

# Medical Assistance Provider Bulletin

**Attention:** All Title XIX Certified Hospitals

**Subject:** DRG Implementation

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Department of Health and Social Services, Division of Health,  
Bureau of Health Care Financing, P.O. Box 308, Madison, Wisconsin 53701

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This MAPB contains important information on the Wisconsin Medical Assistance Program's (WMAAP) implementation of a Diagnosis Related Group (DRG) reimbursement system. It is critical that this MAPB is widely distributed to all hospital staff, including hospital billing staff, programmers, financial managers, and medical records personnel.

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## PART I: DRG REIMBURSEMENT METHODOLOGY AND DRG GROUPER INFORMATION

### I. INTRODUCTION

Effective with dates of discharge on or after January 1, 1991, the Wisconsin Medical Assistance Program (WMAAP) will use a Diagnosis Related Group (DRG) reimbursement system for certified in-state and border status hospitals, including institutions for mental disease (IMDs) and general hospitals. The WMAAP DRG reimbursement system has been developed with input from the Wisconsin Hospital Association, the Medicaid Technical Advisory Committee, and others. This Medical Assistance Provider Bulletin (MAPB) provides hospitals with the final information necessary to prepare for DRG implementation. For earlier discussions of DRGs, providers are referred to previous MAPBs dated October 15, 1989, and February 1, 1990 (MAPB-089-025-B and MAPB-090-026-B).

It is critical that this MAPB is widely distributed to all hospital staff. We encourage you to share this information with hospital billing staff, programmers, financial managers, and medical records personnel.

Providers should be aware that the first-year plan for DRGs will not be finalized until the WMAAP publishes a public notice and distributes a draft Medicaid Title XIX Inpatient Hospital State Plan, followed by federal approval by the Health Care Financing Administration (HCFA).

### II. DRG-RELATED INFORMATION FOR BORDER STATUS HOSPITALS

As indicated in the MAPB dated October 15, 1989, (MAPB-089-025-B) border status hospitals will be reimbursed under DRGs effective with dates of discharge on or after January 1, 1991. The same methodology will be used to establish DRGs that will be applied to in-state and border status hospitals. Border status hospitals are advised to carefully review the methodology presented in Part I of this MAPB. Unless otherwise stated, all policies presented in this MAPB apply to WMAAP-certified border status hospitals.

Border status hospitals must submit Medicare audited cost reports to the WMAAP on an annual basis as soon as Medicare has completed its audit so that WMAAP hospital rates can be updated. Copies of the audited cost reports should be submitted to the following address:

Bureau of Health Care Financing  
Attn: Hospital Unit  
P.O. Box 309  
Madison, WI 53701-0309

### III. DRG METHODOLOGY

This section of the MAPB describes the DRG reimbursement methodology that will be implemented for dates of discharge on or after January 1, 1991.

The WMAP DRG reimbursement system uses the grouper developed for Medicare, modified for certain perinatal, newborn, and psychiatric cases. The WMAP will use the modified grouper (Version VII) to assign DRGs, based on information gathered from the UB-82 inpatient claim form. The grouper and modifications have been applied to Wisconsin-specific claims data to establish a relative weight for each of over 500 DRGs. These weights are based on statewide average hospital costs, and are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a stay assigned a DRG with a weight of .5 would require half the resources. The weights are based on an analysis of over three years of WMAP claims data, and will be reviewed annually.

Each DRG payment is based on a hospital's rate, multiplied by a statewide weight established for the DRG. Each hospital rate is based on a statewide average base rate with hospital-specific adjustments for wages, disproportionate share, and indirect medical education. In addition, the base rate for hospitals located in Milwaukee County will be adjusted for an "HMO adverse selection" to account for the fact that the HMO initiative in Milwaukee County has taken many of the low cost cases out of the fee-for-service population. Hospitals in Milwaukee County, therefore, will receive a base rate that is ten percent greater than hospitals outside of Milwaukee County. Capital and direct medical education costs will be handled as "passthrough" payments, as described in Section V of this MAPB.

Indirect medical education will be paid as an add-on to the base rate for qualified providers. The add-on percentage will be calculated using the same formula that Medicare uses. The WMAP will calculate this add-on percentage using the number of interns and beds identified in the most recent audited cost report available as of September 30, 1990, for the period January 1, 1991 through June 30, 1991. Thereafter, rates will be calculated as of three months prior to the date of the next rate changes. This calculation will be done for all providers by the Bureau of Health Care Financing (BHCF) for all providers having direct medical education. Therefore, no provider action is required.

It is important to note that DRG payments will not include payments for professional services. Professional services must be separately billed using claim forms and provider numbers appropriate to those services. Refer to Section XV of this MAPB for a list of professional services excluded from the DRG payment. (Hospitals with no prior DRG experience under Medicare [i.e., WMAP-certified IMDs and children's hospitals] will receive a hospital-specific add-on payment for professional services and will not need to bill separately for these services. Refer to Section IX of this MAPB for additional information on special provisions for hospitals without prior DRG experience.)

An outlier payment will be made automatically when the cost of providing a service exceeds a pre-determined trim point. Each inpatient hospital claim will be tested to determine whether an outlier payment is necessary. The disproportionate share adjustment will also be applied to the outlier payment. In addition, outlier payments for certain DRGs will be adjusted to account for significant and extensive use of resources. Refer to Section VI of this MAPB for more information on outlier payments.

It should also be noted that reimbursement for organ transplants, AIDS extended care, and long-term ventilator-dependent care will not be processed under the DRG reimbursement system. These claims, which require prior authorization, must continue to be billed using the provider numbers currently assigned to hospitals for such cases. Please refer to the MAPB dated November 15, 1988 (MAPB-088-023-B) for information on exceptional reimbursement.

#### IV. MEDICAL ASSISTANCE VERSUS MEDICARE DRG

The WMAP DRG reimbursement system scheduled for implementation for dates of discharge on or after January 1, 1991, is unique to the WMAP, the type of inpatient services provided to Medical Assistance recipients, and the demographics of Wisconsin Medical Assistance recipients. As a result of these unique factors, the WMAP DRG system will differ from the DRG system used by Medicare. The major differences between the two systems are listed below.

In developing a DRG system, the WMAP has done the following:

- Included all WMAP-certified hospitals in the DRG system. Unlike Medicare, this includes specialty hospitals and psychiatric units of hospitals in the DRG system (except for Mendota and Winnebago Mental Health Institutes and Sacred Heart Rehabilitation Hospital).
- Modified Medicare's DRG grouper logic to better reflect neonatal and psychiatric inpatient resource use, assigning more specific DRGs for both neonatal and psychiatric inpatients. Refer to Sections XII and XIII and Attachments 2 through 5 of this MAPB for information on the neonatal and psychiatric DRG logic.
- Established DRG weights specific to the WMAP.
- Expanded the list of professional services to be excluded from the DRG payment.
- Established a minimum of 120 days of stay before a claim can be interim billed for DRG and any outlier payment, as opposed to Medicare, which allows interim billing after 60 days of stay.
- Established a schedule for updating the DRG system which differs from Medicare. Refer to Section XI of this bulletin for information on scheduled updates.
- Excluded transportation mid-stay from the DRG payment.

## V. PASSTHROUGH PAYMENTS

### A. Introduction

Because of great variability in capital and medical education costs among hospitals, the DRG payment system itself cannot adequately reimburse these costs with a DRG payment. Some hospitals would be paid for these costs which they did not incur, while hospitals which incurred capital and medical education costs would be paid only a fraction of the incurred costs. The WMAP, therefore, has decided to treat these costs as passthrough costs. Each hospital will have its actual capital and medical education costs, from its latest audited cost report, reimbursed outside of the DRG payment system. Each month, each hospital will receive one-twelfth of its allowed annual capital and/or medical education costs. This payment will appear on the Remittance and Status Report from EDS.

### B. Capital Reimbursement

Allowed capital will be paid as a prospective passthrough payment under the DRG system. The calculation will be based on the hospital's last audited cost report on file with the WMAP as of September 30, 1990. If the cost report for a hospital is more than three years old, the hospital may request an adjustment from the BHCF to the capital calculation. In an adjustment situation, the total depreciation and capital-related interest from the audited financial statements for the last year on which an audited cost report is on file will be compared with the audited financial statements for 1987, the year for which the other WMAP-certified hospitals' capital reimbursement is based. The capital passthrough calculated on the audited cost report will be indexed forward by the percent increase in capital-related costs from the year of the most recent audited cost report to 1987.

The capital passthrough will be calculated by taking the total individual hospital capital and dividing this figure by the total individual hospital costs. The total WMAP inpatient costs for the hospital will then be multiplied by the ratio of capital costs to total costs to get the WMAP capital costs. As is currently done, the WMAP capital costs will be reduced by 10 percent (except for providers exempted from the 10% reduction) to get allowable WMAP capital costs. The allowable WMAP capital costs will be indexed to the rate year by the Data Resources, Inc. (DRI) HCFA Hospital Market Basket inflation rate through June 30, 1991. The rate year allowable WMAP costs will be divided by 12 and multiplied by one plus the disproportionate share percentage, if applicable. This will be the monthly capital passthrough amount.

Hospitals which have major new construction that is not reflected in their audited cost report are eligible for an adjustment. A major construction project is defined as a one-time capital expenditure exceeding 25 percent of the original book value of the building and fixtures. The project must be designed to improve, add to, or replace an existing inpatient-care structure. Hospitals that may qualify for this adjustment should submit a request as soon as possible to the following address:

Bureau of Health Care Financing  
Attn: Hospital Unit  
P.O. Box 309  
Madison, WI 53701-0309

Passthrough payments for capital will be made to the hospitals in equal monthly installments. The payments will be included with the first check printed after the first Friday of each month. The payments will be system generated by EDS as a claim and, as a result, appear separately identified on the Remittance and Status Report accompanying the check. Refer to Section XX and Attachment 7d of this MAPB for information on reading the Remittance and Status Report.

No provider action is required for passthrough claims. Any provider-initiated passthrough claims or adjustments will be denied.

C. Direct Medical Education

Direct medical education will be paid as a prospective passthrough. The calculation will be based on the last audited cost report on file with the BHCF as of September 30, 1990. Total inpatient routine and ancillary direct medical education costs for the hospital will be divided by the total hospital costs to obtain the allowable base year percentage of costs. The allowable base year percentage of costs will be multiplied by the total WMAP inpatient costs to obtain the allowable base year medical education costs. The authorized base year medical education costs will be increased by the DRI HCFA Hospital Market Basket inflation rate through June 30, 1991, to obtain the rate year reimbursement for direct medical education. The reimbursable rate year medical education costs will be divided by 12 and then multiplied by one plus the disproportionate share percentage, if applicable, to obtain the monthly medical education payment amount.

Passthrough payments for direct medical education will be made to the hospitals in equal monthly installments. The payments will be included with the first check printed after the first Friday of each month. The payments will be system generated by EDS as a claim and, as a result, appear separately identified on the Remittance and Status Report accompanying the check. Refer to Section XX and Attachment 7d of this MAPB for information on reading the Remittance and Status Report.

No provider action is required for passthrough claims. Any provider initiated passthrough claims or adjustments will be denied.

VI. OUTLIER PAYMENTS

A. Outliers Under DRGs

Since the DRG payment is an average payment, based on average costs, the DRG payment does not adequately reimburse hospitals for extraordinarily costly inpatient stays. Therefore, each inpatient claim will be tested to determine whether an outlier payment is appropriate. An outlier payment will be made on any claim in which costs exceed the DRG payment rate by a hospital-specific

trim point. For hospitals with less than 100 beds, the trim point is \$5,000. For hospitals with 100 or more beds, the trim point is \$30,000. Allowable charges will be reduced to cost using a hospital-specific cost to charge ratio. The WMAP will pay the variable cost in excess of the DRG payment and the trim point, figured at 70 percent of costs (90 percent for burn cases in DRGs 456 through 460 and 472) for those claims in excess of the trim point. In addition, the disproportionate share adjustment will be applied to the outlier calculation as well as the basic DRG payment.

Claims for chronic, stable ventilator-dependent hospital patients will be reimbursed under the ventilator rate and, therefore, are not eligible for outlier payment.

Since outlier payments will be made automatically, no action is necessary in order for a hospital to obtain an outlier payment. Therefore, all provider numbers ending with the suffix "13" will be cancelled effective with dates of discharge on or after January 1, 1991. Effective with dates of discharge on or after January 1, 1991, hospitals will not be required to submit, nor will they be paid for, a UB-82 claim using the "13" provider number suffix in order to obtain outlier reimbursement. Refer to Section XX of this MAPB for information on reading outlier payments on the Remittance and Status Report.

