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MEDICAID MEMO

TO: All Hospitals Participating in the Virginia Medical Assistance Program and Health Maintenance Organizations Providing Services to Virginia Medicaid Recipients

FROM: Dennis G. Smith, Director
Department of Medical Assistance Services

MEMO	Specia
DATE	12-1-99

SUBJECT: Billing Instructions and Reimbursement of Claims by Diagnosis Related Groups (DRG)

The purpose of this memo is to provide instructions and information that will be needed by hospitals when Department of Medical Assistance Services (DMAS) converts from the current per diem method of cla processing to DRG claims processing.

DMAS will be using All Patient Diagnosis Related Groups (AP-DRG), Version 14 for claims with discha dates on or after July 1, 1998. Version 12 of the AP-DRG will be used for discharge dates prior to or on June 1998.

Payment of claims by DRG is scheduled to begin January 1, 2000. This means that not only will settlemen inpatient hospital services be based on DRG rates, but also that payment of each claim will be based on a D per case rate. A number of changes to the billing practices and claims processing procedures are necessar order for DRG-based claims processing to work properly. These are identified below.

1. Start-up and effective date. DRG processing will begin with admission dates on or after January 1, 20 This means that claims for patients admitted on and after January 1, 2000, will be processed in the described in this memo. Patients with admission dates prior to January 1, 2000, will continue to be bil processed, and reimbursed under the current procedures, even if the hospitalization extends past Januar 2000.

2. Billing cycle. The billing cycle has been 21 days for adults and 31 days for recipients under 21 years of For patients admitted before January 1, 2000, this limitation for billing cycles will continue. For pati admitted on and after January 1, 2000, the billing cycle will be 120 days, with the exception identified bel Bill types 112 and 113 with less than 120 days will be denied. Any bill with more than 120 days will als denied.

   Exception: Recipient with multiple identification numbers within same hospital admission.

3. Initial Claim and Case. With a billing cycle of 120 days, most patients will be billed on only one claim type 111). These claims will be processed and payment made based on the DRG grouper. This payment be on the weekly remittance voucher after the claim is processed.

4. Interim and final payment for multi-claim cases. There will be multi-claim cases whenever a hospitalizatio greater than 120 days. These claims will utilize bill types 112, 113, and 114. For these, final pricing u DRG cannot be done until all claims, including the discharge claim, are received. Only then can the "case the entire patient stay be assembled and priced. However, interim payment will be made for claims with

type 112 (the first interim claim). This payment will equal a per diem rate times the number of days on the claim (usually 120). The per diem rate will be equal to the DRG rate for the tentatively assigned DRG divided by the average length of stay for the DRG. The amount paid for claims with bill type 112 will not be allowed to exceed the DRG payment. No interim payment will be made for subsequent interim claims (bill type 113) or for discharge claims (bill type 114), but these claims are needed before final payment can be calculated for the entire case.

Exception: Payment will be made on the first interim claim that the recipient is eligible for Virginia Medicaid during the monthly cycle.

When the final claim for a multi-claim case (bill type 114) is received, the entire case will be assembled or "built" from the various claims that make it up, and it will be priced. This case building process occurs only monthly, so it may occur as much as a few weeks after receipt of the final claim of the case. When the case is built and priced, the difference between the price for the case and the interim payment that was made on the first interim claim of the case (bill type 112) will be reflected as an adjustment to that first interim claim. This adjustment will be reported on the next remittance following the monthly cycle in which the case was built and priced.

5. Transfer cases. A transfer case is a patient who is discharged from one hospital and admitted to another within 5 days with the same or similar diagnosis. If the transferring hospital reports the correct patient discharge status code, the transfer case will be identified in the weekly processing and will be paid correctly. Correct payment equals a per diem rate (described above for interim payments) times the covered days, not to exceed the DRG payment. Transfer cases that are not identified through correct reporting of a patient discharge status code on the claim will be identified in the monthly case building process as "implied transfers." When implied transfers are identified, a DRG payment may have already been made to the transferring hospital. This payment will be adjusted and a per diem payment made. These transactions will be reported on the remittance following the monthly cycle that identified the implied transfer. The receiving hospital will receive the DRG payment.

6. Re-admission cases. A readmission occurs when a patient is discharged and returns to the same hospital within 5 days with the same or similar diagnosis. These cases are considered a single case rather than two. Re-admissions will be identified in the monthly processing cycle. Often when this occurs, one or both claims will already have been paid. The payment of the first claim will be adjusted to reflect a payment for the combined case, and an adjustment will be made to the second claim reflecting a zero payment. The corrected processing will recognize all the coding and charges from both claims for purposes of DRG assignment and potential outlier determination. These transactions will be reported on the remittance following the monthly cycle that identified the readmission and be identified on the "DRG Case Data Adjustment Report."

7. Remittance reporting: A new remittance has been developed that allows for reporting of DRG related activity and the previous claims processing under the per diem payment methodology. This is a combined remittance voucher that reports all claims processed on the weekly or monthly cycle.

