Provider Notification

DRG Transition Effective October 1, 2014 – Detailed Information

Date of Notification: May 19, 2014
Revision Date: 9/2/14

Plan Affected: Mercy Maricopa Integrated Care

In order to align with AHCCCS payment rates, Mercy Maricopa Integrated Care (Mercy Maricopa) will be changing their inpatient pricing methodology from the current tier-based per diem to APR-DRG effective October 1, 2014 for medical claims (integrated care) for SMI members.

Please refer to the AHCCCS Transition to DRG-based Payment webpage for more detailed information including the:
- AHCCCS Communication Letter
- AHCCCS Implementation of APR-DRG Payments
- AZ APR-DRG Calculator

AHCCCS has developed a preliminary draft of the APR-DRG Payment System Design Payment Policies. Mercy Maricopa will be following these payment policies and we wanted to provide you with pertinent information to assist you in understanding how APR-DRG’s will work.

DRG payment will be applied to all inpatient claims from acute care hospitals except the following:
- Claims from a free-standing rehabilitation facility
- Claims from a free-standing long term acute care facility
- Claims from a free-standing psychiatric facility
- Claims from an Indian Health Service facility or tribally operated 638 facility
- Claims paid by Tribal/Regional Behavioral Health Authorities (T/RBHAs) for behavioral health services
- Claims for administrative days only
- Claims for transplant services
- Claims in which admit and discharge are on the same day and the discharge status does not indicate member expired
- Claim is an interim bill

As inpatient claims are received by Mercy Maricopa, they will be sent through the 3M Grouper to determine the approved DRG based on the diagnosis codes and procedure codes billed regardless of the DRG submitted. The pricing for the claim will be attached for payment finalization on an overnight basis through our claim system. While we do not anticipate any issues to this automated process, in case of any unforeseen problems, a stand-alone pricer is available to price claims on a manual basis if needed.
Below are some other key considerations to assist you in understanding how DRG pricing works:

**DRG Outlier Add-On Payments**
Outlier payments are based on a hospital specific threshold and added to the DRG payment, and are no longer triggered by a condition code. Not all claims will qualify for a DRG outlier add-on payment. The DRG outlier add-on payment will be added to the DRG Base Payment to determine the final payment for the claim for those that do qualify.

The Outlier Threshold for Critical Access Hospitals (CAH) is $5,000. For all other providers, the Outlier Threshold is $65,000.

Mercy Maricopa implemented a process that will identify claims that qualify for outlier, and pend the claims for review. Claims will be reviewed to remove any disallowed services before paying additional outlier payments.

If the Claim Cost exceeds the Outlier Threshold, then the claim qualifies for a DRG outlier add-on payment. If the claim does not exceed the Outlier Threshold, the claim receives a $0 DRG outlier add-on payment.

**Admit versus Discharge Date**
DRG pricing is based on the date of discharge. All hospital stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. The Medicaid payer in effect on the date of discharge will always have responsibility for the full payment. The day of discharge is never paid unless the member expires on the date of discharge. It will no longer be necessary to split claims based on plan year.

**Enrollment Change during Hospital Stay**
A recipient may change payers during a single hospital stay while maintaining Medicaid eligibility throughout the entire stay. Services for the entire stay paid via the DRG method will be paid by the payer with which the recipient is enrolled on the date of discharge.

In order to avoid eligibility denials, the “From” date of service should be the first day the recipient became eligible with the plan. The “Through” date of service is the date of discharge. Please note that the “From” date of service may be later than the Date of Admission. Each payer’s claims should only include revenue codes, service units and charges applicable to services performed during the covered days included on the claim (the days between the “From” and “Through” dates).

