

CHAPTER 1163. INPATIENT HOSPITAL SERVICES

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Authority

The provisions of this Chapter 1163 issued under sections 443.1(1) and 443.2(1) of the Public Welfare Code (62 P. S. §§ 443.1(1) and 443.2(1)), unless otherwise noted.

Source

The provisions of this Chapter 1163 adopted September 23, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185, unless otherwise noted. Immediately preceding text appears at serial pages (85031) to (85046), (86839) to (86842), (85051) to (85058) and (86843) to (86846).

Cross References

This chapter cited in 55 Pa. Code § 175.73 (relating to requirements); 55 Pa. Code § 1126.51 (relating to general payment policy); 55 Pa. Code § 1150.59 (relating to PSR program); and 55 Pa. Code § 1187.94 (relating to peer grouping for price setting).

Subchapter A. ACUTE CARE GENERAL HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM

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Cross References

This subpart cited in 55 Pa. Code § 1151.54 (relating to disproportionate share payments); 55 Pa. Code § 1163.402 (relating to definitions); and 55 Pa. Code § 1163.459 (relating to disproportionate share payments).

GENERAL PROVISIONS**§ 1163.1. Policy.**

The MA Program provides payment for medically necessary covered inpatient services provided to eligible recipients by a general hospital enrolled as a provider under the MA Program. Payment for these services is subject to this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.1 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page.

Notes of Decisions

Because petitioner hospital's special rates were challenged in the first year of implementation of the new prospective rate system, the petitioners were entitled to a retroactive adjustment based on a published statement of the Department of Public Welfare in the *Pennsylvania Bulletin*. *Hazleton St. Joseph Medical Center v. Department of Public Welfare*, 532 A.2d 521 (Pa. Cmwlth. 1987); appeal denied 541 A.2d 748 (Pa. 1988).

The prospective payment rate has replaced the cost reimbursement system previously utilized by the Commonwealth. *Hazleton St. Joseph Medical Center v. Department of Public Welfare*, 532 A.2d 521 (Pa. Cmwlth. 1987).

Cross References

This section cited in 55 Pa. Code § 1101.31 (relating to scope).

§ 1163.2. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

APR-DRG—All Patient Refined Diagnosis Related Group.

Buildings—The basic structure or shell and additions thereto.

Children's hospital—A hospital in which 50% or more of the inpatients are 17 years of age or younger.

DRGs or diagnosis related groups—A patient classification system that reflects clinically cohesive groupings of patients that consume similar amounts of hospital resources.

Day of inpatient hospital care—Room, board and professional services furnished to a patient on a continuous 24-hour-a-day basis in a semi-private room of a hospital. The term includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided in an institution other than one maintained primarily for treatment and care of patients with tuberculosis or mental disease.

Fixtures—Attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems and the like. The general characteristics of fixtures are that they are affixed to the building and not subject to transfer and that they have a fairly long life, but shorter than the life of the building to which they are affixed.

Hospital—A facility licensed as a hospital under 28 Pa. Code Part IV, Subpart B (relating to general and special hospitals) which provides equipment and services primarily for inpatient care to persons who require treatment for injury, illness, disability or pregnancy. The term does not include rehabilitation hospitals, public or private psychiatric hospitals, drug and alcohol rehabilitation hospitals, general nursing facilities, hospital-based nursing facilities, county-operated nursing facilities, intermediate care facilities for the mentally retarded, psychiatric transitional facilities or special rehabilitation nursing facilities.

Hospital admission—The formal acceptance of a patient to a hospital inpatient setting for purposes of providing inpatient hospital services.

Inpatient hospital services—Services, other than those provided by an institution for tuberculosis or mental diseases, which are ordinarily furnished in a hospital for the care and treatment of inpatients. Inpatient hospital services exclude services provided in a short procedure unit, direct care practitioners' services and direct care midwives' services. Inpatient hospital services are furnished under the direction of a licensed physician, dentist, podiatrist or nurse-midwife.

Institutionalized individual—A person who is detained or confined under one of the following:

(i) A civil or criminal statute in a correctional, rehabilitative or mental retardation facility, psychiatric hospital or other facility for the care and treatment of mental illness or mental retardation.

(ii) Voluntary commitment in a psychiatric hospital, mental retardation facility or other facility for the care and treatment of mental illness or mental retardation.

Normal newborn—A liveborn neonate whose diagnosis is categorized into severity level 1 of the newborn APR-DRG 640 as of July 1, 2011.

Outlier—An inpatient hospital case having either an extremely long length of stay or extraordinarily high costs in comparison to most discharges for the same DRG.

Patient pay amount—Income or assets that a recipient has available to meet the cost of medical care as determined by the CAO. The recipient, not the MA Program, pays this amount toward the cost of care.

Therapeutic leave—A period of absence from the hospital related to the treatment of an individual's illness.

Authority

The provisions of this § 1163.2 amended under sections 201(2), 403(b) and 403.1 of the Public Welfare Code (62 P. S. §§ 201(2), 403(b) and 403.1).

Source

The provisions of this § 1163.2 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 1, 1990, effective retroactively to April 1, 1987, 20 Pa.B. 2913; amended April 13, 2012, effective for dates of discharge on and after May 1, 2012, 42 Pa.B. 2023. Immediately preceding text appears at serial pages (337500) and (201283).

Notes of Decisions

This section supports the Department's decision to deny reimbursement to a hospital which admitted patient overnight for treatment which could have safely been rendered in Special Procedure Unit. *Episcopal Hospital v. Department of Public Welfare*, 528 A.2d 676 (Pa. Cmwlth. 1987).

Although patient was in hospital less than 24 hours, this does not disqualify from inpatient reimbursement. The phrases "continuous 24 hour a day basis" means only that care provided must be of the type that is provided on a continuous 24-hour-a-day basis. Further, in the absence of specific legislative or regulatory action there is no authority for pro-ration. *Frankford Hospital v. Department of Public Welfare*, 492 A.2d 1179 (Pa. Cmwlth. 1985).

Cross References

This section cited in 55 Pa. Code § 1151.54 (relating to disproportionate share payments); 55 Pa. Code § 1163.51 (relating to general payment policy); 55 Pa. Code § 1163.52 (relating to prospective payment methodology); 55 Pa. Code § 1163.67 (relating to disproportionate share payments); and 55 Pa. Code § 1163.459 (relating to disproportionate share payments).

SCOPE OF BENEFITS**§ 1163.21. Scope of benefits for the categorically needy.**

Categorically needy recipients not enrolled in a health maintenance organization are eligible for medically necessary inpatient hospital services, provided by participating general hospitals and covered by the MA Program subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.21 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85033).

§ 1163.22. Scope of benefits for the medically needy.

Medically needy recipients not enrolled in a health maintenance organization are eligible for medically necessary inpatient hospital services, provided by participating general hospitals and covered by the MA Program subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.22 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85034).

§ 1163.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for inpatient hospital services unless the recipient is also categorically needy or medically needy.

Source

The provisions of this § 1163.23 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85034).

§ 1163.24. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1163.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

HOSPITAL CLASSES AND EXCLUDED UNITS**§ 1163.31. [Reserved].****Source**

The provisions of this § 1163.31 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (177185) and (150091).

§ 1163.32. Hospital units excluded from the DRG prospective payment system.

(a) Payment for inpatient hospital services provided to a recipient admitted to a psychiatric unit of a general hospital as specified in this section, a drug and alcohol rehabilitation unit of a general hospital as specified in this section, or a medical rehabilitation unit of a general hospital as specified in this section, is made under Subchapter B (relating to hospitals and hospital units under cost reimbursement principles).

(b) To be excluded from the prospective payment system, the psychiatric unit, the drug and alcohol rehabilitation unit, or the medical rehabilitation unit of a general hospital shall meet the participation requirements set forth in Subchapter B.

(c) Effective April 1, 1987, payment for hospital services performed in a short procedure unit is made under Chapter 1126 (relating to ambulatory surgical center services and hospital short procedure unit services).

Authority

The provisions of this § 1163.32 amended under section 443.1(1) of the Public Welfare Code (62 P. S. § 443.1(1)).

Source

The provisions of this § 1163.32 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 1, 1990, effective retroactively to April 1, 1987, 20 Pa.B. 2913. Immediately preceding text appears at serial page (138396).

Cross References

This section cited in 55 Pa. Code § 1163.51 (relating to general payment policy).

PROVIDER PARTICIPATION**§ 1163.41. General participation requirements.**

(a) In addition to the participation requirements established in Chapter 1101 (relating to general provisions) general hospitals shall:

- (1) Be licensed by the Department of Health.

- (2) Have in effect a utilization review plan approved by Medicare or, for a hospital not participating in Medicare, a utilization review plan approved by the Office of MA. For a utilization review plan to be approved by the Office of MA, it shall comply with § 1163.73 (relating to the hospital utilization review plan).
- (b) Out-of-State hospitals furnishing inpatient hospital care to Commonwealth recipients shall:
- (1) Be Medicare certified, or certified by the appropriate agency of the state in which the hospital is located as meeting standards comparable to Medicare or be certified by either the Joint Committee on Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA).
- (2) Be currently participating in the Medicaid Program of the state in which the hospital is located.
- (3) Formally enroll in the MA Program and sign a provider agreement if in a contiguous state or if more than three invoices are submitted for payment within a 12-month period. If an out-of-State hospital not in a contiguous state submits less than three invoices within a 12-month period, the Department will process the invoices without requiring the hospital to formally enroll in the MA Program.
- (c) The Department reserves the right to refuse to enter into a provider agreement with a licensed hospital or a distinct part thereof if it determines that it is in the Department's best interest to do so.

Authority

The provisions of this § 1163.41 amended under sections 201 and 443.1(1) and (4) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1) and (4)).

Source

The provisions of this § 1163.41 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384. Immediately preceding text appears at serial pages (112224) to (112225).

§ 1163.42. [Reserved].

Source

The provisions at this § 1163.42 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; reserved June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85035).

§ 1163.43. Ongoing responsibilities of providers.

In addition to the ongoing responsibilities established in Chapter 1101 (relating to general provisions), and as a condition of continued participation in the MA Program, general hospitals shall comply with the following:

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- (1) Maintain transfer agreements with skilled nursing and intermediate care facilities, private psychiatric hospitals and rehabilitation hospitals, for the prompt and appropriate transfer of patients who no longer need acute inpatient hospital care.
- (2) For services provided to MA recipients, keep separate patient statistics and fiscal records on the cost of, and charges for, those services provided in:
 - (i) A distinct part psychiatric unit.
 - (ii) A distinct part drug and alcohol rehabilitation unit.
 - (iii) A distinct part medical rehabilitation unit.
 - (iv) A hospital-based nursing facility.
 - (v) Other inpatient settings.
- (3) Retain complete, accurate and auditable medical and fiscal records for 4 years for MA patients under Chapter 1101.
- (4) Furnish to the Department or its agents, Federal and State auditors, auditable copies of patient records and fiscal records upon request under Chapter 1101.
- (5) For those hospitals not participating in Medicare, submit to the Office of MA for review and approval, details of changes to the hospital's utilization review system, including revisions to the utilization review plan, within 30 days of the date of the change.

Authority

The provisions of this § 1163.43 amended under section 443.1(1) of the Public Welfare Code (62 P. S. § 443.1(1)).

Source

The provisions of this § 1163.43 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563. Immediately preceding text appears at serial pages (131019) to (131020).

Notes of Decisions

During the first year of implementation of the prospective payment plan, it was appropriate to allow a hospital to request retroactive adjustments to its cost reports, even though the errors were unilateral and committed by the hospital. *Lancaster General Hospital v. Department of Public Welfare*, 535 A.2d 1238 (Pa. Cmwlth. 1988).

PAYMENT FOR HOSPITAL SERVICES

§ 1163.51. General payment policy.

- (a) Except for services provided in a hospital unit excluded from the DRG prospective payment system, the Department will pay a prospective rate for inpatient hospital services compensable under the MA Program. See § 1163.2 (relating to definitions) for the definition of "inpatient hospital services." The Depart-

ment will base the prospective payment on the DRG into which the patient is classified and on the prospective payment rate assigned to a hospital.

(b) In addition to the DRG prospective payment made by the Department for a patient discharged from the hospital, the Department will reimburse a participating hospital for:

(1) Costs for depreciation and interest for buildings and fixtures under § 1163.53a (relating to prospective capital reimbursement system).

(2) Costs for direct medical education under § 1163.55 (relating to payments for direct medical education for Fiscal Years 1993-94 and 1994-95).

(c) If a hospital stay meets the requirements for outliers in § 1163.56 (relating to outliers), the prospective payment amount is adjusted under that section.

(d) A hospital that qualifies for disproportionate share payments under § 1163.67 (relating to disproportionate share payments) receives monthly payments as provided under that section.

(e) When provided to an inpatient, the Department makes separate payment to a hospital for:

(1) Direct care services provided by a practitioner as defined in Chapter 1101 (relating to general provisions) who is under salary or contract with the hospital. The Department pays for the services in accordance with Chapters 1141, 1143, 1145, 1147 and 1149 which govern payment for the practitioner.

(2) Direct care services provided by a midwife as defined in Chapter 1142 (relating to midwives' services) who is under salary or contract with the hospital. The services are paid under Chapter 1142.

(f) The Department does not pay for an admission that it determines is not medically necessary.

(g) The Department's prospective payment amount is payment in full for compensable inpatient hospital services. Compensable services provided to an inpatient are covered by the Department's payment, except for direct care services provided by salaried practitioners and midwives.

(h) Except as specified in subsection (i), no payment for inpatient hospital services is made until the recipient is discharged from the hospital. A recipient is considered discharged from the hospital if one of the following occurs:

(1) The recipient is formally released from the hospital, except if the recipient is transferred to another hospital covered under the MA prospective payment system. See § 1163.58 (relating to payment policy for transfers).

(2) The recipient dies in the hospital.

(3) The recipient is transferred to a private psychiatric hospital, public psychiatric hospital, rehabilitation hospital, drug and alcohol rehabilitation hospital or other facility not covered by the MA prospective payment system.

(4) The recipient is transferred to a hospital unit that is excluded from the MA prospective payment system as specified in § 1163.32 (relating to hospital units excluded from the DRG prospective payment system).

(i) A hospitalization for a continuous period of 90 days or longer may be billed, and paid, on an interim basis. Specific procedures for interim billing and payment are specified in the *Inpatient Hospital Handbook* issued to providers by the Department.

(j) Payment for emergency room services provided to patients admitted to the hospital is included in the payment for inpatient hospital services. The hospital may not submit a separate bill for these services.

(k) A hospital may not bill an MA recipient for care related to a noncovered service unless the recipient was informed, prior to receiving the service, that the service and the inpatient care relating to it were not covered under the MA Program.

(l) A hospital may not bill the MA Program for services provided to a person who has made application for MA benefits unless the CAO has notified the hospital that the person is eligible for MA benefits.

(m) If a hospital voluntarily terminates the provider agreement, payment for inpatient hospital services is made for MA patients admitted prior to the effective date of the termination of the provider agreement.

(n) If a hospital provides services to a recipient with a psychiatric principal diagnosis but the hospital does not have a psychiatric unit that is excluded from the prospective payment system under § 1163.32, the Department pays a 2-day per diem amount for the hospital stay. The 2-day per diem amount is determined by dividing the normal payment rate for the DRG by the Statewide average length of stay for the DRG and multiplying the result by two.

(o) If a hospital provides services to a recipient with a psychiatric principal diagnosis and the hospital has a psychiatric unit that is excluded from the prospective payment system under § 1163.32, the Department makes payment for these services under Subchapter B (relating to hospitals and hospital units under cost reimbursement principles). The Department makes no payment for the hospital stay under the DRG prospective payment system unless an emergency situation exists and the psychiatric unit is full, in which case the Department will make a 2-day per diem payment determined by dividing the payment rate for the DRG by the Statewide average length of stay for the DRG and multiplying the result by two.

(p) If a hospital provides services to a recipient with a drug or alcohol principal diagnosis but the hospital's drug and alcohol services have not been approved by the Department of Health, Office of Drug and Alcohol Programs, the Department pays a 2-day per diem amount for the hospital stay. The 2-day per diem amount is determined by dividing the normal payment rate for the DRG by the Statewide average length of stay for the DRG and multiplying the result by two.

(q) Except as specified in subsection (r), if a hospital provides services to a recipient with a drug and alcohol principal diagnosis and the hospital has been

approved by the Department of Health, Office of Drug and Alcohol Programs to provide detoxification services, the Department pays the full DRG rate for the hospital stay.

(r) If a hospital provides services to a recipient with a drug or alcohol principal diagnosis and the hospital has a drug and alcohol rehabilitation unit that is excluded from the prospective payment system under § 1163.32, the Department makes no payment for the hospital stay under the DRG prospective payment system. For these hospitals, payment for services provided to a recipient with a drug or alcohol principal diagnosis is made under Subchapter B.

(s) The Department will not pay an acute care hospital for medical rehabilitation services which are not provided in conjunction with acute care services. For recipients receiving only medical rehabilitation services and requiring no acute care services, payment is made only to distinct part medical rehabilitation units or freestanding medical rehabilitation hospitals enrolled in the MA Program under Subchapter B.

(t) Payment for inpatient hospital services, including acute care general hospitals and their distinct part units, private psychiatric hospitals and freestanding rehabilitation hospitals, will not be made in excess of the amount which would be paid in the aggregate for those services under Medicare principles of reimbursement in 42 CFR Part 413 (relating to principles of reasonable cost reimbursement; payment for end-stage renal disease services).

(u) Capital and operating costs related to new or additional beds are nonallowable for purposes of this subchapter unless a Certificate of Need or letter of nonreviewability related to those beds was issued by the Department of Health prior to July 1, 1993.

(v) The Department will not make a separate APR-DRG payment for inpatient acute care general hospital services of a normal newborn.

Authority

The provisions of this § 1163.51 amended under sections 201, 403(b), 403.1 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201, 403(b), 403.1 and 443.1(1)).

Source

The provisions of this § 1163.51 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241; amended April 13, 2012, effective for dates of discharge on and after May 1, 2012, 42 Pa.B. 2023. Immediately preceding text appears at serial pages (201287) to (201288) and (337501) to (337502).

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Notes of Decisions

During the first year of implementation of the prospective payment plan, it was appropriate to allow a hospital to request retroactive adjustments to its cost reports, even though the errors were unilateral and committed by the hospital. *Lancaster General Hospital v. Department of Public Welfare*, 535 A.2d 1238 (Pa. Cmwlth. 1988).

This section supports the Department's decision to deny reimbursement to hospital which admitted patient overnight for treatment which could have safely been rendered in Special Procedure Unit. *Episcopal Hospital v. Department of Public Welfare*, 528 A.2d 676 (Pa. Cmwlth. 1987).

Cross References

This section cited in 55 Pa. Code § 1163.58 (relating to payment policy for transfers); and 55 Pa. Code § 1163.63 (relating to billing requirements).

§ 1163.52. Prospective payment methodology.

(a) The Department will base payment for inpatient hospital services on the classification of inpatient hospital discharges by DRGs used by the Medicare Program.

(b) The Department will assign a DRG to each MA discharge. The assignment of a DRG is based on:

- (1) The recipient's diagnoses.
- (2) The procedures performed during the recipient's hospital stay.
- (3) The recipient's sex.
- (4) The recipient's age.
- (5) The recipient's discharge status.

(c) For a DRG, the Department will determine a relative value which reflects the cost of hospital resources used to treat cases in that DRG relative to the Statewide average cost of hospital cases. The Department will determine the relative value under § 1163.122 (relating to determination of DRG relative values).

(d) The Department will base payment for compensable inpatient hospital services under the DRG payment system on the hospital's base DRG rate determined under § 1163.126 (relating to computation of hospital specific base payment rates).

(e) The Department will not make a separate APR-DRG payment for a normal newborn when the following occur:

- (1) The hospital receives an APR-DRG payment for the mother's obstetrical delivery.
- (2) The newborn meets the definition of a "normal newborn" under § 1163.2 (relating to definitions).
- (3) The normal newborn is discharged from the hospital before or on the same date as the mother.
- (4) The normal newborn is not discharged to another inpatient setting.

Authority

The provisions of this § 1163.52 amended under sections 201, 403(b), 403.1 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201, 403(b), 403.1 and 443.1(1)).

Source

The provisions of this § 1163.52 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 10, 1986, effective retroactively to July 1, 1986, 16 Pa.B. 3828; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241; amended April 13, 2012, effective for dates of discharge on and after May 1, 2012, 42 Pa.B. 2023. Immediately preceding text appears at serial page (337503).

§ 1163.52a. Assignment of DRG—statement of policy.

