

Manual for Place of Service Review of Inpatient Hospital Services

Effective with Admissions of March 14, 1988

Office of Medical Assistance Programs
Department of Human Services

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PSR TABLE OF CONTENTS

<u>Chapter</u>	<u>Page</u>
ATTACHMENT D - Sample of “Place of Service Review (PSR) Notice”	
ATTACHMENT E - Day Outlier Request for Cases Exempt from the PSR/DRG Process	PSR-V-29
ATTACHMENT F – Hospital Transmittal for Day Outlier Request	PSR-V-31
ATTACHMENT G - PSR Provider Questions and Answers	PSR-V-32

I. GENERAL INFORMATION

A. Introduction

The Department of Human Services, Office of Medical Assistance Programs implemented a preadmission Place of Service Review (PSR) Process, hereafter known as the PSR Process, for admissions on and after March 14, 1988.

Under the PSR Process, the Division of Medical Review (DMR) conducts a preadmission review of all elective admissions of MA recipients to general hospitals, short procedure units (SPUs), and ambulatory surgical centers (ASCs). Since the admission requires certification before the patient is admitted, the practitioner, hospital, and recipient know in advance if the Department will make payment.

The PSR Process emphasizes the responsibilities of the attending physician, the ASC Quality Assurance Committee, and the hospital Utilization Review Committee, in assuring that medical necessity is evident for the admission and planned treatment.

The objectives of the PSR Process are to (1) ensure that eligible MA recipients receive and access care for medically necessary services; (2) ensure that quality care is delivered in the most appropriate and cost effective setting; (3) develop a system which is simple to administer for MA recipients, health care providers, and the Office of Medical Assistance Programs; (4) make decisions in a timely manner; and (5) minimize appeals.

Providers are paid for the appropriate place of service, as certified by the PSR Section, if the recipient continues to be eligible for MA on the date of service and is eligible for services provided. Services, which are noncompensable as established by MA regulations, are not certified by PSR.

B. CHR and DRG Review Processes – Relationship to PSR

The present Concurrent Hospital Review (CHR) and Diagnosis Related Group (DRG) Review Processes evaluate admissions that do not require PSR.

1. Admissions to Cost Reimbursed Providers

The CHR Section reviews admissions and continued stays of MA recipients to the following cost reimbursed providers: rehabilitation hospitals, rehabilitation units of general hospitals or drug and alcohol treatment and rehabilitation units, private psychiatric hospitals or psychiatric units of general hospitals; and extended acute care psychiatric units of general hospitals.

2. Emergency and Urgent Admissions to Prospective Payment Providers

The DRG Section reviews emergency and urgent admissions of MA recipients to the following prospective payment providers: general hospitals, short procedure units; and ambulatory surgical centers.

The definition of an emergency admission, according to [MA regulations 1150.2](#) is an admission in which immediate care is necessary to prevent death,

serious impairment, or significant deterioration of the health of the patient. An urgent admission is defined as an admission where medical care must be administered promptly and cannot be delayed.

Admissions classified by the provider as emergency or urgent are reviewed by the DRG review section. The nurse reviewer evaluates the patient's symptoms, condition and treatment at the time of the admission and determines if the admission has been classified correctly. If the documentation indicates the admission could have been planned and scheduled, additional information is requested to support the emergent/urgent nature of the admission. If the case does not meet the Department's definition of emergency or urgent, it is paid at 50% of the fee, which would be approved if the normal PSR process had not been bypassed. The determination of the admission class will be based on the patient's condition at the time of admission as documented in the patient's medical record.

If a patient is admitted to the SPU and develops complications or the need for a more extensive procedure, which results in admission to the hospital, the unplanned hospital admission requires certification by the DRG Section as an urgent or emergency admission.

C. Purpose

The purpose of this Manual is to give providers instructions to meet the requirements of the PSR Review Process. The review process described in this manual applies to elective admissions to general hospitals and elective procedures performed in ambulatory surgical centers and hospital short procedure units by physicians, dentists, podiatrists, and rural health clinic practitioners.

Facilities Involved

Hospital Short Procedure Units
Ambulatory Surgical Centers
General Hospitals

Practitioners Affected by PSR

Physicians
Dentists
Podiatrists
Rural Health Clinic Practitioners

If the individual is eligible for MA benefits and the service requires PSR, the PSR request must be made before the patient is admitted. Patients awaiting eligibility for MA coverage at the time the service is provided are considered for PSR after MA eligibility is determined. The procedure described herein for processing late pickups should be followed for such cases.

All elective inpatient hospital, ASC, SPU services provided to MA recipients are subject to the review procedures set forth in this instructional manual; [Chapter 1163](#), relating to inpatient hospital services; [Chapter 1150](#) relating to outpatient services, and Chapter 1126 relating to ASC/SPU services, and [Chapter 1101](#) relating to general provisions.

II. PSR PROCESS DESCRIPTION

A. Summary of the PSR Program

PSR for Elective Admissions to Hospitals, ASCs, or SPUs:

1. The eligible MA recipient visits the practitioner's office or clinic. The recipient data is available from the Pennsylvania ACCESS Card, to verify eligibility.
2. The practitioner informs the recipient that treatment will require an admission to a general hospital, ASC, or SPU.
3. The practitioner contacts the facility where the treatment will occur and tentatively schedules the admission.

***Note:** If the practitioner is not enrolled in the MA Program, he/she is informed by the facility regarding PSR requirements for elective services.*

4. The information required to initiate the PSR Process is obtained from the practitioner by the facility if the facility is making the PSR request, (Refer to Attachment A, Information for PSR Request, for a form which may be used to expedite PSR requests.)
5. The facility/practitioner contacts the PSR nurse reviewer via the toll-free telephone number, 1-800-558-4PSR, and provides the appropriate recipient data, the diagnosis, and procedure code(s), and the medical indications or the elective admission. (Refer to Attachment B, Guidelines for Requesting PSR, to determine what information is necessary when requesting certification.)
6. A nurse reviewer enters the information onto a computer screen and verifies the recipient and provider data with the Department's files.
7. The nurse reviewer evaluates the medical information for compensability under the MA Program, the appropriate place of service.
8. The nurse reviewer either certifies the request, asks for additional information, or refers the request to a PSR physician reviewer. Additional information must be submitted via telephone within 14 calendar days or a notice is automatically generated stating that the request cannot be processed.
9. The physician reviewer certifies the request, requests submission of specific additional information, or discusses the case with the attending practitioner by telephone.
10. The service or procedure is certified by the PSR Section for the appropriate setting based on the review of the information provided. The attending practitioner maintains the right to perform the service in the setting he/she deems necessary. However, the Department makes payment only for the setting certified by the PSR Section.
11. The nurse reviewer enters the appropriate decision code on the computer screen and transmits the information onto a file, which generates

certification notices to the practitioner, the facility, and recipient. (Refer to Attachments C and D– MA 342 for providers, MA 343 for recipients).

