Agencies.

In 1984, the Department of Human Services implemented a prospective payment system based on Diagnosis Related Groups (DRGs) for medical assistance reimbursement to general hospitals. Under this system, discharges are classified by DRGs and payment is made accordingly for compensable and medically necessary inpatient services certified by the Department's Division of Medical Review.

The Department has been reviewing inpatient hospital services paid under the DRG prospective reimbursement system since July 1984. The objectives of the DRG review process are to:

1. Assure that admissions are necessary and appropriate medical is rendered to medical assistance patients, and
2. Control costs related to inpatient hospital care.

The process involves the review of emergency and urgent admissions, including readmissions and transfers by the hospital, within two working days after the admission to an acute care general hospital, a short procedure unit (DPU), or an ambulatory surgical center (ASC) to determine the necessity for admission. Elective DRG admissions are reviewed in advance of the admission through the Place of Service Review Program. However, is a recipient is admitted to the SPU or ASC for an elective procedure, but develops a complication or requires a more extensive procedure resulting in the need for an urgent or emergency inpatient admission, the inpatient admission must be certified by the DRG Section. Outlier days, continued hospitalization beyond a length of stay known as the DRG trim point, and outlier costs for neonatal and burn cases are reviewed for medical necessity after discharge.

Effective with admissions on or after August 1, 1992, the hospital representative must call the DRG toll-free number 1-800-558-4DRG, within two working days of the admission date to certify admissions of medical assistance recipients.

The DRG review process is an on-line computerized telephone review of a patient's need for hospital admission. The DRG nurse and the Hospital Nurse Coordinator (HNC) discuss the medical necessity for acute inpatient hospital care. Inpatient care cannot be certified for unnecessary, inappropriate, excessive, or noncompensable care in accordance with Medical Assistance Regulations.

The process emphasizes the responsibilities of the hospital Utilization Review Committee in assuring that medical necessity is indicated for the admission and continued inpatient hospitalization. Through medical record documentation by the attending physician facilities the hospital's review of the need for admission and

continued inpatient care and avoids unnecessary discussions with the Department's reviewers in order to determine if hospital care is necessary.

The quality and duration of hospital care must be consistent with the recognized and accepted medical standards and appropriate to the patient's signs, symptoms, provisional and/or final diagnosis.

THE DEPARTMENT CONTINUES TO MAINTAIN ITS CURRENT POLICIES IN REGARD TO THE PRESENT LIMITATIONS ON SERVICE AND THAT MEDICAL NECESSITY MUST BE ESTABLISHED FOR INPATIENT HOSPITALIZATION.

II. PURPOSE

The purpose of this Manual is to give providers instructions to meet the requirements of the Diagnosis Related Group (DRG) review process, which applies to urgent and emergency admissions to Pennsylvania general hospitals, short procedure units, ambulatory surgical centers approved for participation in the MA Program and to licensed practitioners who admit patients to these facilities.

The procedures described herein should be followed for patients who are eligible for MA benefits during a hospitalization. The hospital must call the DRG Unit within two working days after admission to obtain certification for the admission. All services provided to MA recipients are subject to the utilization review procedures set forth in this instruction manual, Chapter 1163, Subchapter A relating to inpatient hospital services, Chapter 1101 relating to general provisions, and Chapter 1126 relating to ambulatory surgical centers and short procedure units.

III. SUMMARY OF THE DRG EMERGENCY AND URGENT ADMISSION REVIEW PROCESS

A. An MA recipient is admitted to the hospital by the attending physician.

B. The hospital admission staff informs the HNC of the admission subject to certification by the DRG Section.

C. The HNC reviews the admission and calls the toll-free number, 1-800-558-4DRG, within two working days after admission to request admission certification and provides the appropriate recipient data, diagnosis code(s), medical indications for the admission, and the planned treatment.

D. The DRG nurse evaluates the information for medical necessity and compensability of the admission under the MA Program. The DRG nurse certifies the request, asks for addition information, and/or refers to a DRG physician reviewer.

E. The HNC must provide the requested additional information for questionable admissions to the DRG Section within 14 calendar days if the request or a certification notice will be automatically generated stating that this request for certification is denied because of failure to provide requested information within the allotted time.

F. The DRG Section completes the review of questionable admissions. The DRG physician reviewer discusses questionable cases with the Hospital Utilization Review Chairperson through scheduled telephone calls, if necessary.

G. The DRG nurse enters the decision onto the computer file, which generates a certification notice to the hospital and to the physician.

H. The hospital and attending physician enter the preprinted certification number from the certification notice onto the MA invoice submitted for payment.

I. The invoice is matched against the DRG file to ensure that payment is made to the hospital and the attending physician for certified admissions only.

