



APR-DRG Billing Guidelines

Effective: July 1, 2015



Acute Inpatient (APR-DRGs) – Hospital Billing

Table of Contents

APR-DRGs	1
Present on Admission (POA) Indicator	1
Coding Elements	1
Transfer Cases	2
Outlier Cases	2
Billing Guidelines	4

Acute Inpatient (APR-DRGs) – Hospital Billing

APR-DRGs

The APR-DRG classification system classifies patients into clinically meaningful groups that account for the severity of illness and risk of mortality. APR-DRGs also help to provide an accurate and consistent way to compare provider performance. Here are some of the elements available within the APR-DRG classification system:

- Quality and cost improvement
- Outcomes and performance measurement
- Clinical and operational redesign and improvement
- Documentation and coding improvement
- Financial and strategic planning
- Evaluation of resource needs

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 1 of the ICD-9-CM coding guidelines and also in Appendix 1 of the ICD-10-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 guidance on the use of the POA indicator, please refer to Appendix 1 of either the ICD-9-CM or the ICD-10-CM coding guidelines.

POA indicators may affect payment for hospital acquired conditions.

Coding Elements

The following discharge data elements are used for APR-DRG subclass assignment:

- Principal diagnosis coded in ICD-9-CM/ICD-10-CM
- Principal procedure coded in ICD-9-CM/ICD-10-CM
- Secondary diagnoses coded in ICD-9-CM/ICD-10-CM
- Secondary procedures coded in ICD-9-CM/ICD-10-CM

- Age
- Sex
- Birth weight (value or ICD-9-CM/ICD-10-CM code)
- Admit Date
- Discharge Date
- Status of discharge
- Days on mechanical ventilator (value or ICD-9-CM/ICD-10-CM code)

If claims are submitted without all of this information, or at least the fields that are appropriate to the claim, the processing of the claim could be delayed or in some cases, denied.

Transfer Cases

Transfers include any inpatient cases with a discharge status of a transfer to another short term acute care facility (02 and 05). Transfer cases are paid on a per diem basis. The APR-DRG per diem conversion is calculated as follows: Base Rate*APR-DRG weight/Network Average Length of Stay. The transfer per diem payment is calculated as follows: Observed LOS for a transfer case*calculated per diem conversion. Final payment is the lesser of per diem or acute payment.

Example: DRG 53, Severity Level 2

Regular Case Payment Base Rate (\$12,011) * APR Weight (0.6423) =
\$7,715

Per Diem Payment [Acute Payment \$7,715 / Network APR-DRG LOS
(2.8 Days)] * Actual Transfer LOS (2 Days) = \$5,511

Lesser of Regular Case Payment (1) or Per Diem Payment (2) = \$5,511

Outlier Cases

Outlier payments are designed to pay providers an additional amount, over and above the DRG payment, for those cases that fall outside of pre-established thresholds. Under the MS-DRG system, there was an outlier payment calculation for urban facilities and an

outlier payment method for non-urban facilities. In both formula's, the providers received an additional payment equal to 80% of actual charges – outlier threshold.

Under APR-DRGs, outlier payments will be based on cost, rather than charges. The formula for determining outlier cases is as follows:

If (Charge x Overall Hospital Ratio of Cost to Charges (RCC) > Outlier Cost Threshold) then Outlier.

The Overall Hospital RCC was based on the provider's filed Medicare Cost Report – Worksheet C in the June 2014 HCRIS file.

Example: DRG 53, Severity Level 2

1. Calculation of Case Cost –

$$\text{Facility Charges } (\$37,500) * \text{Overall Hospital RCC } (0.7162) = \$26,858$$

2. Outlier Payment –

$$\text{Case Cost } (\$26,858) - \text{Outlier Cost Threshold } (\$21,808) = \$5,050$$

3. APR-DRG Case Rate –

$$\text{Case Weight } (0.6423) * \text{Base Rate } (\$12,011) = \$7,715$$

4. Final Outlier Case Payment –

$$\text{APR-DRG Case Rate } (\$7,715) + \text{Outlier Payment } (\$5,050) = \$12,765$$

Billing Guidelines

1. Submit claims on the UB-04 claim form with Bill Type 111 (Hospital/Inpatient/Admit thru Discharge Date Claim). Claims that are paid based on an APR-DRG are not eligible for interim billing.
2. Report appropriate ICD-9-CM/ICD-10-CM diagnosis codes in FL 67, 67 A-Q, 69 and 72 A-C.
 - 67 Principal diagnosis code. The 8th digit of the field (shaded area) is for the POA indicator.
 - 67 A-Q Secondary diagnosis fields. The 8th digit of the field (shaded area) is for the POA indicator.
 - 69 Admitting diagnosis code.
 - 72 A-C External cause of injury (ECI) code and POA indicator
3. All acute care hospitals must report the POA indicator in FL 67, 67 A-Q in the shaded area corresponding to the 8th digit. The reporting options for all diagnoses are:
 - Y – Yes: Present at the time of admission
 - N – No: Not present at the time of admission
 - U – No Information in the Record: Documentation is insufficient to determine if condition was present on admission or not.
 - W – Clinically Undetermined: Provider is unable to clinically determine whether condition was present on admission or not.
 - Unreported/Not Used or “1” – Exempt from POA reporting
4. Report ICD-9-CM or ICD-10-CM procedure codes and date in FL 74 and 74 A-E.
5. Report changes associated with each Revenue Code.

Note: The revenue codes listed below are not allowed on an inpatient APR-DRG claim. Claims will be returned if one of the following revenue codes is submitted:

Rev Code 0273 – Take Home Supplies

Rev Code 0274 – Prosthetic/Orthotic Devices

Rev Code 029X – Durable Medical Equipment (Other than Rental)

Rev Code 051X – Clinic

Rev Code 052X – Free Standing Clinic

Rev Code 053X – Osteopathic Services

Rev Code 054X – Ambulance

Rev Code 0912 – Partial Hospitalization

6. Report the appropriate discharge status in FL 17.
7. The Statement Covers Period From date in FL6 (“From” Date) is distinctly different than the Admission Date in FL 12 (“Admit” Date). There are times when these dates may be the same, but there are situations when these dates may be different.

The Admit Date is the date that the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims. 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(s) must be identified with Revenue Code 018X and units equal to the number of LOA days. The following are a couple of examples on 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 (1) LOA day should be billed.