**Note:** Claims with a date of discharge prior to January 1, 1991, will be subject to current rate-per-discharge rates and outlier policy, regardless of whether they are submitted for payment on or after January 1, 1991. Therefore, an outlier claim with a discharge prior to the effective date of DRG implementation must still be submitted using the "13" suffix and current billing procedures, even if the claim is submitted after the DRG implementation date. (Late billing requirements, however, are not changed; hospitals have one year from the date of discharge to submit a claim.) EDS will process and pay any normal (i.e., "00" suffix) or outlier claim using the appropriate methodology and rates in effect on the date of discharge.

**B. Length of Stay Outliers in Disproportionate Share Hospitals**

If a Wisconsin hospital which is identified as a "disproportionate share hospital" under section IV.B.5 of the State Plan provides inpatient care to a child under one year of age, the claim may be eligible for an outlier payment above the regular DRG (and cost outlier) payment.

The WMAP will annually review claims paid to disproportionate share hospitals for inpatient care provided to children during their first year of life and, if the cost of care exceeds the 99th percentile of all such claims, calculate and pay an outlier supplemental payment. The WMAP will review the claim and calculate average per diem charges. The payment will be for variable costs, calculated as 70 percent of costs for every covered day above the length-of-stay threshold. Costs are calculated from the charges on the claim multiplied by the hospital's base year cost-to-charge ratio.

Claims for inpatient care for recipients who were one year old or more upon discharge are not eligible for consideration as a length of stay outlier, but may be eligible for cost outlier payment.

The WMAP will pay a cost outlier or a length-of-stay outlier for a claim, but not both. In determining the amount to which a hospital is entitled, the WMAP will calculate both ways and pay the method which gives the greater amount to the hospital.

## VII. INTERIM PAYMENT FOR LONG LENGTHS OF STAY

The WMAP recognizes that certain extraordinarily long and costly inpatient stays may occur. In order to improve a hospital's cash flow under DRGs, the WMAP has modified billing procedures so that any stay in one hospital exceeding 120 days may be submitted to EDS for an interim payment. Effective with dates of discharge on or after January 1, 1991, stays exceeding 120 days are eligible for interim payment(s) prior to discharge.

A hospital submitting a claim for interim payment on a stay exceeding 120 days must submit the first request on a UB-82 claim form, using patient status code "30 - still a patient" in item 21 (STAT) on the UB-82 claim form. If the claim is submitted correctly, EDS will process the claim and make the appropriate DRG payment and outlier payment, if appropriate.

To receive additional or final payment for the stay, the hospital must submit an adjustment to the original claim. Refer to Section X of Part A of the WMAP Provider Handbook for instructions on how to submit an adjustment, and to Attachment 1 of this MAPB for a sample adjustment request form.

The adjustment form must be completed requesting an interim payment if the recipient was not discharged, or final payment if the recipient was discharged. At least 30 additional days of stay must have elapsed since the "through" date indicated on any previous claim or adjustment requests.

The adjustment request form submitted must state, "Interim payment for long length of stay" as the reason for the adjustment, and have an updated UB-82 claim form attached to the request. The updated UB-82 claim form must include the following information:

- All accumulated charges since admission (not just the additional charges since the first interim claim);
- A current patient status code in item 21 of the UB-82 claim form;
- All other updated information that indicates all events up to the "through" date on the claim (e.g., additional surgical procedure codes, new discharge diagnosis).

If the claim qualifies as an outlier, it will be paid the DRG payment and any outlier payment. Claims not exceeding the outlier threshold will be paid only the DRG payment. The claim must, in addition to exceeding 120 days, have a "through" date of service on or after January 1, 1991. Claims not meeting these criteria will be denied.

## VIII. INTERIM "SAFETY NET" PAYMENTS

With implementation of a DRG reimbursement system, the potential exists for some providers to experience a financial hardship, since DRGs are paid based on a statewide average rate, as opposed to the current hospital-specific rate per discharge. While some providers will gain and some will lose under a DRG system, there is a concern that no provider experience a severe financial hardship during the transition year. Therefore, a methodology has been developed for the first 12 months of DRG reimbursement that provides financial relief to providers experiencing a severe financial hardship as a result of DRG implementation. The methodology provides for both a ten percent floor on the amount of financial loss and a ten percent ceiling on the amount of financial gain that any one provider can experience during the first year of DRG reimbursement.

An amount due or payable will be calculated automatically by the BHCF for every provider, for the first year of DRG implementation only. The specifics of this calculation will be contained in the appropriate Medicaid State Plan amendment. If a provider can document that a substantial number of claims having a significant impact on this calculation were paid after this calculation has been made, a request for a change to the amount originally calculated will be reviewed.

In addition, providers who can document that they would have a substantial amount of reimbursement due during the year, based on this calculation, may submit a request for an interim payment along with the calculation of the amount they believe is due their facility, including year to date payment information supporting their calculation. The data and calculation submitted will be verified for accuracy. If the information is correct, an interim payment will be made. All interim payments will be applied at the time the final "safety net"/ceiling settlement is made. Interim payments made under this procedure will be restricted to not more than one per quarter.

Requests for an interim payment under these conditions should be submitted in writing to the following address:

Bureau of Health Care Financing  
Attn: Hospital Unit  
P.O. Box 309  
Madison, WI 53701-0309

## IX. SPECIAL PROVISIONS FOR HOSPITALS WITH NO PRIOR DRG EXPERIENCE UNDER MEDICARE

### A. Introduction

Several WMAP-certified hospitals have not had experience under the Medicare DRG reimbursement system. The WMAP has taken the concerns expressed by these hospitals into account in developing the following special provisions. These provisions apply only to hospitals which are WMAP-certified IMDs and children's hospitals.

Note: Any hospital which becomes certified with the WMAP with an effective date on or after January 1, 1991, is ineligible for these special provisions.

B. Hold Harmless

The WMAP has developed a hold harmless provision for WMAP-certified IMDs and children's hospitals which will insure that, for the first year of DRG implementation, every hospital in this group will be guaranteed reimbursement similar to what is received under the current prospective rate per discharge system. In order to guarantee similar reimbursement to what these hospitals have been receiving, without allowing a greater profit than a hospital could earn under the "safety net" provision discussed in Section VIII of this MAPB, the WMAP has established a ceiling of five percent reimbursement increase under the hold harmless provision.

The calculation of an amount due or payable will be made automatically by the BHCF for every eligible hospital, and will be based on payments made for all applicable inpatient claims processed for the first twelve months of DRG reimbursement. If a provider can document that a substantial number of claims having a significant impact on this calculation were paid after this calculation has been made, a request for a change to the amount originally calculated will be reviewed. Providers should contact the BHCF at the following address:

Bureau of Health Care Financing  
Attn: Hospital Unit  
Post Office Box 309  
Madison, WI 53701-0309

C. Add-On for Professional Services

Hospitals were notified in MAPBs dated October 1, 1989, (MAPB-089-025-B), and February 1, 1990, (MAPB-090-026-B), that effective with dates of discharge on or after January 1, 1991, professional services would no longer be allowed charges on the UB-82 inpatient hospital claim form. Those providers whose services will be excluded from the DRG payment would be required to be separately certified, and their services separately billed, in order for reimbursement to occur.

IMDs and children's hospitals are exempt from this requirement for the first year of DRG implementation. Hospitals that qualify under this provision will be reimbursed for professional services as an add-on to the basic DRG rate. The amount of the add-on will be based on the most recent audited cost report on file with the WMAP as of three months prior to the effective date of the next rate update. This amount will be divided by the case-mix adjusted number of cases for that provider from the most recent of the three years of paid claims data base to determine the amount that will be added to the provider-specific base rate.

**Note:** Hospitals that receive an add-on for professional services should not separately bill these services on the HCFA 1500 claim form, nor should they bill for these services on the UB-82 claim form using revenue codes in the range 960-989.

## X. RETROACTIVE RATE ADJUSTMENTS

Effective with any legislatively authorized hospital rate increases which occur after January 1, 1991, EDS will automatically generate retroactive rate adjustments for all paid inpatient hospital claims with dates of discharge on or after the effective date of the rate increase, but prior to the date the rate increase is authorized. No additional action is required by a hospital in order to receive the retroactive rate adjustment. The adjusted claims will be indicated on the Remittance and Status Report. Legislatively authorized hospital rate increases are normally effective July 1, the beginning of the state's fiscal year. Refer to Attachment 7a for a sample Remittance and Status report reflecting a retroactive rate adjustment.

For example, the Legislature may approve hospital rate increases for dates of discharge on or after July 1, which are not finalized until September 1. In this instance, EDS will retroactively adjust all paid claims with dates of discharge between July 1 and September 1. Both DRG payments and outliers will be adjusted to reflect the rate increase.

## XI. DRG GROUPER

### A. Introduction

Effective with dates of discharge on or after January 1, 1991, the WMAP will implement DRG grouper logic that is composed of three parts:

1. A base, which is the Medicare grouper;
2. An enhancement to Major Diagnostic Category (MDC) 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) for neonatal patients; and
3. An enhancement to MDC 19 (Mental Diseases and Disorders) for psychiatric patients.

The enhancements include expanding the number of DRGs in each of these MDCs to account for factors which are better indicators of resource use in both the neonatal and psychiatric service areas in the WMAP.

The WMAP will not develop software for the neonatal and psychiatric enhancements. Instead, the WMAP is providing hospitals with the following information so that hospitals can modify their own software, if desired:

1. Narrative describing the reassignment logic (for neonatal DRG grouper only);
2. Flow charts depicting the logic (for neonatal DRG grouper only), and
3. Pseudo code developed by EDS (for neonatal and psychiatric DRG groupers).

The narrative provides step by step descriptions of the process used by the WMAP and EDS to reassign the claims to a new DRG. The flow chart and pseudo code provide the UB-82 codes, the ICD-9-CM diagnosis codes, and the system logic used to reassign a DRG. This information is provided in Attachments 2 through 5 of this MAPB.

**Note:** The WMAP is not revising Medicare's grouping logic for MDCs 15 or 19. EDS' claims processing system will first allow claims which meet the criteria for grouping into Medicare MDC 15 or 19 to be grouped into one of the Medicare DRGs in those MDCs, then reassign the claim to the WMAP-specific neonatal or psychiatric DRG. Should you decide to design software to duplicate EDS' reassignment logic, remember that the first selection criteria for the WMAP's neonatal and psychiatric grouping logic is whether the claim is first assigned to Medicare MDC 15 or 19.

**B. Base Grouper Installation**

The WMAP is installing Version VII of the HCFA Medicare grouper effective for dates of discharge on or after January 1, 1991. It is the version that Medicare is using for the period October 1, 1989 through September 30, 1990. It is the intent of the WMAP to use Version VII with Wisconsin-specific data until July 1, 1992, in order to allow 18 months of stable Medical Assistance grouping logic.

Version IX of the base grouper with Wisconsin-specific data will be installed effective for dates of discharge on or after July 1, 1992. Thereafter, annual installations will occur every July 1. Please note that version VIII of the grouper will not be implemented, so that both hospitals and the WMAP will have 18 months of consistent DRGs at the beginning of DRG reimbursement.

**C. DRG Weights**

The DRG weights effective with dates of discharge January 1, 1991, through June 30, 1992, will be sent to all hospitals later this fall. DRG weights will be updated annually effective with dates of discharge July 1, 1992, and after. The updated weights will be available each year by April 1, three months prior to the effective date. They may be purchased from:

Document Sales  
202 South Thornton Avenue  
Post Office Box 7840  
Madison, WI 53707-7840

(608) 266-3358

Document #: 1056

## XII. NEONATAL DRG GROUPER LOGIC

The WMAP has developed an enhancement to the standard Medicare DRG grouper that expands the number of DRGs in MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) from seven DRGs to twenty. The enhancement reassigns Medicare DRGs 385 through 391 to DRGs 601, 602, 604, 610, 614, 620, 624, 637, 638, 639, 648, 649, 650, 656, 657, 670, 676, 677, 678, and 680. All Wisconsin Medical Assistance claims that can be assigned to one of the Medicare DRGs, 385 through 391, will instead be reassigned to one of the new WMAP neonatal DRGs, 601 through 680 and reimbursed accordingly.

