Mercer

welcome to brighter

Afternoon Session:
Coding for APR DRGs

Puerto Rico Plan Vital

October 2024

Agenda

1. Objectives of Today's Training
2. Overview of DRGs
   - MS-DRG vs APR DRGs
   - Advantages of APR DRGs
3. Importance of DRGs
4. APR DRG Classification
5. Demonstration of APR DRG Assignment
6. What Goes into the Coding of DRGs?
7. Items for Hospital Consideration
8. Items for Physician Consideration
9. Hospital Processes — Best Practices
10. Next Steps and Questions

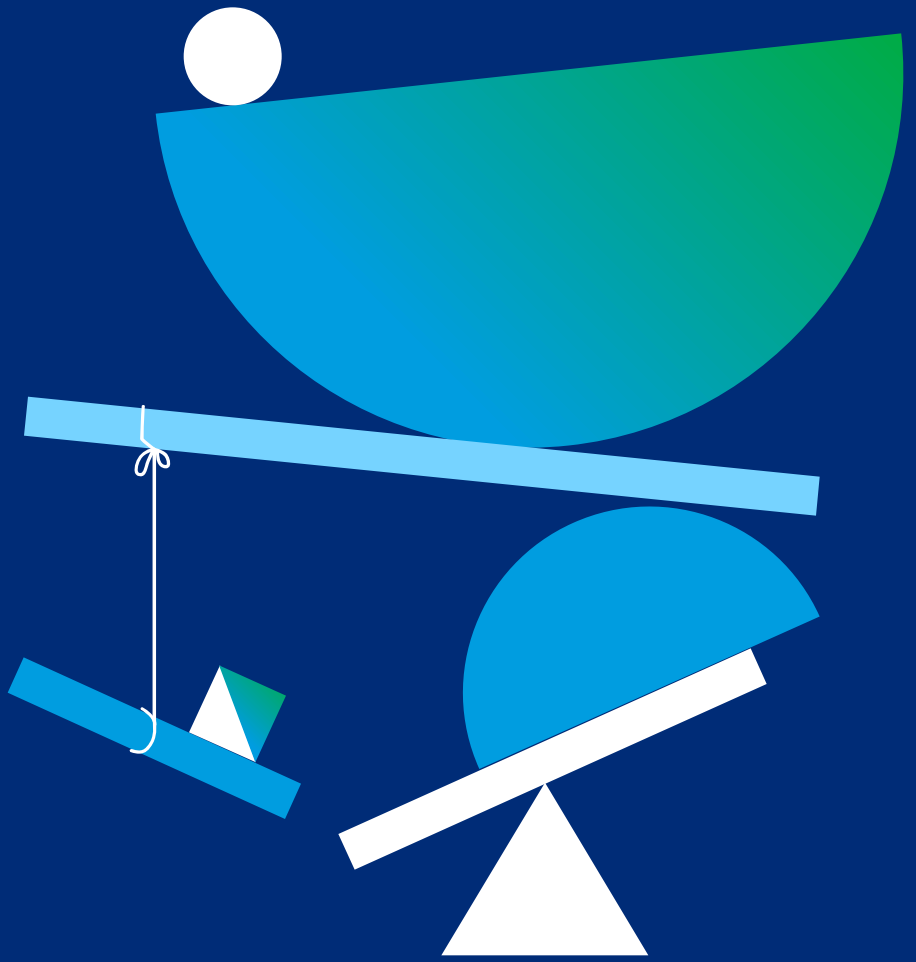
Objectives

1

Today’s Training

Objectives

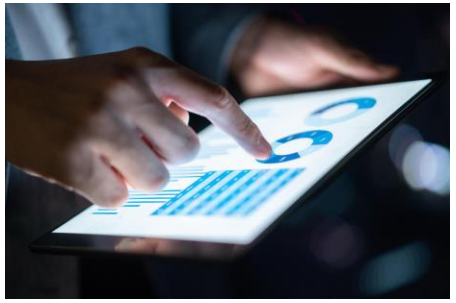
- To provide additional information on the APR DRG system that ASES will implement on October 1, 2025.
- To share the background on APR DRGs and how the software processes the claims data to calculate reimbursement.
- To support a smooth transition to the new reimbursement methodology.
- To set aside time for hospitals to ask questions specific to this transition.



Key Points To Take From This Session

Build upon existing policies for MS-DRG coding.

Without complete documentation, accurate coding cannot be achieved.



Accurate medical coding ensures that hospitals are reimbursed correctly for the services provided.

