ALL PATIENT REFINED DIAGNOSIS RELATED GROUP (APR DRG) TRAINING

JANUARY 2019

Wyoming Department of Health

NAVIGANT

AGENDA

- Wyoming Medicaid's Implementation of APR DRGs
- APR DRG Overview
- Wyoming Medicaid APR DRG Policy Decisions
- APR DRG Payment Methodology
- Pricing Examples
- APR DRG Calculator
- Prior Authorization Under APR DRGs
- Sample Remittance Advice
- Helpful Suggestions and Resources

GENERAL HOUSEKEEPING

- Please mute your line if not asking a question
- To avoid background music, please do not place your phone on hold
- A recording and copy of this training will be available on Conduent's Provider Portal: *https://wymedicaid.portal.conduent.com/provider_home.html*

WYOMING MEDICAID'S IMPLEMENTATION OF DRGS

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WELCOME

Wyoming Medicaid is transitioning from the current Level of Care (LOC) inpatient reimbursement methodology to an All Patient Refined Diagnosis-Related Grouping (APR DRG) methodology, effective for claims with a discharge date of February 1, 2019 or after.

The new DRG payment system will not change the methodology for calculating Qualified Rate Adjustment payments or payments under the Private Hospital Supplemental Payment Program.

WDH engaged Navigant to assist in the development and implementation of an APR DRG reimbursement methodology.

OVERVIEW OF DEVELOPMENT OF WYOMING MEDICAID'S APR DRG METHODOLOGY

- The Wyoming Department of Health convened a Technical Advisory Group (TAG) which:
  - Consisted of a wide range of providers (general, psychiatric hospitals and Critical Access Hospitals)
  - Provided input and insights on key decisions throughout the project (three meetings)
- Key Project Milestones:

Date	Milestone
July 2017	All provider meeting introducing APR DRGs and project timeline
July 2017	First TAG meeting
October 2017	Second TAG meeting
November 2017	Third TAG meeting
January 2018	All provider meeting sharing final model and rates
May 2018	Provider trainings (APR DRG calculations, APR DRG calculator tool, etc.)
January, 2019	Provider trainings (APR DRG calculations, APR DRG calculator tool, etc.)
February 1, 2019	Go-live date (based on claim discharge date; SPA posted for public comment; requires CMS approval; if the SPA is not approved by February 1, the current LOC will continue and affected claims re-processed as DRG once CMS approval has been granted)

APR DRG OVERVIEW

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WHAT ARE DRGS?

- Diagnosis-related groups (DRGs) are used by providers and payers to classify patients into clinically-related “groups” for inpatient services.
  - If two patients had the same DRG, they had similar diagnoses and procedures
  - Example: DRG #420 – Diabetes

- DRGs allow providers and payers to categorize complex patient claims data for analysis and payment.

DRG GROUPER VERSION

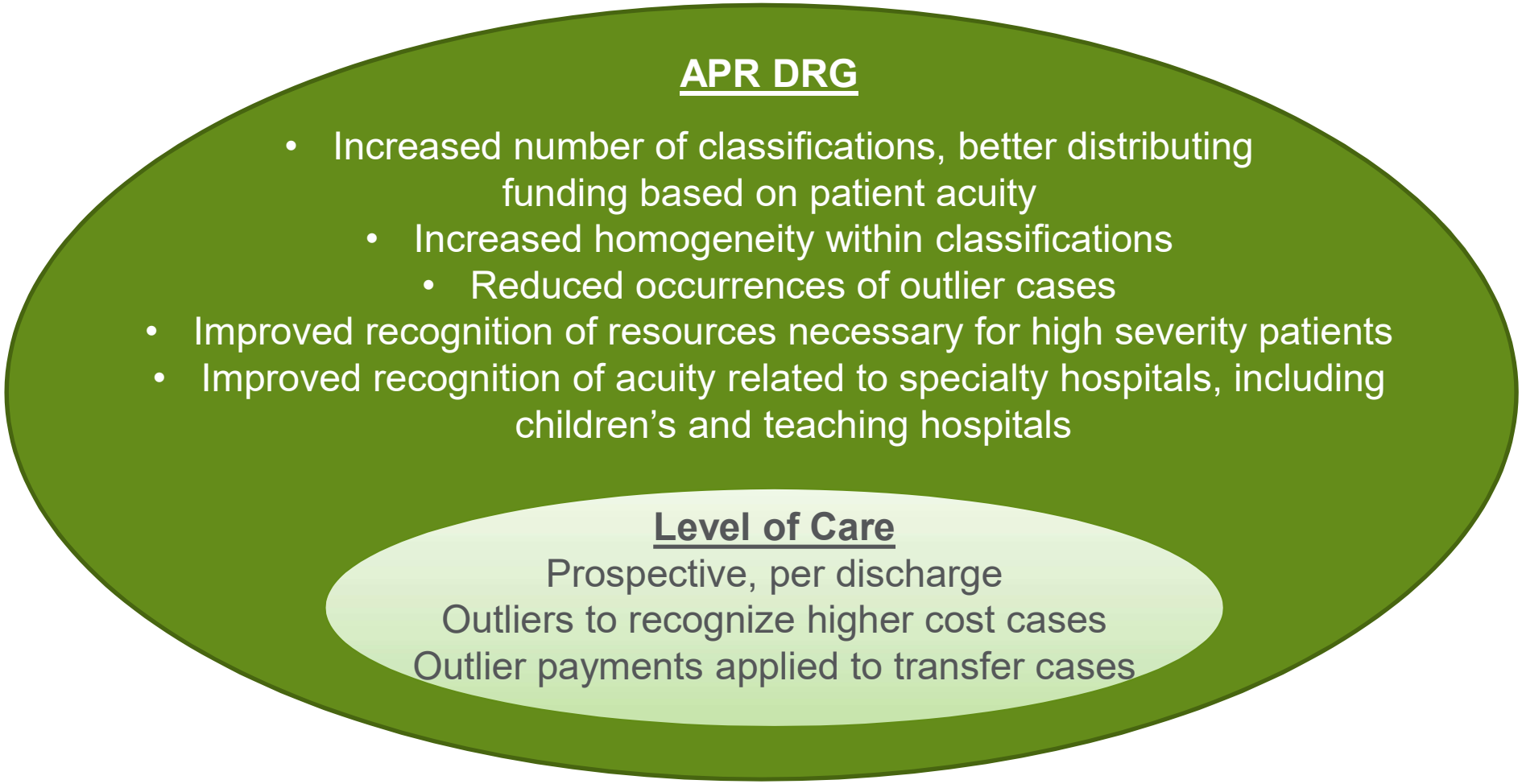
Wyoming Medicaid Decision: Use APR DRG Grouper

- Medicare-Severity DRGs (**MS-DRGs**): publicly available product designed for elderly population with 754 groups
- All-Patient Refined DRGs (**APR DRGs**): 3M propriety product designed for all patient populations

- Contain DRGs for all patient ages, including a large set of DRGs for newborns

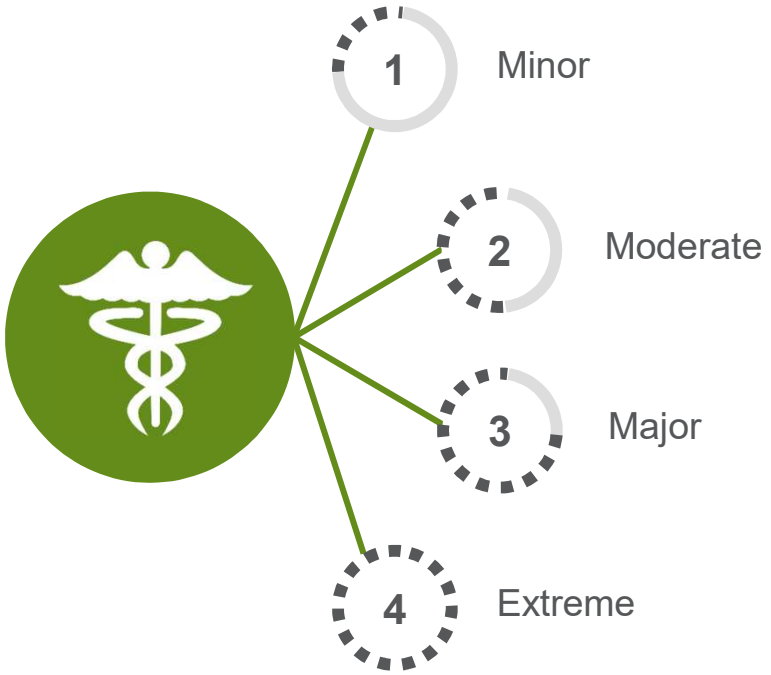
3M™ APR DRG version 33 has been available since October 2015, is ICD-10 compliant and has 1,256 different DRGs.