The reassignments are based largely upon the birth weight of the neonate, but also on whether an operating room procedure was performed, whether the neonate was transferred, or whether other medical problems have arisen. These factors are considered better measures of resource use than those used solely by the base Medicare DRG grouper when grouping claims into DRGs 385 through 391.

For example, if a claim is submitted for a neonate with a unilateral inguinal hernia with obstruction, normal birth weight, and the neonate underwent surgery, the Medicare grouping logic will assign the claim to DRG 389. Once it is determined that the Medicare grouper would have assigned the claim to DRG 389, the WMAP logic will reassign the claim to DRG 680.

The principal and secondary ICD-9-CM diagnosis code indicated on the UB-82 claim form first determined whether the claim would have been assigned one of the Medicare DRGs in MDC 15, which includes Medicare DRGs 385 through 391. If the claim would have been assigned to one of the Medicare DRGs in MDC 15, the WMAP modification reassigns the claim to a WMAP-specific neonatal DRG in the range 601 through 680, based upon one or more of the factors shown in Attachments 2, 3, and 4 of this MAPB. Reimbursement is based upon DRG weights assigned to the WMAP's expanded range of neonatal DRGs, not on Medicare's DRGs.

The WMAP has developed narrative, pseudo code, and flow chart (Attachments 2, 3, and 4) to assist you in adding the WMAP specific DRG logic to the appropriate version of HCFA's Medicare grouper software. If you decide not to add to your software, you may manually verify the new neonatal DRGs (601 through 680) by following the narrative and flow chart in Attachments 2 and 4.

## XIII. PSYCHIATRIC DRG GROUPER LOGIC

The WMAP has developed an enhancement to the standard Medicare DRG grouping methodology that expands the number of DRGs in MDC 19 (Mental Diseases and Disorders) from nine to eighteen for each peer group, incorporating a subdivision by the age of the patient (i.e., less than 18 years of age and 18 and over). The psychiatric enhancement reassigns Medicare DRGs 424 through 432 to one of four new DRG groups, depending on the type of psychiatric facility. Three of the groups are also subdivided by location based on whether or not the provider is located in Milwaukee County.

All inpatient hospital claims with a principal diagnosis indicating mental illness which would have been assigned one of Medicare's DRGs 424 through 432 will be reassigned to one of the new WMAP psychiatric DRGs. Attachment 5 contains the pseudo code for the new psychiatric DRGs.

Following is a brief description of the four groups and locations:

- Claims from Milwaukee County Mental Health Complex that can be assigned to one of the Medicare DRGs 424 through 432 will be reassigned to one of the new psychiatric DRGs in the group 701 through 718.
- Claims from all other Institutions for Mental Diseases (IMDs) that can be assigned to one of the Medicare DRGs 424 through 432 will be reassigned to one of the new psychiatric DRGs in the group 721 through 738 if located in Milwaukee County, and 821 through 838 if not located in Milwaukee County.
- Claims from acute care hospitals with Medicare exempt psychiatric units which can be assigned to one of the Medicare DRGs 424 through 432 will be reassigned to one of the new psychiatric DRGs in the group 741 through 758 if located in Milwaukee County, and 841 through 858 if not located in Milwaukee County.
- Claims from all other inpatient hospitals that can be assigned to one of the Medicare DRGs 424 through 432 will be reassigned to one of the new psychiatric DRGs in the group 761 through 778 if located in Milwaukee County, and 861 through 878 if not located in Milwaukee County.

#### XIV. MEDICAL ASSISTANCE/MEDICARE DRG GROUPER CODE EDITS

As mentioned earlier, the WMAP has selected HCFA's approved Medicare DRG grouper software as its base grouping methodology, modified for neonatal recipients and psychiatric stays. Associated with the base Medicare grouper is edit logic which detects and reports errors in the coding of claims data. The edit logic is collectively referred to as the Medicare Code Editor.

The WMAP is adopting some of this edit logic, modifying some of the edits, and eliminating others. Descriptions of the Medicare code edits can be found in an appendix to each DRG Definitions Manual prepared by Health Systems International (HSI). A revised version of the definitions manual is distributed with each Medicare DRG grouper software package or may be purchased independently from:

HSI  
100 Broadway Street  
New Haven, CT 06511  
(203) 562-2101

The WMAP claim code edit requirements are presented below. They are presented in the same order that the Medicare code edits appear in Version VII, Appendix G, of the DRG Definitions Manual. Hospitals should refer to the DRG Definitions Manual for a list of procedure codes and diagnosis codes that will fail each of the edits listed below. All effective dates, except where otherwise noted, are for dates of discharge on or after

January 1, 1991. Any claim submitted for a date of discharge on or after January 1, 1991, which fails one of these edits will be denied since the WMAP cannot assign a valid DRG to the claim.

1. Invalid Diagnosis or Procedure Code.

This edit is adopted as it appears in the DRG Definitions Manual. A claim submitted with an invalid diagnosis or procedure code (i.e., a code not found in the ICD-9-CM manual) is denied.

2. Invalid Fourth or Fifth Digit.

This edit is adopted as it appears in the DRG Definitions Manual. If a claim is submitted with a diagnosis or procedure code that requires a fourth or fifth digit and the fourth or fifth digit is missing or invalid, the claim will be denied. This edit is currently applied to your claims effective with dates of discharge January 1, 1990 and after.

3. E-Code as Principal Diagnosis.

This edit is adopted with one modification. If a claim is submitted with an etiology (E) code either as the admitting diagnosis (block E on the UB-82 claim form) or the principal diagnosis (item 77 on the UB-82 claim form), the claim will be denied. This edit is currently applied to inpatient claims.

4. Duplicate of Principal Diagnosis.

This edit is adopted with modifications. If one of the secondary diagnoses in items 78 through 81 of the UB-82 claim form is a duplicate of the principal diagnosis, the claim will be denied.

5. Age Conflict - This edit will not be adopted.

6. Sex Conflict.

This edit is adopted as it appears in the DRG Definitions Manual. If a claim is submitted and any of the diagnosis or procedure codes conflict with the sex of the inpatient recipient, the claim is denied because either the patient's diagnosis, procedure code or sex is presumed to be incorrect. Refer to Attachment 10 of this MAPB for assistance in resolving problems with claims denials resulting from this edit.

7. Manifestation Code as Principal Diagnosis.

This edit is adopted as it appears in the DRG Definitions Manual. If any of the diagnosis codes identified as manifestation codes is indicated in UB-82 item 77, principal diagnosis, the claim will be denied. This edit is effective with dates of discharge January 1, 1991 and after.

8. Non-Specific Principal Diagnosis - This edit will not be adopted.

9. Questionable Admission - This edit will not be adopted.
10. Unacceptable Principal Diagnosis - This edit will not be adopted.
11. Non-Specific O.R. Procedure.

This edit will be adopted as it appears in the DRG Definitions Manual. If all operating room procedures performed have been coded as non-specific, the claim will be denied. If a patient had several operating room procedures and only one of the procedures was a specific operating room procedure, the claim will not be denied with this edit.

12. Non-Covered O.R. Procedure - This edit will not be adopted.
13. Open Biopsy Check - This edit will not be adopted.
14. Medicare as Secondary Payor - MSP Alert - This edit will not be adopted.
15. Bilateral Procedure - This edit will not be adopted.
16. Invalid Age - This edit will not be adopted.
17. Invalid Sex - This edit will not be adopted.
18. Invalid Discharge Status.

This edit will be adopted as it appears in the DRG Definitions Manual with one modification. Patient status code "30" (still a patient) is an unacceptable code, unless the stay qualifies for a long length of stay interim payment. Refer to Section VII of this MAPB for more information on interim payments for long length of stay.

Please review the Explanation of Benefit (EOB) codes on your remittance and status report if a claim is denied with one of the above edits. Careful attention to the EOB codes will help in resubmitting the denied claim. Also, review Attachment 10 of this MAPB for further information.

## PART II: DRG-RELATED POLICY INFORMATION

### XV. CERTIFICATION UNDER DRGS

Hospitals are reminded that effective with dates of discharge on or after January 1, 1991, professional services will no longer be allowed charges on the UB-82 inpatient hospital claim form, regardless of the date of admission of the recipient, and are not reimbursable under the hospital's provider number. Those providers whose services will be excluded from the DRG payment are listed below. These providers will need to be separately certified, and their services separately billed, in order for reimbursement to occur for dates of discharge on or after January 1, 1991. This policy does not apply to WMAP-certified IMDs or children's hospitals until January 1, 1992. Refer to Section IX of this MAPB for further information on special provisions for hospitals with no prior DRG experience under Medicare.

The following services are excluded from the DRG payment. Hospitals which intend to bill for these services should obtain certification for their performing providers as soon as possible in order to become familiar with policy and billing requirements and avoid claim denials.

- Physicians (M.D. and D.O., including pathology and the professional component of lab and x-ray services, but excluding residents and interns);
- Psychiatrists and psychologists (including services provided to a hospital inpatient and billed by a hospital or mental health clinic);
- Physician assistants;
- Nurse midwives;
- Certified registered nurse anesthetists (CRNA);
- Anesthesia assistants;
- Chiropractors;
- Dentists;
- Optometrists;
- Hearing aid dealers;
- Audiologists;
- Pharmacy (for take-home drugs on the date of discharge);
- Durable medical equipment (DME) dealers (for equipment for home use provided on the date of discharge);
- Air, water, and land ambulance (for both inpatient and outpatient services);
- Specialized medical vehicle transportation (SMV).
- Podiatrists \*
- Independent Nurse Practitioner \* <sup>1</sup>

\* Provider type added since last MAPB dated February 1, 1990 (MAPB-090-026-B).

<sup>1</sup> Includes only those certified nurse practitioners who provide independent primary care services to Medical Assistance recipients within their scope of practice. General nursing services provided by certified nurse practitioners are included in the DRG and should not be separately billed.

For earlier discussions of those services identified as professional services, providers may refer to previous MAPBs dated October 1, 1989 (MAPB-089--25-B), and February 1, 1990 (MAPB-090-026-B) for information pertaining to certification under the DRG system. Refer to Attachment 6 of this MAPB for an updated list of those services which must be separately billed under DRGs, which includes the appropriate clinic groupings which can be used and the required claim forms and coding structures.

**Note:** Psychiatrists and psychologists who provide inpatient services at county-owned general hospitals must be individually certified by the WMAP if they wish to bill independently for their own services. However, if these providers do not wish to be individually certified in order to separately bill for their services, the services may be billed using the 51.42 board's outpatient mental health clinic provider number (not a hospital outpatient number) if one is already assigned. Psychiatrists and psychologists who do not want to separately bill for their services must meet the certification requirements in sec. HSS 105.22, Wis. Adm. Code, and all applicable billing requirements for outpatient mental health clinics apply. Psychiatrists and psychologists who provide inpatient services at all other hospitals (i.e., non-county owned) must be individually certified by the WMAP, and all claims for their services must indicate their individual performing provider number.

## XVI. ANESTHETIST SERVICES

Services provided by Certified Registered Nurse Anesthetist (CRNA) and Anesthesiologist Assistant (AA) (referred to collectively as "anesthetists") will be excluded from the basic DRG payment. Since these services have not historically been separately reimbursable by the WMAP, it has been necessary to develop a reimbursement methodology specific to these services which is outside of the hospital rate structure. The methodology that has been developed is based on the existing methodology used by Medicare.

Effective for dates of service on or after January 1, 1991, CRNAs and AAs will be allowed to separately bill the WMAP for services provided to Medical Assistance recipients. The WMAP will adopt the Medicare method of reimbursement which recognizes the difference in levels of responsibility between medically directed and non-medically directed anesthetists, reimburses anesthesiologists at higher rates than anesthetists, and allows for reimbursement to anesthesiologists for the medically directed supervision of two, three or four anesthetists performing service during concurrent surgical procedures.

Effective with dates of service on or after January 1, 1991, the WMAP will reimburse medically directed anesthetists (CRNAs and AAs) at a base rate of \$7.50, and non-medically directed anesthetists (CRNAs only) at a base rate of \$13.07. These base rates will be multiplied by the sum of the 15-minute time increments and the "relative value scale unit," or RVSU. (Anesthesiologists who supervise the medically directed anesthetists may also be entitled to reimbursement, based upon the number of anesthetists supervised at a given time.)

This change in reimbursement for anesthesia services under the DRG system has several important implications for anesthesiologists and hospitals.

