UNDERSTANDING DIAGNOSIS RELATED GROUPS (DRG)

Updated 2/5/18
The state of Florida implemented a new inpatient payment method utilizing Diagnosis-Related Groups (DRG) for Medicaid on July 1, 2013.

DRG payment methods involve classifying inpatient stays and then determining a price based on a combination of the classification and the hospital where the services were performed. The classifications are labeled using codes referred to as DRG codes.
REQUIRED DRG PARTICIPANTS

The Agency for Health Care Administration (Agency), along with its consultant, Navigant Healthcare, designed the DRG-based inpatient payment method.

The Agency fiscal agent, DXC Technology (DXC), updated the Florida Medicaid Management Information System (FMMIS) to process claims according to the Agency’s direction.

All hospitals are included in the DRG payment method, with the exception of the four state-owned psychiatric facilities.

All inpatient stays are paid via the DRG method, with the exception of transplant cases and newborn hearing screenings. At this time, inpatient crossovers and outpatient claims are not included in DRG pricing.
CHARACTERISTICS OF DRG PAYMENT

• Payment is based on patient acuity, not length of stay.
• There is a single payment per hospital stay.
• Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in a particular DRG category.
• For example, if the DRG base price is $3,000 and the DRG relative weight is 0.50, then the DRG base payment is $1,500. Similarly, if the DRG relative weight is 2.0, then the DRG base payment is $6,000.
• DRG payment methods reward hospitals that reduce cost.
• DRG benefits hospitals that provide complete coding of diagnoses and procedures.
The Florida Medicaid Web Portal has a page dedicated to DRG pricing.

To access this page, navigate to http://mymedicaid-florida.com and select Public Information for Providers. Click DRG Pricing in the Agency Initiatives menu at the bottom left-hand side of the page.

This page is updated regularly with new information and materials for download.
DRG ON THE AGENCY WEBSITE

DRG information can also be found on the Medicaid Institutional Provider Cost Reimbursement page on the AHCA website at http://ahca.myflorida.com/Medicaid/cost_reim/drg.shtml

This page contains information regarding DRG that has been provided by Navigant, as well as DRG calculators and simulation examples.

AHCA updates this web page regularly.
HELPFUL DOCUMENTS

DXC has created a Quick Reference and Awareness Guide and a Frequently Asked Questions document. These documents contain detailed information about changes related to DRG and can be found on the DRG Pricing page on the Web Portal. Please check back, as they will be updated regularly.

The DRG Conversion and Implementation Plan prepared by Navigant can be found on the Agency DRG web page.
Revisions to the Provider General, UB 04 Reimbursement, and Hospital Coverage and Limitations manuals are currently underway. Until handbook updates occur, providers are strongly encouraged to monitor their e-mail for important, DRG-related provider alerts.

Provider alerts are sent, via email, when any changes are made to the implementation plan and billing rules. For more information on e-mail alerts, please visit the Florida Medicaid’s Health Care Alerts page at http://ahca.myflorida.com/Medicaid/alerts/alerts.shtml.

Additionally, providers can access all posted alerts by visiting the public Florida Medicaid Web Portal and clicking on Public Information for Providers → Provider Support → Provider Alerts.
CHARACTERISTICS OF APR-DRGS

APR-DRGs were developed by 3M Health Information Systems. Most states currently use or are implementing APR-DRG pricing.

APR-DRG consists of 314 base DRGs. Each base DRG has four levels of severity:

Level 1: minor  
Level 2: moderate  
Level 3: major  
Level 4: extreme

There are a total of 1,254 separate codes and relative weights. The number of codes is subject to change.

FL AHCA DRG Project: DRG Payment Method Conversion and Implementation Plan  
– January 2, 2013 Page 34 Submitted to the Florida Agency for Health Care Administration
APR-DRGS RESOURCES


To access the website, use the following login information:

User ID: FLHosp
Password: aprdrg006
There are several benefits to using a DRG-based payment system:

**Fairness:** DRG pricing allows a statewide base rate with adjustments for more expensive patient care.

**Efficiency:** DRG minimizes reliance on individual hospital costs which encourages hospitals to improve efficiency.

**Access:** DRG pays a higher rate for sicker patients, so hospitals will be able to provide more patients with a full spectrum of care.

