APR DRG FAQs

*all red text is new for 11/16/2015

The following FAQs address general topics related to APR DRGs. Additional detail information can also be found at the following links:

Interim Billing
Health Care Acquired Conditions (HCAC) / Present on Admission (POA)
3-Day Rule: Outpatient Services Prior to Inpatient Admissions
Claims Paid Per Diem Rates
Hospital Based Practitioners – Inpatient

1. What is APR DRG?

   A. In general, every complete inpatient stay is assigned to a single diagnosis related group (DRG) using a computerized algorithm that takes into account the patient's diagnoses, age, procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient.

2. What are the characteristics of DRG payment?

   A. DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased.
   B. Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.
   C. Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.
   D. DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers, policymakers, and hospitals better information about services provided.

3. Who developed APR DRGs?

   A. APR DRGs were developed by 3M and the Children's Hospital Association (formerly the National Association of Children's Hospitals and Related Institutions (NACHRI)). According to 3M, APR DRGs have been licensed by more than 20 state and federal agencies and by 1,600 hospitals. APR DRGs have been used to adjust for risk in analyzing hospital performance.

4. In order to be paid would my hospital need to buy APR DRG software?

   A. No. The CMAP claims processing system assigns the APR DRG to the claim and calculates the payment. The hospitals could opt to purchase the software to calculate the expected payment amount.

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5. What version of APR DRGs is being implemented?

   A. Version 31 of APR DRGs was implemented for inpatient claims with date of admission on or after January 1, 2015 and before October 1, 2015.
   B. Version 33 of APR DRGs was implemented for inpatient claims with date of admission on or after October 1, 2015.

6. When will the Inpatient APR DRG methodology be effective?

   A. The Department of Social Services (DSS) has implemented APR DRG on 1/1/2015 for inpatient claims with admission on or after January 1, 2015.

7. When will the changes to hospital based practitioners billing be implemented?

   A. Beginning with inpatient admissions on or after January 1, 2015, all practitioners, including those who work for or are contracted by a hospital are required to bill practitioner services related to inpatient care on a professional claim form. Reimbursement will be via physician fee schedule.

8. What type of inpatient hospital claims will DRG pricing apply to?

   A. DRG pricing applies to most acute care hospital inpatient claims with the exception of chronic disease hospitals, psychiatric hospitals and free-standing birth centers with a date of admission of January 1, 2015 and forward. For more information relating to inpatient admissions for behavioral health and rehabilitation claims, please refer to the 'Claims Paid Per Diem Rates' link located at the top of this page.

9. Do DRG claims require additional information on the UB-04 claim form?

   A. Hospitals are not required to submit any additional information to support APR DRG processing.

10. Will hospitals be required to report DRG codes on their inpatient claims starting with date of admissions of January 1, 2015 and forward?

    A. No. Hospitals will not be required to submit the DRG code on inpatient claims. The CMAP claims processing system will assign the DRG to the claim and calculate the payment.

11. Will paper claims continue to be allowed to be billed with a date of admission of January 1, 2015 and forward?

    A. Yes. At this time there are no specific changes for paper claim submissions.

12. If a sterilization diagnosis is included on a DRG claim, does the sterilization form need to be submitted?

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A. Yes. If a sterilization diagnosis is present on an inpatient claim; the Consent for Sterilization form will still be required. Please follow current guidelines to submit the consent form to DXC Technology.

13. Will the remittance advice (RA) be updated?

A. Yes. A copy of the new RA has been posted to provider manual Chapter 5 "Claim Submissions Information."

14. Will the X12 835 Healthcare Payment be updated?

A. Yes. The X12 835 Health Care Payment has been updated to include the following DRG related fields:
   - DRG code
   - DRG Weight
   - DRG Monetary Amount (MIA04 - Claim DRG Amount)
   - DRG Base Payment Amount
   - Outlier Payment Amount with associated qualifier

15. What if the billed amount is less than the calculated DRG or per diem payment?

A. The hospital claim payment will not exceed the total billed amount of the claim.

16. Are there any impacts to getting Prior Authorization (PA) through CHN for medical admissions or CT BHP for behavioral admissions on January 1, 2015 and forward?

