RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1163]

Elimination of Physician Attestation Requirement

The Department of Public Welfare (Department), by this order, adopts this amendment to read as set forth in Annex A under the authority of sections 201(2) and 443.1 of the Public Welfare Code (62 P. S. §§ 201(2) and 443.1).

Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) and (3) of the Commonwealth Documents Law (CDL) (45 P. S. § 1204(1)(iv) and (3)) and 1 Pa. Code § 7.4(1)(iv) and (3) (relating to omission of notice of proposed rulemaking). The administrative regulation relates to Commonwealth grants and benefits. Moreover, this regulatory change has been advocated by the hospital community and input has been received from the Medical Assistance Advisory Committee. Elimination of the physician attestation requirement will reduce the administrative burden on hospitals and physicians, thus enabling them to increase their efficiency and provide enhanced services to Medical Assistance recipients. Therefore, the Department finds notice of proposed rulemaking is omitted for good cause as unnecessary and contrary to the public interest in accordance with section 204(3) of the CDL and 1 Pa. Code § 7.4(3).

Purpose

This amendment to § 1163.75 (relating to responsibilities of the hospital utilization review committee) eliminates the physician attestation requirement.

Background

Current regulations governing acute care general hospitals under the diagnosis-related group (DRG) prospective payment system require that the attending physician attest to the accuracy of the principal and secondary diagnoses and the procedures performed during an MA patient's stay in the hospital and that an attestation statement be included in each patient's medical record. (§ 1163.75(7)). All discharges from acute care general hospitals are classified into a DRG and MA payment to the hospital is based on the DRG assigned to a particular hospital stay. Because the information which is currently attested to by the physician dictates which DRG is assigned, it is necessary that the information be correct so that proper payment can be made.

Medicare regulations contained a similar attestation requirement for physicians until September 1, 1995. Like the Department, Medicare used the physician attestation statement to ensure correct Medicare payment and to hold hospitals and physicians accountable for the information they submitted on the Medicare claim form. Over the years, Medicare received numerous complaints from both hospitals and physicians concerning the burden of completing the attestation statement. As part of a DRG validation review completed for Medicare, the Peer Review Organization reviewed attestation statements and found less than a 0.01% denial rate of sampled claims. Therefore, because of the small denial rate, and in an effort to reduce the administrative burden on hospitals and physicians, Medicare revised its regulations and eliminated the physician attestation requirement.

The Department also has decided to eliminate the physician attestation requirement, thus reducing the administrative burden for hospitals and physicians, without significantly interfering with the Department's ability to monitor the accuracy of hospital claims and medical records. An existing Department regulation, § 1101.51(d) and (e) (relating to standards of practice; recordkeeping requirements and onsite access) requires providers rendering medical care to MA recipients to document, among other things, each patient's diagnoses and procedures performed during a hospital stay. This requirement is not being changed, and providers remain accountable for the accuracy and completeness of their medical records.

Need for Regulation

This change will eliminate the administrative burden on hospitals and physicians, thus enabling them to increase their efficiency and provide enhanced services to MA recipients. Further, the Department's policy in relation to attestation statements will now be consistent with that of Medicare.

Summary of Amendment

Section 1163.75(7) is deleted.

Section 1163.75(8) is renumbered § 1163.75(7) and modified to eliminate the phrase "and attested to by the attending physician as specified in paragraph (7)."

Paragraphs (8)—(13) are renumbered as Paragraphs (7)—(12).

Fiscal Impact

Public Sector

No fiscal impact is anticipated on the public sector by adopting this amendment.

Private Sector

Acute care general hospitals should realize some savings by adopting this amendment as a result of a decrease in staff time previously devoted to the completion of the physician attestation statements. The amount of savings is difficult to quantify as it would vary from hospital to hospital.

General Public

There is no fiscal impact on the general public in adopting this amendment.

Paperwork Requirements

There are no additional reports or new forms needed to comply with the regulation change.

Sunset Date

The Department's Office of Medical Assistance Programs will evaluate the effectiveness of this regulation on an ongoing basis. Necessary and appropriate changes will be made in response to letters, recommendations and comments from other offices, agencies and individuals, and as a result of Departmental findings. No sunset date is required.

