Ohio Department of Medicaid

Ohio medicaid QUALITY MONITOR

VOLUME. 14, NO 4

APR-DRG

Effective July 1, 2013, the Ohio Department of Medicaid began processing inpatient hospital claims for hospitals subject to prospective payment system utilizing **All Patient Refined Diagnosis Related Groups (APR-DRG), Version 30.** Although this is a change from our current version 15 CMS DRG grouper, there will be no actual change required by providers for claims submission. Providers should continue to submit claims to the department in accordance with standards set forth by the National Uniform Billing Committee (NUBC). Providers are also expected to bill using the most current diagnosis and procedure codes in effect for the dates of the claim. The department will perform annual updates to the APR-DRG software by installing the latest version of the APR-DRG on every October 1st, beginning October 1, 2013.

The following list includes policies/topics of concern, which did **NOT** change with the implementation of APR-DRG on July 1, 2013:

- Medical admissions that are grouped into Psychiatric DRG's do not require precertification. This current policy remains unchanged.
- Revenue Center Code 810 – Acquisition of Body Components (General). For transplant claims, there are no changes to the treatment of organ acquisition charges reported using RCC 810. The current policy remains unchanged.

*** *continued on pg. 5*

HAC – Health Care Acquired Conditions

The Affordable Care Act requires Medicaid to enforce editing to prevent payment for Hospital Acquired Conditions (HAC). Effective July 1, 2011 Ohio has been enforcing this through the retrospective review process. Effective with the APR-DRG implementation, HAC editing will be automated in the claims payment system. As a result, the reimbursement DRG and SOI may be different from the hospitals expected DRG and SOI.

Permedion began issuing a letter when a possible HAC has been identified, effective June 28, 2013. There are two reasons that a hospital will receive a letter when a HAC has been identified.

- HAC was coded and billed by the provider and the POA indicator was billed as a "Y", "N", "U", or "W". The diagnosis is deleted from the claim and the DRG **does not** change. This will be a reporting error only. The provider will receive a letter advising that the HAC diagnosis code will be deleted from the claim. There will be no reimbursement taken back from the provider.
- HAC was coded and billed by the provider and the POA indicator was billed as a "Y", "N", "U", or "W". The diagnosis is deleted and the DRG may change, but the SOI will change. The DRG/coding correction letter will be sent and the reimbursement will be taken back from the provider. The DRG letter will state that the diagnosis was identified as a HAC and will be deleted because it affects the reimbursement of the claim.

permedion an HMS company

All Patient Refined Diagnosis Related Groups (APR-DRG)

CODING CORNER

In this issue of the Coding Corner, we would like to discuss the data element requirements, distinct descriptors, and some examples of this DRG grouper/ classification system.

Effective with dates of discharge on or after July 1, 2013, the Ohio Department of Medicaid will be processing claims utilizing the APR-DRG grouping system. In order to insure wide applicability with minimal burden on the providers, the data elements used to determine patient risk factors used by the APR-DRGs are limited to standard UB-04 data elements. Specifically, the data elements used by APR-DRGs are:

- Principal Diagnosis coded in ICD-9-CM
- Secondary Diagnose coded in ICD-9-CM
- Procedures coded in ICD-9-CM
- Age of the patient
- Sex of the patient
- Discharge disposition of the patient
- Birth Weight (critical for Newborn claims)

These data elements are combined together on a patient specific basis to determine the patient's severity of illness (SOI) and risk of mortality (ROM).

The All Patient Refined Diagnosis Related Groups (APR-DRGs) methodology is a clinical model that expands on the basic DRG structure to:

- provides a classification system for a broad population including a more robust recognition of neonatal and pediatric care
- subdivides each DRG into four subclasses (minor, moderate, major, or extreme) for severity of illness (SOI) based on clinical presentation and resource intensity
- subdivides each DRG into a second set of four subclasses (minor, moderate, major, or extreme) for risk of mortality (ROM)

The following case scenarios will provide you with examples of how a claim would be calculated with the APR-DRG methodology.

EXAMPLES:

In each of the following examples, the patient presented with chest pain and was diagnosed with an acute subendocardial infarction, initial episode of care, (410.71). For each scenario, the patient was diagnosed with a different secondary diagnosis which will show you how the severity of illness (SOI) effects the APR-DRG assignment and the potential relative weight for each.