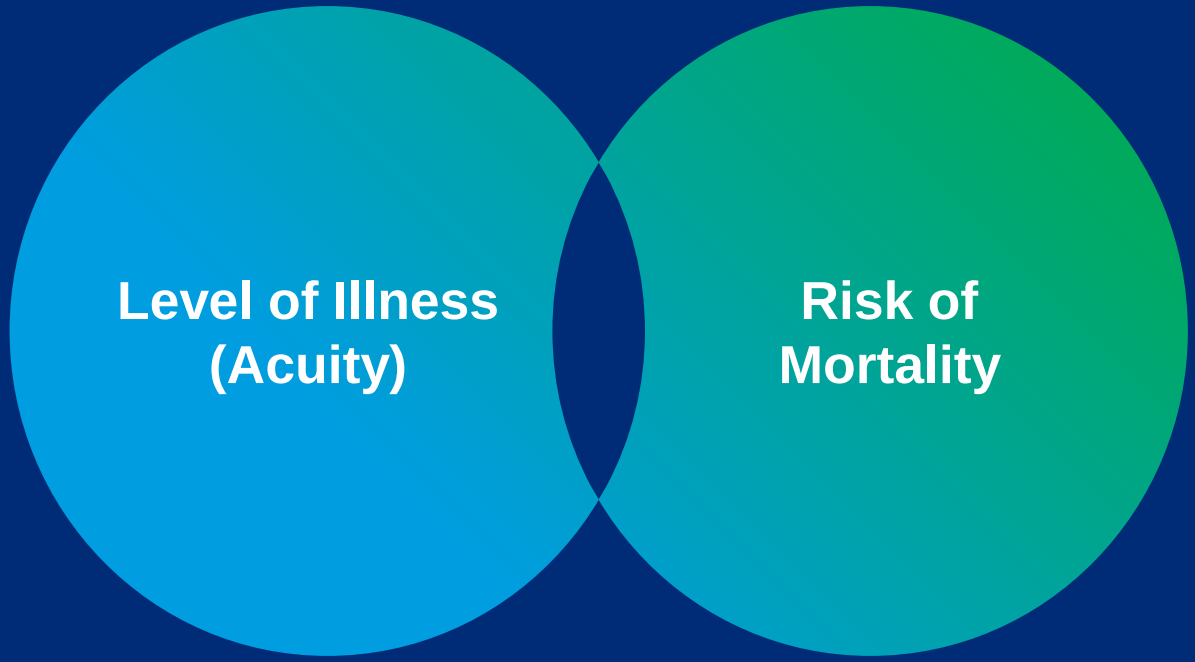
Overview of DRGs

2

Purpose of DRGs

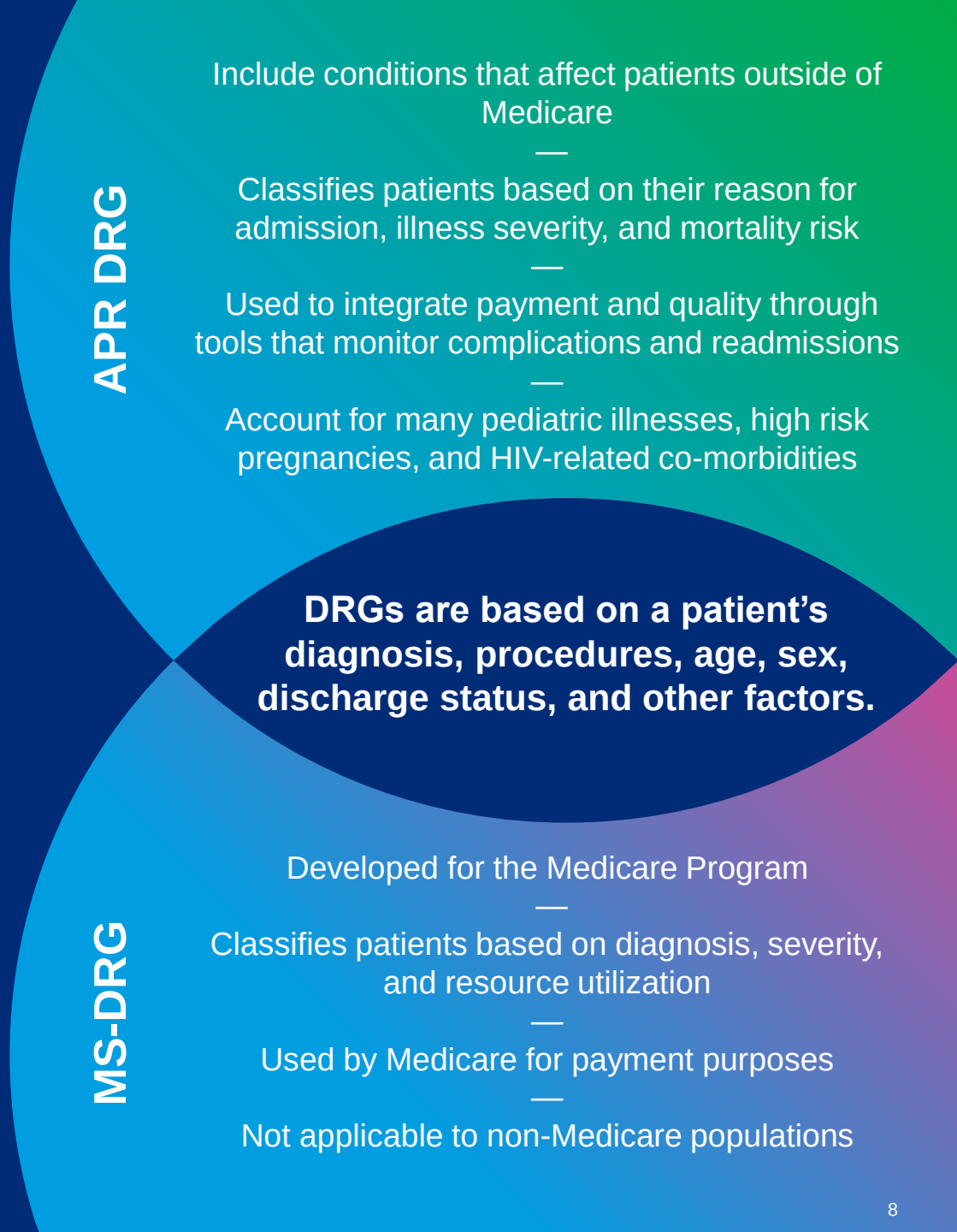
- DRG systems are standardized methodologies used to:
  - Evaluate patient conditions and group similar cases consistently across hospitals, within a state, and across states.
  - Allow communication, improvements, and efficiencies between hospitals and payers.

To determine the DRG assignment for an inpatient stay, two key items are evaluated:



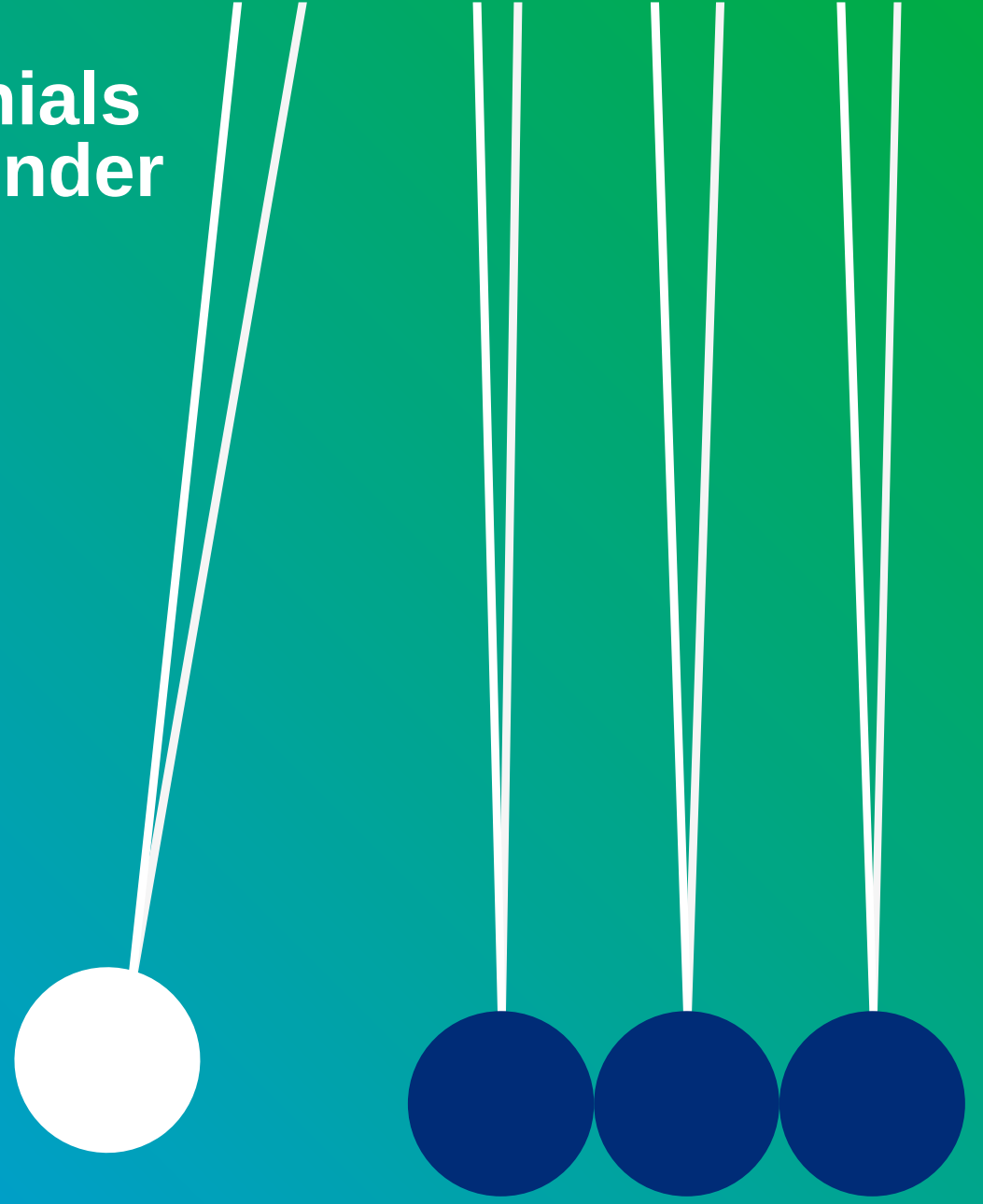
DRGs

- DRG stands for Diagnosis Related Group, which is a system that classifies patients to determine how much a hospital will be reimbursed for their care.
- The goal of DRGs is to pay hospitals fairly for similar care, and to encourage access to care and efficiency.



