

Manual for Concurrent Hospital 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 Single State Agency is mandated under the Federal Social Security Act, Title XIX, Grants to States for Medical Assistance (MA) Programs, to perform utilization review of Medical Services rendered to MA recipients.

The Department has been conducting reviews of inpatient hospital services under a process known as Concurrent Hospital Review (CHR) since February of 1982. The objectives of the CHR Process are to (1) ensure that admissions are necessary and appropriate medical care is rendered to MA patients; (2) control excessive lengths of stay; (3) eliminate retrospective denials to hospitals and physicians; and (4) control costs related to inpatient care.

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

The CHR Process is an on-line computerized telephone concurrent review of a patient's need for admission and continued hospitalization during a hospital stay. The CHR nurse and the Hospital Nurse Coordinator (HNC) discuss the number of days that are compensable and medically necessary for inpatient care. Inpatient days are not certified by the CHR Section for unnecessary, inappropriate, excessive or noncompensable care in accordance with MA regulations.

This process emphasizes the responsibilities of the Hospital Utilization Review Committee to assure that there is medical necessity for the admission and continued inpatient hospitalization. Good medical documentation by the attending physician facilitates unnecessary discussions with the CHR nurse in order to determine if inpatient days are medically necessary.

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

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

II. PURPOSE

The purpose of this manual is to give providers instructions to meet the requirements of the CHR Process, which applies to the following facilities approved for participation in the MA Program and to individual practitioners who admit patients to these facilities.

FACILITIES INVOLVED:

- Rehabilitation Hospitals
- Medical Rehabilitation Units of
General Hospitals
- Drug and Alcohol Treatment
Rehabilitation Hospitals

- Drug and Alcohol Units of General Hospitals which are approved by the Department of Health to provide treatment and rehabilitation
- Private Psychiatric Hospitals
- Psychiatric Units of General Hospitals
- Extended Acute Care Units of General Hospitals
- Residential Treatment Facilities (Please review MA Bulletin [1165-93-07](#) entitled Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age.)

III. SUMMARY OF THE CHR REVIEW PROCESS

- A. The patient is admitted to the hospital by the attending physician.
- B. The hospital assigns an initial length of stay (LOS) based on the “HUP Length of Stay, 1983-1984”, LOS Tables, per diagnostic category per age group.
- C. The HNC calls the toll-free number, 1-800-558-4CHR, to request admission certification within two working days after admission and provides the appropriate recipient data, and the ICD-9-CM diagnosis code(s), if indicated, the initial LOS, the medical indications for the admission and the planned treatment.
- D. The CHR nurse enters the information onto a computer screen and verifies the recipient and the provider data with the Department’s files. The recipient eligibility data can be obtained by using their Pennsylvania ACCESS card in conjunction with the Eligibility Verification System.
- E. The CHR nurse evaluates the information for medical necessity and compensability of the admission under the MA Program. The CHR nurse certifies the request, asks for additional information, or refers the request to a CHR physician reviewer. Additional information must be submitted via telephone within 14 calendar days or a letter will be automatically generated stating that the admission request cannot be certified.
- F. The HNC reviews the patient’s medical status prior to the expiration of the initial LOS.
- G. The HNC discusses with the attending physician, when applicable, the number of continued stay days required to treat the patient’s condition.

- H. The HNC calls the CHR Section to discuss the patient's condition and treatment plan and requests a specific number of days that may be required for continued hospitalization.
- I. The CHR nurse evaluates the number of days requested and the hospital's treatment plan and enters on file the (1) number of days requested; and (2) medical reason(s) for generating the extension(s).
- J. The CHR nurse certifies the medically necessary days.
- K. The CHR nurse discusses questionable days with a CHR physician.
- L. The CHR physician certifies or denies based on medical necessity and compensability for continued hospitalization determined from information documented in the patient's medical record and relayed to the CHR nurse by the HNC. The CHR physician discusses questionable cases with the Hospital Utilization Review Chairperson through scheduled telephone calls.
- M. The CHR nurse informs the HNC of the certified or denied days.
- N. An admission certification number is generated by the computer along with a notification letter, which is sent to the practitioner and the hospital when the initial LOS or extension days expire.
- O. The hospital biller enters the ten-digit certification number, which is obtained from the notification letter, on the MA claim to be submitted for payment.
- P. The hospital biller submits the claim to PROMISE™ for payment.
- Q. PROMISE™ checks the file for certified days.
- R. The hospital retains the notification letter in the Business Office for auditing purposes and a copy in the patient's medical record for utilization review purposes.
- S. Hospital or practitioner appeal requests for denials must be received by the Appeals Section within 30 calendar if the date of the notification letter.