Department policy restricts assignment of a neonate DRG to those cases in which the recipient is under 1 year of age as of the date of admission.

Authority

The provisions of this § 1163.52a amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.52a adopted November 17, 1989, effective October 1, 1989, 19 Pa.B. 4948.

(Editor's Note: This section amended under section 6(b) of the Regulatory Review Act (71 P. S. § 745.6(b)) which provides for emergency regulations to take effect for 120 days. Disapproved by the Independent Regulatory Review Commission on July 2, 1993. See 23 Pa.B. 3632 (July 31, 1993).)

§ 1163.53. [Reserved].**Source**

The provisions of this § 1163.53 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; reserved November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384. Immediately preceding text appears at serial pages (112229) to (112230).

§ 1163.53a. Prospective capital reimbursement system.

(a) The Department defines allowable depreciation and interest costs for buildings and fixtures under Medicare cost reimbursement principles in 42 CFR Part 413 (relating to principles of reasonable cost reimbursement; payment for end-stage renal disease services). Costs for major moveable equipment are not included in allowable depreciation and interest costs for purposes of this section, but are included as part of the prospective payment rate for operating costs.

(b) The Department will pay for allowable depreciation and interest costs for buildings and fixtures—capital costs—as an add-on percentage to each hospital's prospective payment rate.

(c) The add-on percentage is the case-weighted Statewide average percentage of capital costs to operating costs. The Department will determine the add-on percentage by the following method:

(1) For each hospital, determining MA allowable acute care inpatient operating costs by subtracting MA allowable acute care inpatient capital costs and MA allowable acute care inpatient medical education costs from that hospital's total MA allowable acute care inpatient costs.

(2) For each hospital, dividing MA allowable acute care inpatient capital costs by that hospital's MA allowable acute care inpatient operating costs.

(3) For each hospital, multiplying the ratio determined under paragraph (2) by the number of reported MA acute care inpatient cases at that hospital.

(4) Adding the products determined under paragraph (3) for all hospitals.

(5) Dividing the sum obtained under paragraph (4) by the Statewide number of reported MA acute care inpatient cases.

(d) For Fiscal Years 1993-94—1994-95, the Department has established an add-on percentage of 6.58%, on the basis of data reported on Hospital Cost Reports (MA 336) for Fiscal Year 1990-91.

(e) Hospitals that qualify as exceptional hospitals are eligible to apply for additional reimbursement for capital costs.

(1) A hospital will be identified as an exceptional hospital if one of the following conditions exists:

(i) The hospital's total number of reported acute care inpatient MA days for Fiscal Year 1984-85 is greater than or equal to one standard deviation above the mean number of reported acute inpatient MA days for the general hospitals enrolled in the MA Program.

(ii) The hospital's ratio of reported MA acute care inpatient days to its reported total acute inpatient days for Fiscal Year 1984-85 is greater than or equal to one standard deviation above the mean ratio of MA acute inpatient days to total acute inpatient days for the general hospitals enrolled in the MA Program.

(2) A hospital that is determined to be exceptional under paragraph (1) is eligible for additional reimbursement only if it meets the following conditions:

(i) The hospital requests additional reimbursement for the fiscal year by submitting the information necessary for the Department to determine the hospital's eligibility for additional reimbursement and the amount of the additional reimbursement.

(ii) For the fiscal year for which additional reimbursement is being requested, the hospital's ratio of MA allowable acute care inpatient capital costs to the hospital's MA total allowable acute care inpatient operating costs is equal to or greater than 6.58%, the Statewide ratio of capital costs to total operating costs as determined under subsections (c) and (d). For purposes of calculating a hospital's individual ratio, the hospital's allowable inpatient acute care capital costs shall include allowable inpatient capital costs for

buildings and fixtures placed in service prior to October 1, 1986, and allowable inpatient acute care capital costs for projects placed in service on or after October 1, 1986, only if the project has a Certificate of Need which was approved on or before June 30, 1987.

(3) For exceptional hospitals that qualify for additional reimbursement in accordance with paragraph (2), the Department will recognize as allowable costs, the following:

(i) Allowable MA inpatient acute care capital costs for buildings and fixtures placed in service prior to October 1, 1986.

(ii) Allowable MA inpatient acute care capital costs for buildings and fixtures placed in service on or after October 1, 1986, only if the project has a Certificate of Need approved on or before June 30, 1987.

(4) The Department will determine the interim capital payment of an exceptional hospital using the cost information submitted to the Department by the hospital as part of the hospital's exceptional payment request.

(5) For exceptional hospitals that qualify for additional reimbursement under paragraph (2), the final payment amount will be the hospital's allowable MA inpatient acute care capital costs determined under paragraph (3) subject to the following limitations:

(i) If a hospital's inpatient acute care occupancy rate is less than 70% for the fiscal year being audited, the Department will reduce the hospital's full allowable MA acute care inpatient capital costs by a factor determined by dividing the hospital's total inpatient acute care days for the fiscal year by the product found by multiplying the hospital's total available inpatient acute care bed days for the fiscal year by 0.70. For purposes of calculating the hospital's occupancy rate, the Department will include set up and staffed bed-days and patient days related to units reimbursed under the prospective payment system in this subchapter.

(ii) The Department will compare a hospital's MA allowable acute care inpatient capital costs incurred since October 1, 1986, to the Department's capital payments to the hospital since October 1, 1986—hospital specific payments plus Statewide percentage payments. If capital payments exceed capital costs, the Department will deduct the difference from the hospital's MA allowable capital costs incurred in the fiscal year for which additional reimbursement is requested.

(6) The Department will not offset interest income earned from funded depreciation accounts in calculating additional reimbursement for MA allowable acute care inpatient capital costs for hospitals that qualify as exceptional hospitals. The funded depreciation account shall be established under Medicare principles at 42 CFR Part 413.

Authority

The provisions of this § 1163.53a amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.53a adopted November 7, 1986, effective retroactively to July 1, 1986, 16 Pa.B. 4397; amended June 1, 1990, effective retroactively to July 1, 1986, 20 Pa.B. 2913; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181831) to (181832).

Cross References

This section cited in 55 Pa. Code § 1163.51 (relating to general payment policy); and 55 Pa. Code § 1163.70 (relating to changes of ownership or control).

§ 1163.54. [Reserved].**Source**

The provisions of this § 1151.54 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 10, 1986, effective retroactively to July 1, 1986, 16 Pa.B. 3828; amended November 7, 1986, effective retroactively to July 1, 1986, 16 Pa.B. 4397; amended June 1, 1990, effective retroactively to July 1, 1986, 20 Pa.B. 2913; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150103) to (150104).

§ 1163.55. Payments for direct medical education for Fiscal Years 1993-94 and 1994-95.

(a) For Fiscal Years 1993-94 and 1994-95, the Department will reimburse hospitals for inpatient acute care direct medical education costs that are allowable under Medicare cost principles, subject to the limitations in this section.

(b) For Fiscal Years 1993-94 and 1994-95, prior to a settlement based on audited costs, subject to the limitations in this section, the Department will make monthly interim payments for the MA inpatient acute care portion of a hospital's allowable costs for direct medical education. The Department will calculate a hospital's interim payment to approximate, to the extent practicable, that hospital's final audited MA inpatient acute care direct medical education payment.

(c) For Fiscal Years 1993-94 and 1994-95, a hospital's final audited payment for MA inpatient acute care direct medical education costs will be the lesser of the following:

(1) The hospital's final audited MA inpatient acute care direct medical education payment for the prior fiscal year, as increased for inflation to the fiscal year being audited as provided under subsections (d) and (e).

(2) The hospital's actual audited MA inpatient acute care direct medical education costs for the fiscal year being audited.

(d) For Fiscal Year 1993-94, the inflation factor for subsection (c)(1) will be 3%.

(e) For Fiscal Year 1994-95, the inflation factor for subsection (c)(1) will be the Consumer Price Index—Wage Earners Percent Change (% CHYA) Index as published by DRI/McGraw-Hill in the fourth calendar quarter of 1993 for the second calendar quarter of 1995.

Authority

The provisions of this § 1163.55 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of § 1163.55 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 1, 1990, effective retroactively to July 1, 1987, 20 Pa.B. 2913; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181832).

Cross References

This section cited in 55 Pa. Code § 1163.51 (relating to general payment policy).

§ 1163.56. Outliers.

(a) Except for DRGs specified under subsection (f), the Department will pay the hospital an amount in addition to the DRG payment for the hospital stay under subsection (d) if:

- (1) The hospital stay qualifies as a day outlier under subsection (b).
- (2) The payment conditions in subsection (c) are met.

(b) Except for DRGs specified under subsection (f), to qualify as a day outlier the inpatient hospital stay of an MA recipient shall exceed the trim point for the DRG. The trim point for a DRG is the lesser of one of the following:

- (1) Twenty days above the geometric mean length of stay for the DRG.
- (2) 1.94 standard deviations above the geometric mean length of stay for the DRG.

(c) To receive payment for a case identified as a day outlier, the following conditions shall be met:

- (1) The hospital shall submit a copy of the patient's medical record with the invoice submitted for payment.
- (2) The Department will certify the medical necessity of all days of care provided.
- (3) The hospital stay shall qualify as a day outlier under the criteria in subsection (b) based on the medically necessary days certified by the Department.

(d) The Department will determine the outlier payment amount for a day outlier by:

- (1) Determining a per diem amount for the DRG by dividing the hospital's payment amount for the DRG by the Statewide average length of stay for the DRG.

(2) Multiplying the per diem amount for the DRG by 60% to establish the marginal per diem rate for the DRG.

(3) Subtracting the number of days at the trim point for the outlier as identified in subsection (b) from the actual number of inpatient hospital days to establish the number of outlier days.

(4) Multiplying the amount determined under paragraph (2) by the number of days determined in paragraph (3) to establish the outlier payment amount.

(e) If a hospital is requesting a day outlier payment, the Department will approve or disapprove the inpatient days based on the medical necessity of the days. Only the approved inpatient days are used in determining the outlier status of the inpatient case.

(f) The Department will pay an amount in addition to the DRG payment for the hospital stay under subsection (i) if:

(1) The hospital stay qualifies as a cost outlier under subsection (g).

(2) The payment conditions in subsection (h) are met.

(3) The hospital stay groups into DRG 385-390, 456-460 or 472, or is a major burn claim or abnormal newborn claim which would have grouped into one of those DRGs under grouper version 7.

(g) A DRG specified under subsection (f) qualifies as a cost outlier if the cost of the case exceeds 150% of the hospital's DRG base payment. The Department will calculate the cost of the case by multiplying the charges indicated on the invoice by the hospital's cost-to-charge ratio.

(h) To receive payment for a case identified as a cost outlier, the following conditions shall be met:

(1) The hospital shall submit a copy of the patient's medical record with the invoice submitted for payment.

(2) The Department will certify the medical necessity of the days of care and the services provided.

(3) The hospital stay shall qualify as a cost outlier under subsection (g) based on the medically necessary days and services certified by the Department.

(i) The outlier payment amount for a cost outlier is 100% of the cost of the case as certified under subsection (h) that exceeds 150% of the hospital's base payment amount for the DRG.

(j) If a hospital is requesting a cost outlier payment, the Department will approve or disapprove the inpatient services based on the medical necessity of the services. Only the cost of approved services is used in determining the cost outlier status of the inpatient case.

Authority

The provisions of this § 1163.56 amended under sections 201, 403 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201, 403 and 443.1(1)).

Source

The provisions of this § 1163.56 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended February 15, 1991, effective March 1, 1991, 21 Pa.B. 624; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181833) to (181835).

Cross References

This section cited in 55 Pa. Code § 1163.51 (relating to general payment policy); 55 Pa. Code § 1163.57 (relating to payment policy for readmissions); 55 Pa. Code § 1163.59 (relating to noncompensable services, items and outlier days); 55 Pa. Code § 1163.65 (relating to payment for out-of-State hospital services); 55 Pa. Code § 1163.78a (relating to review requirements for day outliers); and 55 Pa. Code § 1163.126 (relating to computation of hospital specific base payment rates).

§ 1163.57. Payment policy for readmissions.

(a) Except as specified in subsection (c), if a recipient is readmitted to a hospital within 30 days of discharge, the Department makes no payment in addition to the hospital's original DRG payment. If the combined hospital stay qualifies as an outlier, an outlier payment will be made.

(b) If a patient is readmitted within 30 days of discharge for the treatment of conditions that could or should have been treated during the previous admission, the Department makes no payment in addition to the hospital's original DRG payment.

(c) Except as specified in subsection (b), if a patient is readmitted to the hospital due to complications of the original diagnosis and this results in a different DRG with a higher payment rate, the Department pays the higher DRG payment rate rather than the original DRG rate.

(d) Except as specified in subsection (b), if a patient is readmitted to the hospital due to conditions unrelated to the previous admission, the Department considers the readmission a new admission for payment purposes.

Source

The provisions of this § 1163.57 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended April 13, 2012, effective July 1, 2011, 42 Pa.B. 2023. Immediately preceding text appears at serial page (201298).

Notes of Decisions

Hospital was permitted to receive cost of treatment from the Department for a patient who suffered a second heart attack within 7 days of her first admission for a heart attack because the second attack was unrelated to the first and could not have been treated during the initial visit. *Windber Hospital, Wheeling Clinic v. Department of Public Welfare*, 545 A.2d 452 (Pa. Cmwlth. 1988).

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§ 1163.58. Payment policy for transfers.

(a) For purposes of this chapter, a transfer is limited to those instances in which a patient is transferred between two hospitals both of which are paid under the MA prospective payment system.

(b) Except as specified in subsection (g), if an inpatient is transferred, the hospital that discharges the inpatient as defined in § 1163.51 (relating to general payment policy) is paid the full DRG rate established under this chapter.

(c) Except as specified in subsections (e) and (f), if an inpatient is transferred, the transferring hospital is paid the lesser of one of the following:

- (1) A per diem rate for each day of inpatient care determined by dividing the hospital's appropriate DRG payment rate for the case by the Statewide average length of stay for the DRG.

- (2) The hospital's appropriate DRG payment rate as determined under this chapter.
- (d) In computing the per diem payment specified in subsection (c), the day of transfer is a noncompensable day unless it is also the day of admission.
- (e) If the case being transferred is classified into DRG 385 or DRG 456 and is transferred, the transferring hospital is paid the full DRG rate.
- (f) A hospital transferring a patient is paid the full DRG rate established under this chapter only if:
- (1) The patient was admitted to the hospital by way of a transfer from the acute care setting of another hospital paid under the DRG payment system.
 - (2) The patient is classified into one of the DRGs from 386 through 390 inclusive or 457 through 460 inclusive.
- (g) If a patient has been transferred to a hospital under the conditions set forth in subsection (f), the discharging hospital is paid the lesser of one of the following:
- (1) The DRG payment rate for the case.
 - (2) An amount determined by:
 - (i) Dividing the hospital's DRG payment rate by the Statewide average length of stay for the DRG.
 - (ii) Multiplying the amount determined in subparagraph (i) by the number of days in the hospital.
 - (iii) Multiplying the amount determined in subparagraph (ii) by .60 to establish a marginal per diem payment amount for the hospital.

Source

The provisions of this § 1163.58 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (138407).

Notes of Decisions

This section supports the Department's decision to deny reimbursement to a hospital which admitted patient overnight for treatment which could have safely been rendered in Special Procedure Unit. *Episcopal Hospital v. Department of Public Welfare*, 528 A.2d 676 (Pa. Commw. 1987).

Cross References

This section cited in 55 Pa. Code § 1163.51 (relating to general payment policy).

§ 1163.59. Noncompensable services, items and outlier days.

- (a) The Department does not pay hospitals for an inpatient hospital stay if the admission is directly or indirectly related to the hospital's provision of:
- (1) Transsexual surgical procedures for gender change or reassignment—for example, penile construction, revision of labia, vaginoplasty, vaginal dilation, vaginal reconstruction, penectomy, orchiectomy, mammoplasty, mastectomy, hysterectomy and release of vaginal adhesions.

(2) Medical or dental services or surgical procedures performed on an inpatient basis which could have been performed in an outpatient department, or practitioner's office—for example, unilateral or bilateral myringotomy, vasectomy, blood transfusions, chronic maintenance hemodialysis, treatment for chronic pain and dental procedures which may be provided in an outpatient setting without undue risk to the patient.

(3) Inpatient hospital services provided in conjunction with physicians' services which are identified as outpatient procedures in Chapter 1150 (relating to the MA Program payment policies), unless performing the procedure on an outpatient basis could result in undue risk to the life or health of the patient and detailed documentation of the conditions of risk to the life or health of the patient is included in the patient's medical record.

(4) Acupuncture, unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileojejunum shunt, except when all other types of treatment of morbid obesity have failed and other procedures which may be experimental are not in accordance with customary standards of medical practice or are not commonly used.

(5) Plastic or cosmetic surgery for beautification purposes—for example, otoplasty for protruding ears or lop ears, rhinoplasty—except for internal nasal deformity—nasal reconstruction, excision of keloids, reduction mammoplasty, augmentation mammoplasty, silicone or silastic implants, facioloplasty, osteoplasty—prognathism and micrognathism—dermabrasion, skin grafts and lipectomy. For accidental injury, plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member.

(6) Inpatient dental cases involving oral rehabilitation or restorative services, except for procedures performed for treatment of a secondary diagnosis, unless:

(i) The nature of the surgery or the condition of the patient precludes performing the procedure in the dentist's office or other outpatient setting.

(ii) A physician or dentist has documented in the patient's medical record the medical justification for performing the procedure in a short procedure unit or inpatient setting.

(7) Diagnostic tests and procedures that can be performed on an outpatient basis and diagnostic tests and procedures not related to the diagnoses that require that particular inpatient stay.

(8) Sterilizations performed on individuals 20 years of age or younger.

(9) Sterilizations performed on individuals 21 years of age or older who have not signed the consent form for sterilization at least 30 days but not more than 180 days prior to the sterilization.

(10) Hysterectomies performed solely for the purpose of sterilization.

(11) Abortion procedures performed on individuals if a "Physician Certification for an Abortion" form has not been completed.

(12) Services and items for which full payment is available through Medicare, other financial resources or other health insurance programs.

(13) Services and items not ordinarily provided to the general public.

(14) Methadone maintenance.

(15) Diagnostic or therapeutic procedures solely for experimental, research or educational purposes.

(16) Unnecessary admissions and conditions which do not require hospital-type care, such as rest cures and room and board for relatives during a patient's hospitalization.

(b) The Department does not pay for an inpatient hospital stay if the admission is not certified under the Department's DRG review process.

(c) For purposes of determining a day outlier under § 1163.56 (relating to outliers) the following days are excluded:

(1) Days of absence from the hospital.

(2) Inpatient days for patients who no longer require acute short term inpatient hospital care—inappropriate hospital services. For patients who require skilled nursing or intermediate care, payment is made to the hospital for this care under Chapter 1181 (relating to nursing facility care) only if the patient is in a certified and approved hospital-based skilled nursing or intermediate care unit.

(3) Days of inpatient care due to unnecessary delays in applying for a court ordered commitment, grace periods, administrative days and custodial care related or unrelated to court commitments or to protective services. For purposes of this chapter, custodial care is defined as maintenance, rather than curative care, on an indefinite basis, while grace periods and administrative days relate to days of care while awaiting placement elsewhere.

(4) Days spent as an inpatient at the transferring hospital on or after the effective date of a court commitment to another facility.

(5) Inpatient days caused by the hospital's failure to promptly request or perform necessary diagnostic studies, medical-surgical procedures or consultations.

(6) Inpatient days when the patient is admitted on a Friday or Saturday and no medical or surgical procedure is performed on the day of or the day following admission, unless the admission is an emergency as documented in the patient's medical record by the attending physician.

(7) Inpatient days resulting from the provision of a noncompensable service or item specified in subsection (a).

(8) Inpatient days resulting from a patient's refusal to leave the hospital after being discharged by the attending physician.

(9) The day of discharge from inpatient hospital care.

(d) The Department will not make payment for drug or alcohol detoxification services in an inpatient hospital unless one of the following circumstances exist:

- (1) Complications exist, or there is a reasonable expectation of complications, that require inpatient hospital medical treatment, including:
 - (i) The presence or reasonable expectation, based on history or other demonstrable findings, of potentially dangerous withdrawal symptoms which could endanger the health or safety of the individual.
 - (ii) The presence or reasonable expectation, based on history or other demonstrable findings, of major medical complications.
 - (iii) The presence of a significant psychiatric problem on admission.
 - (iv) The presence of a clinical state requiring close medical observation.
- (2) A nonhospital, medically appropriate bed is not available within a 50-mile radius of the inpatient hospital to which the patient presents for treatment and the inpatient hospital includes documentation of the nonavailability of the nonhospital detoxification bed in the medical record. A nonhospital detoxification bed will be considered to be not available if the medically appropriate nonhospital facility has no beds available or refuses to accept the patient.

