

(2) Has a financial interest in any hospital.

UR PLAN: INFORMATIONAL
REQUIREMENTS

§ 456.111 Recipient information required for UR.

The UR plan must provide that each recipient's record includes information needed for the UR committee to perform UR required under this subpart. This information must include, at least, the following:

- (a) Identification of the recipient.
- (b) The name of the recipient's physician.
- (c) Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission.
- (d) The plan of care required under § 456.70.
- (e) Initial and subsequent continued stay review dates described under §§ 456.128 and 456.133.
- (f) Date of operating room reservation, if applicable.
- (g) Justification of emergency admission, if applicable.
- (h) Reasons and plan for continued stay, if the attending physician believes continued stay is necessary.
- (i) Other supporting material that the committee believes appropriate to be included in the record.

§ 456.112 Records and reports.

The UR plan must describe—

- (a) The types of records that are kept by the committee; and
- (b) The type and frequency of committee reports and arrangements for their distribution to appropriate individuals.

§ 456.113 Confidentiality.

The UR plan must provide that the identities of individual recipients in all UR records and reports are kept confidential.

UR PLAN: REVIEW OF NEED FOR
ADMISSION¹

§ 456.121 Admission review required.

The UR plan must provide for a review of each recipient's admission to the hospital to decide whether it is needed, in accordance with the requirements of §§ 456.122 through 456.129.

§ 456.122 Evaluation criteria for admission review.

The UR plan must provide that—

- (a) The committee develops written medical care criteria to assess the need for admission; and
- (b) The committee develops more extensive written criteria for cases that its experience shows are—
 - (1) Associated with high costs;
 - (2) Associated with the frequent furnishing of excessive services; or
 - (3) Attended by physicians whose patterns of care are frequently found to be questionable.

§ 456.123 Admission review process.

The UR plan must provide that—

- (a) Admission review is conducted by—
 - (1) The UR committee;
 - (2) A subgroup of the UR committee;
 or
 - (3) A designee of the UR committee;
- (b) The committee, subgroup, or designee evaluates the admission against the criteria developed under § 456.122 and applies close professional scrutiny to cases selected under § 456.129(b);
- (c) If the committee, subgroup, or designee finds that the admission is needed, the committee assigns an initial continued stay review date in accordance with § 456.128;
- (d) If the committee, subgroup, or designee finds that the admission does not meet the criteria, the committee or a subgroup that includes at least

¹The Department was enjoined in 1975 in the case of American Medical Assn. et al. v. Weinberger, 395 F. Supp. 515 (N.D. Ill., 1975), aff'd., 522 F.2d 921 (7th cir., 1975) from implementing the admission review requirements contained in §§ 456.121-456.127. This case was dismissed on the condition that these requirements be revised. They are presently being revised, and will not be in force until that revision is completed.

§ 456.124

one physician reviews the case to decide the need for admission;

(e) If the committee or subgroup making the review under paragraph (d) of this section finds that the admission is not needed, it notifies the recipient's attending physician and gives him an opportunity to present his views before it makes a final decision on the need for the continued stay;

(f) If the attending physician does not present additional information or clarification of the need for the admission, the decision of the committee or subgroup is final; and

(g) If the attending physician presents additional information or clarification, at least two physician members of the committee review the need for the admission. If they find that the admission is not needed, their decision is final.

§ 456.124 Notification of adverse decision.

The UR plan must provide that written notice of any adverse final decision on the need for admission under § 456.123 (e) through (g) is sent to—

- (a) The hospital administrator;
- (b) The attending physician;
- (c) The Medicaid agency;
- (d) The recipient; and
- (e) If possible, the next of kin or sponsor.

§ 456.125 Time limits for admission review.

Except as required under § 456.127, the UR plan must provide that review of each recipient's admission to the hospital is conducted—

(a) Within one working day after admission, for an individual who is receiving Medicaid at that time; or

(b) Within one working day after the hospital is notified of the application for Medicaid, for an individual who applies while in the hospital.

§ 456.126 Time limits for final decision and notification of adverse decision.

Except as required under § 456.127, the UR plan must provide that the committee makes a final decision on a recipient's need for admission and gives notice of an adverse final decision—

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(a) Within two working days after admission, for an individual who is receiving Medicaid at that time; or

(b) Within two working days after the hospital is notified of the application for Medicaid, for an individual who applies while in the hospital.

§ 456.127 Pre-admission review.

The UR plan must provide for review and final decision prior to admission for certain providers or categories of admissions that the UR committee designates under § 456.142(b) (4)(iii) to receive pre-admission review.

§ 456.128 Initial continued stay review date.

The UR plan must provide that—

(a) When a recipient is admitted to the hospital under the admission review requirements of this subpart, the committee assigns a specified date by which the need for his continued stay will be reviewed;

(b) The committee bases its assignment of the initial continued stay review date on—

- (1) The methods and criteria required to be described under § 456.129;
- (2) The individual's condition; and
- (3) The individual's projected discharge date;

(c)(1) The committee uses any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third party payors, to assign the initial continued stay review date;

(2) These regional norms are based on current and statistically valid data on duration of stay in hospitals for patients whose characteristics, such as age and diagnosis, are similar to those of the individual whose case is being reviewed;

(3) If the committee uses norms to assign the initial continued stay review date, the number of days between the individual's admission and the initial continued stay review date is no greater than the number of days reflected in the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate; and