12. If the admitting practitioner or facility does not agree with the PSR decision, a reevaluation by a PSR physician may be requested within ten calendar days of the date on the certification notice. The service may be provided before completion of the reevaluation. If the admitting practitioner or facility is not in agreement with the PSR decision after reevaluation, a formal appeal may be filed.
13. The service must be provided within 60 days from the date of certification (see expiration date on the certification notice), or another request must be made.
14. If any information on file relating to the practitioner, facility, or procedure code changes, the PSR Section must be notified before submission of the invoice for billing.
15. The practitioner or facility must enter the ten-digit PSR number obtained from the certification notice onto the claim submitted for payment according to billing guide instructions.
16. In cases of readmissions or transfers, the last prior admission information is required when making a PSR request. If a provider plans to admit a recipient to a facility within thirty-one (31) days of a previous discharge from the same facility, medical indications for the readmission are required. Readmissions to the same hospital within thirty-one (31) days after discharge from a prior admission for the same reason(s) may not qualify for a separate DRG payment to the hospital.

Medically necessary elective transfers require a PSR request prior to transfer. Either the transferring facility, the facility accepting the patient, or the attending practitioner may make the PSR request.

17. Inpatient admissions certified under PSR are paid under the DRG prospective payment system; therefore, exceptionally long stays may qualify for day outlier payment to a hospital.
18. The information for a PSR request is entered on-line to the PSR file when a decision is made during the telephone contact. When the facility and practitioner bill for services, the claim is matched against the PSR file to ensure that payment is made of the setting certified by the PSR Section.
19. The practitioner, facility, or recipient may request an appeal on an adverse PSR decision. The attending practitioner, the recipient or the facility administrator must submit a letter to the Department to request an appeal. All requests for appeal must be received by the Department within 30 calendar days of the date of the certification notice.

B. Initiating the PSR Request

When an MA recipient is scheduled for an elective admission to the inpatient acute care hospital, ASC, or hospital SPU, certification must be obtained in advance from the PSR Section (for late pick-ups, see Section II, E, 4). It is the provider's responsibility to assure that the recipient is eligible for MA and the services to be provided by accessing the Eligibility Verification System (EVS). If the recipient is restricted to a particular provider, only that provider may treat the patient.

PSR is required if:

1. The admission is elective;
2. The recipient has a current and valid Pennsylvania ACCESS Card; and,
3. The admission is to an inpatient acute care hospital, ambulatory surgical center, or hospital short procedure unit.

Maternity, newborn admissions, Medicare Part A admission to an inpatient hospital, or Medicare Part B admissions to an outpatient hospital short procedure unit and ambulatory surgical center do not require PSR certification.

When you have determined that the admission requires PSR, refer to Attachment A for the necessary information before you telephone the PSR Section. Advise the nurse reviewer if this is a new request or a prior request awaiting additional information; supply the recipient information and the medical information to justify the admission.

The recipient information is obtained from the patient's Pennsylvania ACCESS Card and from the patient's office or clinic medical record. Medical indications for services requested should be documented by the attending practitioner in the patient's medical record to expedite approval of the PSR request.

Requests for PSR should be made to the PSR nurse reviewer by calling the Department's toll-free line, 1-800-558-4PSR. PSR requests may be made from 7:30 a.m. to 4:00 p.m., Monday through Friday, excluding Commonwealth holidays.

C. Exceptions to the PSR Process

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 hospital 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, and medical rehabilitation units and admission to 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. Emergency or urgent admissions to inpatient acute care hospitals, hospital short procedure units, or ambulatory surgical centers – these admissions must be certified for payment in accordance with Department's Diagnosis Related Group (DRG) Process.
6. Admissions of recipient enrolled in a HMO.

D. Information Necessary for PSR

We have included a worksheet as Attachment A to show the information, which the PSR nurse reviewer may request. This form is not sent to the Department. The following information, as applicable, is needed from the requestor in order for the PSR nurse reviewer to complete the PSR request:

Items 1, 2, and 3, Recipient Information – The complete recipient number must be available to request PSR. The nurse reviewer enters the recipient number onto the computer terminal and verifies the recipient's name, age, and eligibility for Medical Assistance coverage. This information can be obtained from the recipient's Pennsylvania ACCESS Card.

Items 4 and 5, Facility Information – The nurse reviewer enters onto the computer terminal the PA PROMISE™ provider number assigned to the hospital, hospital short procedure unit, or ambulatory surgical center. The nurse reviewer then verifies the facility name and provider type against the Department's files.

Items 6, 7, and 10, Practitioner Information – For MA enrolled providers, the PSR nurse reviewer enters the practitioner's PA PROMISE™ provider number onto the computer file and verifies the practitioner's name or rural health clinic's name and provider type against the Department's file. The practitioner's license number is required on all certification requests. 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.

Items 8, 9, and 14, Late Pickup (LPU) Information (only if late pickup) – The PSR nurse reviewer requests the date the recipient became eligible for MA and the date the facility was notified of eligibility. The admission date is required. Requests for late pickups will be considered if submitted within 30 days from the time the facility was notified of MA eligibility.

Items 11 and 12, Person Requesting PSR Certification – The name and telephone number of the person requesting admission certification (Contact Person) is entered.

Items 15 and 16, Diagnosis Information – The PSR nurse reviewer can enter up to "four" diagnosis code(s). The PSR nurse reviewer enters the appropriate

principal ICD-9-CM diagnosis code, and the secondary and subsequent diagnosis codes, if applicable, onto the computer terminal and verifies the Department's narrative description of the diagnoses with the requestor.

