**Section 148.70 Limitation On Hospital Services**

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

a) Payment for inpatient hospital care in general and specialty hospitals, including psychiatric hospitals, shall be made only when it is recommended by a qualified physician, and the care is essential as determined by the appropriate utilization review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.105 through 148.115 and 148.160 through 148.170, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.

b) For hospitals reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code 149.

c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.105 through 148.115 and 148.160 through 148.170, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.

d) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 148.25(d)(1), shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, subparts C and D.

e) Payment for transplantation costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82. Payment for kidney and cornea transplantation costs does not require enrollment as an approved transplantation center.

f) The Department shall reduce the payment for a claim that indicates the occurrence of a provider preventable condition during the admission as specified in this subsection (f).

1) The Department shall reduce each claim by the amount that the payment on the claim is increased directly due to the occurrence of and treatment for a healthcare acquired condition (HAC).

2) The Department shall not pay for services related to Other Provider Preventable Conditions (OPPCs).

3) For HACs, hospitals shall code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. For OPPCs, hospitals shall submit claims to report these incidents and will be instructed to populate the inpatient claims with specific supplementary diagnosis coding.

4) Definitions. As used in this subsection (f), the following terms are defined as follows:

"Provider Preventable Condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 (2012) or an Other Provider Preventable Condition.

"Other Provider Preventable Condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

h) Payment for caesarean sections shall be at the normal vaginal delivery rate unless a caesarean section is medically necessary.

(Source: Amended at 38 Ill. Reg. 15165, effective July 2, 2014)