Authority

The provisions of this § 1163.59 amended under sections 201(2) and 443.1(1) and (4) of the Public Welfare Code (62 P. S. §§ 201(2) and 443.1(1) and (4)).

Source

The provisions of this § 1163.59 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 600; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended August 18, 1989, effective immediately, retroactively applicable to August 1, 1988; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; corrected August 3, 1990, effective July 1, 1988, 20 Pa.B. 4199; amended November 3, 1995, effective November 4, 1995, and apply retroactively to October 1, 1995, 25 Pa. B. 4700; amended November 24, 1995, effective November 25, 1995, apply retroactively to November 1, 1995, 25 Pa. B. 5241. Immediately preceding text appears at serial pages (201299) to (201302).

Notes of Decisions

Although DPW's delay in approving transfer to rehab center resulted in hospital continuing to care for patient who no longer needed acute inpatient care, Office of Hearings and Appeals' decision denying reimbursement was affirmed. The regulations do not allow for discretion in their application. [Note citation to § 9421.74, 7 Pa.B. 2179, 2180 (1977)] *Mercy Hospital v. Department of Public Welfare*, 492 A.2d 104 (Pa. Cmwlth. 1985).

Cross References

This section cited in 55 Pa. Code § 1150.59 (relating to PSR Program); and 55 Pa. Code § 1163.78b (relating to review requirements for cost outliers).

1163-24

§ 1163.59a. Utilization guidelines for inpatient hospital drug and alcohol services under the MA Program—statement of policy.

(a) For inpatient adult drug and alcohol services rendered on or after May 1, 1998, the Department will use the Pennsylvania Client Placement Criteria (PCPC) developed by the Bureau of Drug and Alcohol Programs (BDAP) in the Department of Health as utilization guidelines, both for prospective and retrospective reviews of patient care.

(b) If the BDAP modifies the PCPC guidelines, the Department will also adopt those modifications.

(c) Providers who do not already have a copy of the PCPC may obtain one by contacting the Department of Health, Bureau of Drug and Alcohol Programs, Room 929, Health and Welfare Building, Harrisburg, Pennsylvania 17108.

Source

The provisions of this § 1163.59a adopted November 3, 1995, effective November 4, 1995, and apply retroactively to November 1, 1995, 25 Pa. B. 4705; amended May 8, 1998, effective May 9, 1998, and apply retroactively to May 1, 1998, 28 Pa.B. 2150. Immediately preceding text appears at serial pages (204515) to (204516).

§ 1163.60. Payment conditions for sterilizations.

(a) Payment for covered sterilization procedures is made only if:

(1) The individual requesting sterilization has voluntarily given informed consent under subsection (b).

(2) The individual is 21 years old or older at the time informed consent is obtained.

(3) The individual is not a mentally incompetent individual or an institutionalized individual. For the purposes of this chapter, a mentally incompetent individual is a person who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction for any purpose unless he has been declared competent for purposes which include the ability to consent to sterilization.

(b) An individual requesting sterilization has voluntarily given informed consent only if:

(1) A consent form has been completed correctly in accordance with the instructions in the Provider Handbook and within the time limit specified in subsection (c)(1).

(2) The person obtaining informed consent has explained orally all elements of informed consent that are included in the Consent to Sterilization section of the consent form.

(3) The person obtaining informed consent has advised the individual that a decision not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds and has offered to answer any questions the individual may have concerning the sterilization procedure.

(4) The individual giving informed consent was permitted to have a witness of his choice present when informed consent was given.

(5) The individual was offered a language interpreter, if necessary, or an appropriate interpreter if the individual is blind, deaf or otherwise handicapped.

(6) The requirements of additional State or local laws for obtaining consent have been met.

(c) A consent form is considered to be completed correctly only if:

(1) Except as specified under subsections (d) and (e), at least 30 days, but no more than 180 days, have passed between the date the individual gave written informed consent and the date of the sterilization procedure. In the case of a sterilization performed during emergency abdominal surgery, 72 hours shall have passed between the time of informed consent and the time of sterilization. In the case of sterilization performed during premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery.

(2) The person obtaining informed consent has properly signed the consent form in accordance with instructions in the Provider Handbook on the same date that informed consent was given.

(3) Another witness or interpreter has properly signed the consent form in accordance with instructions in the Provider Handbook.

(4) The physician performing the sterilization procedure has certified and signed the Physician's Statement section of the consent form after the procedure has been performed.

(d) If a sterilization is performed during emergency abdominal surgery, 72 hours shall have passed between the time of informed consent and the time of sterilization.

(e) If a sterilization is performed during premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery.

Source

The provisions of this § 1163.60 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial pages (86842) and (85051).

§ 1163.61. Payment conditions for hysterectomies.

Payment is made for a hysterectomy if:

(1) The hysterectomy is performed for a valid medical reason other than sterilization.

(2) Except as stated otherwise in subparagraphs (i) and (ii), the individual and her representative, if any, has been advised orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing. The individual or her representative, if any, must sign a Patient Acknowledgement Form for Hysterectomy which acknowledges receipt of that information unless one of the following occurs:

(i) The individual is already sterile at the time of the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was sterile prior to the procedure and states the cause of the sterility. The reasons may include, but are not limited to congenital disorders, a previous sterilization or postmenopausal sterility.

(ii) The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible. The physician must include a description of the nature of the emergency, documenting that prior acknowledgement was not possible.

Source

The provisions of this § 1163.61 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85052).

§ 1163.62. Payment conditions for abortions.

(a) Coverage for abortions funded under the MA Program is available only if:

(1) A physician has certified in writing and documented in the patient's record that the life of the woman would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the woman's life is endangered is a medical judgment to be made by the woman's physician. Payment will be made for an inpatient hospitalization for purposes of an abortion only if a "Physician Certification for an Abortion" form signed by a licensed physician is submitted with the invoice for payment. A sample of the required "Physician Certification for an Abortion" form appears in the Provider Handbook.

(2) If the recipient was the victim of rape or incest and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and in the case of incest within 72 hours of the time the physician notified the patient that she was pregnant. A law enforcement agency is an agency or part of an agency which is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service is an agency of the Federal, State or local government or a facility certified by the Federal government as a Rural

Health Clinic which provides health or medical services. Those agencies whose principal function is the performance of abortions are not considered public health agencies.

(i) Payment is made for inpatient hospitalization only if a "Physician Certification for an Abortion" form, signed by a licensed physician is submitted with the invoice for payment along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation must include:

(A) The information specified in subsection (a)(2)(ii).

(B) A statement that the report was signed by the person making the report.

(ii) The report of the rape or incest need not be made by the victim herself but can be reported by another person. The report need not be made in person but may be made by mail. The report itself shall be signed by the person who reports the rape or incest and must include:

(A) The name and address of the victim.

(B) The name and address of the person who made the report if different from the victim.

(C) The date of the incident if it was rape.

(D) The date the report was made.

(b) Insofar as required by 28 Pa. Code Chapter 29 Subchapter D (relating to ambulatory gynecological surgery in hospitals and clinics), during the first 12 weeks of pregnancy, payment is made under the MA Program only for an abortion performed in a licensed physician's office, a clinic or a hospital outpatient facility which has been licensed/approved by the Department of Health for that purpose.

(c) Insofar as required by 28 Pa. Code Chapter 29 Subchapter D, after the first 12 weeks of pregnancy, payment is made under the MA Program only for abortions performed in a hospital which has been licensed/approved by the Department of Health.

Source

The provisions of this § 1163.62 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial pages (85052) to (85053).

§ 1163.63. Billing requirements.

(a) The hospital shall submit invoices to the Department in accordance with the instructions in the Provider Handbook.

(b) The hospital may not submit an invoice until the recipient has been one of the following:

(1) Discharged from the hospital as defined in § 1163.51 (relating to general payment policy).

- (2) Transferred to another hospital that is paid under the Pennsylvania MA DRG prospective payment system.
- (3) Treated as an inpatient in the hospital continuously for 90 or more days.
- (c) A hospital may not submit an invoice to the Department until a final determination of the recipient's eligibility for potential third-party payment has been made.
- (d) Services and items provided to an inpatient shall be billed as hospital inpatient services except:
 - (1) Direct care services provided by a practitioner as defined in Chapter 1101 (relating to general provisions) who is under salary or contract with the hospital.
 - (2) Direct care services provided by a midwife as defined in Chapter 1142 (relating to midwives' services) who is under salary or contract with the hospital.

Source

The provisions of this § 1163.63 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913. Immediately preceding text appears at serial page (90734).

§ 1163.64. Cost reports.

- (a) A hospital shall complete form MA 336 (Financial Report For Hospital and Hospital-Health Care Complex Under the Medical Assistance Program of the Department of Human Services, Commonwealth of Pennsylvania) or its successor in accordance with the Medicare principles governing reasonable cost reimbursement in Medicare's Provider Reimbursement Manual (HIM-15) and in accordance with the instructions accompanying the cost report.
- (b) The hospital shall submit form MA 336 or its successor to the Department's Office of MA by September 30th of each year. If the hospital participates in Medicare, a completed copy of the Medicare cost report also shall be submitted to the Department as a supplement to form MA 336 or its successor.
- (c) The hospital's cost report shall:
 - (1) Be prepared using the accrual basis of accounting.
 - (2) Except as noted in paragraph (4), cover a fiscal period of 12 consecutive months from July 1 through June 30.
 - (3) Include all information necessary for the proper determination of costs payable under the program including financial records and statistical data.
 - (4) In the case of a hospital beginning operations during the fiscal year, cover the period from the date of approval for participation in the MA Program to the end of the fiscal year.

Source

The provisions of this § 1163.64 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 1, 1990, effective retroactively for July 1, 1988, 20 Pa.B. 2913. Immediately preceding text appears at serial pages (90734) to (90735).

§ 1163.65. Payment for out-of-State hospital services.

(a) The Department pays for compensable inpatient hospital services furnished by an out-of-State hospital to an eligible Pennsylvania recipient if one of the following occurs:

(1) Residents in a given area generally receive their care in a particular out-of-State hospital. This would apply when the out-of-State hospital is closer to, or substantially more accessible from, the residence of the recipient than the nearest hospital within this Commonwealth that is adequately equipped and is available for the treatment of the individual's illness.

(2) Documentation is provided verifying one of the following:

(i) While temporarily out-of-State, the recipient required inpatient hospital services on an emergency basis. For the purpose of this chapter, emergency services are those inpatient hospital services that are necessary to prevent the death, or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, require the use of the most accessible hospital available that is equipped to furnish the services.

(ii) An out-of-State hospital is the only facility equipped to provide the type of care that the individual requires.

(b) Payment for inpatient hospital services provided by out-of-State hospitals is subject to the limitations and conditions set forth in this chapter.

(c) The Department's payment for services provided by an out-of-State hospital is the lower of:

(1) The amount of the charges billed by the hospital.

(2) The Statewide average DRG payment rate, excluding capital, increased by 7.1% to account for capital-related costs for buildings and fixtures and, if applicable, an outlier payment as determined under § 1163.56 (relating to outliers).

(d) The Department pays the rate established under subsection (c) minus payments from the recipient, a legally responsible relative or a third-party resource for the services a recipient receives while in the hospital.

Source

The provisions of this § 1163.65 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 1, 1990, effective retroactively to July 1, 1987, 20 Pa.B. 2913. Immediately preceding text appears at serial pages (90735) to (90736).

§ 1163.66. Third-party liability.

(a) Hospitals shall utilize the available third-party resources for services a recipient receives while in the hospital. Medicare lifetime reserve days are considered available resources.

(b) If expected payment by a third party resource is not realized, the hospital may bill the MA Program.

(c) If the hospital receives reimbursement from a third-party subsequent to payment from the Department, the hospital shall repay the Department by submitting a claim adjustment.

(d) If a recipient or the legal representative of a recipient requests a copy of the hospital invoice, the hospital shall submit a copy of the invoice and the request to the Bureau of Claim Settlement, MA Recovery Unit, at the address specified in the Provider Handbook. The Bureau of Claim Settlement will forward the requested copy to the requestor and take follow-up action necessary to ensure the repayment of MA expenditures.

(e) For a hospitalization with a discharge date on or after July 1, 2007, if a recipient is entitled to Medicare Part A benefits, the Department will not pay any deductible and coinsurance amounts if the Medicare payment exceeds the applicable DRG payment, including any outlier payments. If the Medicare payment is less than the applicable DRG payment including any outlier payments, the Department pays Medicare deductible and coinsurance amounts to the extent that the Department's payment, the Medicare payment and any other resources available to the recipient for the hospital inpatient care combined do not exceed the applicable DRG payment, including any outlier payments. The Department will not pay more than the maximum deductible and coinsurance amounts.

(f) Except as specified in subsection (g), if a recipient is entitled to hospital insurance benefits other than Medicare Part A, the Department will pay the applicable DRG payment rate minus the insurer's liability amount and other resources available to the recipient for hospital care, including any Medicare Part B payment.

(g) If the resources available to a recipient for inpatient hospital care equal or exceed the Department's applicable DRG payment rate, the Department will make no payment for the hospital care.

(h) The hospital shall utilize resources available through Medicare Part B for those services provided in the hospital that are covered and approved for payment by Medicare.

Source

The provisions of this § 1163.66 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended July 27, 2007, effective immediately and apply to inpatient hospital services with discharge dates on or after July 1, 2007, 37 Pa.B. 4065. Immediately preceding text appears at serial page (201308).

§ 1163.67. Disproportionate share payments.

(a) The Department will annually determine the acute care general hospitals including their distinct part units, private psychiatric hospitals and freestanding rehabilitation hospitals that qualify for disproportionate share payments by the method in subsections (b)—(e). The Department will annually determine the amount of disproportionate share payments for acute care general hospitals, exclusive of distinct part units, by the method in subsections (f)—(i).

(b) A hospital that meets at least one of the requirements under subsection (d) will qualify for disproportionate share payments if one of the following applies:

(1) The hospital's ratio of Title XIX inpatient days to total inpatient days is equal to or greater than one standard deviation above the mean of the ratios for hospitals in this Commonwealth. To determine the ratio for an acute care general hospital, the Department will include inpatient days for units covered under Subchapter B and Chapter 1151 (relating to hospitals and units covered under cost reimbursement principles; and inpatient psychiatric services), as well as days covered under this subchapter. The Department will include in the database MA administrative days, days of care provided to recipients in other states' Medicaid Programs, MA Health Maintenance Organization (HMO) days and MA Health Insuring Organization (HIO) days.

(2) The hospital's low income utilization rate, as defined under 42 U.S.C.A. § 1396 r-4(b)(3), exceeds 25% under one of the following methods:

(i) The hospital's low income utilization rate as reported on its Cost Report (MA 336) computation of low income utilization rate worksheet exceeds 25%.

(ii) The hospital's low income rate as determined by its ratio of Title XIX and General Assistance inpatient days to total inpatient days exceeds 25%. To determine the ratio for an acute care general hospital, the Department will include inpatient days for units covered under Subchapter B and Chapter 1151, as well as days covered under this subchapter. The Department will include in the database MA administrative days, days of care provided to recipients in other states' Medicaid programs, MA HMO days and MA HIO days.

(3) The hospital is an acute care general hospital which qualifies as a rural hospital or sole community hospital under the Medicare Program, and its ratio of MA acute care inpatient cases to total acute care inpatient cases is equal to or greater than the 75th percentile of the ratios for acute care general hospitals in this Commonwealth. The Department will not include cases for a unit covered under Subchapter B or under Chapter 1151. The Department will include in the database discharges related to other states' Medicaid Programs.

(c) The Department will utilize the following data sources in making disproportionate share eligibility determinations:

(1) For Fiscal Year 1993-94, the Department will utilize data from Fiscal Year 1991-92 Cost Reports (MA 336) and from Fiscal Year 1991-92 for services provided to recipients enrolled in MA HMO Programs and MA HIO Programs. To determine the Title XIX percentage of total MA cases or days, the Department will utilize the most currently available data.

(2) For Fiscal Year 1994-95, the Department will utilize data from Fiscal Year 1992-93 Cost Reports (MA 336) and from Fiscal Year 1992-93 for services provided to recipients enrolled in MA HMO Programs and MA HIO Pro-

grams. To determine the Title XIX percentage of total MA cases or days, the Department will utilize the most currently available data.

(d) To qualify for disproportionate share payments, a hospital shall meet at least one of the following requirements:

(1) The hospital shall be a children's hospital, as defined under § 1163.2 (relating to definitions).

(2) The hospital shall have at least two physicians with staff privileges who have agreed to provide obstetric services to individuals entitled to those services under the MA Program.

(3) The hospital has not, since December 21, 1987, offered nonemergency obstetric services to the general population.

(e) To determine the hospitals that qualify for disproportionate share payments based on the ratio of Title XIX inpatient days to total inpatient days, the Department will do the following:

(1) Identify the total number of MA inpatient days from the hospital's Cost Report (MA 336), including days of care provided to recipients in other states' Medicaid Programs, and to that number:

(i) Add the hospital's number of inpatient days for MA recipients enrolled in MA HMO Programs and MA HIO Programs.

(ii) Add the hospital's number of MA administrative days from the hospital's Cost Report (MA 336).

(iii) Subtract the hospital's number of days of care provided to General Assistance recipients.

(2) Divide the days determined under paragraph (1) by the total number of inpatient days from the hospital's Cost Report (MA 336) to determine the hospital's ratio of Title XIX MA days to total inpatient days.

(3) Array the hospitals, from high to low, according to the ratios determined under paragraph (2) and determine the mean and standard deviation of the array.

(4) Identify as disproportionate share providers hospitals with a ratio of Title XIX inpatient days to total inpatient days equal to or greater than one standard deviation above the mean.

(f) Once the Department determines which hospitals qualify as disproportionate share providers under subsections (b)(1) and (2) for Fiscal Year 1993-94, the Department will calculate disproportionate share percentages for acute care general hospitals, exclusive of distinct part units, by:

(1) Arraying qualifying acute care general hospitals from high to low, according to each hospital's ratio of Title XIX inpatient days to total inpatient days.

(2) Assigning a disproportionate share percentage of 15% to the qualifying hospital with the highest ratio of Title XIX inpatient days to total inpatient days.

(3) Obtaining for other hospitals in the array, the annual disproportionate share percentage, which is 1%, plus 13% multiplied by a fraction, the numerator of which is the ratio of Title XIX inpatient days to total inpatient days of the qualifying hospital, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array; and the denominator of which is the ratio of Title XIX inpatient days to total inpatient days of the second to highest hospital in the array, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array.

(g) Once the Department determines which rural and sole community acute care general hospitals qualify as disproportionate share providers under subsection (b)(3) for Fiscal Year 1993-94, the Department will calculate disproportionate share percentages for acute care general hospitals, exclusive of distinct part units, by:

(1) Arraying qualifying acute care general hospitals from high to low, according to each hospital's ratio of Title XIX inpatient days to total inpatient days.

(2) Assigning a disproportionate share percentage of 10% to the qualifying hospital with the highest ratio of Title XIX inpatient days to total inpatient days.

(3) Obtaining for other hospitals in the array a disproportionate share percentage, which is 1%, plus 8% multiplied by a fraction, the numerator of which is the ratio of Title XIX inpatient days to total inpatient days of the qualifying hospital, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array; and the denominator of which is the ratio of Title XIX inpatient days to total inpatient days of the second to highest hospital in the array, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array.

(h) The Department will assign the higher disproportionate share percentage calculated under subsections (f) and (g) to a hospital qualifying under both subsections.

(i) The Department will determine prospectively the annual disproportionate share payment amount for each qualifying acute care general hospital by:

(1) Multiplying the following:

(i) The hospital's disproportionate share percentage determined under subsection (f) or (g).

(ii) The hospital's base DRG rate in effect on July 1 of the fiscal year, except that the Department will use the new base rate for a hospital whose rate changes during the fiscal year for any reason except for the annual inflationary increase.

(iii) 1.0658 for prospective capital.

(iv) The hospital's most currently available case mix index.

(v) The hospital's projected MA acute care cases, determined as follows:

(A) For Fiscal Year 1993-94, the number of acute care cases reported on the hospital's Fiscal Year 1991-92 Cost Report (MA 336) increased by 3.52%, and then by 2.8%.

(B) For Fiscal Year 1994-95, the number of acute care cases reported on the hospital's Fiscal Year 1992-93 Cost Report (MA 336) increased by utilization increase factors consistent with the Governor's Fiscal Year 1994-95 budget proposal.

