Public Employees Insurance Agency

Inpatient Hospital Prospective Payment Billing Manual

July 2006

INPATIENT HOSPITAL SERVICES

Under West Virginia Public Payers' prospective payment system (PPS), payments are made prospectively on a per-DRG basis. We follow Medicare's definition of inpatient services as the basis for the standardized payment amount for operating costs. The following is a list of inpatient services as defined by Medicare:

- bed and board
- Nursing services and other related services, medical social services that are ordinarily furnished by the hospital for the care and treatment of inpatients;
- drugs, biological, supplies, appliances, and equipment, for use in the hospital for the care and treatment of inpatients;
- diagnostic or therapeutic items or services, furnished by the hospital;
- physical therapy, occupational and speech therapy.

Operating costs of inpatient hospital services, which includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, are included in the standardized operating payment amount under the prospective payment system. The standardized payment amount also includes malpractice costs, costs of prosthetic devices, costs of independent laboratory services and other services related to the admission. In addition, costs from the following ancillary departments are also included in the standardized operating amount: operating rooms, radiology, medical supplies, laboratory, pharmacy, anesthesia, oxygen therapy, physical and occupational therapies, speech pathology, electrocardiology, electroencephalography, and renal dialysis.

To facilitate the identification of services that are specifically included in the inpatient operating standardized payment amount, we have developed a table which contains all revenue codes that are billed on the UB-92. Also identified in this table are non-covered services, e.g.,

luxury items, and services that are excluded from the standardized amount, e.g., professional services of physicians.

The services of hospital-based physicians (e.g., those on salary) include two distinct elements: the professional component and the provider component. The professional component of hospital-based physicians' services include those services directly related to the medical care of the individual patient. These services are billed using the HCFA 1500. The provider component involving professional services that benefit the hospital's patients as a group are included under PPS.

Please refer to the following Revenue Code table for detailed coverage information. This table is applicable to billable revenue codes for inpatient services only.

REVENUE CODE	DESCRIPTION	PEIA'S POLICY
10x	**All Inclusive Rate**	
11x	**Private Room - Med/Gen. ***	Exclude
12x	**Semi-Private Room-2 Beds-Med/Gen**	
13x	**Semi-Private Room -3/4 Beds**	
14x	**Deluxe Private Room ***	Exclude
15x	**Room & Board Ward**	
16x	**Other Room & Board**	
17x	**Nursery**	
18x	**Leave of Absence**	Exclude
20x	**Intensive Care**	
21x	**Coronary Care**	
22x	**Special Charges**	
23x	**Incremental Nursing Charge Rate**	
24x	**All Inclusive Ancillary**	

REVENUE CODE	DESCRIPTION	PEIA'S POLICY
25x	**Pharmacy**	
26x	**IV Therapy**	
27x	**Medical/Surgical Supplies-Devices**	
28x	**Oncology**	
29x	**Durable Medical Equipment (other than rental)**	
30x	**Laboratory**	
31x	**Laboratory/Pathological**	
32x	**Radiology Diagnostic**	
33x	**Radiology Therapeutic**	
34x	**Nuclear Medicine**	
35x	**CT Scan**	
36x	**Operating Room Services**	
37x	**Anesthesia**	
38x	**Blood**	
39x	**Blood Storage-Processing**	
40x	**Other Imaging Services**	
41x	**Respiratory Services**	
42x	**Physical Therapy**	
43x	**Occupational Therapy**	
44x	**Speech-Language Pathology**	
45x	**Emergency Room**	
46x	**Pulmonary Function**	
47x	**Audiology**	
48x	**Cardiology**	
49x	**Ambulatory Surgical Care**	

REVENUE CODE	DESCRIPTION	PEIA'S POLICY
50x	**Outpatient Services**	
51x	**Clinic**	
52x	**Free-Standing clinic**	
53x	**Osteopathic Services**	
54x	**Ambulance**	
55x	**Skilled Nursing**	
56x	**Medical Social Services**	
57x	**Home Health Aide**	
58x	**Home Health Visits**	
59x	**Units of Service-Home Health**	
60x	**Oxygen Home Health**	
61x	**MRI**	
62x	**Medical/Surgical Supplies**	
63x	**Drugs Specifically Identified**	
64x	**Home Health IV Services**	
65x	**Hospice Services**	
66x	**Respite Home Health Only**	
67x	**Not Assigned**	
68x	**Not Assigned**	
69x	**Not Assigned**	
70x	**Cast Room**	
71x	**Recovery Room**	
72x	**Labor Room/Delivery**	
73x	**EKG/ECG**	
74x	**EEG**	
75x	**Gastro-Intestinal**	

