ADMINISTRACIÓN DE SEGUROS DE SALUD

ASES

GOBIERNO DE PUERTO RICO

Puerto Rico All Patient Refined Diagnosis Related Group Reimbursement Guide

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Overview of All Patient Refined Diagnosis Related Group Pricing

For dates of discharge on and after January 1, 2026, managed care organizations (MCOs) will group and price claims using the All Patient Refined Diagnosis Related Group (APR DRG) classification system for most inpatient hospital claims. The APR DRG classification system will align the classification of inpatient hospital claims more appropriately with the needs of the Puerto Rico Medicaid population and expand the DRG system scope to include patient severity of illness (SOI). SOI is based on the extent of physiological decompensation or organ system loss of function. It is represented with a value from one to four, with four being the most severe. Puerto Rico is implementing DRG version 42, which uses national weights.

MCOs apply the Solventum APR DRG grouper and corresponding national weights to each APR DRG. The weights reflect the relative resource consumption for each inpatient stay.

Hospital base rates are assigned to each individual hospital and have been calculated using historical utilization. The hospital base rate is applied to each qualified inpatient discharge to determine the claim payment amount. Hospital base rates will be rebased at the discretion of Administración de Seguros de Salud (ASES).

The hospital rates and DRG weights are available at https://www.ases.pr.gov/drg.

The APR DRG pricing calculator is available at https://www.ases.pr.gov/drg.

Below is a detailed description and calculation of how reimbursement is determined for each type of claim (standard DRG reimbursement, transfer reimbursement, and outlier reimbursement).

Standard DRG Reimbursement

For the majority of hospital inpatient stays that will use the APR DRG methodology, payment to the hospital is calculated by multiplying the hospital's specific base rate by the weight assigned to the DRG and by the Service Line Policy Adjuster. This is referred to as the DRG base payment. Below is an example of a payment that does not qualify for transfer reimbursement, or outlier reimbursement.

DRG: 022 Ventricular Shunt Procedures
SOI: 2
Length of Stay (LOS) in Hospital: 7 days

DRG Base Payment Calculation

DRG Base Rate	$8,009.73
Multiplied by DRG Weight	1.6159
Multiplied by Service Line Policy Adjuster	1.00
Equals DRG Base Payment	$12,942.92

Below is an example of a standard DRG reimbursement payment for a DRG that has a policy adjuster greater than 1.00.

DRG: 041 Nervous System Malignancy
SOI: 1

Length of Stay (LOS) in Hospital: 3 days

DRG Base Payment Calculation

DRG Base Rate	$8,009.73
Multiplied by DRG Weight	0.7170
Multiplied by Service Line Policy Adjuster	1.37
Equals DRG Base Payment	$7,867.88

Transfer Reimbursement

Transfers are cases in which a hospital transfers a patient to another inpatient facility to receive or continue treatment.

DRG weights are derived using full LOS claims and do not reflect the resources used in transfer cases. Transfers are subject to the following transfer reimbursement policy. DRGs 580 and 581 (neonate transfers) will not be considered for transfer reimbursement as those DRGs already reflect the resources consumed for transferring a newborn. To be considered a transfer, one of the following discharge codes must be present on the claim:

- 02 — Discharged/transferred to a short-term general hospital for inpatient care.
- 05 — Discharged/transferred to a designated cancer center or children's hospital.
- 07 — Left against medical advice or discontinued care.
- 82 — Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
- 85 — Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.

Transfers are reimbursed differently than standard DRG base payments for the transferring hospital. The receiving hospital is paid as though the patient were a new admission.

The transferring hospital is paid the lesser of the DRG base payment or the DRG per diem multiplied by the LOS at the transferring hospital, plus one additional day.

