Texas Medicaid DRG Conversion
Frequently Asked Questions
Information posted June 4, 2012

Please note that changes are possible before the implementation date.

OVERVIEW QUESTIONS

1. What is the Texas Medicaid DRG conversion?

Effective for admissions or after September 1, 2012, Texas Medicaid will adopt an All Patient Refined – Diagnosis Related Groups (APR-DRG) payment system, which will replace the Medicare Severity Diagnosis Related Group (MS-DRG) Inpatient Hospital Prospective Payment System (PPS) that is currently in use.

The conversion is in response to Section 536.005 of House Bill 1, 82nd, Legislature, Regular Session, 2011, which requires converting hospital reimbursement systems under Medicaid program to diagnosis-related groups (DRGS) that will allow a more accurate classification of specific patient populations and account for severity patient illnesses and mortality risks.

2. When will the new method be implemented?

It will be effective for stays with a date of admission on or after September 1, 2012.

3. What change is being made?

HHSC will change its current payment method based on MS-DRGs to a new method based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRG will apply to general acute care hospitals, including out-of-state hospitals.

Hospitals currently reimbursed by TEFRA and Psychiatric hospitals are not currently impacted by this change.

4. How will payment be calculated?

The basic approach will continue as it is now: a DRG base payment will be calculated by multiplying a relative weight for the specific DRG by a hospital-specific DRG discharge rate.

5. How will payment be affected if a hospital-acquired condition is present on the claim?

Federal law requires Medicaid programs nationwide to demonstrate that they are not paying for “hospital acquired conditions.” The DRG software will ignore secondary diagnoses that meet the HAC definition.

6. 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. APR-DRGs have been used 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” such as www.floridahealthfinder.gov, and analysis done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

7. In order to be paid does my hospital need to buy APR-DRG software?

No. The Medicaid claims processing system will assign the APR-DRG and calculate payment without any need for the hospital to put the DRG on the claim.

For hospitals interested in learning more about APR-DRGs, please contact:

- Tibor Bajusz, MBA
  Client Relationship Executive
  Houston / South Texas & West Texas
  210) 694-4388 office | tbajusz@mmm.com

- Glenn W. Roberts
  Client Relationship Executive
  Dallas/Ft. Worth Area, Temple/Waco & East Texas
  (985) 778-4115 office | gwroberts@mmm.com

8. What version of APR-DRGs will be implemented?

HHSC/TMHP intends to implement APR-DRG Version 29 which released on October 1, 2011.

9. What does the four-digit APR-DRG represent?

Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG. Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2. Unlike MS-DRGs, there are no universal lists of complications and comorbidities or major complications and comorbidities.

10. How will ICD-10 affect the DRG payment method?

ICD-10 will be implemented nationwide on October 1, 2013. Although this will be a major change for all hospitals and payers, the impact on DRG payment is expected to be minor. The reason is that the APR-DRG grouping algorithm will be re-configured to use ICD-10 codes as inputs. Therefore patients with, e.g., bronchiolitis, heart attack or femur fracture would still be assigned to the same DRGs at the same payment rates, except that the assignment logic would be based on ICD-10 codes rather than ICD-9-CM codes.

11. Does the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction?

No. The claims processing system will assign the APR-DRG based on the diagnoses, procedures, patient age, and patient discharge status, all as submitted by the hospital on
the claim. The UB-04 field for PPS Code (Form Locator 71) is not read by the Medicaid claims processing system. The PPS Code field is used when, for example, the hospital needs to advise a commercial insurer of the DRG for a stay.

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

Hospitals need not make any changes. 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. 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. However, any such review is entirely the hospital’s decision.

13. How many diagnosis and procedure codes does the Medicaid claim processing system accept?

Effective September 1, 2012, the system will accept 25 diagnosis codes and 25 ICD-9-CM procedures codes on each inpatient claim.

14. Is the present-on-admission (POA) indicator required?

Yes. HHSC will continue to require hospitals to submit the POA indicator and the claims processing system will continue to edit POA indicator information. The POA indicator is used to identify hospital-acquired conditions.

15. Will there be changes in prior authorization policy?

No. Changes in prior authorization are being made as part of this project.

16. Will the APR-DRG be shown in the remittance advice?

Yes. The APR-DRG will be displayed.

17. Will the Managed Care Plans be impacted by this change?

No. This change does not impact reimbursement for Managed Care.

18. Will Medicare crossover claims be affected?

Yes. Inpatient Medicare crossover will be assigned an APR-DRG. The payment of the Medicare Part A coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries will continue to be based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.