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State/Territory Name: IL

State Plan Amendment (SPA) #: 15-0017

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

April 21, 2017

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Attn: Teresa Hursey

Dear Ms. Norwood:

Enclosed for your records is an approved copy of the following State Plan Amendment.

Transmittal #15-0017 - Updates Procedures for Inpatient Hospital Utilization Review
- Effective Date: October 1, 2015
- Approval Date: April 21, 2017

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sara Barger, HFS
Kimberley Cox, HFS
Mary Doran, HFS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 15-0017
2. STATE: ILLINOIS
3. PROGRAM IDENTIFICATION: Title XIX of the *Social Security Act* (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 of the *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY 2016 N/A
b. FFY 2017 N/A

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.14-B, Page 1-5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.14-B, Page 1-5

10. SUBJECT OF AMENDMENT:
Updates the utilization review language with our current process

11. GOVERNOR'S REVIEW *(Check One)*
[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Felicia F. Norwood

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED December 31, 2015 *CES, 4/20/17*

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 31, 2015

18. DATE APPROVED: April 21, 2017

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

CONTROL OF THE UTILIZATION OF INPATIENT HOSPITAL SERVICES

Utilization Review

10/15 The Department currently contracts with a Peer Review Organization (PRO) which performs inpatient utilization reviews ~~services~~ to assess medical necessity, length of stay and quality of care provided to persons covered under the Department's fee-for-service ~~by~~ medical assistance program.

~~This review occurs in the form of prepayment review (prior to payment to the hospital) and postpayment review (following payment to the hospital).~~

Case demographic information is provided to the review organization from claims submitted to the Department for payment or claims for which hospitals have received payment. ~~The review organization will provide at least 48 hours notice prior to the scheduled review for hospitals designated for on-site review. Hospitals designated for off-site review will be given seven days to submit copied charts by mail.~~

10/15 I. Medical Review Requirements

The Department, or its designee, may conduct preadmission, concurrent, prepayment, and/or postpayment reviews of:

A. ~~The quality and/or the nature of the utilization of health services.~~ Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;

B. ~~The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions.~~ The medical necessity, reasonableness and appropriateness of hospital admissions and discharges;

C. ~~The validity of the hospital's diagnostic and procedural information.~~ Through DRG validation, the validity of diagnosic and procedural information supplied by the hospital;

D. ~~The completeness, adequacy and quality of the services furnished in the hospital.~~ The completeness, adequacy and quality of hospital care provided;

E. ~~Other medical or other practices with respect to clients or billing for services furnished to clients.~~ Whether the quality of the services meets professionally recognized standards of health care; or

F. Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type.

Hospitals shall be notified at least thirty days in advance of any preadmission, concurrent, or prepayment review requirements imposed by the Department.

CONTROL OF THE UTILIZATION OF INPATIENT HOSPITAL SERVICES

~~Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 *CFR*, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991).~~

II. Utilization Review Conducted by the Hospital

~~The hospital Utilization Review Committee or designee must utilize the Department approved medical criteria when establishing medical necessity of a Medicaid hospital stay.~~

~~A. Initial Certification~~

~~1. A physician must certify for each patient the medical necessity for inpatient hospital admission.~~

~~2. The certification must be made within one working day after admission or within one working day after the hospital is notified of the application for Medical Assistance, or an individual who applies while in the hospital.~~

~~3. A physician, physician assistant or nurse practitioner, acting within the scope of the practice as defined by State law and under the supervision of a physician, must recertify for each applicant or patient that inpatient services in the hospital are needed.~~

~~B. Length of Stay Review~~

~~Each Title XIX (Medicaid) patient must have the length of stay, as initially certified reviewed by the Hospital's Utilization Review Committee. Such reviews can be conducted by the Committee or its designee.~~

10/15 Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare must meet the utilization review plan requirements in 42 CFR 456. Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Attachment 4.19-A, Chapter VII, shall be in accordance with the federal regulations.

~~III. Scope Of Work to be performed by State contracted PRO.~~

~~The Scope of Work to be performed by the PRO under this Agreement includes the following activities:~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

CONTROL OF THE UTILIZATION OF INPATIENT HOSPITAL SERVICES

III. Scope Of Work to be performed by State contracted PRO.

10/15 The Scope of Work to be performed by the PRO under this Agreement includes the following activities:

A. Conduct the review activities identified under subsection I.

~~A~~B. Provide the Department upon request with agreed upon reports of all review activity completed by the PRO.

