**AHCCCS**

**APR-DRG Payment System Design**

**Payment Policies**

**Preliminary Draft**

**February 13, 2014**

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**1. DRG Pricing Information Summary**

Effective October 1, 2014, AHCCCS will determine Medicaid reimbursement for most acute care hospital inpatient services using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems will be used to categorize each inpatient stay. Each inpatient hospital claim will be assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category. The DRG relative weight is a key factor in determining payment to the hospital.

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

Payment under DRG pricing will be comprised of a DRG base payment and a DRG outlier add-on payment. Total payment will equal the sum of these two. DRG base payment is generally set to a hospital DRG base price times the DRG relative weight. In addition, a few payment factors referred to as “policy adjustors” will be applied under specific scenarios to affect the DRG base payment. The DRG outlier add-on payment will be cost-based and calculated based on a fixed-loss threshold.

The following are examples of the payment policy adjustors applied to the DRG base payment under specific scenarios,

* Provider specific policy adjustor
* Service specific policy adjustor – applied based on DRG assigned to the claim/encounter
* Age adjustor – applied based on combination of DRG assigned to the claim/encounter and age of recipient

**All policies and numerical parameters identified in this document are applicable for initial implementation of DRG pricing on October 1, 2014. The payment policies and, in particular, the numerical pricing parameters are subject to change in future years.**

# 2. DRG Pricing Formulas

With DRG pricing, claim payment is made up of a DRG base payment and, when applicable, an outlier add-on payment. Final allowed amount is the sum of DRG base payment and the outlier add-on payment. In the pricing calculation, an unadjusted DRG base payment and an unadjusted outlier add-on payment are calculated. These values may then be adjusted based on covered days and a transitional adjustor which will be in place for the first three years of DRG pricing. A DRG pricing flow chart is listed below and details of the pricing calculation are shown in the following pages.

Adjust DRG base payment and outlier for DRG transition policy and DCI

Adjust DRG base payment and outlier for covered days

Calculate reimb. amount = [allowed amount] – [Oth ins] +/- [Prompt Pay Adjstmt]

**DRG Pricing Flow Summary**

Calculate Medicaid allowed amt = [DRG base pymt] + [outlier amt]

Calculate outlier payment amount

Adjust DRG base payment for acute-to-acute transfers

Calculate base payment =

[hosp base price] \* [DRG rel wt] \* [policy adjuster(s)]

Determine DRG code

DRG Base Payment

Initial DRG Base Payment will be calculated as:

*Initial DRG Base Payment = [Wage Adjusted Provider DRG Base Rate]*

*\* [Post-Health Care Acquired Condition DRG Relative Weight]*

*\* [Provider Policy Adjustor]*

*\* [Maximum of (DRG Service Adjustor) and (DRG Age Adjustor)]*

If the patient discharge status code is in the following list of codes for which the DRG transfer policy applies,

*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*

Then the Transfer DRG Base Payment will be calculated as:

*Transfer DRG Base Payment = [Initial DRG Base Payment]*

*/ [DRG National Average Length of Stay]*

*\* [Medicaid Covered Days + 1]*

If the patient discharge status code is in the list of codes for which the DRG transfer policy applies, then:

*Unadjusted DRG Base Payment = lesser of [Initial DRG Base Payment]*

*and [Transfer DRG Base Payment]*

Otherwise,

*Unadjusted DRG Base Payment = [Initial DRG Base Payment]*

DRG Outlier Add-On Payment

Not all claims will qualify for a DRG outlier add-on payment. For those that do, the DRG outlier add-on payment will be added to the DRG Base Payment to determine the final payment for the claim.

To determine if a claim will qualify for an outlier add-on payment, first the Claim Cost must be calculated. The Claim Cost will be calculated as:

*Claim Cost = {[Claim Total Submitted Charges] – [Claim Non-Covered Charges]}*

*\* Hospital Cost to Charge Ratio*

The Claim Cost must then be compared to the Outlier Threshold. The Outlier Threshold is calculated as:

*Outlier Threshold = Unadjusted DRG Base Payment + Fixed Loss Amount*

The Fixed Loss Amount is $5,000 for Critical Access Hospitals (CAH)/small rural providers and $65,000 for all other providers.

