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MEMORANDUM

MEMO NO.
QI-2206 [Update to QI-2116A]
FFS 22-04 [Update to FFS 21-06A]
CCS-2205 [Update to CCS-2106A]

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

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

SUBJECT: APR DRG BILLING GUIDANCE

This memorandum is an update to memorandum QI-2116A, CCS-2106A, FFS 21-06A "IMPLEMENTATION OF ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS (APR DRG)."

This memo is intended to give new and modified billing guidance to affected hospitals and health plans related to the Med-QUEST (MQD) implementation of the 3M™ All Patient Refined Diagnostic Related Groups (APR DRG) scheduled for July 1, 2022.

APR DRGs are 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.

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.

To meet APR DRG processing requirements the following new or modified edits and billing guidance are provided for UB Inpatient claims forms.

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 form 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
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
Wilcox Memorial Hospital	085500	1225113442
Kaiser Foundation Hospital	082521	1396813861
Shriners Hospital for Children	684804	1316065360

Billing Guidance

While MQD is publishing the below billing guidance that will apply to claims processing for our Fee-for-service program, QI and CCS plans may determine their own policies for their claims processing unless otherwise noted.

Billing for Pre-admission Services

Facility services provided within 72 hours of admission that quality as "pre-admission" services can be billed for by the hospital. All providers should include UB appropriate pre-admission services that were provided up to 72 hours 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 UB claim. When Medicare or another third-party payer is the primary payor, ICF waitlisted days are listed on separate UB claim and paid using the existing per diem methodology.

If there is a change in a patient's level of care (e.g. from ICF to acute), the move back to acute care should be considered a separate stay and billed on a separate claim.

Hospital Admission and Discharge Occurring on the same day

UB 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 UB 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', '40', '41' or '42') or was transferred to another acute care hospital. FOR ALL OTHER INSTANCES where the admission date is the same as the discharge date, the claim should be billed on the UB 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.

Billing for Interim Inpatient Claims

As allowable by health plan policy, 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.

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

Long Acting Reversible Contraceptive (LARC)

A hospital can chose to bill for LARC services on either a UB or CMS 1500 form. Once a hospital decides to use either the UB or CMS1500 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 CONTRACEPTIVE (PARAGARD)	54765038001
J7300	INTRAUTERINE COPPER CONTRACEPTIVE (PARAGARD)	59365512801

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. Health plans are responsible for researching and correcting encounters that trigger these pends.

Birth weight

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.

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 Eric Nouchi at enouchi@dhs.hawaii.gov with any questions or concerns. For questions on encounter data edits, please contact Kate Allen at sallen@dhs.hawaii.gov.