Florida Medicaid DRG (Diagnosis-Related Group)  
Frequently Asked Questions  
July 11, 2017

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Are all service and age adjusters 1.0?
The service and age adjustors provide flexibility within the DRG pricing method to allow Medicaid policy makers to shift reimbursement to specific types of services if they choose. If used, these adjustors are generally to increase payment to help promote access to care for Medicaid beneficiaries. Because these adjustors are used as multipliers in the payment calculation, a value of 1.0 indicates no adjustment and a value other than 1.0 will create an adjustment in the payment.

Information about the DRG payment method, including the DRG calculator, can be found on the Agency for Health Care Administration (Agency) website.

How are high Medicaid utilization and outlier provider adjusters calculated?
For Medicaid utilization, we are using a combination of the percentage of each hospital’s business that comes from Medicaid fee-for-service and managed care recipients. The determination of this percentage for each hospital was done using the Florida all-payer dataset maintained by the Florida Data Center. The Medicaid utilization number and the outlier percentage for each hospital are published on the Agency website in the spreadsheet showing DRG pricing simulation results by hospital.
Where can we find information on the cost-to-charge ratio?
Hospital cost-to-charge ratios are included in the DRG Calculator available on the Agency website and are also included in the “Provider Table” worksheet.

Do DRG claims require additional information on the UB-04 claim form?
Hospital cost-to-charge ratios are included in the DRG Calculator available on the Agency website and are also included in the “Provider Table” worksheet.

Hospital do not need to include the DRG code on their submitted claims. The DRG code and severity of illness are assigned by FMMIS during the claims adjudication process.

With DRG pricing, a present of admission (POA) indicator is required on primary and secondary diagnosis codes, and blanks are NOT accepted for the majority of codes.

POA indicators are not required on the admission diagnosis or diagnosis codes that the Centers for Medicare & Medicaid Services (CMS) has determined to be exempt, such as external cause of injuries codes. For admission and exempt diagnoses, the POA indicator should be left blank.

If a POA indicator is required on the primary or secondary diagnosis code and this indicator is left blank, Explanation of Benefit (EOB) code 1816 “POA INDICATOR MISSING OR INVALID” will post and the claim will deny.

Changes to billing requirements can be found in the DRG Quick Reference and Awareness Guide posted at http://portal.flmmis.com/FLPublic/Provider_AgencyInitiatives/Provider_DRG/tabid/91/Default.aspx.

Can the same prior authorization be used for multiple claims?
No. With DRG pricing, interim or multiple claims containing the same prior authorization number are not reimbursable. If a provider attempts to utilize the same prior authorization more than once (regardless of any units remaining), the claim will deny appropriately.

Does any prior authorization require approval of days, instead of just the admission date?
Yes. With the implementation of APR-DRGs, there are only two scenarios that require a “length of stay” span to be authorized. Care for undocumented non-citizens and care for recipients who reach their 45 day benefit limit prior to admission (BBA claims) will require prior authorizations that specify the actual number of days authorized.

Is a prior authorization required on a DRG claim, if the recipient has third party liability (TPL) coverage?
The presence of TPL on a recipient’s file does not bypass the prior authorization edit.
How are delivery and birth claims impacted by DRG?
Under DRG pricing, the infant and the mother are billed on separate claims and the appropriate DRG payment is issued. For every birth in which the mother and the baby are eligible for Medicaid, two claims are required.

The delivery claim, billed in the mother’s ten-digit recipient ID, requires a prior authorization.

The birth claim, billed in the newborn’s ten-digit recipient ID, does not require a prior authorization, regardless of the length or complication of stay, as long as the newborn was born in the submitting facility.

If the newborn was born elsewhere, such as at home, a prior authorization is required.

Are all diagnosis codes listed on a claim factored into DRG calculations?
The diagnosis code acceptance policy remains unchanged. Up to twenty-five diagnosis codes will be used in the determination of the DRG assignment and SOI.

If a sterilization diagnosis is included on a DRG claim, does the sterilization form need to be attached?
Yes, if a sterilization diagnosis is present on an inpatient claim, the Consent for Sterilization form must be submitted with the claim. For more information on this form, please review the UB 04 Medicaid Provider Reimbursement Handbook.

Will IGT payments be disclosed to the providers?
Yes, the Agency plans to make publicly available the average per claim IGT payments for each hospital. These values are available in the most current version of the DRG Calculator tool and are listed in the “Provider Table” worksheet.