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

For claims that qualify for a DRG outlier add-on payment, the Unadjusted DRG Outlier Add-on Payment will be calculated as:

*Unadjusted DRG Outlier Add-on Payment = [Claim Cost – Outlier Threshold]*

*\* DRG Marginal Cost Percentage*

The DRG Marginal Cost Percentage is 90% for burn DRGs and 80% for all other DRGs. The base DRG codes for burn DRGs are 841, 842, 843, and 844.

Covered Day Adjustment

There are scenarios for which payment will be adjusted because not all days of the inpatient stay are payable by AHCCCS. Some examples are:

* Recipient is enrolled in the Federal Emergency Services Program (FES)
* Recipient gains Medicaid eligibility after admission into the hospital
* Recipient loses Medicaid eligibility after admission and before discharge

For each of these scenarios, a payment adjustment factor will be calculated in order to prorate the payment based on covered days. If the factor is greater than 1, it will be reduced to 1 so that the covered day adjustment never has the effect of increasing payment beyond the full DRG payment. The factor will be applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment.

The formulas for calculating the Covered Day Adjustment Factor are:

If recipient enrolled in the FES program:

*Covered Day Adjustment Factor Unadjusted = {[Medicaid Covered Days] + 1}*

*/ [Length of Stay from Admit Through Discharge]*

Else If recipient gains Medicaid eligibility after admission then:

*Covered Day Adjustment Factor Unadjusted = [Medicaid Covered Days]*

*/ [Length of Stay from Admit Through Discharge]*

Else If recipient loses Medicaid eligibility prior to discharge then:

*Covered Day Adjustment Factor Unadjusted = {[Medicaid Covered Days] + 1}*

*/ [DRG National Average Length of Stay]*

The final covered day adjustment factor is calculated as:

*If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then*

*Covered Day Adjustment Factor Final = 1.0*

*Else*

*Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]*

The Covered Day Adjustment Factor Final gets applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment using the following formulas:

*Covered Day Adjusted DRG Base Payment = [Unadjusted DRG Base Payment]*

*\* [Covered Day Adjustment Factor Final]*

*Covered Day Adjusted DRG Outlier Add-on Payment = [Unadjusted DRG Outlier Add-on Payment]*

*\* [Covered Day Adjustment Factor Final]*

Note: The adjustment factors are applied separately to the DRG base payment and the outlier payment so that the percentage of total payment coming from outliers can be monitored.

Final Payment Adjustment

DRG payment methodology will be transitioned over three years (FFY 2015 through FFY 2017). For FFY 2015, 2016, and 2017 of DRG pricing, there will be a provider-specific payment adjustment applied to every claim paid via the DRG pricing method. This payment adjustment will be made using a numeric multiplier that will be applied to both the DRG base payment and the DRG outlier payment. The multiplier will be loaded into a provider specific DRG pricing table.

The Provider DRG Transition Multiplier will be a combination of two payment adjustments – one for the DRG transition policy and the second for anticipated improvement in documentation and coding (DCI).

By applying this adjustment as the last step in the DRG pricing logic, final payment will be calculated as:

*Final DRG Base Payment = [Covered Day Adjusted DRG Base Payment]*

*\* [Provider DRG Transition Multiplier]*

*Final DRG Outlier Add-on Payment = [Covered Day Adjusted DRG Outlier Add-on Payment]*

*\* [Provider DRG Transition Multiplier]*

*Final Allowed Amount = Final DRG Base Payment + Final DRG Outlier Add-on Payment*

*Final Reimbursement Amount = Final Allowed Amount – Other Insurance Payment*

*+/- Prompt Pay Adjustment*

Note: The current prompt pay policy (slow pay penalties and quick pay discounts) will continue to apply. Refer to section 26 of this document for more information.

# 3. Issue Number in APR-DRG Matrix: 1 – Enrolled in Federal Emergency Services Program (FES)

Inpatient hospital services provided to recipients enrolled in the Federal Emergency Services Program (FES) are paid by the Administration under the fee-for-service program. Payment is limited to those services that meet the Federal definition of an emergency service, as determined through the Administration’s Medical Review process.

The emergency portion of an inpatient hospital service is determined on a claim-by-claim basis by determining the number of days of service for each inpatient hospital claim that meet the Federal definition of an emergency.

