30-day Hospital Readmission Billing Policy Audit

Audit Number 2023-01

August 19, 2025

Utah Office of
Inspector General

Gene Cottrell
Inspector General

August 19, 2025

To: Utah Department of Health and Human Services

Please see the attached report, 30-day Hospital Readmissions Billing Policy Audit, (Report 2023-01.) An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 6 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Sen. Heidi Balderee, Social Services Appropriations Subcommittee, Senate Chair
Rep. Raymond Ward, Social Services Appropriations Subcommittee, House Chair
Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
J. Stuart Adams, President of the Utah Senate
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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Utah Office of Inspector General (UOIG) is required through a Memorandum of Understanding (MOU) agreement with the Department of Health and Human Services (DHHS), to review hospital utilization and 30-day hospital readmissions in the Utah Medicaid program, sometimes also referred to as the Division of Integrated Healthcare.

The UOIG examined the prior and current Utah state policies for 30-day hospital readmissions. The UOIG reviewed a case released in 2012 involving 30-day hospital readmission, in which an Administrative Law Judge (ALJ) ruled against the UOIG during an administrative hearing. The ruling was based on the lack of clear policies in the Utah Medicaid Provider Manual, the Administrative Rule, and the State Medicaid plan, and contributes to the possibility of continuous litigation.

The UOIG's review and examination of the outcome of the case, as well as current and historical policies, resulted in the identification of vulnerabilities in Utah Administrative Rule 414-2A, and the Utah Medicaid Hospital Services Provider Manual. Utah Medicaid rules do not currently provide sufficient instruction to guide 30-day readmissions claim reviews. Policy language governing the criteria for 30-day readmission claims should focus on cost effectiveness and outline a clear claim adjudication process.

Utah Medicaid 30-day hospital readmission policies should be based on the requirements in the Affordable Care Act (ACA)[1], Section 3025 Hospital Readmission Reduction Program, and in the Social Security Act (SSA), Section 1886[2], as a cost reduction process for Medicaid and Medicare. Readmission policies serve as a cost-effective measure that commercial payers and other state Medicaid programs adopt to help prevent duplicative payment for similar situations and ensure that Medicaid remains a good steward of taxpayer resources. Each state's Medicaid program may choose to implement the type of 30-day readmission claim process that they feel best meets the needs of their respective program. Many states combine 30-day hospital readmission claims into one Diagnosis Related Group, or DRG, while others deny payment for the second readmission. One state adopted the Medicare model of reducing payment rates for the readmission.

Utah Administrative Rule R414-2A-10 (5) describes the current Hospital Utilization review process, as well as 30-day readmission claims reviews. At present, the rule identifies medical criteria such as medical necessity and appropriateness of care as the goal of utilization review. Medical focus for Utilization review is appropriate, however; the goal of 30-day readmission review is focused on cost savings. Additionally, the rule identifies a requirement to review all 30-day readmission claims. A requirement to review "All" claims may jeopardize the ability of the UOIG to pursue other elevated risks to Medicaid Program Integrity, whereas a review based upon outliers may result in a more targeted review process.

[1] Affordable Care Act, Sec 3025(a)(1)(2)(B)(i)(ii).
[2] Social Security Act, Sec 1886 (1)(2)(4)(5)

Audit Objectives:

- Evaluate Administrative Hearing Case #11-313-02 released in 2012 concerning a 30-day hospital readmission claim where the ALJ ruled against the UOIG.
- Examine prior and current Medicaid 30-day hospital readmission claims policies.
- Review Private insurance companies' policy on 30-day readmissions claims.
- Review previous proposals for change to Medicaid 30-day hospital readmission claims policies within the last five years.
- Determine recommendations, if any, to the Medicaid 30-day hospital readmissions policy.

Audit Findings:

The current Utah Medicaid provider manual for Hospital Services provides no direction to the provider regarding the policies or processes for 30-day hospital readmission. The manual references two Administrative Rules for additional policy and procedural information in chapters 9-9 and 9-10. One of the two referenced rules in each of these chapters is incorrectly cited. A provider manual should offer detailed and accurate instructions to the provider regarding expectation, both in terms of process and policy.

Utah Administrative Rule R414-2A, referenced in the Hospital Services Provider Manual, does not currently identify cost effectiveness as either a goal or criterion, when evaluating, conducting, and processing 30-day hospital readmission claims. The rule also does not define key terms necessary for the successful evaluation and pursuit of 30-day readmission reviews. Consequently, the currently published rule is ambiguous in its purpose and in its guidance on when or how to combine or not combine a 30-day hospital readmission claim.

R414-2A-10 stipulates a review of all 30-day hospital readmission claims within 30 days of the readmission. This requirement results in inefficiencies; the adoption of policies that result in consistent payment procedures for 30-day readmission claims would be a more fiscally responsible and efficient use of taxpayer resources. Then, a targeted review of outliers and other high-risk readmission claims could result, rather than a blanket review of all claims.

The ACA and SSA permit states to determine the most effective method for cost reduction within their Medicaid programs. After reviewing the practices of several other states, the UOIG found that the majority of states examined in this audit automatically require a readmission to be combined with the original admission for the DRG. Some states simply do not reimburse for readmission, while one state adopted the Medicare model of reducing payment rates for readmissions.

DHHS reported that they are working with a Centers for Medicare & Medicaid (CMS) contact to determine if State Plan Amendment (SPA) is necessary, to incorporate 30-day readmission language. As a result, there is a need for DHHS follow-up, and the possible application for and implementation of a SPA, in accordance with CMS guidance.

Recommendations:

- The UOIG recommends that Utah Medicaid publish detailed policies and procedures directing the combination of 30-day hospital readmission claims, unless it is cost effective to bill the claim separately, in the Utah Medicaid Hospital Services Provider Manual.
- The UOIG recommends that Utah Medicaid develop controls that include programmatic edits to prevent automatic payment of any 30-day readmission claims billed outside of Utah Medicaid policy and procedures.
- The UOIG recommends correction to the incorrect Rule references identified in Chapters 9-9 and 9-10 of the Hospital Services Provider Manual.
- The UOIG recommends amendment to R414-2A, to include language that reflects the policies and processes identified in Recommendations 1.1, and 1.2.
- The UOIG recommends amendment to R414-2A-2, to include language that specifies "Cost Effective" means "achieving a desired outcome at the lowest possible cost."
- The UOIG recommends amendment to R414-2A-10(1) to include "cost effectiveness" in the listed purposes of the hospital utilization review program.
- The UOIG recommends amendment to R414-2A-10(2) to include "cost effectiveness" in the listed criterion of the hospital utilization review program.
- The UOIG recommends amendment to R414-2A-10(3) to include "compliance with Utah Medicaid policies and procedures" in the listed criterion.
- The UOIG recommends amendment to R 414-2A-10(3) to include "cost effectiveness" in the listed criterion.
- The UOIG recommends amendment to R414-2A-10(5)(a) to include "cost effectiveness" in the listed criterion.
- The UOIG recommends amendment to R414-2A-10(5)(a) to incorporate language that clearly communicates that readmission for the same or similar diagnosis, appropriateness of inter-facility transfers, appropriate of intra-facility transfers, and cost effectiveness are all criteria that should be considered independently from each of the listed criteria.
- The UOIG recommends amendment to R414-2A-10(5)(b) to remove the word "All" from the requirement to review 30-day readmission claims.
- The UOIG recommends amendment to R414-2A-10(5)(b) to include "cost effectiveness" in the listed criterion.
- The UOIG recommends amendment to R414-2A-10(9)(a) to incorporate language that clearly communicates that the Department shall recover payment when post-payment review finds that services are not medically necessary, not appropriate, that quality of service is not suitable, or that readmission was not cost effective.
- The UOIG recommends amendment to R414-2A-10(9)(b) to clarify that the Department shall recover payment when it determines there is a violation of Utah Medicaid policies and procedures.
- The UOIG recommends the amendment of R414-2A to correctly update and renumber the Rule to include each of the amendments recommended above.
- The UOIG recommends DHHS complete the process with CMS to determine whether a State Plan Amendment is appropriate in this instance, and that DHHS then take immediate action to implement all guidance and direction provided by CMS on this matter.