1. The patient was discharged with the diagnosis of acute subendocardial myocardial infarction initial episode of care (410.71) with coronary artery atherosclerosis of native coronary vessel (414.01) as a secondary diagnosis. The APR-DRG is 190 (Acute Myocardial Infarction) with severity of illness (SOI) of 1 (minor SOI) and a risk of mortality (ROM) of 1 (minor ROM).

2. The patient was discharged with the diagnosis of acute subendocardial myocardial infarction initial episode of care (410.71) with pneumonia (486) as a secondary diagnosis. The APR-DRG is 190 (Acute Myocardial Infarction) with severity of illness (SOI) of 2 (moderate SOI) and a risk of mortality (ROM) of 1 (minor ROM).

3. The patient was discharged with the diagnosis of acute subendocardial myocardial infarction initial episode of care (410.71) with unspecified septicemia (038.9) as a secondary diagnosis. The APR-DRG is 190 (Acute Myocardial Infarction) with severity of illness (SOI) of 3 (major SOI) and a risk of mortality of 2 (moderate ROM).

4. The patient was discharged with the diagnosis of acute subendocardial myocardial infarction initial episode of care (410.71) with acute respiratory failure (518.81) and septicemia (038.9) as secondary diagnoses. The APR-DRG is 190 (Acute Myocardial Infarction) with severity of illness (SOI) of 4 (extreme SOI) and a risk of mortality of 4 (extreme ROM).

Of note, effective October 1, 2014 , claims with dates of service October 1 or Inpatient date of discharge October 1, providers will need to use ICD-10 CM Code set. All claims prior to October 1, 2014 will continue to be billed with IDC-9-CM.

Disclaimer: The assigned result from the grouper is the official record for claim payments.

Medical Director *dialogue*

By Anthony J. Beisler, MD, MBA, FACS
Medical Director, Permedion

Update: The New Ohio Medicaid Admission Orders Policy

Previously in this column I discussed what elements comprised a valid admission order. I detailed the various circumstances surrounding assigning a level of care. I noted that specifying the level of care (such as inpatient, observation, and outpatient) constitutes best practice. However, with the recent surge in Computerized Physician Order Entry (CPOE) and use of the EHR, adherence to best practices in writing appropriate admission orders has waned and a significant spike in confusing orders has taken place. Therefore, Ohio Medicaid has determined that, as of October 1, 2013, they will be adhering to the following policy:

Physician Order Requirements for Inpatient vs. Observation vs. Outpatient Admissions

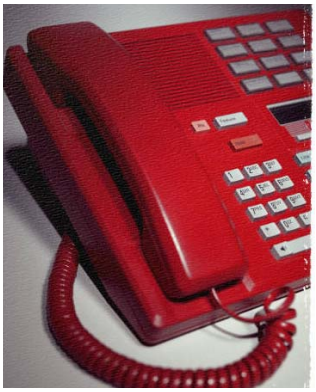
In accordance with the Ohio Administrative Code rule 5101:3-2-02, the definition of an inpatient admission is "a patient who is admitted to a hospital based upon the written orders of a physician or dentist and whose inpatient stay continues beyond midnight on the day of admission". All inpatient admissions must clearly document the level of care status, be signed and dated by the physician or dentist regardless of whether the order is handwritten or in an electronic health record. Any order that is ambiguous will be considered to not meet the requirements for a physician or dentist's order to admit to inpatient, and at best, would be considered to be an order for the observation level of care and the stay. If billed to the department as an inpatient admission, the claim will be denied. Any order, abbreviation, or notation (such as "Admission to the floor," "Admit," "Regular Admit," "Full Admit," "Decision Unit Admit," or "Short Stay Unit") that does not specifically designate the level of care as "inpatient," "observation," or "outpatient" will NOT be accepted. Those who are using electronic order templates must modify their template such that the level of care is unambiguously designated as: "inpatient," "observation," or "outpatient." Please remember that the location within the facility and/or the length of time a patient is in the hospital does not factor into determining the appropriate level of care. Unless the intensity of service and clinical criteria for an inpatient admission is clearly substantiated by the relevant clinical documentation, the department will not accept the order for an inpatient admission and the stay will at best, be considered to be at the observation level of care based upon a failure to establish medical necessity.

Hierarchy of denial reason in regards to an Appeal:

In the Ohio Medicaid Retrospective Review Program, administered by Permedion, an HMS company, a hierarchy table is utilized to determine which denial reason results in an overpaid claim. An understanding of this table will assist hospital providers in submission of proper appeals and in the rebilling of corrected claims.