BENEFITS OF USING APR DRGs VERSUS THE LEVEL OF CARE



CHARACTERISTICS OF DRG PAYMENT

- APR DRG version 33 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 1,256 separate DRG codes and relative weights. The number of DRG codes is subject to change.
- There are two additional “ungroupable” DRGs (assignment due to grouping error)
- APR DRG groupings and weights updated annually prior to the start of the Federal Fiscal Year



EXAMPLE OF SUBCLASS PROGRESSION OF DIAGNOSES

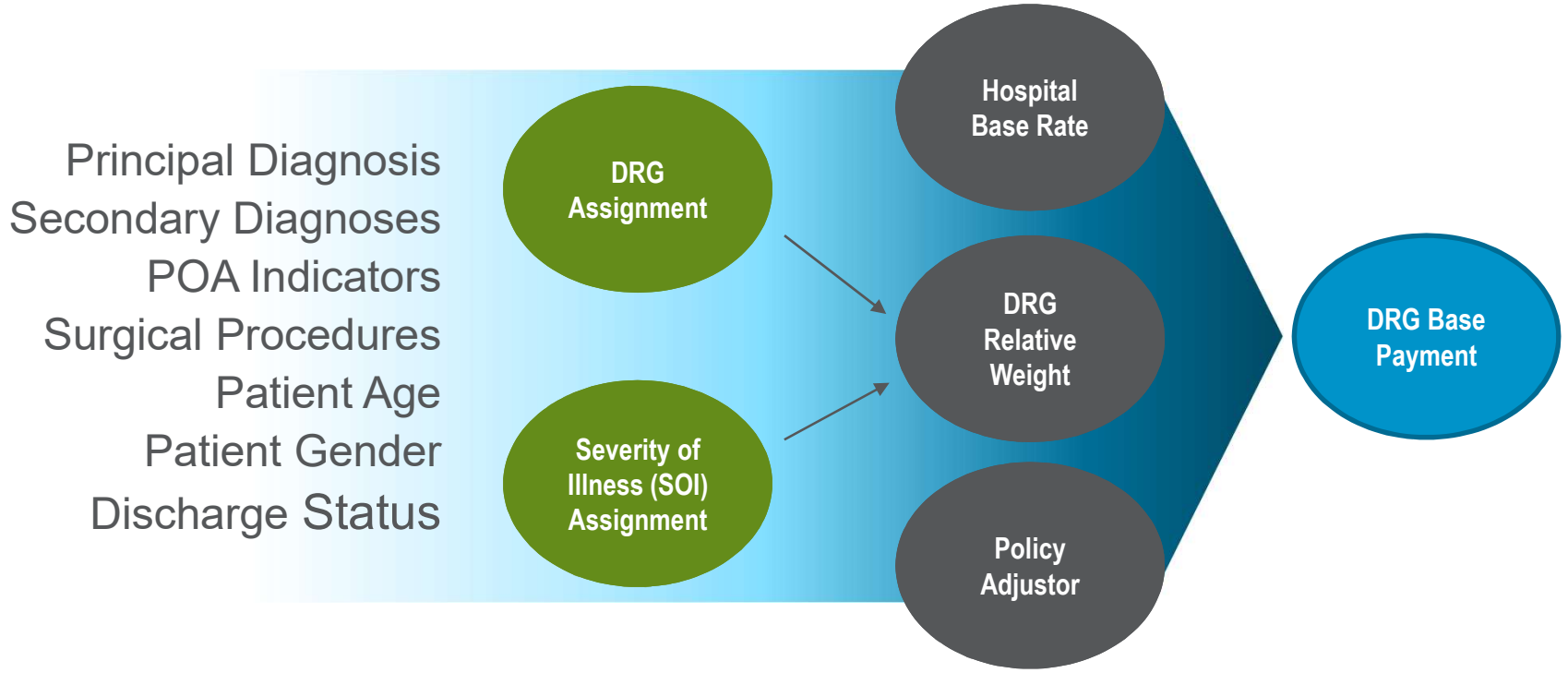
APR DRG 420: Diabetes			
SOI		Secondary Diagnosis	Rel Wt (V33)
1	Minor	Type 1 diabetes mellitus without complications (E10.9)	0.388
2	Moderate	Type 1 diabetes mellitus with hyperglycemia (E10.65)	0.505
3	Major	Type 1 diabetes mellitus with ketoacidosis without coma (E10.10)	0.789
4	Severe	Type 1 diabetes mellitus with ketoacidosis with coma (E10.11)	2.217

CHARACTERISTICS OF DRG PAYMENT

- DRG weights represent the relative resources necessary to treat an inpatient stay with a national average of 1.0
  - A DRG with a national weight less than 1.0 indicates lower than average relative resources are required for the stay
  - A DRG with a national weight greater than 1.0 indicates larger than average relative resources are required for the stay
- For example:
  - If a hospital base rate is $3,000 and a claim has a DRG relative weight is 0.50, then the hospital's DRG base payment is $1,500.
  - Similarly, if the DRG relative weight is 2.0, then the hospital's DRG base payment is $6,000.
- WDH will use 3M's "standard" APR DRG national weights, which are based on two years of Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample discharges (over 15 million, including Wyoming data)

ASSIGNING A DRG CODE AND PRICE TO A CLAIM

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 accurate and defensible. This includes entry of specific admission details, such as newborn birth weight using Value Code 54 on the claim form.

QUESTIONS ON APR DRG OVERVIEW?

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POLICY DECISIONS

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OVERVIEW OF POLICY DECISIONS

PRESENTED DURING THE JANUARY 2018 ALL-PROVIDER MEETING AND THE MAY 2018 ALL-PROVIDER TRAINING

This table summarizes WDH's APR DRG-related policy decisions. The January 25, 2018, All-Provider Meeting materials gave additional information on policy decisions.

Policy	Decision
1. DRG Grouper	APR-DRG 3M™ (version 33)
2. DRG Relative Weights	3M™ National Weights
3. Outlier Payment Policy	Consistent with current practice
4. Transfer Payment Policy	Consistent with current practice
5. Partial Eligibility	Continue current practice
6. Capital Payment	Continue current practice
7. Hospital Acquired Conditions (HAC)	Use Medicaid HAC (version 36) logic
8. Interim Claims	Continue current practice

OVERVIEW OF POLICY DECISIONS *(CONTINUED)*
PRESENTED JANUARY 25, 2018, ALL PROVIDER MEETING

Policy	Decision
9. Payment for Specialty Providers	Continue per diem rate for rehabilitation levels of care (no change)
10. Payment for Specialty Services	For transplants, target 100 percent of estimated costs (using billed charges multiplied by hospital-specific CCR)
11. Budget Goal	Budget neutral, in aggregate
12. Hospital Base Rates (adjusted in the first year of implementation to reflect the transitional corridor payment approach)	• In-State Level II Trauma Centers - two provider-specific rates • Freestanding Psychiatric Hospitals - one provider-specific rate • All Other Providers - one peer group rate

OVERVIEW OF POLICY DECISIONS *(CONTINUED)*
PRESENTED JANUARY 25, 2018, ALL PROVIDER MEETING

Policy	Decision
13. Targeted Policy Adjustors	• Obstetrics: 1.50 • Normal Newborn: 1.90 • Mental Health and Substance Abuse (adult and pediatric): 1.20 • Age Adjustor: 1.30 (WY pediatric <19 years old)
14. Transitional Period	Corridor payment approach (+5% / -4%) based on modeling of two years of claims data
15. Documentation and Coding Improvement (DCI) Adjustment	Adjust base rates to reflect an anticipated five percent DCI increase; monitor and make additional adjustments if needed

QUESTIONS ON POLICY DECISIONS?