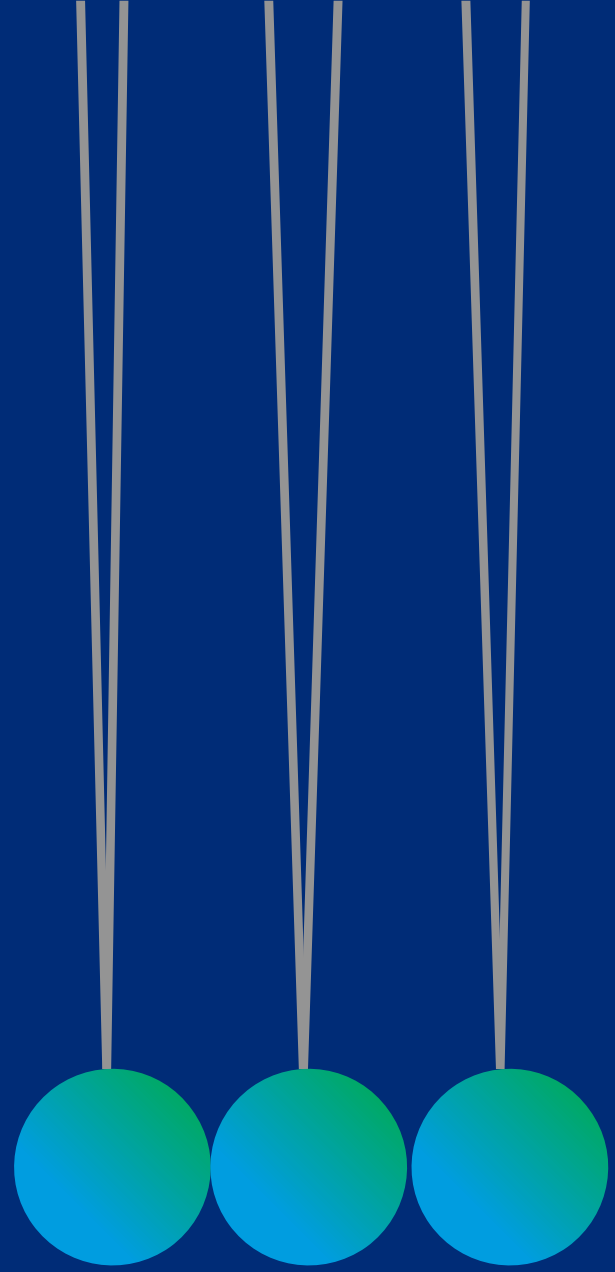
Examples That Can Cause Claim Denials or Claims Paid at a Lesser Amount Under APR DRGs

- Severity of Illness and/or Risk of Mortality are not included on the claim.
- Missing or incorrect Present on Admission (POA) indicators for each diagnosis on the claim.
- Incorrect Discharge Status identified on the claim.
- Medical necessity is not demonstrated by the documentation accompanying the claim.
- Submitted documentation contains inconsistent information compared to the claim.
- Inaccurate sequencing of diagnosis codes.
- Medical records not certified by the physician.
- Lack of itemized list of all charges.
- Lack of physician progress notes.
- Lack of plan of care.



Limitations with Plan Vital Encounter Data

- Hospital claims submitted to MCOs include the necessary information for payment under the current per diem methodology, however, for purposes of APR DRGs:
  - There are missing or incomplete values on the encounter claims, such as discharge status code and present on admission indicators.
  - Not all revenue codes and charges for an inpatient hospital stay are included on the claims.
- Unknown age of newborn inpatient stays: Newborn stays are reported with mother's Medicaid ID.
- MCOs have sub-capitated arrangements for some inpatient hospital services.



Plan Vital APR DRG Simulation Versus National Standards

Severity of Illness

A comparison of the Severity of Illness level in Plan Vital encounter claims assigned using the APR DRG methodology to those published nationally.

	Plan Vital — Version 40		National Totals — Version 40		
Severity of Illness	**Total Count of Claims (CYs 2021 and 2022)**	**Percent to Total**	**Total Count of Claims**	**Percent to Total**	**Difference**
1	109,569	56.4%	4,498,795	34.6%	63.1%
2	60,282	31.1%	4,836,294	37.2%	(16.4%)
3	19,415	10.0%	2,640,152	20.3%	(50.7%)
4	4,806	2.5%	1,032,039	7.9%	(68.7%)
Total	**194,200**	**100.0%**	**13,007,280**	**100.0%**	

Importance of DRGs

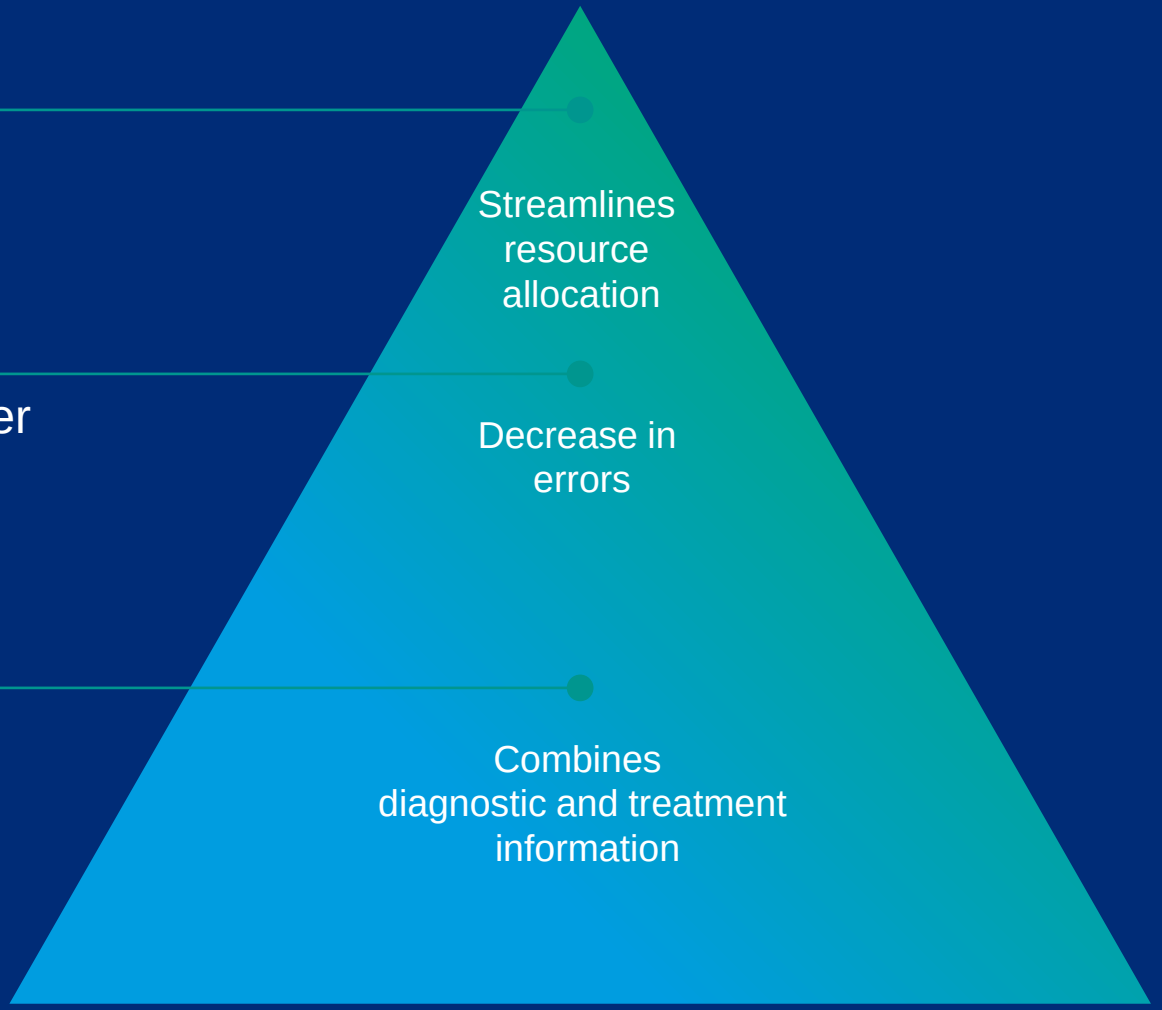
Importance of DRGs

Assessing Patient Outcomes

- Care can be proactive with resources in place.