The following is an example of a transfer payment for the transferring hospital:

DRG: 055 Head Trauma with Coma > 1 Hour or Hemorrhage
SOI: 3
LOS in Transferring Hospital: 3 days

DRG Base Payment Calculation

DRG Base Rate	$8,009.73
Multiplied by DRG Weight	1.2950
Multiplied by Service Line Policy Adjuster	1.00
Equals DRG Base Payment	$10,372.60

DRG Per Diem Payment

DRG Base Payment	$10,372.60
Divided by ALOS	4.06
Equals DRG Per Diem	$2,554.83
Multiplied by LOS In Transferring Hospital Plus One Additional Day	4
Equals Transfer Per Diem Payment	$10,219.31
Transfer Payment (Lower of DRG Base Payment or Transfer Per Diem Payment)	**$10,219.31**

Outlier Reimbursement

When hospital stays are longer than the ALOS for that DRG, the claim is reviewed for potential additional outlier reimbursement. To be eligible for the outlier add-on payment, the outlier day threshold must be met. The outlier day threshold is the greater of the selected DRG and SOI's trimmed geometric ALOS plus 15 days, or the selected DRG ALOS plus three times the untrimmed DRG standard deviation, rounded up to the next whole number. If the outlier threshold is met then additional reimbursement is provided for the outlier days, which are days in the inpatient stay beyond the outlier threshold, or the LOS minus the outlier threshold.

Once outlier days are identified, they are multiplied by the DRG per diem and then multiplied again by 80% to arrive at the total outlier add-on payment.

The following is an example of an outlier add-on payment:

DRG: 022 Ventricular Shunt Procedures
SOI: 2
LOS in Hospital: 25 days

Outlier Day Threshold Calculation:

1) *Using standard deviation*

ALOS	2.64
Plus three times the Standard Deviation (4.06)	12.18
Rounded to the next whole number	14.82
Equals Standard Deviation Outlier Day Threshold	15.00

2) *Adding 15 days*

ALOS	2.64
Plus 15 days	15.00
Rounded to the next whole numbers	17.64
Equals 15-Day Standard Outlier Day Threshold	18.00

The final Outlier Day Threshold is 18 days, the larger of the either the Standard Deviation Outlier Day Threshold or the 15-Day Standard Outlier Day Threshold

Outlier days calculation	25

LOS in Hospital	
Less Outlier Day Threshold	(18)
Equals Outlier Days	7
Outlier Add-On Payment Calculation	
DRG Base Rate	$8,009.73
Multiplied by DRG Weight	1.6159
Multiplied by Service Line Policy Adjuster	1.00
Equals DRG Base Payment	$12,942.92
Divided by ALOS	2.64
Equals DRG Per Diem	$4,902.62
Multiplied by Outlier Days	7
Equals Outlier Add-On Payment Before Payment Adjustment	$34,318.34
Multiplied by Payment Adjustment	80%
Equals Outlier Add-On Payment	**$27,454.67**

Service Line Policy Adjusters

A Service Line Policy Adjuster is a multiplicative factor applied to the DRG Base Payment depending on the DRG's Service Line, intended to enhance payment for select services. The following Service Lines will have a factor greater than 1.00 applied as part of the payment calculation:

- Internal Medicine: 1.08
- Pediatrics (Neonatal)[1]: 1.13
- Dermatology: 1.23
- Mental Health and Substance Abuse: 1.27
- Oncology: 1.37

If a Service Line is not listed above, the factor is set at 1.00.

Separately Reimbursable Services Outside the APR DRG Payment

Most covered services provided during an inpatient are considered hospital inpatient services reimbursed under APR DRG payment methodology. The following services are not covered under the APR DRG payment methodology and must be billed separately by a certified provider on a claim form other than UB-04 or 837i:

- Professional services, which must be provided by a separately certified provider and billed on the Centers for Medicare & Medicaid Services 1500 or 837p claim form.
- Durable Medical Equipment and supplies for non-hospital use.
- Implant and Devices

[1] The Pediatrics Service Line is primarily comprised of DRGs for neonatal services. Non-neonatal services provided to pediatric patients will appear under the Service Line for that type of service (e.g., a pediatric dermatology visit would appear under Dermatology rather than Pediatrics)

- Specialized medical vehicle transportation, including initial transportation to the hospital, transportation after discharge, and transfers.
- Drugs Excluded from APR DRG Payment:
    - Long-Acting Reversible Contraceptives (LARCs) device and insertion at the time of delivery.
        - An additional payment will be made when a LARC is provided during an inpatient stay. The LARC device must be billed separately from the inpatient visit.
    - Gene therapies that treat heritable conditions, orphan, or non-oncology indications.
    - Chimeric antigen receptor T and other cellular therapies that treat cancer or SMA.
    - Hemophilia blood factor products.
    - These drugs will be reimbursed through a professional or pharmacy claim.
    - Hospitals and prescribers must obtain prior authorization (PA) from the Plan Vital MCOs prior to administering any of the drugs excluded from the DRG payment listed on the ASES website. (See ASES website: https://www.ases.pr.gov/drg) This list, along with PA and other requirements, will be updated periodically.
    - For University Pediatric Hospital and Puerto Rico Women and Children's Hospital, any inpatient drug costs which exceed $5,000 are reimbursed separately based on invoice cost.

