Mississippi Medicaid Bulletin

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Family Planning Waiver: (FP)

Effective October 1, 2003, the Division of Medicaid implemented a Family Planning Service Demonstration Waiver Program. The waiver extends Medicaid coverage of Family Planning Services to women throughout the state that meet certain eligibility criteria. Regarding women eligible for Family Planning Waiver, please remember:

- They will be eligible for Medicaid coverage of family planning services **only**.
- The AVRS eligibility transaction response will identify them as eligible for family planning services only, in Aid Category 029 (FP-W).
- They will be issued a yellow Medicaid card to denote that they are in the Family Planning Demonstration Program.
- They will not be eligible to receive other Medicaid benefits.

In the instance that a woman becomes pregnant while on the Family Planning Waiver, she is held responsible for contacting her nearest Regional Office and applying for COE 88 – which is **Medicaid for pregnant women. This is NOT automatic!**

Beginning July 1, 2006, women applying for Family Planning Waiver must have proof of citizenship. Examples of primary documents that may be used are: a copy of a certified birth certificate, certificate of naturalization, certificate of citizenship, certification of Report of Birth (DS-1350), Certification of Birth Abroad. The applicant will also be responsible for proof of identity.

For more details, please call 601-359-6150 or 1-800-421-2408.

Billing Tip

Please note when billing hardcopy claims that require a prior authorization, **the PA/TAN number must be** placed on the appropriate line in field 63 of the UB-92 claim form. For example, if there is another payer on line A in field locator 50, and Medicaid is listed on line B, the treatment authorization code listed in field 63 should be listed on line B. **Improper alignment could cause claim denial as though no TAN number were located on the UB-92 claims form.**

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Reporting Your NPI to Mississippi Medicaid

Reminder
The National Provider Identifier (NPI) is a unique 10-digit number used to identify health care providers. The NPI eliminates the need for health care professionals to use different numbers when conducting transactions with multiple commercial and government health plans. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all covered entities (i.e., providers, clearinghouses and large health plans) to begin using NPI(s) on standard health care electronic transactions on May 23, 2007.

How do I report my NPI?
If you have obtained your NPI(s) with the certification form from the Centers for Medicare and Medicaid Services (CMS), then you are ready to report your NPI(s) to Mississippi Medicaid. **Please prepare a facsimile cover page and include the following information in transmitting your NPI information to the ACS Provider Enrollment fax number 601-206-3015:**

1. The name of a representative in your organization to be contacted
2. A direct telephone number
3. A fax number
4. Email address
5. A corresponding 8-digit Mississippi Medicaid Provider Number
6. A copy of the NPI CMS certification form

Once the information is received, the provider NPI information will be entered into the Mississippi Medicaid Management Information system (MMIS) and cross-referenced to a corresponding 8-digit Mississippi Medicaid Provider Number.

When do I start using my NPI?
Presently, ACS is designing the modifications to accept the NPI on HIPAA standard transactions. On April 27, 2007, you may begin using your NPI on HIPAA standard transactions. Mississippi Medicaid will continue to accept the 8-digit Mississippi Medicaid Provider Number on HIPAA standard transactions until May 23, 2007. The atypical provider will continue to bill using the 8-digit Mississippi Medicaid Provider Number.

Can I verify my NPI information in *Envision*?
Should you need to verify your NPI information in *Envision*, you may contact the ACS Provider and Beneficiary Support Center at 800-884-3222. ACS is modifying the Mississippi *Envision* Web portal to display your NPI information for verification on the web. Additional information will be provided regarding the date that providers may begin using the Mississippi *Envision* Web Portal for verification of their NPI(s).

How Do I Apply for an NPI?
To apply for an NPI, providers should visit the National Plan and Provider Enumeration System (NPPES) website https://nppes.cms.hhs.gov/NPPES as soon as possible. You may request a paper application by calling 1-800-465-3203.

For More Information…
More information on NPI and how to verify your NPI on the Mississippi *Envision* Web portal will be published in future Provider Bulletins, banner messages, and on the Mississippi *Envision* Web portal http://msmedicaid.acs-inc.com. You may also call the ACS Provider and Beneficiary Support Line at 800-884-3222 with questions.

Correction to the X-12 Mandated for Medicare Crossovers July Bulletin Article

The July 2006 issue of the monthly provider bulletin referred providers to an incorrect loop to send the Medicaid provider number for crossovers. The corrected statement is as follows:

"To maximize processing efficiency, please submit all claims for Mississippi Medicaid beneficiaries to Medicare indicating your Mississippi Medicaid Provider number in loop 2330F loop on X12 crossover claims."

