Payment Policy

Subject: All Patient Refined Diagnosis Related Groups ("APR-DRG") – OHIO ONLY

Policy

CareSource has adopted the APR-DRG inpatient classification system for all in-patient discharges occurring on or after July 1, 2013. CareSource will determine DRG codes based on diagnosis codes and other information supplied by the provider and will compute reimbursement amounts based on ODJFS assigned base rates. CareSource uses MCG® (Milliman Care Guidelines) and CareSource policies for inpatient criteria.

Definitions

"**Diagnostic related groups (DRGs)**" – DRGs are a patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources. *(from OAC 5101:3-2-02 (B)(5))*

"**Inpatient**" – 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 of the day of admission. *(from OAC 5101:3-2-02 (B)(1))*

"**Inpatient services**" are those services which are ordinarily furnished in a hospital for the care and treatment of inpatients. Inpatient services include all covered services provided to patients during the course of their inpatient stay, whether furnished directly by the hospital or under arrangement, except for direct-care services provided by physicians, podiatrists, and dentists. Emergency room services are covered as an inpatient service when a patient is admitted from the emergency room. *(from OAC 5101:3-2-02 (B)(2))*

"**Principal diagnosis**" is the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital. *(from OAC 5101:3-2-02 (B)(13))*

Provider Reimbursement Guidelines

All Patient Refined Diagnosis Related Groups ("APR-DRG") codes will change significantly from the previous Diagnosis Related Groups ("DGR") codes after July 1, 2013. Providers should refer to the ODJFS website for an updated list of these codes.

The APR-DRG inpatient classification system was chosen by the Ohio Department of Jobs and Family Services ("ODJFS") because it is suitable for use with a Medicaid population, especially with regard to neonatal and pediatric care, and because it incorporates sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use. Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG.

Claims for payment for inpatient hospital services must be submitted on the UB-92 and include the data essential for assignment of a DRG.

Assignment of the APR-DRG and calculation of payment is based on the standard information already on the hospital claim. The CareSource claims processing system assigns the APR-DRG based on the principal diagnoses, procedures, patient age, and patient discharge status, all as submitted by the hospital. Reimbursement will be calculated and based on the patient's admission date. Hospitals are advised to ensure that these fields are coded completely, accurately and defensibly.

The claims processing system also calculates the payment without need for the hospital to identify the DRG. If a hospital claim contains a DRG code, CareSource will separately assess and determine the correct code.

Interim Payments - A claim for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Ohio Administrative Code.

Medicare crossover stays - There is no change in payment calculations for stays where Medicare is the primary payer and Medicaid is the secondary payer. Note, however, that "No Part A" claims, in which a dually eligible patient either does not have Medicare Part A or has exhausted his or her Part A hospital benefit, are priced using the new DRG method. In these situations, Medicaid acts as the primary payer.

Related Policies & References

OAC Chapter 5160-2-02, "Hospital Services, General Provisions."

State Exceptions

This payment policy applies to Ohio only.

Document History

10/31/2013 – OAC Rule renumbered from "5101:3-2-02," per Legislative Service Commission Guidelines.