Enrollment and Eligibility Changes During Hospital Stay

When the member is an inpatient at a hospital, ASES shall postpone the effective date of disenrollment so that it occurs on the last day of the month in which the member is discharged from the hospital, or the last day of the month following the month in which disenrollment would otherwise be effective, whichever occurs earlier. As a result, there should be no instance in which a member is Medicaid-eligible at time of admission but loses it prior to discharge.

If a member's effective date of disenrollment from one MCO to another MCO occurs during an inpatient hospital admission, the MCO that the member was enrolled with on the date of admission is responsible for covered inpatient facility and professional services associated with the inpatient hospital admission. This responsibility continues from the date of admission until the date the member is discharged from the inpatient stay.

A member may be ineligible for Medicaid upon admission, however, may become eligible for Medicaid during his/her stay in the hospital. In these cases, the eligibility period is the first day of the month in which the member submits its eligibility application with the Medicaid Program Office and they shall be eligible to be enrolled as of that date. Refer to the MCO/ASES contract for eligibility and retroactive enrollment eligibility information.

Medicare Payor

In general, except for services offered by Medicare Platino plans, which operate independently of this Contract, Medicaid does not duplicate coverage provided by Medicare to Dual Eligible Beneficiaries and the Contractor shall not be a secondary payor for services for which Medicare is liable.

However, in a situation in which a covered service is covered in whole or part by both Medicare and Medicaid (for example, hospitalization services for a Dual Eligible Beneficiary who is enrolled in Medicare Part A only and whose hospitalization costs exceed the Medicare limit), the Contractor shall determine liability as a secondary payor as follows:

- If the total amount of Medicare's established liability for the services (Medicare paid amount) is equal to or greater than the APR DRG payment amount for the services, minus any Medicaid cost-sharing requirements, then the provider is not entitled to, and the Contractor shall not pay, any additional amounts for the services.
- If the total amount of Medicare's established liability (Medicare paid amount) is less than the APR DRG payment amount for the services, minus any Medicaid cost-sharing requirements, the provider is entitled to, and the Contractor shall pay, the lesser of:
    - The Medicaid cost-sharing (Deductibles and coinsurance) payment amount for which the Dual Eligible Beneficiary is responsible under Medicare.
    - An amount which represents the difference between APR DRG payment amount for the service minus any Medicaid cost-sharing requirements and the established Medicare liability for the services.

Payment shall not exceed the full APR DRG payment amount.

Secondary Payor (Excluding Medicare)

When Medicaid is not the primary payor for a member's inpatient stay, Medicaid will only reimburse the difference between the primary payor paid amount and the APR DRG payment amount or the deductible and/or coinsurance amounts on the claim, whichever is less.

Same Day Admit and Discharge

Inpatient stay is a stay in which the admission date does not equal the discharge date. A stay in an observation bed where the patient is not admitted is paid as an outpatient visit, even if greater than or equal to 24 hours.

Same Day Admit and Date of Death

Claims with a same date of admission and date of death will be reimbursed under the DRG reimbursement methodology. Providers must report the discharge status code of 20 on the claim indicating death.

Readmission Policy

This policy will be in the ASES's uniform Utilization Management Guidelines for Medicaid Plan Vital.

Health Care Acquired Conditions and Present on Admission

In accordance with Section 2702 of the Patient Protection and Affordable Care Act and 42 CFR 438.3(g), the Contractor must have mechanisms in place to prevent payment for the following provider-preventable conditions and must require all providers to report on such provider-preventable conditions associated with Claims for payment or Enrollee treatments for which payment would otherwise be made. The Contractor must report all identified provider-preventable conditions to ASES as follows:

- All hospital acquired conditions as identified by Medicare other than deep vein thrombosis/Pulmonary Embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients for inpatient hospital services.

