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§482.30(c) Standard: Scope and Frequency of Review

(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of--

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished including drugs and biologicals.

(2) Review of admissions may be performed before, at, or after hospital admission.

(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.

(4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in Part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:

(i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in §412.80(a)(1)(i) of this chapter; and

(ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in §412.80(a)(1)(ii) of this chapter.

Interpretive Guidelines §482.30(c)

Admissions may be reviewed before, during, or after hospital admission as stated in the hospital's UR plan.

Reviews may be conducted on a sample basis, except for reviews of extended stay cases.

In an Inpatient Prospective Payment System (IPPS) hospital, to determine outlier review compliance, "reasonably assumes" is a good faith test. The question to ask is whether the hospital is reviewing outlier cases. In instances where there was no other review of outlier cases, the question is whether it was reasonable for the hospital not to have known that the cases were in fact outliers. Some medical judgment might be required to determine whether it is reasonable for the hospital to have assumed that a patient fell into a DRG other than the one eventually assigned by the intermediary. This would be an issue in long stay outlier cases where the hospital did not review because the hospital erroneously assumed that the patient was in a DRG under which the case would not have been an outlier.

Survey Procedures §482.30(c)

- Examine the UR plan and other documentation to determine that the medical necessity for Medicare and Medicaid patients is reviewed with respect to admission, duration of the stay, and the professional services furnished.

- Determine if the hospital is reimbursed under IPPS. This requirement does not apply to IPPS excluded hospitals or units.

- Verify that in an IPPS hospital the following are being reviewed:

    - Duration of stay in cases reasonably assumed to be outlier cases; and

    - Professional services in cases reasonably assumed to be outlier cases.