A. Effective for admissions on or after April 1, 2015, inpatient services will no longer be reimbursed a per diem rate based exclusively on the DRG assignment. Services that are currently eligible for a per diem payment are identified by DRG assignments 740-776 (behavioral health) and 860 (rehabilitation).

B. Please refer to the Provider Bulletin 2015-22 located on our Web site www.ctdssmap.com and from the Hospital Modernization Page, click on "Provider Bulletins and Policy Transmittals" link on the right hand side under Helpful Information & Publications.

17. Will the PA process change for an inpatient stay following observation?

A. For the observation status to become an inpatient admission, PA from the appropriate Administrative Services Organization (ASO) is required. If admission to the same hospital as an inpatient is approved, the date of admission will be the begin date of the observation. The hospital will not be separately reimbursed for the observation as it is included as part of the inpatient reimbursement. If the admission is to a different hospital, both hospitals will be reimbursed for their services.

18. Will the hospital need to obtain PA for observation without an admission?

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A. Observation for clients with a behavioral health condition requires PA through the Connecticut Behavioral Health Partnership (CT BHP) and will be reimbursed by the Department for up to 23 hours if deemed medically necessary. If PA is not obtained for the observation services within the time frame allowed by DSS, the claim will be denied.

19. Should the hospital obtain PA through CHN CT for a medical admission with a diagnosis of alcohol withdrawal delirium (ICD-diagnosis code 291.0)?

    A. No. The hospital must obtain PA through CTBHP for all inpatient admissions with a diagnosis of alcohol withdrawal delirium (ICD-9-CM diagnosis code 291.0) regardless of whether they are admitted and/or treated in a medical unit or a behavioral health unit.

20. Will the prior authorization (PA) on file cover the entire inpatient stay when the client has transferred from one unit in the hospital to another?

    A. Effective for admissions on or after April 1, 2015, a second per diem PA will, in addition to the authorization received at the time of the admission, is required by the hospital in order to be eligible for the per diem rate. Rehabilitation or behavioral health claims, currently paid at the per diem rate, will need PA reflecting a per diem on file. If the hospital does not obtain a per diem PA at the time of service, the entire stay will pay based exclusively on the DRG assignment.

21. Will a PA for a medical inpatient stay be authorized retroactively if the client becomes eligible at a later date?

    A. The hospital must verify client eligibility through the Secure Web Portal www.ctdssmap.com or the Automated Eligibility Verification System (AEVS) and retain the eligibility verification number once retroactive eligibility for Medicaid has been verified for the dates of service for the inpatient stay. The request for authorization and a copy of the verification of eligibility should be submitted to Community Health Network (CHNCT) along with clinical information and documentation to substantiate the medical necessity of the admission.

22. How should the hospital bill services for a client admitted from the Emergency Department (ED)?

    A. On or after January 1, 2015, if an emergency department (ED) visit results in an inpatient admission, the charges for the outpatient services must be reported on the inpatient claim.

23. Will out of state and border hospitals be included in APR DRG pricing?

    A. Yes. Out of state and border hospitals' claims will utilize a statewide base rate when calculating a DRG payment.

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24. How should a hospital bill for inpatient admissions when the client is only eligible for a portion of the inpatient stay?

    A. Hospitals are required to submit a claim for the entire inpatient stay - with all charges and services related to the entire inpatient stay - for inpatient claims with date of admission on or after January 1, 2015.

25. How will inpatient claims price when the client is only covered for part of the inpatient stay (i.e. client has spend-down)?

    A. The DRG payment methodology used for partially eligible claims is prorated based on the number of days the client is eligible. The formula used to price inpatient claims if the client is only covered for part of the inpatient stay is as follows:

       Base DRG Payment * [number of days Eligible / LOS of claim (through date (TDOS) – admit date)]

    B. For Behavioral Health and Rehabilitation inpatient claims paying at the hospital specific per diem rates, DSS will pay only the eligible covered days at the per diem rate.

       1) Per Diem rate * # of eligible covered days = Medicaid's Allowance.

