Policy

DEPARTMENT: Utilization Management	**POLICY#: UM-018**
TITLE: Non-DRG Hospital Policy	**VERSION: 1.0**
APPROVED BY: UM Committee	**DATE:** 8/29/2022
DEPENDENCIES:	

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Purpose
This policy outlines the criteria and timelines for concurrent reviews for non-DRG hospitals.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
DRG	Diagnosis Related Group – prospective payment rates based on diagnosis related groups have been established as the basis of Medicare's hospital reimbursement system.
Inpt	Inpatient
LHP	Longevity Health Plan, the Plan
CMS	Centers for Medicare and Medicaid Services

Design and Development of the Diagnosis Related Group (DRG)
Prospective payment rates based on Diagnosis Related Groups (DRGs) have been established as the basis of Medicare's hospital reimbursement system. The DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. The design and development of the DRGs began in the late sixties at Yale University. The initial motivation for developing the DRGs was to create an effective framework for monitoring the quality of care and the utilization of services in a hospital setting.

The evolution of the DRGs and their use as the basic unit of payment in Medicare's hospital reimbursement system represents a recognition of the fundamental role which a hospital's case mix plays in determining its costs. In the past, hospital characteristics such as teaching status and bed size have been used to attempt to explain the substantial cost differences which exist across hospitals. However, such characteristics failed to account adequately for the cost impact of a hospital's case mix. Individual hospitals have often attempted to justify higher cost by contending that they treated a more "complex" mix of patients; the usual contention being that the patients treated were "sicker." Although there has been a consensus in the hospital industry that a more complex case mix results in higher costs, the concept of case mix complexity had historically lacked a precise definition. The development of the DRGs provided the first operational means of defining and measuring a hospital's case mix complexity.

Case Mix Complexity
The term case mix complexity has been used to refer to an interrelated but not distinct set of patient attributes which includes:

1. Severity of illness
2. Prognosis
3. Treatment difficulty
4. Need for intervention
5. Resource intensity

Determination for Concurrent Authorizations for non-DRG Hospitals
To ensure prompt turn around time for authorizations for non-DRG hospitals, Longevity Health requires the following:

1. The Utilization Management Department will request the medical and behavioral information to make a determination with 24 business hours or 1 business day, whichever occurs first of the initial request.

2. The Utilization Management Department will complete concurrent reviews every 3 days to ensure continued medical appropriateness and necessity.
3. Regardless of the information that is received from a non-participating provider, the Utilization Management Department is responsible for meeting the same timeframe and notice requirements as it does for in-network, contracted, participating providers.
4. Notification of Utilization Management determinations will be made in writing, electronically, and by telephone where required by state and federal law to members and providers. All verbal, electronic, and written requests will be documented and maintained in the case file.

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
NEW		8/29/2022	Courtney Gonzales	NEW

Appendices

UM Decision Time Frames Procedure.d

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