(2) For Fiscal Years 1993-94 and 1994-95, for those hospitals that do not receive an inflationary increase on July 1, further inflating one-half of the amount calculated under paragraph (1) by the annual inflation increase.

(j) The Department will divide the annual disproportionate share payment amount into 12 monthly payments.

(k) The Department will publish annually, as a notice in the *Pennsylvania Bulletin*, a list of the qualifying hospitals and their annual disproportionate share payment percentages.

Authority

The provisions of this § 1163.67 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.67 adopted June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181838) to (181840).

Cross References

This section cited in 55 Pa. Code § 1163.51 (relating to general payment policy).

UTILIZATION CONTROL

§ 1163.70. Changes of ownership or control.

(a) A hospital is not entitled to additional reimbursement due solely to a change of ownership or control.

(b) If a change of ownership occurs, the Department will establish prospective payment base rates as follows:

(1) If the change involves only one hospital, the Department will use the prospective payment rate assigned to the hospital before the change.

(2) If the change combines two or more hospitals into a single entity, such as a merger or consolidation, the Department will establish a new prospective payment rate for the new entity by averaging rates of the previous entities on a case-weighted basis. To determine that case-weighted average, the Depart-

ment will use the MA cases of each previously enrolled hospital as reported in the most recent fiscal year for which all the previous entities filed acceptable Cost Reports (MA 336).

(3) If the change divides one enrolled hospital into two or more entities, the Department will use the prospective payment rate assigned to the hospital before the change, for the resulting entities.

(4) The Department will not rebase rates established under this subsection until it rebases rates Statewide.

(5) If the Department rebases rates Statewide after a change in ownership has occurred, by using a base year which predates or corresponds to the year of change, the Department will use the Cost Reports (MA 336) and the claims data for the base year regardless of who owned the entity in that base year.

(c) If a change of ownership occurs, the Department will establish cost-to-charge ratios as follows:

(1) If the change involves only one hospital, the Department will use the cost-to-charge ratio assigned to the hospital before the change.

(2) If the change combines two or more hospitals into one entity, such as a merger or consolidation, the Department will establish a cost-to-charge ratio for the new entity by averaging the cost-to-charge ratios of the previous entities on a case-weighted basis. To determine that case-weighted average, the hospital will use the MA cases of each previously enrolled hospital as reported in the most recent fiscal year for which all the previous entities filed acceptable Cost Reports (MA 336).

(3) If the change divides one enrolled hospital into two or more entities, the Department will use the cost-to-charge ratio assigned to the hospital before the change for the resulting entities.

(4) Cost-to-charge ratios established under subsection (c) will not be updated until cost-to-charge ratios are updated Statewide.

(5) If the Department rebases cost-to-charge ratios Statewide after a change of ownership has occurred, by using a base year which predates or corresponds to the year of the change, the Department will use the cost reports for the base year, regardless of who owned the entity in that base year.

(d) If a change of ownership occurs, disproportionate share payment policy will be as follows:

(1) If the change involves only one hospital, the Department will use the disproportionate share status assigned to the hospital before the change, so long as the resulting hospital maintains the nonemergency obstetric services by which it previously complied with section 1923(d) of the Social Security Act (42 U.S.C.A. § 1396r-4(d)).

(2) If the change combines two or more hospitals into a single entity, such as a merger or consolidation, the Department will establish the new entity as eligible for disproportionate share payments if one or more of the previous entities was eligible for disproportionate share payments, so long as the result-

ing entity maintains the nonemergency obstetric services by which one of the previous entities complied with section 1923(d) of the Social Security Act. To determine the monthly disproportionate share payment for the new entity, the Department will add the monthly disproportionate share payments of the previous entities.

(3) If the change divides one enrolled hospital into two or more entities, the Department will use the disproportionate share status assigned to the hospital before the change, so long as each of the resulting entities maintains the nonemergency obstetric services by which the previous entity complied with section 1923(d) of the Social Security Act. The Department will prorate the monthly disproportionate share payment of the previous entity on the basis of ratio of utilization agreed upon by the entities.

(4) The Department will not recalculate a hospital's disproportionate share status established under this subsection until it rebases disproportionate share status Statewide.

(5) If the Department makes a Statewide redetermination of disproportionate share status after a change of ownership has occurred, and uses a base year which predates or corresponds to the year of the change, the Department will use the cost reports for the base year, regardless of who owned the entity in that base year.

(6) For a Statewide redetermination of disproportionate share status, the determination of disproportionate share status for the entities resulting from a division will be made on the basis of ratio of utilization for the base year as agreed upon by the entities.

(e) If a change of ownership occurs, the Department will establish medical education payments as follows:

(1) If the change involves only one hospital, the Department will use the medical education base assigned to the hospital before the change.

(2) If the change combines two or more hospitals into a single entity, such as a merger or consolidation, the Department will establish a medical education base for the new entity by adding the medical education bases of the previous entities.

(3) If the change divides one enrolled hospital into two or more entities, the Department will establish medical education bases for the resulting entities by prorating the base of the previous entity on the basis of ratio of utilization and medical education cost accounting agreed upon by the entities.

(f) If a change of ownership occurs, the Department will establish exceptional capital eligibility as follows:

(1) If the change involves only one hospital, the Department will use the exceptional capital status assigned to the hospital before the change.

(2) If the change combines two or more hospitals into a single entity such as a merger or consolidation, the Department will establish exceptional capital eligibility as follows:

(i) If all of the previous entities were eligible for exceptional capital, the resulting entity will be eligible for exceptional capital.

(ii) If none of the previous entities was eligible for exceptional capital, the resulting entity will not be eligible for exceptional capital.

(iii) In a merger or consolidation of one or more entities eligible for exceptional capital and one or more entities not eligible for exceptional capital, the resulting entity will be eligible for a prorated percentage of the capital payment to which the resulting entity would be entitled if it were designated exceptional in its entirety. The Department will determine eligibility and payment as follows:

(A) The Department will establish a percentage of capital in the final full fiscal year of operation before the merger or consolidation, by dividing the MA allowable acute care inpatient capital costs of the entity previously eligible for exceptional capital, by the combined MA allowable acute care inpatient capital costs of all the previous entities.

(B) To determine the exceptional capital payment for the resulting entity, the Department will first calculate the amount of payment to which the resulting entity would be eligible under § 1163.53a(e) (relating to prospective capital reimbursement system) if the entity were eligible in its entirety. The Department will then multiply the amount determined under this clause by the percentage determined under clause (A).

(3) If the change divides one enrolled hospital into two or more entities, the Department will use the exceptional capital status assigned to the hospital before the change for the resulting entities.

(4) Additional costs resulting solely from change of ownership or control will not be eligible for exceptional capital payments.

(g) A hospital that changes ownership or closes shall submit final Cost Reports (MA 336) to the Department within 45 days of the change of ownership or closure.

(h) This section applies only to hospitals which change ownership in the period July 1, 1993—June 30, 1995.

Authority

The provisions of this § 1163.70 issued under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.70 adopted June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181840) to (181843).

§ 1163.71. Scope of utilization review process.

Hospital inpatient services provided to MA recipients are subject to the utilization review procedures set forth in this chapter and in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.71 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85054).

§ 1163.72. Utilization review: general.

(a) Each hospital shall conduct reviews of each MA recipient's need for admission for inpatient hospital services and short procedure unit services in accordance with the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services.

(b) The Department's Bureau of Utilization Review regularly monitors each hospital's utilization review program to determine whether or not it is operating in accordance with the utilization review process and the MA regulations in this part. Monitoring is carried out through review of the hospital's admissions, readmissions, transfers, outliers, patient records, physicians' practice patterns and paid claims.

(c) The Department approves or disapproves the recipient's need for admission or readmission through its utilization review process.

(d) If a discrepancy exists between a hospital's utilization review plan and the instructions set forth in the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services, the Department's manual takes precedence.

(e) If the Department requests additional information on an admission or a day or cost outlier, the hospital shall submit the information within 30 calendar days of the request. If the hospital does not submit the requested information within 30 calendar days, the Department will make a decision based on the available information.

(f) Unless additional information is requested, the Department approves or disapproves the admission of each MA recipient within 5 days of receipt of the Hospital Admission DRG/CHR Certification Form.

(g) If the Department requests additional information for a hospital admission, the Department will notify the hospital of the approval or disapproval within 30 days of receipt of the additional information.

Source

The provisions of this § 1163.72 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85054).

Notes of Decisions

This section supports the Department's decision to deny reimbursement to a hospital which admitted patient overnight for treatment which could have safely been rendered in Special Procedure Unit. *Episcopal Hospital v. Department of Public Welfare*, 528 A.2d 676 (Pa. Cmwlth. 1987).

Cross References

This section cited in 55 Pa. Code § 1126.71 (relating to scope of utilization review process).

§ 1163.73. Hospital utilization review plan.

(a) Hospital utilization review plans shall provide for a utilization review committee that meets the requirements set forth in § 1163.74 (relating to requirements for hospital utilization review committees).

(b) Hospital utilization review plans shall describe the organization, composition and functions of the utilization review committee and specify the frequency of the meetings of the committee.

(c) Hospital utilization review plans shall provide for a review of each recipient's admission to the hospital under § 1163.77 (relating to admission review requirements).

(d) Hospital utilization review plans shall provide for a review of potential outlier cases under § 1163.78a or § 1163.78b (relating to review requirements for day outliers; or review requirements for cost outliers).

(e) Hospital utilization review plans shall describe the methods that the utilization review committees use to select and conduct Medical Care Evaluation studies under § 1163.79 (relating to Medical Care Evaluation studies).

Source

The provisions of this § 1163.73 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial pages (85054) to (85055).

Cross References

This section cited in 55 Pa. Code § 1163.41 (relating to general participation requirements).

§ 1163.74. Requirements for hospital utilization review committees.

(a) A hospital shall have a utilization review committee composed of two or more physicians, and assisted by other professional personnel as required under 42 CFR 456.106 (relating to organization and composition of UR committee; disqualification from UR committee membership). Committee members need not be members of the hospital medical staff.

(b) A member of the hospital utilization review committee may not participate in the review of a patient's case if he is or was responsible for the care of that patient.

(c) A member of the hospital utilization review committee may not have a direct or indirect financial interest in any hospital.

Source

The provisions of this § 1163.74 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial pages (85055) to (85056).

Cross References

This section cited in 55 Pa. Code § 1163.73 (relating to hospital utilization review plan).

§ 1163.75. Responsibilities of the hospital utilization review committee.

The hospital utilization review committee or its representative shall:

- (1) Conduct admission reviews under § 1163.77 (relating to admission review requirements).
- (2) Conduct continued stay reviews for potential outliers under § 1163.78a (relating to review requirements for day outliers).
- (3) Conduct Medical Care Evaluation studies under § 1163.79 (relating to Medical Care Evaluation studies).
- (4) Conduct reviews for medical necessity of services for potential cost under § 1163.78b (relating to review requirements for cost outliers).
- (5) Provide that each recipient's record include:
 - (i) An identification of the recipient.
 - (ii) Copies of the certification of admission document.
 - (iii) The name of the recipient's physician.
 - (iv) The date of admission and date of application for and authorization of MA benefits if application is made after admission.
 - (v) The initial and subsequent review dates specified under this chapter.
 - (vi) Documentation by the attending physician justifying the recipient's need for admission.
 - (vii) Documentation by the attending physician justifying the recipient's continued need for inpatient hospital services if requesting consideration as a day or cost outlier.
 - (viii) Other supporting material the utilization review committee believes appropriate.
- (6) Complete and submit a Hospital Admission DRG/CHR Certification Form for each MA recipient. If the form is not received by the Department within 10 calendar days of admission, payment for the inpatient services will be denied.
- (7) Validate that the patient's diagnosis and other information specified in the patient's medical record conforms with the information on the invoice submitted for payment.
- (8) Maintain utilization review records for a minimum of 4 years from the end of the fiscal year in which the recipient was discharged.

(9) Submit copies of utilization review records and documents, medical records, certification of admission document and discharge planning information to the Department upon request.

(10) Maintain copies of the certification of admission document with the patient's medical record and with the hospital copy of the invoice submitted for payment.

(11) Initiate discharge planning during the admission review process to provide timely placement in an appropriate level of care for those patients that may require posthospital care.

(12) Follow the procedures specified in the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services in conducting utilization review activities.

Source

The provisions of this § 1163.75 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended April 28, 2000, effective April 29, 2000, 30 Pa.B. 2130. Immediately preceding text appears at serial pages (85056) to (85057).

§ 1163.76. Plan of care.

(a) Before admission or no later than 2 days after admission of a recipient to a hospital, the attending or staff physician shall establish, and include in the recipient's medical record, an individual written plan of care.

(b) The plan of care shall include:

(1) Medical justification for admission and continued stay.

(2) Diagnoses, symptoms, complaints and complications indicating the need for admission.

(3) A description of the functional level of the individual.

(4) Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services and diet.

(5) Plans for continuing care including review and modification of the plan of care.

(6) Plans for discharge.

(c) The orders and activities shall be developed in accordance with physician's instructions and be reviewed and revised as appropriate to treat the recipient's condition.

Source

The provisions of this § 1163.76 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (85057).

§ 1163.77. Admission review requirements.

(a) The hospital utilization review committee or its representative shall review the need for admission of each MA recipient admitted to the hospital within 24 hours after admission. Transfers and readmissions are considered new hospital admissions for utilization review purposes.

(b) The hospital utilization review committee shall make a final determination of the need for admission within 2 working days after admission, unless the case has been designated for preadmission review in accordance with the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services.

(c) If the recipient is readmitted to the hospital within 7 days of discharge, the admission review shall include a review of the patient's previous admission to determine if:

(1) The readmission is for the provision of services that could or should have been provided during the previous admission.

(2) The readmission is the result of complications of the conditions that led to the previous admission.

(3) The readmission is unrelated to the previous admission.

(d) If an individual applies for MA while in the hospital, the committee or its representative shall:

(1) Review the need for hospitalization within 1 working day after the hospital is notified that the individual has applied for MA.

(2) Submit a Hospital Admission DRG/CHR Certification Form for the individual in accordance with the instructions set forth in the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services.

(e) The hospital utilization review committee or its representative shall make a final determination of each recipient's need for admission no later than 2 working days after the admission.

(f) The hospital utilization review committee shall establish written criteria on which it bases a recipient's need for admission. The criteria shall be more extensive for those admissions known to be associated with high costs, associated with the frequent furnishing of excessive services, or authorized by a physician whose patterns of care are questionable.

(g) The hospital utilization review committee or its representative shall assess the need for hospital inpatient services by comparing each admission to the hospital's written criteria established under subsection (f).

(h) The hospital utilization review committee shall allow the attending physician the opportunity to present his views before making a final decision on the need for admission.

(i) In the event of an adverse determination, the hospital utilization review committee shall follow the procedures set forth in § 1163.80 (relating to adverse determinations).

(j) The hospital utilization review committee shall conduct a review of those cases identified by the Office of MA, Bureau of Utilization Review as being a questionable utilization of hospital services and facilities.

Source

The provisions of this § 1163.77 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial pages (85057) to (85058).

Cross References

This section cited in 55 Pa. Code § 1163.73 (relating to hospital utilization review plan); and 55 Pa. Code § 1163.75 (relating to responsibilities of the hospital utilization review committee).

§ 1163.78. [Reserved].

Source

The provisions of this § 1163.78 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; reserved June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial pages (86843) to (86844).

§ 1163.78a. Review requirements for day outliers.

(a) If a hospital intends to apply for an outlier payment on the basis of the hospital stay's qualifying as a day outlier, the hospital utilization review committee or its representative shall review the need for continued stay of the MA case.

(b) The hospital utilization review committee shall establish written criteria on which it bases a recipient's need for continued stay. The criteria shall be based on the recipient's medical condition and must be more extensive for those cases known to be associated with high costs, associated with the frequent furnishing of excessive services or authorized by a physician whose patterns of care are questionable.

(c) The hospital utilization review committee or its representative shall assess the need for continued stay by comparing the case to the written criteria established under subsection (b).

(d) If a hospital stay qualifies as a day outlier under § 1163.56 (relating to outliers) the hospital utilization review committee or its representative shall assign subsequent review dates based on the date continued hospitalization will no longer be necessary.

(e) The hospital utilization review committee shall provide that the justification for the recipient's need for hospital inpatient services be documented in the patient's record.

(f) The hospital utilization review committee shall allow the attending physician the opportunity to present his views before making a final decision on the need for continued stay.

(g) In the event of an adverse determination, the hospital utilization review committee shall follow the procedures set forth in § 1163.80 (relating to adverse determinations).

Source

The provisions of this § 1163.78a adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.73 (relating to hospital utilization review plan); and 55 Pa. Code § 1163.75 (relating to responsibilities of the hospital utilization review committee).

§ 1163.78b. Review requirements for cost outliers.

(a) If a hospital intends to apply for an outlier payment on the basis of the hospital stay's qualifying as a cost outlier, the hospital utilization review committee or its representative shall review the services provided to the recipient to determine medical necessity.

(b) The utilization review committee or its representative shall identify services provided to the recipient listed as noncompensable services and items and services provided during noncompensable outlier days as specified under § 1163.59 (relating to noncompensable services, items and outlier days).

Source

The provisions of this § 1163.78b adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.73 (relating to hospital utilization review plan); and 55 Pa. Code § 1163.75 (relating to responsibilities of the hospital utilization review committee).

§ 1163.79. Medical Care Evaluation studies.

(a) The hospital utilization review committee shall conduct Medical Care Evaluation (MCE) studies under this section.

(b) MCE studies shall identify and analyze medical or administrative factors related to patient care rendered in the hospital and, when indicated, make recommendations for changes that would be beneficial to patients, staff, the hospital and the community.

(c) MCE studies shall include analysis of at least:

- (1) Admissions.
- (2) Length of stay.

- (3) Diagnostic categories.
- (4) Ancillary services, including drugs and biologicals.
- (5) Professional services performed in the hospital.
- (d) At least one MCE study shall be in progress at any time.
- (e) At least one MCE study shall be completed each calendar year.
- (f) The results of each MCE study shall be documented.
- (g) Documentation shall be made describing how the MCE study results have been used to institute improvements in the quality of care and to promote the efficient and effective use of hospital facilities.

Source

The provisions of this § 1163.79 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (86844).

Cross References

This section cited in 55 Pa. Code § 1163.73 (relating to hospital utilization review plan); and 55 Pa. Code § 1163.75 (relating to responsibilities of the hospital utilization review committee).

§ 1163.80. Adverse determinations.

- (a) If the hospital utilization review committee denies admission or continued stay, the committee shall forward a letter regarding the adverse determination to:
 - (1) The recipient.
 - (2) The recipient's next of kin or sponsor, if applicable.
 - (3) The attending physician.
 - (4) The hospital administrator.
 - (5) The Office of MA, Bureau of Utilization Review.
- (b) The adverse determination letter shall include:
 - (1) The patient's name.
 - (2) The patient's age.
 - (3) The patient's full MA number.
 - (4) The hospital's name.
 - (5) The admission date.
 - (6) The discharge date, if known.
 - (7) The diagnoses—required only on copy sent to the Office of MA.
- (c) The hospital utilization review committee shall send the adverse determination letter no later than the day after the determination.
- (d) Each month the hospital utilization review committee shall complete and submit to the Bureau of Utilization Review a summary report of adverse determinations in accordance with the instructions in the Provider Handbook. These instructions are also included in the Manual for Diagnosis Related Group Review of Inpatient Hospital Services.

(e) The hospital utilization review committee shall mail the monthly summary report specified in subsection (d) no later than 5 days after the end of the month.

Source

The provisions of this § 1163.80 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appear at serial page (86845).

Cross References

This section cited in 55 Pa. Code § 1163.77 (relating to admission review requirements); and 55 Pa. Code § 1163.78a (relating to review requirements for day outliers).

§ 1163.81. [Reserved].

Source

The provisions of this § 1163.81 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; reserved June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (86846).

ADMINISTRATIVE SANCTIONS

§ 1163.91. Provider misutilization.

If the Department determines that a provider billed for services inconsistent with this part, provided incorrect information on the billing invoice regarding a patient's diagnosis or procedures performed during the period of hospitalization or otherwise violated the standards set forth in the provider agreement, the provider is subject to the sanctions described in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.91 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (86846).

§ 1163.92. Administrative sanctions.

(a) If the hospital utilization review committee fails to review a MA recipient's need for admission or fails to request approval for the admission through the Department's Bureau of Utilization Review, the Department denies payment for the hospital stay.