APR DRG PAYMENT METHODOLOGY

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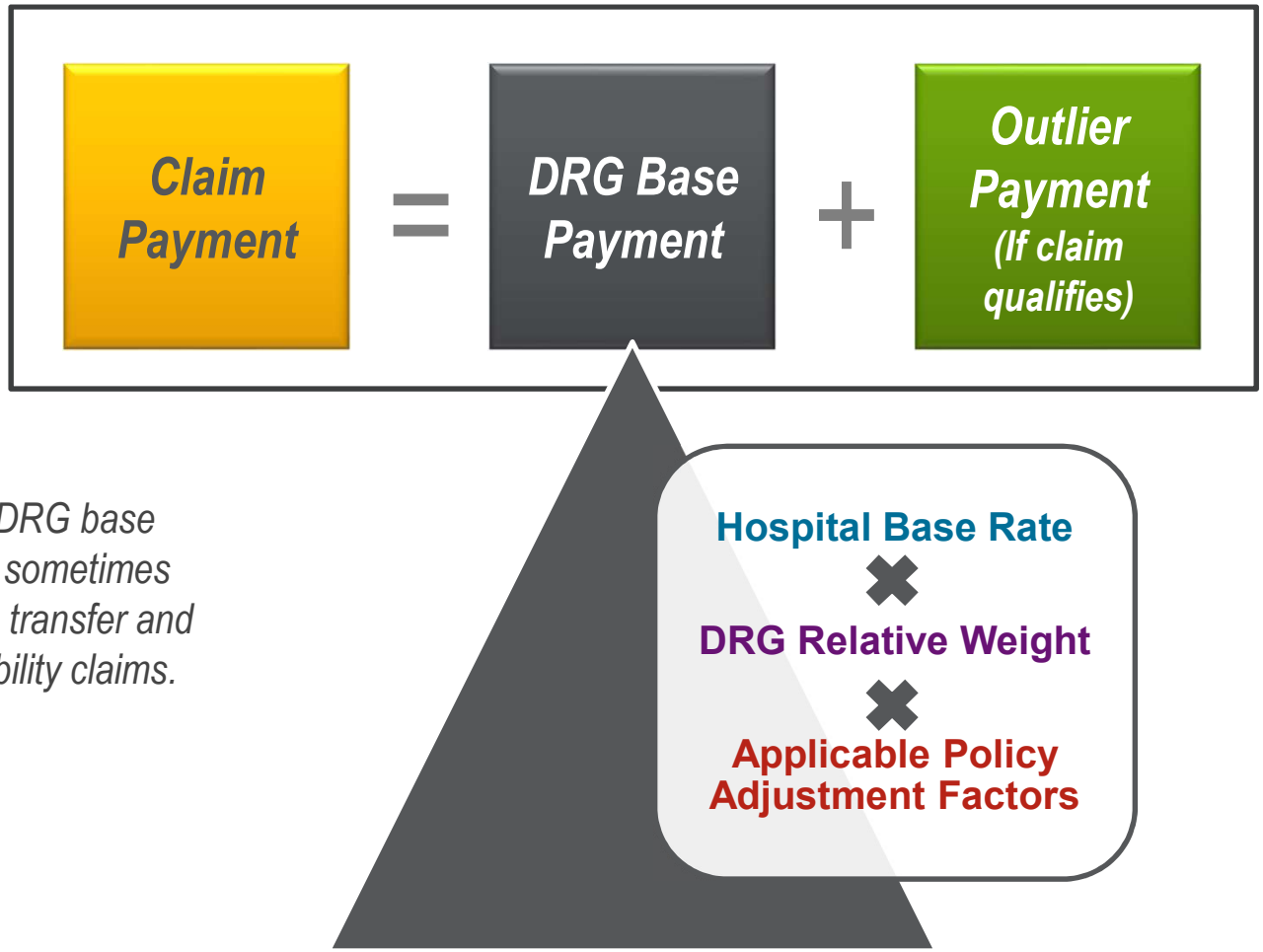
APR DRG CLAIM PAYMENT



Note: *The DRG base payment is sometimes reduced on transfer and partial eligibility claims.*

APR DRG BASE RATE DETERMINATION

APR DRG base rates use a combination of provider-specific rates and a peer group

In-State Level II Trauma Centers – two provider-specific rates

Free-standing Psychiatric Hospitals – one provider-specific rate

All Other Participating Providers – one peer-group rate

Category	Level II Trauma Provider A	Level II Trauma Provider B	Free-Standing Psych	All Other Providers
Base Rate	$9,223.30	$7,239.50	$7,034.52	$8,747.93
Stays	2,831	2,684	688	10,853
APR-DRG Case Mix	0.5662	0.6867	0.5577	0.6615
Model Outlier Percent w/o capital	4.2%	7.8%	2.7%	8.1%

Note: Data based on SFY 2016-2017 claims. For the first year of implementation, the rates will vary by provider to reflect the transitional corridor.

A TRANSITIONAL CORRIDOR WILL BE USED FOR THE FIRST YEAR OF DRG IMPLEMENTATION

Overview:

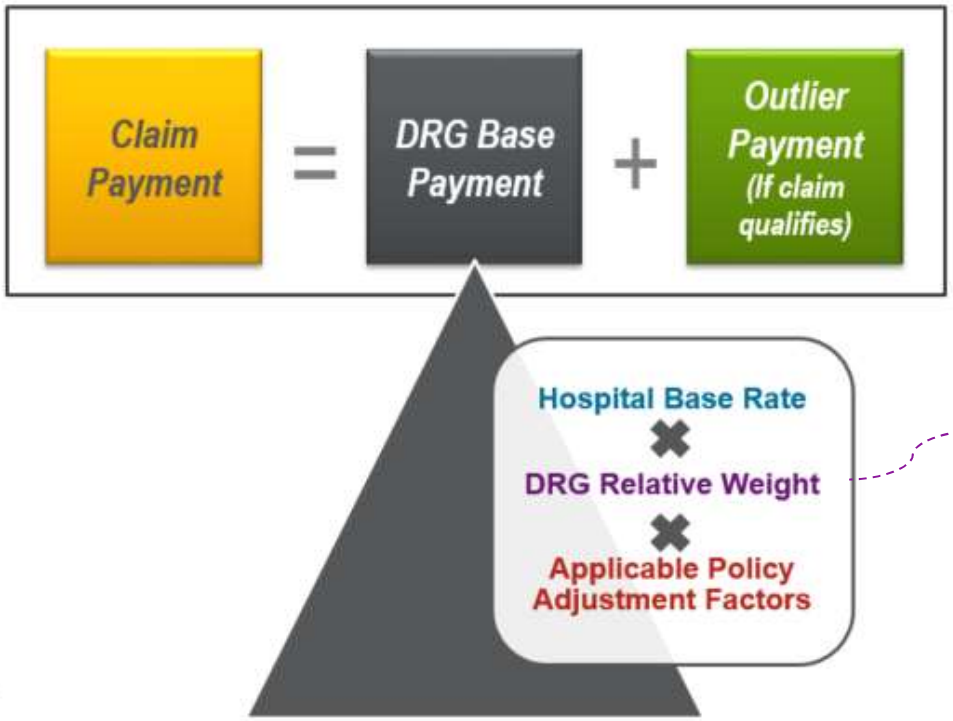
- In year one of APR DRG reimbursement, a transitional corridor is applied to the base rates, modeling no more than a 5% increase or 4% decrease in overall payments relative to Level of Care payment methodology (using SFY 2016 and SFY 2017 claims data)
- Providers outside of the adjustment corridor that are at or above 100 percent of estimated costs are not eligible for a corridor adjustment