IV. INITIATING THE CHR REQUEST

When an MA recipient is admitted to the hospital, certification must be obtained from the CHR Section within two working days after admission. (For late pickups, see Section IX.) It is the provider's responsibility to verify that the recipient is eligible for MA, the services to be provided, and that the recipient is not required to receive services from a particular practitioner or facility.

When it is determined that the admission requires CHR admission certification, the necessary information should be gathered before the HNC telephones the CHR Section. Advise the CHR nurse if this is a new request that has been pended awaiting additional information. Supply the recipient and the 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 certification of the CHR request.

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

V. INFORMATION NECESSARY FOR CHR ADMISSION CERTIFICATION

The following information is needed from the HNC in order for the CHR nurse reviewer to complete the request (refer to Attachment A):

Recipient Information – The complete recipient number must be available to initiate a request. The CHR nurse enters the recipient number onto the computer screen terminal and verifies the recipient's name, age, and eligibility for MA coverage. The recipient number can be obtained from the recipient's Pennsylvania ACCESS Card.

Hospital Information – The CHR nurse enters onto the computer terminal the 13-digit PA PROMISe™ provider number assigned to the hospital.

Late Pickup (LPU) Information (only if a late pickup) – The CHR nurse requests the date the recipient became eligible for MA and the date the facility was notified of eligibility and how they were notified (EVS, PA 162, etc.).

Attending Practitioner License Number and 13-digit PA PROMISe™ provider number for those enrolled – The CHR 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 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 CHR – The name and telephone number of the person requested CHR certification (contact person).

Practitioner Information – The CHR nurse enters the 13-digit PA PROMISe™ provider number onto the computer terminal.

Diagnosis Information – Space is provided on the computer screen for four diagnosis codes. The CHR nurse enters the appropriate principal ICD-9-CM diagnosis code, the secondary diagnosis code, any other applicable diagnosis codes (up to 4) onto the computer terminal and verifies the Department's narrative description of the diagnosis codes 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.

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

Prior Admission Information (if applicable) – If the patient had an inpatient admission within 31 days of the admission, this information must be supplied to the CHR nurse. The hospital's 13-digit PA PROMISe™ provider number, including the appropriate service location, admission and discharge dates are needed.

Transfer Information – The 13-digit PA PROMISE™ provider number, including the appropriate service location of the hospital transferring the patient is needed.

Initial LOS – Provide the appropriate 50th percentile for the initial LOS based on the Hospital Utilization Project LOS tables (refer to Section VII for instructions for determining the initial LOS).

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

Admission Class – Provide the admission class:

0 – Elective

1 – Emergency Admission

2 – Urgent Admission

NOTE: Admission Class Values 0, 1, and 2 differ from the UB-92 Type of Admission Values, which are 1 (Emergency Admission), 2 (Urgent Admission), and 3 (Elective Admission).

VI. SUBSTANTIATING THE NEED FOR ADMISSION AND/OR CONTINUED STAY

When calling the 1-800 number, the HNC must be prepared to discuss medical information to justify the admission or continued stay, such as the following:

1. The attending doctor's assessment of the patient and indication for acute inpatient hospital care.
2. The patient's level of functioning/mental status.
3. The treatment goals to be achieved during the admission.
4. Therapies provided and the patient's response to such therapies.
5. Medications, including initial dosage and adjustments of medications, the patient's response and monitoring of blood levels.
6. Complications or symptoms experienced that would delay progress in therapies.
7. Reassessment of goals.
8. Modifications of treatment plan.
9. Results or consensus of the weekly interdisciplinary team meetings.
10. Court commitment information.
11. The discharge plan.
12. Other pertinent information.

