

§ 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

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(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.

(b) *Recertification.* (1) A physician, or physician assistant or nurse practitioner (as defined in § 491.2 of this chap-

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ter) acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or recipient that inpatient services in a hospital are needed.

(2) Recertifications must be made at least every 60 days after certification.

[46 FR 48561, Oct. 1, 1981]

PLAN OF CARE

§ 456.80 Individual written plan of care.

(a) Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the individual must establish a written plan of care for each applicant or recipient.

(b) The plan of care must include—

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Any orders for—

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Social services;

(vi) Diet;

(4) Plans for continuing care, as appropriate; and

(5) Plans for discharge, as appropriate.

(c) Orders and activities must be developed in accordance with physician's instructions.

(d) Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of an individual.

(e) A physician and other personnel involved in the recipient's case must review each plan of care at least every 60 days.

UTILIZATION REVIEW (UR) PLAN:
GENERAL REQUIREMENT

§ 456.100 Scope.

Sections 456.101 through 456.145 of this subpart prescribe requirements for a written utilization review (UR) plan for each hospital providing Medicaid services. Sections 456.105 and 456.106