

CFR 456 Reference and Requirement		IME Compliance
Subpart A – General Provisions (and state plan requirements)		
456.3 State 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 payment	SURS, Medical Services conducts utilization review for admission and continued stay for ICFs, PMICs and MHIs, and further compliance as defined within this plan
(b)	assesses the quality of those services	Medical Services conducts sampling QA/QI review at ICFs, and further compliance as defined within this plan
(c)	provides for control of utilization of services in accordance of subpart B of 456	Member Health Education Program and Lock-in Program (Medical Services) identifies over utilization, duplication of services, drug abuse and possible drug interactions. The member found to be misusing Medical Services is restricted to one physician, pharmacy, hospital, dentist or combination of these providers. SURS
(d)	provides for control of utilization of services in accordance of subparts C to I of 456	This plan is developed to meet the requirements of subparts C through I current conducted programs and additional programs to be implemented.
456.4 The agency must		
(1)	monitor the statewide program	Medical Services will provide quarterly reports to DHS that document compliance with 42 CFR 456 and report recommended corrective actions and progress relative to corrective action plans
(2)	take necessary corrective action	Based on the results of individual activities exercised to comply with 42 CFR 456 State plan requirements, Medical Services will recommend corrective action plans to the Department. As directed by the Department, Medical Services will implement corrective action and will increase surveillance and other methods of studies to ensure corrective action among providers where necessary.
(3)	establish methods and procedures to implement this section	This compliance plan presents the methods and procedures necessary to implement 42 CFR 456

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(4)	keep copies of methods and procedures on file	Medical Services will draft formal policies and procedures for additional programs implemented; upon approval from DHS, policies and procedures will be posted on the IME Universal Drive. Any changes in policy and/or procedure will be reviewed with DHS and revisions posted on the IME Universal Drive within 30-days of change.
(5)	give copies of methods and procedures to all staff involved	Policies and procedures (methods) will be posted for all staff involved on the IME Universal Drive. All Medical Services staff involved in activities to support 42 CFR 456 will receive training regarding policy and procedure.
456.5 Evaluation criteria		
	Agency must establish and use written criteria for evaluating appropriateness and quality	Medical Services maintains written evaluation criteria for all utilization review activities for evaluating appropriateness and quality of care. Written evaluation criteria and formal assessment score sheets will be established for other Medical Services review activities related to 42 CFR 456.
456.6 Medicaid agency must have an agreement with the State health agency ...		DHS (IME) has ongoing teaming agreements with both the Department of Public Health and the state survey and certification agency (DIA).
Subpart B - Utilization Control: All Medicaid Services		
456.22 Ongoing evaluation of need for, quality and timeliness of Medicaid services on a <u>sample</u> basis		Medical Services contractor conducts a variety of prior authorization, admission, continued stay and retrospective reviews to comply with the requirements of this section. Reviews are conducted based on pre-defined criteria and/or based on a random sample of cases selected on a monthly basis.
456.23 Post-payment review requirements		
(a)	A process that allows review of	
(1)	Recipient utilization profiles	Member Health Education Program and Lock-in Program (Medical Services). See 456.3 (c)
(2)	Provider service profiles	SURS and Medicaid Value Management (Medical Services). MVM is an assessment and analysis of an array of information and data categories. Expert analysis of integrated information will allow for formulation of strategies centered on the objective of increasing the overall value of the Medicaid programs.

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(3)	Exceptions criteria	Medical Services & Policy staff, although a more systematic approach is desirable
(b)	A process that identifies exceptions so that agency can make corrections to member and provider misutilization	MVM, SURS

Subpart C Utilization Control: Hospitals	
456.50 Prescribes requirements for control of utilization of inpatient hospital services including: certification of need for care, plan of care and UR Plans	Hospitals are required to control utilization of inpatient hospital services. Medical Services will assess compliance with these requirements on a periodic basis as defined below.
456.60 and 456.80 Prescribes requirements for certification and recertification of the need for inpatient care and for individual plans of care	Physicians and hospitals are required to meet the requirements these sections for inpatient admissions and continued stay. Medical Services currently does not conduct admission or continued stay review. Medical Services conducts retrospective utilization review on a random sample of hospital admissions on a monthly basis. Review elements include medical necessity, appropriateness of setting and services, coding and billing. Medical Services will implement review of the hospital's UR plan on a periodic basis as defined below.
456.101 to 456.145 prescribe requirements for a written utilization review (UR) plan, including review of need for admission, CSR, and medical care evaluation studies (one in progress at any given time and complete at least one each year)	Hospitals are required to meet the requirements these sections for a written utilization review plan and specified activities including a UR committee and medical care studies. Medical Services will assess compliance with these requirements on a periodic basis as defined below.