J. The hospital retains the certification notice in the Business Office for auditing purposes and a copy in the patient's medical record for utilization review purposes.

K. Hospital or practitioner appeal requests must be received by the Division of Medical Review within 30 calendar days of the date of the certification notice.

IV. REQUESTING DRG ADMISSION CERTIFICATION

When a medical assistance recipient is admitted to the hospital, certification must be obtained from the DRG Section within two working days after admission. (For late pickups, see Section VII.) It is the provider's responsibility to use the recipient's Pennsylvania ACCESS Card to verify that the recipient is eligible for medical assistance, and for the services to be provided; and that the recipient is not required to receive services from a specific practitioner or facility.

When it is determined that the admission requires DRG admission certification, the necessary information should be gathered before the HNC telephones the DRG Section. Advice the DRG nurse reviewer if this is a new request or a request that has been pended awaiting additional information. Then, supply the recipient and provider information and the medical information to justify the admission. Medical indications for services requested should be documented by the attending practitioner in the patient's medical record to expedite admission certification.

Requests for DRG admission certification are made by calling the Department's toll-free line, 1-800-558-4DRG. The DRG lines are open from 7:30 a.m., until 4:00 p.m., Monday through Friday, excluding Commonwealth holidays.

V. INFORMATION NECESSARY FOR DRG ADMISSION CERTIFICATION

The following information is needed from the HNC in order for the DRG nurse reviewer to complete the request.

Recipient Information – The complete recipient number must be available to initiate a request. The nurse reviewer enters the recipient number onto the computer terminal and verifies the recipient's name, age, and eligibility for medical assistance coverage. Obtain this information by using the recipient's Pennsylvania ACCESS Card and the Eligibility Verification System (EVS).

Hospital Information – The DRG nurse enters the hospital's 13-digit PROMIS*e*™ provider number onto the computer terminal.

Practitioner Information – The DRG nurse enters the provider's 13-digit PROMISe™ provider number onto the computer terminal.

Late Pickup (LPU) Information (Only if a late pickup) – The DRG nurse requests the date the recipient became eligible for MA and the date the facility was notified of eligibility.

Attending Practitioner License Number – The DRG nurse enters the license number onto the computer terminal. This is the method of identification for those physicians who are not enrolled in the MA Program. *The license number contains two alpha characters, six numeric characters, and one alpha character(s) if it was issued prior to June 29, 2001. If the license number was issued after June 29, 2001, it will contain two alpha characters and six numeric characters.*

Person Requesting DRG Certification – The name and telephone number of the person requesting admission certification (contact person).

Diagnosis Information - Space is provided on the computer screen for four diagnosis codes. The DRG nurse enters the appropriate principal ICD-9-CM diagnosis code, and the secondary diagnosis code, if applicable, onto the computer terminal and verifies the Department's narrative description of the diagnosis code(s) with the requester.

Procedure Information (if applicable) – Space is provided for a maximum of two procedure codes. The DRG nurse enters the appropriate principal procedure code and secondary procedure code, if applicable, onto the computer terminal and verifies the Department's narrative description of the procedure(s) with the requestor.

Medical Indications – Documentation in the patient's medical record should be used to establish the medical indications for the service requested.

Prior Medical Management – Describe any attempts that have been made to treat this condition on an outpatient basis or previous admission.

Medical Treatment – Supply the DRG nurse with the planned treatment(s).

Prior Admission Information (if applicable) – If the patient had an inpatient admission within 31 days of this admission, this information should be supplied to the DRG nurse. The hospital's 13-digit PROMIS*e*™ provider number, admission and discharge dates, and condition on discharge from the first admission are needed.

Transfer Information (if applicable) – The 13-digit PROMIS*e*™ provider number of the hospital transferring the patient is needed.

Admission Date – Provide the date the patient was admitted to your hospital.

Admission Class – Provide the admission class:

0 Elective Admission – a preplanned admission to a hospital short procedure unit, or ambulatory surgical center. An elective admission is one wherein scheduling options may be exercised by

the physician, facility, or recipient without unfavorably affecting outcome of treatment.

1 Emergency – any condition in which immediate medical care is necessary to prevent death, serious impairment or significant deterioration in the recipient's health status. It is a life-threatening situation.

2 Urgent Admission – a condition that, while not likely to cause death irreparable harm if not treated immediately, must be treated with dispatch and cannot wait for normal scheduling. Scheduling is dictated by the condition's imperative need for treatment but a true emergency does not exist.

NOTE: Admission Class Values 0, 1, and 2 differ from UB-92 Type of Admission Codes 1, 2, and 3.

VI. DRG HOSPITAL ADMISSION UTILIZATION REVIEW REQUIREMENTS

Medical Assistance admissions must be reviewed within 24-hours where practical, but no later than two working days after admission to determine medical necessity for hospitalization except if the physician or category of admission is designated by the Hospital Utilization Review Committee for preadmission review.