(b) For potential day outlier cases, if the Department determines that a day of care occurring any time during the period of hospitalization was not medically necessary, the Department excludes those days in determining entitlement to any outlier payment amount.

2(c) For potential cost outlier cases, if the Department determines that services or items provided by the hospital were not medically justified, or were unnecessary, inappropriate or otherwise noncompensable, the Department excludes the cost for those services as well as the cost of services and items related to the provision of that service in determining entitlement to and payment amount for an outlier payment.

(d) If the Department determines that a hospital bill for services inconsistent with this part, provided incorrect information on the billing invoice regarding a patient's diagnosis or procedures performed during the period of hospitalization, the Department denies payment for the claims either concurrently or retroactively.

(e) If the Department determines that a hospital claim has been inappropriately coded based on information in the patient's medical record or discovers coding errors, the Department corrects the claim for payment purposes.

(f) If the Department determines that a hospital's utilization review process is not in accordance with the Department's Manual for Diagnosis Related Group Review of Inpatient Hospital Services, the hospital shall take corrective action within the time specified by the Department.

(g) If the Department has requested that a hospital take corrective action on its utilization review process and the hospital fails to do so within the specified time, the Department will terminate the hospital's provider agreement.

Source

The provisions of this § 1163.92 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (86846).

RIGHT OF APPEAL

§ 1163.101. Provider right to appeal.

(a) The hospital's right to appeal is under Chapter 1101 (relating to general provisions).

(b) Hospitals and practitioners do not have the right to a separate appeal on the same case.

(c) For cases undergoing the appeal process, payment, including adjustments, will be withheld until the case is adjudicated.

Source

The provisions of this § 1163.101 adopted September 23, 1983, effective September 24, 1983, 13 Pa.B. 2881; amended June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185. Immediately preceding text appears at serial page (86846).

TECHNICAL COMPUTATIONS**§ 1163.121. [Reserved].****Source**

The provisions of this § 1163.121 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150134) to (150137).

§ 1163.122. Determination of DRG relative values.

(a) The relative values for the forthcoming fiscal year are based on the following:

(1) The Department's most recent paid claims data available for at least a 2-year period. For example, the relative values to be used for Fiscal Year 1985-86 are based on paid claims data from the period July 1, 1982—December 21, 1984. The Department establishes a data base of claims appropriate for payment under the DRG payment system by removing claims:

- (i) For distinct part psychiatric units excluded from the DRG payment system.
- (ii) For distinct part drug and alcohol treatment units excluded from the DRG payment system.
- (iii) For services previously paid as inpatient hospital services but which are no longer paid as inpatient claims.
- (iv) For those that group into DRGs 469 and 470.
- (v) For those indicating that Medicare made part of the payment.
- (vi) For those involving patient transfers, except for transfers occurring in DRGs 385 and 456.
- (vii) For distinct part medical rehabilitation units excluded from the DRG payment system.

(2) The hospital's most recent cost report on file with the Department.

(b) From the hospital's most recent cost report on file with the Department, the Department determines each hospital's general care per diem cost, special care units per diem costs and cost to charge ratios for each of the hospital's ancillary departments. For hospitals with excluded units, the general care per diem cost for the prospectively paid portion of the hospital will be used when available.

(c) The Department determines the cost of each claim in its paid claims file in the following manner:

(1) For claims from the year as the hospital's most recent cost report on file with the Department, the cost of each claim is determined by:

- (i) Multiplying the claim's general care unit days by the hospital's general care unit per diem.

- (ii) Multiplying the claim's special care unit days, if any, by the unit's corresponding special care unit per diem.
- (iii) Multiplying the ancillary charges indicated on the invoice by a cost to charge ratio that corresponds to the ancillary department. If detailed ancillary charges are not available, the overall cost to charge ratio of the hospital is used to convert charges to costs.
- (iv) Adding the amounts established under subparagraphs (i)—(iii) to establish the costs of the claim.
- (v) Removing, when necessary, the portion of the costs on the claims attributable to:
 - (A) Depreciation and interest.
 - (B) Direct medical education.
 - (C) Direct care physicians' services.
- (2) For claims from the years preceding the year of the hospital's last filed cost report, the cost of the claim is inflated to be comparable in value to dollars of the year of the hospital's last filed cost report.
- (3) For claims from years following the year of the hospital's last filed cost report, the cost of the claim is deflated to be comparable in value to dollars of the year of the hospital's last filed cost report.
- (d) The Department adjusts the cost of a claim computed under subsection (c) by:
 - (1) Computing a hospital specific average cost per case by dividing the total costs for claims in a hospital by the total number of claims for the hospital.
 - (2) Computing a Statewide average cost per case by dividing the total costs for all claims by the total number of claims.
 - (3) Dividing the cost per case established in paragraph (1) by the Statewide average cost per case established in paragraph (2) to determine a hospital specific standardization factor.
 - (4) Multiplying the cost of a hospital's claim by its corresponding standardization factor.
- (e) The Department computes the relative value for each DRG by:
 - (1) Determining the total standardized cost for all approved claims in the data base.
 - (2) Determining the total number of MA hospital cases in the data base.
 - (3) Dividing the total standardized costs by the total number of cases to establish a Statewide average cost per case for all cases.
 - (4) Determining the total costs and total number of cases for each DRG.
 - (5) Dividing the total costs for each DRG by the corresponding number of MA cases for that DRG to establish an average cost per case for each DRG.
 - (6) Dividing the average cost per case for each DRG by the Statewide average cost per case for all cases as determined under paragraph (3) to establish the relative value for each DRG.

Source

The provisions of this § 1163.122 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 9, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913. Immediately preceding text appears at serial pages (112241) to (112242) and (131031) to (131032).

Notes of Decisions

During the first year of implementation of the prospective payment plan, it was appropriate to allow a hospital to request retroactive adjustments to its cost reports, even though the errors were unilateral and committed by the hospital. *Lancaster General Hospital v. Department of Public Welfare*, 535 A.2d 1238 (Pa. Cmwlth. 1988).

Cross References

This section cited in 55 Pa. Code § 1163.52 (relating to prospective payment methodology).

§ 1163.123. [Reserved].**Source**

The provisions of this § 1163.123 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 9, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; corrective amendment added January 23, 1987, effective November 10, 1984, 17 Pa.B. 392; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150139) to (150142).

§ 1163.124. [Reserved].**Source**

The provisions of this § 1163.124 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 9, 1986, effective October 10, 1986, 16 Pa.B. 3828; reserved November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384. Immediately preceding text appears at serial pages (112250) to (112252).

§ 1163.125. [Reserved].**Source**

The provisions of this § 1163.125 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 9, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150143) to (150144) and (177137).

§ 1163.126. Computation of hospital specific base payment rates.

(a) A hospital's base payment rate, which is exclusive of capital, will be the amount determined under this section.

(b) The Department will determine a hospital's case mix adjusted cost per case by first identifying the hospital's reported MA allowable costs from the hos-

pital's base year Fiscal Year 1986-87 Cost Report (MA 336) and from this amount subtracting each of the following items:

- (1) The MA portion of the hospital's inpatient costs for direct medical education.
- (2) The MA portion of the hospital's allowable net inpatient costs for depreciation and interest for buildings and fixtures.
- (c) The Department will determine a hospital's adjusted net MA allowable cost by adjusting the inpatient acute care MA cost determined under subsection (b) to account for differences between the hospital's reported MA days for the base year and the MA days contained in the Department's claims database for the base year. The Department will determine the adjustment by dividing the hospital's MA claims days by the hospital's reported MA days and multiplying this ratio by the hospital's adjusted inpatient acute care MA costs determined under subsection (b).
- (d) The Department will determine each hospital's net cost to be used in payment rate calculations by subtracting from the net MA allowable costs determined under subsection (c), the following costs determined using the Department's paid claims database for the base fiscal year:
 - (1) The cost outlier portion of costs for claims that qualify as cost outliers under § 1163.56 (relating to outliers).
 - (2) Day outlier portion of costs for claims that qualify as day outliers under § 1163.56.
 - (3) The costs of transfer claims except for DRGs 385 and 456.
 - (4) The costs of the hospital's claims which are no longer paid as inpatient claims.
 - (5) The cost of psychiatric claims exclusive of the first 2 days of the hospital stay, for hospitals without a distinct part psychiatric unit enrolled in the MA Program.
 - (6) The full costs of psychiatric claims, for hospitals with a distinct part psychiatric unit enrolled in the MA Program.
 - (7) The costs of drug and alcohol claims exclusive of the first 2 days of the hospital stay, for hospitals that are not approved for drug and alcohol detoxification services.
 - (8) The full costs of drug and alcohol claims, for hospitals with a distinct part drug and alcohol unit enrolled in the MA Program.
- (e) The Department will reduce a hospital's net cost determined under subsection (d) by the 1.77% overreporting factor.
- (f) The Department will determine a hospital's average cost per case for the base year by dividing the hospital's costs as established under subsection (e) by the adjusted number of MA cases for that year. The Department will determine the adjusted number of MA cases by:
 - (1) Identifying the hospital's total number of MA claims in the base year using the Department's paid claims database for the base fiscal year.

- (2) Subtracting from the amount in paragraph (1) each of the following items:
- (i) The number of claims identified for psychiatric services for hospitals with distinct part psychiatric units enrolled in the MA Program.
 - (ii) The number of claims identified for drug and alcohol treatment services for hospitals with distinct part drug and alcohol units enrolled in the MA Program.
 - (iii) The number of claims involving patient transfers, except for transfers occurring in DRGs 385 and 456.
 - (iv) The number of claims identified involving MA cases which were eligible for Medicare reimbursement.
 - (v) The number of claims which are no longer paid as inpatient claims.
- (g) The Department will standardize a hospital's average cost per case to account for case mix by dividing the hospital's average cost per case as determined under subsection (f) by its case mix index. The resultant value will be referred to as the base year case mix adjusted cost per case. The Department will determine the hospital's case mix index by:
- (1) Identifying the total number of MA DRG cases for the hospital for the base year from the Department's paid claims data.
 - (2) Summing the relative values of each of the cases identified under paragraph (1) to establish an aggregate relative value amount for the hospital.
 - (3) Dividing the hospital's aggregate relative value amount determined under paragraph (2) by the number of MA cases determined under paragraph (1) to establish an average relative value or case mix index for the hospital.
- (h) Except as specified in subsections (i) and (j), the Department will establish base rates for Fiscal Years 1993-94 and 1994-95, by trending forward each hospital's base year case mix adjusted cost per case by use of the following inflation factors:
- (1) 4.5% to account for Fiscal Year 1987-88 inflation.
 - (2) 5.6% to account for Fiscal Year 1988-89 inflation.
 - (3) 5.0% to account for Fiscal Year 1989-90 inflation.
 - (4) 5.3% to account for Fiscal Year 1990-91 inflation.
 - (5) 5.2% to account for Fiscal Year 1991-92 inflation.
 - (6) 4.6% to account for Fiscal Year 1992-93 inflation.
 - (7) 4.3% to account for Fiscal Year 1993-94 inflation, to be applied as follows:
- (i) Hospitals that qualified for a volume or rural disproportionate share rate enhancement for Fiscal Year 1992-93 will receive the 4.3% inflation factor effective July 1, 1993.
 - (ii) Hospitals that did not qualify for a volume or rural disproportionate share rate enhancement for Fiscal Year 1992-93 will receive the 4.3% inflation factor effective January 1, 1994.

(8) For Fiscal Year 1994-95, effective January 1, 1995, acute care general hospitals will receive an inflation factor equal to the prospective payment system type hospital market basket moving average inflation factor published by DRI/McGraw-Hill in the fourth calendar quarter of 1993 for the second calendar quarter of 1995.

(i) The Department will establish base rates as follows for hospitals that changed ownership during the period July 1, 1986, through June 30, 1993:

(1) For a hospital that elected to have its rates rebased upon change of ownership, the base rate for Fiscal Year 1993-94 will be the base rate effective June 30, 1993, trended forward using applicable inflation factors.

(2) For a hospital that elected not to have its rate rebased upon change of ownership, the base rate for Fiscal Year 1993-94 will be the rate calculated under subsections (a)—(h) for the prior entity.

(j) Rates established under subsections (a)—(i) will be limited as follows:

(1) For Fiscal Year 1993-94, a hospital's base rate may not exceed \$6,244.

(2) For Fiscal Year 1994-95, a hospital's base rate may not exceed \$6,244 increased effective January 1, 1995, by the inflation factor described under subsection (h)(8).

Authority

The provisions of this § 1163.126 issued under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.126 adopted June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181849) to (181852).

Cross References

This section cited in 55 Pa. Code § 1163.52 (relating to prospective payment methodology).

§ 1163.127. [Reserved].

Source

The provisions of this § 1163.127 adopted June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181853) to (181855).

Subchapter B. HOSPITALS AND HOSPITAL UNITS UNDER COST REIMBURSEMENT PRINCIPLES**GENERAL PROVISIONS**

- Sec.
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1163.402. Definitions.

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ADMINISTRATIVE SANCTIONS

- 1163.491. Provider misutilization.
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- 1163.501. Provider right to appeal.

CHANGE OF OWNERSHIP

- 1163.511. Change of ownership or control.

Cross References

This subchapter cited in 55 Pa. Code § 1151.54 (relating to disproportionate share payments); 55 Pa. Code § 1163.32 (relating to hospital units excluded from the DRG prospective payment system); 55 Pa. Code § 1163.51 (relating to general payment policy); and 55 Pa. Code § 1163.67 (relating to disproportionate share payments).

GENERAL PROVISIONS

§ 1163.401. Policy.

(a) This subchapter applies to freestanding medical rehabilitation hospitals, drug and alcohol rehabilitation hospitals and drug and alcohol rehabilitation and medical rehabilitation units of general hospitals.

(b) The MA Program provides payment for medically necessary covered inpatient services provided to eligible recipients by providers of inpatient hospital care enrolled in the MA Program. Payment for these services is subject to this chapter and Chapter 1101 (relating to general provisions).

Authority

The provisions of this § 1163.401 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

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Source

The provisions of this § 1163.401 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (177188) and (150147).

§ 1163.402. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Certified day—A day of inpatient hospital care approved by the Department, under the limits established in this chapter.

Day of inpatient hospital care—Room, board and professional services furnished to a patient on a continuous 24-hour-a-day basis in a semiprivate room of a hospital. The term includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided in an institution other than one maintained primarily for treatment and care of patients with tuberculosis or mental disease.

Drug and alcohol rehabilitation hospital—A freestanding entity which meets the definition of a hospital under this section, and is licensed by the Department of Health to provide drug and alcohol treatment and rehabilitation.

Drug and alcohol rehabilitation unit—A unit of an acute care general hospital which is licensed by the Department of Health to provide drug and alcohol treatment and rehabilitation.

Hospital—A facility licensed as a hospital under 28 Pa. Code Part IV, Subpart B (relating to general and special hospitals) which provides equipment and services primarily for inpatient care to persons who require treatment for injury, illness, disability or pregnancy. The term does not include public or private psychiatric hospitals, general nursing facilities, hospital-based nursing facilities, county-operated nursing facilities, intermediate care facilities for the mentally retarded, psychiatric transitional facilities or special rehabilitation nursing facilities.

Inpatient hospital services—Services other than those provided by an institution for tuberculosis or mental diseases which are ordinarily furnished in a hospital for the care and treatment of inpatients, furnished under the direction of a licensed physician, dentist, podiatrist or nurse-midwife.

Institutionalized individual—A person who is detained or confined under one of the following:

- (i) A civil or criminal statute in a correctional, rehabilitative or mental retardation facility, psychiatric hospital or other facility for the care and treatment of mental illness or mental retardation.
- (ii) Voluntary commitment in a psychiatric hospital, mental retardation facility or other facility for the care and treatment of mental illness or mental retardation.

Medical rehabilitation hospital—A freestanding entity which meets the definition of a hospital under this section, and participates in the Medicare Program as an excluded rehabilitation hospital or, for children's hospitals only, meets the Medicare requirements for an excluded rehabilitation hospital in 42 CFR 412.23(b) (relating to excluded hospitals classifications).

Medical rehabilitation unit—A distinct part unit of a general hospital which: is recognized as an excluded rehabilitation unit under the Medicare Program; has formally applied to Medicare for exclusion from the prospective payment system and is undergoing the 12-month evaluation period; or, for the children's hospitals only, would meet the Medicare definition of excluded rehabilitation unit if the unit chose to apply for Medicare exclusion. For the purposes of this subchapter, units that are organized primarily for the treatment of burns are not included, but will continue to be reimbursed subject to Subchapter A and Chapter 1101 (relating to acute care general hospitals under the prospective payment system; and general provisions).

Patient pay amount—Income or assets that a recipient has available to meet the cost of medical care as determined by the CAO. The recipient, not the MA Program, pays this amount toward the cost of care.

Rehabilitation hospital—A hospital which meets the definition of either a drug and alcohol rehabilitation hospital or a medical rehabilitation hospital under this section.

Therapeutic leave—A period of absence from the hospital related to the treatment of an individual's illness.

Authority

The provisions of this § 1163.402 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.402 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181858) to (181860).

SCOPE OF BENEFITS

§ 1163.421. Scope of benefits for the categorically needy.

Categorically needy recipients are eligible for medically necessary inpatient hospital services, provided by participating general or rehabilitation hospitals and covered by the MA Program subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.421 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

§ 1163.422. Scope of benefits for the medically needy.

Medically needy recipients are eligible for medically necessary inpatient hospital services, provided by participating general or rehabilitation hospitals and covered by the MA Program subject to the conditions and limitations established by this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.422 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

§ 1163.423. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for inpatient hospital services unless the recipient is also categorically needy or medically needy.

Source

The provisions of this § 1163.423 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

§ 1163.424. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1163.424 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

PROVIDER PARTICIPATION**§ 1163.441. General participation requirements.**

(a) In addition to the participation requirements established in Chapter 1101 (relating to general provisions), a cost reimbursed provider shall:

- (1) Be licensed by the Department of Health.
- (2) Have in effect a utilization review plan approved by Medicare or, for providers not participating in Medicare, a utilization review plan approved by the Office of Medical Assistance Programs. For a utilization review plan to be approved by the Office of Medical Assistance Programs, it shall meet the requirements in § 1163.473 (relating to hospital utilization review plan).

(b) Out-of-State rehabilitation hospitals furnishing inpatient hospital care to Commonwealth recipients shall:

- (1) Be Medicare certified, or certified by the appropriate agency of the state in which the hospital is located as meeting standards comparable to Medi-

care or be certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

(2) Be currently participating in the Medicaid Program of the state in which the hospital is located.

(3) Formally enroll in the MA Program and sign a provider agreement.

(c) The Department reserves the right to refuse to enter into a provider agreement with a licensed hospital or a distinct part thereof if it determines that it is in the Department's best interests to do so.

Authority

The provisions of this § 1163.441 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1).)

Source

The provisions of this § 1163.441 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181861).

§ 1163.442. Requirements for reimbursement under this subchapter.

(a) Only the following types of providers are eligible to be reimbursed under this subchapter:

(1) Medical rehabilitation hospitals that fully comply with the Medicare regulations at 42 CFR 412.23(b) (relating to excluded hospitals: classifications).

(2) Distinct part drug and alcohol rehabilitation units of general hospitals that meet the requirements set forth in subsection (b).

(3) Drug and alcohol rehabilitation hospitals that meet the requirements set forth in subsection (d).

(4) Medical rehabilitation units of general hospitals that meet the requirements in subsection (e).

(b) To be considered a drug and alcohol rehabilitation unit for MA purposes, the unit shall:

(1) Be part of a hospital enrolled in the MA Program.

(2) Meet the criteria of a distinct part unit as set forth in subsection (c).

(3) Be approved by the Department of Health, Office of Drug and Alcohol Programs to provide drug and alcohol treatment and rehabilitation.

(4) Be enrolled in the MA Program as a distinct part drug and alcohol treatment/rehabilitation unit.

(c) To qualify as a distinct part unit for MA purposes, the unit shall:

(1) Have written admission criteria that are applied uniformly to both MA patients and non-MA patients.