If the medical necessity and compensability for inpatient care is evident, the CHR nurse certifies the requested number of days.

VII. USE OF LENGTH OF STAY TABLES

The sixth edition of the Hospital Utilization Project (HUP) Length of Stay 1983-1984 presents statistical tables reflecting the length of stay of inpatient hospitalizations in the Mid-Atlantic Region of the United States. The data was submitted from hospitals in

Delaware, New Jersey, Ohio, Pennsylvania, and West Virginia that participated in either HUP or the New Jersey Utilization Program (NJUP).

To arrive at the number of days to be initially assigned from the HUP LOS tables, the following information will be required (1) the patient's age; (2) the admitting diagnosis, whether it is a multiple or single diagnosis; and (3) if the attending physician intends to treat the patient medically or surgically (the planned treatment is medical for CHR admissions).

Example:

John Q. Doe, 45 years of age, was admitted with a principal diagnosis of manic-depressive psychosis and no secondary diagnosis.

- a. Determine from the Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the specific three-, four-, or five-digit diagnosis code for the principal diagnosis. In this case, it is five digits, 296.80.
- b. Appearing on each page of the LOS tables, "Length of Stay by Diagnosis" are six, three-digit diagnosis categories. Locate the LOS table for category 296. Category 296 has an asterisk, which indicates a subdivided category; two separate LOS tables are provided for "*296". By referring to each 296 table, find the specific code 296.80* (refer to Attachment B).
- c. From the determination made by the attending physician, refer to the major column headings for either single or multiple diagnosis. (Column headings are at the top of the page.) In this case, use the column under "Single Diagnosis".
- d. From the determination made by the attending physician, refer to the appropriate sub-column for medical or surgical admissions. In this case, medical treatment is indicated by the attending physician.
- e. The initial LOS is then determined by using the 50th percentile and the appropriate line for the age group. In this case, the patient is in age group 35-49 and the LOS is 14 days.

Rehabilitation stays and medical rehabilitation units of general hospitals may assign ten days as the initial LOS for a patient when the HUP 50th percentile for the admitting diagnosis is ten days or less.

An extended acute care unit should assign the HUP 90th percentile for the admitting diagnosis.

VIII. PROCESSING DESCRIPTION AND CONCURRENT UTILIZATION REVIEW REQUIREMENTS

A. Admission Review

All MA admissions must be reviewed within 24 hours, where practical, and a final determination must be made no later than two working days after admission, to determine medical necessity for hospitalization, except if the physician or category for admission is designated by the Hospital Utilization Review Committee for pre-admission review.

It is the responsibility of private psychiatric hospitals to comply with Federal Regulations at 42 CFR 441, subpart D, regarding elective admissions of MA patients under 21, which requires a review of a patient's need for inpatient psychiatric services by an independent team of health professionals not associated with the admitting hospital. The team certifying the need for admission must include: a physician who is competent in the diagnosis and treatment of mental illness, preferably in the area of child psychiatry, and has knowledge of the individual's situation; and other mental health professionals. The team must determine whether the following criteria for admission are met:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
2. Proper Treatment of the individual psychiatric condition requires services on an inpatient basis under the direction of a physician; and,
3. Inpatient psychiatric services can be reasonably expected to improve the individual's condition or prevent further regression so that the inpatient service will no longer be needed.

Validation in the patient's medical record of the above three determining criteria is required as certification of need for an admission.

It is the hospital's responsibility to evaluate the admission against written criteria selected or developed by the Hospital Utilization Review Committee or physician review group to assure the compensability and 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 no later than two working days after admission. Written notification is forwarded to the Hospital Administrator, the attending physician, the CHR Section and, where possible, the recipient's next of kin or sponsor.

The HNC must call the CHR Section to request admission certification within two working days after the admission. Each day of delay in contacting the CHR Section will result in a reduction of a corresponding number of days authorized by the CHR Section.