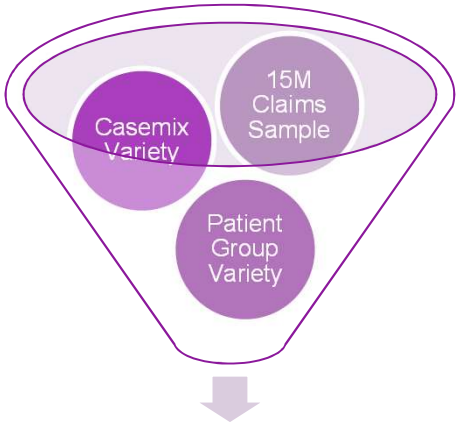
Purpose:

- Decrease risks caused by the initial payment methodology transition
- Allow time for provider budget planning

Notification: WDH provided transitional base rates for all participating providers as part of the all-provider meeting in January 2018

APR DRG BASE PAYMENT *(CONTINUED)*

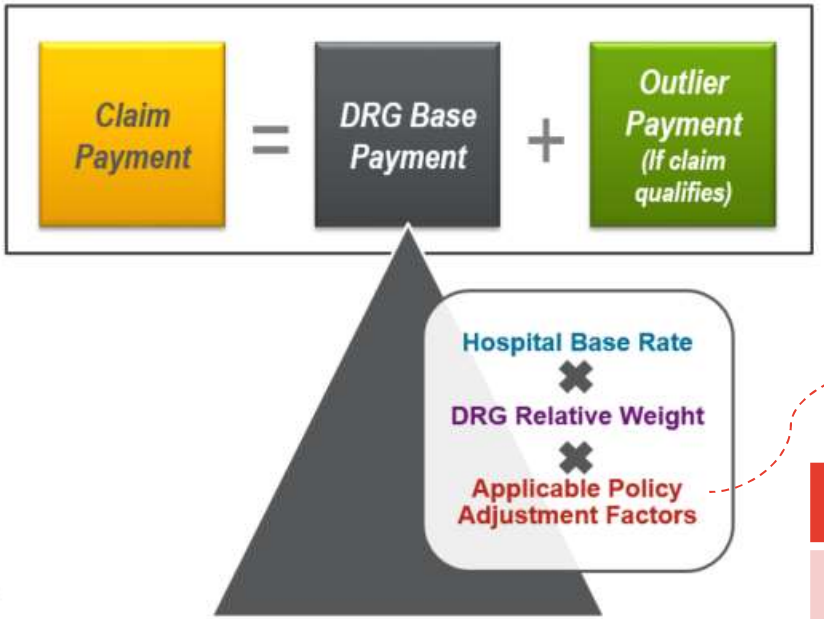




DRG Relative Weight

- Value determined by 3M™ from a nationwide sampling of more than 15,000,000 inpatient claims.
- Represent the average resource requirements for a DRG.

APR DRG BASE PAYMENT *(CONTINUED)*

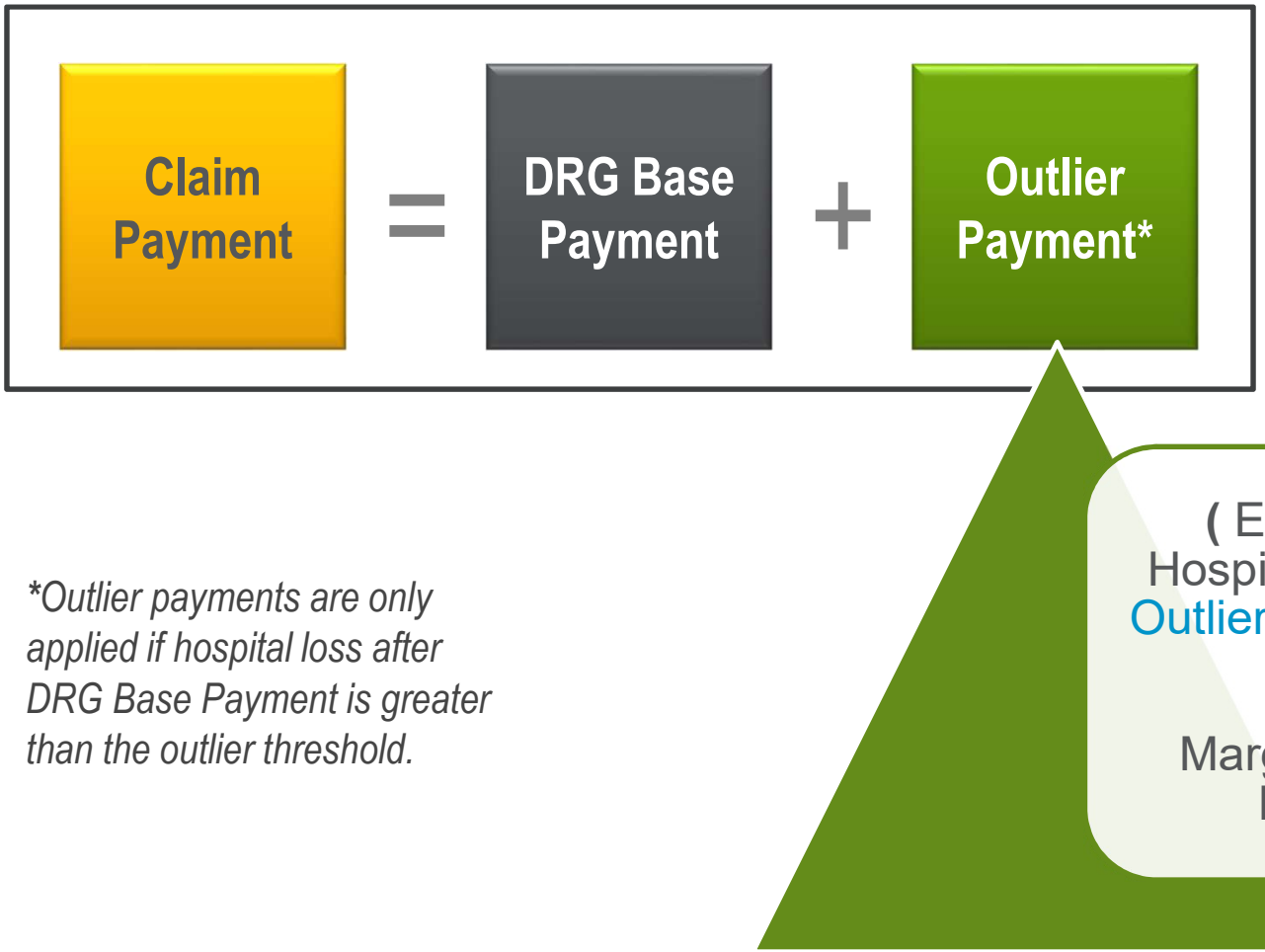


Applicable Policy Adjustment Factors

Policy Adjuster	Basis	Factor*
Mental Health	DRG	1.2
Normal Newborn	DRG	1.9
Obstetrics	DRG	1.5
Pediatric	Age *(< 19 yrs)*	1.3
Substance Abuse	DRG	1.2