26. Can hospitals bill clients for non-eligible days?

    A. Hospitals can only bill clients for days for which the client is not eligible under the Connecticut Medical Assistance Program. This would include spend-down days.

27. Will there be changes to how the hospital will bill the client's spend-down amount on the inpatient claim?

    A. There are no changes to how hospitals bill their spend-down amounts.

28. Are Third Party Liability (TPL) claims calculated differently based on the DRG payment?

    A. No. There are no changes to the way DXC Technology processes TPL claims.

29. How will the DRG payment calculate for an inpatient claim if a patient is transferred from one acute care medical facility to another?

    A. Transfer claims are identified with a patient status 02 "Discharged/transferred to another short-term general hospital for inpatient care" or 05 "Discharged/Transferred to a Designated Cancer Center or Children's Hospital".

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B. If the claim is a transfer claim, the transferring hospital receives a prorated payment based on the number of days on the claim compared to the average length of stay for the assigned DRG. Transfer claim payment is based on a Prorated payment calculated by the following formula:

(Base DRG Payment /ALOS) * LOS +1

C. DRG 580x (Neonate, Transferred < 5 Days Old, Not Born) and 581x (Neonate, Transferred < 5 Days Old, Born) will be excluded from transfer payment calculations and will process at the DRG payment.

30. Will hospitals continue to be allowed to split-bill their inpatient claims with date of admissions on or after January 1, 2015?

A. No. For inpatient admissions on or after January 1, 2015, hospitals no longer can bill interim claims.

Exception: An interim claim will be allowed when the actual length of stay reaches 29 days.

If an interim claim is submitted with a length of stay less than 29 days, the claim will deny with a newly created Explanation of Benefit (EOB) code 0674 "DRG Interim Claims not Allowed."

For more information regarding interim claims, refer to the Interim Billing link at the top of this page.

31. What data elements are needed for the DRG pricing calculator?

A. A calculator spreadsheet is now available to assist hospitals in calculating payment for a single inpatient claim with the input of only a few elements.

B. Elements will include, but are not limited to the following: DRG and Severity of Illness (SOI) code, hospital base rate, hospital-to-charge ratio, and submitted charges.

C. Hospitals will need to include additional information such as: if the client was only eligible for part of an inpatient admission or if the client was a transfer from one hospital to another.

D. The DRG calculator is ready for use and is posted to the new Hospital Modernization Web page on www.ctdssmap.com under "DRG Calculator".

32. Where is the 3M APR DRG Assignment Tool located?

A. The tool is available on the Web site www.aprdrgassign.com. In order to access this Web site, users will be required to enter a User ID and Password. To

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obtain this User ID and Password, please send a request via e-mail to ctxixhosppay@dxc.com.

33. When will hospitals expect to see new Explanation of Benefits (EOB) codes?

A. EOB codes have been posted to provider manual Chapter 12 "Claim Resolution Guide." Providers should access Chapter 12 periodically as new edits will continue to post.

34. How will hospitals be reimbursed for DRG organ transplants?

A. Organ Acquisition costs (RCC 81X) will be reimbursed outside the APR DRG payment methodology effective with admissions on or after January 1, 2015. Claims that contain organ acquisition charges will be suspended to allow the claim to be manually priced. Once finalized, these claims will contain both a DRG payment and an organ acquisition payment and will include EOB 6000 "Claim was manually priced or denied for Missing Information."

35. Where can the rates for organ acquisition costs be found?

A. From the hospital Modernization page on www.ctdssmap.com web site under DSS link (right side of the page) click on DSS Reimbursement Home Page. The follow these steps:
   - On the Reimbursement Modernization page click on link at bottom of page "Return to Medicaid Hospital Reimbursement page."
   - Then click on the Medicaid Hospital Reimbursement page click on "Rates & Settlements."
   - Scroll down to the Organ Acquisition chart that is used to reimburse hospitals for organ acquisition.

   Additional information on Organ Acquisition can be found under Provider Bulletin 2014-79 "Inpatient Hospital Payment Modernization/All Patient Refined-Diagnostic Related Group (APR-DRG)."

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