Items 17, 18, and 19, Procedure Information, if applicable – Space is provided for a maximum of two procedure codes. The ICS-9-CM codes or HCPCS Codes are used for inpatient admissions. The MA Program Fee Schedule codes are used for admissions to ASCs and hospital SPUs. The nurse reviewer 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.

Item 20, Extended Course of Treatment (for ASC/SPU only) if applicable – The requestor supplies the nurse reviewer with the number of treatments requested and where treatment will be provided. When a maximum of ten treatments have been completed, or there is a change in the treatment from what was originally certified, a new request is required.

Items 21, Medical Indications – Documentation in the patient's medical record should be used to establish the medical indications for the service requested. The nurse reviewer enters up to three codes based on the medical indications presented by the requestor.

Item 22, Prior Medical Management – Information on prior medical management should be obtained from the office or clinic record to indicate what treatment was provided prior to initiating the PSR request. Space is provided on the screen for two codes for explanation of prior medical management. The nurse reviewer enters the appropriate code for prior medical management based on the information presented by the requestor.

Item 23, Medical Treatment/Service, if applicable – If the admission is for a medical reason, supply the nurse with any planned treatment(s) or service(s).

Item 24, 25, and 26, Prior Admission Information, if applicable – If the patient had an inpatient admission within 31 days of the admission, this information should be supplied to the PSR nurse. The hospital's PA PROMISE™ provider number, admission and discharge dates, and condition on discharge from the first admission are required. A readmission within thirty-one days to the same hospital is subject to the readmission payment policy.

Item 27, Transfer Information, if applicable – If a request is made to electively transfer a patient to another facility, the PA PROMISE™ provider number of the facility transferring the patient is needed.

If the nurse reviewer or physician is unable to certify the PSR request, additional information is requested. A telephone discussion with the attending practitioner may be needed. A PSR Section physician reviewer will call the attending practitioner at the telephone number provided to discuss the request, if necessary.

E. Instructions for Processing Special Cases

1. Transfers

Elective transfers from any provider type to inpatient acute care hospitals, hospital short procedure units, or ambulatory surgical centers, require PSR certification before transfer. Either the transferring facility, the receiving facility, or the attending physician may request PSR certification.

Unless the transfer falls into an exempt classification (for example, a Medicare Part A case), each transfer from one facility to another must be certified by the Department. If the transfer from one facility to another is urgent or emergent, the DRG Process is followed. The CHR Process is followed if the transfer is from an acute care facility, hospital short procedure unit, or ambulatory surgical center to a rehabilitation hospital, psychiatric hospital, a drug and alcohol rehabilitation unit, a medical rehabilitation unit, or psychiatric unit of an acute care facility.

In addition to the requirements from requesting PSR certification, the Department evaluates the length of time the patient stayed in the transferring facility and the reason(s) for the transfer. The PSR certification notice will be sent to the facility receiving the patient.

2. Readmissions (applied only to inpatient admissions)

A readmission to the same facility within thirty-one (31) days of a previous admission will be examined retrospectively to determine if the condition existed or should have been treated on the first admission. Readmissions to the same hospital within thirty-one (31) days after the discharge for the same reasons(s) may not qualify for a separate DRG payment.

Refer to the appropriate section in [Chapter 1163](#), Inpatient Hospital Services, relating to readmission for additional information and MA Bulletin 11-88-09.

3. Extended Courses of Treatment

An extended course of treatment is any plan of treatment that includes the exact same services repeated over an extended period of time, e.g., chemotherapy.

a. Hospital Short Procedure Unit/Ambulatory Surgical Center

- i) For extended courses of treatment in hospital short procedure units and ambulatory surgical centers, the PSR Section certifies up to ten treatments per request. The services must begin within 60 days of the certification, but do not have to be completed within 60 days of the certification.
- ii) Only one PSR certification is necessary for those ten services unless the treatment plan changes. If the service being provided is altered (e.g., medication change), the change is considered to be a new treatment plan and course of treatment and a new PSR certification is required.

b. Acute Care Inpatient

For extended courses of treatment on an inpatient basis, each admission must be certified through the PSR process.

4. Late Pick Ups

Under certain circumstances, the Department allows providers to request PSR after the procedure has been performed. These cases are called “late pickups”. To qualify for a late pick up, one of the following situations must exist:

a. An elective admission occurs before MA eligibility is determined.

- (1) The individual has applied or plans to apply for MA, but did not receive eligibility before the service was provided.
- (2) When calling to request PSR certification, the case should be identified, as a “late pick up” and the requestor must explain the reason for providing the elective service prior to notification of MA eligibility.
- (3) The following information must be supplied to the PSR Section when making the PSR request:
 - (a) The admission date;
 - (b) The date the recipient was eligible for MA; and,
 - (c) The date the facility was notified of eligibility.
- (4) The PSR request must be made within 30 calendar days of the date the facility was notified of MA eligibility. If the request is not made within the specified time period, the case is denied.

b. Third party coverage fails to materialize.

- (1) At the time of admission, the individual had private insurance, which was expected to make payment. However, the private insurance rejected the claim. If the individual did not have MA when hospitalized, but was determined at a later date to be eligible for MA, a PSR request must be made. The same information required in 4a (3) is required for this request. The PSR request must be made within 30 calendar days of the date the facility was notified of MA eligibility. If the request is not made within the specified time period, the case is denied.
- (2) The individual had private insurance and MA at the time of admission, but the private insurance was expected to pay. However, the private insurance rejected the claim. A PSR request must be made within 30 calendar days of the date the facility received the explanation of benefits (EOB), because the individual is a known MA recipient. If the request is not made within the

specified period, the case is denied. If the patient had MA and private insurance, the provider has the option of requesting PSR before the service is provided; however, all other insurance must be exhausted before billing MA.

The PSR Section conducts its review of the request in accordance with MA regulations and the process described in the manual relating to PSR review. If the request for PSR is made after the service is provided and does not qualify for a late pick up, the facility and the practitioner are paid at 50% of the usual MA payment.

F. Certification Notice

After the decision is made regarding the place of service, the nurse reviewer generates a certification notice, including the PSR number, to the facility, the attending practitioner, and the recipient (see Attachment C).

