Hospital-Acquired Conditions

This section applies to payment for inpatient stays reimbursed according to the DRG methodology. This section applies to all inpatient hospital facility reimbursement provisions, including Medicaid supplemental payments; Medicaid enhanced payments and Medicaid disproportionate share hospital payments.

The DRG to be assigned for an inpatient stay shall be a DRG that does not result in higher payment based on the presence of a hospital acquired condition that was not present on the date of admission. If a hospital acquired condition is not present on the date of admission, the discharge will be assigned to a DRG as though the hospital acquired condition was not present.

Secondary diagnoses that are present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for Medicaid reimbursement to be made. Secondary diagnoses that are not present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for the diagnoses to be excluded for purposes of assigning the claim to a DRG.

For purposes of this section, a "hospital acquired condition" means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and in effect on the date of admission.

Effective for services provided on or after July 1, 2012, this section applies to all inpatient stays reimbursed according to the DRG and level-of-care methodologies. A hospital-acquired condition (or "health care-acquired condition") means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and 42 CFR 447.26(b) and in effect on the date of admission.

Other Provider-Preventable Conditions

Effective for services provided on or after July 1, 2012, the State identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for non-payment under Section 4.19A: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.