Effective for dates of admission on or after January 1, 2014, the reimbursement methodology for many Children with Special Health Care Needs (CSHCN) Services Program facilities that are reimbursed based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) will change to the prospective payment methodology based on All Patient Refined Diagnosis Related Groups (APR-DRG) payment system.

Hospitals that are enrolled in the CSHCN Services program must first be enrolled in Texas Medicaid. If the hospital is reimbursed by Texas Medicaid using the APR-DRG reimbursement methodology, the hospital's CSHCN Services Program reimbursement methodology will be transitioned from TEFRA to APR-DRG. This change in reimbursement methodology includes all hospitals except for state-owned teaching hospitals and inpatient psychiatric facilities.

The reimbursement method will not affect inpatient benefits and limitations. Inpatient admissions will continue to require prior authorization.

**Note:** The 20-percent payment reduction that is currently applied to inpatient claims by the CSHCN Services Program will remain in effect.

**Prospective Payment Methodology**

The prospective payment methodology is based on a DRG payment system. Reimbursement based on DRG includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. Claims may not be submitted for technical services.

The CSHCN Services Program does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, providers may submit only one claim for each inpatient stay. The claim must include appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form or electronic equivalent, to be considered for payment.

The number of days of care charged for a client for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.
A part of a day, including the day of admission and day on which a client returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a client begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (January 1 through December 31). Claims may be subject to retrospective review, which may result in recoupment.

**Outlier Adjustments**

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 21 years of age and younger as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The ER&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information providers, facilities, and third party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data interchange (EDI) companion guide ([ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide](#)) on this website.

**Day Outliers**

The following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.