DRG payment is designed to be payment for a complete hospital stay. For claims paid via DRG pricing in which only emergency services are reimbursed, payment will be prorated based on the number of Medicaid covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as,

*Covered Day Adjustment Factor Unadjusted = {[Medicaid Covered Days] + 1}*

*/ [Length of Stay from Admit Through Discharge]*

*If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then*

*Covered Day Adjustment Factor Final = 1.0*

*Else*

*Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]*

# 4. Issue Number in APR-DRG Matrix: 2, 3, 8, and 13 – Enrollment Change during Hospital Stay

A recipient may change payers during a single hospital stay, while maintaining Medicaid eligibility throughout the entire stay. This may occur under a variety of scenarios including,

* A recipient changing enrollment from fee-for-service into a managed care plan (#2)
* A recipient changing enrollment from a managed care plan into fee-for-service (#2)
* A recipient changing enrollment between managed care plans within the same program (#3)
* A recipient changing enrollment between managed care plans in different programs, for example, moving from an Acute MCO to the Arizona Long Term Care System (ALTCS) (#13)

In these scenarios, services paid via the DRG method will be paid by the payer with which the recipient is enrolled on date of discharge. This payer will be responsible for reimbursement for the entire hospital stay, including any applicable outlier payment.

Unique to these scenarios, providers are expected to submit a claim to the appropriate payer with the “From” date of service (form locator 6 on the UB-04 paper claim form) equal to the first day in which the recipient was enrolled with that payer. This will avoid denial based on eligibility/enrollment edits. Under these scenarios, the “From” date of service for the payer responsible on the Date of Discharge will be later than the Date of Admission. The “Through” date of service will be either the last date of enrollment with the payer or the date of discharge. The claim may include all surgical procedures (form locator 74 on the UB-04 claim form) applicable for the hospital stay (admit through discharge), even if these procedures were performed prior to the recipient’s enrollment with the payer responsible for reimbursement. However, each payer’s claim(s) should only include revenue codes, service units, and charges applicable to services performed during the covered days included on the claim (e.g. days between the “From” and “Through” date).

Interim claims submitted to a payer other than the one with which the recipient is enrolled on date of discharge shall be handled in the same manner as all other interim claims. See Issue Number 8.

# 5. Issue Number in APR-DRG Matrix: 4 – Medicare Dual Eligibles

Throughout the duration of a single hospital stay, a recipient dually eligible for Medicare and Medicaid may exhaust the allowable Medicare Part A benefit.

In the event a recipient exhausts Medicare Part A benefits during a hospital stay, a separate claim should be filed for the Medicaid covered portion of the stay. On the UB-04 paper claim form or the 837 institutional submission, providers shall report the “From” date of service as the first day Medicaid is the primary payer (i.e. the day after Medicare benefits have been exhausted). The “Through” date of service reported on the claim should be the date of the discharge. The provider will include on the claim only the charges associated with the Medicaid portion of the stay (i.e. the “From” date of service through the “Through” date of service reported on the claim). All diagnosis codes describing the patient’s medical condition may be included on the claim. However, only those ICD surgical procedures performed between the “From” and “Through” dates of service may be submitted on the claim to ensure that Medicaid does not make a duplicate payment for services already covered for by Medicare. Since a separate claim is filed there is no proration of the claim; a full DRG payment will be paid for the Medicaid claim.

# 6. Issue Number in APR-DRG Matrix: 5 – Administrative Days

For hospitals reimbursed under the DRG method for acute care services, AHCCCS may also offer reimbursement for Medicaid recipients occupying a bed while not in need of acute care. For example, this may occur prior to an acute care episode when an expecting mother stays in a hospital awaiting birth of a baby. This may also occur 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.

Those days in which the Medicaid recipient is occupying a hospital bed and is not in need of acute care are referred to as administrative days. When prior authorized, administrative days will be reimbursed by AHCCCS using a negotiated per diem rate. Reimbursement for administrative days will be separate from DRG reimbursement for acute care services.

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 reflects 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 a hospital-based Medicare approved swing bed on the acute care claim. Likewise, when the opposite occurs – an administrative day stay is followed by an acute care stay –hospitals shall use patient discharge status 70 on the administrative day claim.

# 7. Issue Number in APR-DRG Matrix: 6 – Admit versus Discharge Date

DRG pricing and the DRG pricing logic will be based on 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.

# 8. Issue Number in APR-DRG Matrix: 9 – Interim Claims

A recipient may be in the hospital for an extended period of time. If a patient stay exceeds a 29 day period, hospitals may submit interim claims related to the patient stay in increments of 30 days. Interim claims will be reimbursed under a per diem rate of $500 per day.