Submission of Minimum Data Set (MDS) Quarterly Assessment

The current Division of Medicaid policy for Quarterly Assessment states:

Full Assessment or MPAF Set of MDS items, mandated by State (contains at least CMS established subset of MDS items).	Must be completed every **ninety (90) days.**

CLARIFICATION: The Medicaid quarterly assessment is required to be submitted not more **than 90 days** from the previously submitted assessment as required under OBRA'97. *The assessment reference date (A3a) of a quarterly assessment should not be less than 80 days and not more than 90 days from the previous assessment. Facilities with Alzheimer Units should only use the Full Assessment for its quarterly assessments.* If you have any questions, please contact Evelyn Silas at 601-359-6750 or the Case Mix Hotline at 601-359-5191.

Pharmacy News

Carbinoxamine

On June 8, 2006, the FDA ordered all manufacturers of unapproved products containing carbinoxamine, including carbinoxamine maleate and carbinoxamine tannate, to cease making the products over the next 30-90 days. For more details, refer to the following websites:

(a) FDA's press release at http://www.fda.gov/bbs/topics/NEWS/2006/NEW01384.html ; and
(b) Carbinoxamine FAQ @ http://www.fda.gov/cder/drug/unapproved_drugs/qa.pdf .

Pediatex® products designated as preferred on the MS Medicaid PDL (effective 4-1-06) retain their preferred status until existing stock in pharmacies is exhausted. Generic carbinoxamine products, currently covered by DOM, will continue to be covered until existing stocks are exhausted. New 'Pediatex ®'formulations, introduced after 4-1-2006, will **NOT** be designated as preferred drugs. The antihistamine category is scheduled for PDL review in April 2007 and preferred drug implementation slated for 7-1-07.

Insulin pen needles for products listed on DOM's PDL

The Pharmacy Bureau routinely receives questions about insulin supplies, in particular pen needles for insulin pens currently listed on DOM's PDL. Syringes and needles are classified as durable medical equipment, or DME, and not pharmacy products. DOM covers many DME and medical supplies through our DME program. Coverage policies for DME, and/or medical supplies are available in our Provider Policy Manual – www.dom.state.ms.us, Click on Provider Manual, then click on Section 10. The provider must be a Mississippi Medicaid DME provider in order to be paid for DME, and/or medical supplies. You may enroll to be a DME provider on-line at http://msmedicaid.acs-inc.com/general/enrollmentOptions.jsp .

The Pharmacy Bureau has prepared a DME billing tips reference guide for pharmacists. This document is available on our webpage at www.dom.state.ms.us, select Pharmacy Services, go to Pharmacy News and select MS Medicaid Insulin Supplies.

Rantidine capsules

Effective August 1, 2006, pharmacy claims submitted for Ranitidine ***capsules*** will deny with NCPDP reject code of' 75-Prior Auth Required' and a Long Description message of 'Ranitidine ***Capsules*** Require Prior Authorization. Use Ranitidine ***Tablets***'. If Ranitidine capsules are medically necessary, a prior authorization request must be submitted to HID. The Preferred Drug List Exception Request form may be found at www.dom.state.ms.us, select Pharmacy Services, and PDL Exception Request Form.

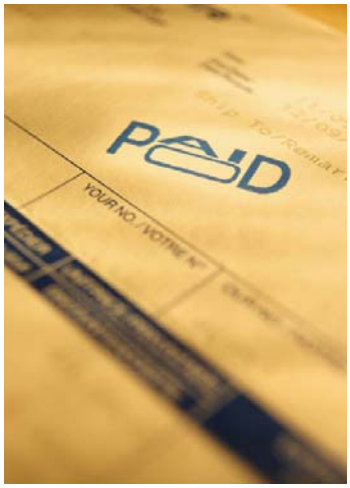
Additions to Products with Quantity Limits

Brand Name	Maximum Quantity per 31 Days[2]	Restrictions	Comments
Restasis ®0.05% Eye Emulsion	64 Maximum Units per month	Minimum Age of 16; claims will deny for < 16 years of age.	64 units = 2 trays of 32 implementation date of 6-5-06
Zelnorm ®2 mg and 6 mg	360 cumulative units[1] per 'calendar year'	If beneficiary AGE is < 12, the claim will deny with NCPDP reject Code of 75- PRIOR AUTHORIZATION REQUIRED**.**	Implementation date 6-05-06
Zelnorm® 2 mg and 6 mg	Quantity Limit for both 2 mg and 6 mg is 2/day	If a higher quantity is billed, the claim will deny with NCPDP reject code of E7-INV QUANTITY DISPENSED- Short Description =' EXCEED DLY DOSE ON CUSTOM[2]	Implementation date 6-22-06
Provigil®100 mg and 200mg	100mg : limit of 1.5 tablets daily; 200mg: limit of 1 tablet daily If a higher quantity is billed, the claim will deny with NCPDP reject code of E7-INV QUANTITY DISPENSED	if age is < **16**, the claim will deny with NCPDP Reject Code of 75-PRIOR AUTH REQUIRED	Implementation date 6-21-06

[1] See page 4 of 'Products with Quantity Limits" list. 'Calendar Year' will be defined as a 'rolling' 12 months, which will BEGIN on the date of the Bene's first claims for Zelnorm® on or after 6-22-2006 * Note that this is a cumulative total and adds both strengths in the 'look back' calculation for Max of 360 units per year.