- Only those services provided to hospital inpatients with dates of discharge on or after January 1, 1991 may be separately reimbursed by the WMAP. The reimbursement for anesthesiologist's services provided to recipients who are discharged prior to January 1, 1991 is already included in the rate per discharge paid to the hospital.
- Anesthesiologist services for hospital inpatients with dates of discharge on or after January 1, 1991 must be billed on the HCFA 1500 claim form. These services can be billed directly by the anesthesiologist, or by a hospital or physician clinic acting as a billing provider in conjunction with the anesthesiologist's performing provider number.
- Any anesthesiologist whose services will be separately billed must be individually certified with the WMAP with an effective date on or before the date on which the service is rendered. Applications for certification with the WMAP can be obtained by calling the EDS Correspondence Unit.
- Anesthesiologist services provided with a date of service prior to January 1, 1991, to a hospital inpatient with a date of discharge on or after January 1, 1991, are not separately reimbursable by the WMAP. Any reimbursement problems which hospitals may have as a result of this policy should be referred to the Hospital Unit at the following address:

Bureau of Health Care Financing  
Attn: Hospital Unit  
P.O. Box 309  
Madison, WI 53701-0309

Complete billing instructions will be sent to anesthesiologists when the certification process is completed.

## XVII. HOSPITAL BASED AMBULANCE SERVICES

The MAPB which all hospitals received, dated February 1, 1990 (MAPB-090-026-B), included a list of professional services which will not be allowed when billed on the UB-82 inpatient claim form for dates of discharge on or after January 1, 1991. Included in the list were air and land ambulance services.

As a further clarification, for dates of discharge and dates of service on or after January 1, 1991, all air, water or land ambulance transportation services billed by a hospital as either an inpatient or outpatient service on the UB-82 claim form will be denied. All air, water, or land hospital based ambulance services must meet the ambulance certification standards in HSS 105.38, Wis. Adm. Code, and be individually certified by the WMAP as an ambulance provider in order to be reimbursed. All transportation services, including transportation mid-stay, provided to Medical Assistance recipients for dates of discharge and dates of service on or after January 1, 1991, must be billed on the HCFA 1500 claim form.

## XVIII. TAKE-HOME DRUGS

Effective with dates of discharge on or after January 1, 1991, take-home drugs (UB-82 revenue code 253) provided on the date of discharge will not be included in the DRG payment, and will no longer be a payable service on the inpatient UB-82 claim form. If your hospital provides take-home drugs on the date of discharge, the hospital pharmacy must become separately certified and the take-home drugs must be billed on the WMAP drug claim form in order for payment to occur for services provided to a recipient discharged on or after January 1, 1991.

This policy and change in billing procedures will affect claims for take-home drugs provided to dual entitlements that are denied by Medicare because they are not covered by Medicare. The hospital will be allowed to continue submitting claims for Medicare denied take-home drugs either as an outpatient crossover claim or as a pharmacy claim on the WMAP drug claim form. When submitting claims for Medicare denied take-home drugs as an outpatient crossover claim, clearly indicate "Pay take-home drugs only" in item 94 (Remarks) on the UB-82 claim form, and attach a copy of the Medicare EOMB to the claim indicating Medicare's rejection of the take-home drugs.

Effective for dates of service on or after October 1, 1990, the drug claim form may not be used for billing legend drugs under the hospital provider number for either inpatients or outpatients. Legend drugs and other pharmacy services (other than take-home drugs) billed for inpatients should be billed on the UB-82 claim form. Take-home drugs should be billed on the drug claim form using the pharmacy's provider number.

## XIX. OUTPATIENT CLAIMS BILLED DURING AN INPATIENT STAY

Effective with dates of service on or after January 1, 1991, hospital outpatient services may no longer be billed when a recipient is an inpatient in the same or another hospital. The UB-82 hospital outpatient claim will be denied (or recouped if already paid) if the outpatient claim is for services provided to an inpatient in any hospital, except on the date of admission or the date of discharge. The hospital providing the outpatient services must arrange the payment with the inpatient hospital. However, if a recipient receives an emergency room service and is subsequently admitted to another hospital, the emergency room visit is separately reimbursable.

### PART III: BILLING INFORMATION

#### XX. REMITTANCE AND STATUS REPORT

Effective January 1, 1991, the format of the Remittance and Status Report will change to reflect information relevant to reimbursement under DRGs. The following information provides a description of how DRG outlier, capital, and medical education reimbursement will appear on the Remittance and Status Report.

Refer to Attachments 7a through 7d of this MAPB for sample Remittance and Status Reports as they will appear after DRG implementation.

##### A. DRG Reimbursement and Outlier

Effective January 1, 1991, the Remittance and Status Report will include the DRG to which a claim is assigned, the description of the DRG, and any qualified outlier amount. The DRG code, description and outlier amount will be located immediately below the claim total line. This line will be identified by the numeric code "769". This numeric code is not the DRG code.

The label "DRG-CD" (DRG Code) will follow the "769" numeric code, then the DRG number, followed by the DRG description. At the end of this line, after the DRG description, is the label "OUTL-ALLOWED", followed by the calculated outlier payment amount, if any. If the claim is below the outlier trim point and no outlier payment is made, this field will be blank.

Both the "Total Charge" line and the claim "Total" line will include the DRG payment for the claim and the outlier payment, if any is due.

Claims submitted for payment after January 1, 1991, with dates of discharge before that date, will be paid a rate per discharge and will appear on the Remittance and Status report in the current format.

##### B. Capital and Medical Education Passthrough Payments

The Remittance and Status Report will also include a subsection with lines describing passthrough payments for both capital expenses and direct medical education expenses.

The section on passthrough payments can be identified by the first four digits, "4094", of the claim number. The pseudo recipient Medical Assistance identification number for passthrough payments will always be 9990000000.

Passthrough payments will be issued and will appear on the Remittance and Status Report sent with the first check printed after the first Friday of each month. Refer to Attachment 7d of this MAPB for a sample Remittance and Status Report showing reimbursement for capital and medical education passthroughs.

### C. Organ Transplant Payments

The Remittance and Status Report for providers of organ transplants (provider numbers ending with the suffix "05", "06", "07", "08", or "09") will undergo a change similar to that under DRG reimbursement. A transplant code, labeled "TPC", (Transplant Code Number), along with a description of the type of organ transplant, will be located immediately below the claim total line. The transplant code is not a DRG code. It is a unique number identifying the type of transplant that was performed. The last two digits of the number will be the same as the provider number suffix.

## XXI. REVENUE CODES

UB-82 revenue codes are used by the WMAP to identify accommodation or ancillary services that may be billed by the provider. Some revenue codes indicate a service or benefit not covered by the WMAP (e.g., revenue code 374, acupuncture). Some revenue codes indicate a service which is a benefit of the program but is not billable by an inpatient or outpatient hospital (e.g., revenue code 570, home health aide charges for home health agency personnel). Other revenue codes represent services subject to restrictions or limitations (e.g., revenue code 914, individual psychiatric/psychological therapy). With the implementation of DRGs, many formerly billable revenue codes for professional services will no longer be reimbursed for hospital inpatients. These must be billed by certified providers using the appropriate claim form and HCPCS procedure codes.

Refer to Attachment 8 of this MAPB for the revenue code requirements effective January 1, 1991 with DRG implementation. This attachment replaces the information from MAPB-086-020-B dated July 18, 1986. All assigned revenue codes published in the State Unified Billing Committee's UB-82 Manual are valid when billing the WMAP within the parameters outlined in the matrix.

Note: It is important to remember that hospitals may no longer bill on the UB-82 claim form for those services provided to hospital inpatients which are not included in the DRG payment rate. These services must be billed on the appropriate claim form. Refer to Section XV of this MAPB for information on separate certification, and to Attachment 6 for an updated list of services which must be separately billed and the appropriate claim forms.

## XXII. DURATION OF MECHANICAL VENTILATION FOR NEONATES

The duration of mechanical ventilation, which identifies those neonates with severe respiratory problems, is a critical factor in hospital resource use. Studies have proven that the number of days spent on a mechanical ventilator is an important variable, along with birth weight, when revising DRGs for neonatal patients.

Before the WMAP can include duration of mechanical ventilation as a factor in DRG payment, neonatal ventilation data must be obtained from hospitals via the UB-82 claim form, and the data must be evaluated. As a result, the WMAP is requesting that hospitals collect duration of mechanical ventilation in days for neonates only and enter the information on the UB-82 claim form for dates of discharge on or after January 1, 1991.

Please indicate value code 85 in one of UB-82 items 46 through 49 when mechanical ventilator services are provided to a neonate. Indicate the number of acute care days of mechanical ventilation in the associated value field. The last two positions in the value field must always be zero when reporting value code 85. (For example, report five days as "500.") Refer to Attachment 9 of this MAPB for a sample UB-82 claim form showing duration of mechanical ventilation.

### XXIII. MOTHER/BABY CLAIMS

Current WMAP policy allows hospitals to submit a baby's claim using the mother's Medical Assistance identification number if the baby's hospital stay is 10 days or less and a Medical Assistance identification number has not been assigned to the baby. If the baby's hospital stay is 11 or more days, the claim must be submitted using the baby's Medical Assistance identification number once it is assigned.

Effective with dates of discharge on or after January 1, 1991, the inpatient UB-82 claim form must be completed according to the following instructions if the baby's claim is submitted using the mother's Medical Assistance identification number. This replaces the procedure described in MAPB-086-020-B dated July 18, 1986.

- Place the baby's name in item 10 of the UB-82 claim form;
- Indicate in the occurrence code field (UB-82 claim form items 28 through 32) an occurrence code of 50 if the baby is male, or an occurrence code of 51 if the baby is female;
- Indicate the baby's date of birth as the associated occurrence date with occurrence code 50 or 51;
- Place the mother's name and date of birth in item 65; and
- Place the mother's Medical Assistance identification number in item 68.
- If multiple births occur, please submit a separate claim for each newborn.

Remember, when billing a baby's claim using the mother's Medical Assistance identification number, you must indicate the sex of the baby with occurrence code 50 or 51 and the baby's date of birth in the occurrence date field associated with code 50 or 51. If this procedure is not followed, the claim will be denied. Refer to Attachment 9 for a sample UB-82 claim form.

Note: If claims are submitted with the baby's Medical Assistance identification number, the occurrence codes and dates are not needed.

### XXIV. UB-82 SOURCE OF ADMISSION

Source of admission (item 18 on the UB-82 claim form) is required by the WMAP and must be completed by all hospitals submitting an inpatient hospital claim. Effective with dates of discharge on or after January 1, 1991, a valid value (1 through 9) must be indicated in the UB-82 claim source of admission field (item 18), or the inpatient claim

will be denied. In some instances, source of admission data is one of the criteria for assigning the claim to a DRG. Refer to the Hospital UB-82 Manual for a list of valid codes and their associated definitions.

#### XXV. OUTPATIENT CROSSOVER CLAIMS

Hospitals should note that in order for automated outpatient crossover claims from Blue Cross to process correctly, the following information must be indicated on the UB-82 claim form submitted to Medicare:

- Covered days in item 23;
- "T-19 WI Medicaid" in item 57; and
- The recipient's Medical Assistance identification number in item 68.

If you bill electronically, please indicate the above information as requested in Medicare's electronic claim instructions, and indicate the covered days as required by Medicare.

#### XXVI. PROVIDER QUESTIONS ON DRGS

As the WMAP moves to implement a DRG system, hospitals will have questions that have not been addressed in the series of three MAPBs or the training workshops devoted to DRG implementation. This section of the MAPB will provide guidelines on where providers should direct DRG related questions, after they have carefully reviewed the relevant MAPBs and handbooks.

Questions on the following issues should be directed to the EDS Correspondence Unit at the telephone numbers listed below:

- Certification under DRGs;
- All claims processing questions relating to paid, pending, or denied claims, or claim adjustments, for hospital and professional services;
- Claim form completion clarification for hospital and professional services;
- Reading the Remittance and Status Report;

Providers in Fond du Lac, Dodge, Jefferson, Rock, Walworth, Racine, Kenosha, Waukesha, Milwaukee, Washington, Ozaukee, and Sheboygan counties:

1-800-323-0847 (in-state toll-free)  
(608) 221-9773 (local)

Providers in all other counties:

1-800-323-0861 (in-state toll-free)  
(608) 221-9236 (local and out-of-state)

Questions on the following issues should be directed to the Hospital Unit at the BHCF at the address listed below:

- DRG policy issues;
- Rates and weights;
- Calculation of passthrough payments for capital and direct medical education;
- Interim "safety net" and hold harmless payments;
- Inpatient and outpatient hospital reimbursement;

Bureau of Health Care Financing  
Attn: Hospital Unit  
P.O. Box 309  
Madison, WI 53701-0309

Questions on policy issues relating to those professional services excluded from DRG payments should be directed to the Policy Planning and Evaluation Section at the BHCF at the address listed below:

Bureau of Health Care Financing  
Attn: Policy, Planning and Evaluation Section  
P.O. Box 309  
Madison, WI 53701-0309

In addition, hospitals are directed to Attachment 10 of this MAPB for assistance in resolving questions pertaining to the systems logic that results in a hospital claim being assigned a particular DRG or paid a particular DRG rate. Questions or problems that cannot be resolved through the series of questions and answers presented in Attachment 10 may be directed to the Hospital Operations Specialist from the BHCF at (608) 266-8532.