- (2) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.
 - (3) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.
 - (4) Have utilization review standards applicable for the type of care offered in the unit.
 - (5) Have beds physically separate from; that is, not commingled with the hospital's other beds.
 - (6) Be treated as a separate cost center for cost finding and apportionment purposes.
 - (7) Use an accounting system that properly allocates costs.
 - (8) Maintain adequate statistical data to support the basis of allocation.
 - (9) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.
- (d) For a drug and alcohol rehabilitation hospital to be eligible for reimbursement under this subchapter, the hospital shall:
- (1) Be enrolled in the MA Program.
 - (2) Be approved by the Department of Health to provide inpatient drug and alcohol rehabilitation services.
 - (3) Have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75% required treatment for drug or alcohol abuse.
- (e) To be considered a medical rehabilitation unit for MA purposes, the unit shall:
- (1) Be part of a hospital enrolled in the MA Program.
 - (2) Meet the criteria of a distinct part unit in subsection (c).
 - (3) Be enrolled or have applied for enrollment in the Medicare Program as an excluded rehabilitation unit, unless the unit is located in a non-Medicare participating children's hospital in which case the unit shall be able to meet the Medicare rehabilitation unit criteria, but will not be required to enroll in the Medicare Program.
 - (4) Be enrolled in the MA Program as a distinct part medical rehabilitation unit.
 - (5) Be certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and if certified by JCAHO, also be certified under JCAHO rehabilitation standards.

Authority

The provisions of this § 1163.442 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.442 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended October 9, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (177190) to (177191) and (150151) to (150152).

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.443. Ongoing responsibilities of providers.

In addition to the ongoing responsibilities established in Chapter 1101 (relating to general provisions), and as a condition of continued participation in the MA Program, rehabilitation hospitals and those general hospitals providing distinct part unit services that are reimbursed under this subchapter shall comply with the following:

- (1) Maintain transfer agreements with skilled nursing and intermediate care facilities, private psychiatric hospitals, and rehabilitation hospitals, for the prompt and appropriate transfer of patients who no longer need acute inpatient hospital care. Rehabilitation hospitals need not maintain agreements with each other.
- (2) Retain complete, accurate and auditable medical and fiscal records for 4 years for all MA patients under Chapter 1101.
- (3) Furnish to the Department or its agents, Federal and State auditors, auditable copies of patient records and fiscal records upon request under Chapter 1101.
- (4) For those hospitals not participating in Medicare, submit to the Office of MA for review and approval, details of any changes to the hospital's utilization review system, including revisions to the utilization review plan, within 30 days of the date of the change.
- (5) Hospitals being reimbursed for distinct part unit services shall keep separate patient statistics and fiscal records on the cost of, and charges for, services provided to MA patients in each distinct part unit being reimbursed under this subchapter.

Source

The provisions of this § 1163.443 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

PAYMENT FOR COST REIMBURSED HOSPITAL SERVICES**§ 1163.451. General payment policy.**

(a) The payment policy established in this section and §§ 1163.452—1163.458 applies to cost reimbursed inpatient services provided by participating

hospitals. The Department will reimburse hospitals for the allowable costs they incur in providing compensable cost reimbursed services to MA recipients. As a condition of payment, those services shall meet the requirements of, and be provided within, the limitations in this subchapter and Chapter 1101 (relating to general provisions). The Department will assume responsibility for payment only after other possible sources of payment are exhausted.

(b) The Department will reimburse hospitals for cost items that it determines are allowable under § 1163.453 (relating to allowable and nonallowable costs).

(c) Prior to a settlement based on audited costs and charges, the Department will pay hospitals an interim per diem rate for inpatient cost reimbursed services provided to MA recipients under § 1163.452(a) (relating to payment methods and rates).

(d) A final settlement will be made after the hospital's cost report has been audited by the Department of the Auditor General. The final settlement is subject to § 1163.452(c).

(e) The hospital shall submit invoices to the Department in accordance with the instructions in the Provider Handbook.

(f) The readmission of a patient to a hospital within 24 hours of the patient's discharge from the same hospital is not considered a new admission for MA purposes. It is considered a continuation of the original admission.

(g) Payment for preadmission laboratory tests, radiology services and other diagnostic services provided to patients admitted to the hospital will be included in the payment for inpatient services. The hospital may not submit a separate bill for these services. If preadmission diagnostic services are provided to a scheduled inpatient who is not admitted to the hospital as expected, the diagnostic services shall be billed as outpatient services according to the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program Fee Schedule.

(h) For payment to be made for laboratory tests and other diagnostic procedures, the studies shall be related to the patient's condition and be specifically ordered in writing for the particular patient by the attending physician or other licensed practitioner who is responsible for determining the diagnosis or treatment of that patient. In emergency situations, an exception is made to the requirement that studies be specifically ordered in writing if the test or procedure is necessary to prevent the death or serious impairment of the health of the recipient. Payment will not be made for diagnostic services performed pursuant to a pre-printed regimen.

(i) The hospital may not seek reimbursement from an MA recipient if certification for days of care is denied by the hospital's utilization review committee or the Department through its Concurrent Hospital Review (CHR) process. If a patient who has been discharged by a physician refuses to leave the hospital at the end of a certified stay, the hospital may bill the recipient for days used beyond the certified length of stay.

(j) The hospital may bill an MA recipient for days of care related to a non-covered service if the recipient was informed, prior to receiving the service, that the particular service and the inpatient care relating to it is not covered under the MA Program.

(k) The hospital may not bill the MA Program for services provided to a person who has applied for MA benefits unless the CAO has notified the hospital that the person is eligible for MA benefits.

(l) If a hospital voluntarily terminates the provider agreement, payment for inpatient hospital services continues, for MA patients admitted prior to the date on which the facility announced its intent to withdraw from the Program, until the effective date of the termination. Departmental payment will stop for services provided on and after the effective date of the termination of the provider agreement.

(m) If a patient is admitted to the distinct part, medical rehabilitation or drug and alcohol detoxification/rehabilitation unit of a general hospital from the emergency room, the services provided in the emergency room shall be billed on the inpatient invoice.

(n) Except as specified in subsection (o), cost-reimbursed services and items provided to an inpatient shall be billed as inpatient services.

(o) The following services and items may not be billed as inpatient services:

(1) Direct care services provided by salaried practitioners.

(2) Ambulance services for:

(i) Patients transferred from the emergency room or clinic of a hospital to another hospital for admission.

(ii) Inpatients discharged from one hospital, transferred by ambulance to another hospital and then admitted by the second hospital.

Authority

The provisions of this § 1163.451 amended under section 443.1(1) of the Public Welfare Code (62 P. S. § 443.1(1)); and Articles I—XI and XIV of the Public Welfare Code (62 P. S. §§ 101—1411).

Source

The provisions of this § 1163.451 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended through October 9, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended December 14, 1990, effective January 1, 1991, 20 Pa.B. 6164; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181864) to (181867).

Cross References

The section cited in 55 Pa. Code § 1163.451a (relating to clarification of the term “in writing”—statement of policy); and 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.451a. Clarification of the term “in writing”—statement of policy.

(a) The term “in writing” in § 1163.451(h) (relating to general payment policy) includes orders that are handwritten or transmitted by electronic means.

(b) Written orders transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

Source

The provisions of this § 1163.451a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

§ 1163.452. Payment methods and rates.

(a) Subject to the per diem cap on interim and final payment specified in subsection (f), the Department's payment policies relating to interim payments for cost reimbursed services are as follows:

(1) The Department will pay an interim per diem rate for inpatient hospital care provided by freestanding licensed rehabilitation hospitals, general hospital distinct part medical rehabilitation units and distinct part units of general hospitals that are approved by the Department of Health to provide both detoxification and rehabilitation services.

(2) The amount of the Department's interim payment for services provided to each MA recipient per admission will be the hospital's or the unit's interim per diem rate as specified in this section multiplied by the number of compensable days minus payment owed by the recipient, a legally responsible relative or a third-party payor. Medicare Part B payments and other resources available to the patient to meet the cost of inpatient hospital care also are deducted from the interim payment.

(3) For Fiscal Years 1991-92—1994-95, for existing freestanding rehabilitation hospitals and medical rehabilitation units, the Department will determine the interim payment rate as described in subparagraphs (i)—(iv). "Existing" refers to hospitals and units which have submitted an MA cost report covering the 12-month cost reporting period ending June 30, 1988.

(i) The Department will use Fiscal Year 1987-88 as the base year for determining the interim payment rate.

(ii) The Department will use the following inflation factors in the interim rate calculation:

(A) 5.6% from Fiscal Year 1987-88 to 1988-89.

(B) 5.0% from Fiscal Year 1988-89 to 1989-90.

(C) 5.3% from Fiscal Year 1989-90 to 1990-91.

(D) 5.2% from Fiscal Year 1990-91 to 1991-92.

(E) 4.6% from Fiscal Year 1991-92 to 1992-93.

(F) 4.3% from Fiscal Year 1992-93 to 1993-94 to be applied as follows:

(I) Hospitals and units that qualified for a disproportionate share payment other than a supplemental disproportionate share payment for Fiscal Year 1992-93 will receive the 4.3% inflation factor effective July 1, 1993.

(II) Hospitals and units that did not qualify for a disproportionate share payment other than a supplemental disproportionate share payment for Fiscal Year 1992-93 will receive the 4.3% inflation factor effective January 1, 1994.

(G) For Fiscal Year 1994-95, effective January 1, 1995, hospitals and units will receive an inflation factor equal to the prospective payment sys-

tem type hospital market basket moving average inflation factor published by DRI/McGraw-Hill in the fourth calendar quarter of 1993 for the second calendar quarter of 1995.

(iii) For freestanding rehabilitation hospitals, the Department will determine the interim rate as follows:

(A) The Department will identify the audited MA per diem cost without ceiling adjustments for Fiscal Year 1987-88 and later.

(B) If the audited MA per diem cost for Fiscal Year 1987-88 or thereafter is not available, the Department will use the reported MA per diem cost for Fiscal Year 1987-88 in the calculation.

(C) The Department will inflate each per diem cost identified under clause (A) or (B), as applicable, by the applicable inflation factors in subparagraph (ii).

(D) The Department will establish the interim per diem rate at the lowest of the rates calculated under clause (C).

(iv) For medical rehabilitation units, the Department will determine the interim rate as follows:

(A) The Department will identify audited MA per diem costs without ceiling adjustment for all fiscal years and MA reported per diem costs for unaudited years.

(B) The Department will inflate each per diem identified under clause (A) by the applicable inflation factors in subparagraph (ii).

(C) The Department will establish the interim rate at the lowest of the rates calculated under clause (B).

(4) For Fiscal Years 1991-92—1994-95, for new freestanding rehabilitation hospitals and medical rehabilitation units, the Department will determine the interim payment rate as described in subparagraphs (i)—(iii). “New” refers to facilities which had not completed a 12-month cost report for the period ending June 30, 1988.

(i) For the first fiscal year of operation, the Department will base the interim per diem rate on a projected budget submitted to, and accepted by, the Department for the forthcoming fiscal year.

(ii) For subsequent fiscal years except as provided under subparagraph (iii), the Department will base the interim per diem rate on the projected budget submitted to the Department for the first fiscal year of operation, adjusted for inflation by the applicable inflation factors specified in paragraph (3)(ii).

(iii) When a full fiscal year cost report is submitted to the Department by a new hospital or unit, covered under this paragraph, the interim per diem rate paid by the Department will be based on the full fiscal year reported cost, adjusted for inflation by the applicable inflation factors under paragraph (3)(ii).

- (5) The MA Program recognizes only one interim per diem rate for a hospital at one time.
- (6) If the patient pay amount plus the insurance payment for hospital care equals or exceeds the hospital's interim per diem rate multiplied by the number of compensable days, the Department will not make payment for the hospital care.
- (7) For Fiscal Years 1993-94 to 1994-95, for existing drug and alcohol units, the Department will determine the interim payment rate as described in subparagraphs (i)—(iii). "Existing" refers to hospitals and units which have submitted an MA cost report covering the 12-month cost reporting period ending June 30, 1990.
- (i) The Department will identify the following per diem rates for each facility:
- (A) The Fiscal Year 1989-90 audited MA per diem cost without ceiling adjustment.
- (B) The latest MA final audited per diem payment rate, subsequent to Fiscal Year 1989-90.
- (C) The reported MA per diem costs for unaudited Fiscal Years 1989-90 or later.
- (ii) The Department will inflate each per diem rate identified under subparagraph (i) to the forthcoming fiscal year by the applicable inflation factors in paragraph (3)(ii).
- (iii) The Department will establish the interim rate at the lowest of the per diem rates calculated under subparagraph (ii).
- (8) For Fiscal Years 1993-94 and 1994-95, for new drug and alcohol units, the Department will determine the interim payment rate as described in subparagraphs (i)—(iii). "New" refers to units which have not submitted an MA cost report covering the 12-month cost reporting period ending June 30, 1990.
- (i) For the first fiscal year, the Department will base the interim per diem rate on a projected budget submitted to, and accepted by, the Department for the forthcoming fiscal year of operation.
- (ii) Except as provided under subparagraph (iii), for subsequent fiscal years, the Department will base the interim per diem rate on the projected budget submitted to the Department for the first fiscal year of operation adjusted for inflation by the applicable inflation factors specified in paragraph (3)(ii).
- (iii) When a full fiscal year cost report is submitted to the Department for a unit covered under this paragraph, the interim per diem rate paid by the Department will be based on the full fiscal year reported cost adjusted for inflation by the applicable factors under paragraph (3)(ii).
- (b) The Department's payment policies relating to cost settlements pertaining to cost reimbursed providers are as follows:

- (1) A hospital shall complete form MA 336 (Financial Report for Hospital and Hospital-Health Care Complex Under the Medical Assistance Program of the Department of Human Services, Commonwealth of Pennsylvania) or its successor in accordance with Medicare principles at 42 CFR Part 413 (relating to principles of reasonable cost reimbursement; payment for end-stage renal disease services) and in accordance with the instructions accompanying the cost report.
- (2) The hospital shall submit form MA 336 to the Department's Office of Medical Assistance Programs by September 30 of each year. If the cost reimbursed provider participates in Medicare, a completed copy of Form HCFA-2552 (Hospital and Hospital Health Care Complex Cost Report) also shall be submitted by the hospital to the Department as a supplement to form MA 336.
- (3) The cost reimbursed provider's cost report shall:
 - (i) Be prepared using the accrual basis of accounting.
 - (ii) Cover a fiscal period of 12 consecutive months from July 1 to June 30, except as noted in subparagraph (iv).
 - (iii) Include information necessary for the proper determination of costs payable under the program, including financial records and statistical data.
 - (iv) Cover the period from the date of approval for participation in the MA Program to the end of that fiscal year, for a cost reimbursed provider beginning operations during the fiscal year.
 - (v) Identify separately the costs attributed to each of those units, for distinct part drug and alcohol detoxification/rehabilitation and medical rehabilitation units of general hospitals.
 - (vi) Be adjusted to remove the costs of direct care by salaried physicians and other salaried practitioners.
- (4) For cost reporting periods ending prior to October 1, 1985, if the total amount of the MA payment for interim claims for services rendered by a cost reimbursed provider during the fiscal year exceeds that provider's total audited costs, the Department will notify the provider that an overpayment has occurred. If an overpayment has occurred, the Department offsets the overpayment against the current payments due to the provider unless the provider, within 60 days of the notification of the overpayment, either:
 - (i) Makes payment in full for the overpayment.
 - (ii) Makes arrangements for repayment with the Department's Office of the Comptroller and repays the overpayment with 180 days of this arrangement.
- (c) Subject to the per diem cap on final payment specified in subsection (f), the Department's payment policies relating to upper limits to final audited payments to cost reimbursed providers are as follows:
 - (1) Except as specified in paragraphs (2) and (3), the Department will not pay a final audited per diem rate that exceeds the hospital's or the unit's audited per diem rate for the preceding fiscal year multiplied by the applicable

inflation factor in subsection (a)(3)(ii). The audited per diem rate ceiling will be calculated to exclude costs excluded under subsection (d).

(2) For Fiscal Years 1991-92—1994-95, for freestanding rehabilitation hospitals and distinct part medical rehabilitation units of general hospitals, the Department will use Fiscal Year 1987-88 as the base year to establish reimbursement ceilings. The Department will use the first complete fiscal year of enrollment as the base year for new hospitals and units. For hospitals and units covered under this paragraph, the Department will calculate reimbursement ceilings by inflating the base year MA audited per diem by the applicable inflation factors in subsection (a)(3)(ii). The Department will establish the final per diem payment rate at the lesser of the facility's audited per diem cost or the reimbursement ceiling. If a facility's audited per diem cost falls below the reimbursement ceiling, its base year will be its lowest cost year.

(3) For Fiscal Year 1993-94—1994-95, for distinct part drug and alcohol units of general hospitals, the Department will use Fiscal Year 1989-90 as the base year to establish reimbursement ceilings. For units which enrolled in the MA Program after July 1, 1989, the Department will use the first complete fiscal year of enrollment as the base year. For units covered under this paragraph, the Department will calculate reimbursement ceilings by inflating the base year MA audited per diem by the applicable inflation factors listed in subsection (a)(3)(ii). The Department will establish the final per diem payment rate at the lesser of the facility's audited per diem cost or reimbursement ceiling. If a facility's audited per diem cost falls below the reimbursement ceiling, its base year will be its lowest cost year.

(4) For a medical rehabilitation unit that is not recognized by Medicare for exclusion after completing the 12-month evaluation period, final payment will be the lesser of the unit's audited per diem rate determined by the Department in accordance with the Department's regulations and Medicare cost reimbursement principles, or the number of allowable MA days for the unit multiplied by a Statewide average of the final per diem rates of enrolled Medicare excluded medical rehabilitation units for the same fiscal year.

(5) Payment for inpatient hospital services, including acute care general hospitals and their distinct part units, private psychiatric hospitals and freestanding rehabilitation hospitals, may not exceed the lower of the amount that would be paid in the aggregate for the services under Medicare principles of reimbursement under 42 CFR Part 413 (relating to principles of reasonable cost reimbursement, payment for end stage renal disease services), or the hospital's customary charges to the general public for the services.

(d) The Department's payment policies relating to costs excluded from upper limits on payments to cost reimbursed providers are as follows:

(1) The Department will exclude certain costs from the final audited per diem rate limits established in subsection (c). To apply for this cost exclusion, a provider shall submit documentation sufficient to enable the Department to

verify that the requirements of this section are met. For the purposes of this subsection, "provider" refers to the cost reimbursed hospital or cost reimbursed hospital unit covered under this subchapter, and references to the provider's costs or data refer to the specific costs or data of the cost reimbursed provider.

(2) Costs excluded from the per diem rate limit are:

(i) Increases in a provider's allowable depreciation and interest costs for a fixed asset which was entered in the hospital's fixed asset ledger in the year being audited.

(ii) Costs incurred by a provider which meets the requirements of paragraph (3).

(iii) Costs attributable to a fixed asset project that is:

(A) Subject to review for Certificate of Need approval and approved under 28 Pa. Code Chapter 301 or 401 (relating to limitation on Federal participation for capital expenditures; or Certificate of Need Program).

(B) Related to patient care under Medicare standards.

(3) For cost reimbursed providers to qualify for the cost exclusion in this subsection, the following requirements shall be met:

(i) The provider's rate of increase in overall audited costs shall exceed 15%. This rate of increase is established by comparing the provider's audited costs for the fiscal year for which eligibility for the exclusion is being sought to its audited costs for the preceding fiscal year.

(ii) The provider's rate of increase for allowable depreciation and interest shall exceed its rate of increase for net operating costs. The rate of increase in a provider's net operating costs is established by comparing the provider's audited net operating costs for the fiscal year for which eligibility for the exclusion is being sought to its audited net operating costs for the preceding fiscal year. The rate of increase of a provider's depreciation and interest costs is established as follows:

(A) The provider's allowable audited depreciation and interest costs for the preceding fiscal year are determined, including costs excluded in a preceding fiscal year, under paragraph (2).

(B) The amount allowable under paragraph (2) for the fiscal year being audited is added to the amount determined in clause (A).

(C) The amounts determined in clauses (A) and (B) are compared to determine the rate of increase.

(4) Costs excluded from the limits established in subsection (c) are excluded in subsequent fiscal years, until base year rates are rebased to a period which is either the same as, or is subsequent to, the period of the cost exclusion.

(e) For cost reporting periods ending on or after October 1, 1985, if the total amount of MA payment for interim claims for services during the fiscal year

exceeds the total audited costs, the Department will recover the overpaid amount from the provider under § 1101.69(b) (relating to overpayment—underpayment).

(f) For Fiscal Years 1993-94 and 1994-95, the cap on both the interim and final per diem rates for cost reimbursed services will be as set forth in paragraphs (1) and (2). The cap does not apply to services rendered to a recipient who has not attained his first birthday, or in the case of such an individual who is an inpatient on his first birthday until the individual is discharged.

(1) For Fiscal Year 1993-94, \$950 inclusive of costs which may be excluded from the upper limits on payment under subsection (d), but exclusive of disproportionate share payments determined under § 1163.459 (relating to disproportionate share payments).

