

AHCCCS

APR-DRG Payment System Design

Payment Policies

January 1, 2018

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1. DRG Pricing Information Summary

Effective October 1, 2014, AHCCCS determines Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals and out-of-state hospitals using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems is used to categorize each inpatient stay. Each inpatient hospital claim is 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. Exceptions to APR-DRG payments are described below and elsewhere in this document. Modifications to components of the APR-DRG pricing for certain in-state and most out-of-state hospitals are also defined later in this document.

DRG payment is applied to all inpatient claims from 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 for which admit and discharge are on the same day and the discharge status does not indicate member expired
- Claim is an interim bill

AHCCCS Contractors are not mandated to utilize AHCCCS’ methodology or rates except in the absence of a contract. Contractors may enter into contracts with hospitals which specify alternative methodologies and/or rates. In the absence of a contract as noted above, unless otherwise specified in these policies, the use of the term AHCCCS refers to both the AHCCCS program and its Contractors.

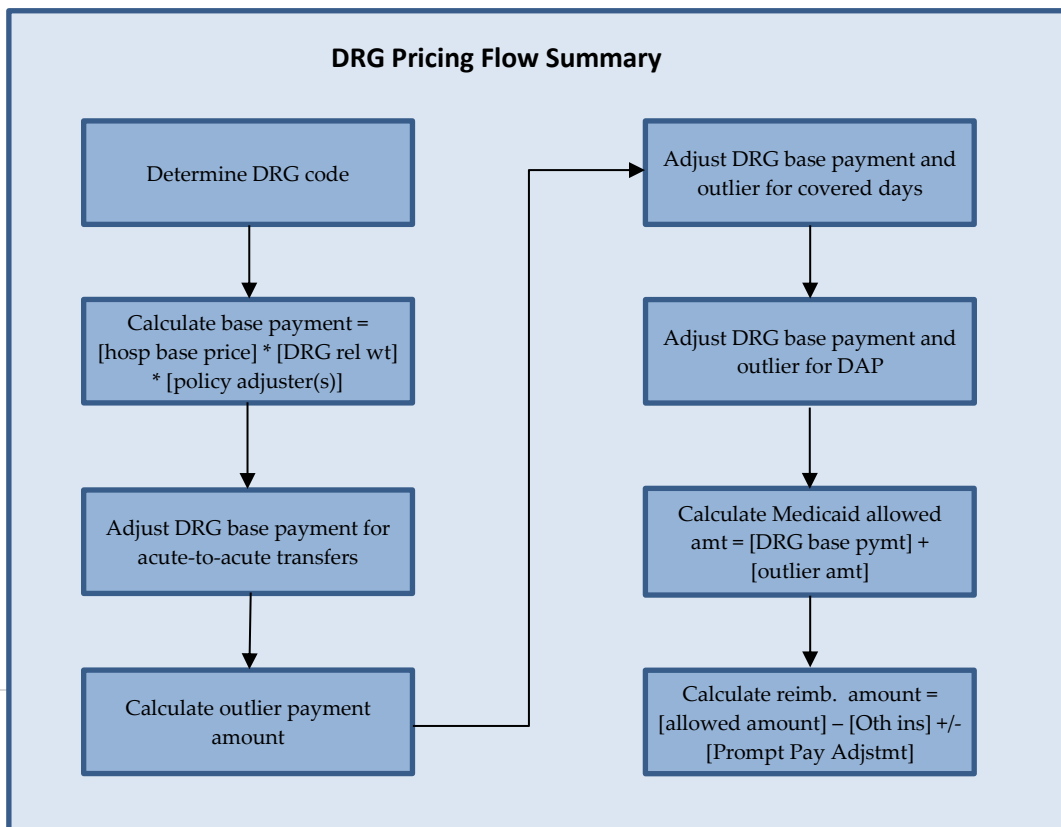
Payment under DRG pricing will comprise a DRG base payment and a DRG outlier add-on payment. Total payment will equal the sum of these two. DRG base payment is generally set to a hospital DRG base price times the DRG relative weight. In addition, a few payment factors referred to as “policy adjustors” 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

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. The final allowed amount is the sum of the 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/or, effective with dates of discharge on and after October 1, 2016, a Differential Adjusted Payment (DAP) Multiplier. A DRG pricing flow chart is given below and details of the pricing calculation are shown in the following pages.