## XXVII. DRG TRAINING WORKSHOPS

The Wisconsin Hospital Association, in conjunction with the BHCF and EDS, will be conducting a series of DRG training workshops throughout Wisconsin.

The workshops will be at:

<u>Date</u>	<u>Location</u>
November 6, 1990	Sheraton Madison, WI
November 8, 1990	Holiday Inn Eau Claire, WI
November 13, 1990	Marriott Brookfield, WI

November 14, 1990

Hilton  
Oshkosh, WI

The Wisconsin Hospital Association will be sending out Workshop registration materials in the near future.

#### XXVIII. PAPERLESS CLAIMS

Submit your claims electronically. Experience shows that electronic billers get quicker results with fewer errors than conventional paper billers. EDS offers free software and consultation services to get you started right. Simply fill out Attachment 12 of this MAPB and mail it to EDS, or call (608) 221-4746 and ask for the Electronic Medic Claims (EMC) Unit. Experience the advantages of paperless claims.

PART IV: ATTACHMENTS

XXIX. ATTACHMENTS

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ATTACHMENT 1

ADJUSTMENT FORM

MAPB-090-027-B

Date: 09/25/90

**DO NOT WRITE IN THIS SPACE**

I.M. HOSPITAL 87654321  
**1. PROVIDER NAME** **2. PROVIDER NO.**

**3. RECIPIENT NAME** Ima Recipient

**5. R/S NUMBER** 1234567 **6. R/S DATE** MM/DD/YY  

4	0	9	8	9	0	X	X	X	X	X	X	X	X	X
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

1	2	3	4	5	6	7	8	9	0
---	---	---	---	---	---	---	---	---	---

**4. RECIPIENT NUMBER**

**7. CLAIM NUMBER**

8. PROC/NDC	9. SERVICE DATES	10. AMOUNT BILLED	11. QUANTITY & SIZE BILLED	12. SERVICE DESCRIPTION/ NAME OF DRUG/MANUFACTURER
1.				
2.				
3.				
4.				
5.				

**REASON FOR ADJUSTMENT**  
 (State the specific reason that this claim needs to be adjusted [e.g., the procedure code needs to be corrected or the quantity billed, date of service, billed amount, etc., is incorrect].)  
 Interim payment for long length of stay. Revised claim attached to Adjustment form.  
 I.M. Provider MM/DD/YY  
**Provider Signature/Date**

**INSTRUCTIONS:** (See reverse side for further instructions.)

- A. Please use a separate form for each claim. Continue on a second page if more than five adjustment requests per single copy inquiry.
- B. Forward original to: E.D.S. FEDERAL CORPORATION  
 6406 Bridge Road  
 Madison, Wisconsin 53784-0002
- C. Please attach a copy of the original claim.

## ADJUSTMENT REQUEST COMPLETION INSTRUCTIONS

This form should be used only to request a review for an adjustment of claims paid or partially paid by EDS. Please do not include any questions or request information concerning policies or procedures. These may be directed to EDS' Correspondence Unit.

A claim that was totally denied may be resubmitted after the additional information has been supplied or the necessary correction to the claim has been made. Adjustment requests must be submitted within 90 days from the date of payment on the original claim.

The adjustment request is reviewed based on the information provided to EDS on this form. Be as specific as possible. Complete the adjustment request as follows:

### A. ENTER INFORMATION AS IT APPEARS ON THE REMITTANCE AND STATUS REPORT:

1. Provider Name.
2. Medical Assistance provider number to which claims were paid (8 digits).
3. Complete name of the Medical Assistance recipient for whom payment was received.
4. Recipient's Medical Assistance number (10 digits).
5. Remittance and Status Report number.
6. Date of Remittance and Status Report.
7. Claim number (15 digits).
8. Procedure number/NDC (National Drug Code).
9. Dates of service.
10. Amount billed.
11. Quantity billed. If applicable, give quantity and size. Drugs must be given in metric units (e.g., 1 tube = 3.5 grams).
12. Description of service or drug name, manufacturer, and drug strength.

### B. REASON FOR ADJUSTMENT:

1. Indicate what error was made (what the quantity should be, what code or description should be used, change in dates of service . . .).
2. If there are extenuating circumstances, complicated or new procedures, attach a report or operative report.
3. If the provider feels an increased payment is warranted, clarify the reason why. Be specific.
4. Indicate performing provider number if applicable.

**NOTE:** The adjustment request is processed more quickly if a copy of the original claim is attached.

## NEONATAL DRG GROUPER NARRATIVE

Following is the narrative description of the logic used to reassign Medicare DRGs 385 through 391 to WMAP neonatal DRGs 601 through 680.

Step 1. A neonatal claim will be reassigned to one of the new neonatal WMAP DRGs if the claim would have originally grouped into Medicare DRGs 385 through 391. The selection criteria for all the following steps is to determine whether the claim can first be assigned to one of the Medicare DRGs, 385 through 391.

Step 2. Test whether the claim is for services provided to a neonate who died within one day of admission by subtracting the admission date from the discharge date.

If the result is less than or equal to one and the patient was born in the admitting (your) hospital but died within one day, the DRG is reassigned to 601.

But if the claim is for a neonate transferred from another hospital to your hospital and the neonate died within one day (the discharge date minus the admission date is less than or equal to one), the DRG is reassigned to 602.

Step 3. If the claim does not meet the criteria in step 2, then determine whether the recipient was transferred to another hospital within four days.

Subtract the admission date from the discharge date. If the result is less than or equal to four, and the claim indicates the patient was transferred to another hospital, then the DRG is reassigned to 604.

Note regarding steps 4 through 8: If the claim is for a neonate who neither died within one day of admission nor was transferred to another hospital within four days of birth, then birth weight becomes the major determining factor in reassigning the DRG. The neonate's birth weight is identified by ICD-9-CM diagnosis codes 764.01 through 765.18. The patient's birth weight must be identified on the UB-82 claim form as an ICD-9-CM diagnosis code in any of the diagnosis code fields, items 77 through 81.

If none of the diagnosis codes indicated on the claim form are for birth weight, a normal birth weight of 2500 grams is assumed.

Step 4. If the neonate's birth weight was less than 750 grams and the neonate died in the hospital, DRG 610 will be reassigned to the claim. If the neonate was discharged alive, DRG 614 will be reassigned.

Step 5. If the neonate's birth weight was between 750 and 999 grams and the neonate died in the hospital, DRG 620 will be reassigned to the claim. If the neonate was discharged alive, DRG 624 will be reassigned.

Step 6. If the neonate birth weight was between 1,000 and 1,499 grams and the neonate died in the hospital, DRG 637 will be reassigned to the claim.

If the neonate (whose birth weight is between 1,000 and 1,499 grams) was discharged alive, the next test is whether an operating room (O.R.) procedure (excluding circumcision) was performed. If an O.R. procedure was performed, DRG 638 should be reassigned to the claim. If an O.R. procedure was not performed, DRG 639 will be reassigned.

Step 7. If the claim indicates the neonate's birth weight was between 1,500 and 1,999 grams and the neonate underwent an operating room procedure, then the claim is reassigned to DRG 648. If an operating room procedure was not performed, DRG 649 will be reassigned.

**Note on the logic in step 8:** The following logic is presented for two birth weight groups: (a) patients whose birth weights were between 2,000 and 2,499 grams, and (b) patients whose birth weights were 2,500 grams or more. Birth weights of 2,500 grams or more, and their DRG reassignments, will be indicated in parentheses.

Step 8. If the claim indicates a neonate's birth weight was between 2,000 and 2,499 grams (or 2,500 grams or more) and the neonate underwent an operating room procedure (excluding circumcision), then the claim is reassigned to DRG 650 (or DRG 680 if the birth weight is 2,500 grams or more).

If no operating room procedure was performed, then the claim must be tested for the presence of a major or minor medical condition.

**Note:** A major medical condition is defined as a condition or set of conditions that when present, would cause the claim to group into one of the Medicare DRGs 386, 387, or 389 in MDC 15. A minor medical condition is identified as a condition or set of conditions that, if present, would cause the claim to group into one of the Medicare DRGs 388 or 390 in MDC 15.

If the claim indicates no operating room procedure, a patient's birth weight between 2,000 and 2,499 grams (or 2,500 grams or more) and a major medical condition, then the claim is reassigned to DRG 656 (DRG 676 if birth weight is 2,500 grams or more).

If the conditions for a major medical condition are not present, then the claim must be tested for presence of a minor medical condition. If a minor problem is indicated, the birth weight is between 2,000 and 2,499 grams (or 2,500 grams or more), and no operating room procedure is indicated, then the claim is reassigned to DRG 657 (DRG 677 if birth weight is 2,500 grams or more).

If the claim indicates the patient's birth weight was between 2,000 and 2,499 grams (or 2,500 grams or more), an operating room procedure is not indicated, and neither a major nor a minor medical condition is present, then the claim is reassigned to DRG 670 (DRG 678 if birth weight is 2,500 grams or more).

All normal newborn claims for patients born under normal birth conditions and with normal birth weight (2,500 grams or more) will be assigned, under the above logic, to DRG 678.

## PSEUDO-CODE

=====

If DRG from grouper  $\geq 385$  and  $\leq 391$  then

    Perform Neo-Natal Patch logic

endif

## Neo-Natal Patch Logic

=====

Calculate Length of Stay = Discharge Date - Admission Date

If Length of Stay  $\leq 1$  and Patient Status Code = 20 then

    If Source of Admission  $\neq$  (not equal to) 4

        DRG = 601                      Died in birth hospital

    else

        DRG = 602                      Died in receiving hospital

    endif

else

    If Length of Stay  $> 0$  and Length of Stay  $\leq 4$

        If Patient Status Code = { 02 03 04 05 06 07 }

            DRG = 604

        else

            Perform Birth-weight procedure

        endif

    else

        Perform Birth-weight DRG procedure

    endif

endif

Birth-weight DRG procedure

=====

Perform Calculate Birth-weight Procedure using birth-weight

If birth-weight < 750 grams

    If discharge status = 20 then

        DRG = 610

    else

        DRG = 614

    endif

endif

If birth-weight >= 750 grams and birth-weight < 1000 grams

    If discharge status = 20

        DRG = 620

    else

        DRG = 624

    endif

endif

If birth-weight >= 1000 and birth-weight < 1500 grams

    If discharge status = 20

        DRG = 637

    else

        IF O.R. Procedure exists (from grouper table) and O.R. Procedure <> 640

            DRG = 638

        else

            DRG = 639

        endif

endif

endif

If birth-weight  $\geq$  1500 grams and birth-weight  $<$  2000 grams

If O.R. Procedure exists and procedure code  $\neq$  640 (circumcision)

DRG = 648

else

DRG = 649

endif

endif

If birth-weight  $\geq$  2000 grams and birth-weight  $<$  2500 grams

If O.R. Procedure exists and procedure code  $\neq$  640 (circumcision)

DRG = 650

else

If Major Problem (DRGs 386, 387 and 389)

DRG = 656

else

If Minor Problem (DRGs 388, 390)

DRG = 657

else

DRG = 670

endif

endif

endif

endif

If birth-weight  $\geq$  2500 grams

If O.R. Procedure exists and procedure code  $\neq$  640

DRG = 680

else

If Major Problem (DRG 386, 387, 389)

DRG = 676

else

If Minor Problem (DRG 388, 390)