- Complete and accurate documentation results in fewer oversights or misunderstandings of care.
- Billing is less subjective.

- Allows for analysis of comparable patient groups.
- Supports quality and performance measures which can aid in improving patient care.
- Supports quality and performance measures which can aid in improving patient care.



Importance of DRGs

Consistency in Billing

Comparable Patients Billed the Same

Providers can better predict reimbursement:

- ✓ Improves fiscal planning
- ✓ Simplifies the billing process and increases transparency
- ✓ Decreases the number of denied or delayed payments

Better Data Analytics

Ability to generate comprehensive reports and explore trends in outcomes and care:

- ✓ Advances the ability to detect gaps in service or care
- ✓ Gain insight into trends

Insight into Trends

Improves ability to make comparisons across providers:

- ✓ Allows for better benchmarking

Importance of DRGs

Better Benchmarking

Identifying Areas for Improvement

- Providers can compare DRG mix and/or costs with industry benchmarks
- Identify areas where you can increase efficiencies, reduce costs, and streamline internal operations

Managing Resources

- Better prediction of future events
- Improved organizational decisions

Improved Audit Outcomes

- Ability to compare hospital departments or other regional facilities

Importance of DRGs

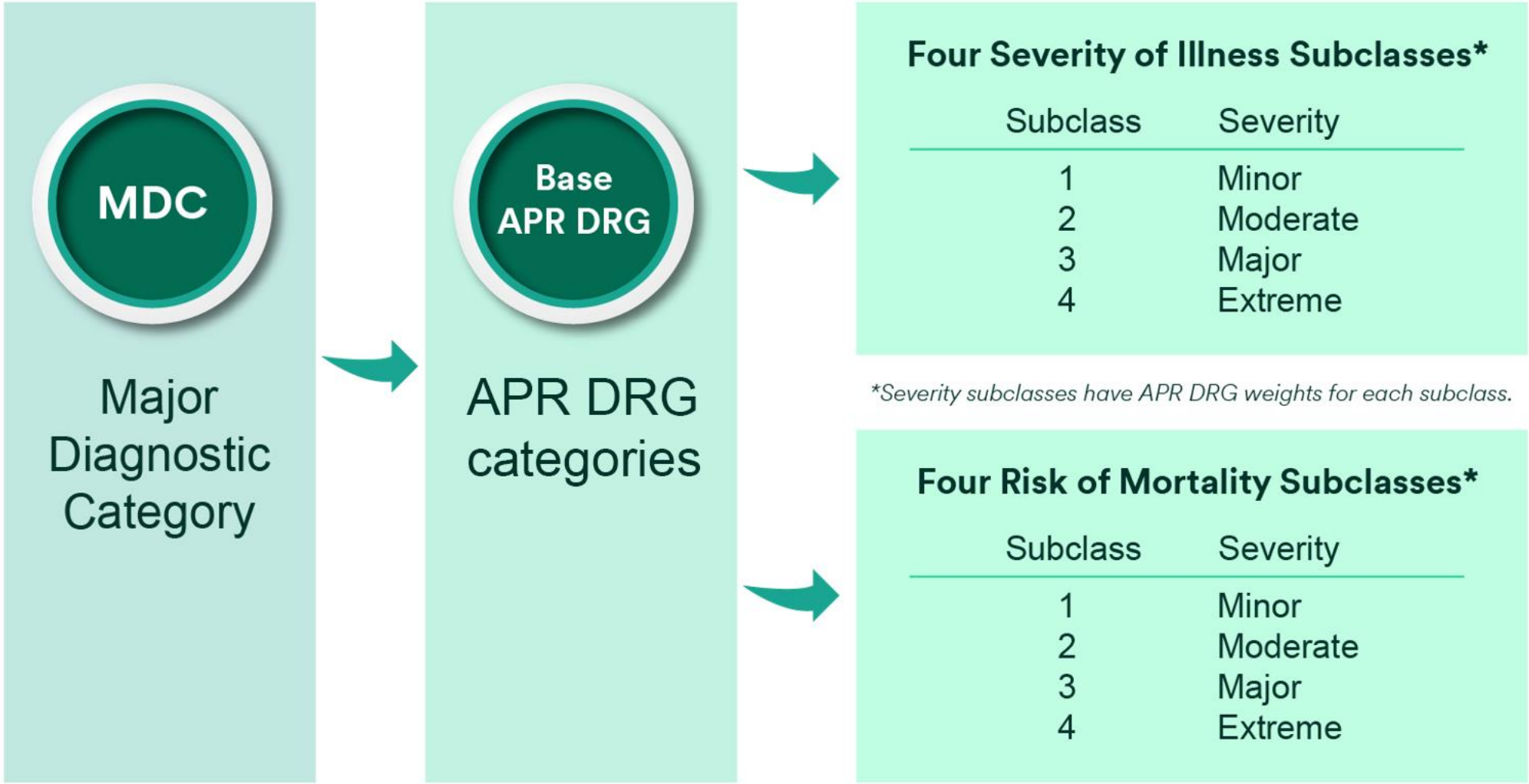
Performance Measure Tracking

- Standardizes the framework for performance measures:
  - Streamlines the process
  - Better categorization of patient conditions
  - Less subjectivity concerning measure outcomes

APR DRG Classification

4

APR DRG classification data elements



What is Severity of Illness (SOI) and Risk of Mortality (ROM)

SOI

Severity of Illness, a reflection of how severely ill or sick a patient is due to their disease burden, how difficult he/she is to manage, the types of intervention required, and the intensity of those resources

ROM

Risk of Mortality, the likelihood a patient will die due to their disease burden

3M™ APR DRG assignment is driven by:

- Principal diagnosis
- Procedures performed
- Most additional or secondary diagnoses
- Patient age
- Patient gender