It is the responsibility of the hospital to evaluate the admission against written criteria selected or developed by the Committee or physician review group to assure the medical necessity for admission. More extensive criteria and closer professional scrutiny are applied in the review for high costs, frequent or excessive services and/or questionable patterns of physician services.

It is the responsibility of the Hospital Utilization Review Committee and Chairperson to afford the attending physician an opportunity to present his/her views prior to the Committee determining that the admission is not medically necessary.

Final determination of necessity for admission and any notification of adverse decisions are made not later than two working days after admission. Written notification is forwarded to the hospital administrator, the attending physician, the Bureau of Program Integrity (BPI), and when possible, the recipient's next of kin or sponsor. Refer to Section IX for maintaining the BPI copy of the adverse determination notification.

The HNC must call the DRG Section within two working days after admission. A 50% payment will be certified for untimely requests unless the admission meets the requirements for processing special cases (See Section VII).

Questionable admissions, misutilization of hospital services and facilities, and noncompensable services will be brought to the attention of the Hospital Utilization Review Chairperson by the DRG Section to justify the medical necessity for the hospitalization. If the requested additional information is not received within 14 calendar days of the date of the request, certification will be denied.

Also, refer to the Medical Assistance Regulations, Chapter 1163, Subchapter A, Inpatient Hospital Services, for noncompensable services, hospital utilization control review requirements, and to MA Bulletin 11-88-09 regarding payment for readmissions.

Early discharge planning is essential to assure placement of the patient at the time of discharge. This is accomplished during the admission review. The Department does not reimburse general hospitals for patients requiring other than acute, short-term hospital inpatient care.

The DRG nurse enters the decision to certify or deny the hospital admission onto the computer database, which generates a DRG Certification Notice (Attachment B) to the hospital and the physician.

VII. DRG EXCEPTIONS AND INSTRUCTIONS FOR PROCESSING SPECIAL CASES

A. Exceptions

1. Maternity Admissions – admissions, which are expected to result in the delivery of one or more infants (DRGs 370 to 375 inclusive).
2. Newborn Admissions – a newborn is defined as an infant who was born in the hospital or who was born on the way to the hospital and has not been discharged or transferred from the hospital since birth.
3. An inpatient admission that is paid for, all or in part, by Medicare Part A, or an outpatient admission to a short procedure unit /ambulatory surgical center paid for, all or in part, by Medicare Part B.
4. Admissions to rehabilitation hospitals, drug and alcohol treatment, and rehabilitation units, psychiatric hospitals and psychiatric units of general hospitals – these admissions must be certified for payment in accordance with the Department's Concurrent Hospital Review (CHR) Process
5. Elective admissions to general hospitals, hospital short procedure units, or ambulatory surgical centers – these admissions must be certified for payment in accordance with the Department's Place of Service Review (PSR) Process.
6. Admissions of recipients enrollment in and HMO/HIO Program.

B. Processing Cases with Combined Insurance Coverage

If a patient has MA coverage at the time of admission and other insurance and Medical Assistance is expected to pay a portion of the hospitalization along with other third party coverage, the usual procedures for certifying admissions must be followed.

C. Late Pickups

Cases in which MA eligibility was not anticipated at the time of admission and determination was made during the hospital stay, or after discharge and cases, in which other insurance coverage failed to materialize, are processed as late pickups. The DRG Section conducted its review of later pickups in accordance

with MA regulations and the process described in this manual relating to admissions and outlier reviews.

To qualify for a late pickup, one of the following situations must exist:

1. The patient is not eligible for MA at the time of admission but obtains eligibility during the admission or following discharge from the facility.
   a. If the patient obtains MA eligibility during the hospital stay, the hospital must notify the Department within two working days of the notification of MA eligibility. Otherwise, 50% of the established fee will be certified. The date of notification of eligibility must be provided at the time of the request.
   b. If the patient obtains MA eligibility after discharge, the admission certification request must be made within 30 calendar days of the date the facility was notified of MA eligibility. Otherwise, the request for certification is denied. The date of discharge and the date of notification of eligibility must be provided at the time of request.
2. The patient has both private insurance and MA and the private insurance was expected to make total payment. However, the private insurance rejected the claim because benefits were exhausted, or only made a partial payment for the admission.
   a. If the insurance rejection occurs while the individual is still hospitalized, the hospital, the hospital must request admission certification within two working days of the notification of the rejection. Otherwise, 50% of the established fee will be certified. The date of the notification of rejection must be provided at the time of the request.
   b. If the insurance was expected to pay, but rejected the claim or paid less than the Department's fee, and the individual has been discharged, the admission certification request must be made within 30 days of the date the facility receives the Explanation of Benefits (EOB) from the other insurance. Otherwise, the request for certification is denied. The date the hospital received the EOB must be provided at the time of the request.

