

§ 456.5 Evaluation criteria.

The agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. This section does not apply to services in hospitals and mental hospitals. For these facilities, see the following sections: §§ 456.122 and 456.132 of subpart C; and § 456.232 of subpart D.

[43 FR 45266, Sept. 29, 1978, as amended at 61 FR 38399, July 24, 1996]

§ 456.6 Review by State medical agency of appropriateness and quality of services.

(a) The Medicaid agency must have an agreement with the State health agency or other appropriate State medical agency, under which the health or medical agency is responsible for establishing a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services.

(b) The purpose of this review plan is to provide guidance to the Medicaid agency in the administration of the State plan and, where applicable, to the State licensing agency described in § 431.610.

Subpart B—Utilization Control: All Medicaid Services**§ 456.21 Scope.**

This subpart prescribes utilization control requirements applicable to all services provided under a State plan.

§ 456.22 Sample basis evaluation of services.

To promote the most effective and appropriate use of available services and facilities the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

§ 456.23 Post-payment review process.

The agency must have a post-payment review process that—

- (a) Allows State personnel to develop and review—
 - (1) Recipient utilization profiles;
 - (2) Provider service profiles; and
 - (3) Exceptions criteria; and

(b) Identifies exceptions so that the agency can correct misutilization practices of recipients and providers.

Subpart C—Utilization Control: Hospitals**§ 456.50 Scope.**

This subpart prescribes requirements for control of utilization of inpatient hospital services, including requirements concerning—

- (a) Certification of need for care;
- (b) Plan of care; and
- (c) Utilization review plans.

§ 456.51 Definitions.

As used in this subpart:

Inpatient hospital services—

(a) Include—

(1) Services provided in an institution other than an institution for mental disease, as defined in § 440.10;

(2) [Reserved]

(3) Services provided in specialty hospitals and

(b) Exclude services provided in mental hospitals. Utilization control requirements for mental hospitals appear in subpart D.

Medical care appraisal norms or *norms* means numerical or statistical measures of usually observed performance.

Medical care criteria or *criteria* means predetermined elements against which aspects of the quality of a medical service may be compared. These criteria are developed by health professionals relying on their expertise and the professional health care literature.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 22041, June 17, 1986]

CERTIFICATION OF NEED FOR CARE**§ 456.60 Certification and recertification of need for inpatient care.**

(a) *Certification*. (1) A physician must certify for each applicant or recipient that inpatient services in a hospital are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.