DRG Base Payment

Initial DRG Base Payment will be calculated as:

$$\begin{aligned}
 \text{Initial DRG Base Payment} &= [\text{Wage Adjusted Provider DRG Base Rate}] \\
 &* [\text{Post-Health Care Acquired Condition DRG Relative Weight}] \\
 &* [\text{Provider Policy Adjustor}] \\
 &* [\text{DRG Service Policy Adjustor}]
 \end{aligned}$$

The DRG Service Policy Adjustor will be determined based on the category of the DRG code found on the claim. Listed below are the DRG code categories along with the applicable DRG Service Policy Adjustor.

1. Normal newborn DRG codes: 1.550
2. Neonates DRG codes: 1.100
3. Obstetrics DRG codes: 1.550
4. Psychiatric DRG codes: 1.650
5. Rehabilitation DRG codes: 1.650
6. Burn DRG codes: 2.700

The applicable DRG Service Policy Adjustors for claims for members under the age of 19 for which the assigned DRG codes fall outside of the categories listed above are:

1. Severity of Illness 1 or 2: 1.250
2. Severity of Illness 3 or 4: 2.300

Where none of the DRG Service Policy Adjustors above apply to the claim, a DRG Service Policy Adjustor of 1.025 is applied the claim.

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:

$$\begin{aligned}
 \text{Transfer DRG Base Payment} &= [\text{Initial DRG Base Payment}] \\
 &/ [\text{DRG National Average Length of Stay}] \\
 &* [\text{Length of Stay} + 1]
 \end{aligned}$$

Note: The “DRG National Average Length of Stay” means the national arithmetic mean length of stay published in version 34 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.

Note: The “Length of Stay” means the total number of days of an inpatient stay beginning with the date of admission through the date of transfer, but not including the date of transfer.

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

$$\text{Unadjusted DRG Base Payment} = \text{lesser of [Initial DRG Base Payment] and [Transfer DRG Base Payment]}$$

Otherwise,

$$\text{Unadjusted DRG Base Payment} = [\text{Initial DRG Base Payment}]$$

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. The outlier add-on payment is equal to the Claim Cost minus the Outlier Threshold, multiplied by the DRG Marginal Cost Percentage.

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:

$$\text{Claim Cost} = \{[\text{Claim Total Submitted Charges}] - [\text{Claim Non-Covered Charges}]\} * \text{Hospital Cost-to-Charge Ratio}$$

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

$$\text{Outlier Threshold} = \text{Unadjusted DRG Base Payment} + \text{Fixed Loss Amount}$$

The Fixed Loss Amount is \$5,000 for Critical Access Hospitals (CAH) 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; 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:

$$\text{Unadjusted DRG Outlier Add-on Payment} = [\text{Claim Cost} - \text{Outlier Threshold}] * \text{DRG Marginal Cost Percentage}$$

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

In some cases, 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:

$$\text{Covered Day Adjustment Factor Unadjusted} = \frac{\{[\text{AHCCCS Covered Days}] + 1\}}{[\text{DRG National Average Length of Stay}]}$$

Else if recipient gains Medicaid eligibility after admission then:

$$\text{Covered Day Adjustment Factor Unadjusted} = \frac{[\text{AHCCCS Covered Days}]}{[\text{DRG National Average Length of Stay}]}$$

Else if recipient loses Medicaid eligibility prior to discharge then:

$$\text{Covered Day Adjustment Factor Unadjusted} = \frac{\{[\text{AHCCCS Covered Days}] + 1\}}{[\text{DRG National Length of Stay}]}$$

The final covered day adjustment factor is calculated as:

$$\begin{aligned} &\text{If } [\text{Covered Day Adjustment Factor Unadjusted}] > 1.0 \text{ Then} \\ &\text{Covered Day Adjustment Factor Final} = 1.0 \\ &\text{Else} \\ &\text{Covered Day Adjustment Factor Final} = [\text{Covered Day Adjustment Factor Unadjusted}] \end{aligned}$$

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:

$$\text{Covered Day Adjusted DRG Base Payment} = [\text{Unadjusted DRG Base Payment}] * [\text{Covered Day Adjustment Factor Final}]$$

$$\text{Covered Day Adjusted DRG Outlier Add-on Payment} = [\text{Unadjusted DRG Outlier Add-on Payment}] * [\text{Covered Day Adjustment Factor Final}]$$

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

The DRG payment methodology was transitioned over two years (FFY 2015 through FFY 2016). For FFY 2015 and 2016 of DRG pricing, a provider-specific payment adjustment was applied to every claim paid via the DRG pricing method. The Provider DRG Transition Multiplier was a combination of two payment adjustments – one for the DRG transition policy and the second for anticipated improvement in documentation and coding (DCI). The transition to APR-DRG is now complete, and the Transition Multiplier is no longer applicable.