solventum

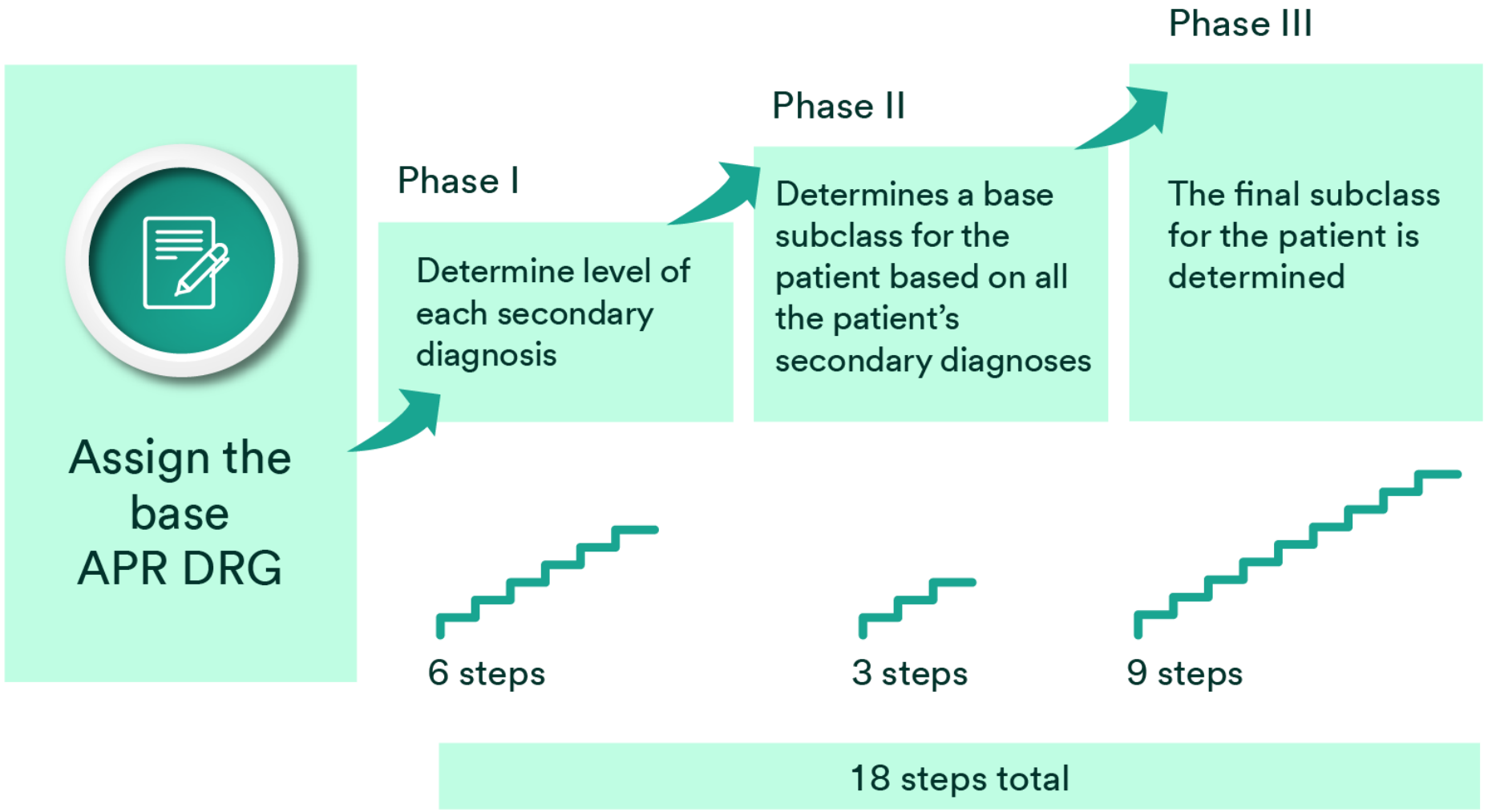
Underlying principle of 3M™ APR DRGs

Severity of Illness and Risk of Mortality are dependent on patient’s underlying problems

High SOI and ROM are characterized by multiple serious diseases and the interaction among those diseases

solventum

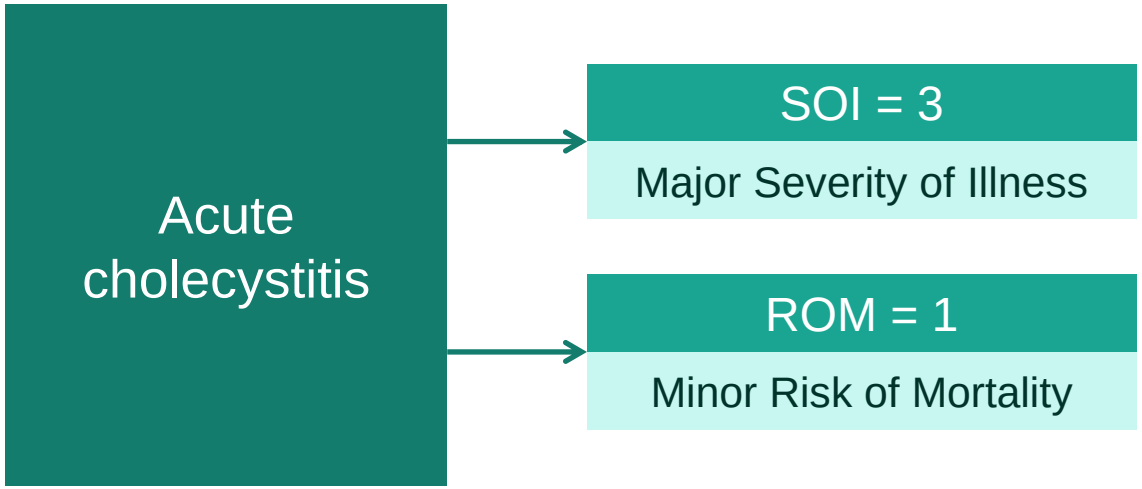
APR DRG methodology process



SOI and ROM are independent

The severity of illness and risk of mortality subclass are calculated separately and may be different from each other.

- Severity of Illness is weight based
- Risk of Mortality is based on many factors including age and gender



solventum

Impact of additional or secondary diagnoses on 3M™ APR DRGs

	OPTION 1	OPTION 2	OPTION 3	OPTION 4
APR DRG	APR DRG 139 Weight 0.4011 SOI Subclass 1 ROM Subclass 1	APR DRG 139 Weight 0.5261 SOI Subclass 2 ROM Subclass 2 Driver: CHF	APR DRG 139 Weight 0.7912 SOI Subclass 3 ROM Subclass 2 Driver: Malnutrition	APR DRG 139 Weight 1.4375 SOI Subclass 4 ROM Subclass 4 Driver: Acute respiratory failure
PDx	Viral pneumonia	Viral pneumonia	Viral pneumonia	Viral pneumonia
SDx	None	Acute on chronic diastolic congestive heart failure (CHF)	Acute on chronic diastolic CHF Malnutrition	A/C diastolic CHF Malnutrition Acute respiratory failure

solventum

Demonstration of APR DRG Assignment

5

What Goes Into Coding?

6

What Goes Into Accurate Coding?

Diagnosis Codes

Principal

The diagnosis is determined after reviewing all documentation from licensed physicians in the patient's medical record.

Requires the most resources.

Carries significant weight in determining the DRG.

Secondary

Any condition that is clinically evaluated, diagnostically tested, or treated, or that increases the patient's nursing care or length of stay.

Can be co-existing conditions or complications arising during stay.

What Goes Into Accurate Coding?

Procedure Codes

Significant Procedure

- ✓ Carries an operative or anesthetic risk
- ✓ Requires highly trained personnel or special equipment

Other Procedures

- ✓ Can range from surgeries to diagnostic tests

Accurate Coding

- ✓ Ensures proper categorization
- ✓ Justifies billing

What Goes Into Accurate Coding?

Discharge Status

Discharge Status determines whether transfer policy applies or not.

DRG assignment can be affected by discharge status if they are transferred to a different institution, for example for newborns/NICU cases.

Incorrect status can result in errors in reimbursement and prolonged payment.

What Goes Into Accurate Coding?

Patients Demographics

Age can affect assignment of DRGs

- ✓ Pediatric patients, or those 17 years old and younger, are often assigned to separate DRGs

- ✓ If a patient's age is non-numeric or coded greater than 124, the patient will be assigned to DRG 470

- ✓ Neonates defined as newborns and all other patients of age less than 29 days at admission

- ✓ Severity of illness designation can be affected by age

Items for Hospital Consideration

7

Items for Hospital Consideration

Accurate Coding

No special resources beyond what you may already have

- Billing staff that have specialized coding
- Certified coders or employees who specialize in coding
- Clinical Documentation Improvement Specialists (CDIs)

Current Medicare FFS coding can be applied (with enhanceme

- Additional All-Patient groups such as newborns and maternity
- Other types of care that are not specific to Medicare

Items for Hospital Consideration

Provider Education

Studies show that physicians educated on documentation and coding requirements results in more accurate DRG assignments

https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN6447308-ICD-10-CM/icd10cm/index.html

https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN4151758-ICD-10-PCS/ICD10PCS/index.html

CDIs — Clinical Documentation Improvement specialists — if you have these, put them to work helping providers with coding

Feedback to your providers is important!

