

DRG Q&A

Adjustments

1. **Q:** What will be the acceptable forms for submitting an adjustment?

A: You can submit adjustments through Provider Electronic Solution Software (PES), as a HIPAA 837 transaction (claim frequency code 7 – xxx or 8 – xxx) or send in a “Adjustment Request Form” with your attached paper claim. The adjustment forms can be found on the VTMedicaid website under Downloads/forms.

Late Charges

1. **Q:** What purpose is there in submitting a late charges under the DRG system?

A: There may be potential for a outlier payment.

2. **Q:** Should we bill minimal late charges?

A: The decision to bill minimal late charges is at the provider’s discretion.

Aid Category Change during Inpatient Stay

1. **Q:** Currently, hospitals are required to split the bill when an eligible member changes aid categories in the middle of a inpatient stay. How will we bill a DRG claim when we have to discharge to bill?

A: Split bill will no longer be required for this situation. EDS will process the claims appropriately if the member changes aid categories during an inpatient stay. EDS will prorate the DRG payment if the change in aid category results in a loss of inpatient coverage.

Eligibility Loss during Inpatient Stay

1. **Q:** Currently, hospitals have to split a claim if the patient loses eligibility during their inpatient stay. How will providers bill a DRG claim when we have to discharge bill?

A: EDS will prorate DRG based on length of stay.

DRG Q&A

Discharge Status codes

Transfer to a rehab facility, including distinct part rehab facility (code 62).

1. **Q:** Providers stated they code a patient going to the distinct part rehab facility as two claims. Will VTMedicaid allow one claim for the initial part of the stay with discharge code 62 and the second claim for the distinct part rehab portion of the stay?

A: Yes, EDS will process these two claims as distinct DRG payments.

Transfer to a psychiatric hospital, including distinct part psych unit (code 65).

2. **Q:** Providers stated they split the claims when a patient starts in one part of the facility then move to a distinct part psych unit. Although some hospitals do not have a distinct part psych unit as recognized by Medicare, they indicated that other insurance carriers require them to separate the distinct part psych claims and they use code 65 as if they had a Medicare-designated distinct part psych unit. Will VTMedicaid follow this practice?

A: Yes, providers can bill two claims.

Interim Claims

1. **Q:** Currently providers have been submitting interim claims to VTMedicaid for long term patients, that are in house at the end of the year and their stay will cross over into the next year. Would the interim claims need to be recouped and submitted on one claim?

A: You will not need to recoup the previous paid interim claims and bill on one claim. VTMedicaid is recommending that you bill any interim claims up to 12/30/07. If a patient is still in house, then bill the remaining day in 2007 (12/31/07) through the discharge of the patient in 2008 on a new (final) interim claim. These claims that have a from date of service in 2007 but overlap the two calendar years will be paid under the current Per Diem methodology for the remainder of the stay. Any claims submitted with a 'from date of service' in 2008 will be priced using DRG. Note that after the initial implementation, any updates to groupers or changes to the system will be based on the discharge date.

DRG Q&A

Medicare 72 Hour Rule

1. **Q:** Is VTMedicaid observing Medicare's "72 Hour Rule"?

A: No

2. **Q:** Explain the example if a patient goes to the ER on Tuesday evening, stays in observation through the night into Wednesday, gets admitted Wednesday morning. The Hospitals' practice would be to wrap the entire Tues/Wed outpatient time into the inpatient bill, can we do this still?

A: VTMedicaid will allow hospitals the flexibility to either roll all together or bill the outpatient services as a separate Outpatient claim.

3. **Q:** What the patient goes to the ER Tuesday morning, goes home, then comes back Tuesday evening and follows pattern of the example in Question #2?

A: VTMedicaid will allow hospitals the flexibility to either roll all together or bill the outpatient services as a separate Outpatient claim.

Mom and Baby

1. **Q:** Mom and baby claims must be billed on separate claims but both claims can use the mother's ID if the claim is for a stay of less than 7 days and the mother and baby discharged at the same time. Providers are concerned that the claims would still suspend due to name/ID mismatch. Can there be a bypass from suspense in this situation due to the volume of claims that could be impacted?

A: At this time, we do not believe that the fact that claims may be suspended due to this edit is a significant issue. The provider can use the baby's temporary number or social security number to bypass the claim suspending for dup logic. The majority of the mom/baby claims submitted to EDS today suspend for manual review even when submitted on the same claim. However, EDS will monitor the suspense levels and look for possible edit enhancements to reduce suspense as necessary.

Remittance Advices

1. **Q:** Will VTMedicaid remittance advices (RA's) report DRG information?

A: The DRG code and DRG weight will be provided on both paper and electronic RA's.

DRG Q&A

Modifiers

1. **Q:** Modifiers are not being used for reimbursement with VTMedicaid, will this change with implementation of the DRG payment methodology?

A: The OVHA does not intend to use modifiers for payment reimbursement, however we do allow the reporting of modifiers.

Revenue Code/HCPCS Requirements

1. **Q:** Revenue code 280 does not require HCPCS to be present, why is it denying for a HCPCS?

A: The system was changed to eliminate the HCPCS requirement from this revenue code on 11/23/2007. Providers may resubmit any claims that were denied for this reason.

2 **Q:** When billing the same revenue code, same HCPCS code and units, should providers bill one line with 2 units or bill the units separately on a detail line?

A: Providers should bill one line with both units on that one line.

Timely Filing-180 day rule

1. **Q:** When providers eliminate interim bills, there may be an issue for lengths of stay near or exceeding 180 days. Currently, the 180-day claim filing rule applies to date of admission, not date of discharge. How will we bill a DRG claim if length of stay is 180 days or more since we will have to wait for discharge to bill?

A: The timely filing limit edit will be modified to evaluate 180 days from the date of discharge for inpatient claims.