In addition, the Agency is considering creating a separate, more easily accessible spreadsheet to post these values. The automatic IGT values were determined using the Florida Legislature’s direction on distribution of automatic IGT funds for state fiscal year 2013/2014. The self-funded IGT values currently included in the DRG Calculator were determined based on contributions negotiated for state fiscal year 2012/2013. After letters of agreement for self-funded IGTs for state fiscal year 2013/2014 are completed (by the end of October 2013), the average per-discharge self-funded IGT payments for each hospital will be re-calculated and re-posted.

Are the DRG and severity of illness (SOI) codes listed on the remittance advice (RA) or the X12 835?
Yes, DRG codes are included as part of the inpatient header information section on the RA between the claim amounts and admission date.
As of June 1, 2013, Florida Medicaid began reporting the DRG code on remittance advices (RA) for each inpatient claim containing an admission date of January 1, 2013 and after. The DRG code consists of the three-digit DRG code followed immediately by the one-digit severity of illness code and appears in the same field without a space or dash (ex. XXXX). The same is true for the X12 835 transaction. As of July 29, 2013, the following additional fields are visible on the 835 report:

- Automatic IGT Payment Amount
- DRG Base Payment Amount
- Outlier Payment
- Self-Funded IGT Payment
- Maximum Policy Adjustor

Please refer to the 835 Companion Guide for additional detail information on X12 835 transactions.

Are inpatient Medicare Part A crossovers included in DRG pricing?
At this time, there is no change to pricing logic of Inpatient crossover (Medicare Part A) claims. Florida Medicaid will continue to pay the sum of Medicare coinsurance and deductible on Inpatient crossover claims. However, if Medicare Part A benefits have been exhausted, providers will continue to submit straight Medicaid claims to their local Medicaid Area Offices for force of the Medicare Present edit. The straight claims will need to include the occurrence code of A3 and the date of exhaustion.

How will a provider handle inpatient admissions that span the 07/01/13 date?
Florida Medicaid DRG pricing is based on the date of admission present on the claim form. If a patient is admitted to a hospital on 07/01/2013 or after, DRG pricing will be used. If a patient is admitted to a hospital on 06/30/2013 or prior, per diem pricing will be used.

How are transfers from an acute bed to a rehabilitation bed (or a psychiatric bed) within the same facility processed with DRG pricing?
In order for Florida Medicaid to appropriately reimburse the hospital for both acute and rehabilitation/psychiatric bed charges, two separate claims need to be billed. Two separate claims, each containing its own prior authorization, are needed so that separate DRG assignments can be determined.

One claim for the acute bed hospital stay, including a discharge status of 62 (transfer to a rehabilitation bed) or 65 (transfer to a psychiatric bed).
One claim for the rehabilitation/psychiatric bed stay, including the date of admission that corresponds to the first date that the recipient occupied a rehabilitation/psychiatric bed.

How does Florida Medicaid calculate an adult recipients’ inpatient days benefit on DRG claims?
With DRG pricing logic, a comparison is made between the covered days calculated on the claim versus the DRG average length of stay. The lesser of those two values is then used to contribute to the recipient’s 45-day cap. For example, if the DRG average length of stay is four days and the recipient was only in the facility for three covered days, three days are contributed to the recipient’s 45-day inpatient benefit.

If using the DRG average length of stay, the system uses basic rounding in the calculation of days, rounding down for values of 0.4 and lower and rounding up for values of 0.5 and higher. For example, if the DRG average length of stay of 3.65 is less than the actual length of stay, then rounding up occurs and four days are contributed to the recipient’s 45-day inpatient benefit.

Does the Florida Medicaid Web Portal display DRG information?
The Florida Medicaid secure Web Portal displays the following DRG pricing data on inpatient claims:

1. DRG code and description
2. Maximum Policy Adjustor
3. DRG Base Payment
4. Outlier Payment
5. Automatic IGT Add-On Payment
6. Self-Funded IGT Add-On Payment

How are low birth-weight infant claims submitted?
The actual birth weight is not reported on the claim. Providers need to code claims properly, using diagnosis coding to reflect low birth-weight newborns. If low birth-weight coding is not present, the APR-DRG Grouper software (version 30) will default the birth weight to 2500 grams to be used in the determination of the DRG assignment. For more information on the APR-DRG software, please review the Understanding DRG Training presentation.
For More Information

Agency

For more information regarding DRG and related policies, visit the Agency website at http://ahca.myflorida.com/Medicaid/cost_reim/drg.shtml.

DXC Technology

DXC Technology posts DRG-specific information to the DRG Pricing page of the Florida Web Portal at http://portal.flmmis.com/FLPublic/Provider_AgencyInitiatives/Provider_DRG/tabId/91/Default.aspx