INTRODUCTION

BACKGROUND

30-Day Hospital readmissions occur when a patient is readmitted to a hospital within 30 days of their discharge, and the hospital readmission is for the same or similar illness that the patient was initially treated for. CMS "recognizes that the frequency of readmission to an acute care hospital shortly after discharge is an indicator of quality of care and, therefore, has implemented a process for reviewing such readmissions"[3]. According to both The National Library of Medicine[4] and the JAMA Network[5], "early hospital readmissions have been recognized as a common and costly occurrence, particularly among elderly and high-risk patients." A September 2023 Statistical Brief by the Agency for Healthcare Research and Quality[6] found that "hospital stays with an expected payer of Medicare had the highest readmission rate, followed by stays with an expected payer rate of Medicaid". Such elevated levels of risk to the patient, combined with an increased risk to taxpayer resources results in a need for governance and monitoring. Consequently, thirty (30)-day hospital readmission policies outlined in Sections 1861(k) and 1886(q) of the Social Security Act (SSA)[7], and Section 3025 of the Affordable Care Act (ACA)[8] provide framework for state Medicaid Authorities to develop policies surrounding this issue.

Section 1861 (k) of the SSA governs hospital Utilization Review. The Act identifies the components each review must meet to be considered sufficient, such as the duration of stay, the medical necessity of services, and the scope of services provided. Section 1886(q) of the SSA defines readmission as, "in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge." It further specifies, "Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(i) such time period (such as 30 days) shall be consistent with the time period specified for such measure." Section 3025 of the ACA amended portions of the SSA related to readmissions. The Centers for Medicare & Medicaid Services (CMS) issued a guidance document regarding the changes and state that they now require a "readmission [payment] adjustment factor that is the higher of a ratio described in Section 3025 of the ACA or a floor specified in section 1886(q)(3) of the Act.[9]" CMS communicated to Utah Medicaid (Centers for Medicare & Medicaid Services, 2015) that "CMS interpretive guidelines state that the UR [Utilization Review] requirements under Medicaid are largely

[3] Tennessee Provider News: Tennessee Medicaid DRG Readmission Payment, 2023 https://providernews.wellpoint.com/tn/articles/tennessee-medicaid-drg-readmission-payment-16287-16287
[4] National Library of Medicine, Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials, 2015 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249925/
[5] JAMA Network (A medical journal published by the American Medical Association) https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1868538
[6] AHRQ 30-Day hospital readmission Statistical Brief https://hcup-us.ahrq.gov/reports/statbriefs/sb304-readmissions-2016-2020.jsp
[7] Social Security Act, Section 1886 (7)(q) Hospital Readmissions Reduction Program (1) to (8).
[8] Affordable Care Act, Section 3025 Hospital Readmissions Reduction Program (a) to (b)
[9] https://www.hhs.gov/guidance/document/affordable-care-act-aca-section-3025-expansion-field-inpatient-provider-specific-file-psf

determined by those under Medicare, and that the UR plan [outlined in these regulations] serves as the plan required by Medicaid…".

In Utah, Medicaid must conduct utilization review for Medicaid claims for members who are admitted to the hospital to determine if the utilization was: "efficient and resulted in the effective delivery of services; services are appropriate, and medically necessary; service quality is maintained; and the State satisfies federal requirements for a statewide surveillance and utilization control program", in accordance with R414-2A-10. Consequently, Utah Medicaid hospital utilization reviews focus on these elements, and evaluate the medical necessity of the claim. However, 30-Day Hospital readmissions are unique; when someone is readmitted for the same or similar medical condition within 30 days of a previous discharge, a question of "medical necessity" for utilization was previously established. As a result, utilization review for 30-Day Hospital readmission does not include a "medically necessary" component. Instead, these claims are evaluated to determine if they meet appropriate payment methodology.

Utah Medicaid hospital utilization reviews are the responsibility of the UOIG. A Memorandum of Understanding, or MOU agreement between the UOIG and DHHS[10] stipulates: "The UOIG shall be responsible for conducting hospital utilization reviews and 30-day readmission reviews in accordance with the State Utilization Control Program."[11] The State Utilization Control Program is not defined in the MOU, but Utah Medicaid reports that it is their name for the process by which the UOIG conducts 30-day readmission reviews.

Historically, the UOIG performed reviews on 30-day hospital readmissions claims based on medical and re-admittance information identified in each respective claim, and in accordance with InterQual evidence-based criteria guidelines[12]. The UOIG scrutinized an administrative hearing case (Case #11-313-02) involving a 30-day hospital readmission hearing in which the ALJ ruled against UOIG and Utah Medicaid 30-day readmission processes. According to the hearing Interlocutory Decision report dated April 11, 2012, and the audio recording of the hearing, the ALJ determined that the Rule and Manual policies were "almost inconsistent". She ruled that "the controlling rules and regulation [should] offer a clear and predictable approach that could be applied in all such cases." She noted, "The State Plan and Administrative Rule, however, do not provide such a directive or guidance, whether read separately or read together. The Plan, Rule, and Manual do not provide clear and consistent instructions on this issue."[13] This issue persists in the current Rule R414-2A-10 and is exacerbated by the lack of policy or procedural guidance in the current Medicaid Hospital Services provider manual. Together, this has resulted in policy vulnerabilities and compromises the UOIG's ability to successfully conduct 30-day readmission claims reviews.

The UOIG examined Utah Medicaid policies for 30-day hospital re-admittance in the Hospital Services Provider Manual and Administrative Rule. The policies changed numerous times since 2012, but in 2017, the policy for 30-day readmittance located in the Hospital Services

[10] MOU, UOIG and DHHS, Section 4.3, Hospital and ICF/ID Utilization Review
[11] MOU between UOIG and DHHS signed 5/10/2023.
[12] InterQual Solutions is an evidence-based clinical decision support solution for payers, providers and government agencies.
[13] Interlocutor decision U of U Vs UOIG case number 11-313-02

Provider Manual was removed, and all versions of the manual since then refer users to Utah Administrative Rules R414-2A and R414-112.

R414-2A-10 governs hospital utilization, as well as 30-day readmission. At present, the rule identifies the purpose of Utilization Control and Review Program for Hospital services as ensuring: "efficient and effective delivery of services; services are appropriately and medically necessary; service quality is maintained; and the State satisfies federal requirements for a statewide surveillance and utilization control program". R414-2A-10(5) details policies for 30-day readmission, directing the claims reviewer to review for: "readmission for the same or similar diagnosis to the same hospital, or a different hospital; appropriateness of inter facility transfers; and appropriateness of intra facility transfers". R414-2A-10(5)(b) mandates the review of "All" suspected readmissions for appropriate medical necessity, discharge, and financial impact to the Department[14].

R414-112, as referenced in the Hospital Services provider manual, does not exist. However, R414-1-12 does exist, and governs Utilization Review (UR). R414-1-12 specifies that the reviewer shall "determine medical necessity and appropriateness of inpatient admissions through utilization reviews. Utilization reviews shall use an evidence-based criteria tool determined by the Department (DHHS) through the state's procurement process". It additionally states that URs shall be conducted "as outlined in the Hospital Services Utah Medicaid Provider Manual" and that "The Department shall use the Hospital Services Utah Medicaid Provider Manual in effect at the time the service is rendered".