[2] For greater quantities per month, submit max dose override to HID; see www.hidmsmedicaid.com for form

Billing Tips for Claims with Attachments



When submitting claims with attachments, please utilize the following terminology:

- Other Insurance Denial-TPL DENIAL, SEE ATTACHED
- Medicare Denial- MEDICARE DENIAL, SEE ATTACHED
- Third party payments less than 20% of charges- LESS THAN 20%, PROOF ATTACHED

NOTE: This information should appear on the face of the claim and any attachments should be marked with the recipient's name and Medicaid ID number. Please do not staple attachments more than once as all attachments must be separated prior to filming and batching.

Did you know…..

1. The timely filing transaction control number (TF TCN) is the 17-digit transaction control number (TCN) from the FIRST time the claim adjudicated.

2. Field 29 of the CMS 1500 is for TPL payments only.

3. All professional licenses must be faxed to provider enrollment annually upon renewal.

4. Using correction fluid (white-out) on claims will cause the claim to be returned.

5. The CLIA number goes in field 10d of the CMS 1500.

6. HIPAA mandates electronic claims can only be adjusted electronically.

7. WINASAP is the free MS Medicaid software and can be downloaded at http://msmedicaid.acs-inc.com.

8. Sterilization consent forms must be signed by the beneficiary 30 days prior to the procedure and are only valid for 180 days.

9. If a straight Medicaid claim is filed within the first 12 months of date of service, the provider actually has another 12 months from that date to get the claim paid by using the TF TCN.

10. Crossover claims CANNOT be adjusted only voided.

11. You can print your RA's on Mondays on the Envision web portal at http://msmedicaid.acs-inc.com .

12. The prior authorization number goes in field 23 of the CMS 1500 and field 63 of the UB-92.

13. Claims can be submitted electronically 24/7, 365 days a year.

14. All claims require an original signature or a signature stamp in field 31 of the CMS 1500 and field 85 of the UB-92.

15. The TF TCN can be retrieved from the Envision web portal at http://msmedicaid.acs-inc.com.

16. Crossover claims can be submitted on a CMS 1500 and the UB-92, therefore, eliminating the usage of the crossover form.

17. Policy mandates hospitals complete the New Born ID Form for all babies born to MS Medicaid beneficiaries, and those forms are to be faxed by the hospital to the Regional Offices.

18. Submitting claims electronically reduces claim denials and results in faster claims payment.

19. Timely filing for crossover claims is 180 days from the Medicare payment date.

20. MS Medicaid ID numbers are only nine digits.

21. All policy manuals are available on the Envision web portal at http://msmedicaid.acs-inc.com

22. Children under 21 can receive expanded service limits through the EPSDT program.

23. You can send questions to Provider and Beneficiary Services electronically by logging on to the Envision web portal and choosing the "Ask Provider Relations" link.

24. Electronic claims submitted by 5:00 p.m. Thursday are on the following Monday's RA.

Attention Hospital Providers!

Hospitals, did you miss the "Hospital Inpatient Workshop?" Would you like to obtain the workshop materials? Go to www.dom.state.ms.us for the presentations including Q & A's and rate sheets. In addition, the Q & A's are available on page 7 of this bulletin.

Policy Manual Additions/ Revisions

The following policies and policy sections have been added and/or revised in the DOM Provider Policy Manual. Providers of these services may view these changes by accessing the DOM website at www.dom.state.ms.us and clicking on "Provider Manuals" in the left window.

Manual Section	Policy Section	New	Revised	Effective Date
*25.0 Hospital Inpatient	25.27 Inpatient Per Diem Rates		X	08/01/06
*26.0 Hospital Outpatient	26.23 Outpatient Rates		X	08/01/06
*28.0 Transplants	28.15 Reimbursement		X	08/01/06
50.0 Anesthesia	51.02 Anesthesia Services		X	08/01/06
1.0 Introduction	1.07 Medicaid Regional Office 1.08 Reserved For Future Use 1.09 Utilization Management/Quality Improvement Organization		X X X	09/01/06
2.0 Benefits	2.01 Medicaid Services 2.02 Benefits and Limitations 2.03 Exclusions		X X X	09/01/06
7.0 General Policy	7.03 Maintenance of Records 7.05 Healthcare Practitioner Peer Review Protocol 7.07 Administrative Hearings-Eligibility Decisions		X X X	09/01/06
41.0 Dialysis	41.05 Documentation Requirements		X	09/01/06
53.0 General Medical Policy	53.25 Vagus Nerve Stimulation for Treatment of Depression	X		09/01/06