DRG = 677

else

DRG = 678

endif

endif

endif

else

DRG = 697

endif

Calculate Birth-weight Procedure

=====  
IF diagnoses = \* any of the discharge diagnoses 1-5

764.01 764.02 764.11 764.12 764.21  
764.22 764.91 764.92 765.01 765.02  
765.11 765.12

birth-weight = 749 grams

else

if diagnoses = {764.03 764.13 764.23 764.93 765.03 765.13}

birth-weight = 999 grams

else

if diagnoses = {764.04 764.05 764.14 764.15 764.24 764.25  
764.94 764.95 765.04 765.05 765.14 765.15}

birth-weight = 1499 grams

else

if diagnoses = { 764.06 764.07 764.16 764.17 764.26 764.27  
764.96 764.97 765.06 765.07 765.16 765.17}

birth-weight = 1999 grams

else

if diagnoses = {764.08 764.18 764.28 764.98 765.08 765.18}

birth-weight = 2499 grams

else

birth-weight = 2500 grams

endif

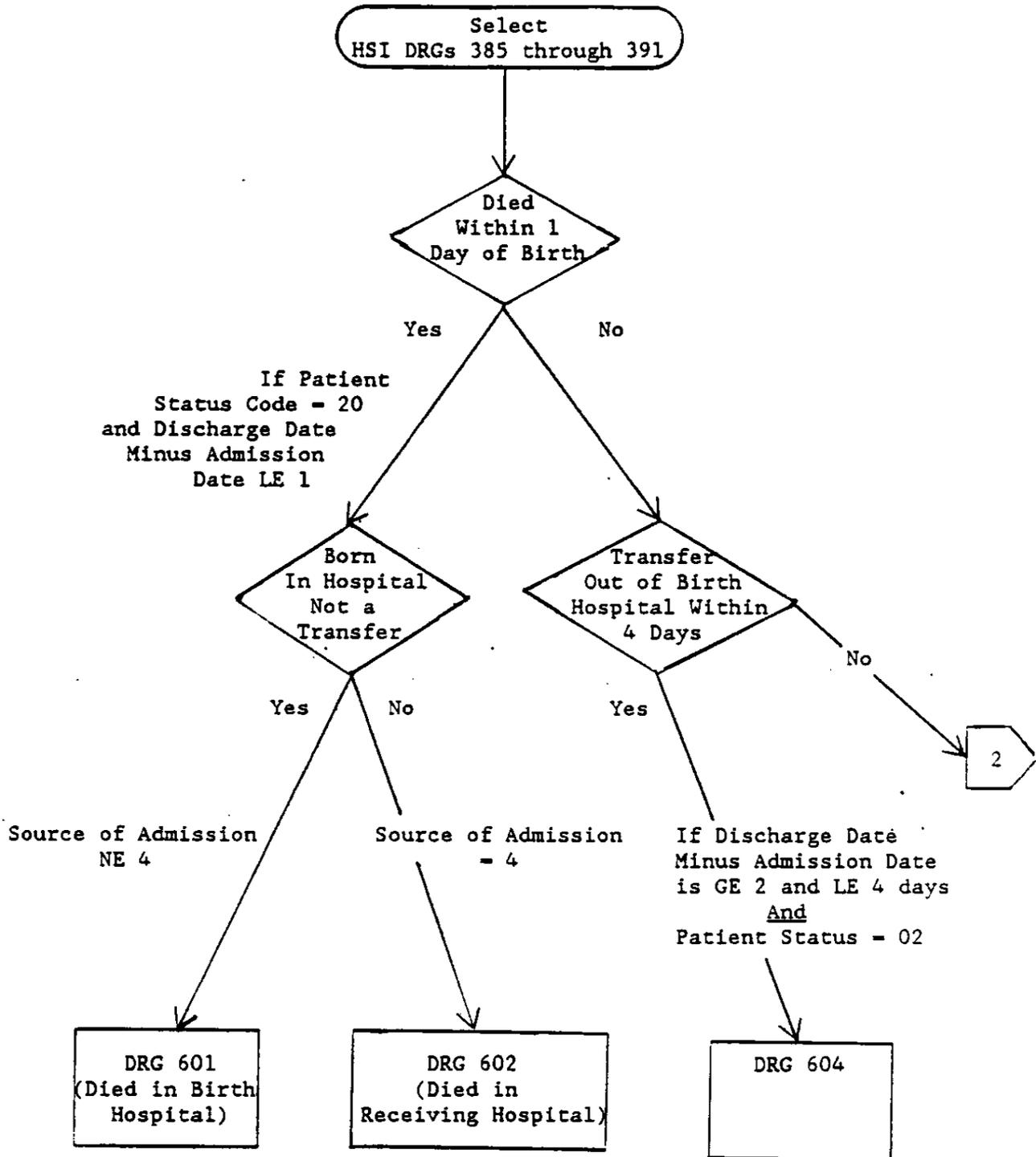
endif

endif

endif  
endif

ATTACHMENT 4  
 Neonatal DRG Grouper  
 Flow Chart

MAPB-090-027-B  
 Date: 09/25/90



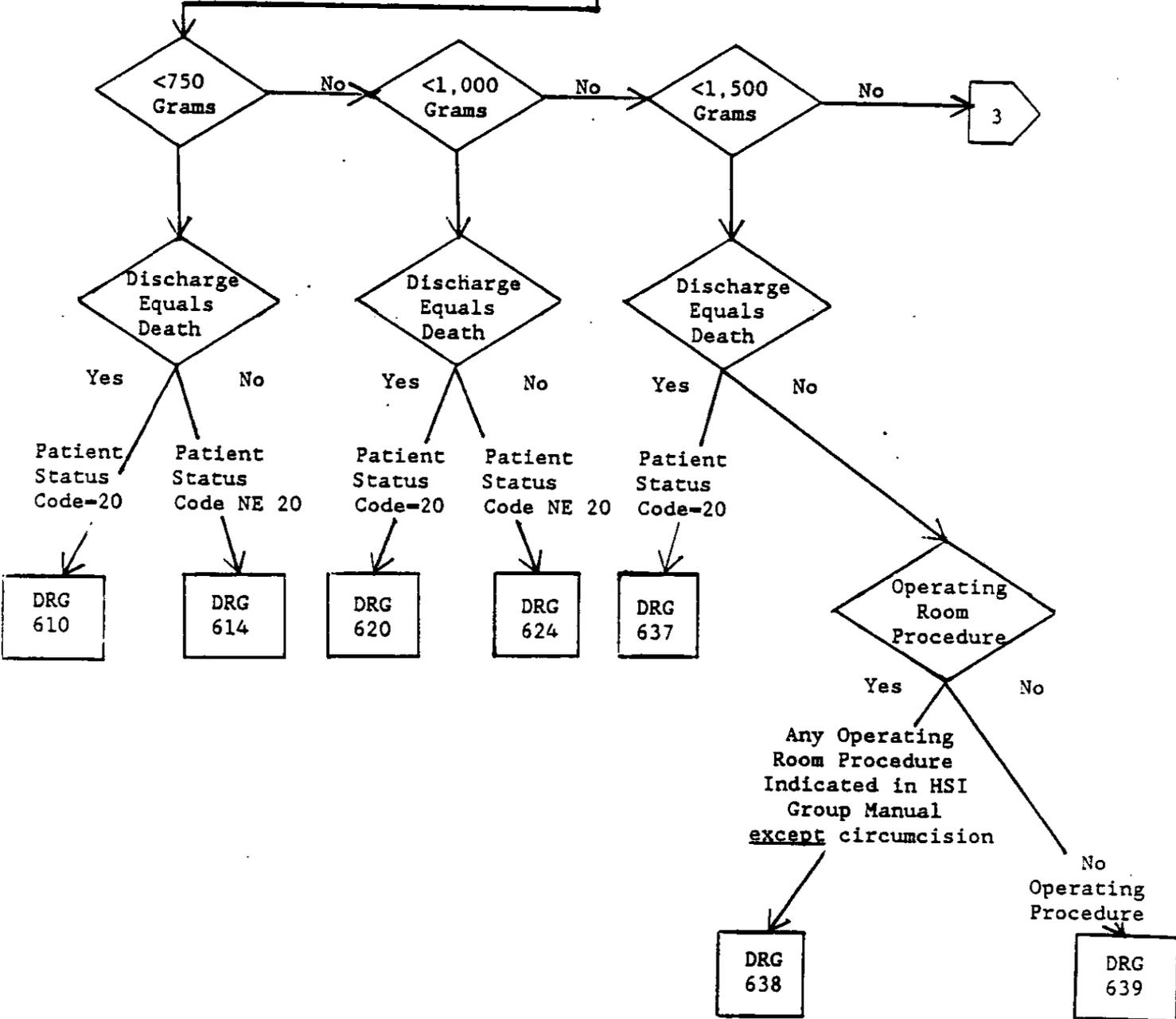
2

Birthweight

ICD-9-CM  
Diagnosis  
Codes:  
764.01 764.91  
764.02 764.92  
764.11 765.01  
764.12 765.02  
764.21 765.11  
764.22 765.12

ICD-9-CM  
Diagnosis  
Codes:  
764.03 764.93  
764.13 765.03  
764.23 765.13

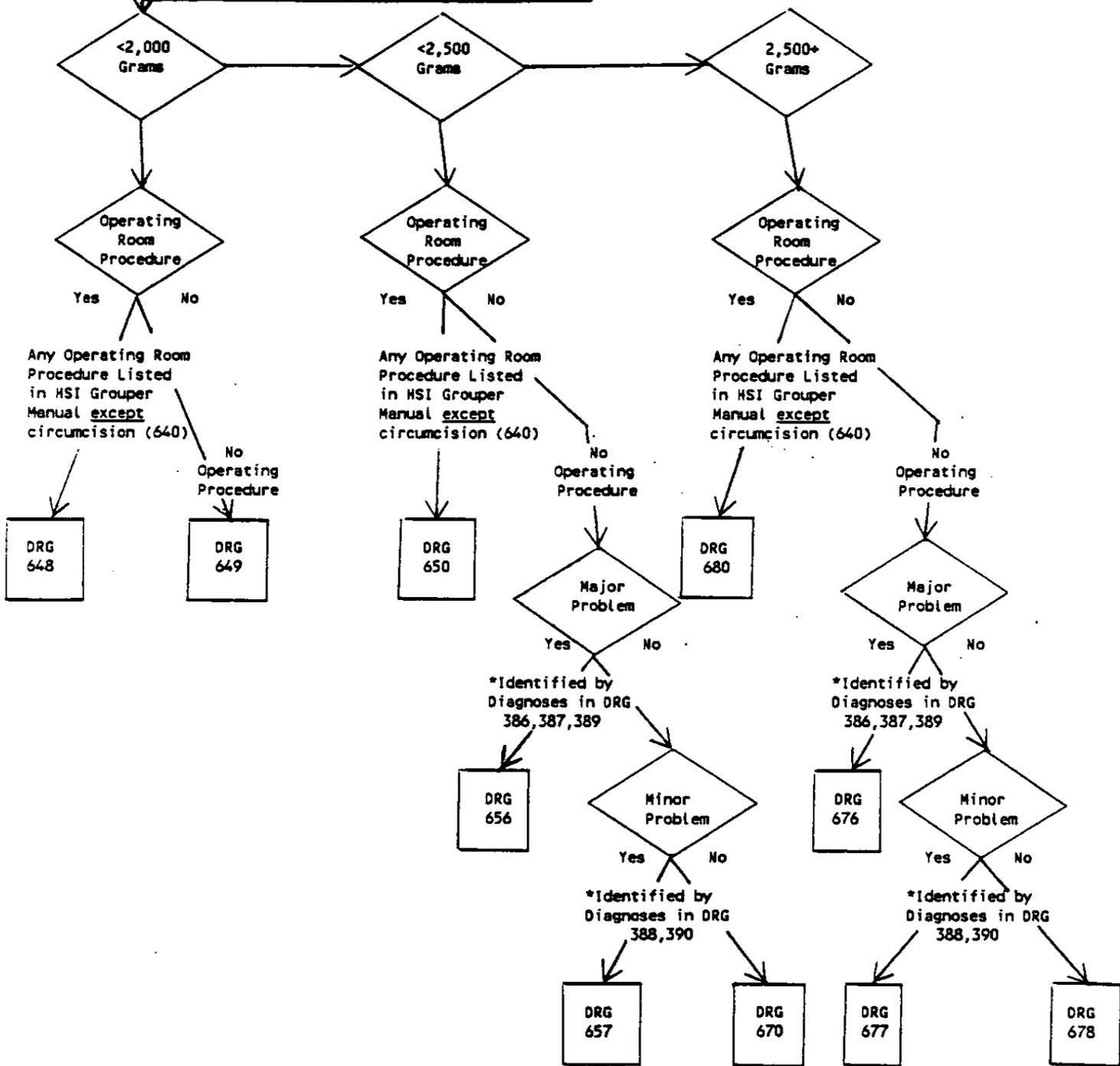
ICD-9-CM  
Diagnosis  
Codes:  
764.04 764.94  
764.05 764.95  
764.14 765.04  
764.15 765.05  
764.24 765.14  
764.25 765.15



3

ICD-9-CM  
Diagnosis Codes:  
764.06 764.96  
764.07 764.97  
764.16 765.06  
764.17 765.07  
764.26 765.16  
764.27 765.17

ICD-9-CM  
Diagnosis Codes:  
764.08 764.98  
764.18 765.08  
764.28 765.18



\* Note: Diagnoses used in previous grouping will not be repeated, or used, here.