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	<p>Medical Services will review hospital UR plans every 3rd year. Documentation requested from each hospital will include the complete UR plan; meeting minutes for the last year; JCAHO certification; UR committee membership, charter, and certification of lack of financial interest for UR committee members; medical care evaluation study plans and results/reports. Information will be requested from hospitals via letter. Desk review will be conducted upon receipt of information. Each hospital will receive a report that includes the evaluation of their UR Plan compliance and recommendations for enhancements and/or corrective action. The written report will include the basis for the evaluation results. A copy of each written report will be submitted to the Department. Recommendations for enhancements and/or corrective actions will not be issued without prior notification to the Department.</p>
	<p>Where enhancements or corrective action are recommended, the UR committee will be required to submit an improvement plan to Medical Services within a specified period of time ranging from 30-days to 90-days. The time period will be dependent upon the nature of the recommendation. An annual follow-up will be conducted by Medical Services until the improvement plan is fully implemented. The annual follow-up will consist of requests for UR committee meeting minutes for the last year and for documentation of enhancements and corrective action. Upon full implementation of the enhancement or corrective action, the hospital will be placed back on the three-year rotation for review. During the next standard three-year review, Medical Services will review documentation for evidence of sustained improvement.</p>
	<p>Annually, Medical Services will review selected statistical data to identify hospital (facility) outliers relative to utilization - potential statistics include:</p> <ul style="list-style-type: none"> - admissions per membership (review at county level and then drill down to facility level where needed) - ALOS - 30-day readmissions - county-level mapping of AHRQ Quality Indicators <p>Medical Services will prepare a formal written report of review results. The report will include identification of any concerns requiring follow-up actions. Follow-up actions may include focused studies and focused interventions with identified facilities. Other actions may be implemented as determined appropriate. No such actions will be implemented without prior written approval of the Department.</p>
<p>Subpart D - Utilization Control – Mental Hospitals</p>	<p>Applies to MHIs (4 in the state of Iowa) and describes requirements for utilization review.</p>

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456.160 and 456.170 Physician requirements to certify, recertify inpatient services needed. Requirement for medical psych and social evaluations at admission and under continued care	Medical Services verifies compliance with these requirements conducting 100% admission and continued stay review on all members over age 65 entering MHIs. The timing of continued stay review is determined by the member’s needs, but no less than annually. The admission and continued stay review are completed utilizing medical information provided by the MHI. Medical Services will verify compliance with these requirements during onsite visits and inspections of care in compliance with 42 CFR 456 Subpart I (see below)
456.171 Medicaid agency or its designee must evaluate each recipients need for admission	Medical Services currently conducts admission and continued stay review for 100% of Medicaid members over age 65; IFMC will continue to perform this review. (Magellan conducts admission review for those members between the ages of 18 and 65).
456.180 and 181 Requirement for individual plans of care and written report of plan of care and evaluations	Medical Services will verify compliance with these requirements during onsite visits and inspections of care in compliance with 42 CFR 456 Subpart I (see below)
456.200 through 238 UR Plan requirements for Mental Hospitals	Iowa Medicaid Agency utilizes the QIO to conduct utilization management of MHIs. Requirement is met.
456.241 to 456.245 UR Plan requirements for Medical Care Evaluation Studies by Mental Hospitals	Iowa Medicaid Agency utilizes the QIO to conduct utilization management of MHIs. Requirement is met.
Subpart E [Reserved]	
Subpart F - Utilization Control – Intermediate Care Facilities	By definition (in the code), this section applies to ICF/MRs (144 in state of Iowa) and NFMIIs (2 in state of Iowa) and describes requirements for utilization review.
456.360 to 456.371 Requirements for certification and recertification; medical, psychological and social evaluations and exploration of alternative services	Medical Services currently conducts 100% admission review of all members admitting to ICF/MRs and NFMIIs. Continued stay review is conducted annually on 25% of members residing in ICF/MRs and NFMIIs. The admission and continued stay review are completed utilizing medical information provided by the ICFs. Medical Services will verify compliance with these requirements during onsite visits and inspections of care in compliance with 42 CFR 456 Subpart I (see below)