Hospitals must submit a final claim associated with the patient stay upon the patient’s discharge. The final claim should reflect all procedures performed and all charges incurred during the entire patient stay – admit through discharge unless dates of service on the claim must be limited due to changes in Medicaid eligibility or changes in payer enrollment during the stay. The final claim will be paid under the DRG payment methodology.

***Single Medicaid Payer for Entire Stay***

Hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided.

***Multiple Medicaid Payers for Entire Stay***

The initial Medicaid payer will recoup all interim payments at the time Medicaid enrollment changes to another Medicaid payer. To the extent that interim bills are submitted to and paid by the Medicaid payer in effect on the date of discharge, hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions in Issue #4, and paid by the Medicaid payer in effect on the date of discharge.

***Medicaid Eligibility Changes During the Stay***

A member may lose or gain Medicaid eligibility during an inpatient stay. To the extent there are interim bills submitted to and paid by the Medicaid payer, hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions in Issue #4, and paid by the Medicaid payer in effect on the date of discharge or the date that eligibility changes.

The Administration will not pay reinsurance on interim claims. The final claim submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration. Any final claims which cross over contract years will not be eligible for reinsurance.

# 9. Issue Number in APR-DRG Matrix: 10 – 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*

Under this transfer payment policy, DRG base payment for the transferring hospital will be calculated as follows:

*Lesser of:*

*Or:*

*Initial DRG Base Payment*

The base DRG payment reimbursed to the “transferring” hospital will be the lesser of the adjusted Transfer DRG Base Payment, as calculated above, or the calculated Initial DRG Base Payment for the full hospital stay. The adjusted 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 actual length of stay, the date of the discharge will not be included. The date of discharge is only payable by AHCCCS 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 adjusted Transfer DRG Base Payment or the Initial DRG Base Payment as appropriate) to determine the final DRG payment.

# 10. Issue in APR-DRG Matrix: 14 – 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 Medicaid covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment is calculated as,

*Covered Day Adjustment Factor Unadjusted = [Medicaid Covered Days]*

*/ [Length of Stay from Admit Through Discharge]*

*If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then*

*Covered Day Adjustment Factor Final = 1.0*

*Else*

*Covered Day Adjustment Factor Final = [Covered Day Reduction Factor Unadjusted]*

The covered day adjustment factor does not include one additional day to account for the first part of the stay when a disproportionate amount of costs are incurred since the recipient is not Medicaid eligible upon the admission of the stay. Rather the recipient gains eligibility at some point after admission.

When submitting a claim under this scenario, providers are expected to report the “From” date of service as the first date the recipient is eligible for reimbursement. Assuming the recipient is enrolled with Medicare through discharge, the “Through” date of service will be set to the date of discharge. The actual length of stay will be calculated as the duration of the hospital stay from the date of admission up through the date of the discharge (i.e. “Through” date of service less the admission date). The number of Medicaid covered days will be calculated as the “Through” date of service on claim less the “From” date of service. If the recipient expires in the hospital, the day of discharge is reimbursable and one day will be added to the number of Medicaid covered days and actual length of stay to account for date of discharge.

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

# 11. Issue in APR-DRG Matrix: 15 – 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 Medicaid covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as,

*Covered Day Adjustment Factor Unadjusted = [Medicaid Covered Days + 1 Day]*

*/ [DRG National Average Length of Stay]*

*If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then*

*Covered Day Adjustment Factor Final = 1.0*

*Else*

*Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]*

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.

When submitting a claim in this scenario, providers are expected to report “From” date of service as the first date the recipient is eligible for reimbursement. 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 the Medicaid payer. The number of Medicaid 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.

# 12. Issue in APR-DRG Matrix: 16 – Reinsurance - PPC and Regular

AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC).

# 13. Issue in APR-DRG Matrix: 17 – 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.

# 14. Issue in APR-DRG Matrix: 18 – Specialty Hospitals

Hospitals licensed as short term specialty hospitals by the Arizona Department of Health Services (ADHS) will be reimbursed under the DRG methodology, under a separate DRG base rate that will be reflected in the rate tables as with all other DRG providers.

The base rate for hospitals falling under this category will be loaded in AHCCCS’s system.

Note that final criteria still need to be established for this designation. The current definition of short term specialty hospitals does not encompass Mayo.

# 15. Issue in APR-DRG Matrix: 19 – Rehabilitation Specialty Hospitals

Hospitals designated as specialty per diem facilities will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate that will be reflected in a provider specific rate table as all other per diem providers. A new provider type will be established to identify these providers and will include certain freestanding rehabilitation providers and long term care providers (LTACs).