~~B~~C. Provide the Department with the following review and Hospital Monitoring Services:

~~1. Retrospective prepayment review of any outstanding emergency admissions prior to September 1, 1991 to hospitals, which did not participate in the Department's Illinois Competitive Access and Reimbursement Equity (ICARE) Program. This review will include verification of the medical necessity of admission and continued stay as well as documentation of the emergency status of patients, determination of stability date, potential quality issues and coding validation of all diagnosis and procedure codes.~~

~~2. Retrospective prepayment review of procedures from the Hospital Ambulatory Reform Inpatient Justification List for the purpose of determining medical necessity of admission and continued stay, determination of potential quality issues and coding validation of all diagnosis and procedure codes.~~

~~3. Retrospective prepayment review of all cases involving inpatient stays for Department of Children and Family Services (DCFS) wards and all specifically designated inpatient stays of 28 days or longer. This review will include verification of medical necessity of admission and continued stay, determining potential quality issues and coding validation of all diagnosis and procedure codes.~~

~~4~~1. Retrospective post-payment review of a random sample of admissions selected by the Department for the purpose of verifying the medical necessity of the patient's admission and continued stay, determining potential quality issues and coding validation of all diagnosis and procedure codes. Analyses of post-payment review findings to identify trends, such as high referral rates for specific codes, types of care (*i.e.*, obstetrics, pediatrics), or facilities which indicate the need to initiate prepayment review requirements or intensify post-payment review requirements. Post-payment review findings, verified at the physician reviewer level when appropriate, may also be used in the Department's recoupment process after reconsideration appeal, if any.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

CONTROL OF THE UTILIZATION OF INPATIENT HOSPITAL SERVICES

~~5. Retrospective post-payment review of a random sample of observation services selected by the Department to determine the appropriateness of the service for the treatment of the illness or injury, verify diagnosis and procedure codes and identify potential quality issues.~~

~~6. Retrospective post-payment review of day and cost outliers to determine the medical necessity of admission and length of stay, verify diagnosis and procedure codes, identify potential quality issues and, in the case of cost outliers, verify the hospital's charges.~~

~~7. Retrospective review for the presence and validation of the appropriateness of physician attestations. If no attestation is present, or if the attestation is blank or unsigned by the physician, an administrative denial will result. Attestation errors will be profiled to identify patterns of errors with results reported to the Department on a quarterly basis.~~

~~8~~2. By mutual agreement, Contractor may perform special studies or review projects for the Department. These projects will be negotiated on an individual basis.

~~9. Post-payment review of DRG reimbursed readmissions within 30 days of initial admission.~~

~~10. Review of all inpatient transfers and referrals from one hospital to another.~~

~~11. Retrospective prepayment review of all inpatient psychiatric care provided to children, adolescents and adults which is billed with ICD-9-CM diagnosis ranges 290 through 302 and 306 through 319.~~

~~12~~3. Retrospective prepayment review of specific ~~ICD-9-CM~~ diagnosis codes, which have been identified through data analysis as having a high incidence of questionable care. This review will include verification of medical necessity of admission and continued stay, determination of potential quality issues and coding validation of all diagnosis and procedure codes.

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CONTROL OF THE UTILIZATION OF INPATIENT HOSPITAL SERVICES

~~13. Retrospective prepayment review of all hospital inpatient lengths of stay of one (1) day excluding Category of Service (COS) 22 – Rehabilitation. ICD-9-CM diagnosis codes 630-676 and obstetrical stays for mothers and newborns not billed with the ICD-9-CM diagnosis code of V30 or V31 and a secondary diagnosis code. One-day stays for newborns billed with the ICD-9-CM diagnosis code of V30 or V31 and a secondary diagnosis code are subject to review. This review will include verification of medical necessity of admission and continued stay, determining potential quality issues and coding validation of all diagnosis and procedure codes.~~

~~C. Determine the performance of individual hospitals in areas of prepayment review and identify the necessity of continuing prepayment review at those hospitals for specific diagnosis codes or types of care (*i.e.*, obstetrics, pediatrics).~~

10/15 [MATERIAL REMOVED]