REVENUE CODE	DESCRIPTION	PEIA'S POLICY
76X	**Treatment Observation Room Holding Beds**	
77x	**Preventive Care Services**	
78x	**Telemedicine**	
79x	**Lithotripsy**	
80x	**Inpatient Renal Dialysis**	
81x	**Kidney Acquisition**	
82x	**Hemodialysis-OP/Home**	
83x	**Perritoneal Dialysis-OP/Home**	
84x	**Continuous Ambulatory Peritoneal Dialysis-OP/Home**	
85x	**Continous Cycling Peritoneal Dialysis-OP/Home**	
86x	**Reserved for Dialysis**	
87x	**Reserved for Dialysis**	
88x	**Miscellaneous Dialysis**	
89x	**Reserved for National Assignment**	
90x	**Psychiatric/Psychological Treatments**	
91x	**Psychiatric/Psychological Services**	
92x	**Other Diagnostic Services**	
93x	**Not Assigned**	
94x	**Other Therapeutic Services**	
95x	**Other Therapeutic Services (extension of 94X)**	
96x	**Professional Fees**	Bill on HCFA 1500

REVENUE CODE	DESCRIPTION	PEIA'S POLICY
97x	**Professional Fees**	Bill on HCFA 1500
98x	**Professional Fees**	Bill on HCFA 1500
99x	**Patient Convenience Items†**	Exclude

*Exclude amount that exceeds the semi-private rate.

† Admission Kit is covered.

DRG ASSIGNMENT

Under the prospective payment system all cases are to be assigned to a DRG using the Medicare Grouper Version **23**. The Medicare Grouper is updated on an annual basis and is maintained by 3M.

Each hospital is responsible for assigning patient cases to the correct DRG. DRGs were developed as a patient classification scheme consisting of classes of patients who were similar clinically and in terms of their consumption of hospital resources. The process of forming the DRGs was begun by dividing all possible principal diagnoses into 25 mutually exclusive principal diagnosis areas referred to as Major Diagnostic Categories (MDCs). MDCs are divided into medical and surgical categories. Surgical patient cases are further defined based on the precise surgical procedure performed while medical patients are defined based on the precise principal diagnosis for which they are admitted to the hospital.

Since a patient can have multiple procedures related to their principal diagnosis during a particular hospital stay, and a patient can be assigned to only one surgical class, the surgical classes in each MDC were defined in a hierarchical order. Patients with multiple procedures would be assigned to the surgical class highest in the hierarchy.

The first step is the assignment to an MDC. The patient is then classified as a surgical or medical patient. Surgical patients are then assigned to a surgical class in the appropriate hierarchical order. Surgical cases are then assigned to DRGs based upon the presence or absence

of complications. Medical patients are assigned to DRGs based upon their principal diagnosis and as well as their age, sex, discharge status, or the presence of complications.

The DRG assignment should be made by evaluating the principal and the secondary diagnosis fields and the surgical procedure code fields in the UB-92 hospital bill for each patient. The DRG number to which the patient has been assigned should be placed in field #84, REMARKS, on the UB-92 and in Positions 906-908, if submitting via ASAP and in the 906-908 field, if submitting via tape.

In an effort to ensure the appropriate DRG assignment, the Public Payers have decided to follow the edit guidelines found in the Medicare Code Editor. The Medicare Code Editor (MCE) detects and reports errors in the coding of billing data and inconsistencies in DRG assignment. Some examples of conflicts are: a 75-year-old delivery, a male patient with cervical cancer or male patient with a hysterectomy. Appendix G of the Medicare Grouper Version **23** Manual contains a description of each coding edit.