The UOIG met with Utah Medicaid policy leadership, claims processing leadership, and staff to learn how 30-day readmission claims are currently processed through the Utah Medicaid system. Utah Medicaid reports that the current process for these claims relies upon post-payment review conducted by the UOIG. The claims in Utah Medicaid's Provider Reimbursement Information System (PRISM) are currently set to a "pay and report" status, and two edits exist to delineate between urban or rural claims. Utah Medicaid reported that intended changes will affect how these claims are processed in their system in the future, but that as of the conclusion of the audit, Medicaid is unable to provide the UOIG with any information or specifics about what the intended changes may entail. However, additional conversations with Utah Medicaid staff and leadership have indicated that there may be an amendment to the process, to incorporate policy surrounding Leave of Absence (LOA) claims processes. The National Uniform Billing Code (NUBC) defines LOA as "Days during which a patient is discharged from the hospital temporarily. A patient may be placed on a leave of absence when readmission is expected for follow-up care or surgery and the patient does not require a hospital level of care during the interim period". NUBC identifies examples of situations where LOA billing is appropriate, including "situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests, but cannot begin immediately". According to NUBC, when one of these situations occurs, "only one bill is prepared for a leave of absence, and one MS-DRG payment is made".

NUBC definitions for correct coding specify that LOA does not apply any time the second admission to the hospital is unexpected. CMS directs, "Institutional providers must not use the

[14] Utah Administrative Code 414-2A-10 Bulletin 2023-19 October 1, 2023/

leave of absence billing procedure when the second admission is unexpected.[15]". Discussions with Utah Medicaid staff indicate that they may consider utilizing broader LOA policies, such as if a Medicaid Member did not improve as desired following discharge, or if a member required readmission to the hospital before an originally anticipated readmission date. Both circumstances, however, indicate an unexpected or unanticipated readmission to the hospital; the readmission would not be planned. Consequently, a LOA policy should not apply when considering a 30-Day readmission claim review in either of those two circumstances. If Utah Medicaid were to adopt LOA policies, those policies should follow NUBC definitions, and delineate between a planned Leave of Absence, and an unplanned readmission within 30-days for the same or similar diagnosis.

The UOIG reviewed and examined the 30-day hospital readmission policies of 15 other states. It was discovered that there is no standardized approach to fulfilling the requirements set out in the ACA or SSA for Medicaid programs. All states reviewed employ clinical requirements for medical necessity in readmissions. However, the manner in which each state addresses readmission payment and documentation processes varies by state. Some states do not reimburse for readmission, while others follow the Medicare example of reducing the payment rate for readmissions. Additionally, some states only pay for readmissions that occur with 72 hours of the initial admission. Some states limit the readmission to 15 days after the initial admission. The interpretation of the federal rules for implementation varies greatly despite the shared goal of reducing the cost of readmission to each respective state's Medicaid program. Despite the variety of processes, most states examined during this audit require the combination of the first admission and the readmission into one DRG, with limited exemptions:

- Illinois follows the Medicare example of reducing the payment rate on the readmission.[16]
- Arizona employs a prepaid system of reviewing the admission and readmission before payment is issued.[17]
- Kentucky combines the original admission and the readmission into one DRG.[18]
- Wyoming doesn't pay for a readmission.[19]
- Tennessee doesn't pay for a readmission.[20]
- New York combines the original admission and the readmission.[21]
- Hawaii combines the admission and readmission.[22]
- Florida combines the admission and the readmission.[23]

[15] Centers for Medicare and Medicaid, Regulations and Guidance, Inpatient Hospital Billing, 40.2.5 Repeat Admissions, Rev. 12948, Issued 11/6/24
[16] Illinois Department of Health and Family Services policy publication Updated September 5, 2014.
[17] AHCCCS APR-DRG payment system design payment policies, July 1, 2016.
[18] Kentucky Medicaid Provider Portal, Inpatient Readmission Policy, Section 3025 Section 1886(q).
[19] Wyoming Inpatient Hospital Reimbursement, Attachment 4.19a Part 1 May 20, 2019.
[20] Tennessee Medicaid DRG readmission payment Provider news Tennessee December 1, 2023.
[21] New York Claim submission, Inpatient Hospital Version 2021-2, 2.3.3.4, September 1, 2021.
[22] State of Hawaii, Department of Human Services, Med-Quest Division, Attachment 4.19-A Effective January 1, 2022.
[23] Florida Providers Bulletins, Wellcare, Inpatient Readmission Policy, Provider Portal.

- South Dakota combines the admission and readmission if within 72 hours of occurrence.[24]
- New Jersey combines the admission and readmission.[25]
- North Carolina combines the admission and readmission. [26]
- Oregon combines the admission and readmission if within 30 days.[27]
- New Mexico combines the admission and readmission. [28]
- Texas combines the admission and readmission if within 15 days.[29]
- Iowa combines all admissions with readmissions within 30 day.[30]

UOIG examined four private insurance provider's 30-day hospital readmissions policies. Like the majority of the state Medicaid policies examined, most of the private insurance companies require combination of the first admission and the readmission:

- Anthem Blue Cross of California combines all 30-day readmissions.[31]
- Blue Cross Blue Shield of Nebraska combines all 30-day hospital readmissions.[32]
- United Healthcare does not pay for a 30-day hospital readmission.[33]
- Healthy Blue, Blue Choice of South Carolina will only pay for combined admissions and readmissions.[34]

FUNDING SOURCE

Information available on the Medicaid and CHIP annual report dashboard for expenditure is unavailable at the time of the audit. Funding for this audit comes from Inpatient Hospital expenditures which would not have a specific line item for readmissions. (As of March 15, 2022)

OBJECTIVES AND SCOPE

Audit Objectives:

- Evaluate Administrative Hearing Case #11-313-20 released in 2012 concerning 30-day hospital readmission claim that the ALJ ruled against the UOIG and Utah Medicaid.

[24] South Dakota Medicaid Billing and Policy Manual, Inpatient Hospital Services, Updated September 2023.
[25] New Jersey Admin code 10:52-14.16, Section 10:52-14.16 Payment for readmission.
[26] North Carolina, Medicaid Acute Inpatient Hospital Services, Clinical Coverage Policy No. 2A-1 Amended June 1, 2023.
[27] Oregon Health Authority, Health Systems Division: Medicaid Assistance Program Chapter 410, Division 125 Hospital Services.
[28] New Mexico Hospital Services, Methods and Standards for establishing Payment-Inpatient Hospital Services 6-1-16
[29] Texas EQRO technical notes, Hospital Quality-Based Program, Potentially Preventable Readmissions, and July 22, 2020.
[30] Iowa Human Services Dept., Administrative Code 249A.4 published 11/14/18
[31] Anthem Blue Cross, Reimbursement Policy effective 7/1/22
[32] Blue Cross Blue Shield Nebraska, Guidelines for Bundling Admission
[33] United Healthcare, Readmission Review Program for Medicare Advantage Plans. 8/02/2022
[34] Healthy Blue, Blue Choice Health Plan of South Carolina, Reimbursement policy 7/1/2022

- Examine prior and current Medicaid 30-day hospital readmission policy.
- Examine Private Insurance companies' policy on 30-day hospital readmissions.
- Examine prior proposals for change to Medicaid 30-day hospital readmission policy.
- Determine recommendation, if any, in the Medicaid 30-day hospital readmission policy.

Audit Scope

Current Medicaid policy for 30-day hospital Readmissions for inpatient hospital stay claims, with lookbacks to 2012.

