Diagnosis Related Group (DRG)

The DRG system classifies patients into clinically consistent groups with similar length-of-stay (LOS) patterns and utilization of hospital resources. Payment for an acute hospital stay is based on these groups which are comprised of diagnosis codes and procedure codes reported by the provider. All acute hospital stays within a particular DRG are paid the same base DRG rate.

Claims are grouped using the Medicare Severity Diagnosis Related Group (MS-DRG) grouper, a software that uses ICD-9-CM diagnosis and procedure codes submitted on the claim to assign an acute hospital stay to a particular DRG. Claims are assigned a DRG using the grouper effective for the discharge date of the claim. A reimbursement amount is assigned to each DRG through an annual re-weighting process using Blue Cross Blue Shield of North Dakota (BCBSND) claims history.

Present on Admission (POA) Indicator

BCBSND requires all acute care hospitals to report Present on Admission (POA) indicators for each diagnosis code on inpatient claims. According to the official POA reporting guidelines, located in Appendix I of the ICD-9-CM coding guidelines, “Present on admission is defined as present at the time the order for inpatient admission occurs - conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.”
For additional clarification on how to assign the appropriate POA indicator, reference the official present on admission reporting guidelines, located in Appendix I of the ICD-9-CM coding guidelines. The POA indicator is reported on the UB-04 in the eighth digit of Form Locator (FL) 67 for the principal diagnosis and the eighth digit of FL 67 A-Q for each corresponding secondary diagnosis code. POA indicators may affect payment for hospital acquired conditions.

**Transfers**
Claims for a patient transferred to another facility must report the appropriate transfer discharge status. Reimbursement for a transfer from an acute hospital to another acute hospital will be a per diem rate up to the full DRG rate. The per diem is calculated by taking the DRG rate divided by the average length of stay for that DRG. The first day will be reimbursed twice the per diem rate with subsequent days receiving a single per diem amount not to exceed the total DRG.

**Outliers**
The outlier methodology applied depends on the hospital categorization of the provider (urban or non-urban). The hospital categorization is identified in the institutional reimbursement notice sent annually with the fee schedules.

**Urban Hospital Outlier Methodology**
Claims that reach charges greater than the DRG-specific outlier threshold amount are eligible for an outlier payment. Outlier thresholds are included in the current DRG fee schedule. Updated fee schedules are sent to providers each October with a January effective date. An example of the urban outlier calculation is provided below. Dollar amounts do not reflect current fee schedule or outlier threshold rates.

Example of urban outlier calculation:
Charges = $75,000
DRG rate 240 = $22,000
Outlier Threshold = $58,000

<table>
<thead>
<tr>
<th>Charges</th>
<th>$75,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outlier threshold</td>
<td>$58,000</td>
</tr>
<tr>
<td>Difference</td>
<td>$17,000</td>
</tr>
<tr>
<td>X 80%</td>
<td>$13,600</td>
</tr>
<tr>
<td>Additional Outlier Payment</td>
<td>$13,600</td>
</tr>
<tr>
<td>DRG Rate</td>
<td>$22,000</td>
</tr>
<tr>
<td>Total Payment</td>
<td>$35,600</td>
</tr>
</tbody>
</table>
Non-Urban Hospital Outlier Methodology
Claims with length of stays (LOS) greater than the DRG specific LOS threshold are eligible for an outlier payment. LOS thresholds are included in the current DRG fee schedule. Updated fee schedules are sent to providers each October with a January effective date. An example of the non-urban outlier calculation is provided below. The dollar amounts and LOS figures do not reflect current fee schedule LOS thresholds.

Example of non-urban outlier calculation:
Actual LOS = 6 days
LOS Threshold 195 = 5.5
Charges = $10,000
DRG rate 195 = $6,000

Charges $10,000
DRG Rate - 6,000
Difference $ 4,000

X 80%
Additional Outlier Payment $ 3,200
DRG rate + 6,000
Total Payment $ 9,200

Billing Guidelines
1. Submit claims on the UB-04 claim form with type of bill 111 (Hospital/Inpatient/Admit thru Discharge claim). DRG claims do not allow interim bills.

2. Report appropriate ICD-9-CM diagnosis codes in FL 67, 67A-Q, 69 and 72A-C.
   - 67 Principal diagnosis code. The 8th digit of the field (shaded area) is for the POA Indicator.
   - 67A-Q Secondary diagnosis fields. The 8th digit of the field (shaded area) is for the POA indicator.
   - 69 Admitting diagnosis code
   - 72A-C External cause of injury (ECI) code and POA indicator

3. All acute care hospital admissions must report the POA indicator in FL 67, 67A-Q in the shaded area corresponding to the 8th digit. The six reporting options for all diagnoses are:
   - Y (Yes) – Present at the time of inpatient admission
   - N (No) – Not present at the time of inpatient admission
   - U (No Information in the Record) – Documentation is insufficient to determine if condition is present on admission
   - W (Clinically Undetermined) – Provider is unable to clinically determine whether condition was present on admission or not
   - Space (exempt from POA reporting-for use on 837)
   - 1 (exempt from POA reporting-for use on UB-04)

4. Report ICD-9-CM procedure codes and date in FL 74 and 74A-E.
5. Report charges associated with each revenue code.

**Note:** The revenue codes listed below are not allowed on an inpatient DRG claim. Claims will be returned if one of the following revenue codes is submitted:
- Rev. 0273 – Take Home Supplies
- Rev. 0274 – Prosthetic/Orthotic Devices
- Rev. 029X – Durable Medical Equipment (Other Than Rental)
- Rev. 051X – Clinic
- Rev. 052X – Free-Standing Clinic
- Rev. 053X – Osteopathic Services
- Rev. 054X – Ambulance
- Rev. 0912 – Partial Hospitalization

6. Report the appropriate discharge status in FL 17.

7. The Statement Covers Period From date in Form Locator 6 (“From” Date) is distinctly different than the Admission Date in Form Locator 12 (“Admit” Date). There are times when these dates may be the same but there are also situations when these dates may be different.

The Admit Date is the date the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims whether the claim is an initial, interim or final bill. The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included on the claim. The “From” date should be the earliest date of service on the bill.

8. If the patient has a leave of absence (LOA) during the inpatient stay, the LOA day must be identified with revenue code 018X and units equal to the number of LOA days. Following are examples of how to count LOA days:

- If the patient leaves the hospital on Saturday afternoon and returns on Sunday afternoon, there is no LOA as the patient received services on both days.
- If the patient leaves the hospital on Saturday afternoon and returns on Monday afternoon, one LOA day should be billed.