**Predictability:** DRG payments are predictable and take into consideration patient acuity and volume.

**Transparency:** DRG calculators and full policy information will be available online.

**Administrative Improvements:** DRG pricing methods allow hospitals to simplify some of their administrative processes.
DRG PAYMENTS AND PRICING

DRG payments are based on the admission date present on the claim form. Because DRG is date of service driven, providers should anticipate a transitional period in which both payment methods, DRG and per diem, will be reflected in payments and appear on their remittance advice (RA).

The vast majority of hospital stays are priced using the following formula, although variances can occur:
DRG PRICING CALCULATION

The following variables are used to calculate the DRG Base Payment:

The **hospital base rate** is determined by the Agency for each active hospital provider at the beginning of each fiscal year.

The **DRG relative weight** is calculated using the DRG code. Each claim is assigned a DRG code based on patient diagnosis, any surgical procedures, age, and discharge status. Each DRG code has an associated relative weight. The weight indicates, on average, the relative amount of resources that the treating hospital utilizes to treat a patient with this DRG code.

**Policy adjustors** are numerical multipliers intended to help protect access to care for specific services and/or specific types of providers by increasing payment. Three are currently three types of adjusters: Service Adjusters, Age Adjusters, and Provider Adjusters.
OTHER DRG BASE PAYMENT ADJUSTERS

Many factors are included in the determination of the DRG Base Payment.

It is the hospital’s responsibility to ensure that the coding used is correct and defensible in order to prevent payment recoupment in an audit.

- Principal Diagnosis
- Secondary Diagnoses
- POA Indicators
- Surgical Procedures
- Patient Age
- Patient Gender
- Discharge Status
INTER-GOVERNMENTAL TRANSFER (IGT) PAYMENTS

The provider base rate is a key factor in the calculation of DRG payment and is funded from state general revenue and the Public Medical Assistance Trust Fund.

Distribution of funds from Inter-Governmental Transfers (IGTs) are made separately as per-claim supplemental payments and these funds do not contribute to the provider base rate.
After the DRG assignment is determined and the DRG base payment is calculated, **automatic** IGT payments, if present, are added to the claim’s reimbursement.

**Automatic IGTs are not reduced down by adjustments regardless if the covered days are less than the length of stay or if a charge cap applies.**

For a hospital participating in IGTs, the relative weight assigned to a claim is divided by the hospital’s yearly average relative weight, known as the “casemix.” This calculation is then multiplied by the hospital’s annual average IGT payment, to determine the per-claim IGT payment.

The below illustrates the automatic IGT payment calculation. **Note:** Self-funded IGTs are not paid out with claims, but are paid out quarterly to the applicable hospitals.
ADJUSTMENTS TO THE DRG BASE PAYMENT

A variety of special situations exist in which the DRG Base Payment may be adjusted.

- Transfer pricing adjustment
- Cost outlier adjustment
- Non-covered days adjustment
- Charge cap adjustment

Detailed information regarding the above special situations can be found in the DRG Quick Reference and Awareness Guide posted to the DRG Pricing page on the Florida Web Portal. The above special situations can also be modeled using the DRG pricing calculator on the AHCA website.
The Agency website contains a DRG pricing calculator. This allows providers to model payments for different billing situations.
DRG PRICING EXAMPLES AND CALCULATORS

Florida Medicaid DRG Calculator:
Assists providers by demonstrating how rates are impacted due to various policy adjustors.
http://ahca.myflorida.com/Medicaid/cost_reim/drg.shtml

DRG Simulation Results by Provider:
Assists providers by projecting the financial impact of all active and participating Florida Medicaid hospitals for the 2013-2014 State fiscal year based on historical claim data. This document contains the Final Simulation data published November 1, 2013.
http://ahca.myflorida.com/Medicaid/cost_reim/drg.shtml

Examples of Priced Claims:
Appendix A of the DRG Implementation presentation below contains DRG pricing examples.
BILLING PROCEDURES

Present on Admission Indicator

The present on admission (POA) indicator is a required field under DRG.

Newborn and One-day Emergency Inpatient Stays

With DRG pricing, separate claims must be submitted for the mother (the delivery) and the baby (the birth) in all cases. Separate DRG payments are made for the delivery and for the birth.

If a one-day emergency inpatient stay has an admission date of 07/01/13 and after, it requires a post admission authorization.

Interim Claims

Interim claims are not accepted under DRG. The hospital must wait until the patient is discharged before submitting a claim.