METHODOLOGY

To evaluate the current Utah Medicaid 30-day hospital readmission policy, UOIG reviewed records from prior discussions on the topic, to determine past issues and adjustments to the policy. UOIG then performed the following:

- Reviewed the current and historical Medicaid Hospital Services Provider Manual Section 9-9 and 9-10.
- Reviewed the current and historical Administrative Rules.
- Reviewed the current Utah State Codes.
- Reviewed the current CMS guidelines.
- Reviewed the guidelines from the ACA.
- Reviewed medical journals and white papers regarding 30-day readmissions and risk factors to beneficiaries
- Reviewed federal and national financial reports and data regarding 30-day readmissions costs.
- Reviewed the policy as written in the Social Security Act, Title XIX.
- Examined the types of reviews performed prior by UOIG PI section.
- Met with UOIG PI Director and UOIG Nurse Investigators regarding historical processes and policy changes necessary to facilitate successful 30-day readmission reviews.
- Reviewed the Utah Medicaid State Plan for 30-day hospital readmission policy guidelines.
- Reviewed the draft policy provided by Utah Medicaid, and currently being updated by Utah Medicaid.
- Reviewed reports from the prior UOIG Assistant Attorney General.
- Reviewed reports from UOIG PI Managers.
- Reviewed reports and policy from prior UOIG Policy Coordinator.
- Obtained audio records of case 11-313-02 from a hearing in which UOIG was ruled against concerning 30-day hospital readmission issued in 2012.
- Obtained the Interlocutory Decision report of a prior hearing involving 30-day readmissions.
- Reviewed the policies of many states Medicaid programs on 30-day hospital readmission.

CONCLUSION

The 30-day hospital readmission review is a required UOIG responsibility, outlined in the MOU agreement between UOIG and DHHS. The basis of the review requirements come from legislation based upon the ACA and SSA. Utah Medicaid has written administrative rule R414-2A-10 to document the process and policy for Utah Medicaid. Federal policies and regulations governing 30-day hospital readmissions are designed to ensure cost effectiveness within the Medicaid program.

The UOIG scrutinized a previous case (Case #11-313-02) involving a 30-day hospital readmission, in which the ALJ ruled against the UOIG and Utah Medicaid, based upon unclear policies in the Rule, the Medicaid provider manual and Utah's State Plan. The State Plan is written in a way that typically does not include detailed procedural guidance; is it expected that the Plan would not contain the breadth of information that a provider manual or Rule should contain. The UOIG additionally concluded that the current 2024 State Plan does not contain any reference to 30-day readmissions. The UOIG met with DHHS to discuss the potential need for a state plan amendment, but as of the conclusion of this audit, DHHS was still awaiting CMS feedback on this matter. Consequently, the UOIG concentrated the audit on the Rule and the Provider Manual as directed in the federal laws and regulations detailed in this report.

UOIG concludes that Utah Medicaid has a choice of the type of cost reduction program to use but needs to ensure that the policy governing the process is properly documented in both the Medicaid Hospital Services provider manual and the administrative rules.

Currently, R414-2A-10(5)(b) requires a review on all 30-day hospital readmissions within 30-day of the readmission date. The UOIG should have the flexibility to determine the scope and direction of work, based upon several factors that may impact the fluctuating levels of risk to the Medicaid program. A requirement to prioritize a review of every 30-day readmission claim over the possibility of emergent or newly identified high risk activities in other program areas within Medicaid may adversely affect the effectiveness of the UOIG's ability to safeguard taxpayer resources and the Medicaid program. These readmission claims are currently set to "pay and report" by Utah Medicaid. A change in how the incoming claims are processed, combined with policy clarification resulting in a post-payment review of 30-day readmission claims based upon risk and cost efficiency may result in lower overall levels of risk, but would require Rule Amendment.

FINDING 1 — Medicaid Provider Manual gives limited guidance and has incorrect references

The current Utah Medicaid Hospital Services Provider Manual, Chapter 9-9, refers the reader to "See Utilization Control Review Program for Hospital Services in Utah Administrative Rule R414-2A." The manual then refers the reader to "Outpatient Hospital Services, and R414-112 Utilization Review". The reference for this Rule is incorrect and should cite R414-1-12. R414-1-12 also does not include detailed procedural information or guidance regarding 30-day hospital readmissions. Beyond these two references, the manual contains no additional policy or programmatic guidance regarding the process or coverage.

The Provider Manual should provide clear direction to the reader as to what is covered and thoroughly detail the process or procedure. Incorrect reference and a lack of procedural guidance may result in confusion or the inability of providers to comply with policy and regulatory requirements. Policies should guide the reader to a quick and accurate understanding of the policy and what the provider should do, without need for multiple additional searches.

Similar to Chapter 9-9, Chapter 9-10, Exceptions to the 30-day Readmissions Policy, only references the above-mentioned Rules and does not include any additional guidance or explanation as to what the policy and procedure is. A lack of clear guidance in a manual meant to direct provider behavior is unlikely to result in the desired outcome.

The UOIG reviewed 15 state Medicaid programs and 4 private insurance companies' 30-day hospital readmission policies. Most of the reviewed policies combine the original admission with the readmission. The next most common practice was to not pay for the readmission. One state, Illinois, used the Medicare model of reducing payment rates on the readmission. CMS guidance and recent approvals for several state's State Plan, Medicaid Waivers, and State Plan Amendments have included requirements for prepayment claim review. Utah Medicaid's current process for 30-day readmission claims is set to "pay and report" and relies solely upon manual post-payment review. Utah Medicaid reported that they do not currently conduct prepayment review of these claims. Prepayment review can take many forms, such as edits within the PRISM system that result in automatic denial of inappropriately billed 30-day readmission claims. Aligning Utah's 30-day readmission policies to result in automatic denial of inappropriately billed claims and clear processes for the combination of the original and readmission claim, would likely result in a more efficient use of taxpayer resources through a combination of both a prepayment and post-payment review process.

Recommendations

1.1 The UOIG recommends that Utah Medicaid publish detailed policies and procedures directing the combination of 30-day hospital readmission claims, unless it is cost effective to bill the claim separately, in the Utah Medicaid Hospital Services Provider Manual.

1.2 The UOIG recommends that Utah Medicaid develop controls that include programmatic edits to prevent automatic payment of any 30-day readmission claims billed outside of Utah Medicaid policy and procedures.

1.3 The UOIG recommends correction to the incorrect Rule references identified in Chapters 9-9 and 9-10 of the Hospital Services Provider Manual.

FINDING 2 — Medicaid 30-day Readmission policies in R414-2A are ambiguous and difficult to enforce

The Utah Medicaid Provider Manual for Hospital Services does not contain any direction or policy or procedural information about 30-day hospital readmissions. Instead, it directs readers to Utah Administrative Code for the Hospital Utilization Review Program, under R414-2A. R414-2A lacks key definitions and does not identify cost effectiveness as either a goal or criterion when conducting 30-day readmission claims reviews. The currently written rule, and discussions with Utah Medicaid regarding potential rule amendments, each feature "Medically Necessary" as criterion for determining the allowability in hospital utilization claim reviews. Although a medical necessity determination is a vital component to general hospital utilization review, it is not the goal of 30-Day Hospital readmission utilization review. The purpose of 30-Day Hospital readmission review is to determine if the payment methodology used was appropriate for that claim, or if the claim should follow alternative payment methodology processes applied in instances when a Medicaid member is readmitted to the hospital within 30 days of discharge for the same or similar diagnosis. Criteria for 30-Day Hospital readmission utilization review within the rule should therefore be separated from other hospital utilization review criteria and focus on a question of whether the readmission claim was "Cost Effective", rather than "Medically Necessary".