VIII. DRG OUTLIER REVIEW

A. Day Outliers

If the patient's hospital stay has reached the DRG trim point, and the attending practitioner has documented in the medical record the medical necessity for continued inpatient care, the Hospital Utilization Review Committee or its representative reviews each day of the admission to determine medically necessary inpatient days. A plan of treatment and medical justification must be documented in the patient's medical record.

It is the responsibility of the hospital to evaluate each continued-stay case against written criteria selected and developed by the Committee or physician review group. More extensive criteria and closer professional scrutiny are applied in the review for high costs, frequent or excessive services, and/or questionable patterns of physician services.

An inpatient stay must exceed the DRG trim point to qualify as a day outlier. DRGs relating to burns and neonates (with the exception of DRG 391 – normal newborns) do not qualify as day outliers (see Section VIII, B., Cost Outliers). After the patient is discharged, the hospital must bill and receive the base DRG payment before an outlier is requested. The only exception is when a third party payment exceeds the anticipated medical assistance base DRG payment (refer to MA Bulletin 11-85-07). If the hospital has received interim bill payment, the required outlier documents MUST be submitted to the DRG Outlier Review Section within 365 days from the end date of service (refer to MA Bulletin 11-85-06).

1. Requests for Day Outlier Payment

   When requesting certification for outlier days, the following required information is securely packaged and forwarded to the DRG Outlier Review Section by the hospital:

   - ✓ Completed hospital transmittal form for DRG Day Outlier Requests (MA 116 – see Attachment C).
   - ✓ Appropriate Outlier Request Form, copy of the "DRG/CHR Certification Notice" or Day Outlier Request for Cases Exempt from the PSR/DRG Process", with the requested number of outlier days completed (see Attachment D).
   - ✓ Hospital claim adjustment or invoice
   - ✓ Third party statement, when applicable.
   - ✓ Copy of the Remittance Advice (RA) Statement showing either the base DRG payment or the most recent interim bill payment.
   - ✓ Hospital Utilization Review Committee Comments on hospital letterhead stationary. Any days denied by the Committee must be identified by the date in the comments section.
   - ✓ Copy of the complete inpatient medical record.

2. Day Outlier Review Process

The Division of Medical Review reviews, within 30 days of receipt, the recipient's complete medical record to identify the medical necessity and compensability for the admission and for each day of the inpatient stay. Inpatient days are not approved for unnecessary, inappropriate, excessive, or noncompensable care in accordance with MA regulations. The medical necessity for the admission and each day of inpatient care must be properly documented in the medical record.

If the hospital denies all or part of a stay, the Outlier Review Section denies as a minimum the same services. Outlier payments for days and services denied by the hospital are not included on the inpatient claim.

If the Outlier Review Section denies days of an inpatient stay, the hospital's utilization review department is notified by telephone of the number of days and the dates denied. The hospital's utilization review chairperson is afforded the opportunity to discuss the questionable days by telephone conference (telecon) with the physician reviewer. If a telecon is completed, the outlier will be processed with decision as discussed. If no telecon is scheduled by the hospital within 14 days of notification if the decision, the outlier is processed with the Outlier Review Section's decision.

3. Certification of Day Outlier Days

Under the DRG system, days denied that are before the DRG trim point are known as carve out days. If the Outlier Review Section denies such days, the number of denied carve out days is subtracted from the requested number of eligible outlier days according to MA regulations. Days denied after the DRG trim point (outlier days) are subtracted from the requested number of eligible outlier days. The remaining outlier days are certified if within the scope of the Medical Assistance Program. If no days remain, the outlier request is denied.

Day outlier inpatient stays for patients remaining in the hospital beyond one year may also be reviewed by Outlier Review Section during the course of the stay to ensure compliance with MA Regulations.

4. Final Processing of Day Outliers

The Outlier Review Section enters the outlier review request and decision onto the computer database. This entry will generate an outlier certification notice to the hospital indicating the outlier decision.

The outlier claim is then forwarded to PROMIS*e*™ for payment processing of certified outlier days. If no outlier days are certified, the outlier claim will not be processed.

Refer to Section XI for the Appeals Process.

B. Cost Outliers

Burn and neonatal cases with extremely high costs may be eligible for additional payments above the DRG payment. A plan of treatment and the medical

necessity for the admission and continued stay must be documented in the patient's medical record.

It is the responsibility of the hospital to evaluate each continued-stay case against written criteria selected and developed by the Committee or physician review group. More extensive criteria and closer professional scrutiny are applied in the review for high costs, frequent or excessive services, and/or questionable patterns of physician services.