Medicare Part A Exhausted Claims

If a recipient is dually eligible for Medicare and Medicaid, then the hospital can bill Medicaid for the portion of the stay not covered by Medicare. On the Medicaid claim, the hospital should include the full length of stay. Medicaid calculates a DRG payment for the full stay and then reduces the payment down to cover only those days reimbursable by Medicaid.

Medically Needy Recipients

If a recipient obtains Medicaid eligibility because his/her share of cost is met during an inpatient stay, then the hospital should submit a Medicaid claim which includes the full length of stay and then reduces the payments down to cover only those days for which the recipient was Medicaid eligible.
A POA indicator is required on primary and all 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.
POA INDICATOR CONTINUED

- POA indicators are used in the review of claims for Health Care Acquired Conditions (HCACs).
- Two DRGs are assigned to each claim and are referred to as “pre-HCAC” and “post-HCAC” DRGs. The pre-HCAC DRG is assigned using all the diagnosis and surgical procedure codes on the claim. The post-HCAC DRG is assigned when ignoring any diagnosis and surgical procedure codes identified as HCACs. If the pre-HCAC and post-HCAC DRGs are different, then the DRG code with the lower relative weight will be used to price the claim. In all or nearly all cases, the DRG code with the lower relative weight will be the post-HCAC DRG.
# HCAC PAYMENT ADJUSTMENT EXAMPLE

<table>
<thead>
<tr>
<th>Diag Code</th>
<th>Description</th>
<th>POA Indicator</th>
<th>HCAC?</th>
<th>HCAC Category: 05 - Falls and Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>715.35</td>
<td>Loc osteoarth NOS-pelvis</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>820.20</td>
<td>Trochanteric fx NOS-clos</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

**DRG Assignment**

<table>
<thead>
<tr>
<th>Using</th>
<th>Code</th>
<th>Relative Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both diagnosis codes</td>
<td>351-2</td>
<td>0.5911</td>
</tr>
<tr>
<td>Ignoring the HCAC diagnosis code</td>
<td>351-1</td>
<td>0.4634</td>
</tr>
</tbody>
</table>
## EXAMPLE WITHOUT HCAC PAYMENT ADJUSTMENT

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
<th>Description</th>
<th>POA Indicator</th>
<th>HCAC?</th>
</tr>
</thead>
<tbody>
<tr>
<td>806.4</td>
<td>Diag</td>
<td>Cl lumbar fx w cord inj</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>998.59</td>
<td>Diag</td>
<td>Other postop infection</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>81.05</td>
<td>Proc</td>
<td>Drsl/dslmb fus post/post</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HCAC Category: 12 - Surgical site infection

### DRG Assignment

<table>
<thead>
<tr>
<th>Using</th>
<th>Code</th>
<th>Relative Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both diagnosis codes</td>
<td>023-2</td>
<td>2.0907</td>
</tr>
<tr>
<td>Ignoring the HCAC diag and proc</td>
<td>023-2</td>
<td>2.0907</td>
</tr>
</tbody>
</table>
BILLING DELIVERY AND NEWBORN CLAIMS

• 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.

• **Infant:** The infant claim must include the child’s ten-digit Medicaid recipient ID number, all charges and services associated with the birth, and only those provided to the infant. The admission date and from date of service must correspond to the infant’s date of birth. If the infant was born elsewhere, the admission and from date of service should equal the date the infant was admitted. Services provided to the mother cannot be included in the infant claim.

• **Mother:** The mother claim must include the mother’s ten-digit Medicaid recipient ID number, all charges and services associated with the delivery and provided to the mother only.
INTERIM CLAIMS

Interim claims, sometimes referred to as split-bills, are not accepted under DRG pricing.

Claims with an admission date of July 1, 2013 or later that contain interim bill codes or contain a patient status of 30 (still a patient) are not reimbursable by Florida Medicaid.
BILLING MEDICARE PART A EXHAUSTED CLAIMS

If a recipient is dually eligible for Medicare and Medicaid and his/her Medicare Part A benefits are fully consumed during a hospital stay, then the hospital can bill Medicaid for the portion of the stay not covered by Medicare.

This is billed as a straight Medicaid paper claim, not a Medicare crossover claim. On the Medicaid claim, the hospital must include the full length of stay and all the charges associated with the admission. Medicaid calculates a DRG payment for the full stay, including any applicable outlier payments, and then reduces the payment down to cover only those days reimbursable by Medicaid. Outlier payments are calculated independent of IGTs.