In its place, a Differential Adjusted Payment (DAP) Multiplier is applied as the last step in the DRG pricing logic. Where a hospital qualifies for DAP, the multiplier will increase the total DRG payment.

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

$$\text{Final DRG Base Payment} = [\text{Covered Day Adjusted DRG Base Payment}] * [\text{DAP Multiplier}]$$

$$\text{Final DRG Outlier Add-on Payment} = [\text{Covered Day Adjusted DRG Outlier Add-on Payment}] * [\text{DAP Multiplier}]$$

$$\text{Final Allowed Amount} = \text{Final DRG Base Payment} + \text{Final DRG Outlier Add-on Payment}$$

$$\text{Final Reimbursement Amount} = \text{Final Allowed Amount} - \text{Other Insurance Payment} \pm \text{Prompt Pay Adjustment}$$

Note 1: The current prompt pay policy (slow pay penalties and quick pay discounts) will continue to apply. Refer to section 25 of this document for more information.

Note 2: A non-contracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the final payment, unless otherwise negotiated by both parties.

3. Admit versus Discharge Date

DRG pricing and the DRG pricing logic are based on date of discharge. All hospital stays with a date of discharge ~~on or after~~ 10/1/2014 thru 12/31/2017 are priced using V31 of the DRG methodology and all dates of discharge on or after 1/1/2018 are priced using V34 of the DRG methodology. The Medicaid payer in effect on the date of discharge will always have responsibility for the full DRG for the entire AHCCCS stay. The day of discharge is never paid unless the member expires on the date of discharge.

4. Recipient 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. Any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day. It is possible that an entire stay will meet the definition of emergency and no covered day adjustment factor will be applied.

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 AHCCCS covered days, if not all days of the stay meet the emergency definition. 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,

<i>Covered Day Adjustment Factor Unadjusted</i>	=	$\frac{[AHCCCS\ Covered\ Days] + 1}{[DRG\ National\ Average\ Length\ of\ Stay]}$
<i>If [Covered Day Adjustment Factor Unadjusted]</i>	> 1.0 Then	
<i>Covered Day Adjustment Factor Final</i>	=	1.0
<i>Else</i>		
<i>Covered Day Adjustment Factor Final</i>	=	$[Covered\ Day\ Adjustment\ Factor\ Unadjusted]$

5. Enrollment Change during Hospital Stay

A recipient may change AHCCCS 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

- A recipient changing enrollment from a managed care plan into fee-for-service
- A recipient changing enrollment between managed care plans within the same program
- 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)

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, except as noted below. This payer will be responsible for reimbursement for the entire hospital stay, including any applicable outlier payment. If the member is eligible but not enrolled with a contractor on the date of discharge, the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay.

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 is 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, except as described below for outliers, each payer’s claim 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 the discharge date).

In the event the claim is expected to qualify as an outlier, the claim must include condition code 61 (Cost Outlier) indicating the provider’s desire for special outlier consideration. A claim that includes condition code 61 may include all revenue codes, service units, charges, and surgical procedures applicable for the full AHCCCS enrolled eligible hospital stay (admit through discharge), even if performed prior to the recipient’s enrollment with the payer responsible for reimbursement.

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.

Note: When the recipient changes enrollment from payer 1 to payer 2 during the inpatient stay such that the change to payer 2 is effective on the date of discharge, the AHCCCS administration will make a manual adjustment, upon request, to the system to reflect a change of enrollment effective the day after discharge to ensure that a single AHCCCS payer retains responsibility for paying the claim.

6. 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 0111 or 0851 bill type claim should be filed for services performed after the date the maximum Medicare Part A benefit is exceeded. 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, the claim(s) should only include those revenue codes, surgical procedures, service units, and charges for services performed between the “From” and “Through” dates of service 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.

7. 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 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. Administrative days also include discharges/transfers from one acute care facility to another when the receiving hospital provides sub-acute services to the member (see Issue Number 9). 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. 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 reflect an administrative rate. Further, administrative days for the provision of sub-acute services shall be billed with revenue code 016X (Room & Board).

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. 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.