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

Providers with questions regarding the PSR Process may call 1-800-558-4PSR. If the recipient has a question, the recipient should call the recipient "hot line" number shown on the PSR Certification Notice under "Attention All Recipients".

III. REEVALUATION PROCESS

A. Purpose of the Reevaluation

A reevaluation is an additional review done by a PSR Section physician at the request of the facility or attending practitioner to resolve a disagreement regarding a PSR decision. The review is done within two working days of the request, and a second certification notice is generated with the decision after reevaluation.

B. Initiation of the Process

It is the responsibility of the admitting practitioner or facility to request reevaluation after receiving notification of the Department's decision. The request for reevaluation must be made by calling the PSR Section within ten calendar days of the date of the PSR certification notice. A PSR physician reviews the information provided with the PSR request and calls the attending practitioner if it is necessary to discuss the case.

If the admitting practitioner or facility is not in agreement with the decision reached by the PSR physician, a formal appeal may be filed. The request for an appeal must be filed within thirty calendar days of the date of the PSR certification notice.

IV. PSR APPEAL PROCESS

The facility, practitioner, or the recipient has the right to appeal adverse actions of the Department by submitting a written request containing information to support the reason for the appeal. The appeal must be received by the Department within 33 calendar days

of the date of the Department's certification notice. Send the appeal to the following address:

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

Recipients may appeal an adverse decision by submitting a short letter marked as an appeal request to the address noted on the back of the certification notice. The recipient should include a contact telephone number.

Regardless of which party initiates the appeal, the written request must be received by the Division within 33 calendar days of the date of the certification notice.

- A. Prior to initiating an appeal, all steps described in the Department's manual for the PSR Process and the MA Regulations relating to the admission and outlier reviews must be completed.
- B. The notice of appeal is considered filed on the date it is received by the Department. Facility and physician appeals must include a copy of the certification notice.
- C. After the appeal is filed, the Division requests additional documentation, if needed, in order to evaluate the appeal. This required documentation must be submitted within thirty days of the request made by the Division or the Department requests that the Office of Hearing and Appeals dismiss the appeal for lack of prosecution.
- D. If the decision remains the same, the appeal is referred to the Office of Hearings and Appeals. The appellant is notified directly by that office of the date, time, and location of the appeal hearing.
- E. If a hospital/ASC appeals a decision by the Department to totally or partially deny payment for a case, payment for the denied time is withheld pending a decision on the appeal.
- F. Hospitals, practitioners, or recipients do not have the right to a separate appeal on the same case.

Also, see Section VII, Sanctions.

V. OUTLIERS (FOR INPATIENT ADMISSIONS ONLY)

A. General Information

An MA inpatient stay must exceed the [DRG trim point](#) to qualify as a day outlier. DRGs relating to burns and neonates may be paid as cost outliers. In order to obtain payment for a day outlier, the facility must request outlier days. Refer to [Chapter 1163](#) of the MA Regulations for additional information.

After the patient is discharged, the hospital must bill for the base DRG Payment before requesting certification for outlier days unless no payment is anticipated for the base DRG due to payment from a third party resource exceeding the base DRG payment.

B. Requesting Day Outliers

1. Required Information

- a. The initial hospital claim or hospital claim adjustment.
- b. A copy of the Remittance Advice (RA) showing either the base DRG payment or adjustment prior to the final interim. (For those cases in which payment from a third party resource exceeded the anticipated DRG, the hospital may not have an RA.
- c. A photocopy of the PSR Notice or the Day Outlier Request for Exempt Cases (Refer to Attachment E if the case was exempt from PSR review), with the requested number of outlier days completed.
- d. The hospital UR Committee comments on hospital letterhead stationary.
- e. A copy of the complete inpatient medical record including the attestation statement.
- f. Third party statement, if applicable.
- g. Hospital Transmittal Form for Outlier Requests (see Attachment F).

C. Outlier Determination

The Outlier Review Section reviews the patient's complete medical record to identify the medical necessity 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. It is extremely important that the medical necessity for the admission and each day of the inpatient care be properly and legibly documented in the patient's medical record. If the hospital denies all or part of the stay, the Outlier Review Section, at a minimum, denies the same services.

Under the DRG payment system, days denied that are within a DRG trim point are known as carve-out days. If the Outlier Review Section denies such days,

the number of days denied is subtracted from the requested number of outlier days. The remaining outlier days are certified if the medical necessity is evident for the continued stay, and if those days are within the scope of the MA Program; if no days remain, the outlier request is denied. The day of discharge is not covered under the MA Program.

The Outlier Review Section enters the outlier decision data into the PA PROMIS^e[™] Prior Authorization System, which generates a PSR or CHR/DRG Certification Notice. For exempt cases, this notice will include a Department generated certification notice which is the hospital's only record of the number which is necessary for billing adjustments to the outlier payment or resubmission of rejected claims. The claim adjustment or original bill will be process for outlier payment after PROMIS^e[™] has been updated to show the certified outlier days.

D. Outlier Appeal Process

The facility has the right to appeal adverse actions of the Department. A written request from the administrator containing information to support the reason for the appeal must be received by the Department within 30 calendar days of the Department's denial.

Prior to initiating the appeal, all steps described in the PSR Manual and the MA Regulations relating to admission and outlier reviews must be completed.

1. The notice of appeal is considered to be filed on the date it is received by the Appeals Section.
2. The notice of appeal must include a copy of the certification notice, the Hospital Utilization Review findings, and a statement that the recipient's complete inpatient medical record has been previously submitted with the outlier request.
3. The appeal is referred to the Office of Hearings and Appeals. The hospital is notified directly by that office of the date, time, and location of the appeal hearing.
4. If a hospital appeals a decision by the Department to fully or partially deny payment of a case, payment for the denied time is withheld pending a decision on the appeal.

VI. 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 patients; 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 IS BROUGHT TO THE ATTENTION OF THE HOSPITAL ADMINISTRATOR FOR CORRECTIVE ACTION.

Failure to comply with the MA 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 MA 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 (BPI) analyzes the determinations made by the hospital's Utilization Review Committee through the review of monthly adverse determination summary reports submitted by the hospital.

D. On-Site Visits

The Department will conduct 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.

