DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files, where available, or from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).

2. The comprehensive, clinically-based, patient-focused medical review criteria and system developed by InterQual, Inc.

3. The appropriate, Utah-specific Administrative Rules or criteria developed through the Utilization Review Committee for programs and services not otherwise addressed.

4. The determination, where deemed necessary, of the Utilization Review Committee. The Committee must include at least two physicians and two registered nurses. The Committee will review and make recommendation on complicated or questionable individual cases.

190 Exempt Hospitals -- Two categories of hospitals are exempt from DRGs:

The State Hospital will continue to be reimbursed per diem cost for each operating unit. The per diem is calculated using Medicare regulations to definite allowable costs. In applying cost reimbursement principles, the Utah State Hospital is required to capitalize only those assets costing more than $5,000.00. A separate per diem is calculated for each operating unit. Therapeutic leave days are included in the total count of Medicaid days, unless the patient was discharged. However, if a patient is admitted as an inpatient to a second hospital, the patient is deemed to be discharged from the State hospital and the days are not counted. The day count used in the Medicaid cost settlement must be consistently applied for all admissions for all classes and/or groups of patients. Because of their unique patient population, the Utah State Hospital is not part of the DRG system. Medicaid does not use the Medicare methodology to pay an average cost per discharge.

TEFRA limits do not apply because of long lengths of stay experienced by many of the patients.

Rural hospitals located in rural areas of the state are exempt from DRG. Medicare definition of "rural hospital" is adopted by Medicaid. Rural hospitals are paid 89 percent of charges.

191 Payment Adjustments -- Effective July 1, 2010, urban hospitals will have their calculated DRG payment reduced by 14.3 percent. This reduction to the calculated paid amount will occur after all calculated payments (base payment, outlier, etc.) and before third party liability and co-pay are applied to the payment.

194 Specialty Out-Of-State Hospitals -- These hospitals provide inpatient services that are not available in the State of Utah. To qualify for this special payment provision, prior authorization must be obtained from the Utah State Department of Health, Division of Health Care Financing. The payment amount will be established by direct negotiations for each approved patient. The DRG method may or may not be used depending on the negotiated payment. Typically, the Medicaid rate in the State where the hospital is located is paid.

INPATIENT HOSPITAL
Provider-Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions (HCACs) for non-payment under Section 4.19-A.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric surgery and obstetric patients.

For claims with dates of service on or after July 1, 2011, Utah Medicaid will not reimburse providers for any of the HCACs indicated above. Payment will be denied for HCACs in any health care setting identified in Attachment 4.19-A. Denial of payment will be limited to the additional care required by the HCAC.

Utah Medicaid requires inpatient hospital providers to list any charges associated with HCACs not present on admission as non-covered charges on claims submitted for payment. Reimbursement for DRG-paid inpatient hospital claims will be based only on covered charges and shall be paid as though the HAC diagnosis is not present. Reimbursement for non-DRG-paid inpatient hospital claims will be based only on covered charges.

Inpatient hospital providers will be required to provide a valid Present-On-Admission (POA) indicator for each diagnosis submitted with their claim.

INPATIENT HOSPITAL
Provider-Preventable Conditions (Continued)

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A.

__X__ 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.

____ Additional Other Provider-Preventable Conditions identified below:

For claims with dates of service on or after July 1, 2011, Utah Medicaid will not reimburse providers for any of the OPPCs indicated above. Payment will be denied for OPPCs in any health care setting identified in Attachment 4.19-A.

In compliance with 42 CFR §447.26(c):

1. No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC existed prior to the initiation of treatment for that patient by that provider.
2. The reductions in provider payment may be limited to the extent that the following apply:
    a. The identified provider-preventable condition would otherwise result in an increase in payment.
    b. The State can isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.
3. The State provides assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursement according to the methodology above.

Provider-Preventable Conditions (Continued)

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section 4.19 (B) of this State plan.

__X__ 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.

____ Additional Other Provider-Preventable Conditions identified below:

For claims with dates of service on or after July 1, 2012, Utah Medicaid will not reimburse providers for any of the OPPCs indicated above. Payment will be denied for OPPCs in any health care setting identified in Attachment 4.19-B.

In compliance with 42 CFR §447.26(c):

1. No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC existed prior to the initiation of treatment for that patient by that provider.
2. The reductions in provider payment may be limited to the extent that the following apply:
    a. The identified provider-preventable condition would otherwise result in an increase in payment.
    b. The State can isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.
3. The State provides assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursement according to the methodology above.