Questionable admissions, misutilization of hospital services and facilities and noncompensable services under the MA Program, etc., will be brought to the attention of the Hospital Utilization Review Chairperson by the CHR Section to justify the medical necessity for the hospitalization. The CHR nurse will request additional information. The hospital has 14 calendar days to submit the information or a letter will be automatically generated to the hospital stating the request cannot be certified.

Also, refer to MA Inpatient Hospital Services Regulations, Chapters, 1151 and [1163](#), Subchapter B, regarding admission review and/or certification of need for admission.

B. Processing Length of Stay Extensions and Changes in Diagnosis

1. Extension Requests

If the attending physician determines an extension to the initial LOS is needed, a request for additional days must be discussed with the Hospital's Utilization Review Committee/Nurse Coordinator 48 hours prior to or on the disposition date set for the initial LOS. The attending physician must justify and document the medical necessity for continued hospital care in the patient's medical record.

The HNC relays the medical justification to the CHR nurse for confirmation of the extended days no later than the date of expiration of the assigned LOS. The HNC must be fully prepared to discuss the medical reasons/treatment plan for the extension requests.

IF THE EXTENSION REQUEST IS DENIED AND THE HOSPITAL UTILIZATION REVIEW CHAIRPERSON DISAGREES, THE CHAIRPERSON OR PHYSICIAN MEMBER OF THE COMMITTEE MAY DISCUSS WITH A CHR PHYSICIAN THE DOCUMENTED MEDICAL NECESSITY IN THE PATIENT'S MEDICAL RECORD FOR CONTINUED STAY.

The call should be scheduled through the HNC and CHR nurse. The Hospital's Utilization Review Chairperson must be fully prepared to discuss the medical reasons/treatment plan as documented in the medical record for continued hospitalization.

Each day of delay in requesting an extension subsequent to the original disposition date will result in the reduction of a corresponding number of days authorized by the CHR Section for the extension.

2. Continued Stay Review

The difference between the HUP 75th percentile and 50th percentile, per age group, may be used as a guideline to determine the first reassessment for further inpatient care.

However, the certification period assigned should relate to the nature of the patient's medical condition and the projected point in time when continued hospitalization will no longer be medically necessary. Continued stay review is accomplished on or before the expiration date of the assigned initial LOS and communicated to the CHR Section. Subsequent reviews must be accomplished on or before the expiration of the previously assigned LOS. A plan of treatment and medical justification for continued hospitalization must be documented in the patient's medical record.

It is the hospital's responsibility 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 to 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 further stay is not medically necessary.

Notice of adverse decisions by the hospital representatives for continued stay is made by the last day of the previously approved LOS period, or the day after the adverse decision, whichever is earlier. Written notification is forwarded to the Hospital Administrator, the attending physician, the Division of Medical Review, and when possible, the recipient's next of kin or sponsor.

Also, refer to the MA Inpatient Hospital Services Regulations, regarding Continued Stay Review.

3. Change in Diagnosis

Sometimes after evaluation of the patient's medical condition, the diagnosis may change. If the stay exceeds the initial LOS and continued stay is requested, the change in diagnosis must be reported to the CHR nurse.

C. Processing of Extension Requests Requiring Alternate Type of Care

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 hospitals for patients requiring other than acute short-term hospital inpatient care.

D. Certification Notice

After the decision is made regarding admission certification, the CHR nurse generates a certification number and a certification notice to the attending practitioner and the hospital when the initial LOS or extension days expire (refer to Attachment C).

The provider's certification notice is sent to the service location identified in the request.

IX. CHR EXCEPTIONS AND INSTRUCTIONS FOR PROCESSING SPECIAL CASES

A. Medicare Part A/MA Deductible and Coinsurance Cases

Medicare/MA Deductible and Coinsurance cases are exempted from the CHR Process. Hospitals should not request certification for these admissions.

B. Processing Cases with Combined Insurance Coverage

If MA is expected to cover a portion of the hospitalization along with other third party coverage, the usual procedures for admissions and continued stay days must be followed.

C. Late Pickups

Cases in which MA eligibility was not anticipated at the time of admission and eligibility determination was made during the hospital stay or after discharge, or other insurance coverage failed to materialize, are processed as late pickups.