As described above, interim payments will be made for claims with bill type 112. This interim payment will be reported on the remittance immediately following the processing of the 112. Subsequent claims for the same case (with bill type 113 and 114) will be processed when they are received. They will be reported on the weekly remittance immediately following their processing, but payment will equal zero. Case building will occur in the next monthly case building cycle and the calculated final payment will result in an adjustment to the first claim of the case (bill type 112), the claim which generated the interim payment. This adjustment will be reported in the weekly remittance that follows the monthly case building cycle. This means that all adjustments based on case building will be reported once a month. Bill types 113 and 114 will

only have payments associated with them if the recipient is not eligible for Virginia Medicaid on the dates of service placed on the bill type 112. This process will be identified during the monthly cycle.

Identification of implied transfers and re-admissions will only occur in the monthly case building cycle and the resulting voids, adjustments, and reprocessing will be reported in the weekly remittance that follows the monthly cycle.

The weekly remittance itself will report only claims and their disposition. It will not report information about case building for multi-claim cases, implied transfers, or re-admissions. That is, when an adjustment of a bill type 112 is reported as a result of the monthly case building, the remittance will not identify the other claims that made up the case or provide other information about case building. Nor will reporting of transactions related to implied transfers and re-admissions include identification of related claims. However, when transactions resulting from case building are reported on the remittance (and this will occur only once a month), a separate claims adjustment report will be sent to the hospital. This "DRG Case Data Adjustment Report" will provide information about case building for each case for which a case building-related transaction appears on the corresponding remittance. Transactions resulting from case building that are reported on the remittance will be reported with a message code that indicates that the transaction is the result of case building, and this should inform the hospital that it needs to consult the DRG Case Data Adjustment Report for further information.

8. Outlier Payment. Outlier payments are made on those DRG cases where estimated costs exceed the DRG payment by specified thresholds.

9. Capital payment. Interim payment for capital in the new methodology will be accomplished through a percentage increase of the hospital-specific rate per case and rate(s) per day. Hospitals will be informed of both their operating rates and the rates, including the interim adjustment for capital, which will be used to process claims. At year-end settlement, the interim payment for capital will be adjusted based on the calculation of capital as a pass-through.

10. Missing Discharge Claim(s). When a multi-claim case occurs and no discharge claim (bill type 114) is received, DMAS cannot build the case for DRG processing. In order to build the case, DMAS needs billing for the entire stay, from admission to discharge. When one or more claims of a multi-claim case have been received, and more than 120 days have passed after the most recently submitted interim claim, DMAS will expect to receive another interim or final claim. If this does not occur, letters will be generated monthly requesting the provider to submit the next or final claim. Failure to submit final claims will eventually result in voiding of all interim claims.

11. DRG Non-Groupable Cases. Some claims fail to group to a DRG due to reporting of multiple error reasons (invalid diagnosis or procedure codes, invalid age/sex). Individual claims will be denied if not groupable during the weekly cycle. Case building claims that are not groupable will have all associated claims voided during the monthly cycle. Information about cases that fail to group will be provided via a monthly denial letter. Such claims cannot be adjusted, but must be voided and resubmitted.

12. Pre-authorization. Pre-authorization requirements will change for inpatient hospital admissions for medical/surgical treatment with the implementation of DRG reimbursement methodology. There will be no change to the current pre-authorization requirements for inpatient psychiatric services or intensive rehabilitative services.

Admissions to a general hospital for medical/surgical care, occurring on and after January 1, 2000, **will continue to require pre-authorization within one working day of the admission**. Concurrent review will no longer be required to justify length of stay. The criteria that DMAS' pre-authorization contractor, WVMI, will use to authorize these admissions will continue to be the InterQual ISD-AC. Patients must meet both the "Severity of Illness" and "Intensity of Service" criteria corresponding to the admitting diagnosis in order to obtain approval for the admission. If criteria are met, WVMI will enter the date of admission into the pre-authorization file and advise the hospital caller of the authorization number to be used for billing. The reconsideration process for cases that do not meet criteria will remain the same as before implementation of DRG reimbursement methodology. **Concurrent review will no longer be required to justify length of stay for inpatient medical/surgical care.**

Inpatient psychiatric services, both in general hospitals and free-standing psychiatric hospitals **are not affected by DRGs and will continue to require pre-authorization within one working day of the admission and concurrently for length of stay.** If the primary diagnosis falls within the ICD-9 CM Range of 290 through 319, the stay is considered a mental health stay and is exempted from DRG reimbursement methodology. Reimbursement for authorized psychiatric inpatient days will continue to be reimbursed at the hospital's per diem rate.

Intensive rehabilitative services are also not affected by DRGs. These services will continue to require pre-authorization both for the admission and continued length of stay. Reimbursement for authorized intensive rehabilitative services will continue to be reimbursed at the provider's per diem rate.

Pre-authorization by WVMI does not supersede the utilization review requirements described in each hospital's Utilization Management Plan.