**Medicare Dual Eligibles**
In the event a recipient exhausts Medicare Part A benefits during a hospital stay, a separate claim should be filed for services performed after the date the maximum Medicare Part A benefit is exceeded. The “From” date of service should be the first day Medicaid is the primary payer. The “Through” date of service should be the date of discharge. Only charges applicable during the Medicaid portion should be billed between the “From” and “Through” dates of service. All diagnosis codes describing the patient’s medical condition may be included on the claim. Since a separate claim is filed there is no proration for the claim; a full DRG payment will be paid for the Medicaid claim.
Administrative Days
For hospitals reimbursed under the DRG method for acute care services, Mercy Maricopa may also offer reimbursement for Medicaid recipients occupying a bed while not in need of acute care. Those days in which a member does not meet the criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available or the member cannot be safely discharged or transferred are referred to as Administrative Days. Examples of this include:

- An expectant mother stays in a hospital awaiting the birth of her baby.
- At the end of an acute care episode in which a recipient is awaiting placement in a nursing home or other sub-acute or post-acute setting.

Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital’s administrative or operational delays.

Administrative Days must be prior authorized and will be reimbursed using a negotiated per diem rate. Reimbursement for Administrative Days will be separate from DRG reimbursement for acute care services. In order to enable separate payment, Administrative Days must be billed on a different claim from acute care services. Administrative days are identified by the presence of a prior authorization for the member, the provider, and the dates of service that reflect an administrative rate.

When an acute care stay is followed by an administrative day stay, hospitals shall use patient discharge status 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) on the acute care claim. The same applies when an administrative day stay is followed by an acute care stay – hospitals shall use patient discharge status of 70 on the administrative day claim.

Interim Claims
Hospitals may submit claims in increments of 30 days. Interim claims will be reimbursed under a per diem rate of $500.00 per day. Hospitals must submit a final claim associated with the entire patient stay upon the patient’s discharge. Prior interim claims will be voided and the final claim will be paid at the DRG rate for the entire stay.

Transfer Policy
In the event a recipient is transferred from one acute care facility to another, payment to the “transferring” hospital will be subject to reduction. The “transferring” and “receiving” hospitals will file separate claims and may result in different DRG assignments. Payment to the receiving acute care facility will follow standard DRG pricing rules and is not subject to transfer payment reduction unless the recipient is transferred again out of the receiving hospital.

The transfer payment methodology is applicable when a patient is transferred from one acute care facility to another, as identified by the following discharge status codes:

- 02: Discharged/transferred to a short-term general hospital for inpatient care
- 05: Discharged/transferred to a designated cancer center or children’s hospital
- 66: Discharged/transferred to a critical access hospital
The base DRG payment reimbursed to the “transferring” hospital will be the lesser of the Transfer DRG Base Payment, or the calculated Initial DRG Base Payment for the full hospital stay. The base payment is a prorated per diem amount for each day the recipient is in the hospital prior to the transfer. One additional day is added to the length of stay to account for the disproportionate amount of costs related to the stabilization of the recipient prior to the transfer since the costs of stabilization are generally higher than the remaining days of the patient stay. In calculating the length of stay, the date of the discharge will not be included. The date of discharge is only payable when the recipient expires in the hospital, which is not a scenario in which the transfer payment policy applies.

AHCCCS will allow outlier payments for the “transferring” hospital if the claim meets the outlier criteria. The outlier payment will be added to the base payment (i.e. the Transfer DRG Base Payment or the Initial DRG Base Payment as appropriate) to determine the final DRG payment.

Recipient Gains Medicaid Eligibility after Admission
A recipient may be ineligible for Medicaid upon admission, however, may become eligible for Medicaid during his/her stay in the hospital. Under this circumstance, the DRG payment which is designed to cover the full hospital stay will be prorated based on the number of AHCCCS covered days.

When submitting claims under this scenario, providers are expected to report the “From” date of service as the first date the recipient is eligible for reimbursement. The “Through” date of service would be set to the date of discharge, assuming the member is still covered on that day.

Only claims with dates of service where the recipient is enrolled with that payer will be accepted.

Recipient Loses Medicaid Eligibility Prior to Discharge
A recipient may be an eligible member upon admission, however, may lose eligibility during the duration of a single hospital stay. In this scenario, the DRG payment attributable to the entire stay will be prorated based on the number of AHCCCS covered days.

When submitting a claim in this scenario, the date of admission and the first date of service should be the same. The “Through” date of service on the claim should be reported as the last date the recipient is enrolled with Mercy Maricopa. The number of AHCCCS covered days will be calculated as the “Through” date of service less the date of admission.

Only claims with dates of service where the recipient is an enrolled member will be accepted.