If data analysis points to providers or groups having issues with coding, provide feedback and resources if available.

Items for Hospital Consideration

Streamlined Billing

- Fixed payments from DRGs allow for improved cost consciousness:
  - Data analytics can show trends more easily
  - Better matching of cost to payments
- Standardization improves time spent on individual claims or batches:
  - Fewer outliers mean less time spent in research
  - Eases administrative tasks and decreases billing errors
- Payment accuracy levels increase

Items for Hospital Consideration

Documentation

- Accurate DRGs are dependent on complete and detailed documentation.
- Encourage providers to maintain coding education

Complexity of Coding

- Best to have certified coders to manage the complexity

Annual Updates

- Important to keep up with updates due to changes in technology and medical practices

Coding errors

- Incorrect DRG assignment can lead to denial of claims.
- Consider regular audits and enhanced reporting to make sure errors are corrected.

Upcoding

- Need to audit for this as it can lead to fraud

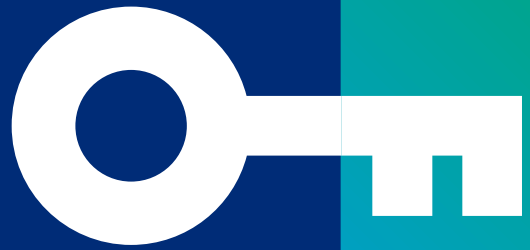
Items for Physician Consideration

Items for Physician Consideration

Accurate Documentation

Complete and Accurate Coding is the Key to APR DRG Assignment

- Make sure all procedures and services are included in the documentation
- ALL diagnoses must be recorded as well
- An incorrect DRG, whether due to a co-condition being omitted or a secondary diagnosis not recorded, can result in thousands of dollars of unrealized revenue



Coding Education

- CMS has basic training for ICD-10 (diagnosis) and PCS (surgical procedure codes)
  - https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN6447308-ICD-10-CM/icd10cm/index.html
- Subscribe to the updates that come out quarterly to keep up with the new codes
  - https://www.ama-assn.org/practice-management/cpt/cpt-news-and-publications-cpt-code-set
  - https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm

Annual Updates

- Be sure to review the annual updates to learn of new technologies and procedures that have been added
  - Codes ending in “T” are temporary codes which are used to determine how much a new technology/procedure will be used. Typically, they remain valid for three years before being reviewed for possible inclusion as a permanent code
  - Codes ending in “F” are performance metric codes and are usually not billed

Items for Physician Consideration

Insight into Patient Care

- DRGs allow for prediction of resource allocation
  - Reduction in the overuse of certain resources
  - All diagnoses should be recorded as well
- Ability to gain insight with comparisons of patient groups
  - Can compare patient outcomes, resource utilization and cost across hospitals or healthcare settings
  - Better able to communicate with payers and hospitals concerning comparable patients
- Quality Improvement
  - By analyzing outcomes and resource utilization within specific DRG categories, physicians can identify areas for improvement, implement evidence-based practices, and enhance patient care
- Research and Analysis
  - Physicians can use DRGs to study patient populations, evaluate treatment outcomes, and compare the effectiveness of different interventions

Items for Physician Consideration

Improvement in Billing

- Reduction in administrative burden
  - Patients that are similar in diagnosis, treatment, and demographics are billed equally
  - Better able to predict reimbursement and budgeting
- Reduction in denied claims
  - Complete and accurate DRG assignment results in fewer denied claims and requests for additional information.
  - Reimbursement is more timely
- Reduction in “surprise” bills for patients

Hospital Processes — Best Practices

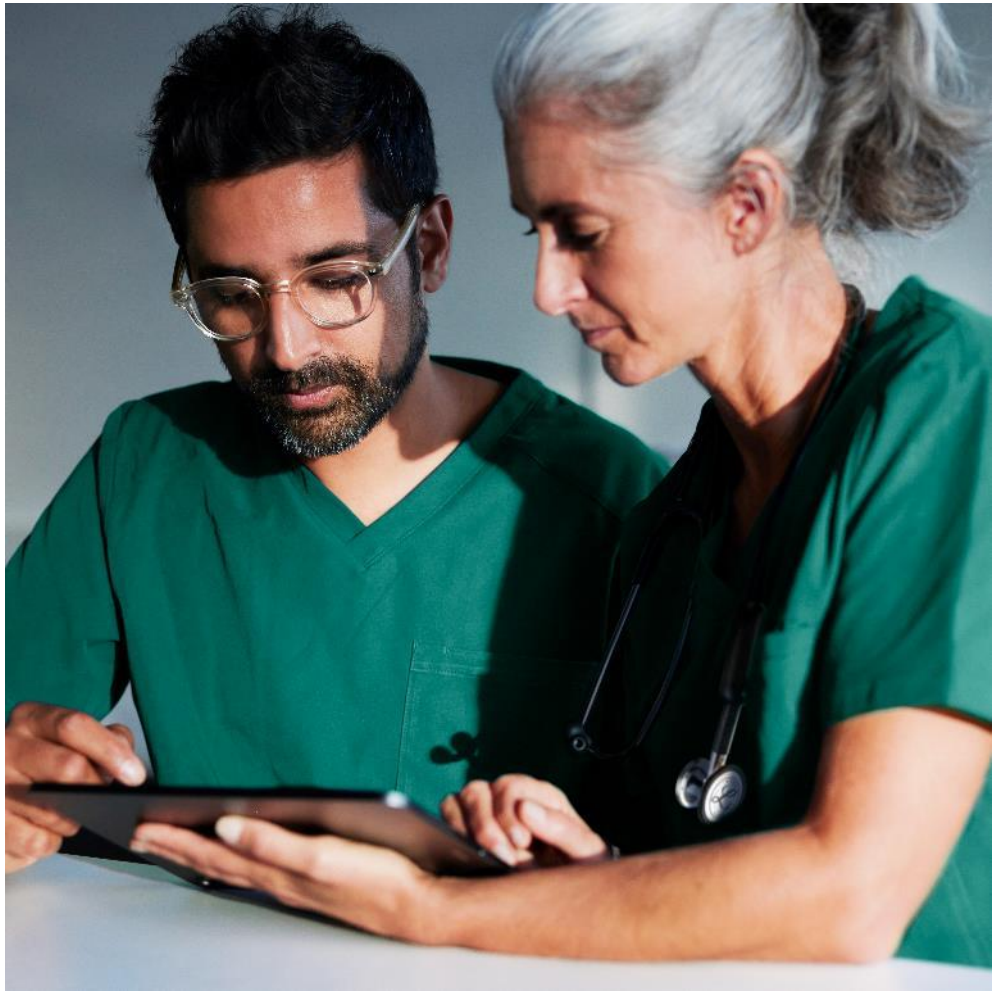
Success with APR DRG methodology

1. Accurate APR DRG assignment
2. Accurate, thorough and complete coding
3. Accurate, thorough and complete physician documentation
4. Clinical Documentation Improvement (CDI) program