VII. SANCTIONS

If the Department determines that a provider billed for services inconsistent with MA Program Regulations, provided incorrect information on the invoice 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 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 an MA recipient's need for admission or outlier days 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 MA Program when certifying or denying outlier 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 payment for cases in which medical record documentation and hospital claim information differ;
- F. Require hospitals to do preadmission reviews for selected PSRs, diagnoses, procedures, or practitioners;
- G. Bring pattern of care, such as a high number of inappropriate transfers or readmissions to the attention of the hospital 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.

INFORMATION FOR CERTIFICATION REQUEST – 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
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TRANSFER INFORMATION

27. FACILITY PA PROMISE™ PROVIDER NUMBER
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MA 341 01/04

ATTACHMENT B

Guidelines for Requesting Place of Service Review (PSR) Certification

The following guidelines are to assist the attending physician or facility in determining when an admission requires Place of Service Review (PSR) certification and the type of information that is necessary in order to certify a request under the PSR Process.

1. Admissions Requiring PSR

Under the MA Program, PSR is required for all elective inpatient hospital admissions to acute care general hospitals; and for elective admissions to freestanding ambulatory surgical centers (ASCs); and hospital short procedure units (SPUs).

Exceptions to the above include:

- a. Maternity Admissions – admissions which are expected to result in the delivery of one or more live infants (DRG 370 to 375 inclusive).
- b. 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 (DRG 385 to 391, inclusive).
- c. 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 admission paid for, all or in part, by Medicare Part B.
- d. 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 CHR Process.
- e. Emergency or urgent admissions to acute care general hospitals. These admissions must be certified for payment in accordance with the Department's DRG Process.
- f. Admissions of recipients enrolled in an HMO Program.

2. Determining if an Admission is Elective

An elective admission is defined as a preplanned admission to a hospital, short procedure unit, or ambulatory surgical center. The term includes an admission in which scheduling options may be exercised by an attending practitioner, facility, or recipient without unfavorably affecting the outcome of treatment. The term does not include cases in which a delay may result in death or irreversible harm to the patient.

An urgent admission is defined as an admission where medical care must be administered promptly and cannot be delayed.

An emergency admission is an admission for a condition in which immediate medical care is necessary to prevent death, serious impairment, or significant deterioration in the health of the patient. It is a life-threatening situation.

3. Initiating a PSR Request

The PSR request for an MA recipient, who needs to be admitted to an inpatient hospital bed, and SPU, or an ASC, may be initiated by calling the Department's toll-free Automated Utilization Review (AUR) lines, which will be staffed by nurse reviewers. Either the attending physician or the facility initiates the request; the attending physician must provide the facility's designated representative with the information that will be required for a PSR request.

4. Required Information for PSR Request

Recipient and provider MA identification data, diagnostic and procedure codes, and medical information to justify the planned treatment and setting are required when the PSR request is made. Physicians and facilities will be provided with a listing of required data so that the information may be obtained before the request is initiated.

General identification information includes the recipient number, facility and physician's PA PROMISE™ provider numbers, and the name and telephone number of the person making the request.

The medical information necessary for the PSR request includes the diagnosis description, diagnosis code(s), procedure description and procedure code(s); the medical indications for the planned treatment; prior medical management; and other medical problems that affect the setting in which the service must be provided.

Procedures are certified for the most appropriate, least costly setting. Procedures that can be performed safely in a practitioner's office, or in a clinic setting, will not be certified for an SPU, ASC, or in an inpatient setting. Also, procedures that can be performed safely in an ASC or SPU will not be certified for an inpatient admission. Therefore, information to justify the planned setting must be presented when making a PSR request.

5. Substantiating the Need for an Inpatient Admission Because of Co-Existing Medical Conditions

Major operative procedures and the need for intense medical treatment and observation require an inpatient setting. However, in many instances, the justification for an inpatient stay is not because of the complexity of the procedure or treatment, but due to co-existing medical conditions. Problems, symptoms, and conditions of such severity that they have the potential to increase mortality or morbidity with surgery or anesthesia must be described when PSR is requested. The presence of a chronic condition, which is well controlled, does not necessarily warrant an inpatient stay. When a co-existing medical condition makes an inpatient admission necessary, the following information specific to the disease process of concern should be evaluated prior to making a PSR request:

- a. What is the current treatment (include drugs, dosage, etc.)?

- b. Have there been any recent changes in current treatment?
- c. Have there been recent complications or symptoms experienced, or is the patient stable and under control?
- d. Has the patient been hospitalized in the past three months? When was the last time the patient visited a physician for a problem?
- e. What are the most recent lab/x-ray/diagnostic values (blood pressure (B/P), blood sugar, EKG, chest x-ray, blood gases, etc.)?
- f. What other information supports the need for an inpatient setting?

Inpatient admission requested because of a co-existing medical problem are considered on a case-by-case basis, depending on the severity of the problem. Examples of circumstances that may justify an inpatient admission for a procedure usually designated as outpatient or same day surgery are as follows:

- (1) Heart disease, which is under active treatment and shows evidence of recent changes or complications, such as B/P of 200 systolic or 100 diastolic, or greater; enlarged ventricle on chest x-ray or echocardiogram; frequent, severe, and/or refractory episodes of angina and increased nitroglycerine use; atrial fibrillation evident on EKG; mitral or aortic valve insufficiency; regurgitation or stenosis; drug therapy with potential for complications during anesthesia.
- (2) Diabetes, which is poorly controlled or unstable; e.g., unstable blood sugar, recent medication changes, highly variable insulin dosages, additional complicating cofactors, such as renal failure or neuropathy, depending upon the surgery to be performed.
- (3) Respiratory disease such as acute asthma, particularly if there has been an attack in the past month; COPD, bronchitis, or emphysema with recent abnormal blood gases; use of three or more respiratory drugs, e.g., Theo-Dur, Brethine, Alupent, Intal; continuous or frequent use of prn oxygen or corticosteriod inhalers; need for and length of time for general anesthesia.
- (4) Severe debilitating disease which contributed to comorbidity or has an adverse effect on general health; e.g., a severe chronic disease process, severe psychiatric disease such as manic depressive under Lithium treatment, severe alcoholism or drug addiction with potential of DTs/withdrawal, severe Parkinson's, profound retardation, severe myasthenia gravis, end-stage renal disease, amyothrophic lateral sclerosis, or senility/chronic brain disease.
- (5) Severe epilepsy with recent grand mal or frequent episodes of other seizure activity, medication changes in the past three months due to continued seizure activity, drug therapy with potential for complications during anesthesia.