It is the responsibility of the Hospital Utilization Review Committee to review each service/item for which the hospital is requesting additional monies, to determine if the service was ordered by the attending physician and the medical necessity for such services. Medical justification for each service/item ordered and rendered must be documented in the patient's medical record.

It is the responsibility of the Hospital Utilization Review Committee and Chairperson to afford the attending physician an opportunity to present his/her views prior to the Committee determining that the stay is not medically necessary.

Written notification of the adverse decision is forwarded to the hospital administrator, the attending physician, the Bureau of Program Integrity, Division of Analysis and Quality Improvement, and, when possible, the recipient's next of kin or sponsor. Refer to Section IX regarding adverse determinations.

The only inpatient cases subject to cost outliers are the DRGs 385 through 390 inclusive, relating to neonates; and DRGs 456 through 460 inclusive and DRG 472 relating to burn cases.

Cost outliers are reviewed by the Bureau of Program Integrity, Division of Analysis, and Quality Improvement on a retrospective basis. In addition, cost outlier hospital inpatient stays for patients remaining in the hospital beyond one year are also reviewed by this Division during the course of the hospital stay to ensure compliance with the MA Program Regulations. Refer to Section XII for Monitoring Mechanisms, Section XIII for Sanctions, and Section XI for the Appeal process.

IX. ADVERSE DETERMINATIONS BY HOSPITAL UTILIZATION REVIEW COMMITTEE

A monthly summary report of the Hospital Utilization Review Committee's Adverse Determination Letters for medical assistance cases must be mailed to the Bureau of Program Integrity, Division of Analysis and Quality Improvement by the fifth day of each month for the previous month's activities. See Attachment E for the report format, which should be copied to submit future reports.

Complete the monthly report as follows:

1) Enter the month and year covered by the report.
2) Enter the name of the hospital and city where the hospital is located.

3) Enter the hospital's 13-digit PA PROMIS*e*™ provider number assigned by the Office of Medical Assistance Programs (OMAP).

4) Enter the total number of hospital-discharged cases for the month for all patients.

5) Enter the total number of medical assistance discharged cases for the month.

6) Summarize the monthly medical assistance case denials made by the Hospital Utilization Review Committee. Enter the number of cases and days denied according to the following categories: (a) unnecessary admissions, (b) unnecessary delay prior to surgery or treatment, and (c) continued stay denials. Enter the total number of cases and days denied. Do not include admission or extension denials made by the CHR section.

7) Maintain admission denial letters and continued stay denial letters (Adverse Determinations) for each case reported in Item 6 on file and submit to the Department only on request.

8) The Hospital Administrator signs the report.

9) The monthly summary report must be sent to the following address:

Department of Human Services
Office of Medical Assistance Programs
Bureau of Program Integrity
Division of Analysis and Quality Improvement
P.O. Box 2675
Harrisburg, PA 17105-2675

X. MEDICAL CARE EVALUATION STUDIES

Refer to the Medical Assistance Inpatient Hospital Regulations on Medical Care Evaluation (MCE) studies. MCEs are performed to promote the most effective and efficient use of available health facilities and services with patient needs and professionally recognized standards of health care.

Each MCE study, whether medical or administrative in emphasis, identifies and analyzes factors related to the patient care rendered in the hospital and where indicated, results in recommendations for changes beneficial to patients, staff, the hospital, and the community.

At least one MCE study must be in progress in each hospital at any given time; at least one study shall be completed each year.

Studies on a sample or other basis must include but not be limited to admission, duration of stay, diagnostic category, ancillary services including drugs and biologicals, and the professional services performed on hospital premises.

The review group must document the results of each MCE and indicate how such results have been used to institute changes to improve the quality of care and promote more effective and efficient use of inpatient facilities and services.

XI. APPEAL PROCESS

Providers have the right to appeal adverse actions by the Department upon written request of the Hospital Administrator to:

Bureau of Hearings and Appeals
2330 Vartan Way, 2nd Floor
Harrisburg, PA 17110

A copy of the identical information plus the medical record, if applicable, must be sent to:

Department of Human Services
Office of Medical Assistance Programs
Division of Clinical Review
Appeals Section
P.O. Box 8050
Harrisburg, PA 17105

The request must be received within 33 days of the date of the notice of the DPWs decision.

A. The notice of appeal will be considered filed on the date it is received by the Department.

B. The notice of appeal to the Bureau must include a letter from the administrator, and a copy of the certification notice, the Hospital Utilization Review Committee's review findings.

C. Prior to initiating an appeal, all steps described in the DPWs Manual for Diagnosis Related Group Review for Inpatient Hospital Services and the Medical Assistance Regulations relating to admission and outlier reviews must be completed.