***Correction: The July 2006 Provider bulletin stated these revisions would be effective 07/01/06. The correct effective date is 08/01/06.**

Claim Exception Codes for EPSDT Providers

Issue	*Description of Issue*	*Resolution*
0434 – Procedure/Age Conflict	The beneficiary's age on the claim does not match the procedure code age range.	Verify beneficiary's age, match with the correct EPSDT screening procedure code, correct claim and resubmit.
3234 – Procedure Code/EPSDT age restriction	For procedure codes 99382, 99392, 99383, 99393, 99384 and 99394, set system to correctly read minimum and maximum age in days, years, etc.	The EPSDT provider should contact their ***provider representative*** regarding denied claims with this edit. The provider representative must review the claim to determine whether edit 3234 posted appropriately. If it is not appropriate, then the provider representative will override this edit for payment.

Split Billing Inpatient Claims

Hospital providers are required to split bill claims for inpatient stays that span the Medicaid fiscal year end of June 30. When split billing a stay which spans a fiscal year, the first claim should be type of bill 112. Occurrence code C3 should be used in field locator 32 of the UB-92 claim form with the occurrence date of June 30. In conjunction with occurrence code C3, occurrence code 42 should be used in field locator 33 of the UB-92 claim form to indicate the occurrence date representing the actual date of discharge for the beneficiary. Patient status code 30 should be entered in field locator 22 since the patient has not been discharged.

Occurrence code C3 should also be used when a Medicaid beneficiary's inpatient days are exhausted during a hospital stay. Occurrence code C3 should be used in field locator 32 of the UB-92 claim form with the date benefits were exhausted. In conjunction with occurrence code C3, occurrence code 42 should be used in field locator 33 of the UB-92 claim form to indicate the occurrence date representing the actual date of discharge for the beneficiary. Patient status code 30 should be entered in field locator 22 since the patient has not been discharged.

A New Inpatient Hospital Payment Method for Mississippi Medicaid

On January 1, 2007, the Mississippi Division of Medicaid will move to a new method of paying for hospital inpatient services. Our goals are to improve access to care, increase fairness to hospitals, reward efficiency, improve purchasing clarity, and reduce administrative burden for both the Division and the hospitals.

This document provides questions and answers about the new method. We invite additional questions and we welcome suggestions. The Division is working with a hospital technical advisory group convened by the Mississippi Hospital Association on questions of payment policy, implementation and provider education.

The New Inpatient Hospital Payment Method

1. What change is being made?

The Mississippi Division of Medicaid will change the method it uses to pay hospitals for inpatient care. Under the new method, hospitals will be paid per stay based on All Patient Refined Diagnosis Related Groups (APR-DRGs).

2. What providers and services will be affected?

The new method will apply to inpatient care in all acute care hospitals, including general hospitals, freestanding mental health hospitals and freestanding rehabilitation hospitals. The following services provided by acute care hospitals are not affected: outpatient care, Medicare crossover claims, and swing bed services. Psychiatric residential treatment facilities and nursing facilities are among the provider types not affected by the new method.

3. How much money is affected?

In the fiscal year that ended June 30, 2006, the Division of Medicaid paid acute care hospitals $514 million for inpatient care (preliminary data). This figure excludes "DSH" payments to hospitals and payments for care received by Medicaid patients for whom Medicare was the primary payer, which are made using a separate crossover payment policy.

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4. How did the previous payment method work?

Inpatient Payment Method Dates		
Method	Dates	Description
Previous	Before 10/1/05	Hospital-specific payment per diem made on interim basis, with cost settlement 2-3 years afterward.
Interim	10/1/05-12/31/06	Hospital-specific payment per diem, without cost settlement
New	As of 1/1/07	DRG-based payment per stay, without cost settlement

Until October 1, 2005, each hospital received an interim payment per day of care. The amount was specific to each hospital and ranged from about $500 a day to about $1,500 a day. The interim payment was based on cost reports filed by hospitals two to three years earlier and was subject to caps by hospital class. (There were five classes, depending on number of beds.) For example, for care provided in June 2005, the hospital would receive an interim payment based on its cost report for 2003. After the hospital submitted its 2003 cost report, the report would be audited by a federal contractor and reviewed by Division staff. After cost settlement, final payment for a service provided in June 2005 would typically be made in 2007 or 2008.

5. What change did the Division make on October 1, 2005?

Effective October 1, 2005, the Division established an interim payment method until the new DRG-based method goes into effect. The interim method is essentially a simplified version of the previous method. Hospitals are still paid per diem, but there is no longer a cost-settlement process. The per-diem rate for each hospital is the hospital's interim rate in RY 2005 unless the hospital's interim RY 2004 rate was higher, in which case the rate is the average of RY 2004 and RY 2005. The rates are adjusted for inflation. Although the interim method is simpler than the previous method, it has many of the same drawbacks as the previous method.