R414-2A-2, Definitions, does not include definitions for either "Cost Effectiveness" or "Medically Necessary". The UOIG met with DHHS, as well as UOIG legal counsel, and agreed that a need to identify cost effectiveness in 30-day readmission claims reviews existed, in relation to R414-2A. DHHS staff reported that they felt the definition for "Medically Necessary" found in R414-1-2(18)(b) would suffice to meet this need. That definition currently states, ""Medically necessary service" means that: (a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and (b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly." UOIG legal counsel disagreed with this assessment; multiple Utah Assistant Attorney Generals (AAG) consulted each determined that the definition for "Medically Necessary" located in R414-1-2(18) did not provide suitable grounds for successful claim recoupment, should a 30-day readmission claim review result in an Administrative Hearing. Instead, Utah AAGs suggested that DHHS amend R414-1-2, to define "Cost Effective" as "achieving a desired outcome at the lowest possible cost.".

R414-2A-10(1) does not currently identify cost effectiveness as a purpose for 30-day readmission claims reviews. The rule currently identifies efficient and effective delivery of services, services that are appropriate and medically necessary, the maintenance of service quality, and compliance with federal requirements, but it does not speak to the need to review these claims to ensure policy compliance or the cost effectiveness of billing practices. Similarly, R414-2A-10(3) does not include either cost effectiveness or Utah Medicaid provider manual policy compliance as part of the directive to conduct 30-day readmission assessments. Nor does R414-2A(10)(5) include cost effectiveness as criterion that must be used to conduct these assessments and ensure the appropriateness of Medicaid claim submissions. R414-2A(10)(9) also does not identify a requirement to evaluate whether or not readmission was cost-effective, when directing the recovery process of Medicaid funds. Discussions with the staff who historically conducted 30-day readmission claims reviews revealed that these

reviews were most successful when cost effectiveness was the primary goal of the reviews. Consequently, ensuring cost effectiveness and Utah Medicaid policy compliance should each be identified as both a purpose and criterion for conducting reviewing 30-day readmissions claims reviews.

R414-2A-10(5)(b) describes the process of reviewing "All" Medicaid claims for readmission within 30-days of the original admission to a hospital providing Medicaid services. The ACA and SSA are the federal laws that the program is based on. They allow each state to determine what is the best method for cost savings and the reduction of readmissions for their Medicaid program. The removal of the word "all" from the rule, combined with the other changes listed here, would provide the Hospital Utilization Review Program the necessary flexibility to target their efforts toward areas of non-compliance or high risk, such as outliers.

The UOIG reviewed R414-2A and found it ambiguous and difficult to enforce. The primary rationale behind 30-day readmission regulations is to reduce the frequency and cost of readmission to a hospital. UOIG determined that in the review process if a claim did not meet the clinical requirements of medical necessity for readmission, the claim would be denied. The process of determining the payment method was difficult to follow and enforce. The rule does not give clear expectations to the provider regarding whether to combine the readmission with the original admission or to bill the readmission as a separate billing apart from the original admission. The current Administrative Rule therefore requires amendment, and policies in both the Rule and the manual should have clear guidance that the provider can understand and follow.

Recommendations

2.1 The UOIG recommends amendment to R414-2A, to include language that reflects the policies and processes identified in Recommendations 1.1 and 1.2.

2.2 The UOIG recommends amendment to R414-2A-2, to include language that specifies "Cost Effective" means "achieving a desired outcome at the lowest possible cost."

2.3 The UOIG recommends amendment to R414-2A-10(1) to include "cost effectiveness" in the listed purposes of the hospital utilization review program.

2.4 The UOIG recommends amendment to R414-2A-10(2) to include "cost effectiveness" in the listed criterion of the hospital utilization review program.

2.5 The UOIG recommends amendment to R414-2A-10(3) to include "compliance with Utah Medicaid policies and procedures" in the listed criterion.

2.6 The UOIG recommends amendment to R 414-2A-10(3) to include "cost effectiveness" in the listed criterion.

2.7 The UOIG recommends amendment to R414-2A-10(5)(a) to include "cost effectiveness" in the listed criterion.

2.8 The UOIG recommends amendment to R414-2A-10(5)(a) to incorporate language that clearly communicates that readmission for the same or similar diagnosis, appropriateness of inter-facility transfers, appropriateness of intra-facility transfers, and cost effectiveness are all criteria that should be considered independently from each of the listed criteria.

2.9 The UOIG recommends amendment to R414-2A-10(5)(b) to remove the word "All" from the requirement to review 30-day readmission claims.

2.10 The UOIG recommends amendment to R414-2A-10(5)(b) to include "cost effectiveness" in the listed criterion.

2.11 The UOIG recommends amendment to R414-2A-10(9)(a) to incorporate language that clearly communicates that the Department shall recover payment when post-payment review finds that services are not medically necessary, not appropriate, that quality of service is not suitable, or that readmission was not cost effective.

2.12 The UOIG recommends amendment to R414-2A-10(9)(b) to clarify that the Department shall recover payment when it determines there is a violation of Utah Medicaid policies and procedures.

2.13 The UOIG recommends the amendment of R414-2A to correctly update and renumber the Rule to include each of the amendments recommended above.

FINDING 3 — The Utah Medicaid State Plan may require amendment

The current Utah Medicaid State Plan does not include any reference to 30-day readmission reviews. The UOIG met with DHHS staff to determine the potential need for amendment. DHHS reported that they are working with their CMS contacts to determine need, but at the time of the conclusion of the audit, DHHS was still awaiting a response from CMS.

Recommendation

3.1 The UOIG recommends DHHS complete the process with CMS to determine whether a State Plan Amendment is appropriate in this instance, and that DHHS then take immediate action to implement all guidance and direction provided by CMS on this matter.

Appendix: Current R414-2A

R414. Health and Human Services, Integrated Healthcare.
R414-2A. Inpatient Hospital Services.
R414-2A-1. Introduction and Authority.

This rule defines the scope of inpatient hospital services that are available to Medicaid members. This rule is authorized under Section 26B-3-108 and governs the services allowed under 42 CFR 440.10.

R414-2A-2. Definitions.

(1) "Admission" means the acceptance of a Medicaid member for inpatient hospital care and treatment when the member meets established criteria for severity of illness and intensity of service and the required service cannot be provided in an alternative setting.
(2) "Inpatient" is an individual whose severity of illness and intensity of service requires continuous care in a hospital.
(3) "Inpatient Hospital Intensive Physical Rehabilitation" means an intense program of physical rehabilitation provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.
(4) "Inpatient Hospital Services" are services that a hospital provides for the care and treatment of inpatients.
(5) "Observation services" means services, often less than 24 hours, including use of a bed and monitoring by hospital staff, which are reasonable and necessary to evaluate the medical condition or determine the need for a possible admission to the hospital.
(6) "Prepaid Mental Health Plan" means the Medicaid mental and/or substance use disorder managed care plan that covers inpatient and/or outpatient mental health services and outpatient substance use disorder services for PMHP-enrolled Medicaid members.

R414-2A-3. Member Eligibility Requirements.

Inpatient hospital services are available to categorically and medically needy individuals.

R414-2A-4. Hospital Admission Requirements.

(1) An inpatient hospital must meet Medicare participation requirements.
(2) Each hospital that provides inpatient services must have a utilization review plan as described in 42 CFR 482.30.
(3) Each hospital that accepts a Medicaid member for treatment is responsible to verify that the member receives all medically necessary services from Medicaid providers.
(4) Each hospital is financially responsible for any services a member receives from a non-Medicaid provider.
(5) Inpatient hospital intensive physical rehabilitation participation is subject to 42 CFR 482.56 and 42 CFR 412, Subpart B and Subpart P.

R414-2A-5. Prepaid Mental Health Plan.

Before admitting a Prepaid Mental Health Plan (PMHP) member for an inpatient psychiatric stay, a hospital must obtain prior authorization from the PMHP serving the member's county of residence. If the hospital is not contracted with the PMHP, the PMHP may choose to transfer the member to a contracted hospital.

R414-2A-6. Service Coverage.

