**Section 149.75 Conditions for Payment Under the DRG Prospective Payment System**

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

a) General Requirements

1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medical Assistance clients, the Department may, as appropriate:

A) Withhold Medicaid payments (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

B) Terminate the hospital's Provider Agreement pursuant to 89 Ill. Adm. Code 140.16.

b) 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 Medical Assistance as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 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 federal regulations.

c) Medical Review Requirements: Admissions and Quality Review

Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:

1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.

3) The validity of the hospital's diagnostic and procedural information.

4) The completeness, adequacy and quality of the services furnished in the hospital.

5) Other medical or other practice with respect to program participants or billing for services furnished to program participants.

d) Medical Review Requirements: DRG Validation. The Department, or its agent, may require and perform pre- or-post-payment review of diagnosis and procedure codes to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records. The review may be undertaken by way of a sample of discharges. The review may, at the sole discretion of the Department, take place at the hospital or away from the hospital site.

e) Utilization Review Requirements: The Department, or its designated peer review organization, as described in 89 Ill. Adm. Code 148.240(j), may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews, as defined at 89 Ill. Adm. Code 148.240.

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

1) The payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsection (f)(1)(B).

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

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 are:

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, but only 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.

(Source: Amended at 38 Ill. Reg. 15477, effective July 2, 2014)