**Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements**

Effective for dates of discharge on or after July 1, 2014:

a) Utilization Review

The Department, or its designated peer review organization, shall conduct utilization review in compliance with Section 1152 of the Social Security (42 U.S.C. 1320c-1) and 42 (Chapter IV, Subchapter F (October 1, 2013). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its branches, engaged in the active practice of medicine, board certified or board eligible in the physician's specialty and has admitting privileges in one or more Illinois hospitals. Payment will only be made for those admissions and days approved by the Department or its designated peer review organization. Utilization review may consist of, but not be limited to, preadmission, concurrent, pre-payment, and post-payment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, 2013), the following:

1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;

2) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges, including, but not limited to, the coordination of care requirements defined in Section 148.40(a)(9) for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program;

3) Through DRG validation, the validity of diagnostic and procedural information supplied by the hospital;

4) The completeness, adequacy and quality of hospital care provided;

5) Whether the quality of the services meets professionally recognized standards of health care; or

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

b) Notice of Utilization Review

The Department shall provide hospitals with notice 30 days before a service is subject to utilization review, as described in subsections (c), (d), (e) and (f) of this Section, that the service is subject to such review. In determining whether a particular service is subject to utilization review, the Department may consider factors that include:

1) Assessment of appropriate level of care;

2) The service could be furnished more economically on an outpatient basis;

3) The inpatient hospital stays for the service deviate from the norm for inpatient stays using accepted length of stay criteria;

4) The cost of care for the service;

5) Denial rates; and

6) Trends or patterns that indicate potential for abuse.

c) Preadmission Review

Preadmission review may be conducted prior to admission to a hospital to determine if the services are appropriate for an inpatient setting. The Department shall provide hospitals with notice of the criteria used to determine medical necessity in preadmission reviews 30 days before a service is subject to preadmission review.

d) Concurrent Review

Concurrent review consists of a certification of admission and, if applicable, a continued stay review.

1) The certification of admission is performed to determine the medical necessity of the admission and to assign an initial length of stay based on the criteria for the admission.

2) The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed in an inpatient stay.

e) Pre-payment Review

The Department may require hospitals to submit claims to the Department for pre-payment review and approval prior to rendering payment for services provided.

f) Post-payment Review

Post-payment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct post-payment review on specific types of care.

g) Hospital Utilization Control

Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare must meet the utilization review plan requirements in 42 CFR 456 (October 1, 2013). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 148.25(d)(1) shall be in accordance with the federal regulations.

h) Denial of Payment as a Result of Utilization Review

1) If the Department determines, as a result of utilization review, that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission, transfer of an individual or failure to comply with the coordination of care requirements of Section 148.40.

B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.

2) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization, under subsection (h)(1)(A) as a result of prepayment review, a reconsideration will be provided within 30 days upon the request of a hospital or physician if such request is the result of a medical necessity or appropriateness of care denial determination and is received within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.

3) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization under subsection (h)(1)(A) as a result of a preadmission or concurrent review, the hospital or physician may request an expedited reconsideration. The request for expedited reconsideration must include all the information, including the medical record, needed for the Department or its designated peer review organization to make its determination. A determination on an expedited reconsideration request shall be completed within one business day after the Department's or its designated peer review organization's receipt of the request. Failure of the hospital or physician to submit all needed information shall toll the time in which the reconsideration shall be completed. The results of the expedited reconsideration shall be communicated to the hospital by telephone within one business day and in writing within three business days after the determination.

4) A determination under subsection (h)(1), if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:

A) Withholding payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

B) Termination of the hospital's Provider Agreement.

i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The applicable payments made under this Part and 89 Ill. Adm. Code 149 are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (i)(1)(B)(i) through (i)(1)(B)(v).

A) Hospital-based physicians who may not bill separately on a fee-for-service basis:

i) A physician whose salary is included in the hospital's cost report for direct patient care.

ii) A teaching physician who provides direct patient care, if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis:

i) A physician whose salary is not included in the hospital's cost report for direct patient care.

ii) A teaching physician who provides direct patient care, if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident, when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, when, by the terms of his or her contract with the hospital, he or she may charge for professional services and does, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a nonteaching administrative or staff position in a hospital or medical school, to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

j) "Designated peer review organization" means an organization designated by the Department that is experienced in utilization review and quality assurance, which meets the guidelines in 42 U.S.C. 1320c-1 and 42 CFR 475 (2013).

(Source: Amended at 47 Ill. Reg. 13121, effective August 25, 2023)