## Psychiatric DRG Grouper Pseudo Code

1. If Hospital = Milwaukee Co. Mental Health Center	<u>Milwaukee County</u>	<u>Non-Milwaukee County</u>
If Medicare DRG = 424 and Age < 18 then WMAP Psych DRG = 701		NA
If Medicare DRG = 424 and Age ≥ 18 then WMAP Psych DRG = 702		NA
If Medicare DRG = 425 and Age < 18 then WMAP Psych DRG = 703		NA
If Medicare DRG = 425 and Age ≥ 18 then WMAP Psych DRG = 704		NA
If Medicare DRG = 426 and Age < 18 then WMAP Psych DRG = 705		NA
If Medicare DRG = 426 and Age ≥ 18 then WMAP Psych DRG = 706		NA
If Medicare DRG = 427 and Age < 18 then WMAP Psych DRG = 707		NA
If Medicare DRG = 427 and Age ≥ 18 then WMAP Psych DRG = 708		NA
If Medicare DRG = 428 and Age < 18 then WMAP Psych DRG = 709		NA
If Medicare DRG = 428 and Age ≥ 18 then WMAP Psych DRG = 710		NA
If Medicare DRG = 429 and Age < 18 then WMAP Psych DRG = 711		NA
If Medicare DRG = 429 and Age ≥ 18 then WMAP Psych DRG = 712		NA
If Medicare DRG = 430 and Age < 18 then WMAP Psych DRG = 713		NA
If Medicare DRG = 430 and Age ≥ 18 then WMAP Psych DRG = 714		NA
If Medicare DRG = 431 and Age < 18 then WMAP Psych DRG = 715		NA
If Medicare DRG = 431 and Age ≥ 18 then WMAP Psych DRG = 716		NA
If Medicare DRG = 432 and Age < 18 then WMAP Psych DRG = 717		NA
If Medicare DRG = 432 and Age ≥ 18 then WMAP Psych DRG = 718		NA

2. If Hospital = IMDs	<u>Milwaukee County</u>	<u>Non-Milwaukee County</u>
If Medicare DRG = 424 and Age < 18 then WMAP Psych DRG = 721		821
If Medicare DRG = 424 and Age ≥ 18 then WMAP Psych DRG = 722		822
If Medicare DRG = 425 and Age < 18 then WMAP Psych DRG = 723		823
If Medicare DRG = 425 and Age ≥ 18 then WMAP Psych DRG = 724		824
If Medicare DRG = 426 and Age < 18 then WMAP Psych DRG = 725		825
If Medicare DRG = 426 and Age ≥ 18 then WMAP Psych DRG = 726		826
If Medicare DRG = 427 and Age < 18 then WMAP Psych DRG = 727		827
If Medicare DRG = 427 and Age ≥ 18 then WMAP Psych DRG = 728		828
If Medicare DRG = 428 and Age < 18 then WMAP Psych DRG = 729		829
If Medicare DRG = 428 and Age ≥ 18 then WMAP Psych DRG = 730		830
If Medicare DRG = 429 and Age < 18 then WMAP Psych DRG = 731		831
If Medicare DRG = 429 and Age ≥ 18 then WMAP Psych DRG = 732		832
If Medicare DRG = 430 and Age < 18 then WMAP Psych DRG = 733		833
If Medicare DRG = 430 and Age ≥ 18 then WMAP Psych DRG = 734		834
If Medicare DRG = 431 and Age < 18 then WMAP Psych DRG = 735		835
If Medicare DRG = 431 and Age ≥ 18 then WMAP Psych DRG = 736		836
If Medicare DRG = 432 and Age < 18 then WMAP Psych DRG = 737		837
If Medicare DRG = 432 and Age ≥ 18 then WMAP Psych DRG = 738		838

3. If Hospital = Medicare Psych Exempt Unit	<u>Milwaukee County</u>	<u>Non-Milwaukee County</u>
If Medicare DRG = 424 and Age < 18 then WMAP Psych DRG = 741		841
If Medicare DRG = 424 and Age ≥ 18 then WMAP Psych DRG = 742		842
If Medicare DRG = 425 and Age < 18 then WMAP Psych DRG = 743		843
If Medicare DRG = 425 and Age ≥ 18 then WMAP Psych DRG = 744		844
If Medicare DRG = 426 and Age < 18 then WMAP Psych DRG = 745		845
If Medicare DRG = 426 and Age ≥ 18 then WMAP Psych DRG = 746		846
If Medicare DRG = 427 and Age < 18 then WMAP Psych DRG = 747		847
If Medicare DRG = 427 and Age ≥ 18 then WMAP Psych DRG = 748		848
If Medicare DRG = 428 and Age < 18 then WMAP Psych DRG = 749		849
If Medicare DRG = 428 and Age ≥ 18 then WMAP Psych DRG = 750		850
If Medicare DRG = 429 and Age < 18 then WMAP Psych DRG = 751		851
If Medicare DRG = 429 and Age ≥ 18 then WMAP Psych DRG = 752		852
If Medicare DRG = 430 and Age < 18 then WMAP Psych DRG = 753		853
If Medicare DRG = 430 and Age ≥ 18 then WMAP Psych DRG = 754		854
If Medicare DRG = 431 and Age < 18 then WMAP Psych DRG = 755		855
If Medicare DRG = 431 and Age ≥ 18 then WMAP Psych DRG = 756		856
If Medicare DRG = 432 and Age < 18 then WMAP Psych DRG = 757		857
If Medicare DRG = 432 and Age ≥ 18 then WMAP Psych DRG = 758		858

4. If Hospital = All Other Hospitals	<u>Milwaukee County</u>	<u>Non-Milwaukee County</u>
If Medicare DRG = 424 and Age < 18 then WMAP Psych DRG = 761		861
If Medicare DRG = 424 and Age ≥ 18 then WMAP Psych DRG = 762		862
If Medicare DRG = 425 and Age < 18 then WMAP Psych DRG = 763		863
If Medicare DRG = 425 and Age ≥ 18 then WMAP Psych DRG = 764		864
If Medicare DRG = 426 and Age < 18 then WMAP Psych DRG = 765		865
If Medicare DRG = 426 and Age ≥ 18 then WMAP Psych DRG = 766		866
If Medicare DRG = 427 and Age < 18 then WMAP Psych DRG = 767		867
If Medicare DRG = 427 and Age ≥ 18 then WMAP Psych DRG = 768		868
If Medicare DRG = 428 and Age < 18 then WMAP Psych DRG = 769		869
If Medicare DRG = 428 and Age ≥ 18 then WMAP Psych DRG = 770		870
If Medicare DRG = 429 and Age < 18 then WMAP Psych DRG = 771		871
If Medicare DRG = 429 and Age ≥ 18 then WMAP Psych DRG = 772		872
If Medicare DRG = 430 and Age < 18 then WMAP Psych DRG = 773		873
If Medicare DRG = 430 and Age ≥ 18 then WMAP Psych DRG = 774		874
If Medicare DRG = 431 and Age < 18 then WMAP Psych DRG = 775		875
If Medicare DRG = 431 and Age ≥ 18 then WMAP Psych DRG = 776		876
If Medicare DRG = 432 and Age < 18 then WMAP Psych DRG = 777		877
If Medicare DRG = 432 and Age ≥ 18 then WMAP Psych DRG = 778		878

**PROVIDER NUMBERS, CLAIM FORMS, AND  
PROCEDURE CODES UNDER DRGS**

<u>Provider Type</u>	<u>Billing Performing Provider Number</u>	<u>Non-Billing Performing Provider No.</u>	<u>Group Billing No.</u>	<u>Claim Form</u>	<u>Procedure Coding</u>
Physician	X		X	HCFA 1500	HCPCS
Psychiatrist	X		X*	HCFA 1500	HCPCS
Psychologist	X		X	HCFA 1500	HCPCS
Physician Assistant		X	X**	HCFA 1500	HCPCS
Nurse Midwife	X		X	HCFA 1500	HCPCS
CRNA and Anes- thesia Assistant	X		X**	HCFA 1500	HCPCS
Chiropractor	X		X	HCFA 1500	HCPCS
Dentist	X		X	Dental	HCPCS
Optometrist	X		X	HCFA 1500	HCPCS
Hearing Aid Dealer	X		X	HCFA 1500	HCPCS
Audiologist	X		X	HCFA 1500	HCPCS
Pharmacy	X			WMAP Drug	NDC
DME	X***			HCFA 1500	HCPCS
DMS	X***			WMAP Drug	NDC
Ambulance	X			HCFA 1500	HCPCS
SMV	X			HCFA 1500	HCPCS
Podiatrist+	X		X	HCFA 1500	HCPCS
Nurse Practitioner+	X		X	HCFA 1500	HCPCS

\* May use Physician Clinic Number or Mental Health Clinic Number.

\*\* May use Physician Clinic Number.

\*\*\* May use Pharmacy Number.

+ Added since prior MAPB dated February 1, 1990 (MAPB-090-026-B). Refer to Section XV of this MAPB for clarification of nurse practitioner services excluded from the DRG payment.

E.D.S. FEDERAL CORPORATION

6406 BRIDGE ROAD 800/323-0847 - Southeast Wisconsin  
 Madison, WI. 53784 800/323-0861 - North, West, Central Wisconsin

FISCAL AGENT FOR WISCONSIN MEDICAL ASSISTANCE PROGRAM

REMITTANCE AND STATUS REPORT

IM HOSPITAL  
 I W. WILLIAMS  
 ANYTOWN, WI 55555

R/S NUMBER 1234567

PROVIDER NUMBER 87654321

REPORT SEQ NUMBER 1

DATE MM/DD/YY

PAGE 1

PATIENT NAME/ID NUMBER		MEDICAL RECORD NO		ACCOUNTING NO	CLAIM NUMBER	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
SERVICE DATES FROM	TO	PERF PROV/ RX NUMBER	DAYS QTY	PROC/ACCOM/ DRUG CODE	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION						
RECIPIENT, IMA/1234567890					491091XXXXXXXXXX						
011791	011991		20	E 121	MED-SUR GYN/2 BED	XXX XX	XXXXX	00	00	00	
011791	011991		20	C 232	NUR INCR/OB	XXX XX	XXXXX	00	00	00	
011791	011991		90	C 250	PHARMACY	XX XX	XXXX	00	00	00	
011791	011991		10	C 260	IV THERAPY	XX XX	XXXX	00	00	00	
011791	011991		70	C 270	MED-SUR SUPPLIES	XX XX	XXXX	00	00	00	
011791	011991		10	C 300	LAB	X XX	XXX	00	00	00	
011791	011991		10	E 001	TOTAL CHARGE	XXXX XX	XXXXXX	00	00	XXXXX	123
					CLAIM TOTAL	XXXX XX	XXXXXX	00	00	XXXXX	
		769 DRG CD 373		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES		OUTL-ALLOWED					
		123 THIS IS AN		ADJUSTMENT TO PREVIOUS CLAIM		401391XXXXXXXXXX		PAID ON		MMDDYY	
RECIPIENT, IMA/1234567890					401391XXXXXXXXXX						
011791	011991		20	E 121	MED-SUR-GYN/2 BED	-XXX XX	-XXX XX	00	00	00	
011791	011991		20	C 232	NUR INCR/OB	-XXX XX	-XXX XX	00	00	00	
011791	011991		90	C 250	PHARMACY	-XX XX	-XX XX	00	00	00	
011791	011991		10	C 260	IV THERAPY	-XX XX	-XX XX	00	00	00	
011791	011991		70	C 270	MED-SUR SUPPLIES	-XX XX	-XX XX	00	00	00	
011791	011991		10	C 300	LAB	-X XX	-X XX	00	00	00	
011791	011991		10	E 001	TOTAL CHARGE	-XXXX XX	-XXXX XX	00	00	-XXXX XX	116
					CLAIM TOTAL	-XXXX XX	-XXXX XX	00	00	-XXXX XX	
		769 DRG CD 373		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES		OUTL-ALLOWED					