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456-372 Requirements for Medicaid agency to review need for admission and continued stay	Medical Services currently conducts 100% admission review of all members admitting to ICF/MRs and NFMI. Continued stay review is conducted annually on 25% of members residing in ICF/MRs and NFMI.
456.380 and 381 Requirement for individual plans of care and written report of plan of care and evaluations	Medical Services will verify compliance with these requirements during onsite visits and inspections of care in compliance with 42 CFR 456 Subpart I (see below)
456.401 to 456.438 UR Plan requirements for ICFs	Iowa Medicaid Agency utilizes the QIO to conduct utilization management of ICFs. Requirement is met.
Other	Iowa Medicaid Agency utilizes the QIO to conduct utilization management of ICFs. Requirement is met.
Subpart G - IP Psychiatric Services for under age 21: Admission and Plan of Care	
456.481 and 482 Requirement for admission certification, individual plans of care and medical, psychological, and social evaluations	Medical Services currently conducts 100% admission and continued stay review for all PMICs. The admission and continued stay review are completed utilizing medical information provided by the PMIC. Medical Services will verify compliance with these requirements during onsite visits and inspections of care in compliance with 42 CFR 456 Subpart I (see below).
Subpart H - UR Plans: FFP, Waivers and Variances for Hospitals and Mental Hospitals	This is direction to Medicaid Agency regarding how FFP is affected by compliance/noncompliance and information regarding waivers and variances to alleviate FFP impact.
Subpart I – Inspections of Care in ICFs and IMDs	By definition, this section applies to MHI, ICF/MR, NFMI and PMIC and defines requirements for periodic inspections of care.
456.602-605 Inspection team and other team requirements	Medical Services will comply with all requirements of these sections in establishing teams for periodic inspections of care. Medical Services anticipates that teams will be comprised of some home-based staff located across the state so that inspections may be made efficiently and at appropriate intervals.

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456.606 Frequency of inspections	Medical Services will conduct inspections annually, with inspections occurring between months 10 and 12 following the prior inspection. If problems or concerns are identified at a facility during inspection or via another validated source, inspections may occur in 1 to 6 month intervals based on nature of concern. Such problems or concerns shall be reviewed with the Department prior to increased frequency of inspections for a facility.
456.607 Notification before inspection	Medical Services will notify facilities between 24-48 hours before the team will arrive onsite for inspection. In no case will a facility be provided with more than 48 hours of an impending inspection. Notice to the facility will include the scope of the review, authority for the review, a plan of action or agenda for the inspection, and a list of requirements that the facility will need to support to accommodate the inspection.
456.608 Personal contact and observation and review of records 456.609 and 456.610 Determinations and Basis for determinations	The Medical Services inspection team will review current medical records for all patients admitted at the time of the onsite inspection. A member of the inspection team will have personal contact (observation) with each recipient under age 21. Additionally, a member of the inspection team will have personal contact (observation) with each recipient age 65 or older where the medical record reviewed does not contain a complete report of periodic assessment (see 441.102).
	Medical record review will be conducted to assess facility compliance with the requirements of 456.160, 456.170, 456.180 and 456.181, OR 456.360 through 456.371 and 456.380 and 456.381, OR 456.481 and 456.482 dependent upon the type of facility being inspected. Inspections at all facilities will also be conducted to determine the adequacy of the facility in meeting the needs of members as defined by 456.609 and 456.610. All quality of care concerns and all non-compliance concerns will be reviewed by a physician and/or psychiatrist. Grave concerns will be reported immediately to the Department and to the appropriate licensing agency.

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456.611 to 456.613 Reports, Copies of reports and Action on reports	Medical Services will submit a report to the Department within 30 days following each inspection. The report will include all elements required by 456.611 and copies of the report will be distributed in accordance with 456.612. Any corrective actions determined to be appropriate by the Medical Services inspection team will be reviewed with the Department prior to finalizing and distributing the report. Approved corrective actions will be included in the final report. Medical Services will direct and oversee corrective actions at facilities upon approval from the Department.
UR Plans	Iowa Medicaid Agency utilizes the QIO to conduct utilization management. Requirement is met.
Subpart I – 456.614 Inspections by UR committee - Allows committee to conduct inspections if committee is not based in the facility and composition of committee meets requirements of subpart.	The Department has chosen to implement inspections through contract with Medical Services contractor.
Subpart J – Penalty for Failure To Make a Satisfactory Showing of an Effective Institutional Utilization Control Program	This plan is designed to ensure a satisfactory showing of an effective institutional utilization control program in compliance with 42 CFR 456 for Medicaid in the state of Iowa.