D. The hospital will be notified directly by the DPW Office of Hearings and Appeals of the date, time, and location of the appeal hearing.

E. Hospitals and practitioners do not have the right to file a separate appeal on the same case.

F. If a hospital appeals a decision by the Department to fully or partially deny payment for a case, payments will be withheld pending decision on the appeal.

For adverse actions initiated by the Bureau of Program Integrity, Division of Analysis and Quality Improvement, the appeal process to be followed is described in the violation notification letters sent to the hospital. To ensure timely receipt of appeals, please follow the directions given in the notification, especially noting the address for sending such appeals to the Department. Failure to do so may cause the appeal to be denied.

XII. MONITORING MECHANISMS

A. Retrospective Case Review

DPWs Office of Medical Assistance Programs retrospectively monitors hospital inpatient services and utilization review activities through the review of patient's medical and fiscal records and claims paid by the Department.

Services that are not within the scope of the Medical Assistance Regulations are denied for payment regardless of whether the hospital admission was previously certified.

IDENTIFICATION OF MEDICAL ASSISTANCE VIOLATIONS IS BROUGHT TO THE ATTENTION OF THE HOSPITAL ADMINISTRATORS FOR CORRECTIVE ACTION.

Failure to comply with Medical Assistance Regulations may result in the hospital being denied payment by the Department for all or part of the hospital stay on a retrospective basis, and may result in the hospital being precluded from participating in the Medical Assistance Program. Potential cases of fraud will be forwarded to the Office of Attorney General, Medicaid Fraud Control Unit, and or the Office of Inspector General, for appropriate action.

B. Analysis of Computer Generated Reports

From the data elements obtained from the inpatient claim and the PSR/DRG/CHR certification file, computer reports are generated to assist the Department in identifying hospital/practitioner patterns, aberrant activities, and services that deviate from statistical forms.

C. Hospital Adverse Determination Reports

The Bureau of Program Integrity analyzes the determinations made by the hospital's Utilization Review Committee through the review of the monthly adverse determination summary reports submitted by the hospital.

D. On-Site Visits

The Department conducts on-site visits of hospitals. The on-site visit is an opportunity for direct communication between the Department and the providers on issues and concerns about the utilization review process

Providers may be notified in advance of the date of the on-site visit. An entrance and exit conference is held to explain the purpose of the visit and to summarize and/or review findings and recommendations.

XIII. SANCTIONS

If the Department determines that a provider billed for services inconsistent with Medical Assistance Program Regulations, provided incorrect information on the invoice or admission certification request regarding a patient's diagnosis or procedures performed during the period of hospitalization or otherwise violated the standards set forth in the provider agreement, the provider is subject to the sanctions described in Chapter 1101 of this title (relating to the general provisions) and the Department will:

A. Deny payment to hospitals and practitioners for unnecessary, inappropriate, or noncompensable services or items, admissions, outliers, and other MA violations;

B. Deny payment for the hospital stay when the Hospital Utilization Review Committee fails to review a Medical Assistance recipient's need for

admission/outliers or fails to request the required certification for selected admissions within the specified time requirements;

C. Exclude inpatient days that are not medically necessary or are not within the scope of the Medical Assistance Program when certifying or denying outliers days or costs;

D. Exclude services or items provided by the hospital that were not medically necessary or were unnecessary, inappropriate, or otherwise noncompensable when determining entitlement to outlier costs;

E. Adjust payments for cases in which medical record documentation and hospital invoice information differ;

F. Require hospitals to do preadmission reviews for selected DRGs, diagnoses, procedures, or practitioners;

G. Bring patterns of care, such as a high number of inappropriate transfers or readmissions, to the attention of the hospitals for corrective action;

H. Terminate agreements with hospitals and practitioners for extreme misuse of hospital services and facilities; and

I. Refer hospitals with a high number of payment adjustments due to inaccurate claim information or aberrant utilization patterns to the Office of Attorney General, Medicaid Fraud Control Unit, and/or the Office of Inspector General for possible fraudulent billing practices.