13. Patients who are transferred between medical/surgical and psychiatric units. DMAS will continue to require that whenever a patient is transferred between a medical/surgical unit and a psychiatric unit of the same hospital, the stay in the medical/surgical unit must be billed as an admission and discharge separate from the stay in the psychiatric unit. The medical/surgical stay will be processed and reimbursed under the DRG methodology as one stay, while the days in the psychiatric unit will be reimbursed under the psychiatric per diem rates.

14. Newborn billing. Presently, certain newborn revenue codes cannot be combined on a single claim. This results in split billings to accommodate the changes in the level of newborn care to be reflected in the appropriate newborn revenue code. For births on and after January 1, 2000, any applicable newborn revenue codes may be reported on a single claim. For births before that date, the previous rules remain in force.

15. Recipient's eligible for coverage by an HMO and Virginia Medicaid fee-for-service during same hospitalization. For these situations, hospitals should submit claims to DMAS for the entire stay, and should report the HMO and any other payments on the final claim (bill type 114) as third party payments. DMAS will price the entire stay under the DRG methodology and will offset HMO and other payments. Billing to DMAS should follow DMAS billing procedures, regardless of the admission date or the way the HMO was billed.

16. Medicare patients who exhaust benefits. Some dually eligible Medicare patients exhaust their Medicare benefits during a hospital stay. This should be handled in a way similar to the HMO situations above. The entire stay should be billed to DMAS, and any payments from Medicare, Medicaid coinsurance and deductibles or any other payers should be reported on the final claim (bill type 114). Medicare's notification of exhausted days must be attached to these claims. DMAS will manually review these claims to confirm that Medicare days have been exhausted. DMAS will price the entire case and will offset payments from

Medicare or other payers. Billing to DMAS should follow DMAS billing procedures, regardless of the admission date or the way Medicare was billed.

17. Specialty forms. Specialty forms will continue to be required when abortion, hysterectomy, or sterilization is performed. Current practice is to allow charges for the sterilization to be excluded if this procedure was performed in conjunction with a labor and delivery hospitalization and an acceptable form is not available for submission with the claim. Effective with admissions on and after January 1, 2000, it will be required that both the appropriate charges and procedure codes related to the sterilization procedure be excluded if an acceptable form is not submitted.

    Providers will need to indicate in locator 84 that the charges and procedure code for the sterilization have been deleted for audit purposes. Claims submitted for a hysterectomy or abortion must have an acceptable DMAS specific form. No payment will be made if the required specialty form is unacceptable.

18. Transplants. Except for kidney and cornea transplants, transplant services are reimbursed under special arrangements, and are not covered under the DRG methodology. Hospitals providing transplant services under these special arrangements should continue the existing billing procedures for transplant patients (except kidney and cornea transplants) admitted prior to January 1, 2000. DMAS will continue to process the claims and pay a per diem rate. The additional contract payment will continue to be made as a separate check. Billing for transplant services to patients admitted on and after January 1, 2000, remain the same as existing billing procedures except the 120-day billing cycle rule will apply. Per-diem rates will be based on updated pre-DRG rates. The per diem payment for these claims will be reported on the remittance voucher.

19. 21-day limit within 60 days. The coverage limit of 21 days within 60 days for adults has been eliminated for medical and surgical services paid under DRG. However this limit remains in place for psychiatric services, which will continue to be paid under per diem rates.

20. Revenue Code(s). DMAS has revised the revenue code table. For claims submitted with admissions on or after January 1, 2000, these codes will be accepted. Claims submitted with deleted or inappropriate revenue code(s) will be denied. Claims submitted for admission dates prior to or on December 31, 1999, must use the current acceptable revenue codes.

21. Children's Medical Security Insurance Plan (CMSIP). Inpatient hospital services provided to CMSIP clients must be billed for admissions on or after January 1, 2000, the same as claims for Virginia Medicaid recipients. These CMSIP claims will be processed and reimbursed under DRG guidelines and payment methodology.

22. CMSIP and Virginia Medicaid eligiblity. Claims that have dates of service that span CMSIP and Virginia Medicaid eligibility are to be billed as one claim. When this claim is received, the system will duplicate the claim in its entirety. The first claim will be assigned to the Virginia Medicaid Program Designation, and the CMSIP eligible days will be considered non-eligible days. The second claim will be assigned to the CMSIP Program Designation, and the Medicaid eligible days will be considered non-eligible days. This will result in the DRG payment being prorated across the two programs. All third party payments will be subtracted from the Virginia Medicaid claim.

23. State and Local Hospitalization. This program will remain on a per diem reimbursement methodology. The current billing and claim(s) processing edits will remain effective.

THIS MEMO WILL TERMINATE UPON RECEIPT OF A REVISED *HOSPITAL MANUAL* EARLY NEXT YEAR.

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

This memo does not apply to HMOs and is provided for information.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273 Richmond Area
1-800-552-8627 All Other Areas

Please remember that the "HELPLINE" is for provider use only.