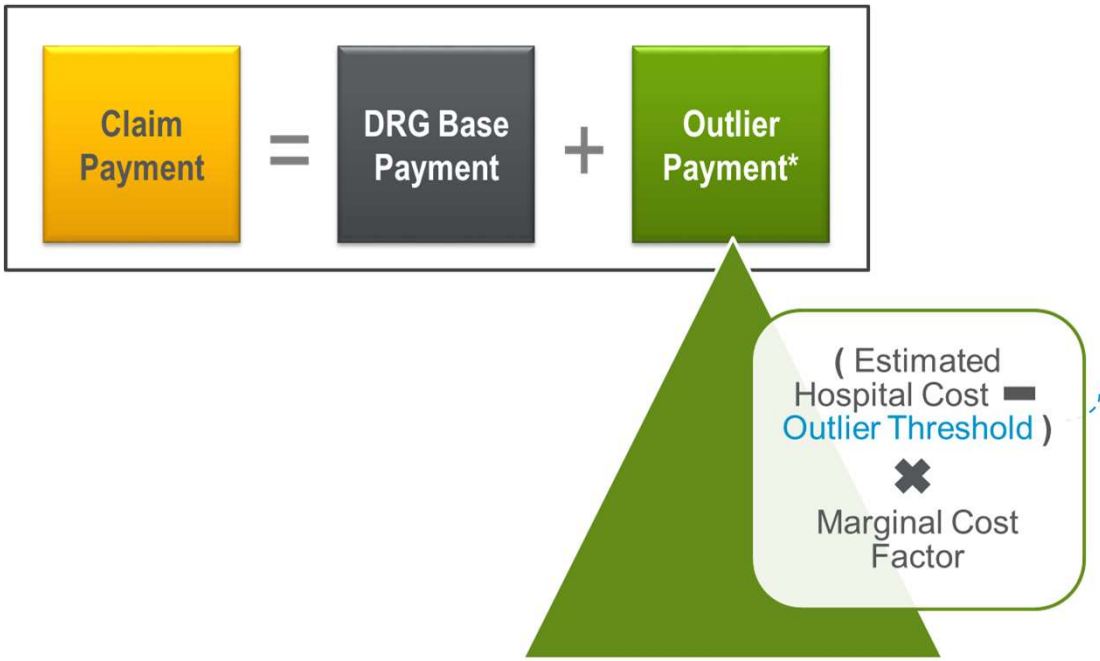
**Pricing logic does not compound policy adjusters. In the event of multiple policy adjusters applying to one claim, such as Pediatric and Mental Health together, only the highest policy adjuster is applied.*

OUTLIER PAYMENT



**Outlier payments are only applied if hospital loss after DRG Base Payment is greater than the outlier threshold.*

OUTLIER PAYMENT *(CONTINUED)*



Outlier Threshold

Provider Type	Outlier Threshold
Acute Care	$39,331
Critical Access	$12,884
Children's	$185,971
Psychiatric	$6,189

PAYMENT EXAMPLE

Assumptions

Hospital Base Rate	= $	8,747.93
Cost Outlier Threshold	= $	39,331.04
Outlier Percentage	=	75%

= Hospital Base Rate
** DRG Relative Weight*
** Policy Adjustment Factor*

= (Estimated Hospital Loss – Cost Outlier Threshold)
** Outlier Percentage*

DRG	DRG Relative Weight	Policy Adj Factor	DRG Base Payment	Estimated Hospital Cost	Estimated Hospital Loss	Outlier Payment	Final DRG Payment
254-2	0.6264	1.0	5,479.70	3,300.00	N/A	N/A	**$5,479.70**
560-2	0.3445	1.5	4,520.49	2,550.00	N/A	N/A	**$4,520.49**
651-3	2.2133	1.0	19,361.79	63,770.70	44,408.91	3,808.24	**$23,170.19**

= Estimated Hospital Cost – DRG Base Payment, only when (Estimated Hospital Cost – DRG Base Payment) > Cost Outlier Threshold

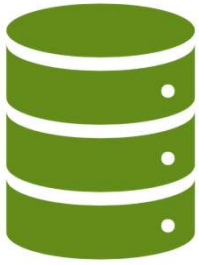
= DRG Base Payment + Outlier Payment

NOTE: Examples are for illustration purposes only.

PRICING CALCULATION FLOW

DRG Data

- *DRG relative weight*
- *Avg length of stay*
- *Policy Adjusters (Service, Age)*



Provider Data

- Hospital base rate
- Provider adjuster
- Cost-to-charge ratio

❶ Calculate Base Payment =
[Hospital Base Rate] × [DRG Relative Weight] × [max Policy Adjuster]

❷ Adjust DRG Base Payment for Acute-to-Acute Transfers (if applicable)

❸ Calculate Outlier Payment Amount

❹ Calculate Medicaid Allowed Amt =
[DRG Base Payment] + [Outlier Amount]

❺ Calculate Reimbursement Amount =
[Allowed Amount] – [Other Insurance] – [Copay]

QUESTIONS ON APR DRG PAYMENT METHODOLOGY?

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PRICING EXAMPLES

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BASIC EXAMPLE

Claim/Encounter Information	Value
Submitted Charges	$30,000
Length of Stay	3
Medicaid Covered Days	3
Transfer	No
Patient Age	25
DRG (Allergic Reaction)	811-3

Base Payment Information	Value
DRG Relative Weight	0.8738
Base Rate	$8,747.93
Service Line Adjuster	No (1.0)
Pediatric Adjuster (<= 18 yrs)	No (1.0)
Max Policy Adjuster	1.0
DRG Base Payment	**$7,643.94**

Outlier Add-On Payment	Value
Hospital Specific CCR	0.3000
Claim Cost (CCR x Charges)	$9,000
Estimated Hospital Loss (Claim Cost – DRG Base Payment)	$0
Outlier Threshold	$39,331.04
Hospital Loss Above Threshold	$0
Outlier Add-On Payment (Loss Above Threshold x 0.75)	**$0**

Final Allowed Amount	Value
Final Base DRG Payment	$7,643.94
Final Outlier Add-on Payment	$0
Final Allowed Amount	**$7,643.94**

Note: *The final reimbursement amount to providers is subject to other insurance payments.*

OUTLIER EXAMPLE

Claim/Encounter Information	Value
Submitted Charges	$200,000
Length of Stay	2
Medicaid Covered Days	2
Transfer	No
Patient Age	58
DRG (Knee Joint Replacement)	302-2

Base Payment Information	Value
DRG Relative Weight	1.6326
Base Rate	$8,747.93
Service Line Adjuster	No (1.0)
Pediatric Adjuster (<= 18 yrs)	No (1.0)
Max Policy Adjuster	1.0
DRG Base Payment	**$14,281.87**

Outlier Add-On Payment	Value
Hospital Specific CCR	0.3000
Claim Cost (CCR x Charges)	$60,000
Estimated Hospital Loss (Claim Cost – DRG Base Payment)	$45,718.13
Outlier Threshold	$39,331.04
Hospital Loss Above Threshold	$6,387.09
Outlier Add-On Payment (Loss Above Threshold x 0.75)	**$4,790.32**

Final Allowed Amount	Value
Final Base DRG Payment	$14,281.87
Final Outlier Add-on Payment	$4,790.32
Final Allowed Amount	**$19,072.19**

Note: *The final reimbursement amount to providers is subject to other insurance payments.*

SERVICE LINE EXAMPLE (OBSTETRIC)

Claim/Encounter Information	Value
Submitted Charges	$24,000
Length of Stay	3
Medicaid Covered Days	3
Transfer	No
Patient Age	27
DRG (Cesarean Delivery)	540-1

Base Payment Information	Value
DRG Relative Weight	0.5185
Base Rate	$8,747.93
Service Line Adjuster	Yes (1.5)
Pediatric Adjuster (<= 18 yrs)	No (1.0)
Max Policy Adjuster	1.5
DRG Base Payment	**$6,803.70**

Outlier Add-On Payment	Value
Hospital Specific CCR	0.3000
Claim Cost (CCR x Charges)	$7,200
Estimated Hospital Loss (Claim Cost – DRG Base Payment)	$0
Outlier Threshold	$39,331.04
Hospital Loss Above Threshold	$0
Outlier Add-On Payment (Loss Above Threshold x 0.75)	**$0**

Final Allowed Amount	Value
Final Base DRG Payment	$6,803.70
Final Outlier Add-on Payment	$0
Final Allowed Amount	**$6,803.70**

Note: *The final reimbursement amount to providers is subject to other insurance payments.*

SERVICE LINE EXAMPLE

Claim/Encounter Information	Value
Submitted Charges	$2,679.10
Length of Stay	2
Medicaid Covered Days	2
Transfer	Yes
Patient Age	0
DRG (Normal Newborn)	640-1

Base Payment Information	Value
DRG Relative Weight	0.0969
Base Rate	$8,747.93
Service Line Adjuster	Yes (1.9)
Pediatric Adjuster (<= 18 yrs)	Yes (1.3)
Max Policy Adjuster	1.9
DRG Base Payment	**$1,610.58**

Outlier Add-On Payment	Value
Hospital Specific CCR	0.3000
Claim Cost (CCR x Charges)	$803.73
Estimated Hospital Loss (Claim Cost – DRG Base Payment)	$0
Outlier Threshold	$39,331.04
Hospital Loss Above Threshold	$0
Outlier Add-On Payment (Loss Above Threshold x 0.75)	**$0**

Final Allowed Amount	Value
Final Base DRG Payment	$1,610.58
Final Outlier Add-on Payment	$0
Final Allowed Amount	**$1,610.58**

Note: *The final reimbursement amount to providers is subject to other insurance payments.*

TRANSFER BASICS

- For acute-to-acute transfers, modeled payment for the transfer-out claim is based on the **lesser of**:
  APR DRG base payment or calculated APR DRG per diem
  (consistent with the Medicare IPPS approach)

- Modeled transfers are identified using a discharge status of: 02, 05, 65, 66, 82, 85, 93, or 94.