ATTACHMENT A

COMMONWEATH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

INFORMATION FOR CERTIFICATION REQUEST

Date	AUR CERTIFICATION NUMBER
DEPT. REVIEWER	

☐ PSR ☐ DRG ☐ CHR

☐ 1st REQUEST ☐ ADD.INFO ☐ SETTING CHANGE ☐ EXTENSION REQUEST

RECIPIENT/PROVIDER INFORMATION		
1. RECIPIENT NUMBER	2. RECIPIENT NAME	3. BIRTHDATE
4. FACILITY PA PROMISe™ PROVIDER NUMBER	5. FACILITY NAME	
6. PRACTITIONER PA PROMISe™ PROVIDER NUMBER	7. PRACTITIONER NAME	
8. LATE PICKUP ELIG. DATE	9. DATE FACILITY NOTIFIED OF ELIG.	10. PRACTITIONER LICENSE #
11. PERSON MAKING REQUEST	12. TELEPHONE NUMBER	13. S.O. NUMBER (if applicable)

ADMISSION INFORMATION	
14. A. ADMISSION DATE	B. ADMISSION CLASS
15. ADMITTING DIAGNOSIS CODE ▶	ICD-9-CM CODE DESCRIPTION
16. SECONDARY DIAGNOSIS CODE ▶	ICD-9-CM CODE DESCRIPTION
17. ASC/SPU (Only) HCPCS Procedure Code(s) ▶ 1. 2.	18. INPATIENT (ONLY) ICD-9-CM Procedure Code(s) ▶ 1. 2.
19. PROCEDURES TO BE PERFORMED 1.	2.

20. NUMBER OF EXTENDED TREATMENTS REQUESTED (ASC/SPU Only) (Maximum of 10)

21. WHAT ARE THE INDICATIONS FOR SURGERY/TREATMENT? Describe any pathology and justification for setting.

22. DESCRIBE ANY ATTEMPTS THAT HAVE BEEN MADE TO TREAT THIS CONDITION ON AN OUTPATIENT BASIS.

23. WHAT TREATMENT IS PLANNED OR WHAT SERVICES ARE NEEDED?

PRIOR ADMISSION INFORMATION		
24. ADMISSION DATE	25. DISCHARGE DATE	26. FACILITY PA PROMISe™ PROVIDER NUMBER

TRANSFER INFORMATION
27. FACILITY PA PROMISe™ PROVIDER NUMBER

MA 341 01/04

ATTACHMENT B

HOSPITAL ADMISSION DRG/CHR CERTIFICATION NOTICE

This is to notify you of the Department's decision regarding the following admission. An explanation of the reason code for the service requested appears in the reason box. **Please read the reverse side of this notice for complete directions and appeal rights.**

Date of Notice: **Certification Reference #**: **Recipient Name**: **Recipient ID #:** **Expiration Date**:

	Diagnosis Description	**Reason Code(s)**

Special Information
Days Approved:
Days Denied:

Reason Code	

Reason Code	

Reason Code	

Reason Code	

Reason Code	

THIS DECISION DOES NOT ALTER YOUR DOCTOR'S RESPONSIBILITY TO DETERMINE YOUR MEDICAL CARE AND TO PROVIDE YOU WITH ALL NECESSARY CARE. THE PROCESS IS A REVIEW TO DETERMINE PAYMENT ONLY AND IS NOT A DETERRENT TO MEDICAL CARE. THE DECISION IS BASED SOLELY UPON REVIEW OF THE INFORMATION PROVIDED TO DATE.

IMPORTANT

READ THE REVERSE SIDE OF NOTICE

FOR RECIPIENT USE ONLY:

Questions related to this notice may be asked by calling the following toll free number 1-800-537-8862.

Si esta una traduccion de este aviso, marque este encasillado y envie esta forma inmediatamente.

ATTENTION ALL PROVIDERS: PLEASE READ THE FOLLOWING CAREFULLY

- If you have any questions regarding this notice, call the appropriate Unit using the number assigned.
- To receive payment for any authorized service, the recipient must be eligible for medical assistance on the date of service. Check the recipient's card prior to rendering service and your Provider's Manual to ensure the service is covered under the category indicated. Payment will not be made if a recipient is enrolled in any HMO or HIO at the time of the service.
- You must be enrolled in the Medical Assistance Program.

THIS SECTION APPLIES TO ALL REQUESTED SERVICES FOR WHICH AN APPEAL MAY BE REQUESTED

- If you disagree with the decision that is identified in the Reason Description box on the reverse side of this notice, you have the right to request an appeal.
- An appeal request with appropriate documentation must be in writing and must be filed with the Bureau of Hearings and Appeals within 33 days of the date of this notice. If the request was filed by first-class mail, the United States postmark appearing upon the envelope in which the request was mailed shall be considered the filing date. The filing date of a request filed in any other manner or bearing a postmark other than a United States postmark shall be the date on which the request is received in the Bureau of Hearings and Appeals. A copy of this notice must be included with the appeal. The appeal must be sent to the following address:

Bureau of Hearings and Appeals
2330 Vartan Way, 2nd Floor
Harrisburg, PA 17110

- The Provider must also send an exact and complete copy of the appeal request and all documents attached to it to the program office that issued the notice of agency action. The copy of the appeal must be sent to the following address:

Appeals Section
Division of Clinical Review
P.O. Box 8050
Harrisburg, PA 17105

- The Certification Reference Number must be on all inquiries regarding this notice.