6. Why change to the new payment method?

The Division has five reasons.

- ***Improve access to care.*** Under the new method, the Medicaid payment for a particular inpatient stay will be closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients can expect higher payments, which should improve access to care.

- ***Increase fairness to hospitals.*** Under the previous method, two hospitals were often paid very different amounts for the care of very similar patients. Under the new method, all hospitals will be paid similarly for similar patients.

- ***Reward efficiency.*** Under the previous method, hospitals that became more efficient and decreased cost were penalized with lower payments. Under the new method, hospitals will receive a flat rate for each stay of a given casemix level. If they improve efficiency, they will keep the savings.

- ***Improve purchasing clarity.*** The new method will allow the Division clearer insight into the services being covered. Each stay is assigned to a single DRG with a single payment. DRGs are organized so that each DRG contains stays that are similar both clinically and in terms of hospital resources used.

- ***Reduce administrative burden.*** Under the previous method, delays and adjustments to cost reports and payment rates bedeviled financial planning for both the hospitals and the Division. After a patient was discharged, hospital and Division financial managers had to wait several years before payment for that stay

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was finalized. Under the new method, a hospital will receive final payment for a stay shortly after it submits a claim. As well, the previous method depended on the Division receiving audited hospital cost reports from Medicare contractors. The future accuracy and timeliness of these audits is in question because hardly any Medicare payment now depends on these audits.

7. When will the new method go into effect?

The new method will be used for stays with admission dates on or after January 1, 2007. Claims received after January 1 for stays with admission dates before January 1 will be paid as they are now.

Components of the New Payment Method

8. Overall, how will the new payment method work?

The operation of the new method will be very similar to DRG-based payment methods currently in use by Medicare, BlueCross BlueShield of Mississippi and 34 other state Medicaid programs. Every inpatient stay will be assigned to a single DRG that reflects the difficulty of that case. For example, a patient with pneumonia will be assigned to one DRG and a patient with pneumonia and heart failure will be assigned to a different DRG. For each stay, the DRG base payment equals:

Relative weight for that DRG x base price = DRG base payment

For example, if DRG 1 has a relative weight of 0.75, DRG 2 has a relative weight of 1.5 and the base price is $3,500, then payment is as follows:

DRG 1: 0.75 x $3,500 = $2,625
DRG 2: 1.50 x $3,500 = $5,250

Hospitals are therefore paid more for more difficult cases and less for less difficult cases. At the same time, payment does not depend on the hospital's charges or costs, so the hospital has an incentive to improve efficiency.

9. How will hospitals be protected against the cost of exceptionally expensive cases?

About 5% of payments will be made as "outlier" payments. There will be two types of outlier payments.

- For mental health cases, where exceptionally expensive cases tend to be associated with long lengths of stay, hospitals will be paid additional per-diem amounts for days that exceed the "DRG long-stay threshold," which is expected to be about 20 days. This per-diem amount is called the DRG day outlier amount.

- For all other cases, hospitals will receive "DRG cost outlier payments" for stays where the gap between the hospital's estimated cost and the DRG base payment exceeds a certain amount. The hospital's estimated cost equals the charges for that stay times the hospital-specific cost-to-charge ratio. The cost outlier payment policy is patterned after Medicare's cost outlier policy.

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10. What changes, if any, will be made to disproportionate-share hospital (DSH) payments, medical education payments and payments for capital?

The DRG-based payment method will have no effect on DSH payment policy. No change is being made to the medical education policy. Although the policy will not change, the mechanics of payment will. Medical education payments will be made on a per-stay basis, in place of the per-diem payments currently made. Under DRG-based payment, there will be no separate payment for capital.

11. What other factors might affect payments for individual cases?

As is common in DRG payment methods, there will be special calculations for transfer cases and for situations in which the patient has Medicaid coverage for only part of the stay (e.g., exhausted days).

The Division will pay the same rates to all hospitals, without labor-market adjustments such as Medicare has. This decision will promote access to hospital care in rural areas, since the typical effect of labor-market adjustments is to reduce payments in rural areas.

Overall Payment Levels

12. How will the new payment method affect overall funding to hospitals?

The new method will be implemented on a budget-neutral basis. The base price of the new method will be set so that expected average payment per stay is the same under both the current and the new payment methods. The calculation will include adjustments for expected coding improvement, for the three-day window (see Question 22) and for the rate increase scheduled for October 1, 2006.

13. How will payments to individual hospitals be affected?

For some hospitals, payments will rise while for other hospitals they will fall. When a simulation was done of the new payment method using six months of data from January-June 2004, payments rose by more than 10% for 39 hospitals, rose by less than 10% for 19 hospitals, declined by more than 10% for 26 hospitals and declined by less than 10% for 14 hospitals.