# 16. Issue in APR-DRG Matrix: 20 – 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 Medicaid Allowed Amount.

# 17. Issue in APR-DRG Matrix: 23 – Carved-out Services

DRG payment when applied to an inpatient hospital claim will cover all inpatient services related to that stay. No services or supplies will be carved out or separately reimbursed.

# 18. Issue in APR-DRG Matrix: 25 – Psychiatric Hospitals

Hospitals designated as freestanding psychiatric per diem facilities will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate consistent with current reimbursement policy for this provider type (71).

# 19. Issue in APR-DRG Matrix: 26 – Non-covered Charges

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

# 20. Issue in APR-DRG Matrix: 27 and 48 – Transplants

Transplant cases are exempted from DRG payment, and will continue to be reimbursed under the current methodology of contracted rates. Days in the hospital beyond day 60 will continue to be reimbursed via a per diem when primary payment for the hospital stay is covered under the transplant policy.

# 21. Issue in APR-DRG Matrix: 28 – Negotiated Settlements

AHCCCS 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 global fee methodology.

# 22. Issue in APR-DRG Matrix: 30 – Detox / Behavioral Health versus Medical Reimbursement

A recipient admitted to a hospital may require both medical treatment as well as psychiatric/behavioral health treatment. Only one claim will be submitted and reimbursed for a single hospital stay in which both medical 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 MCO under which the member is eligible or to the Regional Behavioral Health Authority (RBHA) assigned to the member.

If upon admission into the facility, the primary diagnosis of the recipient is a medical diagnosis, the claim should be submitted to the associated MCO 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 the appropriate RBHA and will be reimbursed under the current RBHA methodology.

# 23. Issue in APR-DRG Matrix: 31 – HCAC and POA

Health care acquired conditions (HCACs) are identified using the standard rules put forth by the Center 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, AHCCCS 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.

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 the logic will be implemented to compare both relative weights and select the DRG with the lower relative weight to price the claim.

# 24. Issue in APR-DRG Matrix: 32 – Same Day Admit and Date of Death

Claims with a same date 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.

# 25. Issue in APR-DRG Matrix: 33 – Out-of-State Hospitals

Out-of-state providers will be reimbursed under the DRG methodology. Rates and payments for high volume out-of-state hospitals will be established using the same method used for in-state hospitals. Their base rate will be established using their own FFY 2014 Medicare IPPS wage index (with reclassification, if applicable), and they will be assigned their hospital specific Medicare outlier cost-to-charge ratio that was in effect prior to the DRG methodology implementation date.

Note: Criteria for high volume out-of-state hospitals need to be revisited and finalized. Preliminary criteria provided by Jean Ellen was those with Medicaid payments exceeding $200,000 in a year.

Low volume out-of-state hospitals will be assigned a DRG base rate equal to the average in-state DRG base rate. Similarly, low volume out-of-state hospitals will be assigned a cost to charge ratio equal to the average in-state cost-to-charge ratio.

# 26. Issue in APR-DRG Matrix: 35 – Slow Pay Penalties and Quick Pay Discounts

The Administration will continue to support the current slow pay penalty and quick pay discount policies. The Administration will calculate the quick pay discounts and slow pay penalties on the AHCCCS Allowed Amount for providers classified as type 02, excluding IHS and 638 providers, and freestanding rehabilitation and freestanding psychiatric facilities billed on the UB-04 claim form.

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 AHCCCS.

# 27. Issue in APR-DRG Matrix: 38 – Readmission Policy

A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, the Administration 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.

Specific criteria for identifying preventable readmissions by a hospital during the medical review process will be developed. The criteria will be the same for FFS as well as MCO claims. In addition, the Administration will seek opportunities to educate providers on the readmission policy as well the medical review process.

The Administration may consider monitoring readmission rates across providers and may consider rate adjustments for providers with potentially preventable rates in excess of their peers.

# 28. Issue in APR-DRG Matrix: 49 – Claims Crossing Contract Years

The Administration will not pay reinsurance on interim claims. 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. Any final claims which cross over contract years will not be eligible for reinsurance.

# 29. Issue in APR-DRG Matrix: 54 – Non-covered Services

Robotic surgeries, which in many cases are not covered by AHCCCS, do not affect APR-DRG assignment, Severity of Illness (SOI), or the DRG relative weights.