- Transfer status is **not** considered for the following DRGs:
  580 – Neonate transfer, <5 days old not born here
  581 – Neonate transfer, <5 days old born here

TRANSFER BASICS *(CONTINUED)*

- With the exception of APR DRGs 580 and 581, national weights are developed using only non-transfer claims (i.e., full lengths of stay).
- The transfer payment formula (not to exceed full DRG base payment) is:

$$\frac{\textit{DRG Base Payment}}{\textit{DRG Average Length of Stay}^{\dagger}} \times [\textit{Actual Length of Stay} + 1]$$

†3M national average length of stay

TRANSFER EXAMPLE

Claim/Encounter Information	Value
Submitted Charges	$25,000
Length of Stay (LOS)	1
Medicaid Covered Days	1
Transfer	Yes
Patient Age	0
DRG (Neonate Bwt 1250-1499 Grams w Maj Problem)	607-3

Base Payment Information	Value
DRG Relative Weight	6.7296
Base Rate	$8,747.93
Service Line Adjuster	No (1.0)
Pediatric Adjuster (18 and under)	Yes (1.3)
Max Policy Adjuster	1.3
Unadjusted DRG Base Payment	**$76,531.09**

Transfer Payment	Value
DRG National Avg Length of Stay (ALOS)	44.31
Transfer Payment *(DRG Base Payment ÷ ALOS)*	$1,727.17
Transfer Base Payment *(DRG Base Payment ÷ ALOS) * (LOS + 1)*	**$3,454.35**
Lessor of DRG and Transfer Payment	**$3,454.35**

Outlier Add-on Payment	Value
Cost Outlier Threshold	$39,331.04
Outlier Payment Percent	75%
Hospital Loss Above Threshold	$0
Outlier Add-on Payment	$0

Final Allowed Amount	Value
Final Base DRG Payment	$3,454.35
Final Outlier Add-on Payment	$0.00
Final Allowed Amount	**$3,454.35**

Note: The final reimbursement amount to providers is subject to other insurance payments.

QUESTIONS ON PRICING EXAMPLES?

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APR DRG CALCULATOR

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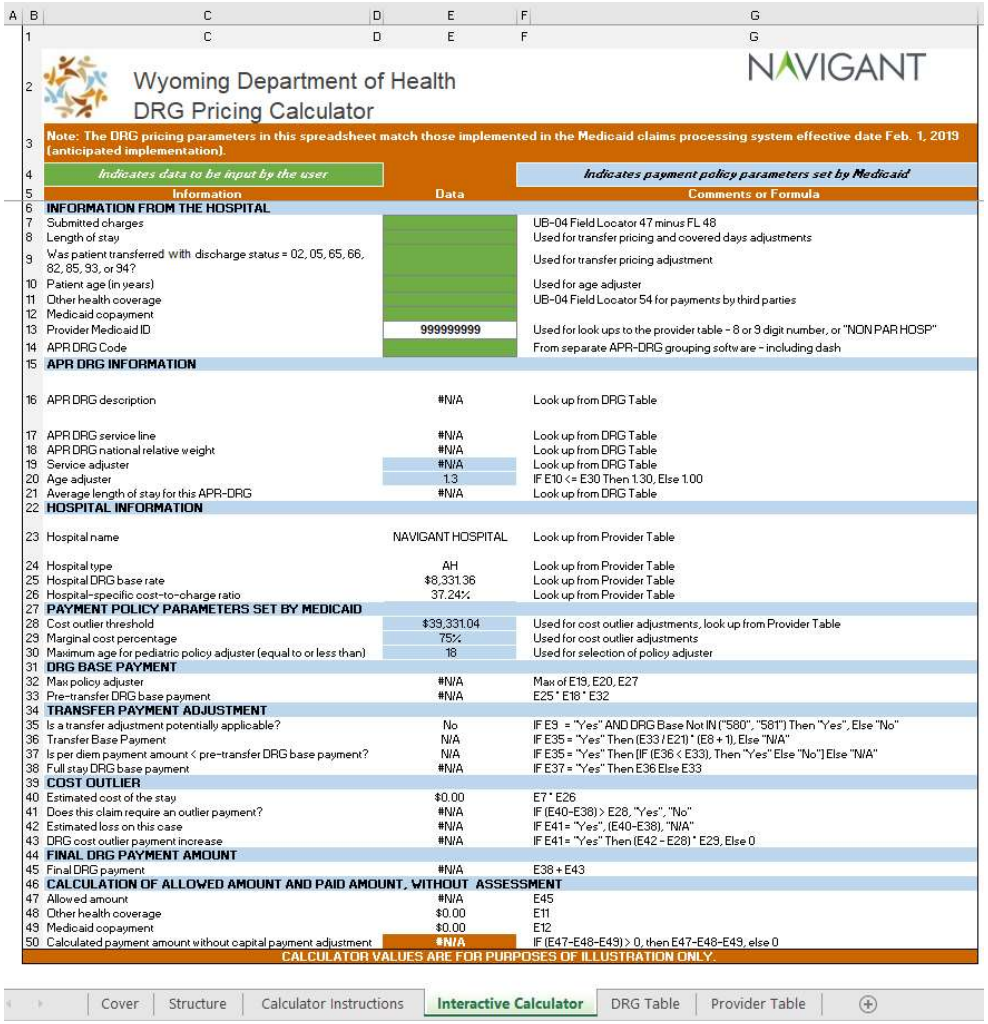
APR DRG CALCULATOR



Wyoming Department of Health
DRG Pricing Calculator

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Note: The DRG pricing parameters in this spreadsheet match those implemented in the Medicaid claims processing system effective date Feb. 1, 2019 (anticipated implementation).

Indicates data to be input by the user | *Indicates payment policy parameters set by Medicaid*