Effective APR DRG assignment

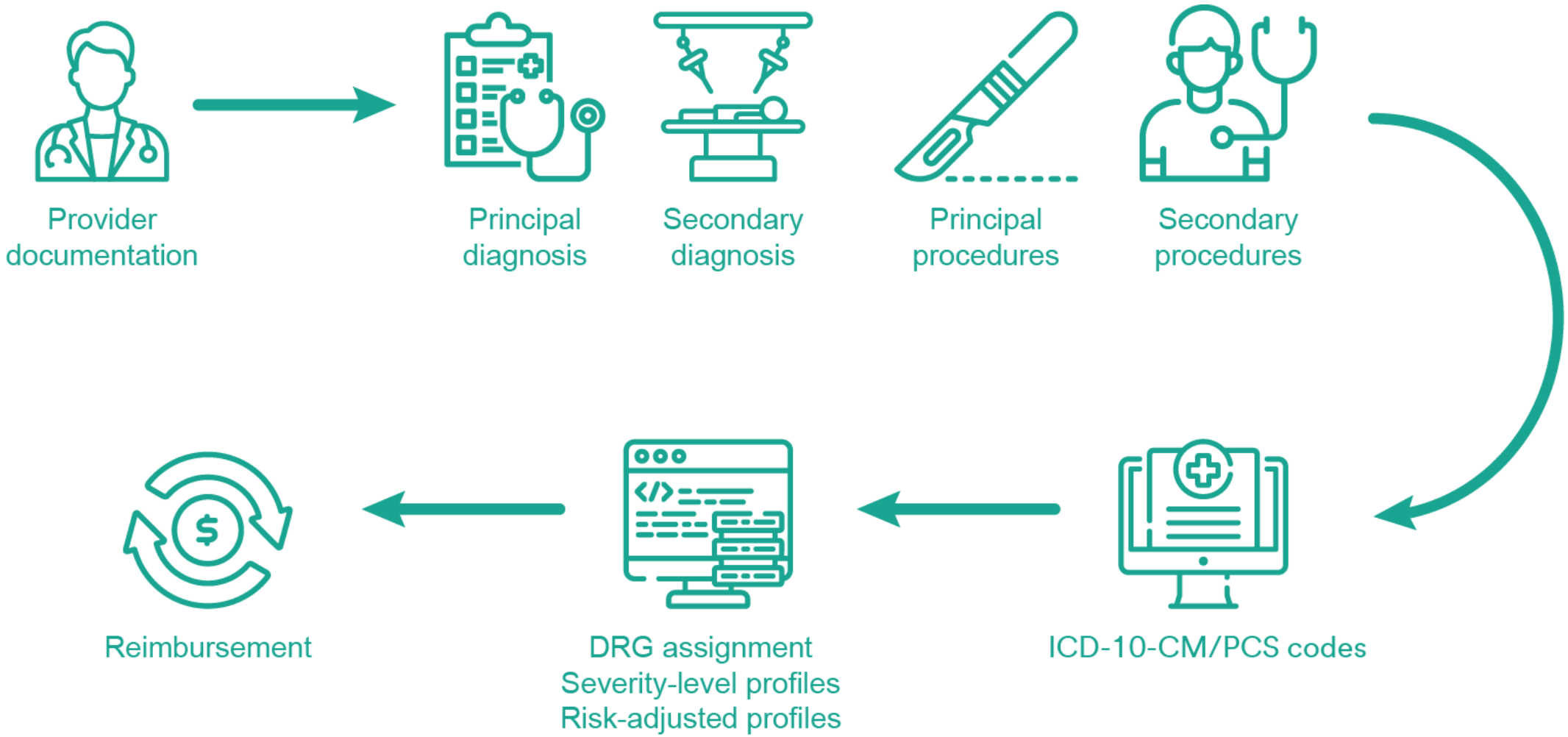
It is imperative that all documented diagnoses that meet the UHDDS (Uniform Hospital Discharge Data Set) coding guidelines be reported for each patient

- Principal diagnosis: The condition established after careful study to be chiefly responsible for occasioning the admission to the hospital
- Additional or secondary diagnoses: additional clinically significant conditions that affect patient care in terms of requiring at least one of the following:
- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring



solventum

Why is documentation important?



solventum

Principal diagnosis impact

The principal diagnosis is defined as the condition established **after careful study** to be **chiefly responsible** for occasioning the admission to the hospital

Selection of principal diagnosis will determine level of severity of illness and reimbursement

PDx: CHF

SDx: Pseudomonas pneumonia

APR DRG: 291

RW: 0.5937

SOI: 2 ROM: 1

PDx: Pseudomonas pneumonia

SDx: CHF

APR DRG: 137

RW: 0.6787

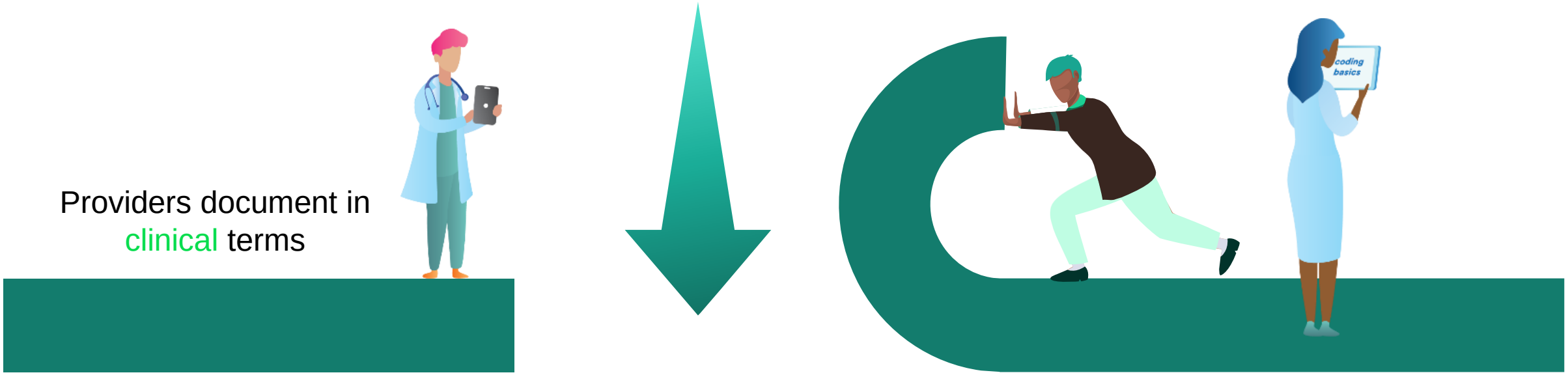
SOI: 2 ROM: 2

solventum

Clinical Documentation Improvement program

A CDI program creates a bridge between the gap

Providers document in clinical terms



Two separate languages

Documentation for coding, profiling & compliance requires specificity in diagnosis terms.