Bills that do not meet these edits will result in denial. Please refer to the Medicare Code Edit Table that follows for a listing of the code edits and the process by which the payers will ensure compliance. A detailed description of the Medicare edits is available upon request.

MEDICARE CODE EDITS

Medicare Code Edits	Claim Edit	Utilization Review
1 Invalid Diagnosis of Procedure Code	Bill will be denied	
2 E-Code as Principal Diagnosis	Bill will be denied	
3 Duplicate of Principal Diagnosis		Medical Record/Bill Audit will be Conducted
4 Age Conflict	Bill will be denied	
5 Sex Conflict	Bill will be denied	
6 Manifestation Code as Principal Diagnosis	Bill will be denied	

MEDICARE CODE EDITS

Medicare Code Edits	Claim Edit	Utilization Review
7 Non-Specific Principal Diagnosis		Medical Record/Bill Audit will be Conducted
8 Questionable Admission		Medical Record/Bill Audit will be Conducted
9 Unacceptable Principal Diagnosis	Bill will be denied	
10 Non-specific O.R. Procedure		Medical Record/Bill Audit will be Conducted
11 Non-covered Procedure	Bill will be denied	
12 Open Biopsy Check		Medical Record/Bill Audit will be Conducted
13 Medicare as Secondary Payor--MSP Alert	Not Applicable	
14 Bilateral Procedure		Medical Record/Bill Audit will be Conducted
15 Invalid Age	Bill will be denied	
16 Invalid Sex	Bill will be denied	
17 Invalid Discharge Status	Bill will be denied	
Detailed definitions available upon request.		

EXCLUSIONS FROM PPS HOSPITAL PAYMENT

Facilities Excluded

Specialty hospitals such as freestanding psychiatric, rehabilitation, and long-term care hospitals, as well as distinct-part units of acute general hospitals treating similar patients are excluded from the DRG payment system. Cases treated in any of these facilities are not paid under PPS. Each hospital must have a separate hospital identification number to identify their distinct-part psychiatric and rehabilitation units.

Cases treated in West Virginia Critical Access Hospitals are paid based on published per diem rates and they are not paid under PPS.

DRG Exclusions

The following DRGs are excluded from the prospective payment system:

> DRG 462, Rehabilitation: If rehabilitation treatment is rendered outside a distinct-part rehabilitation unit or a freestanding rehabilitation hospital, the patient cannot be assigned to the rehabilitation DRG. Payment will be denied.

Transfer Cases Excluded

Under the transfer payment policy, all sending hospitals will receive a graduated per diem based upon the DRG to which the case is assigned for the sending hospital's phase of the treatment. Hospitals that receive a transfer case from another acute care hospital and transfer the case on to another acute care hospital or back to the original sending hospital are considered transferring hospitals under this payment policy. These hospitals receive the per diem payment rates. The final discharging hospital receives a full DRG payment amount. Each phase of the hospitalization is assigned a DRG based upon the principal diagnosis and surgical procedures

performed during the respective phase. Transfer cases are eligible for high cost outlier payments.

- All transfer cases must have an “02" value in the patient discharge status code field #23 on the UB-92.

- Cases assigned to DRG 385 are not eligible for transfer payment. These cases will be paid the full DRG rate because the weighting factors for this DRG assumes the patient will be transferred.

SPECIAL PAYMENT CONSIDERATIONS

Sole Community Hospitals

Sole Community hospitals, not classified as West Virginia Critical Access Hospitals (CAH), will receive special payment considerations. Sole community hospitals’ payment will be a blend of the hospital’s own specific costs and the standardized amount for rural hospitals.

The following is a list of Sole Community Hospitals (other than those classified as CAH’s):

- Greenbrier Valley
- United Hospital Center
- Boone Memorial Hospital
- Jackson General Hospital
- Grant County Hospital
- Davis Memorial Hospital
- Summersville Memorial Hospital
- Welch Emergency Hospital

Rural Referral Centers

Rural Referral Centers will be paid like all other PPS hospitals (i.e., no special payment considerations will be provided). The following is a list of Rural Referral Centers:

- West Virginia University Hospital
- Greenbrier Valley Medical Center
- United Hospital Center
- Princeton Community Hospital

EACH Hospitals

Essential Access Community Hospitals (EACH) will receive payment like Sole Community Hospitals. These hospitals will be paid based on a blend of their own facility costs per case and the appropriate peer group standardized amount. The following is a list of EACH hospitals:

- Davis Memorial Hospital
- United Hospital Center

Level III NICU

Hospitals with Level III Neonatal Intensive Care Units (NICU) which bill DRGs 385-390 will be paid at a higher rate than hospitals with Level I and II units.

