MEDICARE CONDITIONS OF PARTICIPATION

482.30 Condition of participation: Utilization review.

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

(a) ***Applicability.*** The provisions of this section apply except in either of the following circumstances:
(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.
(2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.
(b) ***Standard: Composition of utilization review committee.*** A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).
(1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:
(i) A staff committee of the institution;
(ii) A group outside the institution—
(A) Established by the local medical society and some or all of the hospitals in the locality; or
(B) Established in a manner approved by CMS.
(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.
(3) The committee's or group's reviews may not be conducted by any individual who—
(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or
(ii) Was professionally involved in the care of the patient whose case is being reviewed.
(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.
(d) ***Standard: Determination regarding admissions or continued stays.***
(1) The determination that an admission or continued stay is not medically necessary—
(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
(ii) Must be made by at least two members of the UR committee in all other cases.
(2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the

patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.
(3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);
(e) ***Standard: Extended stay review.***
(1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may—
(i) Be the same for all cases; or
(ii) Differ for different classes of cases.
(2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in § 412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.
(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.
(f) ***Standard: Review of professional services.*** The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.