ADMINISTRATIVE POLICY STATEMENT
OHIO MEDICAID

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
10/31/2013	09/08/2017	09/08/2016

Policy Name	Policy Number
All Patient Refined Diagnosis Related Groups ("APR-DRG")	AD-0015

Policy Type		
☐ Medical	☒ Administrative	☐ Payment

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

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A. SUBJECT

All Patient Refined Diagnosis Related Groups ("APR-DRG")

B. BACKGROUND

The Ohio Department of Medicaid (ODM) converted to a Medicaid All Patient Refined, Diagnosis-Related Group prospective payment system (APR-DRG PPS), effective July 1, 2013. The APR-DRG replaced an unsophisticated, 15-year-old, Medicare-based PPS that did not allow ODM to severity-adjust Medicaid discharges for more accurate analysis and payment. The APR-DRG inpatient classification system was chosen 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.

C. 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.
- "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.
- "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.

- "Principal diagnosis" is the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

D. POLICY

I. General

A. Effective for inpatient hospital claims with a discharge date on or after July 1, 2013 and in accordance with ODM's Hospital Payment Policy, CareSource has implemented All Patient Refined Diagnosis Groups (APR-DRGs) grouping and pricing methodology.

B. CareSource will determine DRG codes based on diagnosis codes and other information supplied by the provider and will compute reimbursement amounts based on ODM assigned base rates. CareSource uses MCG® (Milliman Care Guidelines) and CareSource policies for inpatient criteria.

C. APR-DRG payments expand the basic DRG structure by considering the patient's age, severity of illness (SOI) and risk of mortality. 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 and more accurately reflect the increased difficulty and costs of treatment. The APR-DRG will be displayed as four numeric digits. The fourth digit is the SOI indicator.

D. Claims for payment for inpatient hospital services must be submitted on the UB-04 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.

II. Interim Payments

A. 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 5160-2-22 of the Ohio Administrative Code.

III. Medicare Crossover Stays

A. 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.

CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	10/31/2013
Date Reviewed:	10/31/2013, 09/08/2016
Date Revised:	09/08/2016

G. REFERENCES

1. OAC Chapter 5160-2-02
2. http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/HospitalProviderInformation/HospitalPaymentPolicy.aspx

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.