In October 2006, another simulation will be done using more recent data from the January-June 2006 period. That simulation will reflect the final values of the base price, the DRG long-stay threshold, the cost outlier threshold and other payment policies. In November 2006, each hospital will receive the simulation results for its stays.

14. Will the new method apply even to small hospitals? Medicare exempts critical access hospitals from its DRG-based payment method.

The new method will apply to all hospitals. The simulation using January-June 2004 data showed that of 45 Mississippi hospitals with fewer than 50 beds, 36 would see an increase in payments, with 30 of those hospitals seeing an increase of more than 10%. Small hospitals will be protected against exceptionally expensive cases by the outlier features and by the fact that they often transfer complex cases to larger hospitals.

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15. How will mental health stays be paid?

A mental health stay is one that groups to one of the 72 DRGs for treatment of psychiatric and substance abuse conditions. Both general and freestanding hospitals will be paid using the same set of 72 payment rates, with higher payments for more complex stays regardless of setting. The payment rates will equal the national relative weights for each DRG times a policy adjustor times the DRG base price. The policy adjustor recognizes the importance of Medicaid funding in ensuring continued access to acute mental health care in Mississippi. As a result of the policy adjustor, payments to the group of freestanding mental health hospitals will be roughly unchanged while payments to the general hospitals for mental health stays will be close to what they are currently.

Exceptionally long mental health stays—those that exceed a threshold expected to be about 20 days—will be eligible for day outlier payments for each day that exceeds the threshold.

16. How will payments change in future years?

At least annually, the Division will review the base price to determine what change, if any, would be appropriate. The combination of the base price, the number of stays and the average casemix per stay determines the overall level of payments. We will also update the APR-DRG grouping algorithm to include new ICD-9-CM diagnosis and procedure codes.

All Patient Refined Diagnosis Related Groups

17. Why were APR-DRGs chosen? Why not Medicare DRGs?

Medicare DRGs were designed for the Medicare population and are a poor fit for conditions that are especially important in a Medicaid population, such as neonatal medicine, pediatrics, and obstetrics. In the past Medicare said it had plans to redesign its neonatal DRGs, but in 2004 it explicitly said it would not do so and recommended that Medicaid programs not use Medicare DRGs.

Another issue, even for Medicare itself, has been that Medicare DRGs are relatively unsophisticated in reflecting the complications and comorbidities that can have very significant effects on a hospital's costs. For many Medicare DRGs there is only one level of severity. For some, there are two. For APR-DRGs, by contrast, each DRG has four levels of severity. The table below shows an example. As a result, the DRG assignment—and therefore the payment—more closely reflects the difficulty and expense of the case to the hospital. In April 2006, Medicare announced its intention to replace its current grouping algorithm (in use since 1983) with a new grouper based on APR-DRGs.

Example of How Medicare DRGs and APR-DRGs Handle Complications and Comorbidities

Primary Dx = 562.11 Diverticulitis

Primary Px = 45.71 Multiple resection of colon

	Patient 1	Patient 2	Patient 3	Patient 4	Dx Description
Secondary Dx	569.41	569.41	569.41	569.41	Anal ulcer
		560.9	560.9	560.9	Intestinal obstruction
			422.99	422.99	Acute myocarditis
			426.0	426.0	A-V block, complete
				584.9	Acute renal failure
Medicare DRG	149	148	148	148	
APR-DRG	221-1	221-2	221-3	221-4	

Explanation: A hospital has four patients, each with diverticulitis and each of whom undergoes a colon resection. Patient 1 has a single, minor secondary diagnosis. The case is assigned to Medicare DRG 149 and APR-DRG 221-1. Patient 2 has a significant complication, which results in a "higher" DRG and higher payment under both Medicare DRGs and APR-DRGs. Patient 3 has additional complications, resulting in no change to the Medicare DRG but assignment to APR-DRG 221-3. Patient 4 is gravely ill, but the Medicare DRG assignment is unchanged. The APR-DRG assignment is to 221-4, which has a higher weight and higher payment rate than 221-3.

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18. What was done and will be done to verify that APR-DRGs are appropriate for the Mississippi Medicaid population?

The Division hired ACS Government Healthcare Solutions to conduct a thorough assessment of the options. ACS analyzed six months of Mississippi Medicaid claims using three groupers: Medicare DRGs, All Patient DRGs, and All Patient Refined DRGs. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Mississippi data very well, and better than either of the other groupers. The results for the Mississippi Medicaid population were similar to those found in an evaluation of national data that focused on neonatal care. That evaluation, published in the journal *Pediatrics*, is available at no charge at http://pediatrics.aappublications.org/cgi/reprint/103/1/SE1/302.