On the Medicaid claim, occurrence code “A3” must be included along with the date in which Medicare Part A benefits were exhausted. Providers should continue to send this type of claim to their local Area Offices for review and override of the Medicare-present edit.
BALANCED BUDGET ACT (BBA) CLAIMS

Under DRG pricing, a BBA claim is required only if the recipient has zero days available within their 45-benefit limit.

If the recipient has at least one day left within their benefit limit at the time of admission, or gains a new 45-days when crossing state fiscal years during an admission, then full DRG payment will apply.

If neither of these are true, then a BBA claim is required, including authorization of the covered portion of the stay. Payment for BBA claims will be prorated downward based on a comparison of the covered days to the full length of stay.
PRIOR AUTHORIZATIONS

The rules defining which inpatient stays require a prior authorization and which do not require a prior authorization remain the same, under DRG pricing. The exceptions are newborn claims and one-day inpatient emergency stays.

Under DRG, no prior authorization is needed for the baby’s birth claim.

Although one-day emergency stays were previously exempt from prior authorization review, if the date of admission is July 1, 2013 and after, the one-day emergency stay requires a prior authorization. Providers need to contact eQ Health Solutions to receive a post admission authorization on all emergency admissions, including those with a one-day length of stay.
PRIOR AUTHORIZATIONS CONTINUED

With DRG, a prior authorization should only be billed once. Florida Medicaid allows one claim per one prior authorization.

Interim or multiple claims containing the same prior authorization are not reimbursable.

Since a one-to-one relationship between the claim and its PA occurs with DRG pricing, most claims are prior authorized for one unit and the authorized effective dates span corresponds to the admission date of the hospital stay.

If a provider attempts to utilize the same PA more than once (regardless of any units remaining), the claim will deny appropriately.

The PA status is automatically updated to a “used” status once a corresponding claim has been billed with that particular PA and a DRG payment rendered.
PRIOR AUTHORIZATIONS SPANNING TWO FISCAL YEARS

Claims priced by per diem and DRG payment methods cannot utilize the same prior authorization.

If a PA has an approved date range that spans two fiscal years, such as 06/01/2013 – 07/31/2013 AND there are multiple inpatient stays, the provider must contact eQHealth Solutions and request the following actions:

1. Request an end date of the existing PA to correspond with the last date of service provided within the 2012-2013 fiscal year.

2. Request a new PA to correspond with the dates of service span provided within the 2013-2014 fiscal year.
PRIOR AUTHORIZATIONS FISCAL YEARS EXAMPLE #1

ONE PRIOR AUTHORIZATION:
06/01/2013 Authorized Effective Date  -  07/31/2013 Authorized End Date

TWO SEPARATE STAYS OCCUR WITHIN AUTHORIZED RANGE:
1.) Admit Date: 06/01/2013 , FDOS – TDOS: 06/01/2013 – 06/22/2013, Patient Status: 01
2.) Admit Date: 07/02/2013, FDOS – TDOS: 07/02/2013 – 07/09/2013, Patient Status: 01

PRIOR AUTHORIZATION MUST BE UPDATED WITH eQHEALTH SOLUTIONS.

FIRST CLAIM:  EXISTING PA MUST BE END-DATED.
Note: Claim will process with per diem pricing, due to the admission date.

SECOND CLAIM:  A NEW PA MUST BE REQUESTED.
Note: Claim will process with DRG pricing, due to the admission date.
PRIOR AUTHORIZATIONS FISCAL YEARS EXAMPLE #2

ONE PRIOR AUTHORIZATION:
06/28/2013 Authorized Effective Date - 07/02/2013 Authorized End Date

ONLY ONE INPATIENT STAY OCCURS WITHIN AUTHORIZED RANGE:
Admit Date: 06/29/2013, FDOS – TDOS: 06/29/2013 – 07/02/2013, Patient Status: 01

SINCE THE ADMISSION DATE FALLS WITHIN THE APPROVED PA SPAN, THE CLAIM WILL PROCESS AND ALLOW FOR PER DIEM PRICING.
INPATIENT DAYS BILLING EXAMPLE #1

Under DRG pricing, claims continue to post the edit 6354 when a recipient has met their 45-day inpatient stay limit. However, there are no reimbursement cut backs based on covered days on fully-eligible stays.