- Any incorrect surgical or other invasive procedure performed on a patient; any surgical or other invasive procedure performed on the incorrect body part; or any surgical or other invasive procedure performed on the incorrect patient for inpatient and non-institutional services.

Interim Claims

For those claims with extended stays (greater than 29 days) and a discharge status code 30, providers are allowed to submit an interim bill to be paid at the full APR DRG payment amount. Submission of interim claim(s) is voluntary and not mandatory under any circumstance. Interim bill types of 112 and 113 are only accepted for stays exceeding 29 days.

When the patient is discharged, a single admit-through-discharge claim should be submitted using bill type 111 (Admit-through-discharge claim) containing the full LOS, all diagnosis and surgical procedure codes, and all the charges for the entire stay which will be priced using the APR DRG method. All previous interim claims shall be voided.

Split Billing

Split Billing will not be allowed on either the hospital or state fiscal year end. The DRG reimbursement will recognize all services on the date of discharge.

Newborn Guidelines and Billing

Claims for newborns will not be denied by the APR DRG software if submitted with the mother's Medicaid identification (ID) number. Claims for newborns are to be billed using any combination of revenue codes, and their claims will be reimbursed based on the DRG payment methodology. The delivery is charged to the Mother's ID, but all services provided to the newborn are charged in a separate claim. Claims for newborns delivered to a mother enrolled in a MCO at the time of birth must be submitted to the mother's MCO.

For claims submitted related to newborns, providers should include the birth weight of the newborn on all claims. Claims without birth weight will be denied. Birth weight should be communicated in a value amount field with an associated value code equal to 54. Birth weight should be billed as a number of grams using whole numbers.

Hospitals must bill neonatal claims in accordance with International Classification of Diseases coding guidelines and level of care.

Incarcerated Members

Hospitals are reimbursed for incarcerated members under the APR DRG methodology similar to other enrolled members.

Lesser of Logic

This policy is not applicable for FFY 2026.

The "lesser of" paid or billed logic will be applied under the DRG payment methodology. The final payment shall not exceed the total charges for the inpatient stay.

New Hospitals

New Hospitals shall receive 80% of the island-wide weighted average DRG base rate. A new hospital is classified as new if it has no prior Medicaid enrollment in Puerto Rico. If a new hospital is created and shares an existing Medicare ID with a current Medicaid provider, the current Medicaid provider's existing DRG base rates will be used for the new hospital.

Replacement Hospital

If a new hospital is opened for the purpose of replacing an existing hospital facility identifiable to a unique Medicaid provider number and the original facility closes, the rates from the original facility shall be used for reimbursement.

Change of Ownership

Hospitals that have a change of ownership shall receive the prior owner's DRG base rate.

Hospital Mergers

When hospitals that can be identified by a unique Medicaid provider number undergo a merger, the rates for the surviving Medicaid provider number will be used for reimbursement. In situations in which services may be discontinued at one hospital and transferred to another hospital, the receiving hospitals base rates shall be used for reimbursement.

Out of Territory Hospitals

Acute care services provided by hospitals located outside of Puerto Rico will be reimbursed under the DRG methodology. The hospital shall receive the island-wide weighted average DRG base rate as part of the DRG payment calculation. Alternatively, MCOs have the option to enter into a single case agreement if the service being provided is not available in Puerto Rico. Single case agreements are not allowed for non-covered services.

Hospitals Excluded from the APR DRG Payment Methodology

The following hospital types are excluded from the APR DRG Payment Methodology and are reimbursed under separate payment methodology:

- Freestanding Psychiatric Hospitals and Psychiatric Hospitals included within the walls of a short-term acute care hospital but maintains a different NPI than the STAC

- Freestanding Rehabilitation Hospitals and Rehabilitation Hospitals included within the walls of a short-term acute care hospital but maintains a different NPI than the STAC
- Hospitals that have current capitated arrangements for inpatient services prior to January 1, 2026. These hospitals may continue to be reimbursed for inpatient services under their capitated arrangement payment model. Any reconciliation process and data submitted and reported by the Managed Care Organization should be based on DRG rates.