GENERAL BILLING INSTRUCTIONS

Outpatient Services Treated as Inpatient Services:

Certain outpatient services are included in the inpatient DRG rate. When a patient receives outpatient hospital services the day of an admission, the outpatient hospital services are treated as inpatient services. Payment for these outpatient services is included in the applicable PPS payment and may not be billed separately. Only one claim is billable and should be inclusive of outpatient services and all inpatient services. Submission of separate claims may result in denial of both claims. A corrected bill must then be submitted.

Transfers Between PPS Hospitals:

The transferring hospital will be paid based upon a per diem rate. The per diem rate will be the prospective payment rate divided by the average length of stay at the transferring hospital. Admissions of less than 1 day will be paid for 1 day. If the patient was admitted with the expectation of staying overnight, pay for 1 day. If the patient is treated in the emergency room without being admitted and is then transferred, outpatient billing is appropriate.

The discharging hospital will be paid the full prospective payment rate. When a transfer case results in treatment in the second hospital for a DRG different than the DRG in the transferring hospital, each hospital is paid based on the DRG under which the patient was treated.

Transfers to Hospitals/Units excluded from PPS:

Payment for patients transferred to hospitals or distinct-part units which are excluded from PPS, will be made based upon the payment methodology in place for non-transfer cases at those facilities.

Discharges to Nursing Homes or Home Health for Qualified DRG Status:

The Secretary of Health and Human Services issues a list of DRGs which have Qualified DRG Status. As of July 1, 2006 discharges from a PPS hospital to a Nursing Home (discharge code 03) or Home Health (discharge code 06) for patients with a Qualified DRG, will for purposes of payments to the discharging PPS hospital, be treated as if the patient was transferred to another PPS hospital.

Qualified DRGs on the list effective October 1, 2004 were as follows:

DRG 012	DRG 014	DRG 024	DRG 025	DRG 088	DRG 089
DRG 090	DRG 113	DRG 121	DRG 122	DRG 127	DRG 130
DRG 131	DRG 209	DRG 210	DRG 211	DRG 236	DRG 239
DRG 277	DRG 278	DRG 294	DRG 296	DRG 297	DRG 320
DRG 321	DRG 395	DRG 429	DRG 468	DRG 541	DRG 542

We will utilize the Qualified DRG list as updated by the Secretary of Health and Human Services.

When to Bill Adjustment:

Under PPS, adjustments are required where errors occur in diagnosis and procedure coding that change the DRG, or where utilization is affected. Hospitals must submit adjustment bills within 60 days of your payment notice.

Billing Frequency:

Under PPS, hospitals may bill 60 days after an admission if the patient is still hospitalized, and every 60 days thereafter. The initial claim will be processed through the DRG grouper, and the following claim(s) will be processed as an adjustment.

Admissions of less than 60 days must be billed once the patient is discharged. Interim bills for less than 60 days will be denied.

Readmissions Within Seven (7) Days of Discharge:

Hospital admissions occurring within seven (7) days of discharge from an acute care hospital will be reviewed by the utilization review department if it appears that the two confinements could be related. If unrelated, two separate payments will be made.

Payment for Purchased Services:

Payment of non-physician services which hospitals must obtain for their patients are included in the PPS payment rate. The following medical items, supplies, and services are covered as hospital services:

- Laboratory services (excluding anatomic pathology services);
- Pacemakers and other prosthetic devices including lenses, artificial limbs, knees, and hips;
- Radiology services, including CT scans furnished to inpatients by a physician's office, other hospital or radiology clinic;

- Total parenternal nutrition (TPN) services; and
- Transportation, including transport by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient. Hospitals include the cost of these services in the appropriate ancillary service cost center (i.e., in the cost of the diagnostic or therapeutic service, not under revenue code 540).