In October 2006, a second simulation will be done using January-June 2006 data to verify the validity of APR-DRGs, set the base price and other payment parameters, and simulate impacts on a hospital-specific basis.

19. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children's Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. To date, APR-DRGs have been used mostly to adjust for risk in analyzing hospital performance. Examples are the "America's Best Hospitals" list by *U.S. News & World Report*, state "report cards," and analysis done by organizations such as the Agency for Healthcare Research and Quality (AHRQ), the Medicare Payment Advisory Commission (MedPAC) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The State of Maryland uses APR-DRGs for risk adjustment in setting hospital-specific payment rates. Among the payers considering adoption of APR-DRGs for payment purposes are Medicare, Pennsylvania Medicaid, Montana Medicaid and Wellmark, the BlueCross BlueShield plan in Iowa.

20. Does my hospital need to buy APR-DRG software to be paid by Medicaid?

No. The Medicaid claims processing system will assign the DRG and calculate payment without any need for the hospital to put the DRG on the claim. (This was how the January-June 2004 simulation was done using existing data.)

At their option, hospitals can buy APR-DRG software for use in calculating expected payments and managing their own operations. In a letter to the Division dated January 6, 2006, 3M Health Information Systems listed the prices that it would charge Mississippi hospitals for basic APR-DRG software.

- Hospitals with fewer than 1,000 admissions a year: $3,500
- Hospitals with 1,001 to 5,000 admissions a year: $5,800
- Hospitals with 5,001 to 10,000 admissions a year: $8,700
- Hospitals with more than 10,000 admissions a year: Variable scale depending on bed size

Price increases would be limited to an inflation adjustment. 3M also makes the APR-DRG available to other vendors (e.g., Premier, HBOC) so that APR-DRGs can be integrated into their systems.

Hospitals interested in using APR-DRG should contact their information systems vendor. If the vendor is not familiar with APR-DRGs, more information is available at:
www.3m.com/us/healthcare/his/products/coding/refined_drg.jhtml
.

Such decisions are up to the hospital; the Division does not require that hospitals install APR-DRGs nor does the Division or ACS have any financial interest in whether hospitals buy this software.

Impacts on Coding, Billing and Other Hospital Operations

21. How will the new payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly. Hospitals may want to review their inpatient coding and make any necessary improvements as soon as possible. As do other DRG payers, the Division will review claims from hospitals whose claims show a marked increase in average casemix following implementation of DRGs.

22. Will Medicaid use a "three-day window" like Medicare does?

Yes. If a patient is admitted on a Thursday, the hospital should not submit separate outpatient claims for emergency room or other outpatient services provided on Monday, Tuesday or Wednesday. Payment for the inpatient stay is intended to cover all services provided during the stay and during the three-day window before the admission date. The DRG base price will be set so that it reflects payments previously made for both the stay and any outpatient services within the three-day window.

To reduce administrative burden on hospitals, the Division's intention is to apply the three-day window in the same way that Medicare does. Note that this window includes all outpatient services regardless of whether they are directly related to the admission.

23. What will the policy be for interim claims?

Hospitals will not be required to submit interim claims under any circumstances. Unlike many DRG payers, the Division will make interim payments if a hospital chooses to submit an interim claim during an exceptionally long stay. This policy is intended to encourage hospitals to treat patients who may need weeks or months of acute care.

If a stay exceeds a certain threshold (probably 30 days) then the hospital can submit an interim claim (type of bill 112 or 113) and will be paid an interim per diem amount (probably around $475) times the number of days. When the patient is discharged, the hospital would void the interim claims and submit a single admit-thru-discharge claim (type of bill 111). The claims processing system will recover the interim payments and calculate the DRG-based payment for the entire stay.

Claims for "interim—last claim" (type of bill 114) and late charges (type of bill 115) will be denied. Hospitals should use the other bill types as applicable.

24. How will hospitals be paid for newborns?

Starting with dates of admission on January 1, 2007, hospitals should bill each newborn on his or her own claim. (Currently, most newborns are billed on their mother's claim.) As do other DRG payers, Medicaid will make separate payments for the mother and the baby depending on the DRG that is assigned to each stay.

25. What if the patient is not Medicaid-eligible during the entire length of stay?

Medicaid beneficiaries over the age of 20 are subject to a service limit of 30 days of acute hospital inpatient care per state fiscal year (July-June). Other circumstances can cause a patient to be eligible for Medicaid for less than the entire length of stay. Currently, the claims-processing system denies any claim that includes non-covered days.

Under the new payment method, if a patient is eligible for Medicaid and has at least one day left under the service limit, the hospital should submit an admit-thru-discharge claim as it would for any other beneficiary. The claims processing system will price the entire stay using DRG-based logic (including outlier provisions as appropriate) and then prorate the payment using covered days as a percentage of length of stay (e.g., 5/10 = 50%).

