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MEMORANDUM

MEMO NO.
QI-2403 [Update to QI-2319]
FFS 24-01 [Update to FFS 23-08]
CCS-2402 [Update to CCS-2306]

TO: Hospitals
QUEST Integration (QI) Health Plans
Community Care Services (CCS) Plans

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: APR DRG BILLING GUIDANCE

This memo modifies and revises memorandum QI-2319/CCS-2306/FFS 23-08 which was issued on May 12, 2023. The text of memorandum QI-2319/CCS-2306/FFS 23-08 is incorporated into this revision, identified as EVV memo QI-2403/CCS-2402/FFS 24-01. Updated guidance is inserted as shaded text. Voided text from QI-2319/CCS-2306/FFS 23-08 is stricken. To avoid confusion with updated guidance, certain table header row shading was removed and the header row text bolded.

This memo ~~is an update to memorandums QI-2206 and QI-2206/CCS-2205/FFS-22-04 and~~ is intended to give updated guidance to affected hospitals and health plans related to the Med-QUEST (MQD) implementation of the All Patient Refined Diagnostic Related Groups (APR DRG) that occurred on July 1, 2022.

APR DRG is a patient classification system developed by 3M™and used by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups with similar

average resource requirements. APR DRGs provide a mechanism for healthcare payers to make a single case rate payment for similar services provided in a hospital inpatient stay.

3M™ APR DRGs are the most widely used DRG software, or "grouper", by Medicaid agencies for determining payments for inpatient acute services. Due to APR DRGs' enhanced granularity (particularly for key Medicaid service lines) and widespread adoption ~~of~~ across states, MQD will use the APR DRG grouper as the patient classification system for its new Medicaid inpatient prospective payment methodology.

APR DRG implementation methodology
MQD's APR DRG methodology is applicable for certain inpatient stays with admission dates beginning on or after July 1, 2022.

Claims and encounters for inpatient stays with an admission date before July 1, 2022, will be processed using existing protocols. For eligible hospitals and qualifying bill types (111, 112, 117), covered services for inpatient stays with an admission date after July 1, 2022, will be processed using APR DRG. APR DRG rules do not apply to Department of Public Safety (DPS) claims unless the patient is actively enrolled in Medicaid.

Pricing of APR DRG codes require the APR DRG code and the APR DRG system calculated "severity of Illness" (SOI) value. SOI has four values (1 through 4). The 835 transaction has defined locations for the APR DRG code, MQD will work with the health plans to provide SOI data.

Eligible Hospital Provider IDs
The following Hospitals and associated MQD Provider IDs are eligible to submit claims for DRG payment:

Hospital	**MQD Provider ID**	**Provider NPI on file with MQD**
Castle Medical Center	082268	1316937691
Hilo Medical Center	251745	1780757856
Kapiolani Medical Center for Women & Children	085498	1043263080
Kona Community Hospital	005774	1639217300; 1952332991
Kona Community Hospital Psychiatric	592338	1639252133
Kuakini Medical Center	006236	1215939335
Maui Memorial Medical Center – General	803678	1013379460
North Hawaii Community Hospital	078352	1477559029
Pali Momi Medical Center	085499	1013961408
Straub Clinic and Hospital	506074	1598976540; 1720031701

The Queen's Medical Center – General	490417	1801298708; 1184612764
Wahiawa General Hospital	490368	1689643553
Wahiawa General Hospital Psychiatric Unit	592247	1629032164
Wilcox Memorial Hospital	085500	1225113442
Kaiser Foundation Hospital	082521	1396813861
Shriners Hospital for Children	684804	1316065360

Billing Guidance

To meet APR DRG processing requirements the following new or modified edits and billing guidance are provided for 837I Inpatient claims forms processed through the MQD Fee-for-Service (FFS) program. MQD's health plans shall follow the edit and billing guidance described in this memo. Aside from the guidance below, health plans may determine their own policies for their claims processing.

Billing for Pre-admission Services

Facility services provided within a three-day window of admission that quality as "pre-admission" services can be billed for by the hospital. All providers should include 837I appropriate pre-admission services that were provided three calendar days prior to the admission on inpatient hospital claims.