(1) Inpatient hospital services must be medically necessary and ordered by an appropriate Medicaid-enrolled provider for the diagnosis and treatment of a member's illness.
(2) Services performed for a member by the admitting hospital or by an entity wholly-owned or wholly-operated by the hospital within three days of patient admission, are considered inpatient services. This three-day window

applies to diagnostic and non-diagnostic services that are clinically related to the reason for the member's inpatient admission regardless of whether the inpatient, outpatient, or observation diagnoses are the same.
(3) Medical supplies, appliances, drugs, and equipment required for the care and treatment of a member during an inpatient stay are included in the inpatient reimbursement.
(4) Outpatient hospital services during an inpatient episode are included in the inpatient reimbursement.
(5) Inpatient hospital psychiatric services are available to all Medicaid members. If the member is not enrolled in a PMHP, providers may bill the State directly on a fee-for-service basis. Otherwise, the provider must bill the member's PMHP.
(6) Inpatient hospital intensive physical rehabilitation services must meet the classification criteria of 42 CFR 412.29.
(7) Inpatient hospital intensive physical rehabilitation services are covered for acute conditions from birth through any age and are available one time per event.

R414-2A-7. Limitations.

Inpatient hospital care is limited to medical treatment of symptoms that lead to medical stabilization of the member. This medical stabilization care is irrespective of any underlying psychiatric diagnosis.
(1) Detoxification for a substance use disorder in a hospital shall meet the criteria in the Department's evidence-based criteria tool for inpatient detoxification. The Department does not cover any lesser level of detoxification in an inpatient hospital. The standards for the evidence-based criteria tool shall be in accordance with Section R414-1-12.
(2) Abortion procedures require prior authorization. Refer to Rule R414-1B.
(3) Sterilization and hysterectomy procedures require prior authorization and must meet the requirements of 42 CFR 441, Subpart F.
(4) Organ transplant services are governed by Rule R414-10A.
(5) Take-home supplies, dressings, non-rental durable medical equipment, and drugs are included in the inpatient reimbursement.
(6) Coverage of sleep studies requires sleep center accreditation through one of the following nationally recognized accreditation organizations:
(a) American Academy of Sleep Medicine (AASM);
(b) Accreditation Commission for Health Care (ACHC); or
(c) The Joint Commission (TJC).
(7) Hyperbaric oxygen therapy is limited to service in a facility in which the hyperbaric unit is accredited by the Undersea and Hyperbaric Medical Society. Hyperbaric oxygen therapy is therapy that places the member in an enclosed pressure chamber for medical treatment.
(8) Medicaid does not cover inpatient services solely for pain management. Pain management is adjunct to other Medicaid services.
(9) Inpatient rehabilitation services require prior authorization.
(10) Observation services are limited to cases where observation and evaluation is required to establish a diagnosis and determine the appropriateness of an inpatient admission or discharge. Observation is used to monitor the member's condition, complete diagnostic testing to establish a definitive diagnosis and formulate the treatment plan.
(a) Medicaid covers observation services with a physician's written order that outlines specific medically necessary reasons for the service, such as the member requires more evaluation to determine the severity of illness through laboratory, imaging, or other diagnostic test, and an order to continue monitoring for clinical signs and symptoms to determine improving or declining health status.
(b) Outpatient procedures include an uneventful recovery period.
(i) Observation is used to monitor complications of outpatient procedures beyond an uneventful recovery period.
(c) Medicaid does not cover observation services for convenience of the hospital, member or family, or when awaiting transfer to another facility.
(d) When an ordered hospital inpatient admission improves to the point of discharge with a stay less than 24 hours, the admission is covered as inpatient when documentation supports the medical necessity.
(e) Inpatient admissions solely for observation or diagnostic evaluation do not qualify for reimbursement under the diagnosis-related group (DRG) system.
(11) Medicaid does not cover admission solely for the treatment of eating disorders.
(12) Medicaid does not cover non-physician psychosocial counseling outside of the DRG.
(13) An undocumented immigrant who does not meet United States residency requirements may only receive emergency services, including emergency labor and delivery, to treat an emergency medical condition.
(a) Medicaid does not cover prenatal and post-partum services for undocumented immigrants.

(b) Medicaid does not cover prescriptions for a member who is eligible to receive emergency services only.
(14) Inpatient hospital intensive physical rehabilitation services are not covered when the condition and prognosis meet the requirements of placement into a long-term facility, skilled nursing facility, or outpatient rehabilitation service.
(15) Medicaid does not cover admission for deconditioning in an inpatient hospital intensive physical rehabilitation facility.
(16) Inpatient hospital intensive physical rehabilitation services for a member who has suffered a stroke or other cerebral vascular accident may be provided only when admission and therapy is initiated within the first 60 days after onset of the incident.

R414-2A-8. Provider-Preventable Conditions.

(1) Medicaid does not pay for Provider Preventable Conditions (PPC).
(a) Medicaid utilizes the Medicaid Severity-Diagnosis Related Group (MS-DRG) to identify a PPC.
(b) For inpatient hospital claims, Medicaid does not cover PPCs in Medicare crossover patients.
(c) To qualify as a PPC, one of the Medicare-listed diagnoses must develop during hospitalization.
(i) When present on admission, these diagnoses are not considered to be a PPC for that hospitalization.
(ii) Providers are expected to identify Present on Admission (POA) status for all diagnoses on each claim according to correct coding standards.
(d) Providers must assure that all PPC-related diagnoses, services, and charges are noted as "non-covered charges" on the claim.
(i) The Department does not use non-covered charges in calculating the hospital reimbursement.
(e) The Department shall deny PPC-related claims that result in an outlier payment and medical records will be required.
(i) Providers will receive Remittance Advice (RA) that confirms the occurrence of a PPC outlier claim.
(ii) The Department requires providers to know which medical records and other required documents are needed.
(iii) Upon RA notification of a PPC, the provider shall submit the following documents within 30 days:
(A) "Outlier PPC Medical Record Documentation Submission Form";
(B) Complete medical records from the associated hospital stay;
(C) Itemized bill (tab de-limited text file or Excel spreadsheet), including a detailed listing of PPC-related charges as non-covered charges, with total charges matching the total charges submitted on the claim.
(f) The Department will review and, if appropriate, re-process the claim based upon the review of the required documents submitted within the 30-day period of RA notification.
(g) The Department shall deny review of the claim unless the required documentation is submitted within 30 days of RA notification.
(h) The Department requires providers to report PPCs in accordance with Section R414-1-28.

R414-2A-9. Reporting Routine Services.

Routine services in a hospital must be included in a daily service charge, also referred to as room and board. These types of routine services that are not separately reported include:
(1) Room;
(2) Dietary services;
(3) Nursing services;
(4) Minor medical and surgical supplies;
(5) Medical and psychiatric social services;
(6) Use of hospital and facilities;
(7) Drugs, biologicals, supplies, appliances, and equipment, such as:
(a) Anything necessary or otherwise integral to the provision of a specific service, the delivery of services in a specific location, or both;
(b) Items and supplies that may be purchased over the counter;
(c) Reusable items, supplies, and equipment that are provided to all patients admitted to a given treatment area or unit receiving the same service;
(d) Certain other diagnostic or therapeutic services;
(e) Medical or surgical services provided by certain interns or residents-in-training; and
(f) Transportation services, including transport by ambulance.

R414-2A-10. Utilization Control and Review Program for Hospital Services.