Same Day Admit and Discharge
Inpatient claims with an admission date equal to the date of the discharge will be paid using the AHCCCS outpatient fee schedule methodology, including same day admission and discharge claims for maternity and nursery. There is one exception to this methodology. Claims with a same date of admission and date of death will be reimbursed a full DRG payment.

Specialty Hospitals
Specialty Hospitals will be reimbursed under the DRG methodology, under a separate DRG base rate. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent inpatient days for patients who reside outside of Arizona, and at least 50 percent of
discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare will also be reimbursed under a separate DRG base rate that will also be reimbursed under the DRG methodology. The DRG base rate for these providers will be reflected in the rate tables as with all other DRG providers.

Rehabilitation and LTAC Hospitals
Hospitals designated as rehabilitation and long term acute care (LTAC) hospitals will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate, including provisions for outlier payments, where rates and outlier thresholds will be included in the capped fee schedule.

A new provider type (C4) is established to identify these providers and includes freestanding rehabilitation and LTAC providers.

Psychiatric Hospitals
Hospitals designated as freestanding psychiatric facilities will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate consistent with ADHS reimbursement policy for this provider type (71). There is no outlier provision.

Inpatient Claims for Recipients with Medicare Part B Only
The treatment of Medicare Part B payments on inpatient claims is not changing with the implementation of DRG pricing. On inpatient claims in which the Medicaid recipient has Medicare Part B coverage, no Medicare Part A coverage, or Medicare Part A coverage has been exhausted, final Medicaid reimbursement is calculated by subtracting the Medicare Part B payment amount from the Final Allowed Amount.

Carved-out Services within Claims Paid under DRG Methodology
DRG payment when applied to an inpatient hospital claim will cover all inpatient services related for that stay. No services or supplies will be carved out or separately reimbursed.

Non-covered Charges
The current billing policy regarding the recording of non-covered charges remains unchanged. Hospitals shall report non-covered charges and Mercy Maricopa shall consider them where appropriate.

Transplants
Transplant cases are exempted from DRG payment, and will continue to be reimbursed under the current methodology of contracted rates.

Negotiated Settlements
Mercy Maricopa will continue to support the current claim dispute and settlement process. The grievance settlement process will be conducted after initial adjudication of the claim and providers will be expected to follow the current claim dispute process independent of whether claim payment is calculated using a per diem, DRG, or other payment methodology.

Detox/Behavioral Health versus Physical Health Diagnosis
A recipient admitted to a hospital may require both physical health treatment as well as psychiatric/behavioral health treatment. Only one claim will be submitted and reimbursed for a single
hospital stay in which both physical and behavioral health treatment are necessary. The primary diagnosis for the recipient for the hospital stay will determine if the claim will be submitted to the Medicaid Payer or to the Tribal/Regional Behavioral Health Authority (T/RBHA) assigned to the member.

If upon admission into the facility, the primary diagnosis of the recipient is a physical health diagnosis, the claim should be submitted to the AHCCCS Payer (GMHSA members) or Mercy Maricopa (SMI members) and will be reimbursed under DRG methodology, if DRG pricing applies. If upon admission into the facility, the primary diagnosis of the recipient is a behavioral diagnosis, the claim should be submitted to Mercy Maricopa and will be reimbursed under a per diem rate consistent with ADHS reimbursement policy.

HCAC and POA
Health care acquired conditions (HCACs) are identified using the standard rules put forth by the Centers for Medicare and Medicaid Services (CMS). These rules include a finite list of diagnosis codes and surgical procedure codes. In some cases, the surgical procedure codes are considered to be a HCAC only if billed in conjunction with a specific diagnosis code, and only in the absence of a present on admission (POA) indicator.

For claims paid via the DRG methodology, Mercy Maricopa will utilize DRG assignment to determine payment reductions in cases of health care acquired conditions. If a Medicaid recipient acquires a medical condition while in the hospital, that condition will be ignored when assigning a DRG code and calculating DRG payment.