- (6) Complication of vascular disease with an adverse effect on general health; e.g., embolic episodes, alchemic limbs, or history of CVA, episodes of Teas or “blackout” spells, considered in conjunction with the type of surgery or anesthesia planned.
 - (7) History of clotting or bleeding disorder or oral anticoagulant therapy.
 - (8) Past History of hypersensitivity to drugs or anesthetics directly relating to present condition and planned treatment; previous history of post-op complication depending on type and severity; or medical conditions such as cirrhosis or myasthenia gravis which would promote anesthetic complications.
 - (9) Carcinoma, suspicion of metastasis to, or known CA of, the same area as operative site; CA of lung, if general anesthesia is to be given; treatment and medications indicating advanced metastasis, or generalized debilitation as a result of advanced disease.
 - (10) Obesity which is debilitating; greater than 60% of ideal body weight for abdominal surgery; obesity with Pickwickian syndrome; type and length of anesthesia.
6. Substantiating the Need for an Inpatient Admission because of the Complexity of the Procedure or Existing Complications Relating to the Procedure

Inpatient admissions requested for procedures that can often be performed on an outpatient basis or same day surgical setting, but, because of complexity of the planned treatment or existing complications, may necessitate admission, will be considered on a case-by-case basis, depending upon the severity of the problem. Examples of circumstances that MAY warrant inpatient admission are as follows:

- a. Rectal Surgery with the potential for bleeding, necessitating rectal packing and urinary retention; high or broad based polyp.
- b. Wound Debridement with current infection or cellulites; debridement of a large wound.
- c. Eye Surgery in which the patient is near blind (20/100 or worse) in the non-operative eye; glaucoma under treatment with a tonometer reading of 20 or above, or if increased to 20 or above post-op on previous surgery; vitreous hemorrhage in past six months, or any time as a post-op complication; peripheral neuropathy; diabetic retinopathy.
- d. Inguinal or Femoral Hernia Repair for bilateral procedure; when hernia is nonreducible or incarcerated; has recurred two or more times.
- e. Nasal Surgery for the diagnosis of hypertrophy or turbinates or when posterior packing is necessary.
- f. Foot Surgery involving the following: a radical procedure; a bilateral procedure; pins, wires, or plastic joints when metatarsals are involved; impaired circulation.

- g. Urological Surgical Procedures performed above bladder level, or involving multiple bladder level, or involving multiple bladder tumors to be excised/biopsied.

7. Other Exceptional Circumstances that may Warrant Consideration for Inpatient Admission

The Medical Assistance Program may determine that inpatient hospital care is required only if the patient's medical condition, safety, or health would be significantly or directly threatened if the care was provided in a less intense setting. Examples of factors that MAY be considered are:

- a. Spinal anesthesia or classification as a Class III or greater anesthesia risk as documented by patient's symptomatology or medical condition.
- b. Pre-op or post-op IV antibiotics or other IV meds for twelve hours or greater with supporting medical indications for treatment.
- c. Documented failure in performing preadmission bowel prep, or saline bowel prep in a patient with severe cardiac problems or with severe hypotension.
- d. Bed rest and close observation required for eight hours or more following a procedure, if well documented.
- e. The potential for postoperative complication, assessing the extent or location of the procedure, in addition to the length of time that a major anesthetic is required.
- f. Past unsuccessful attempts at outpatient surgery which are strongly anticipated for this surgery,
- g. The patient's age and general medical condition.
- h. The presence of another medical condition(s) that would limit daily functional activities postoperatively.
- i. The presence of another medical condition(s) that makes the patient's care unmanageable on an outpatient basis.
- j. The distance of the patient's home from the facility in conjunction with the severity of the existing medical condition(s).

The availability and need for home health care or family support should be evaluated by the patient's physician and planned for prior to providing the service. The patient's home environment is of considerable importance. If monitoring will be required after some type of elective care, it is important to know if anyone at home can care for the patient.

8. Consideration of the Severity of the Illness and Planned Treatment

The following information MAY also be applicable when requesting PSR for an elective admission. The list includes:

- a. Reason for Admission

- (1) Scheduled for surgical procedure within 24 hours requiring general or regional anesthesia or equipment; services and facilities available only in inpatient setting.
 - (2) Sudden onset of unconsciousness or disorientation.
 - (3) Acute progressive sensory, motor, circulatory, respiratory, or other systems conditions sufficient to incapacitate the patient (describe).
 - (4) Wound dehiscence or evisceration.
 - (5) Severe electrolyte, blood gas abnormality or other abnormal studies (specify).
 - (6) EKG evidence of acute ischemia with suspicion of new MI.
 - (7) Pulse rate: <50 or >120.
 - (8) BP: Systolic <90 or >200; Diastolic <60 or >120.
 - (9) Persistent fever for more than five days: T>101.
 - (10) Other(s). Specify.
- b. Prescribed Treatment
- (1) Treatment in ICU or CCU.
 - (2) Other special care unit (specify).
 - (3) IV medications or fluid replacement.
 - (4) Intermittent or continuous respirator use.
 - (5) Vital sign monitoring every two hours or more frequently.
 - (6) IM antibiotics at least every eight hours.
 - (7) Use of chemotherapeutic agents that require continuous observation for life-threatening toxic reaction.
 - (8) Other(s) (specify).

ATTACHMENT C (PSR Notice for Recipients)
PLACE OF SERVICE REVIEW (PSR)
NOTICE OF DECISION

The following shows the place of service approved for the service requested. 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: PSR Reference #: Recipient Name: Recipient ID #: Expiration Date:

Service Requested	Service Description	Reason Code(s)
Service Approved Other Than As Requested	Service Description	Reason Code(s)
Reason Code		
Reason Code		
Reason Code		
Reason Code		
Reason Code		

IMPORTANT

**READ THE FOLLOWING SECTIONS ON THE BOTTOM AND REVERSE SIDE
OF NOTICE**

ABC Hospital
123 Main Street
Yourtown, PA 11111-
0000

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

Si necesita una traduccion de este aviso, marque este encassillado y envíe esta forma inmediatamente.