UB92 (HCFA 1450) Consistency Edits:

In order to be processed correctly and promptly, a bill must contain complete and accurate information. Claims with incomplete information will be denied and returned to the provider for correction. Form Locator four (4) is especially important because for PPS processing, it may determine payment and/or eligibility of the admission. Definitions listed in the UB92 National Uniform Billing Instructions will be required to correctly indicate the "Type of Bill" you are submitting.

PROCESSING FOR PPS EXCLUSIONS

FACILITIES: Freestanding psychiatric, rehabilitation, long-term care facilities and distinct-part units of acute care hospitals are not paid under PPS. These facilities and distinct-part units will have a separate hospital identification number to identify their psychiatric and/or rehabilitation status. Claims for these facilities/distinct-part units will be processed with a 45% discount from charge.

VETERANS HOSPITALS: Veterans Administration Hospitals are excluded from PPS. Claims for these facilities will be processed with a 45% discount from charge. Treatment related to war-related injuries or disabilities are not covered.

OUT-OF STATE FACILITIES: Claims for out-of-state admissions to non-contracted hospitals will be processed with a 45% discount from charge. They will continue to be billed either on paper or electronically with correct UB92 billing information.

SKILLED NURSING FACILITIES: Admissions to skilled nursing facilities will be processed with a 45% discount from charge unless otherwise negotiated through the Third Party Administrator. Electronic or paper claims with correct UB92 billing information will be required.

DRG 462, REHABILITATION: If rehabilitation treatment is rendered outside a distinct part rehabilitation unit of an acute care facility, the patient cannot be assigned to the rehab DRG payment will be denied.

ORGAN TRANSPLANT DRGs: All cases receiving a transplant DRG will be paid outside PPS. If the transplant procedure is rendered within the Organ Transplant Network (OTN), it will be processed per the contractual agreement between PEIA and the OTN facility. If the facility is a non-network facility outside West Virginia, the claim will be processed with a 45% discount from charge. Organ transplant DRGs are:

DRG 103, Heart Transplant
DRG 302, Kidney Transplant
DRG 480, Liver Transplant
DRG 481, Bone Marrow Transplant
DRG 495, Lung Transplant

INVALID DRGs: DRGs which are not defined in Grouper 23 are not valid and will be denied.

SAME DAY LIVE DISCHARGES: Prior to July 1, 2005, PEIA paid for "Same Day Live Discharges" as an out patient service. Effective July 1, 2005, PEIA allows payment of "one per diem" allowance for "Same Day Live Discharges."

Mother and Baby bills must be submitted as two separate claims.

PRECERTIFICATION. The precertification process will not change at this time. You, the patient, or an individual designated by the patient must call the Third Party Administrator (TPA) at least five business days prior to an inpatient admission or within 48 hours of an urgent or emergency admission. This applies to all inpatient admissions whether the admission is to be paid under the PPS system or through the discounted methodology.

- **DRG ADMISSIONS:** Precertification is required to determine whether or not the criteria for an inpatient admission is met. The concurrent utilization review process will be administered when the TPA determines it would be appropriate.

- **ADMISSIONS EXCLUDED FROM PPS**: All admissions processed outside of PPS will be reviewed for medical necessity and assigned a length of stay. Concurrent utilization review will be required in order to extend the number of days initially approved by the TPA. This applies to psychiatric, rehab, and transplant admissions to all facilities not paid through PPS, as well as all out-of-state facilities.

HOSPITAL BILL AUDIT: Criteria for auditing inpatient hospital claims will vary. While charge audits to validate expenses will be performed, the auditing of PPS services will place more emphasis upon the appropriate utilization of services with review of ICD-9 diagnosis and procedural coding.

PEIA will honor the same hospital audit requirements which were in place prior to implementation of PPS.

EFFECTIVE DATE. Claims incurred on or after July 1, 2006 will be processed in accordance with this manual. If a patient was admitted prior to July 1, 2006, the claim for that admission will be paid via the payment methodology in place at the "time of the admission."

January 8, 2007 Rev. – Corrected the 32% discount amount to 45% discount amount.