solventum

Common documentation issues

CLINICAL TERMS **(Documentation needs clarification)**	DIAGNOSTIC STATEMENT **(Accurate code may be assigned)**
Continue home medications such as nitrates, beta-blockers, furosemide, phenytoin	Document specific diagnosis such as CAD, chronic atrial fibrillation, chronic systolic heart failure, unstable angina, HTN, grand mal seizure disorder
1. History of CHF, will continue furosemide, ACE inhibitors 2. CXR reveals cardiomegaly, patient treated with diuretics, progress notes reveal no overt CHF 3. Ejection fraction 24%, JVD, lungs bibasilar rales	Heart failure (specify type such as systolic, diastolic, combined systolic and diastolic; specify acuity such as acute, chronic, acute on chronic)
Cardiac enzymes elevated, elevated troponin, EKG positive	Acute myocardial infarction (specify type such as STEMI or NSTEMI; specific artery involved such as LAD, left circumflex; exact date of any recent AMI)
1. LUL infiltrate 2. + sputum culture, productive cough	Pneumonia (specify type and organism (known or suspected), such as Klebsiella pneumonia – must link responsible pathogen to the pneumonia; document cause such as aspiration pneumonia)
1. SOB, pO_2 55, pCO_2 64, pH 7.32, O_2 sat 88%, Bi-PAP, O_2 2. Respiratory distress, cyanosis, ↑HR, labored respirations	Respiratory failure (specify acuity (known or suspected): acute, chronic or acute on chronic; document if acute respiratory failure is hypoxemic, hypercapnic or both)
Emaciated, ↓ albumin, weight loss, BMI 16.5, non-healing wounds, nutritional consult, ordered supplements, consider TPN	Malnutrition (specify type such as protein calorie, protein energy; document severity such as mild, moderate or severe or 1st, 2nd or 3rd degree)
Dry mucus membranes, poor skin turgor, will rehydrate	Dehydration

solventum

Example of documentation improvement

BEFORE

APR DRG: 139
SOI 4 **ROM** 3
Relative weight 1.2765

PDx:
Pneumonia, Unspecified

SDx:
Atrial Fibrillation
Left Heart Failure
Pulmonary Collapse
Hypotension
Cystic Kidney Disease
Edema
Renal Insufficiency
Hx Colon CA

Procedure:
Endotracheal Intubation
Mechanical Ventilation <96 hours

Patient presented to ED unresponsive to tactile and verbal stimuli. Temp 102.9, BP 97/57; O_2 sat 84% on R/A. WBCs 20,000 with left shift. BUN/Creatinine = 49/2.6. ABGs: pH 7.28; pCO_2 45; pO_2 63. Placed on 100% NRB mask. BP started to drop: 85/57, 90/60, 80/40. Placed on Levophed infusion titrated. BP cont'd to drop. Dopamine infusion added; no change in BP. Received IV Rocephin and IV Flagyl. Patient's condition continued to deteriorate; cardiac arrest occurred. Patient was subsequently intubated, placed on mechanical ventilation for 48 hours, and **expired.**

An opportunity exists to concurrently query physician for Sepsis as PDx and Septic Shock, Respiratory Failure, Renal Failure and Coma as secondary diagnoses to impact SOI and ROM

AFTER

APR DRG: 720
SOI 4 **ROM** 4
Relative weight 2.0434

PDx:
Sepsis
SDx:
Pneumonia
Atrial Fibrillation
Left Heart Failure
Pulmonary Collapse
Hypotension
Cystic Kidney Disease
Edema
Hx Colon CA
Septic Shock
Acute Respiratory Failure
Acute Renal Failure
Cardiac Arrest
Coma
Procedure:
Endotracheal Intubation
Mechanical Ventilation <96 hours

Next Steps

10

Moving Forward

Anticipated Next Steps

June 2024

- Meet with Plan Vital MCO entities to discuss the DRG methodology system and operational changes (system updates with Solventum)
- Meet with hospitals to review DRG methodology system

Late Summer/Fall 2024

- Continued conversations with MCO entities and hospitals
- Training sessions with hospitals related to DRG reimbursement and billing practices

July 2025

- Finalize Rates for Implementation using updated data
- Medicaid Regulation Updates: State Plan Amendment

Moving Forward

Anticipated Next Steps

To finalize the APR-DRG Rates for Implementation:

Update Claims Period:

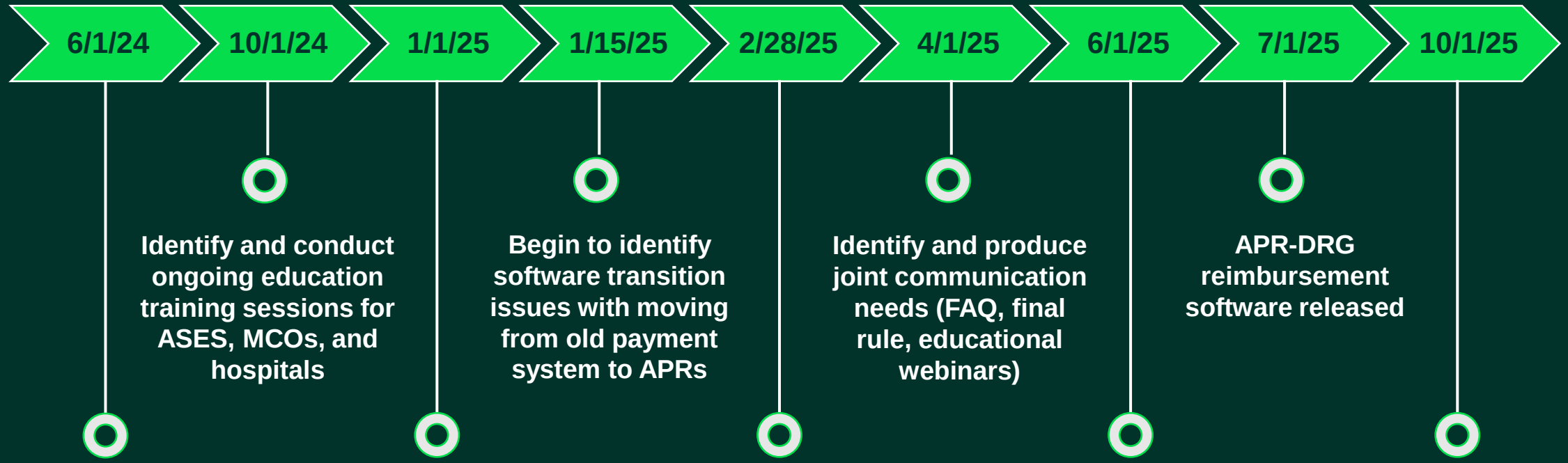
- From discharges Occurring in Calendar Year 2021 and 2022 encounter claims
- To discharges Occurring in Calendar Year 2022 and 2023 (paid through December 2024)

Update the APR-DRG Grouper to recent version:

Currently using V40

Update the STAC Directed Payments Based on Most Recent Year

Next Steps – APR-DRG Software Development



If you have questions regarding the DRG Implementation, please submit **by December 1, 2024** using the form located at the link below:

Plan Vital APR DRG Implementation Questions

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

ASES

Notices

- Incorporating the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision (ICD-10), Copyright World Health Organization, Geneva, Switzerland. ICD-10-CM (Clinical Modification) is the United States' clinical modification of the WHO ICD-10.
- The International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) was developed for the Centers for Medicare and Medicaid Services (CMS). CMS is the US Governmental agency responsible for overseeing all changes and modifications to the ICD-10-PCS.
- If this presentation includes CPT® or CPT® Assistant:
  - CPT ® copyright 2024 American Medical Association. CPT is a registered trademark of the American Medical Association. This product includes CPT and/or CPT Assistant which is commercial technical data and/or computer databases and/or commercial computer software and/or commercial computer software documentation, as applicable which were developed exclusively at private expense by the American Medical Association. The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.
- If this presentation includes Coding Clinic:
  - Coding Clinic is the official publication for ICD-10-CM/PCS coding guidelines and advice as designated by the four cooperating parties. The cooperating parties listed below have final approval of the coding advice provided in this publication: American Hospital Association, American Health Information Management Association, Centers for Medicare & Medicaid Services (formerly HCFA), National Center for Health Statistics. © 2024 by the American Hospital Association. All rights reserved.
- If this presentation includes UB-04 information:
  - Copyright 2024, American Hospital Association ("AHA"), Chicago, Illinois. Reproduced with permission. No portion of this publication may be reproduced, sorted in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior express, written consent of AHA.

Mercer

Services provided by Mercer Health & Benefits LLC.

A business of Marsh McLennan