Administrative or "Waitlisted" Days

This occurs when a patient's level of care is "downgraded" indicating that the patient is still hospitalized but waiting to be admitted to (1) an Intermediate Care Facility (ICF) indicated by the Occurrence Span Code = 74 or (2) a Skilled Nursing Facility (SNF) indicated by an Occurrence Span Code = 75.

When Medicaid is the primary or only payor, administrative or "waitlisted" days should be included on the 837I claim. When Medicare or another third-party payer is the primary payor, ICF waitlisted days are listed on separate 837I claim and paid using the existing per diem methodology.

If there is a change in a patient's level of care from acute to waitlist to acute, the move back to acute care should be considered the same confinement and billed on the same claim.

If there is a change in a patient's level of care from acute to subacute, the claim will need to be split into the appropriate bill type. If in the same confinement the patient moves out of subacute and into acute and/or waitlist status, that segment would be billed as a new claim paid as APR DRG if it includes acute days and paid as waitlist per diem if there are no acute days.

Aside from temporary waivers that may be granted from time to time by the Department of Health, Office of Health Care Assurance, inpatient claims for confinements that originate as a patient transfer from another hospital (as defined below) and are composed of only waitlist days, and contain no acute or subacute days, will not be considered for payment. When there is a QI plan or insurance responsibility change mid-confinement, then the guidance in QI-2141 applies and the new plan would be responsible for the new segment post level of care change.

Hospital Admission and Discharge Occurring on the same day

837I inpatient claims with the same admission and discharge date will be processed through the APR DRG methodology when the patient status indicates that the patient expired or if the patient was transferred.

Hospitals should not submit an inpatient 837I form for a patient that was admitted and discharged from the hospital on the same calendar day unless the patient expired (patient discharge status equals '20', '41' or '42') or was transferred to another acute care hospital ('02', '66'). For all other instances where the admission date is the same as the discharge date, the claim should be billed on the 837I outpatient form.

Per QI-2141, which replaces QI-1714, for acute inpatient hospitalizations, the admitting health plan is responsible for hospital services from admission to discharge or to change in level of care, whichever comes first.

Patient Transfers

Patient transfers are defined as a patient discharging from hospital with discharge status codes 02 (Discharged/transferred to a short-term general hospital for inpatient care) or 66 (Discharged/transferred to a critical access hospital (CAH)) and being admitted to a different hospital.

- **Transferring hospital**: Hospital that transferred patient out with discharge status of 02 or 66
- **Receiving hospital**: Hospital that receives a transfer

The transferring hospital receives a pro-rated payment proportionate to the length of stay the patient spent at the transferring hospital. The receiving hospital receives the full DRG payment as long as the stay is classified as an inpatient admission for the receiving hospital.

Readmissions

A readmission to the same or different facility within twenty four (24) hours of discharge for the same spell of illness and for the same general diagnosis as the original admission is considered to be the same admission and must be billed as a single stay. When two different facilities are involved, denial or partial payments may be made for the original admission, if

MQD determines that the services should have been provided during the initial inpatient stay. This policy does not apply to patients who leave the original facility against medical advice.

Readmission to the same facility within 30 days of a discharge for a similar diagnosis is subject to review by MQD. DRG payment for a readmission within 30 days may be consolidated with the index admission DRG payment, based on review subject to administrative guidelines.

Billing for Interim Inpatient Claims

Hospitals may submit an interim bill 30 days after the admission date and every 30 days after that. The initial claim should include type of bill '112' (interim, 1st claim). Subsequent interim claims should use type of bill '117' (Replacement of prior claim).

For interim billing, the first interim claim can be billed 30 days after the admission day. Providers should use type of bill = 112 for the first interim claim. Subsequent interim bills can be submitted every 30 days. Subsequent interim bills should use type of bill = 117 (replacement claim). Patient discharge status on interim bills should remain 30 (Still Patient) until the patient is discharged.

Third Party Liability Payments

Third party liability payments occur when either Medicare or another insurer pays for services received by a Medicaid recipient. In these situations, Medicaid will pay ONLY if the recipient has a coinsurance or deductible. If the recipient is liable for a coinsurance or deductible, MQD will pay the lesser of the coinsurance plus deductible or Medicaid allowed minus Medicare paid. If the latter is less than zero, MQD payment is $0.