	Information	Data	Comments or Formula
6	**INFORMATION FROM THE HOSPITAL**		
7	Submitted charges		UB-04 Field Locator 47 minus FL 48
8	Length of stay		Used for transfer pricing and covered days adjustments
9	Was patient transferred with discharge status = 02, 05, 65, 66, 82, 85, 93, or 94?		Used for transfer pricing adjustment
10	Patient age (in years)		Used for age adjuster
11	Other health coverage		UB-04 Field Locator 54 for payments by third parties
12	Medicaid copayment		
13	Provider Medicaid ID	999999999	Used for look ups to the provider table - 8 or 9 digit number, or "NON PAR HOSP"
14	APR DRG Code		From separate APR-DRG grouping software - including dash
15	**APR DRG INFORMATION**		
16	APR DRG description	#N/A	Look up from DRG Table
17	APR DRG service line	#N/A	Look up from DRG Table
18	APR DRG national relative weight	#N/A	Look up from DRG Table
19	Service adjuster	#N/A	Look up from DRG Table
20	Age adjuster	1.3	IF E10 <= E30 Then 1.30, Else 1.00
21	Average length of stay for this APR-DRG	#N/A	Look up from DRG Table
22	**HOSPITAL INFORMATION**		
23	Hospital name	NAVIGANT HOSPITAL	Look up from Provider Table
24	Hospital type	AH	Look up from Provider Table
25	Hospital DRG base rate	$8,331.36	Look up from Provider Table
26	Hospital-specific cost-to-charge ratio	37.24%	Look up from Provider Table
27	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**		
28	Cost outlier threshold	$39,331.04	Used for cost outlier adjustments, look up from Provider Table
29	Marginal cost percentage	75%	Used for cost outlier adjustments
30	Maximum age for pediatric policy adjuster (equal to or less than)	18	Used for selection of policy adjuster
31	**DRG BASE PAYMENT**		
32	Max policy adjuster	#N/A	Max of E19, E20, E27
33	Pre-transfer DRG base payment	#N/A	E25 * E18 * E32
34	**TRANSFER PAYMENT ADJUSTMENT**		
35	Is a transfer adjustment potentially applicable?	No	IF E9 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
36	Transfer Base Payment	N/A	IF E35 = "Yes" Then (E33 / E21) * (E8 + 1), Else "N/A"
37	Is per diem payment amount < pre-transfer DRG base payment?	N/A	IF E35 = "Yes" Then (IF (E36 < E33), Then "Yes" Else "No"] Else "N/A"
38	Full stay DRG base payment	#N/A	IF E37 = "Yes" Then E36 Else E33
39	**COST OUTLIER**		
40	Estimated cost of the stay	$0.00	E7 * E26
41	Does this claim require an outlier payment?	#N/A	IF (E40-E38) > E28, "Yes", "No"
42	Estimated loss on this case	#N/A	IF E41 = "Yes", (E40-E38), "N/A"
43	DRG cost outlier payment increase	#N/A	IF E41 = "Yes" Then (E42 - E28) * E29, Else 0
44	**FINAL DRG PAYMENT AMOUNT**		
45	Final DRG payment	#N/A	E38 + E43
46	**CALCULATION OF ALLOWED AMOUNT AND PAID AMOUNT, WITHOUT ASSESSMENT**		
47	Allowed amount	#N/A	E45
48	Other health coverage	$0.00	E11
49	Medicaid copayment	$0.00	E12
50	Calculated payment amount without capital payment adjustment	#N/A	IF (E47-E48-E49) > 0, then E47-E48-E49, else 0

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

Cover | Structure | Calculator Instructions | **Interactive Calculator** | DRG Table | Provider Table

PRIOR AUTHORIZATION UNDER APR DRGS

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PRIOR AUTHORIZATION UNDER APR DRGS

There is no change to the types of services that require prior authorization. All Levels of Care requiring prior authorization have been mapped to DRGs.

Prior authorization is required **only for admission** (not length of stay) for all inpatient stays.

Exceptions:

- stays where only emergency care is covered
- stays where provider is excluded from DRG payment
- continue current policy of accepting incremental authorization(s) for inpatient psychiatric stays

DRGS REQUIRING PRIOR AUTHORIZATION

DRG	Description	Former Level of Care Value
001	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	09
002	HEART &/OR LUNG TRANSPLANT	08
003	BONE MARROW TRANSPLANT	10
006	PANCREAS TRANSPLANT	18
130	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	30
440	KIDNEY TRANSPLANT	07
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	37
750	SCHIZOPHRENIA	37
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	37
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	37
753	BIPOLAR DISORDERS	37
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	37
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	37
756	ACUTE ANXIETY & DELIRIUM STATES	37
757	ORGANIC MENTAL HEALTH DISTURBANCES	37
758	CHILDHOOD BEHAVIORAL DISORDERS	37
759	EATING DISORDERS	37
760	OTHER MENTAL HEALTH DISORDERS	37
770	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	37
772	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	37
773	OPIOID ABUSE & DEPENDENCE	37
774	COCAINE ABUSE & DEPENDENCE	37
775	ALCOHOL ABUSE & DEPENDENCE	37
776	OTHER DRUG ABUSE & DEPENDENCE	37
850	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	31
860	REHABILITATION	31

SAMPLE REMITTANCE ADVICE

NAVIGANT

SAMPLE REMITTANCE ADVICE (GROUPABLE)

REMITTANCE ADVICE
WYMC8000-R001 (CP-O-12) WYOMING DEPARTMENT OF HEALTH
AS OF 10/24/18 MEDICAID MANAGEMENT INFORMATION SYSTEM RUN D[redacted]/26/18
R E M I T T A N C E A D V I C E
TO: [redacted] R.A.: [redacted] DATE PAID: 10/24/18 PROV: [redacted] PAGE: [redacted]

TRANS-CONTROL-NUMBER		COVERED PERIOD FROM	TO	COVER DAYS	LOC	BILLED AMT.	OTHER INS.	PAID BY MCAID	WRITE OFF	DRG	S	PLAN	CO[redacted]
* * * CLAIM TYPE: INPATIENT						* * * CLAIM STATUS: PAID							
ORIGINAL CLAIMS:													
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18292-00-076-0000-09		09/10/18	09/12/18	2	37	6781.51	0.00	4911.03	1870.48	0981	W	ADSS	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18292-00-076-0000-10		09/05/18	09/06/18	1	37	3490.92	0.00	1488.19	2002.73	6541	W	MCAD	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18296-00-225-0000-28		10/14/18	10/16/18	2	33	14513.71	0.00	3571.72	10941.99	2102	8	KIDA	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18295-00-261-0000-23		09/15/18	09/17/18	2	33	11464.22	0.00	3571.72	7892.50	8765	W	KIDA	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18291-00-128-0000-16		10/07/18	10/09/18	2	33	13115.98	0.00	3571.72	9544.26	4321	W	KIDA	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18296-00-225-0000-27		10/13/18	10/14/18	1	33	9002.10	0.00	3571.72	5430.38	0982	8	MCAD	
* XXXXXX	XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18296-00-225-0000-29		09/27/18	09/29/18	2	32	12981.55	0.00	5893.39	7088.16	6543	W	KIDA	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18296-00-225-0000-30		09/26/18	09/29/18	3	38	5201.40	0.00	1687.66	3513.74	2101	W	KIDA	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18292-00-076-0000-07		09/17/18	09/19/18	2	37	4779.84	0.00	4911.03	0.00	8761	9	KIDA	
* XXXXXX	X XXXXXX	RECIP ID: XXXXXXXX		PATIENT ACCT #: XXXXXXXX									
3-18296-00-225-0000-31		09/27/18	09/28/18	1	38	2154.40	0.00	1687.66	466.74	4321	7	KIDA	

DRG: DRG & SOI

S: Allowed Charge Source

New Allowed Charge Source values for DRG:

W - DRG Standard Rate
7 - DRG Standard Rate With Outlier
8 - DRG Transfer
9 - DRG Transfer With Outlier

SAMPLE REMITTANCE ADVICE (UNGROUPABLE)

REMITTANCE ADVICE
WYMC8000-R001 (CP-O-12)
AS OF 01/16/19

WYOMING DEPARTMENT OF HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 01/18/19

R E M I T T A N C E A D V I C E

TO: [redacted] R.A.: [redacted] DATE PAID: 01/16/19 PROV: [redacted] PAGE: 1

TRANS-CONTROL-NUMBER	COVERED PERIOD FROM	TO	COVER DAYS	LOC	BILLED AMT.	OTHER INS.	PAID BY MCAID	WRITE OFF	DRG	S	PLAN	COPAY
* * * CLAIM TYPE: INPATIENT							* * * CLAIM STATUS: PAID					
ORIGINAL CLAIMS:												
* LNAME FNAME RECIP ID: XXXXXXXXX PATIENT ACCT #: XXXXXXXXX												
0-19002-32-001-0018-00	10/24/18	10/26/18	2		11151.19	0.00	3897.02	7254.17	560	W	MATR	
* LNAME2 J FNAME2 RECIP ID: XXXXXXXXX PATIENT ACCT #: XXXXXXXXX												
0-19002-32-001-0010-00	10/18/18	10/25/18	7		105222.48	0.00	9604.15	95618.33	309	W	COAW	
* LNAME3 L FNAME3 RECIP ID: XXXXXXXXX PATIENT ACCT #: XXXXXXXXX												
0-19002-32-001-0011-00	11/01/18	11/30/18	29		98598.00	0.00	0.00	98598.00	956	W	SUCW	
* * * CLAIM TYPE: INPATIENT							* * * CLAIM STATUS: IN PROCESS					
ORIGINAL CLAIMS:												
* XXXXXX X XXXXXX RECIP ID: XXXXXXXXX PATIENT ACCT #: XXXXXXXXX												
0-19002-32-001-0029-00	11/10/18	11/12/18	2	37	6781.51	0.00	0.00	0.00	775		ADSS	
HEADER EOB(S): 900												
* XXXXXX X XXXXXX RECIP ID: XXXXXXXXX PATIENT ACCT #: XXXXXXXXX												
0-19002-32-001-0028-00	10/19/18	10/20/18	1	37	1384.57	0.00	0.00	0.00	758		ADSS	
HEADER EOB(S): 900												
* XXXXXX XXXXXX RECIP ID: XXXXXXXXX PATIENT ACCT #: XXXXXXXXX												
0-19002-32-001-0026-00	10/28/18	11/01/18	4	37	7833.60	0.00	0.00	0.00	751		MCAD	
HEADER EOB(S): 900												