ATTACHMENT C

HOSPITAL TRANSMITTAL FOR DAY OUTLIER REQUEST

PATIENT NAME (Last, First)
ADMISSION DATE

In order to facilitate the review of day outliers, the hospital must check (✓) below that the required documents are included with the outlier request being submitted to the Department.

☐ A. APPROPRIATE ADMISSION CERTIFICATION/OUTLIER REQUEST FORM

☐ 1. Elective Admissions on or after 03/14/88

a. A copy of the "Place Of Service Review Notice"
Note: "Requested Outlier Days" must be completed

– OR –

b. A "Day Outlier Request For Cases Exempt From The PSR/DRG Process" form
Note: Item 1 must be completed.

☐ 2. Urgent or Emergency Admissions from 08/01/92

c. A copy of the "DRG/CHR Certification Notice"
Note: "Requested Outlier Days" must be completed

– OR –

d. A "Day Outlier Request For Cases Exempt From The PSR/DRG Process" form
Note: Item 2 must be completed.

☐ B. HOSPITAL CLAIM ADJUSTMENT OR INVOICE
Note: Must be original and on one page.

☐ C. COPY OF REMITTANCE ADMIVE SHOWING EITHER THE BASE DRG PAYMENT OR THE MOST RECENT INTERIM BILL PAYMENT.

☐ D. HOSPITAL UTILIZATION REVIEW COMMITTEE COMMENTS ON HOSPITAL LETTERHEAD STATIONARY.

☐ E. COPY OF **COMPLETE** INPATIENT MEDICAL RECORD.

☐ F. THIRD PARTY STATEMENT, OR PA162RM, IF APPLICABLE.

Without the complete documentation, the Division of Medical Review cannot review your outlier request in a timely manner.

_____
NAME OF HOSPITAL PERSON TO CONTACT ON THIS REQUEST TELEPHONE NUMBER

_____
HOSPITAL NAME

MA 116 (4-95)

ATTACHMENT D

Commonwealth of Pennsylvania
Department of Human Services

DAY OUTLIER REQUEST

FOR CASES EXEMPT FROM THE PSR/DRG PROCESS

FOR DPW USE
1. CERTIFICATION NUMBER
FOR HOSPITAL USE
2. OUTLIER DAYS REQUESTED

RECIPIENT/PROVIDER INFORMATION		
3. RECIPIENT NUMBER	4. RECIPIENT NAME	
5. FACILITY PA PROMISe™ PROVIDER NUMBER	6. FACILITY NAME	
7. PRACTITIONER PA PROMISe™ PROVIDER NUMBER	8. PRACTITIONER	9. LICENSE NUMBER
10. PERSON MAKING REQUEST		11. PHONE NUMBER

RECIPIENT/PROVIDER INFORMATION	
12. ADMITTING DIAGNOSIS ICD-9-CM Code(s) 1. 2.	13. PROCEDURE(S) ICD-9-CM Code(s) 1. 2.

PRIOR ADMISSION INFORMATION		
14. ADMISSION DATE	15. DISCHARGE DATE	16. FACILITY PA PROMISE PROVIDER NUMBER

FOR DPW USE ONLY				
PRIOR ADMISSION INFORMATION				
17. OUTLIER DAYS REQUESTED	18. DAYS CONFIRMED	19. DAYS DENIED	20. RC	21. ADMISSION CARVE OUT DAYS
22. COMMENTS				
23. REV CODE	24. REVIEWER SIGNATURE			25. DATE PROCESSED

ENTERED BY	DATE

ATTACHMENT E

Commonwealth of Pennsylvania
Department of Human Services
Hospital Utilization Review Committee's Monthly Adverse Determination Summary

Reporting Month_____Year _____

Hospital Name_____City._____

PROMISe MA Provider Number_____NPI Number____
Total Number of Discharged Cases This Month (All Patients) __
Total Number of MA Discharged Cases This Month _____
Fee-For-Service (FFS) _____
Managed Care (MCO) _____

Summary of MA Denials for the Month by Your Hospital Utilization Review (UR) Committee

HURC Internal Denials	FFS Cases	FFS Days Denied
Unnecessary Admissions		
Unnecessary Delay Prior to Surgery or Treatment		
Continued Stay or Outlier Denials		
Totals		

Recipient Name	RID Number	FFS Denial Reason	FFS Days Denied

HURC Internal Denials	MCO Cases	MCO Days Denied
Unnecessary Admissions		
Unnecessary Delay Prior to Surgery or Treatment		
Continued Stay or Outlier Denials		
Totals		

Recipient Name	RID Number	MCO Denial Reason	MCO Days Denied

Chief Executive Officer / President_____Date _____