To implement this policy, POA indicators will continue to be required on all inpatient claims. This is because the HCAC payment reduction policy only applies if the HCAC condition(s) were acquired in the hospital (after admission). POA indicators associated with each diagnosis code on the claim (except the admit diagnosis code) will be edited to ensure they are valid. Claims with invalid POA indicators will be denied. Diagnosis codes defined as exempt from POA reporting will not require a POA code. CMS publishes a list of diagnoses exempt from POA reporting annually.

The following values are valid for the POA indicator:

- **Y** Diagnosis was present at time of inpatient admission
- **N** Diagnosis was not present at time of inpatient admission
- **U** Documentation insufficient to determine if condition was present at the time of inpatient admission
- **W** Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
- Blank Diagnosis is exempt from POA reporting

Under the DRG pricing methodology, values of “N,” “U,” and “W” will all be interpreted as indicating the diagnosis was not present at the time of admission. This is consistent with current Mercy Maricopa policy applied to claims paid via per diem. Blank is a valid value only for diagnoses included on CMS’ list of codes exempt from POA reporting.

Under the DRG payment methodology, two DRGs will be assigned to every claim, one referred to as a “pre-HCAC” DRG and a second referred to as a “post-HCAC” DRG. The “pre-HCAC” DRG is assigned
using all diagnosis codes on the claim whether or not they were present on admission. The “post-HCAC” DRG is assigned after removing any diagnosis and/or procedure codes identified as HCACs.

On the rare cases where the pre-HCAC and post-HCAC DRGs are different, the DRG with the lower relative weight will be used to price the claim. This will almost always be the post-HCAC DRG, but logic will be implemented to compare both relative weights and select the DRG with the lower relative weight to price the claim.

**Same Day Admit and Date of Death**
Claims with a same date of admission and date of death will be reimbursed a full DRG payment. Providers must report the discharge status code of 20 on the claim indicating death.

**Out-of-State Hospitals**
Acute care services provided by out-of-state providers will be reimbursed under the DRG methodology.

**Slow Pay Penalties and Quick Pay Discounts**
Mercy Maricopa will continue to support the current slow pay penalty and quick pay discount policies. A quick pay discount of 1 percent will continue to be applied to claims paid within 30 days. The slow pay penalty will continue to be based on a 30 calendar day month, as illustrated below:

- Claim paid within 31-60 days of clean claim date: 0% discount/penalty
- Claim paid within 61-90 days of clean claim date: 1% penalty
- Claim paid within 91-120 days of clean claim date: 2% penalty

The slow pay penalty will continue to accrue at a rate of 1 percent per month or partial month until the claim is paid by Mercy Maricopa.

**Readmission Policy**
A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, Mercy Maricopa will identify certain readmission cases and conduct a medical review prior to finalizing payment associated with the readmission claim.

The following criteria will prompt a medical review:
1. Recipient must be readmitted to the same hospital within 72 hours; and
2. The base DRG assignment on the readmission claim must match the base DRG assignment on the initial claim (the base DRG assignment is identified by the first three digits of the DRG code); and
3. The readmission claim has not been prior authorized. If prior authorized, the readmission claim will be considered to have already gone through medical review.

If the claim associated with the readmission meets the criteria above, the claim will be pended for medical review. The payment associated with the readmission claim will be held until the completion of the medical review process. Upon the medical review, if the readmission is determined to have been preventable by the hospital, the payment associated with the readmission claim will be disallowed. Alternatively, if upon the medical review it is determined the hospital would not have been able to prevent the readmission; the claim will be paid under DRG methodology.
**Reinsurance**
Any final claims which cross over contract years will not be eligible for reinsurance.

Reinsurance on interim claims will not be paid. The final claim submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the hospital stay do not cross contract years.

Reinsurance will not be paid on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

**Non-covered Services**
Charges associated with use of robotic technology will be disallowed when claims are reviewed for outlier consideration.

**Newborn Birth Weight Reporting**
For claims submitted related to newborns, providers should include the birth weight of the newborn on all claims in which the age of the newborn is fourteen (14) days or less. Birth weight should be communicated in a value amount field with associated value code equal to 54. Birth weight should be billed as a number of grams.

**Hemophilia HCPCS/NDC Reporting**
For claims which include Hemophilia drugs, providers should include the appropriate HCPCS, NDC code and units, on the corresponding Pharmacy revenue code.