The Hospital Utilization Review Program is administered and operated in accordance with Title 63A, Chapter 13.
(1) The purpose of the hospital utilization review program is to ensure:
(a) efficient and effective delivery of services;
(b) services are appropriate and medically necessary;
(c) service quality is maintained; and
(d) the State satisfies federal requirements for a statewide surveillance and utilization control program.
(2) The Hospital Utilization Review Program shall conduct assessments and audits to ensure the appropriateness and medical necessity of the following:
(a) Admissions to a hospital or a designated distinct part unit within a hospital;
(b) Transfers from one acute care hospital to another acute care hospital, or to an inpatient rehabilitation hospital or psychiatric unit in another acute care hospital (inter-facility transfer);
(c) Transfers from an acute care setting to an inpatient rehabilitation unit of a hospital or psychiatric unit within the same facility (intra-facility transfer);
(d) Continued stays;
(e) Services, surgical services and diagnostic procedures;
(f) Principal diagnosis, principal surgical procedure or both, reflected on paid claims to ensure consistency with the attending physician's determination and documentation as found in the member's medical record;
(g) Determine whether co-morbidity, as found on the claim, is correct and consistent with the attending physician's determination and compatible with documentation found in the member's medical record; and
(h) Quality of care.
(3) The Hospital Utilization Review Program shall conduct assessments and audits to determine:
(a) Appropriate utilization;
(b) Compliance with state and federal Medicaid regulations;
(c) Whether documentation meets state and federal requirements for sufficiency, and whether it accurately describes the status of services provided to the member; and
(d) Whether procedures that require prior authorization have been approved before the provision of services, except in cases that meet the criteria listed in the Utah Medicaid Section 1: General Information Provider Manual (Retroactive Authorization).
(4) The Hospital Utilization Review Program shall make determinations of medical necessity, appropriateness of care, and suitability of discharge planning in accordance with the following criteria and protocols:
(a) InterQual Criteria;
(b) Administrative rules or criteria developed by Medicaid for programs and services not otherwise addressed; and
(c) DRGs.
(5) Hospital Utilization Readmission Policy and Reviews.
(a) Whenever information available to the reviewer indicates the possibility of readmission to acute care within 30 days of the previous discharge, the staff administering and operating the Hospital Utilization Review Program may review any claim for:
(i) Readmission for the same or a similar diagnosis to the same hospital, or to a different hospital;
(ii) Appropriateness of inter-facility transfers; and
(iii) Appropriateness of intra-facility transfers.
(b) The Hospital Utilization Review Program shall review all suspected readmissions within 30 days of a previous discharge to ensure that Medicaid criteria have been met for severity of illness, intensity of service, and appropriate discharge planning and financial impact to the Department as noted in Subsection R414-2A-10(3).
(c) If a member is readmitted for the same or similar diagnosis within 30 days of discharge and, if after review as described in Subsection R414-2A-10(5)(b), program review staff determines that readmission does not meet the criteria in Subsection R414-2A-10(3)(b), then the payment shall be combined into a single DRG payment, unless it is cost effective to pay for two separate admissions. The first DRG (initial admission) shall be the DRG that is paid. This policy does not apply to cases related to pregnancy, neonatal jaundice, or chemotherapy.
(6) Definition, Policy Application.
(a) When applying policy, a similar diagnosis is defined as:
(i) Any diagnoses code with similar descriptors;
(ii) Any exchange or combination of principal and secondary diagnosis; and
(iii) Any other sets of principal diagnoses established to be similar by Utah Medicaid policy in written criteria and published to the hospitals prior to service dates.
(b) The evaluation criteria for utilization control are severity of illness, intensity of service, and cost effectiveness as noted in Subsection R414-2A-10(5)(b).

(7) Appropriate remedial action will be initiated for inappropriate readmissions when identified though the hospital utilization post-payment review process.
(8) Applicability to Outpatient Hospital Services.
(a) When a Medicaid member is readmitted to the hospital, or readmitted as an outpatient within 30 days of a previous discharge for the same or similar diagnosis, Medicaid will evaluate both claims to determine if they should be combined into a single payment or paid separately.
(9) Recovery of Funds.
(a) The Department shall recover payment when post-payment review finds that services are not medically necessary, not appropriate, or that quality of service is not suitable.
(b) The Department shall recover payment when it determines there is a violation of the 30-day re-admission policy.
(10) Hospital Utilization Review.
(a) Each month, the Hospital Utilization Review Program shall review at least 5 percent of a selected universe of claims adjudicated in the previous month. At least 2.5 percent of the claims shall be a random sample. Up to 2.5 percent may be a focused review on a specific service. A staff decision to focus on a specific service shall be made no later than the beginning of the sample cycle.
(b) The Department shall select the universe from paid inpatient hospital claims within the Data Warehouse. The universe from which the random sample is selected is defined as all inpatient hospital claims adjudicated before the beginning of the review cycle, except for:
(i) Claims showing, as a principal diagnosis, any International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) delivery code in the ICD-10-CM Manual Chapter 15 -- Pregnancy, Childbirth, and the Puerperium, in the range of O00 through O9A.53, and other ICD-10-CM codes or DRG or DRGs as specified by policy or administrative decision.
(ii) Claims that show $0 payment by Medicaid;
(iii) Medicare crossover claims;
(iv) Claims with other codes or diagnoses determined by the review program staff to be inappropriate for review.
(c) The sample cycle shall begin on the first working day of each month.
(11) Utah State Hospital Utilization Review.
(a) The purpose of this utilization review is to ensure that Medicaid funds, as defined under 42 CFR 456, Subpart D, are expended appropriately and to ensure that services provided to Medicaid members at the Utah State Hospital (USH) are necessary and of high quality. Review program staff shall conduct oversight activities at USH.
(b) Oversight activities include quarterly clinical utilization reviews in which program staff review a sample of members who are under 21 years of age and are 65 years of age or older, and who were reviewed by USH utilization review staff during a previous quarter. These reviews are performed to:
(i) Evaluate the USH utilization process; and
(ii) Address the clinical topic selected for that quarter's review.
(c) Reviews of USH Quality Improvement and Quality Assurance programs are conducted to determine whether:
(i) The programs have been implemented in accordance with written hospital policy;
(ii) The programs are effective in meeting stated goals;
(iii) Improvements or modifications have been made to increase the effectiveness of program design.
(12) Applicability to Inpatient Psychiatric Care and Inpatient Rehabilitation Services.
(a) Provisions in the Hospital Utilization Review Program also apply to inpatient psychiatric care and inpatient rehabilitation services.

R414-2A-11. Cost Sharing.

A Medicaid member is responsible for a copayment as established in the Utah Medicaid State Plan and incorporated by reference in Rule R414-1.

R414-2A-12. Reimbursement.

Reimbursement for inpatient hospital services is in accordance with Attachment 4.19-B of the Utah Medicaid State Plan, which is incorporated by reference in Rule R414-1.

KEY: Medicaid
Date of Last Change: November 10, 2023
Notice of Continuation: September 14, 2022
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108; 26B-3-110

GLOSSARY OF TERMS

Term	Description
AAG	Assistant Attorney General
ACA	Affordable Care Act
ALJ	Administrative Law Judge
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis Related Group
DHHS	Utah Department of Health and Human Services
LOA	Leave of Absence
MOU	Memorandum of Understanding
NUBC	National Uniform Billing Code
PRISM	Provider Reimbursement Information System
SPA	State Plan Amendment
SSA	Social Security Act
UOIG	Utah Office of Inspector General
UR	Utilization Review, as defined in Section 1861(k) of the SSA

MANAGEMENT RESPONSE

State of Utah

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Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
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Deputy Director

July 31, 2025

Gene Cottrell
Inspector General
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P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

On behalf of the Department of Health and Human Services, thank you for the opportunity to respond to the audit titled *30-day Hospital Readmission Billing Policy Audit (Audit Number 2023-01)*. I appreciate the effort and professionalism of you and your staff in this review. The final product reflects a significant effort and time of the DHHS staff collecting information for OIG review, answering questions, and planning changes to improve the program. This audit and its responses will result in a better, more efficient program.