ATTENTION ALL RECIPIENTS: PLEASE READ THE FOLLOWING CAREFULLY

- If you have any questions regarding this notice, you may call the Toll Free number 1-800-537-8862.
- To receive the approved service, you should contact your doctor to arrange care.
- You must be eligible for medical assistance and the service requested on the date the service is provided. Your doctor has agreed to consider the Department's fee payment in full. A provider may bill you for a noncompensable service or item only if you are told before the service is rendered that the Department does not cover it.

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 or your representative have the right to ask for and have a fair hearing. At the hearing you can give your reasons and present witnesses and evidence. You can represent yourself or have someone represent you. If you want legal help, your County Assistance Office should tell you where you can get a lawyer without charge. If you wish to appeal, you must ask for an appeal in writing within 30 days of the date of this notice by writing a short letter. Make sure you have marked your name, case number, and PSR Reference Number on the letter. **The appeal letter must be sent to the address below:**

Appeals Section
Division of Clinical Review
PO Box 8050
Harrisburg, PA 17105

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.

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

- If you wish an appeal of the decision on the reverse side of this notice you must ask for an appeal in writing within 30 days of the date of this notice. Refer to the PA PROMISE™ Provider Handbook for the appeal process.
- The PSR Reference Number must be on all inquiries regarding this notice.

ATTACHMENT D

**PLACE OF SERVICE REVIEW (PSR)
NOTICE OF DECISION**

The following shows the place of service approved for the service requested. 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 PSR Reference #: Recipient Name: Recipient ID #: Expiration Date:

Service Requested	Service Description	Reason Code(s)
Service Approved Other Than As Requested	Service Description	Reason Code(s)
Reason Code		
Reason Code		
Reason Code		
Reason Code		
Reason Code		

IMPORTANT

**READ THE FOLLOWING SECTIONS ON THE BOTTOM AND REVERSE SIDE
OF NOTICE**

**John J. Recipient
123 Any Street
Yourtown, PA 11111-
0000**

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

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

ATTENTION ALL RECIPIENTS: PLEASE READ THE FOLLOWING CAREFULLY

- If you have any questions regarding this notice, you may call the Toll Free number 1-800-537-8862.
- To receive the approved service, you should contact your doctor to arrange care.
- You must be eligible for medical assistance and the service requested on the date the service is provided.
- Your doctor has agreed to consider the Department's fee payment in full. A provider may bill you for a noncompensable service or item only if you are told before the service is rendered that the Department does not cover it.

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 or your representative have the right to ask for and have a fair hearing. At the hearing you can give your reasons and present witnesses and evidence. You can represent yourself or have someone represent you. If you want legal help, your County Assistance Office should tell you where you can get a lawyer without charge. If you wish to appeal, you must ask for an appeal in writing within 30 days of the date of this notice by writing a short letter. Make sure you have marked your name, case number, and PSR Reference Number on the letter. **The appeal letter must be sent to the address below:**

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

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.

ATTACHMENT E

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)	13. PROCEDURE(S)	ICD-9-CM Code(s)
	1. 2.		1. 2.

PRIOR ADMISSION INFORMATION

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

**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 ADVISE 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)

PSR PROVIDER QUESTIONS AND ANSWERS

1. A patient is admitted for an elective diagnostic procedure in an ASC/SPU, which results in the need for more extensive surgery at that time.
Q. Is a PSR certification necessary for the surgical procedure?
A. No. The initial PSR certification covers all related procedures. If an inpatient admission results, the Hospital Utilization Review Department is responsible for contacting the DRG Section to certify the after care.
2. A baby who is born in hospital A is transferred to hospital B acute care, and once stabilized, is transferred back to hospital A for growth and development.
Q. Is a PSR request necessary for the transfer back to hospital A?
A. Yes. A PSR request is required on all elective transfers to an acute care facility.
3. A patient with Medicare Part B coverage and MA is admitted to a hospital short procedure unit or ambulatory surgical center for an elective procedure.
Q. Is PSR necessary?
A. An admission to a hospital short procedure unit or ambulatory surgical center is exempt from PSR when the patient has Medicare Part B coverage for the service. If the patient has only Medicare Part B coverage and is admitted to an inpatient facility, the admission requires PSR certification.
4. A pregnant woman is admitted to the hospital and delivers an infant. Two days after delivery, a tubal ligation is planned.
Q. Is PSR necessary?
A. No. Maternity admissions are exempt from PSR and any service provided during that admission is exempt from PSR. The provider must still obtain the required Sterilization Patient Consent Form (MA 31) within the designated time frames and submit it with the claim in order to be paid for the tubal ligation.
5. A patient is admitted to an acute care facility for an urgent or emergency medical problem and during the admission also has an elective surgical procedure.
Q. Is a PSR request necessary before the elective surgical procedure is performed?
A. No. If a patient is already an inpatient in an acute care facility, services provided during that admission are considered part of the initial admission.
6. A patient is hospitalized in an acute care facility, which also has a rehab unit.
Q. Is a PSR request necessary if the patient is transferred from acute care to rehab?
A. Rehabilitation hospitals/units are exempt from PSR. The facility must contact the CHR Section at 1-800-558-4CHR to certify the transfer.
7. Please see question and answer.