(2) For Fiscal Year 1994-95, \$950, adjusted for inflation effective January 1, 1995, by the inflation factor listed in subsection (a)(3)(ii)(G), inclusive of cost which may be excluded from the upper limits on payment under subsection (d), but exclusive of disproportionate share payments determined under § 1163.459.

Authority

The provisions of this § 1163.452 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.452 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended July 12, 1985, effective July 13, 1985, 15 Pa.B. 2572, and will apply to reimbursement for services for FY 1984-85 and for each fiscal year thereafter; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; corrected April 10, 1987, effective July 13, 1985, 17 Pa.B. 1502; amended February 5, 1988, effective February 6, 1988, 18 Pa.B. 556; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; amended June 18, 1993, provisions relating to reimbursement for inpatient rehabilitation services for Fiscal Years 1991-92 and 1992-93 are effective July 1, 1991 and subsection (c)(7)—(11) is effective July 1, 1984; corrected July 9, 1993, 23 Pa.B. 3289; amended October 29, 1993, the provisions relating to reimbursement for inpatient rehabilitation services for Fiscal Years 1991-1992 and 1992-1993 is July 1, 1991, and subsection (c)(7)—(11) is effective July 1, 1984, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181867) to (181874).

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy); and 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.453. Allowable and nonallowable costs.

(a) Payment for cost reimbursed inpatient hospital services is based on the allowable cost for the services in this section.

(b) Unless clearly specified to the contrary in this chapter, allowable costs for the MA Program are computed under Medicare principles under the Social Security Act (42 U.S.C.A. §§ 301—1397f) and Federal regulations and instructions.

(c) The Department may not make payment for a service at a rate higher than the hospital's customary charge. For the purpose of this chapter, the hospital's customary charge is the usual charge to the general public for a specific service.

(d) Costs not allowable under the MA Program are:

(1) Costs exceeding the limits established by the Department of Health and Human Services under Medicare regulations set forth at 42 CFR 413.30 (relating to limitations on reimbursable costs).

(2) Costs related to the provision of a noncompensable service or item under § 1163.455 (relating to noncompensable services and items).

(3) Costs related to depreciation and interest for rehabilitation hospitals unless the hospital was one of the following:

(i) Constructed prior to July 1, 1983.

(ii) Issued either a Section 1122 approval letter or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a certificate of need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health no later than June 30, 1983. The Department will not recognize depreciation or interest as an allowable cost if the facility does not substantially implement the project as defined at 28 Pa. Code § 401.5(j)(2) (relating to Certificate of Need) within the effective period of the original Section 1122 approval or the original certificate of need.

(4) Costs for legal services relating to litigation against the Commonwealth, including administrative appeals, if the litigation is finally decided in favor of the Commonwealth.

(5) Costs for relocating or housing employees.

(6) Telephone, television and radio services in patient rooms.

(7) Personal care and maternity kits.

(8) Costs related to depreciation and interest for providers reimbursed under this subchapter except for medical rehabilitation units unless:

(i) An application for a certificate of need for the new or additional beds has been approved by the Department of Health, with an effective date of June 30, 1986, or earlier. In order for the facility to receive payment, the project shall be substantially implemented as defined at 28 Pa. Code § 401.5(j)(2) within the effective period of the certificate of need.

(ii) A letter nonreviewability has been issued on or before June 30, 1986.

(9) For medical rehabilitation units, costs related to capital costs for new or additional beds unless one of the following applies:

(i) The new or additional medical rehabilitation beds were placed in service prior to July 1, 1988, and are located in a medical rehabilitation unit which was enrolled in the MA Program with an effective date no later than July 1, 1988. This includes beds which are one of the following:

- (A) Located in a unit which has applied to the Medicare Program for exclusion prior to July 1, 1988 and completes its 12-month evaluation period prior to July 1, 1989.
- (B) Placed in service during the 12-month Medicare evaluation period ending prior to July 1, 1989.
- (C) Covered in Medicare's initial letter of exclusion related to those beds.
 - (ii) Either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 or a certificate of need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the new or additional medical rehabilitation unit beds was issued by the Department of Health no later than June 30, 1988. In addition, the project shall have been substantially implemented as defined at 28 Pa. Code § 401.5(j)(2) within the effective period of the original Section 1122 approval or the original certificate of need, including one 6-month extension period.
- (e) Allowable costs in addition to those costs allowable under subsection (b) are:
 - (1) Costs for direct and indirect chaplaincy expenses related to patient care, excluding training costs associated with the chaplaincy program.
 - (2) Costs for necessary diagnostic services provided to a recipient by another hospital. The costs may be included by the hospital at which the recipient is an inpatient at the time of the cost settlement.
- (f) For providers reimbursed under this subchapter, capital costs related to replacement beds will be recognized as allowable if:
 - (1) The facility received a certificate of need or letter of nonreviewability for the replacement beds.
 - (2) The replacement beds are physically replacing beds in the same facility and capital costs related to the beds being replaced were recognized as allowable.
 - (3) The project is substantially implemented as defined at 28 Pa. Code § 401.5(j)(2) within the effective period of the original Section 1122 approval or the original certificate of need, including one 6-month extension period.

Authority

The provisions of this § 1163.453 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.453 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 600; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181874) to (181877).

1163-72

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy); 55 Pa. Code § 1163.452 (relating to payment methods and rates); and 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.454. Limitations on payment.

(a) Payment for blood will be limited to the first three pints of whole blood provided during a period of hospitalization. An exception to this limit is made only if the patient has hemophilia, in which case payment is made for the amount of whole blood or blood products the patient requires.

(b) Payment for cost reimbursed drug and alcohol detoxification-rehabilitation services in a general hospital will be limited to days certified under § 1163.471 (relating to scope of claims review process) during which the individual with a drug or alcohol diagnosis is a patient in a drug and alcohol detoxification rehabilitation unit approved by the Department of Health.

(c) A recipient is limited to two periods of therapeutic leave per calendar month. Neither of these periods of therapeutic leave may exceed 12 hours in a calendar day.

Authority

The provisions of this § 1163.454 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.454 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended July 12, 1985, effective July 13, 1985, 15 Pa.B. 2572, and will apply to reimbursement for services for FY 1984-85 for each fiscal year thereafter; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181877) to (181878).

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy); 55 Pa. Code § 1163.455 (relating to noncompensable services and items); and 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.455. Noncompensable services and items.

(a) The Department will not pay hospitals for inpatient services directly or indirectly related to or in conjunction with:

(1) Inpatient hospital services provided in conjunction with physicians' services which are identified as outpatient procedures in Chapter 1150 (relating to MA Program payment policies) and the MA Program Fee Schedule unless the procedure is performed as a secondary necessary procedure.

(2) Diagnostic tests and procedures that can be performed on an outpatient basis and diagnostic tests and procedures not related to the diagnoses that require that particular inpatient stay.

(3) Services and items for which full payment is available through Medicare, other financial resources or other health insurance programs.

(4) Services and items not ordinarily provided to the general public.

(5) Periods of absence from the hospital for a purpose such as employment or school attendance except for therapeutic leaves that enable individuals to attend family matters of significant importance. The number of therapeutic leaves during one period of hospitalization is limited under § 1163.454(c) (relating to limitations on payment).

(6) Diagnostic or therapeutic procedures solely for experimental, research or educational purposes.

(7) Unnecessary admissions and conditions which do not require hospital-type care, such as rest cures and room and board for relatives during a patient's hospitalization.

(8) Inpatient services provided to patients who no longer require acute short-term inpatient hospital care—inappropriate hospital services. For patients who do require skilled nursing or intermediate care, payment will be made to the hospital under Chapter 1181 (relating to nursing facility care) or successor provisions for this care only if the patient is in a certified and approved hospital-based skilled nursing or intermediate care unit.

(9) Inpatient hospital days not certified under the Department's Concurrent Hospital Review (CHR) process or, if the hospital is granted an exemption from CHR, not certified by the hospital's in-house utilization review process. If an MA patient refuses to leave after being discharged by the attending practitioner when the approved length of stay is exhausted, the hospital may bill the patient.

(10) Days of inpatient care due to unnecessary delay in applying for a court-ordered commitment, grace periods, administrative days and custodial care related or unrelated to court commitments or to the child protective services. For purposes of this chapter, custodial care is defined as maintenance, rather than curative care, on an indefinite basis. Grace periods and administrative days relate to days of care while awaiting placement elsewhere.

(11) Inpatient hospital services provided to a recipient by the transferring hospital on or after the effective date of a court commitment to another facility.

(12) Days of inpatient hospitalization due to the failure to promptly request or perform necessary diagnostic studies, medical-surgical procedures or consultations.

(13) Friday or Saturday admissions unless one of the following occurs:

(i) The admission is an emergency as documented in the patient's medical record by the admitting physician.

- (ii) The medical or surgical procedure for which the patient was admitted is performed on the day of or the day following admission.
- (14) The day of discharge from inpatient hospital care except for same calendar day admissions and discharges.
- (15) A day of inpatient hospital care provided to a recipient whose medical condition makes the person suitable for an alternate level of care.
- (16) Drug or alcohol, or both, detoxification and rehabilitation or rehabilitation services in an inpatient facility unless one of the following circumstances exists:
 - (i) Complications exist, or there is a reasonable expectation of complications, that require inpatient facility medical treatment, including:
 - (A) An individual requires acute inpatient treatment based on the presence of a major medical complication or a significant psychiatric problem, or an individual has a history of significant substance abuse and a complication as described in § 1163.59(d)(1)(i), (ii), (iii) or (iv) (relating to non-compensable services, items and outlier days).
 - (B) An individual in residential care exhibits significant medical or psychiatric complications as described in § 1163.59(d)(1)(i), (ii), (iii) or (iv), and requires more intensive treatment and observation.
 - (ii) Detoxification has been certified by the Department and completed in an acute care general hospital, and the patient is discharged directly from the acute care general hospital where the detoxification occurred to the inpatient hospital rehabilitation setting.
 - (iii) A nonhospital, medically appropriate bed is not available within a 50-mile radius of the inpatient hospital to which the patient presents for drug or alcohol detoxification or rehabilitation services and the inpatient hospital rehabilitation facility includes documentation of the nonavailability of the nonhospital bed in the medical record. A nonhospital bed will be considered to be not available if the medically appropriate nonhospital facility has no beds available or refuses to accept the patient.
- (b) The Department will not pay hospitals for services or items listed in subsection (a) even if the attending physician or hospital utilization review committee determines that the stay was medically necessary.
- (c) The Department will not pay hospitals on a cost related basis for services or items covered under this subchapter even if the attending physician or hospital utilization review committee determines that the services or items were medically necessary.

Authority

The provisions of this § 1163.455 amended under sections 201(2) and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201(2) and 443.1(1)).

Source

The provisions of this § 1163.455 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended through October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241; amended November 3, 1995, effective November 4, 1995, and apply retroactively to October 1, 1995, 25 Pa. B. 4700; amended November 24, 1995, effective November 25, 1995, and apply retroactively to November 1, 1995, 25 Pa. B. 5241. Immediately preceding text appears at serial pages (181878) to (181880).

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy); 55 Pa. Code § 1163.453 (relating to allowable and nonallowable costs); 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); and 55 Pa. Code § 1163.475 (relating to responsibilities of the hospital utilization review committee).

§ 1163.455a. Utilization guidelines for inpatient hospital drug and alcohol services under the MA Program—statement of policy.

(a) For inpatient adult drug and alcohol services rendered on or after May 1, 1998, the Department will use the Pennsylvania Client Placement Criteria (PCPC) developed by the Bureau of Drug and Alcohol Programs (BDAP) in the Department of Health as utilization guidelines, both for prospective and retrospective reviews of patient care.

(b) If the BDAP modifies the PCPC guidelines, the Department will also adopt those modifications.

(c) Providers who do not already have a copy of the PCPC may obtain one by contacting the Department of Health, Bureau of Drug and Alcohol Programs, Room 929, Health and Welfare Building, Harrisburg, Pennsylvania 17108.

Source

The provisions of this § 1163.455a adopted November 3, 1995, effective November 4, 1995, apply retroactively to November 1, 1995, 25 Pa.B. 4705; amended May 8, 1998, effective May 9, 1998, and apply retroactively to May 1, 1998, 28 Pa.B. 2150. Immediately preceding text appears at serial pages (204522) to (204524).

§ 1163.456. Third-party liability.

In addition to the conditions set forth in Chapter 1101 (relating to general provisions) the following policies apply to third-party resources for hospital services:

(1) Sources of payment other than MA shall be researched prior to billing the Department. If a resource is found, it shall be depleted to the full extent of the liability of that resource prior to billing MA. Lifetime reserve days under Medicare are considered an available resource.

(2) If the hospital receives payment from a third party subsequent to payment from the Department, repayment to the MA Program shall be made by way of a claim adjustment.

Source

The provisions of this § 1163.456 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy); and 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.457. Payment policies relating to out-of-State hospitals.

(a) Payment is made on a per diem basis for out-of-State hospital services if the services are covered by the MA Program and are provided under §§ 1163.451—1163.456 and 1163.458, including the limitations on inpatient days of care as set forth at § 1163.454 (relating to limitations on payment). Out-of-State hospitals shall meet the requirements for rehabilitation hospitals and distinct part units as set forth in § 1163.442 (relating to requirements for reimbursement under this subchapter).

(b) MA recipients are eligible for care provided by an out-of-State hospital only if one of the following occurs:

(1) Residents in a given area generally receive their care in that particular hospital. This would apply when the out-of-State hospital is closer to, or substantially more accessible from, the residence of the recipient than the nearest hospital in this Commonwealth that is adequately equipped to deal with, and is available for the treatment of, the individual's illness or injury.

(2) Documentation is provided verifying one of the following:

(i) While temporarily out of this Commonwealth, the recipient required inpatient hospital services on an emergency basis. For the purposes of this chapter, emergency services are those inpatient hospital services that are necessary to prevent the death, or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available that is equipped to furnish the services.

(ii) An out-of-State hospital is the only facility equipped to provide the type of care that the individual requires.

(c) The final payment for inpatient hospital services provided by an out-of-State cost related provider is the lowest of:

(1) The hospital's interim per diem rate, if one is established by the Medicaid agency in the hospital's state.

(2) The projected average interim per diem MA rate in this Commonwealth as developed by the Department for the fiscal year.

(3) The amount of total charges billed by the hospital.

(4) The Medicare deductible or coinsurance, if applicable, under § 1163.456 (relating to third-party liability).

(d) At the discretion of the Department, out-of-State hospitals are subject to the Department's Concurrent Hospital Review (CHR) process in accordance with §§ 1163.471—1163.481 (relating to utilization control).

(e) In no case will the Department's payment rate be based on costs which are precluded from recognition by Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395XX).

Authority

The provisions of this § 1163.457 issued under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

Source

The provisions of this § 1163.457 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended February 28, 1986 effective March 1, 1986, 16 Pa.B. 600. Immediately preceding text appears at serial pages (99366) to (99367).

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy).

§ 1163.458. Payment policies relating to same-calendar-day admissions and discharges.

(a) The Department pays for inpatient stays consisting of an admission with subsequent discharge during the same calendar day.

(b) The services must be provided under this chapter.

(c) The interim payment rate is based on 50% of the inpatient per diem rate on file determined in this chapter.

(d) Payment for ancillary services provided to patients during same- calendar-day stays are included in the interim payment. The hospital may not submit a separate bill for these services.

(e) For auditing purposes each same-calendar-day admission and discharge will be counted as 1/2 day.

(f) Without exception same-calendar-day stays, regardless of the reason for the stay, are subject to §§ 1163.471—1163.481 (relating to utilization control) and will be reimbursed only if provided under this section.

Source

The provisions of this § 1163.458 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.451 (relating to general payment policy); and 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals).

§ 1163.459. Disproportionate share payments.

(a) The Department will annually determine the acute care general hospitals including their distinct part units, private psychiatric hospitals and freestanding rehabilitation hospitals that qualify for disproportionate share payments by the method in subsections (b)—(e). The Department will annually determine the amount of disproportionate share payments for eligible freestanding rehabilitation

hospitals and distinct part rehabilitation units of acute care general hospitals by the method in subsections (f)—(i).

(b) A hospital that meets at least one of the requirements under subsection (d) qualifies for disproportionate share payments if one of the following applies:

(1) The hospital's ratio of Title XIX inpatient days to total inpatient days is equal to or greater than one standard deviation above the mean of the ratios for hospitals in this Commonwealth. To determine the ratio for an acute care general hospital, the Department will include inpatient days covered under Subchapter A and Chapter 1151 (relating to acute care general hospitals under the prospective payment system; and inpatient psychiatric services), as well as days covered under this subchapter. The Department will include in the database MA administrative days, days of care provided to recipients in other states' Medicaid Programs, MA Health Maintenance Organization (HMO) days and MA Health Insuring Organization (HIO) days.

(2) The hospital's low income utilization rate, as defined under section 1923 of the Social Security Act (42 U.S.C.A. § 1396r-4(b)(3)), exceeds 25% under one of the following methods:

(i) The hospital's low income utilization rate as reported on its Cost Report (MA 336) computation of low income utilization rate worksheet exceeds 25%.

(ii) The hospital's low income utilization rate as determined by its ratio of Title XIX and General Assistance inpatient days to total inpatient days exceeds 25%. To determine the ratio for an acute care general hospital, the Department will include inpatient days covered under Subchapter A and Chapter 1151, as well as days covered under this subchapter. The Department will include in the database MA administrative days, days of care provided to recipients in other states' Medicaid Programs, MA HMO days and MA HIO days.

(c) The Department will utilize the following data sources in making disproportionate share eligibility determinations:

(1) For Fiscal Year 1993-94, the Department will utilize data from Fiscal Year 1991-92 Cost Reports (MA 336) and from Fiscal Year 1991-92 for services provided to recipients enrolled in MA HMO Programs and MA HIO Programs. To determine the Title XIX percentage of total MA days, the Department will utilize the most currently available data.

(2) For Fiscal Year 1994-95, the Department will utilize data from Fiscal Year 1992-93 Cost Reports (MA 336) and from Fiscal Year 1992-93 for services provided to recipients enrolled in MA HMO Programs and MA HIO Programs. To determine the Title XIX percentage of total MA days, the Department will utilize the most currently available data.

(d) To qualify for disproportionate share payments, a hospital shall meet at least one of the following requirements:

- (1) The hospital shall be a children's hospital, as defined under § 1163.2 (relating to definitions).
- (2) The hospital shall have at least two physicians with staff privileges who have agreed to provide obstetric services to individuals entitled to those services under the MA Program.
- (3) The hospital has not since December 21, 1987, offered nonemergency obstetric services to the general population.
- (e) To determine hospitals that qualify for disproportionate share payments based on the ratio of Title XIX inpatient days to total inpatient days, the Department will:
 - (1) Identify the total number of MA inpatient days from the hospital's Cost Report (MA 336), including days of care provided to recipients in other states' Medicaid Programs, and to that number:
 - (i) Add the hospital's number of inpatient days for MA recipients enrolled in MA HMO Programs and MA HIO Programs.
 - (ii) Add the hospital's number of MA administrative days from the hospital's Cost Report (MA 336).
 - (iii) Subtract the hospital's number of days of care provided to General Assistance recipients.
 - (2) Divide the days determined under paragraph (1) by the total number of inpatient days from the hospital's Cost Report (MA 336) to determine the hospital's ratio of Title XIX inpatient days to total inpatient days.
 - (3) Array the hospitals, from high to low, according to the ratios determined under paragraph (2) and determines the mean and standard deviation of the array.
 - (4) Identify as disproportionate share providers hospitals with a ratio of Title XIX inpatient days to total inpatient days equal to or greater than one standard deviation above the mean.
- (f) Once the Department determines which hospitals qualify as disproportionate share providers under this section, the Department will calculate annual payments to qualifying freestanding rehabilitation hospitals and distinct part rehabilitation units of acute care general hospitals by:
 - (1) Arraying the qualifying rehabilitation hospitals and units from high to low according to each hospital's ratio of Title XIX inpatient days to total inpatient days.
 - (2) For Fiscal Years 1990-91—1992-93, for each hospital or unit covered by this subchapter and included in the array, prospectively calculating the annual disproportionate share percentage, which is 0.5%, plus 8.0% multiplied by a fraction, the numerator of which is the ratio of Title XIX inpatient days to total inpatient days of the qualifying hospital or unit, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array; and the denominator of which is the ratio of Title XIX inpatient days to total

inpatient days of the highest hospital in the array, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array.