956 = Ungroupable

REMITTANCE ADVICE
TO: [redacted] R.A.: [redacted] DATE PAID: 01/16/19 PROV: [redacted] PAGE: 2

REMITTANCE T O T A L S

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	3	---------	214,971.67	13,501.17
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	3	---------	15,999.68	0.00
AMOUNT OF CHECK:					13,501.17

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:
900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM. 3

----**** NCCI DENIALS CANNOT BE BILLED TO MEDICAID CLIENTS BUT CAN BE APPEALED TO THE DIVISION OF
**** HEALTHCARE FINANCING PER WYOMING MEDICAID RULES, CHAPTER 16. APPEALS MUST BE SENT IN WRITING
**** TO WYOMING MEDICAID, ATTN: MEDICAL POLICY, PO BOX 667, CHEYENNE, WY 82003-0667.

---- THE FOLLOWING IS A DESCRIPTION OF THE LEVEL OF CARE CODES THAT APPEAR ABOVE: COUNT:
37 PSYCHIATRIC AS OF 090109 3

SAMPLE EXPLANATION OF BENEFITS (UNGROUPABLE)

```
REMITTANCE ADVICE
WYMC8000-R001 (CP-O-12)                    WYOMING DEPARTMENT OF HEALTH
AS OF 01/16/19                          MEDICAID MANAGEMENT INFORMATION SYSTEM                    RUN DATE  01/18/19
                                         R E M I T T A N C E   A D V I C E

TO: [redacted]                                   R.A.: [redacted] DATE PAID: 01/16/19 PROV: [redacted]   PAGE:      1

                                 COVERED PERIOD  COVER        BILLED       OTHER      PAID BY       WRITE
        TRANS-CONTROL-NUMBER       FROM     TO    DAYS LOC     AMT.         INS.       MCAID         OFF    DRG  S PLAN      COPAY

              * * *  CLAIM TYPE:  INPATIENT                        * * *  CLAIM STATUS:  DENIED

ORIGINAL CLAIMS:

* LNAME          M FNAME       RECIP ID: XXXXXXXXXX  PATIENT ACCT #: XXXXXXXXXX
        3-18337-00-403-0000-02     11/24/18 11/25/18   1        4091.71        0.00        0.00        0.00  956  K KIDA
           HEADER EOB(S): 263 186 324

REMITTANCE   T O T A L S
PAID ORIGINAL CLAIMS:                    NUMBER OF CLAIMS       0  ---------          0.00                      0.00
PAID ADJUSTMENT CLAIMS:                  NUMBER OF CLAIMS       0  ---------          0.00                      0.00
DENIED ORIGINAL CLAIMS:                  NUMBER OF CLAIMS       1  ---------      4,091.71                      0.00
DENIED ADJUSTMENT CLAIMS:                NUMBER OF CLAIMS       0  ---------          0.00                      0.00
PENDED CLAIMS (IN PROCESS):              NUMBER OF CLAIMS       0  ---------          0.00                      0.00
AMOUNT OF CHECK:          ------------------------------------------------------------------------------          0.00

----  THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:                 COUNT:

      186  THE RECIPIENT'S SEX IS NOT ALLOWED FOR ONE OF THE DIAGNOSIS CODES                                        1
           LISTED ON  THE CLAIM.
      263  VALID DRG CODE COULD NOT BE DETERMINED
      324  INVALID OR MISSING PRESENT ON ADMISSION INDICATOR.
```

Note: *There is no change to the EOB process, but the new MMIS edits will post new EOB codes. The actual EOB code values will soon be finalized. EOB 263 shown above is only a sample.*

MMIS Edit	Description	EOB Code
486	Valid DRG Code Could Not Be Determined	TBD
487	DRG Invalid Recipient Discharge Age In Years Or Invalid Recipient Admission Age In Days	TBD
488	DRG Invalid Recipient Gender	TBD
489	DRG Invalid Discharge Status	TBD
490	DRG Invalid Birth Weight	TBD
492	DRG Invalid Recipient Discharge Age In Days	TBD
493	DRG Invalid Principal Diagnosis Code	TBD

HELPFUL SUGGESTIONS AND RESOURCES

NAVIGANT

SUGGESTIONS FOR APR DRG SUCCESS

1. In submitting claims, particular attention to completeness and accuracy of:
   - Diagnoses and present-on-admission indicators
   - ICD-10-PCS procedures and procedure code dates
   - Value codes for birthweight
2. Understand the DRG payment rules of Wyoming Medicaid specifically
   - See Wyoming Medicaid DRG pricing calculator
   - If you use an APR DRG grouper, use the same grouper settings as Wyoming
3. Analyze and manage cost per stay, especially length of stay
4. APR DRGs are much more than a means of payment
   - If using APR DRGs for casemix analysis, use the national relative weights not including Wyoming-specific policy adjustors
   - Don't compare severity levels across DRGs; compare relative weights instead
   - In analyzing length of stay, be consistent in using trimmed or untrimmed arithmetic or geometric average length of stay

3M

RESOURCES ON ALL PATIENT REFINED DRGS

3M™ APR DRG Assignment
www.aprdrgassign.com
For 3M log in and password, please contact Conduent Provider Relations

3M™APR DRG Software Fact Sheet
https://multimedia.3m.com/mws/media/478415O/3m-apr-drg-fact-sheet.pdf&fn=aprdrg_fs_R3.pdf

3M™ APR DRG eBook
https://multimedia.3m.com/mws/media/910941O/3m-apr-drg-ebook.pdf&fn=3m_apr_drg_ebook_R2.pdf

WYOMING MEDICAID APR DRG GROUPER SETTINGS

3M Grouper	Wyoming Medicaid Setting	Comment
APR DRG version	Version 33.0	3M maps ICD-10 codes back and forth as needed to match the grouper version
APR DRG relative weights	V33.0 standard weights (national)	
APR DRG ALOS benchmarks	V33.0 arithmetic trimmed (national)	
APR used for payment	Discharge APR DRG	
Number of diagnoses and procedure values accepted	Unlimited	
Birthweight option	1—Entered in the birthweight field only	UB-04 value code 54, in grams
Admission DRG	1 - Compute Admission DRG/Discharge DRG excluding non-POA Complication of Care	This option is called "Discharge DRG" in the desktop grouper. Same effect.
Interpretation of W and U POA indicators	0 - W treated as N, U treated as N (default)	W=clinically undetermined, U=documentation insufficient
Missing/Invalid POA Interpretation	0 - Treat as non-POA	
POA flag coding	0 - Accepts blank for exempt indicators	
Medicaid Healthcare Acquired Condition (HCAC)	V36.0 CMS national Medicaid HCAC list; pediatric = less than 19	Wyoming defines pediatric as <19; CMS defines pediatric as <18

3M

QUESTIONS?

NAVIGANT

CLOSING REMARKS

LINDSEY SCHILLING, PROVIDER OPERATIONS ADMINISTRATOR, WDH

SARA ROGERS, SENIOR BENEFIT QUALITY CONTROL MANAGER, WDH

NAVIGANT

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