Medicare Duals

Throughout the duration of a single hospital stay, a recipient dually eligible for Medicare and Medicaid may exhaust the allowable Medicare Part A benefit. Medicare is the primary payor for all services from admission through exhaust date, and Medicaid pays as secondary for these services. Effective on the day after the Part A exhaust date through discharge, Medicaid pays as primary payor for all Part A services. Diagnoses codes based on the entire confinement from admission to discharge shall be included on the claim where Medicaid is primary, even if those codes apply to the dates prior to exhaust. MQD will continue working with plans and hospitals to develop specific payment guidance for Medicare duals in a Part A exhaust scenario.

Retrospective Claims/Encounter reviews resulting in changes to covered services

If a retrospective review results in changes to covered services, the provider should submit the revised claim/encounter with a type of bill = 117.

QI/CCS Billing

For psychiatric inpatient services, providers should bill either CCS or QI for the services.

If the inpatient bill contains one of the following revenue codes, the entire inpatient bill should be paid by the CCS plan. Otherwise, the QI plan should pay the bill.

Code	Description
114	Room & Board Private (One Bed)-Psychiatric
124	Room & Board Semiprivate (Two Beds)-Psychiatric
134	Room & Board Three and Four Beds-Psychiatric
144	Room & Board Deluxe Private-Psychiatric
154	Room & Board Ward-Psychiatric
204	Intensive Care-Psychiatric

Carveouts

MQD's APR-DRG methodology carves out the following services from APR DRG payment methodology. These services will be reimbursed separately and excluded from APR DRG outlier payment thresholds.

1. Long Acting Reversible Contraceptive (LARC)
   A hospital can chose to bill for LARC services on either an 837I or 837P Once a hospital decides to use either the 837I or 837P form, the hospital must use that selected form for billing of LARC services for all patients. Note that LARC services must be billed with an appropriate CPT-4 procedure code and the correct corresponding NDC code – see below.

Code	Code Description	NDC Code
11981	INSERTION OF DRUG DELIVERY IMPLANT INTO TISSUE	
11982	REMOVAL OF DRUG DELIVERY IMPLANT FROM TISSUE	
11983	REMOVAL WITH REINSERTION OF DRUG DELIVERY IMPLANT INTO TISSUE	
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEXPLANON)	00052027401
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEXPLANON)	00052433001
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES (NEXPLANON)	78206014501
58300	PLACEMENT OF INTRA-UTERINE DEVICE (IUD) FOR PREGNANCY PREVENTION	
58301	REMOVAL OF INTRA-UTERINE DEVICE (IUD) FOR PREGNANCY PREVENTION	
J7296	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (KYLEENA), 19.5 MG	50419042401

J7296	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (KYLEENA), 19.5 MG	50419042408
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	00023585801
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG	52544003554
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042101
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042301
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG	50419042308
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	50907038006
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (SKYLA), 13.5 MG	50419042201
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	50907038007
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	51285020401
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	51285020402
J7300	INTRAUTERINE COPPER CONTRACEPTIV (PARAGARD)	54765038001
J7300	INTRAUTERINE COPPER CONTRACEPTIV (PARAGARD)	59365512801

2. SBIRT Services Carved out of APR DRG

   Effective January 1, 2024, the following SBIRT services will be a carveout from APR DRGs. Procedure codes and pricing can be found in the following table.

Code	Description
H0049	ALCOHOL AND/OR DRUG SCREENING
G2011	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) MISUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND BRIEF INTERVENTION, 5-14 MINUTES
G0396	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) MISUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND BRIEF INTERVENTION 15 TO 30 MINUTES
G0397	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) MISUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND INTERVENTION, GREATER THAN 30 MINUTES

Submission of DRG Code on Encounters

Health plans shall submit the DRG code they calculated for the inpatient stay on the 837I in Loop 2300, HI segment. Note, this is the DRG code that the health plan calculated and not the DRG code the provider calculated.

Loop ID Name	Reference	Name		Codes/Notes/Comments
2300	HI	DIAGNOSIS RELATED GROUP (DRG) INFORMATION		Required when an Inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.
2300	HI01	HEALTH CARE CODE INFORMATION		
2300	HI01-1	Qualifier	DR=Diagnosis Related Group (DRG)	Expect 'DR'
2300	HI01-2	DRG Code		Expect MCO's Qualified Diagnosis Related Group code – not the provider's DRG. FORMAT without hyphen: DRG(3)SOI(1) Example: 0201

New Data Edits

The following edits will assess encounters eligible for DRG grouping. These edits will be effective for admission states beginning July 1, 2022, and will pend encounters that trigger the edits. For the initial months post-implementation these edits will all be set to a "soft" status, allowing MQD to monitor encounters that trigger the edits. MQD will share results of these soft pends with the health plans for research. MQD will work with the health plans to address any questions or issues related to these encounter edits prior to changing the status to "pend" or "deny" and will formally communicate any changes in edit status with an agreed-upon timeframe with the health plans. Health plans are responsible for researching and correcting encounters that trigger these pends.