(3) For Fiscal Years 1993-94 and 1994-95, for each hospital or unit covered by this subchapter and included in the array, prospectively calculating the annual disproportionate share percentage which is 1.0%, plus 9.0% multiplied by a fraction, the numerator of which is the ratio of Title XIX inpatient days to total inpatient days of the qualifying hospital or unit, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array; and the denominator of which is the ratio of Title XIX inpatient days to total inpatient days of the highest hospital in the array, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest hospital in the array.

(4) Multiplying the following:

(i) The facility's disproportionate share percentage determined under paragraph (2) or (3).

(ii) The facility's base per diem rate in effect on July 1 of the fiscal year, except that the Department will use the new base rate for a hospital whose rate changes during the fiscal year for any reason except for the annual inflationary increase.

(iii) The facility's projected Title XIX inpatient days determined as follows:

(A) For Fiscal Year 1993-94, the number of Title XIX inpatient days based on the hospital's Fiscal Year 1991-92 Cost Report (MA 336) increased by 3.52% and then by 2.8%.

(B) For Fiscal Year 1994-95, the number of Title XIX inpatient days based on the hospital's Fiscal Year 1992-93 Cost Report (MA 336) increased by utilization increase factors consistent with the Governor's Fiscal Year 1994-95 budget proposal.

(5) For Fiscal Years 1993-94 and 1994-95 for hospitals that do not receive an inflationary increase on July 1, further inflating one-half of the amount calculated under paragraph (4) by the annual inflation increase.

(g) Effective with Fiscal Year 1993-94, the Department will pay the interim disproportionate share amounts, determined under subsection (f)(4), in equal monthly installments.

(h) The Department will determine final semiannual disproportionate share amounts for hospitals and units under this subchapter by multiplying the following:

(1) The facility's disproportionate share percentage determined under subsection (f)(2) or (3).

(2) The facility's final audited per diem rate for the period.

(3) The facility's final audited Title XIX inpatient days for the period.

(i) The Department will add the semiannual disproportionate share payments calculated under subsection (h) and reconcile any difference between the final

payment and the interim payment determined under subsection (f)(4) at cost settlement for the fiscal year.

(j) The Department will publish annually a notice in the *Pennsylvania Bulletin* listing the qualifying hospitals and their annual disproportionate share payment percentages.

Authority

The provisions of this § 1163.459 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.459 adopted June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1990, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181882) to (181885).

Cross References

This section cited in 55 Pa. Code § 1163.452 (relating to payment methods and rates).

UTILIZATION CONTROL

§ 1163.471. Scope of claim review process.

All cost reimbursed services provided to MA recipients are subject to the utilization review procedures set forth in this chapter and in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.471 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.454 (relating to limitations on payment); 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); and 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges).

§ 1163.472. Concurrent hospital review.

(a) For cost reimbursed services, the Department reviews the need for a recipient's admission and continued hospitalization through its Concurrent Hospital Review (CHR) process and approves or disapproves the stay unless a hospital has been granted an exemption by the Department.

(b) For cost reimbursed services, each hospital shall follow the instructions in the Department's Manual for Concurrent Review of Inpatient Hospital Services. The provisions of the Department's Manual shall take precedence over the hospital's Utilization Review Plan.

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); and 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges).

§ 1163.473. Hospital utilization review plan.

(a) A hospital participating in the MA Program shall have in effect a written utilization review plan approved by Medicare that provides for the review of each recipient's need for hospital inpatient services. The terms and conditions imposed under the hospital's utilization review plan for Medicare will, if applicable, apply to MA. If the Medicare utilization review plan is not consistent with this chapter, the Manual for Concurrent Review of Inpatient Hospital Services will take precedence. Those hospitals not participating in Medicare shall submit to the Department's Bureau of Utilization Review, a utilization review plan which meets the requirements of this chapter.

(b) A hospital utilization review plan shall provide for a utilization review committee that meets the requirements set forth in § 1163.474 (relating to requirements for hospital utilization review committees).

(c) A hospital utilization review plan shall describe the organization, composition and functions of the utilization review committee and shall specify the frequency of the meetings of the committee.

(d) A hospital utilization review plan shall provide that for utilization review purposes each recipient's record includes:

- (1) Identification of the recipient.
- (2) Copies of the certification of days records.
- (3) The name of the recipient's physician.
- (4) The date of admission and date of application for an authorization of MA benefits if application is made after admission.
- (5) The plan of care required under § 1163.476 (relating to plan of care).
- (6) Initial and subsequent review dates specified under this chapter.
- (7) Reasons and plan for continued stay, if the physician believes continued stay is necessary.
- (8) Other supporting material the utilization review committee believes appropriate.

(e) A hospital utilization review plan shall provide for a review of a recipient's admission to the hospital under § 1163.477 (relating to admission review requirements).

(f) A hospital utilization review plan shall provide for a review of a recipient's continued stay in the hospital under § 1163.478 (relating to continued stay review requirements).

(g) A hospital utilization review plan shall describe the methods that the utilization review committee uses to select and conduct Medical Care Evaluation studies under § 1163.479 (relating to Medical Care Evaluation studies).

Source

The provisions of this § 1163.472 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.441 (relating to general participation requirements); 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); and 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges).

§ 1163.474. Requirements for hospital utilization review committees.

(a) Each hospital shall have a utilization review committee composed of two or more physicians, and assisted by other professional personnel as required under 42 CFR 456.106 (relating to organization and composition of UR committee; disqualification from UR committee membership). Committee members need not be members of the hospital medical staff.

(b) A member of the hospital utilization review committee may not participate in the review of a patient's case if he is or was responsible for the care of that patient.

(c) A member of the hospital utilization review committee may not have a direct or indirect financial interest in any hospital.

Source

The provisions of this § 1163.474 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges); and 55 Pa. Code § 1163.473 (relating to hospital utilization review plan).

§ 1163.475. Responsibilities of the hospital utilization review committee.

The hospital utilization review committee or its representative shall:

(1) Conduct admission reviews under § 1163.477 (relating to admission review requirements).

(2) Conduct continued stay reviews under § 1163.478 (relating to continued stay review requirements).

(3) Conduct Medical Care Evaluation studies under § 1163.479 (relating to Medical Care Evaluation studies).

(4) Notify the Department's Concurrent Hospital Review Section of a recipient's assigned initial or continued length of stay. This notification shall be done on the form specified and in accordance with the instructions in the Manual for Concurrent Hospital Review of Inpatient Services.

(5) Provide that the justification for a recipient's need for admission and need for continued hospital inpatient services be documented by the attending physician in the recipient's medical record.

- (6) Notify the Department's Concurrent Hospital Review Section of a change in a recipient's diagnosis.
- (7) Maintain utilization review records for a minimum of 4 years from the date of submission of the year end cost report.
- (8) Submit copies of utilization review records and documents, medical records, certification of days records and discharge planning information to the Department upon request.
- (9) Maintain copies of certification of days records with the patient's medical record and with the hospital copy of the invoice submitted for payment.
- (10) Review cases that the Department has identified as being of questionable utilization of hospital facilities or services or that contain noncompensable services or items as listed in § 1163.455 (relating to noncompensable services and items).
- (11) Initiate discharge planning during the admission review process to provide timely placement in an appropriate level of care for those patients that may require posthospital care.
- (12) Follow the procedures specified in the Department's Manual for Concurrent Hospital Review of Inpatient Services in conducting utilization review activities.

Source

The provisions of this § 1163.475 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); and 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges).

§ 1163.476. Plan of care.

- (a) Before admission or no later than 2 days after admission of a recipient to a cost reimbursed hospital or hospital unit, the attending or staff physician shall establish, and include in the recipient's medical record, an individual written plan of care.
- (b) The plan of care must include:
 - (1) Medical justification for admission and continued stay.
 - (2) Diagnoses, symptoms, complaints and complications indicating the need for admission.
 - (3) A description of the functional level of the individual.
 - (4) Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services and diet.
 - (5) Plans for continuing care including review and modification of the plan of care.
 - (6) Plans for discharge.

(c) The orders and activities shall be developed in accordance with physician's instructions and be reviewed and revised as appropriate to treat the recipient's condition.

Source

The provisions of this § 1163.476 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges); and 55 Pa. Code § 1163.473 (relating to hospital utilization review plan).

§ 1163.477. Admission review requirements.

(a) The hospital utilization review committee or its representative shall review the need for admission of each MA recipient admitted to the hospital within 24 hours after admission. The committee shall make a final determination of the need for admission within 2 working days after admission, unless the case or category of admission is designated for preadmission review.

(b) The hospital utilization review committee shall establish written criteria on which it bases a recipient's need for admission. The criteria shall be more extensive for admissions known to be associated with high costs, associated with the frequent furnishing of excessive services or authorized by a physician whose patterns of care are questionable.

(c) The hospital utilization review committee shall assess the need for hospital inpatient services by comparing each admission to the hospital's written criteria established in accordance with subsection (b).

(d) Except as noted in subsection (e), an initial length of stay for general hospitals must be no greater than the 50th percentile of the latest Hospital Utilization Project (HUP) length of stay guidelines per diagnosis category, per age group. Ten days will be assigned as the initial length of stay for rehabilitation hospitals when the HUP 50th percentile for the admitting diagnosis is 10 days or less with the actual HUP 50th percentile used to assign the initial length of stay for other admissions. The HUP length of stay guidelines appear in the HUP Length of Stay Manual designated by the Department, and are statistical tables reflecting the length of stay of inpatient hospital stays in the Mid-Atlantic Region of the United States.

(e) If a recipient's diagnosis is unconfirmed upon admission, the hospital utilization review committee, or its representative, shall assign an initial length of stay of no more than 2 days. If the committee is unable to confirm the recipient's diagnosis within 2 days, the committee shall notify the Department's Concurrent Hospital Review unit and initiate continued stay review in accordance with § 1163.478 (relating to continued stay review requirements).

(f) The hospital utilization review committee shall allow the attending physician the opportunity to present his views before making a final decision on the need for admission.

(g) In the event of an adverse determination, the hospital utilization review committee shall follow the procedures in § 1163.480 (relating to adverse determinations).

(h) The hospital utilization review committee shall conduct a review of cases identified by the Office of MA Programs, as being a questionable utilization of hospital services and facilities.

Authority

The provisions of this § 1163.477 amended under sections 201 and 443.1(1) of the act of June 13, 1967 (P. L. 31, No. 21) (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.477 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150179) to (150181).

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges); 55 Pa. Code § 1163.473 (relating to hospital utilization review plan); and 55 Pa. Code § 1163.475 (relating to responsibilities of the hospital utilization review committee).

§ 1163.478. Continued stay review requirements.

(a) The hospital utilization review committee or its representative shall review the need for continued stay of each MA recipient admitted to the hospital.

(b) The hospital utilization review committee shall establish written criteria on which it bases a recipient's need for continued stay. The criteria shall be more extensive for those admissions known to be associated with high costs, associated with the frequent furnishing of excessive services, or authorized by a physician whose patterns of care are questionable.

(c) The hospital utilization review committee shall assess the need for continued stay in the hospital by comparing each case to the written criteria established under subsection (b).

(d) The hospital utilization review committee shall assign a subsequent review date based on the recipient's medical condition and the time continued hospitalization will no longer be necessary.

(e) The hospital utilization review committee shall conduct the continued stay review and provide the Department's Concurrent Hospital Review Section with the medical justification for the continued stay on or before the expiration date of the initial length of stay. Subsequent reviews shall be completed, and the Department shall be notified before the expiration of the previously assigned length of stay.

(f) If the hospital utilization review committee fails to conduct the continued stay review or fails to notify the Department on or before the expiration of the previously assigned length of stay, the Department does not certify those hospital days between the expiration of the previously assigned length of stay and the date the request for continued stay is made and approved.

(g) If an individual applies for MA while in the hospital, the committee shall:

(1) Assign the continued stay review date within 1 working day after the hospital is notified that the individual has applied for MA.

(2) Contact the Department's Concurrent Hospital Review (CHR) Section for approval of the assigned length of stay.

(h) The hospital utilization review committee shall allow the attending physician the opportunity to present his views before making a final decision on the need for continued stay.

(i) In the event of an adverse determination, the hospital utilization review committee shall follow the procedures under § 1163.480 (relating to adverse determinations).

Source

The provisions of this § 1163.478 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges); 55 Pa. Code § 1163.473 (relating to hospital utilization review plan); 55 Pa. Code § 1163.475 (relating to responsibilities of the hospital utilization review committee); and 55 Pa. Code § 163.477 (relating to admission review requirements).

§ 1163.479. Medical Care Evaluation studies.

(a) The hospital utilization review committee shall conduct Medical Care Evaluation (MCE) studies in accordance with this section.

(b) MCE studies shall identify and analyze medical or administrative factors related to patient care rendered in the hospital and, when indicated, make recommendations for changes that would be beneficial to patients, staff, the hospital and the community.

(c) MCE studies shall include analysis of at least:

(1) Admissions.

(2) Length of stay.

(3) Diagnostic categories.

(4) Ancillary services, including drugs and biologicals.

(5) Professional services performed in the hospital.

(d) At least one MCE study shall be in progress at any time.

(e) At least one MCE study shall be completed each calendar year.

(f) The results of each MCE study shall be documented.

(g) Documentation shall be made describing how the MCE study results have been used to institute improvements in the quality of care and to promote the efficient and effective use of hospital facilities.

Source

The provisions of this § 1163.479 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges); 55 Pa. Code § 1163.473 (relating to hospital utilization review plan); and 55 Pa. Code § 1163.475 (relating to responsibilities of the hospital utilization review committee).

§ 1163.480. Adverse determinations.

(a) If the hospital utilization review committee denies admission or continued stay, the committee shall forward a letter regarding the adverse determination to:

- (1) The recipient.
- (2) The recipient's next of kin or sponsor, if applicable.
- (3) The attending physician.
- (4) The hospital administrator.
- (5) The Office of MA Programs.

(b) The adverse determination letter shall include:

- (1) The patient's name.
- (2) The patient's age.
- (3) The patient's full MA number.
- (4) The hospital's name.
- (5) The admission date.
- (6) The discharge date, if known.
- (7) The diagnoses—required only on copy sent to the Office of MA Programs.

(c) The hospital utilization review committee shall send the adverse determination letter no later than by the last day of the approved length of stay or the day after the determination, whichever is earlier.

(d) If a continued stay has been denied, based on lack of medical necessity, the hospital shall attach a copy of the adverse determination letter to the invoice submitted for payment.

(e) Each month the hospital utilization review committee shall complete and submit to the Office of Medical Assistance Programs a summary report of adverse determinations in accordance with the instructions in the Provider Handbook or in the Manual for Concurrent Review of Inpatient Hospital Services.

(f) The hospital utilization review committee shall mail the monthly summary report specified in subsection (e) within 5 days after the end of the month.

Authority

The provisions of this § 1163.480 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1169.480 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181893) to (181894).

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges); 55 Pa. Code § 1163.477 (relating to admission review requirements); and 55 Pa. Code § 1163.478 (relating to continued stay review requirements).

§ 1163.481. Utilization review sanctions.

(a) The Office of MA Programs regularly monitors each hospitals utilization review program to determine whether or not it is operating under the Concurrent Hospital Review process and this part. Monitoring is carried out through review of admissions, continued stays, patient records and claims paid by the Department.

(b) If the Department identifies delays in assigning the initial or continued length of stay, the Department will deny payment for all or part of the hospital stay.

(c) If the Department determines that services or items provided by the hospital were not medically justified, or were unnecessary, inappropriate or noncompensable, the Department will deny payment for the service or item and for services related to the provision of that service or item. Payment will also be denied to the practitioner who ordered the service.

Authority

The provisions of this § 1163.481 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.481 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (150184).

Cross References

This section cited in 55 Pa. Code § 1163.457 (relating to payment policies relating to out-of-State hospitals); and 55 Pa. Code § 1163.458 (relating to payment policies relating to same-calendar-day admissions and discharges).

ADMINISTRATIVE SANCTIONS**§ 1163.491. Provider misutilization.**

Providers determined to have billed for services inconsistent with this part, to have provided services outside the scope of customary standards of medical practice, or to have otherwise violated the standards set forth in the provider agreement are subject to the sanctions described in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1163.491 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

§ 1163.492. Payment policy relating to administrative sanctions.

If a hospital appeals a decision by the Department to fully or partially deny payment for a case, the denied payments will continue to be withheld pending decision on the appeal.

Source

The provisions of this § 1163.492 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

RIGHT OF APPEAL**§ 1163.501. Provider right to appeal.**

(a) The hospital's right of appeal is under Chapter 1101 (relating to general provisions).

(b) Hospitals and practitioners do not have the right to a separate appeal on the same inpatient case. For purposes of this chapter, inpatient services are considered to be those services provided by hospital personnel. Practitioner appeals relating to inpatient services are expected to be resolved through the utilization review process.

(c) For cases undergoing the appeal process, payment, including adjustments, will be withheld until the case is adjudicated.

Source

The provisions of this § 1163.501 adopted June 22, 1984, effective July 1, 1984, 14 Pa.B. 2185.

CHANGE OF OWNERSHIP**§ 1163.511. Change of ownership or control.**

(a) A hospital or hospital unit is not entitled to additional reimbursement due solely to change of ownership or control.

(b) In the event of change of ownership, the Department will establish interim per diem rates as follows:

- (1) If the change involves only one hospital or unit, the Department will use the interim per diem rate assigned to the entity before the change.
 - (2) If the change combines two or more hospitals or units into a single entity, such as a merger or consolidation, the Department will establish an interim per diem rate for the new entity by averaging the rates of the previous entities on a days-weighted basis. To determine that days-weighted average, the Department will use the MA days of each previously enrolled entity as reported in the most recent fiscal year for which the previous entities filed acceptable Cost Reports (MA 336).
 - (3) If the change divides one enrolled hospital or unit into two or more entities, the Department will use the interim per diem rate assigned to the entity before the change, for the resulting entities.
- (c) In the event of change of ownership, the Department will establish final audited per diem rates based on the following ceilings:
- (1) If the change involves only one hospital or unit, the Department will use the ceiling for the entity existing before the change.
 - (2) If the change combines two or more hospitals or units into a single entity, such as a merger or consolidation, the Department will establish a ceiling by averaging the audited per diem rates of the previous entities on a days-weighted basis. To determine that days-weighted average, the Department will use audited MA days for the previous entities in the final full fiscal year of operation before the change.
 - (3) If the change divides one enrolled hospital or unit into two or more entities, the ceiling assigned to the entity before the change is used for each resulting entity.
 - (4) The Department will not rebase ceilings established under this subsection until Statewide rebasing occurs.
 - (5) If after a change of ownership has occurred, the Department rebases ceilings Statewide, using a base year which predates or corresponds to the year of the change, the Department will use the Cost Report (MA 336) and the claims data for the base year regardless of who owned the entity in that base year.
- (d) In the event of change of ownership, the Department will establish disproportionate share payments as follows:
- (1) If the change involves only one hospital or unit, the Department will use the disproportionate share status assigned to the entity before this change, so long as the resulting entity maintains the nonemergency obstetric services by which the previous entity complied with section 1923(d) of the Social Security Act (42 U.S.C.A. § 1396r-4(d)).
 - (2) If the change combines two or more hospitals or units into a single entity, such as a merger or consolidation, the Department will establish the new entity as eligible for disproportionate share payments if one or more of the previous entities was eligible for disproportionate share payments, so long as the

resulting entity maintains the nonemergency obstetric services by which one of the previous entities complied with section 1923(d) of the Social Security Act. To determine the monthly disproportionate share payment for the new entity, the Department will add the monthly disproportionate share payments of the previous entities.

(3) If the change divides one enrolled hospital or unit into two or more entities, the Department will use the disproportionate share status assigned to the hospital or unit before the change, so long as each of the resulting entities maintains the nonemergency obstetric services by which the previous entity complied with section 1923(d) of the Social Security Act. The Department will prorate the monthly disproportionate share payment of the previous entity on the basis of ratio of utilization agreed upon by the entities.

(4) The Department will not recalculate a hospital's disproportionate share status established under this subsection until it recalculates disproportionate share status Statewide.

(5) If the Department makes a Statewide redetermination of disproportionate share status after a change of ownership has occurred, and uses a base year which predates or corresponds to the year of the change, the Department will use the cost reports for the base year, regardless of who owned the entity in that base year.

(6) For a Statewide redetermination of disproportionate share status, the determination of disproportionate share status for the entities resulting from the division is made on the basis of ratio of utilization for the base year as agreed upon by the entities.

(e) A hospital that changes ownership or closes shall submit final Cost Reports (MA 336) to the Department within 45 days of the change of ownership or closure.

(f) This section applies only to hospitals and units which change ownership in the period July 1, 1993, through June 30, 1995.

Authority

The provisions of this § 1163.511 issued under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1163.511 adopted June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181895) to (181898).

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