

Frequently Asked Questions regarding Hospital Reimbursement Modernization

1. With the delay of ICD-10, will there also be a delay in the IP Modernization methodology?

Response: The department's plans to implement APR-DRG on 1/1/2015 have not changed. We will provide an update if this timing changes for any reason.

2. What will happen to DSH under DRGs?

Response: Federal DSH program payments will be handled as they are currently and as such will not be incorporated into the APR-DRG prospective payment system.

In addition, DSS has maintained a "DSH add-on" based on similar logic, which has increased some hospital's per-discharge target rate and interim per-diem rates. The timing of this calculation does not allow it to fit into the prospective payment approach of APR-DRG. As such, this funding stream will be handled outside of APR-DRG as a supplemental payment, although the calculation approach will remain relatively unchanged.

3. When is the expected implementation of the OP methodology?

Response: The department's implementation target for outpatient payment modernization is 1/1/2016.

4. What version of the APR-DRG grouper will be used for implementation in January 2015?

Response: Our intent is to use the most current version that will retain ICD-9 compatibility. At this point we anticipate Version 31. There is some possibility that we will select Version 32, depending on its actual release date. We will update this FAQ as we gather more information. Note that Versions 30, 31, and 32 are developed to produce the same resulting scores and payments.

5. Regarding the CPT/HCPCS requirement on outpatient claims effective May 1, 2014, why are the codes not required for the therapy codes?

Response: The therapy codes in question, Physical Therapy, Occupational Therapy & Speech Therapy, are excluded from Medicare's APC methodology and it is up to the individual payer to decide how to reimburse for these services. The Department plans to continue paying for these services as it does today, i.e. a set per visit fee. DSS has no purpose or reason to append the CPT codes to the RCC. Any hospital may decide to include the CPT code on the claims for these RCCs for internal informational purposes. DSS will not be requiring them on therapy claims beginning May 1, 2014 or in the final APC rate setting methodology.