

§ 456.2

42 CFR Ch. IV (10–1–06 Edition)

(6) Denial of FFP for failure to have specified utilization review procedures. Section 1903(i)(4) provides that FFP is not available in a State's expenditures for hospital or mental hospital services unless the institution has in effect a utilization review plan that meets Medicare requirements. However, the Secretary may waive this requirement if the Medicaid agency demonstrates to his satisfaction that it has utilization review procedures superior in effectiveness to the Medicare procedures.

(7) State health agency guidance on quality and appropriateness of care and services. Section 1902(a)(33)(A) requires that the plan provide that the State health or other appropriate medical agency establish a plan for review, by professional health personnel, of the appropriateness and quality of Medicaid services to provide guidance to the Medicaid agency and the State licensing agency in administering the Medicaid program.

(8) Drug use review program. Section 1927(g) of the Act provides that, for payment to be made under section 1903 of the Act for covered outpatient drugs, the State must have in operation, by not later than January 1, 1993, a drug use review (DUR) program. It also requires that each State provide, either directly or through a contract with a private organization, for the establishment of a DUR Board.

TABLE 1

[This table relates the regulations in this part to the sections of the Act on which they are based.]

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| Subpart A—General | 1902(a)(30) 1902(a)(33)(A) |
| Subpart B—Utilization Control: All Medicaid Services. | 1902(a)(30) |
| Subpart C—Utilization Control: Hospitals | |
| Certification of need for care | 1903(g)(1)(A) |
| Plan of care | 1903(g)(1)(B) |
| Utilization review plan (including admission review). | 1902(a)(30) 1903(g)(1)(C) 1903(i)(4) |
| Subpart D—Utilization Control: Mental Hospitals | |
| Certification of need for care | 1903(g)(1)(A) |
| Medical evaluation and admission review. | 1902(a)(26)(A) 1903(g)(1)(C) |
| Plan of care | 1902(a)(26)(A) 1903(g)(1)(B) |
| Admission and plan of care requirements for individuals under 21. | 1902(a)(26)(A) 1903(g)(1)(B), (C) |
| Utilization review plan | 1902(a)(30) 1903(g)(1)(C) 1903(i)(4) |

TABLE 1—Continued

[This table relates the regulations in this part to the sections of the Act on which they are based.]

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| Subpart F—Utilization Control: Intermediate Care Facilities | |
| Certification of need for care | 1903(g)(1)(A) |
| Medical evaluation and admission review. | 1902(a)(31)(A) 1903(g)(1)(C) |
| Plan of care | 1902(a)(31)(A) 1903(g)(1)(B) |
| Utilization review plan | 1902(a)(30) 1903(g)(1)(C) 1903(i)(4) |
| Subpart G—Inpatient Psychiatric Services for Individuals Under Age 21: Admission and Plan of Care Requirements. | 1905 (a)(16) and (h) |
| Subpart H—Utilization Review Plans: FFP, Waivers, and Variances for Hospitals and Mental Hospitals. | |
| Subpart I—Inspections of Care in Intermediate Care Facilities and Institutions for Mental Diseases. | |
| Subpart J—Penalty for Failure To Make a Satisfactory Showing of An Effective Institutional Utilization Control Program. | 1903(g) |
| Subpart K—Drug Use Review (DUR) Program and Electronic Claims Management System for Outpatient Drug Claims. | 1927(g) and (h) |

[43 FR 45266, Sept. 29, 1978, as amended at 46 FR 48561, Oct. 1, 1981; 57 FR 49408, Nov. 2, 1992; 61 FR 38398, July 24, 1996]

§ 456.2 State plan requirements.

(a) A State plan must provide that the requirements of this part are met.

(b) These requirements may be met by the agency by:

(1) Assuming direct responsibility for assuring that the requirements of this part are met; or

(2) Deeming of medical and utilization review requirements if the agency contracts with a QIO to perform that review, which in the case of inpatient acute care review will also serve as the initial determination for QIO medical necessity and appropriateness review for patients who are dually entitled to benefits under Medicare and Medicaid.

(c) In accordance with § 431.15 of this subchapter, FFP will be available for expenses incurred in meeting the requirements of this part.

[46 FR 48566, Oct. 1, 1981, as amended at 50 FR 15327, Apr. 17, 1985; 51 FR 43198, Dec. 1, 1986]

§ 456.3 Statewide surveillance and utilization control program.

The Medicaid agency must implement a statewide surveillance and utilization control program that—

(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

(b) Assesses the quality of those services;

(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and

(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

§ 456.4 Responsibility for monitoring the utilization control program.

(a) The agency must—

(1) Monitor the statewide utilization control program;

(2) Take all necessary corrective action to ensure the effectiveness of the program;

(3) Establish methods and procedures to implement this section;

(4) Keep copies of these methods and procedures on file; and

(5) Give copies of these methods and procedures to all staff involved in carrying out the utilization control program.

§ 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