<u>Birth weight</u>

Birth weight is a required field for all inpatient claims where Recipient Age (calculated as Admit Date – Recipient Date of Birth) is less than or equal to 28 days. Birth weight shall be recorded in the Value Code fields as value '54'. Birth weight shall be recorded in grams. If birth weight is not recorded in these conditions, the claim will be denied and returned to the provider. Encounters submitted to HPMMIS where birth weight is not present, but recipient age is less than or equal to 28 will pend with **R100: BIRTH WEIGHT IS REQUIRED**.

Birth weight reasonableness

The birth weight value must be greater than or equal to 150 grams and less than or equal to 9,000 grams. If birth weight falls outside of the expected range, the claim will be denied and returned to the provider.

Encounters submitted to HPMMIS where birth weight is outside of the expected range defined above will pend with **R105: BIRTH WEIGHT IS OUT OF RANGE**.

Readmission

Per above billing guidance , a readmission to the same or different facility within twenty four hours of discharge for the same spell of illness and for the same general diagnosis as the original admission is considered to be the same admission and must be billed as a single stay. Should an Encounter for a member and facility list an admission date that is equal to a discharge date for that same member and facility, that encounter will deny with **Z646: INVALID READMISSION TO SAME FACILITY ON SAY OF DISCHARGE**.

If a readmission to the same facility within 30 days of discharge for a similar diagnosis occur, the encounter will soft pend with **Z715: READMISSION TO THE SAME FACILITY WITHIN 30 DAYS OF DISCHARGE**. MQD will review encounters that trigger Z715 and may consolidate payment with the index admissions DRG payment based on review subject to administrative guidelines. This edit will remain set to "soft" for internal reporting.

DRG Code Mismatch

HPMMIS will compare the DRG code submitted in Loop 2300, HI segment to what MQD calculates using the version of the grouper in use by MQD at the date of admission. If the DRG codes do not match, the encounter will pend with **A906: HP DRG CG <> MATCH STATE CALC'D DRG CD.**

Pricing Errors

For the majority of encounters priced using DRG MQD expects the amount the health plan paid for the claim to be within the dollar amount of what MQD calculates payment should be for that DRG using the published DRG calculator. Should an encounter list a health plan paid amount that exceeds this amount, the encounter will deny with **A908: HP DRG PMT EXCEEDS STATE CALC'D DRG**. Conversely, if the encounter lists a health plan paid amount that subceeds the expected amount, the encounter will deny with **A911: HEALTH PLAN DRG PMT SUBCEEDS MEDQUEST CALC DRG PMT**.

Encounters representing interim claims and claims with services carved-out from DRG payment (e.g. LARC) will follow a different set of edits. MQD expects the amount the health plan paid for these claims to be within a range of +/ - 2.5% of what MQD calculates the payment should be, due to differences in health plan fee schedules and billing guidelines. Should an encounter

representing an interim claim or claim with carved-out service list a health plan paid amount that exceeds 2.5% of the payment MQD calculates, the encounter will deny with **A907: HP DRG PRICE IS ABOVE ACCEPTABLE RANGE.** Conversely, if the encounter lists a health plan paid amount that is below 2.5% of the payment MQD calculates, the encounter will deny with **A909: HEALTH PLAN DRG PRICE IS BELOW THE ACCEPTABLE RANGE**.

Data gathering Error

In the case the 3M grouper is unable to assign a DRG code to an encounter, HPMMIS will return the error **A956: DRG – DOES NOT MEET CRITERIA FOR ANY DRG**.

For questions on billing guidance, please contact Mr. Eric Nouchi at enouchi@dhs.hawaii.gov with any questions or concerns. For questions on encounter data edits, please contact MQD Encounters inbox at mqd-encounters@dhs.hawaii.gov.