SOUTH FLORIDA Community Care Network
Memorial Healthcare System · North Broward Hospital District · Public Health Trust

PROVIDER NEWS FLASH

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DRG PRICING FOR INPATIENT HOSPITAL CLAIMS

The state of Florida is implementing a new inpatient hospital payment method utilizing Diagnosis-Related Groups (DRG) effective July 1, 2013. The inpatient hospital claims will be priced based on DRG with two notable exceptions: (1) newborn hearing and screening; and (2) transplants currently paid via a global fee. Newborn hearing screenings will continue to be reimbursed separately, above and beyond the DRG payment. Similarly, transplants will continue to be paid using a global fee that covers all related services for a one-year period.

How DRG Pricing is Determined and Calculated

DRG payment methods involve classifying inpatient hospital stays and then determining a price based on a combination of the classification and the hospital where the services were performed. Classification of the hospital stay is based on the diagnoses describing the patient's condition, the surgical procedures performed (if any), the patient's age, and the discharge status. Admission diagnosis code is not considered. The Agency is implementing the APR-DRG (version 30) grouping method which has over 1,200 codes including several hundred based codes separated into four levels of severity and is widely used by multiple payers. The vast majority of hospital stays are priced using the following formula, although variances can occur:

[DRG Base Payment] = [Hospital base rate] * [DRG relative weight] * [Policy adjustor(s)]

Will payment adjustments for health care acquired conditions change with DRG reimbursement?

Medicaid will adjust payment for health care acquired conditions (HCACs) in a way similar to that used by Medicare with the implementation of DRG reimbursement. Two DRGs will be assigned to each claim; one determined using all diagnosis and procedure codes on the claim and a second determined while ignoring diagnoses and procedure codes associated with HCACs. HCACs are very rare, so in most cases these two DRGs will be the same. But in cases where they are different, the DRG with the lower relative weight will be used to calculate payment.

Does the recipient's 45 day inpatient benefit limit still apply with transition to DRG?

Recipients aged 21 and over will continue to have a maximum of 45 covered inpatient days per fiscal year. With DRG pricing logic, a comparison will be made between the covered days calculated on the claim versus the DRG average length of stay. The lesser of those two values will be used to contribute to the recipient's 45 day cap.

Will BBA claim requirements change with the implementation of DRG?

Effective with DRG pricing, a Balanced Budget Act (BBA) claim is required only if the recipient has zero days available within their 45-benefit limit. If the recipient has at least one day remaining within their benefit limit at the time of admission, or gains a new 45-days when crossing state fiscal years during an admission, then full DRG payment will apply.

If neither of these is true, then a BBA claim is required, including authorization of the covered portion of the stay. Florida Medicaid payment for BBA claims will be prorated downward based on a comparison of the covered days to the full length of stay.

For additional information, please contact the SFCCN Subnetwork for which you are contracted:

MHS 954-276-3131 Broward Health 954-767-5600 PHT 877-838-7526

www.sfccn.org

ICD-10 NEWS

ICD-10 is coming October 1, 2014. The Agency for Health Care Administration (AHCA) encourages providers to be proactive about planning end-to-end testing. CMS will not be conducting testing, so providers are responsible for reaching out to payers and health plans for testing assistance. All HIPAA covered entities MUST implement the new ICD-10 code sets of claims with date of service (DOS) or date of discharge that occur **on or after October 1, 2014**. *ICD-9 should be used if the DOS or date of discharge is prior to October 1, 2014*. For more information from CMS regarding testing, review CMS's ICD-10 Implementation Guide for Small and Medium Practices at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10SmallMediumPracticeHandbook.pdf or CMS's ICD-10 Implementation Guide for Large Practices at http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD10LargePractices508.pdf.

SFCCN PROVIDER SATISFACTION SURVEY

The 2012-2013 SFCCN Provider Satisfaction Survey will be distributed to all the high volume PCPs in late July. Please take a moment to fill it out and fax it back to us.

WE WANT TO HEAR FROM YOU!

AFFORDABLE CARE ACT PRIMARY CARE FEE INCREASE

Physicians who completed the self-attestation process prior to May 31, 2013 will be eligible for the rate increase retroactively to January 1, 2013. The Medicaid fiscal agent will complete a one-time reprocessing of claims after May 31, 2013 for dates of services on or after January 1, 2013.

Physicians who self-attest after May 31, 2013 are eligible for the increase on the first day of the month of self-attestation, and may reprocess/adjust claims retroactively to the first of the month.

To access a copy of the AHCA Certification and Attestation for Primary Care Rate Increase go to: http://portal.flmmis.com/flpublic/portals/0/staticcontent/public/public%20misc%20files/attestation%20form.pdf

SPECIAL REMINDER

Do you know that you could access the most updated SFCCN Provider Directory on our website? Please visit www.sfccn.org for the provider directories, newsletters, cultural competency plan, clinical practice guidelines and other provider related information.

ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

South Florida Community Care Network has voluntarily requested the AAAHC survey as a means of assisting its own efforts to improve the quality of health care and enrollee services. The onsite survey is scheduled from October 7-9, 2013.

QUICK REMINDER TIPS IN TREATING PATIENT WITH DIABETES

A For the A1C Test. A minimum of a yearly HbA1c and maintenance of good glycemic control defined as a HbA1c <8%.

B For Blood Pressure. The goal for enrollees with diabetes is < 130/80, maintained over time. Blood pressure reading to be done at each visit.

C For Cholesterol. A minimum of a yearly lipid profile screening, more often if LDL is not within the goal of less than 100 mg/dl.

D For Diabetic Education. The goal is to increase the knowledge of diabetes, impact on all phases of life and offer lifestyle changes.

E For Eye Exam. The goal is to have yearly dilated eye exam done by an eye care professional for early prevention and detection of diabetic eye disease.

HOT SPOTS FOR PERFORMANCE IMPROVEMENT

* Many of the asthma enrollees did not fill a prescription on the preferred asthma therapy medication list as defined by the National Committee for Quality Assurance (NCQA). To obtain the list of the Preferred Asthma medication, please go to http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013FinalNDCLists.aspx or contact your subnetwork's QI Department.
* Hypertensive clinical management can be a challenge for many enrollees and providers. Assisting your hypertensive enrollees to achieve target goal systolic BP < 140 and diastolic BP < 90 will decrease the risk of complications.