- Q. Can we call the PSR Section the same day the practitioner wants to perform a procedure subject to PSR or must we call the PSR Section in advance? Is there a specified time frame to request PSR before the scheduled procedure?
- A. You should contact the PSR Section as soon as possible to ensure sufficient time to process the request. The request must be certified prior to providing the service.
8. A patient is admitted to a hospital short procedure unit or an ambulatory surgical center for elective surgery and develops complications resulting in the need for an inpatient admission.
- Q. Is a PSR request required for the inpatient admission?
- A. This would be an urgent or emergency situation. The hospital Utilization Review Department is responsible for contacting the DRG Section at 1-800-558-4DRG (374) to certify the inpatient admission with the specific reason for the admission to the hospital.
9. A patient is admitted to a facility (Provider Type 01, Specialty Code 010) for inpatient detoxification.
- Q. Is a PSR request necessary?
- A. If the admission is urgent or emergency, the DRG Process is followed.
10. A facility specializing in the treatment of cancer routinely admits patients on a weekly basis for a two- or three-day hospital stay for chemotherapy.
- Q. Is a PSR request necessary?
- A. Yes. Extended courses of treatment, e.g., chemotherapy provided on an inpatient basis, require the certification of each inpatient admission. However, if the patient is treated in an ASC/SPU, the PSR Section can certify up to ten extended courses of treatment per one PSR request.
11. A patient has been certified for extended courses of treatment (e.g., ten treatments in an ASC/SPU).
- Q. Is there a time frame in which the total number of treatments must be completed?
- A. No. The treatment must begin within 60 days from the date the request was certified by the PSR Section. There is no time frame in which treatment must be completed.
12. A PSR request is made and the PSR nurse reviewer tells the contact person the recipient number is incorrect.
- Q. Can the PSR Section give the correct recipient number? Can this be processed as a late pickup?
- A. No. The PSR nurse reviewer cannot give you the recipient number. They can only confirm the identity of the patient when the number is given. If the patient has MA and gives you an incorrect number, this is not a late pickup situation. You must get the correct number before the PSR request can be implemented.

13. A patient is scheduled for an elective transfer to a facility, acute care hospital, Provider Type 01, Specialty Code 010.
- Q. Who is responsible for making the PSR request?
- A. Either the facility or the practitioner can call the PSR Section to make the request. The facility receiving the patient receives the PSR certification notice.
14. A patient had Medical Assistance and other insurance.
- Q. If you have MA coverage and another insurance, do you always have to request PSR for an elective admission?
- A. If the admission would normally require PSR, a PSR certification will be required in order to bill MA.
- You may request PSR before the admission in order to know in advance what setting will be certified. Or, you may wait until the insurance was billed so you will know if MA has any financial responsibility. If the other insurance pays more than the MA fee for the service, MA should not be billed and you would not need to request PSR.
- If you did not request PSR certification, you must request the certification within 30 calendar days of the date the facility is notified of what the insurance will pay.
15. A pregnant woman is admitted for an induction, which fails and she is discharged without the delivery of an infant.
- Q. Is PSR necessary for this admission?
- A. In most cases, delivery of an infant is expected and maternity admissions are exempt. However, if the induction fails and the patient is discharged without delivery, the induction is considered to be an elective admission and PSR must be requested as a late pickup.
16. A patient has a lithotripsy or cardiac catheterization done at one facility, but is transferred to a facility convenient to his home for overnight observation.
- Q. Is this admission for after care elective and does this require PSR?
- A. Yes. The admission for the lithotripsy or cardiac catheterization was planned and scheduled. Therefore, the Department will consider a transfer for the patient or facility's convenience also to be elective.
17. A patient is admitted to an ASC or SPU for a cystoscopy and biopsy. The biopsy was not performed.
- Q. Does the facility notify the PSR Section about the change?
- A. Yes. The PSR Section will record the change in procedure code on the PSR file, so that the claim submitted by the facility will match the PSR file and be paid.
18. Please see question and answer.
- Q. Will the toll-free lines be available from 12 Noon to 1:00 p.m.?

- A. Yes. The toll-free PSR lines are available from 7:30 a.m., through 4:00 p.m., Monday through Friday, except Commonwealth holidays.
19. A patient is scheduled for an admission for an elective surgical procedure to an ASC or SPU. The MA fee schedule codes are required for procedures in an ASC or SPU.
- Q. Where can the Hospital Utilization Review Committee obtain these codes and why is this necessary?
- A. The MA Fee Schedule codes are kept in the billing department by most facilities. The PSR Section has designed and distributed a PSR worksheet for the facility to complete prior to making the request. The MA Fee Schedule Code for ASC/SPU should be obtained and noted on the worksheet before calling to request PSR. The correct procedure code is required on the claim for billing purposes and must match the code on the PSR file. When billing for ASC/SPU services, the MA Fee Schedule procedure codes are required on the claim.
20. A facility or practitioner request PSR.
- Q. Can the PSR Section guarantee the recipient will still be eligible for services if the procedure is not done for two or three weeks after the request was made?
- A. No. It is the responsibility of the facility and practitioner to determine if the recipient is eligible for services on the day the service is performed. The PSR Section only verifies the recipient number of the recipient and knows the eligibility of the recipient on the day the request is made.
21. An attending practitioner admits the patient through the ER at night and classifies the admission as urgent or emergency.
- Q. Can the Hospital UR Coordinator request PSR as a late pickup if the admission is evaluated by the Hospital UR Coordinator and is determined to be elective?
- A. No. If the documentation by the admitting practitioner indicates this was an urgent or emergency situation and does not allow for a planned scheduled admission, the request should be evaluated by the DRG Section.
- The PSR Process applied only to elective admissions, which the Department defines as those, which can be planned and scheduled in advance.
22. The PSR certification notice is sent to the facility, practitioner, and recipient.
- Q. To whom is the certification notice sent at the facility?
- A. The PSR certification notice is sent to the service location identified on the request.

23. The provider is unable to locate the certification notice.

Q. 1.) Can the PSR Section issues a second notification letter?

2.) What form is used by the hospital to request a day outlier if the certification notice is lost?

A. 1.) The PSR certification notice is not reissued. A copy of the physician's notice is acceptable. The PSR number can be obtained by calling the PSR Section and supplying the patient's recipient number or the PSR worksheet that was completed and retained by the provider.

2.) To request a day outlier review when the facility does not have a copy of the certification notice, use the Day Outlier Request for Elective Cases Exempt from the PSR Process (See Attachment D) noting that the certification notice is unavailable.

24. A case is referred to the Department's physician reviewer and a teleconference is necessary.

Q. Will the Department allow resident physicians to do physician teleconferences?

A. Yes. However, an attending practitioner must be identified on the PSR file. These must match the practitioner PA PROMIS^eTM provider number and license number on the claim submitted by the provider when requesting payment for services.

25. An MA patient is admitted to a facility for elective services and the admission was not certified.

Q. How is this situation handled?

A. Elective admissions to hospitals, ASCs, and SPUs on or after March 14, 1988, must be certified by the PSR Process for payment to be made. A place of service will be certified and the Department will make payment at the level certified. A 50% penalty will be assessed when certification is requested after the admission.