The hierarchy table includes nine review categories. Please note these categories in the depiction below:

1. No Documentation
2. No Admit Order for Inpatient
3. Medical Necessity
4. Readmit
5. Transfer
6. Compliance
7. DRG Reassign
8. Billing Error
    - B1 - Admit source incorrect
    - B2 - Patient Status code incorrect
    - B3 - Medicaid # incorrect
    - B4 - Age is incorrect
    - B5 - i.e., The admission should have been billed as an outpatient observation stay, as the patient did not remain an inpatient past midnight on the date of admission
    - B6 - Unsubstantiated bill charges
    - B99 - other not listed above (i.e., HAC, POA, AN codes, Hospice patient)
9. Bill Audit



No documentation denials are issued when the hospital did not produce the requested medical record in a timely manner. No documentation denials cannot be appealed or rebilled. The next denial reason that is listed on this table is the medical necessity denial which will take precedence over all of the other denial reasons that are listed below it on the table.

As noted in this table, no admit order for inpatient, medical necessity denials. transfers, DRG reassignments and bill audits can be appealed directly to Permedion. The other denial reasons [readmits, compliance (precertification denial), and billing errors] are appealed directly to to ODM. Each denial letter contains the specific appeal language and address to which the appeal should be mailed. Please note that you cannot rebill compliance denials.

If multiple denial reasons are identified when reviewing a case, then the hierarchy table is put into effect. An example of multiple denial reasons would be the identification of a medical necessity denial as well as a DRG reassignment. A hospital provider can appeal both concerns to Permedion (see table). If the DRG concern would be overturned upon appeal and the medical necessity denial would be upheld, then the medical necessity denial reason would stand because it takes precedence according to the hierarchy table. In this case, the provider could then rebill the inpatient stay as observation. On the other hand, if the medical necessity decision was overturned and the DRG concern was upheld then the provider would need to submit a corrected claim with a newly assigned principle and secondary diagnosis that resulted in a newly assigned DRG.

Permedion mails denial letters to each hospital provider on the last day of the month. The letters are accompanied by a "Hospital Summary of Denials Report" which identifies all of the cases that have been reviewed and have been denied. For cases with multiple denials, an asterisk is placed next to the concern that is lower on the hierarchy table. The claim disagreement amount will equal 0 for this concern. The dollar amount for the claim disagreement amount will be found with the other denial reason that is higher on the hierarchy table.

For additional information concerning the Ohio Medicaid Retrospective Review Program and use of the hierarchy table, please call Michelle Armstrong, UM Service Line Manager at (614) 895-9900.

APR-DRG (Cont)

- Pre-certification, Prior Authorization, and Transplant Authorizations. There are no changes to the services or procedures that require precertification or prior authorization. The current policies and procedures remain unchanged.
- Interim Bills. There are no changes to the billing procedures or payment methodology for interim claims. Hospitals may continue to bill interim claims in 30 day intervals in accordance with paragraph (C)(3) of OAC rule 5101:3-2-07-11, and will be paid at their hospital-specific cost to charge ratio.
- Peer groups. The existing hospital peer groups remain unchanged.

POA – Present on Admission

Hospitals are required to submit POA information on diagnosis codes for inpatient discharges. POA is defined as present at the time the order for inpatient admission occurs – conditions that develop during an out-patient encounter including emergency department, observation or outpatient surgery are considered POA. POA indicator are assigned to the principle and secondary diagnose.

Permedion began issuing a letter when a possible POA indicator has been identified, effective June 28, 2013. There are two reasons that a hospital will receive a letter.

•POA was incorrectly reported. The diagnosis **was** valid/treated during the admission but the POA indicator was billed as a "Y" but should have been billed as a "N". There is no change in the DRG and will be reported as an error only.

•POA indicator was incorrectly reported. The diagnosis **was not** valid/ treated during the admission and the POA was billed as a "Y but should have been billed as an "N". By deleting the diagnosis code, the DRG does change. A DRG/coding correction letter will be created. The letter will reflect that the diagnosis/diagnoses were not present on admission and or treated during this admission.

Contact Information

Permedion • Michelle Armstrong, Project Manager
350 Worthington Rd., Suite H • Westerville, OH 43082 • 614/839.3401 • fax 614/895-6784
www.hmspermedion.com • marmstrong@hms.com
Ohio Department of Medicaid – Surveillance and Utilization Review Section
Rachel Jones, Contract Administrator
50 West Town Street, 5th Floor • Columbus, OH 43215 • 614/752-2634 • fax 614/644-2217 •
www.medicaid.ohio.gov

350 Worthington Rd., Ste. H
Westerville, OH 43082