DHHS agrees with the recommendations in this report. DHHS is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Jennifer Strohecker (Jul 24, 2025 11:14:59 MDT)

Jennifer Strohecker, PharmD, BCPS
Medicaid Director
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Response to Recommendations

Finding 1: Medicaid Provider Manual gives limited guidance and has incorrect references

Recommendation 1.1

The UOIG recommends that Utah Medicaid publish detailed policies and procedures directing the combination of 30-day hospital readmission claims, unless it is cost effective to bill the claim separately, in the Utah Medicaid Hospital Services Provider Manual.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will publish detailed policies and procedures within the Utah Medicaid Hospital Services Provider Manual and Utah Administrative Code R414-2A, directing the combination of 30-day hospital readmission claims, unless it is cost-effective to bill the claims separately.

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 1.2

The UOIG recommends that Utah Medicaid develop controls that include programmatic edits to prevent automatic payment of any 30-day readmission claims billed outside of Utah Medicaid policy and procedures.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will develop controls that include programmatic edits to prevent automatic payment of 30-day readmission claims billed outside of the established policies and procedures. These updates will include improvement to the editing for claims that may or may not meet the 30-day readmission policy. We will pursue a PRISM system change that will consider claim diagnoses to screen conditions (e.g., cancer, pregnancy, etc.) that are allowable under the improved readmission policy. Diagnoses that do not meet these specific conditions will be flagged for post-payment review.

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 1.3

The UOIG recommends correction to the incorrect Rule references identified in Chapters 9-9 and 9-10 of the Hospital Services Provider Manual.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update the manual to remove the incorrect references.

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.1

The UOIG recommends amendment to R414-2A, to include language that reflects the policies and processes identified in Recommendations 1.1 and 1.2.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update the R414-2a to reflect policies in the manual.

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.2

The UOIG recommends amendment to R414-2A-2, to include language that specifies "Cost Effective" means "achieving a desired outcome at the lowest possible cost."

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-2 to include the definition of cost effective to state: "'Cost Effective' means achieving a desired outcome at the lowest possible cost, while considering the definition of medically necessary service in R414-1-2(18), and how resources used align with R414-2A-10(1)."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.3

The UOIG recommends amendment to R414-2A-10(1) to include "cost effectiveness" in the listed purposes of the hospital utilization review program.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(1)(b) to state: "(b) services are appropriate, cost-effective, and medically necessary;"

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.4

The UOIG recommends amendment to R414-2A-10(2) to include "cost effectiveness" in the listed criterion of the hospital utilization review program.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will amend R414-2A-10(2) to state: "The Hospital Utilization Review Program shall conduct assessments and audits in accordance with the purpose defined in R414-2A-10(1) to ensure the appropriateness and medical necessity of the following:"

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.5

The UOIG recommends amendment to R414-2A-10(3) to include "compliance with Utah Medicaid policies and procedures" in the listed criterion.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(3) to state:

"(3) The Hospital Utilization Review Program shall conduct assessments and audits to determine:

(a) Appropriate utilization;

(i) Medical necessity as defined in R414-1-2(18)

(ii) cost-effectiveness

(b) Compliance with state and federal Medicaid regulations;

(c) Compliance with the Division of Integrated Healthcare published policies and procedures.

(d) Whether documentation meets state and federal requirements and whether it accurately describes the status of services provided to the member; and

(e) Whether procedures that require prior authorization have been approved before the provision of services, except in cases that meet the criteria listed in the Utah Medicaid Section 1: General Information Provider Manual (Retroactive Authorization)."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.6

The UOIG recommends amendment to R 414-2A-10(3) to include "cost effectiveness" in the listed criterion.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(3) to state:

"(3) The Hospital Utilization Review Program shall conduct assessments and audits to determine:

(a) Appropriate utilization;

(i) Medical necessity as defined in R414-1-2(18)

(ii) cost-effectiveness

(b) Compliance with state and federal Medicaid regulations;

(c) Compliance with the Division of Integrated Healthcare published policies and procedures.

(d) Whether documentation meets state and federal requirements and whether it accurately describes the status of services provided to the member; and

(e) Whether procedures that require prior authorization have been approved before the provision of services, except in cases that meet the criteria listed in the Utah Medicaid Section 1: General Information Provider Manual (Retroactive Authorization)."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.7

The UOIG recommends amendment to R414-2A-10(5)(a) to include "cost effectiveness" in the listed criterion.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(5)(a) to state: "(a) Whenever information available to the reviewer indicates the possibility of readmission to acute care within 30 days of the previous discharge, the staff administering and operating the Hospital Utilization Review Program may review any claim for the purposes outlined in R414-2A-10(1) and:"

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.8

The UOIG recommends amendment to R414-2A-10(5)(a) to incorporate language that clearly communicates that readmission for the same or similar diagnosis, appropriateness of inter-facility transfers, appropriateness of intra-facility transfers, and cost effectiveness are all criteria that should be considered independently from each of the listed criteria.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(5)(a) to state: "(a) Whenever information available to the reviewer indicates the possibility of readmission to acute care within 30 days of the previous discharge, the staff administering and operating the Hospital Utilization Review Program may review any claim for the purposes outlined in R414-2A-10(1) and:"

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.9

The UOIG recommends amendment to R414-2A-10(5)(b) to remove the word "All" from the requirement to review 30-day readmission claims.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(5)(b) to state: "(b) The Hospital Utilization Review Program shall review suspected readmissions within 30 days of a previous discharge to ensure that Medicaid criteria have been met for severity of illness, intensity of service, and appropriate discharge planning and financial impact to the Department as noted in Subsection R414-2A-10(3)."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.10

The UOIG recommends amendment to R414-2A-10(5)(b) to include "cost effectiveness" in the listed criterion.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(5)(b) to state: "(b) The Hospital Utilization Review Program shall review suspected readmissions within 30 days of a previous discharge to ensure that Medicaid criteria have been met for severity of illness, intensity of service, and appropriate discharge planning and financial impact to the Department as noted in Subsection R414-2A-10(3)."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.11

The UOIG recommends amendment to R414-2A-10(9)(a) to incorporate language that clearly communicates that the Department shall recover payment when post-payment review finds that services are not medically necessary, not appropriate, that quality of service is not suitable, or that readmission was not cost effective.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(9)(a) to state: "(a) The Department shall recover payment, in accordance with R414-1-14(3) when the utilization review program review finds that services do not meet the requirements of R414-2A."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.12

The UOIG recommends amendment to R414-2A-10(9)(b) to clarify that the Department shall recover payment when it determines there is a violation of Utah Medicaid policies and procedures.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will update R414-2A-10(9)(a) to include the reference to R414-1-14(3) to state that the Department can recover payments and delete R414-2A-10(9)(b). The new rule will state: "(a) The Department shall recover payment, in accordance with R414-1-14(3) when the utilization review program review finds that services do not meet the requirements of R414-2A."

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 2.13

The UOIG recommends the amendment of R414-2A to correctly update and renumber the Rule to include each of the amendments recommended above.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will renumber the rule.

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 3.1

The UOIG recommends DHHS complete the process with CMS to determine whether a State Plan Amendment is appropriate in this instance, and that DHHS then take immediate action to implement all guidance and direction provided by CMS on this matter.

Department Response:

DHHS agrees with this recommendation.

What: Utah Medicaid will work with CMS to determine whether a State Plan Amendment is appropriate.

When: 07/01/2026

Contact: James Stamos, Director, Office of Health Policy and Authorization

EVALUATION OF MANAGEMENT RESPONSE

UOIG appreciates the response provided by DHHS to this audit. Based on its response, DHHS agrees with the audit recommendations and is taking measures to address the audit findings. UOIG looks forward to the implementation of those measures and will review the actions taken.

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UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services will protect taxpayer dollars by identifying fraud, abuse and waste risks and vulnerabilities in the State Medicaid Program and by taking action to mitigate or eliminate those risks.

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