Public Comments

Although this amendment is being adopted without prior notice, interested persons are invited to submit their written comments, within 30 days of the date of this publication, for consideration by the Department. The comments should be sent to the Department of Public Welfare, Office of Medical Assistance Programs, Attention:

Regulations Coordinator, c/o Deputy Secretary's Office, Room 515, Health and Welfare Building, Harrisburg, PA 17120.

Persons with a disability may give comments within 30 days from the date of this publication by calling the AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (Voice users). Persons who require another alternative should contact Thomas Vracarich at (717) 783-2209.

Regulatory Review Act

Under section 5.1(c) of the Regulatory Review Act (71 P. S. § 745.5(c)), on March 6, 2000, the Department submitted a copy of this amendment with proposed rulemaking omitted to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Welfare and the Senate Committee on Public Health and Welfare. On the same date, the amendment was submitted to the Office of Attorney General for review and approval under the Commonwealth Attorneys Act (71 P. S. §§ 732-101—732-506). In accordance with section 5.1(d) of the Regulatory Review Act, on March 27, 2000, this amendment was deemed approved by the House and Senate Committees. Under section 5.1(e) of the Regulatory Review Act, on April 13, 2000, IRRC met and approved the amendment.

Findings

The Department finds that:

(1) Public need of intention to amend the administrative regulation amended by this order has been omitted under section 204(1)(iv) of the CDL (45 P. S. § 1204(1)(iv)) and the regulation thereunder (1 Pa. Code § 7.4(1)(iv)) and is unnecessary and contrary to the public interest under section 204(3) of the CDL and the regulation thereunder, 1 Pa. Code 7.4(3).

(2) The adoption of this amendment in the manner provided in this order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

Order

The Department, acting under the Public Welfare Code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 1163, are amended by amending § 1163.75 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Attorney General and General Counsel for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify this order and Annex A and deposit them in the Legislative Reference Bureau as required by law.

(d) This order shall take effect immediately upon publication in the *Pennsylvania Bulletin*.

FEATHER O. HOUSTOUN,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 30 Pa.B. 2176 (April 29, 2000).)

Fiscal Note: 14-465. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1163. INPATIENT HOSPITAL SERVICES

Subchapter A. ACUTE CARE GENERAL HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM

UTILIZATION CONTROL

§ 1163.75. Responsibilities of the hospital utilization review committee.

The hospital utilization review committee or its representative shall:

(1) Conduct admission reviews under § 1163.77 (relating to admission review requirements).

(2) Conduct continued stay reviews for potential outliers under § 1163.78a (relating to review requirements for day outliers).

(3) Conduct Medical Care Evaluation studies under § 1163.79 (relating to Medical Care Evaluation studies).

(4) Conduct reviews for medical necessity of services for potential cost under § 1163.78b (relating to review requirements for cost outliers).

(5) Provide that each recipient's record include:

(i) An identification of the recipient.

(ii) Copies of the certification of admission document.

(iii) The name of the recipient's physician.

(iv) The date of admission and date of application for and authorization of MA benefits if application is made after admission.

(v) The initial and subsequent review dates specified under this chapter.

(vi) Documentation by the attending physician justifying the recipient's need for admission.

(vii) Documentation by the attending physician justifying the recipient's continued need for inpatient hospital services if requesting consideration as a day or cost outlier.

(viii) Other supporting material the utilization review committee believes appropriate.

(6) Complete and submit a Hospital Admission DRG/CHR Certification Form for each MA recipient. If the form is not received by the Department within 10 calendar days of admission, payment for the inpatient services will be denied.

(7) Validate that the patient's diagnosis and other information specified in the patient's medical record conforms with the information on the invoice submitted for payment.

(8) Maintain utilization review records for a minimum of 4 years from the end of the fiscal year in which the recipient was discharged.

(9) Submit copies of utilization review records and documents, medical records, certification of admission document and discharge planning information to the Department upon request.

(10) Maintain copies of the certification of admission document with the patient's medical record and with the hospital copy of the invoice submitted for payment.

(11) Initiate discharge planning during the admission review process to provide timely placement in an appropriate level of care for those patients that may require posthospital care.

(12) Follow the procedures specified in the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services in conducting utilization review activities.

[Pa.B. Doc. No. 00-698. Filed for public inspection April 28, 2000, 9:00 a.m.]