8. 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 at 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 Number 5, 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 Issues Number 10 and 11, and paid by the Medicaid payer in effect on the date of discharge or the date that eligibility changes.

See Issue Number 28 for information on reinsurance related to interim claims.

9. 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 (see clarification below regarding sub-acute services).

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:

$$\text{Transfer DRG Base Payment} = \left[\left(\frac{\text{Initial DRG Base Payment}}{\text{DRG National Average Length of Stay}} \right) * (\text{Length of Stay} + 1 \text{ Day}) \right]$$

Or:

Initial DRG Base Payment

The base DRG payment reimbursed to the “transferring” hospital will be the lesser of the Transfer DRG Base Payment, as calculated above, 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 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 Transfer DRG Base Payment or the Initial DRG Base Payment as appropriate) to determine the final DRG payment.

Clarification Regarding Transfers for Sub-Acute Services: A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharged/transferred to another type of health care institution not defined elsewhere in code list) for the provision of sub-acute services. Dates of service for sub-acute services shall be considered administrative days. See Issue Number 7 for information on payment of administrative days.

10. 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. 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,

$$\begin{aligned}
 \text{Covered Day Adjustment Factor Unadjusted} &= \frac{[\text{AHCCCS Covered Days}]}{[\text{DRG National Average Length of Stay}]} \\
 \text{If } [\text{Covered Day Adjustment Factor Unadjusted}] > 1.0 \text{ Then} \\
 \quad \text{Covered Day Adjustment Factor Final} &= 1.0 \\
 \text{Else} \\
 \quad \text{Covered Day Adjustment Factor Final} &= [\text{Covered Day Reduction Factor Unadjusted}]
 \end{aligned}$$

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 Medicaid through discharge, the “Through” date of service will be set to the date of discharge. The number of AHCCCS 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 AHCCCS covered days to account for date of discharge.

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

11. 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. 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,

$$\begin{aligned}
 \text{Covered Day Adjustment Factor Unadjusted} &= \frac{[\text{AHCCCS Covered Days} + 1 \text{ Day}]}{[\text{DRG National Average Length of Stay}]} \\
 \text{If } [\text{Covered Day Adjustment Factor Unadjusted}] > 1.0 \text{ Then} \\
 \quad \text{Covered Day Adjustment Factor Final} &= 1.0
 \end{aligned}$$

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 since the costs of stabilization are generally higher than the remaining days of the patient stay.

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 the Medicaid payer. 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.

12. 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. Claims with a same date of admission and date of death will be reimbursed a full DRG payment. (See Issue Number 23)

13. Specialty Hospitals

Hospitals designated as type: hospital, subtype: short-term that have a license number beginning “SH” in the Provider & Facility Database for Arizona Medical Facilities posted by ADHS 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 2016 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.

14. 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, with provider designation of condition code 61 for consideration, where rates and outlier thresholds will be included in the capped fee schedule published by the Administration. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The resulting amount will be the total reimbursement for the claim.

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

15. 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 AHCCCS reimbursement policy for this provider type (71). There is no outlier provision.

16. Inpatient Claims for Recipients with Medicare Part B Only

The treatment of Medicare Part B payments on inpatient claims has not changed with the implementation of DRG pricing. On inpatient claims in which the Medicaid recipient has Medicare Part B coverage, has no Medicare Part A coverage, or the 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.

17. Carved-out Services Within Claims Paid Under DRG Methodology

With the exception of claims described under Issue Number 33, 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. 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.

19. Transplants

Transplant cases are exempted from DRG payment, and will continue to be reimbursed under the current methodology of contracted rates. The current methodology for identifying claims as transplants will remain the same. The evaluation component, when performed during an inpatient stay, will be paid under the DRG methodology (see Issue Number 31 for more information). Days in the hospital beyond the days covered by the transplant contract will be reimbursed via a per diem when primary payment for the hospital stay is covered under the transplant contract.

20. 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 other payment methodology.

21. 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 principal 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 Tribal/Regional Behavioral Health Authority (T/RBHA) assigned to the member. An exception to this rule applies to members who are enrolled with integrated payers. Integrated payers are described more fully below. If the principal diagnosis on the claim is a physical health diagnosis, the claim should be submitted to the associated MCO and will be reimbursed under DRG methodology, if DRG pricing applies. If the principal diagnosis on the claim is a behavioral diagnosis, the claim should be submitted to the appropriate T/RBHA and will be reimbursed under a per diem rate consistent with AHCCCS reimbursement policy for behavioral health services.