Please see the following examples, assuming the recipient is the same for each scenario:

1

SCENARIO: Recipient has a few days benefit remaining, but does not have enough inpatient days left for entire claim span.

Claim Data: Type of Bill: 0111; FDOS: 09/01/13 – TDOS: 09/22/13; Billed for 21 days on 10/13/13; Patient status: 01.

DRG PRICING: The system will reimburse the full DRG payment. Edit 6354 will not post and the claim will not be cut back.
INPATIENT DAYS BILLING EXAMPLE #2 & #3

2

SCENARIO: Recipient has zero inpatient days remaining.

Claim Data: Type of Bill: 0111; FDOS: 09/30/13 – TDOS: 10/02/13; Billed for 02 days on 10/20/13; Patient status: 01.

DRG PRICING: The system will deny the claim. Edit 6354 will post because the recipient has exceeded their 45 day inpatient stay limit. For reimbursement consideration, a BBA claim would be required.

3

SCENARIO: An inpatient stay spans over the state fiscal year and the recipient has exhausted their 45 day inpatient stay limit of the previous fiscal year.

Claim Data: Type of Bill: 0111; FDOS: 06/22/14 – TDOS: 07/05/14; Billed for 13 days on 07/10/14; Patient status: 01.

DRG PRICING: The system will reimburse the full DRG payment. The recipient’s date of discharge falls within the new fiscal year and therefore will be covered under the new year’s benefit limits. Edit 6354 will not post and the claim will not be cut back.
CALCULATION OF THE 45 INPATIENT DAYS BENEFIT

Recipients ages 21 and over have a maximum of 45 covered inpatient days per fiscal year. 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 used to contribute to the recipient’s 45 day cap.

**SCENARIO:** Claim contains 10 covered days and the DRG average length of stay is 8 days.

**Claim Data:** Type of Bill: 0111; FDOS: 09/01/13 – TDOS: 09/11/13; Billed for 10 days on 10/13/13; Patient status: 01. The DRG average length of stay is 8 days.

**DRG 45 DAY INPATIENT DAYS CAP CALCULATION:** The system will use the lesser of the claim’s covered days and the DRG average length of stay. In this case, the DRG average length of stay of eight days is counted towards the recipient’s inpatient days cap because it is the lesser of the two.
FREQUENTLY ASKED QUESTIONS

Q: Is Risk of Mortality (ROM) used in the calculation of DRG?
   A: No. Risk of mortality values are not utilized in the calculation of DRG payments.

Q: Does the DRG code need to be entered on claims?
   A: No, hospitals do not need to include the DRG code on their submitted claims. The DRG code and severity of illness (SOI) is assigned by the Florida Medicaid Management Information System (FMMIS) during the claims adjudication process.

Q: Does the Florida Medicaid remittance advice (RA) include DRG values?
   A: The DRG code has been added as part of the inpatient header information section on the RA between the claim amounts and admission date and appear for all inpatient claims with an admission date of 01/01/2013 and after that were processed on 06/01/2013 and after. The three-digit DRG code and the one-character SOI are included in the same field without a space or dash (ex. XXXX) on both the remittance advice and the X12 835 transaction.
FREQUENTLY ASKED QUESTIONS

Q: Do any prior authorizations require approval of days, instead of just the admission date?
A: Yes. There are only two scenarios which will 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) require prior authorizations that specify the actual number of days authorized. The C3 occurrence code must be added to the claim form along with the actual dates approved.

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

Q: Is there a way for providers to calculate their estimated IGT payments?
A: Hospitals can utilize the DRG calculator tool to simulate the expected IGT payment occurring for both self-funded and automatic IGTs. Using correct data to complete the DRG calculator yields the most accurate results.
FOR MORE ASSISTANCE

Online training opportunities are being offered through the DRG webinar series.

Check the AHCA and HP websites for dates and further training information.

For policy questions, contact AHCA Medicaid Hospital Issues at the following email address: Medicaid_Hospital_Issues@ahca.myflorida.com
WE’RE HERE TO HELP

To support our hospitals through this transition, seven dedicated local field representatives are available throughout the state.

Need more assistance? Call Provider Services Call Center at 1-800-289-7799, Option 7 today to schedule a visit with a DRG Field Representative.
WANT MORE INFORMATION? IT’S JUST A TAP AWAY.

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

DRG-specific information and documents can be found on the Florida Web Portal at http://mymedicaid-florida.com under Agency Initiatives → DRG Pricing.

Thank you.