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.
 - 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.
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 make a partial payment for the admission.

- a. If the insurance rejection occurs while the individual is still hospitalized, the hospital must request admission certification within two working days of the notification of the rejection.

The case must be discussed between the HNC and the CHR nurse to determine the number of medically necessary and compensable inpatient days for MA payment. The hospital must give the date MA is to begin and the date of rejection from the other insurance. If additional time is needed, the CHR procedure for requesting continued stay days is followed.

- b. If the insurance rejection occurs after the individual has been discharged, the admission certification must be made within 30 days of the date the facility receives the Explanation of Benefits (EOB) from the other insurance.

The case must be discussed between the HNC and the CHR nurse to determine the number of medically necessary and compensable inpatient days for MA payment. The hospital must give the date that MA is to begin and the date of rejection from the other insurance.

If the admission certification request for a late pickup is not made within the specified time period, the request is denied. Each day of delay in discussing the case at any step will result in the reduction of a corresponding number of days authorized by the CHR Section.

X. ADVERSE DETERMINATIONS BY HOSPITAL UTILIZATION REVIEW COMMITTEE

A monthly summary report of the Hospital Utilization Review Committee's Adverse Determination Letters for MA cases must be mailed to the Bureau of Program Integrity (BPI), Division of Analysis and Quality Improvement, by the fifth day of each month for the previous month's activities. See Attachment D 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 PA PROMISE™ 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

XI. MEDICAL CARE EVALUATION STUDIES

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

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.

XII. 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.

1. The notice of appeal will be considered filed on the date it is received by the Department.
2. 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.
3. Prior to initiating an appeal, all steps described in the Department's Manual for Concurrent Hospital Review of Inpatient Hospital Services and the MA Regulations relating to admission and extension reviews must be completed.
4. The hospital will be notified directly by the DPW Office of Hearings and Appeals of the date, time, and location of the appeal hearing.
5. Hospitals and practitioners do not have the right to file a separate appeal on the same case.

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

XIII. 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 MA Regulations are denied for payment regardless of whether the hospital admission was previously certified.

IDENTIFICATION OF MEDICAL ASSISTANCE VIOLATIONS ARE BROUGHT TO THE ATTENTION OF THE HOSPITAL ADMINISTRATOR FOR CORRECTIVE ACTION.

Failure to comply with MA regulations may result in the hospital being denied payment by the Department for all or part of a 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 norms.

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 to hospitals. The on-site visit is an opportunity for direct communication between the Department and the provider 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 explain review findings and recommendations.

XIV. SANCTIONS

If the Department determines that a provider billed for services inconsistent with MA Program regulations, provided incorrect information on the claim or on the 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 sanctions described in Chapter [1101](#) of this title (relating to general provisions) and the Department will:

1. Deny payment to hospitals and practitioners for unnecessary, inappropriate, or noncompensable services or items, admissions, outliers, and other MA violations;
2. Deny payment for the hospital stay when the Hospital Utilization Review Committee fails to review an MA recipient's need for admission/continued stay or fails to request the required certification for selected admissions within the specified time requirements;
3. Exclude inpatient days that are not medically necessary or are not within the scope of the MA Program when certifying or denying days or costs;
4. Exclude services or items provided by the hospital that were not medically necessary or were unnecessary, inappropriate, or otherwise noncompensable;
5. Adjust payment for cases in which medical record documentation and hospital claim information differ;
6. Require hospitals to do preadmission reviews for selected diagnoses, procedures, or practitioners;
7. Bring pattern of care, such as a high number of inappropriate transfers or readmissions to the attention of the hospital for corrective action;
8. Terminate agreements with hospitals and practitioners for extreme misuse of hospital services and facilities; and,
9. 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

COMMONWEALTH 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)	18. INPATIENT (ONLY)	ICD-9-CM Procedure Code(s)
	▶ 1. 2.		▶ 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 - LENGTH OF STAY BY DIAGNOSIS

ATTACHMENT C

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)

		<u>Special Information</u>
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 traducción de este aviso, marque y envíe esta forma
este encasillado 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 D

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 _____