26. How will prior authorization be affected?

Changes in prior authorization processes have not yet been finalized. Future versions of this Q&A document will provide final details. At this time, the policy under consideration is as follows:

- Authorization of admission
  - In general, all admissions will continue to need prior authorization from the quality improvement organization (HealthSystems of Mississippi).
  - One exception concerns deliveries. As is true now, an admission for delivery need not be authorized by HSM if the length of stay is less than three days (vaginal delivery) or less than five days (Cesarean). These deliveries, however, must be reported to HSM in order to receive a Treatment Authorization Number (TAN). If the length of stay exceeds two days (vaginal) or four days (Cesarean), the hospital must contact HSM for authorization of the stay and issuance of a TAN.
  - The other exception concerns normal newborns. These admissions do not need to be authorized or reported to HSM. The *Envision* claims processing system will not require a Treatment Authorization Number if:
    - Date of admission = date of birth, and
    - Length of stay is less than five days.

    Sick newborns—those whose length of stay is five days or more—do require authorization from HSM.

- Authorization of length of stay
  - In general, prior approval for the length of stay is not required.
  - If a stay exceeds the "DRG Long Stay Threshold," then the hospital must call the QIO for authorization of additional days. The threshold value will be set in October 2006 but likely will be about 20 days. This requirement will affect less than 5% of all stays but is appropriate because long stays may result in cost or day outlier payments.

Other Questions and Next Steps

27. Will hospitals still have to submit cost reports?

Yes. This is a requirement under federal law. The Division will use cost reports as a data source in the annual review of the base price.

28. Will payments be subject to adjustment after cost reports have been submitted?

No. Payment based on DRG will be final. A major benefit of the new payment method is that payments will not be subject to adjustment two to three years after the date of service.

29. What testing will be done to ensure a smooth implementation?

The new payment method is a major change to the Envision claims processing system and extensive testing will be undertaken. ACS will provide updates to the hospital technical advisory group at monthly meetings. A key step will be the reprocessing of about 50,000 claims in the Envision test system. These claims will also be used in a separate simulation of the new payment method, thereby enabling claim-by-claim verification of payment calculations.

As well, hospitals that would like to submit beta test claims to ACS are welcome to do so. Interested hospitals are asked to call ACS by September 15; see the contact information under Question 31.

30. What will Medicaid do to educate and train hospitals about the new payment method?

Workshops for hospitals are occurred from 10:00 am to 2:00 pm in Grenada on July 12, Jackson on July 14, and Hattiesburg on July 18. Additional workshops will be scheduled for November 2006.

Training materials from those workshops will be available on the Division's provider relations website, http://msmedicaid.acs-inc.com. The website will also include updates of this Q&A document and examples of how claims will be priced under a wide range of scenarios.

In November 2006, each hospital will be sent claim-by-claim information about how the January-June 2006 data simulation affected it.

For each hospital, the Medicaid field representative assigned to that area will be the primary source of information.

31. Who can I contact for more information?

- ***Questions about provider education.*** The Medicaid field representative assigned to your hospital. If you don't have the contact information, contact Suzanne Danilson, Provider and Beneficiary Services Manager, ACS Government Healthcare Solutions, suzanne.danilson@acs-inc.com, 601-206-2936.

- ***Questions about submitting beta claims.*** Darrell Bullocks, Business Analyst, ACS Government Healthcare Solutions, darrell.bullocks@acs-inc.com, 601-206-2992.

- ***Technical questions about APR-DRGs, outliers, etc.*** Kevin Quinn, Director, Payment Method Development, ACS Government Healthcare Solutions, kevin.quinn@acs-inc.com, 406-457-9550.

- ***Questions about Division policy.*** Margaret King, Director, Bureau of Reimbursement, Division of Medicaid, rbmck@medicaid.state.ms.us, 601-359-6155.

- ***Questions about the hospital technical advisory group.*** Mary Patterson, Vice President, Mississippi Hospital Association, mpatterson@mhanet.org, 800-289-8884.

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Mississippi Medicaid Manuals
are on the Web
www.dom.state.ms.us
And
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

August

August 2006

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
		1	2	3 **EDI Cut Off 5:00 p.m.**	4	5
6	7 CHECKWRITE	8	9	10 **EDI Cut Off 5:00 p.m.**	11	12
13	14 CHECKWRITE	15	16	17 **EDI Cut Off 5:00 p.m.**	18	19
20	21 CHECKWRITE	22	23	24 **EDI Cut Off 5:00 p.m.**	25	26
27	28 CHECKWRITE	29	30	31 **EDI Cut Off 5:00 p.m.**		

Checkwrites and Remittance Advices are dated every Monday. The Remittance Advice is available for download each Monday morning at http://msmedicaid.acs-inc.com while funds are not transferred until the following Thursday.