When a member is enrolled with the following integrated payers, DRG pricing will apply regardless of principal diagnosis (if DRG pricing applies to the hospital):

- ALTCS Elderly & Physically Disabled (EPD) MCO
- CRS Fully Integrated
- CRS Partially Integrated – Behavioral Health (if the physical health diagnosis is NOT related to the CRS condition, the CMDP or DDD plan of enrollment is the payer)

When the member with Serious Mental Illness is enrolled with the integrated RBHA, pricing will apply as follows:

- If the principal diagnosis is a physical health diagnosis, DRG pricing will apply (if DRG pricing applies to the hospital)
- If the principal diagnosis is a behavioral health diagnosis, AHCCCS per diem pricing will apply

22. 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, 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.

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 AHCCCS 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.

23. 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.

24. Out-of-State Hospitals

Acute care services provided by out-of-state providers will be reimbursed under the DRG methodology. Out-of-state hospitals determined by the Administration to be high volume out-of-state hospitals will be reimbursed using hospital-specific Wage Adjusted Provider DRG Rates and hospital-specific Cost-to-Charge Ratios. All other out-of-state hospitals will be reimbursed using a uniform Wage Adjusted Provider DRG Rate and a uniform Cost-to-Charge Ratio. Out-of-state hospitals are not eligible for the Provider Policy Adjustor or the Differential Adjusted Payment Multiplier.

25. 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 Final Allowed Amount for providers classified as types 02 and C4, excluding IHS and 638 providers, 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.

26. 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. In the event that the claim has been prior authorized, the readmission claim may 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.

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

27. Reinsurance

Any final claims which cross over contract years will not be eligible for reinsurance.

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.

AHCCCS will not pay reinsurance 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.

28. Non-covered Services

Charges associated with use of robotic technology will be disallowed when claims are reviewed for outlier consideration.

29. 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 an associated value code equal to 54. Birth weight should be billed as a number of grams.

For claims submitted related to newborns under the following additional circumstances, the provider should include the birth weight of the newborn:

- Age at admission = 15-28 days and principal diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures.
- Age at admission = 15-28 days with a secondary diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures.

Refer to the relevant list of principal and secondary diagnoses contained in the 3M APR-DRG documentation.

30. 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.

31. Inpatient Services Preceding Transplant

During a hospitalization in which transplant services are performed (where those services are governed under specialty transplant contracts between AHCCCS and the hospital, and paid under component pricing) a recipient may first receive inpatient hospital services that are not related to the any transplant components. These services are paid under the APR-DRG methodology.

In the event a recipient receives services during an inpatient stay prior to the “Prep and Transplant” component, services should be billed separately on an admit through discharge claim with a bill type of 0111 or 0851 and a Discharge Status code of 70. The begin date of service reported should be equal to the original admission date of the member. The date of discharge will be the initial date of the prep and transplant and will correspondingly be billed as part of the transplant component. Accommodation days must be equal to the number of days in the UB04 claim less day of discharge. All diagnosis codes describing the patient’s medical condition may be included on the claim and should reflect only the services that are not related to any component of the transplant. Since the claim is filed separately, there is no proration of the claim and a full DRG payment will be paid.

32. Hospital Presumptive Eligibility

DRG claims will be submitted to the recipient’s health plan on the date of discharge. AHCCCS and its contractors will not accept split billing of these claim types.

33. Long Acting Reversible Contraceptives (LARC)

Effective for dates of discharge on and after 10/01/2016, Long Acting Reversible Contraceptive (LARC) devices are permitted to be separately reimbursed outside of the DRG payment when billed by the hospital on a professional form 1500 or on and after 10/01/2017 on an Outpatient form UB04 with the

appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code. AHCCCS-identified LARC procedure codes are as follows:

- J7297 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg, 3 Year Duration
- J7298 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg, 5 Year Duration
- J7300 Intrauterine Copper Contraceptive
- J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg
- J7307 Etonogestrel (Contraceptive) Implant System, Including Implant And Supplies

Revision History

Date	Description of changes	Page(s)
Chapter posted 6/8/18 Update to the AHCCCS transition to DRG web page completed on 1/1/2018	The entire DRG policy was updated on 1/1/2018, on the AHCCCS web page. The information contained in this chapter matched, however the billing manual chapter and the formal DRG policy will now be one and the same.	All