ATTACHMENT 7a  
 Retroactive Rate Adjustment  
 MAPB-090-027-B  
 Date: 09/25/90

E.D.S. FEDERAL CORPORATION

6408 BRIDGE ROAD | 800/323-0847 - Southeast Wisconsin  
Madison, WI. 53784 | 800/323-0861 - North, West, Central Wisconsin

FISCAL AGENT FOR WISCONSIN MEDICAL ASSISTANCE PROGRAM

REMITTANCE AND STATUS REPORT

IM HOSPITAL  
1 W.WILLIAMS  
ANYTOWN, WI 55555

R/S NUMBER 1234567

PROVIDER NUMBER 87654321

REPORT SEQ NUMBER 1

DATE MM/DD/YY

PAGE 1

PATIENT NAME/ID NUMBER		MEDICAL RECORD NO		ACCOUNTING NO	CLAIM NUMBER	TOTAL BILLED		TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPY	PAID AMOUNT	EOB CODES					
SERVICE DATES FROM	TO	PERF PROV/RX NUMBER	DAYS QTY	PROC/ACCOM/DRUG CODE	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION												
RECIPIENT, IMA/1234567890					401391XXXXXXXXXX												
010191	010291		10	E 121	MED-SUR-GYN/2 BED	XXX	XX	XXX	XX	00	00	00					
010191	010291		10	C 230	NUR INCR/ICU	XXX	XX	XXX	XX	00	00	00					
010191	010291		40	C 250	PHARMACY	XX	XX	XX	XX	00	00	00					
010191	010291		20	C 260	IV THERAPY	XX	XX	XX	XX	00	00	00					
010191	010291		20	C 270	MED-SUR SUPPLIES	XX	XX	XX	XX	00	00	00					
010191	010291		30	C 300	LAB	XX	XX	XX	XX	00	00	00					
010191	010291		10	E 001	TOTAL CHARGE	XXX	XX	XXX	XX	00	00	XXX	XX				
CLAIM TOTAL						XXX	XX	XXX	XX			XXX	XX				
769 DRG CD 298 NUTRITIONAL & MISC METABOLIC DISORDERS														AGE 0-17	OUTL-ALLOWED		
RECIPIENT, IMA/0987654321					401391XXXXXXXXXX												
121190	121590		40	E 121	MED-SUR-GYN/2 BED	XXX	XX	XXX	XX	00	00	00					
121190	121590		40	C 230	NURSING INCREM	XXX	XX	XXX	XX	00	00	00					
121190	121590		10	C 250	PHARMACY	XXX	XX	XXX	XX	00	00	00					
121190	121590		80	C 258	IV SOLUTIONS	XX	XX	XX	XX	00	00	00					
121190	121590		380	C 270	MED-SUR SUPPLIES	XXX	XX	XXX	XX	00	00	00					
121190	121590		30	C 300	LAB	XX	XX	XX	XX	00	00	00					
121190	121590		10	C 320	DX X-RAY	XXX	XX	XXX	XX	00	00	00					
121190	121590		10	C 360	OR SERVICES	XXX	XX	XXX	XX	00	00	00					
121190	121590		50	C 370	ANESTHESIA	XXX	XX	XXX	XX	00	00	00					
121190	121590		10	C 710	RECOVERY ROOM	XX	XX	XX	XX	00	00	00					
121190	121590		10	E 001	TOTAL CHARGE	XXXX	XX	XXXX	XX	00	00	XXXX	XX				
CLAIM TOTAL						XXXX	XX	XXXX	XX	XX	XX	XXXX	XX				

DRG and Rate Per Discharge Payments

ATTACHMENT 7b

MAPB-090-027-B  
Date: 09/25/90

E.D.S. FEDERAL CORPORATION

6408 BRIDGE ROAD 800/323-0847 - Southeast Wisconsin  
 Madison, WI. 53784 800/323-0861 - North, West, Central Wisconsin

FISCAL AGENT FOR WISCONSIN MEDICAL ASSISTANCE PROGRAM

REMITTANCE AND STATUS REPORT

IM HOSPITAL  
 1 W.WILLIAMS  
 ANYTOWN, WI 55555

R/S NUMBER 1234567

PROVIDER NUMBER 87654321

REPORT SEQ NUMBER 1

DATE MM/DD/YY

PAGE 1

PATIENT NAME/ID NUMBER		MEDICAL RECORD NO		ACCOUNTING NO	CLAIM NUMBER	TOTAL BILLED	TOTAL ALLOWED		OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES															
SERVICE DATES FROM	TO	PERF PROV/ RX NUMBER	DAYS QTY	PROC/ACCOM/ DRUG CODE	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION																						
RECIPIENT, IMA/1234567890																											
010591	033091		460	E 120		ROOM-BOARD SEMI	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		380	E 208		ICU/TRAUMA	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		380	C 250		NURSING INCREM	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		3550	C 250		PHARMACY	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		4780	C 258		IV SOLUTIONS	XXXX	XX	XXXX	XX	00	00	00														
010591	033091		6570	C 270		MED-SUR SUPPLIES	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		5540	C 300		LAB	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		1610	C 320		DX X-RAY	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		40	C 360		OR SERVICES	XXXX	XX	XXXX	XX	00	00	00														
010591	033091		20	C 370		ANESTHESIA	XXXX	XX	XXXX	XX	00	00	00														
010591	033091		1380	C 391		BLOOD/ADMIN	XXXX	XX	XXXX	XX	00	00	00														
010591	033091		6550	C 412		INHALATION SVC	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033091		370	C 420		PHYSICAL THERP	XXXX	XX	XXXX	XX	00	00	00														
010591	033091		380	C 430		OCCUPATION THER	XXX	XX	XXX	XX	00	00	00														
010591	033091		50	C 450		EMERG ROOM	XXX	XX	XXX	XX	00	00	00														
010591	033091		30	C 480		CARDIOLOGY	XXX	XX	XXX	XX	00	00	00														
010591	033091		50	C 730		EKG/ECG	XXX	XX	XXX	XX	00	00	00														
010591	033091		320	C 800		RENAL DIALYSIS	XXXXXX	XX	XXXXXX	XX	00	00	00														
010591	033991		10	C 922		EMG	XX	XX	XX	XX	00	00	00														
010591	033091		10	E 001		TOTAL CHARGE	XXXXXXXX	XX	XXXXXXXXXX		00	00	XXXXXXXXXX														
						CLAIM TOTAL	XXXXXXXX	XX	XXXXXXXXXX		XX	XX	XXXXXXXXXX														
			769	DRG CD 457		EXTENSIVE BURNS W/O OR PROCEDURE OUTL	ALLOWED		\$XXXX	XX																	

ATTACHMENT 7c  
 DRG with Outlier Payment

MAPB-090-027-B  
 Date: 09/25/90



E.D.S. FEDERAL CORPORATION

8408 BRIDGE ROAD 800/323-0847 - Southeast Wisconsin  
 Madison, WI 53784 800/323-0881 - North, West, Central Wisconsin

FISCAL AGENT FOR WISCONSIN MEDICAL ASSISTANCE PROGRAM

REMITTANCE AND STATUS REPORT

IM HOSPITAL  
 1 W. WILLIAMS  
 ANYTOWN, WI 55555

PROVIDER NUMBER 87654305

REPORT SEQ NUMBER 1

DATE MM/DD/YY

R/S NUMBER 1234567

PAGE 1

PATIENT NAME/ID NUMBER		MEDICAL RECORD NO		ACCOUNTING NO	CLAIM NUMBER	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES								
SERVICE DATES FROM	TO	PERF PROV/ RX NUMBER	DAYS QTY	PROC/ACCOM/ DRUG CODE	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION						COL 1	COL 2	COL 3	COL 4					
RECIPIENT, IMA/1234567890					401391XXXXXXXXXX														
010191	011791		10	E 120	ROOM-BOARD/SEMI	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 230	NURSING INCREM	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 250	PHARMACY	XXXX	XX XX	00	00	00									
010191	011791		10	C 258	IV SOLUTIONS	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 270	MED-SUR SUPPLIES	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 300	LAB	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 310	PATH LAB	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 320	DX X-RAY	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 324	DX X-RAY CHEST	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 341	NUC MED/DX	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 360	OR SERVICES	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 370	ANESTHESIA	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 391	BLOOD ADMIN	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	C 412	INHALATION SVC	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 420	PHYSICAL THERP	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 480	CARDIOLOGY	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 730	EKG/ECG	XXXXX	XXX XX	00	00	00									
010191	011791		10	C 892	DONOR BANK/ORGAN	XXXXXX	XXXX XX	00	00	00									
010191	011791		10	E 001	TOTAL CHARGE	XXXXXXXX	XXXXX XX	00	00	XXXX XX									
					CLAIM TOTAL	XXXXXXXX	XXXXX XX		XXXX	XXXXX XX									
					769 TPC CD1905 HEART TRANSPLANT														

Organ Transplant Payments

ATTACHMENT 7e

MAPB-090-027-B  
Date: 09/25/90

## REVENUE CODES

Policy	Specific Revenue Codes
Revenue Codes which require a 3rd digit detail for Medical Assistance.	11X, 12X, 13X, 15X, 16X, 17X, 20X, 21X, 25X, 36X, 51X, 71X, 90X, 91X, 92X, 94X, 96X
Revenue Codes which require a CPT-4 Lab Procedure Code for outpatient services performed on or after January 1, 1986.	30X, 31X, 923, 925
Revenue Code for Vision Care Services.	519 (Use when providing vision care services as part of an outpatient visit.)
Outpatient Observation Room.	719 (Use when recipient is under observation after recovering from ambulatory surgery.)
Revenue Codes Exempt From Copay.	820-859, 901, 918 Note: Revenue code 253 is exempt from copayment on crossover claims. Revenue code 450 is exempt from copayment on the <u>outpatient</u> claim form.
Non-Covered Revenue Codes.	These codes are not a covered benefit of the WMAP program and will be denied. 140-149, 167, 180-189, 220-229, 374, 941, 990-999
Non-Covered Revenue Codes for Psychiatric Hospitals.	These revenue codes are not a covered benefit in a psychiatric hospital and will be denied. 520, 529, 940, 949
Non-covered revenue codes for general hospitals billing psychiatric or AODA services.	These revenue codes are not a covered benefit in a general hospital when billing for services provided to a patient with psychiatric or AODA diagnoses. 520, 529, 940, 949

**Non-billable revenue codes.**

The following revenue codes may not be billed on the inpatient UB-82 claim form (bill type 11X, even though the services, including professional services, are covered by the WMAP and billable on another claim form).

100, 101, 115, 125, 135, 155, 240, 249, 253, 259, 279, 291-293, 299, 470-472, 479, 500, 509, 530, 531, 539, 540-546, 549, 551, 552, 559, 570-572, 579, 580-582, 589, 590, 599, 600-604, 650-657, 659, 912, 913, 960-964, 969, 971-979, 981-989.

\*Note: Charges for Revenue codes 910, 911, 914-919, should not include charges for professional services provided to inpatients.

The following revenue codes may not be billed on the outpatient UB-82 claim form (bill type 13X) even though the services are covered by the WMAP and billable on another claim form.

All accommodation revenue codes included in the range 180 through 239, 240, 249, 259, 279, 299, 500, 509, 540-546, 549, 550-552, 559, 570-572, 579, 580-582, 589, 590, 599, 600-604, 650-657, 659, 912, 913, 990-999.

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Policy

Billable, non-covered revenue code.

Specific Revenue Codes

180 (Use this code when billing a mental health accommodation and the recipient is on a leave of absence. Indicate in item 52 the number of days on leave.)

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**Restricted Revenue Codes.**

The following revenue codes for private room accommodations may be billed when the physician certified that a private room is necessary, under HSS 107.08(3)(c), Wisconsin Administrative Code:

110, 111, 112, 113, 114, 116, 117, 119

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**Revenue Code for Medication Check.**

All hospitals must use revenue code 510 for medication checks (medication checks are only covered when performed on an outpatient basis).

IM Hospital 1 W. Williams Anytown, WI 55555		1234567890			PATIENT CONTROL NUMBER 1234567		4 TYPE OF BILL 111
3 BCBS PROV NO		6 FEDERAL TAX NO		7 MEDICARE NO		8 MEDICID NO 87654321	

12 PATIENT'S LAST NAME Recipient, Baby A		13 FIRST NAME		11 PATIENT'S ADDRESS 609 Oak St. Anytown, WI 55555		14 STATE		15 ZIP	
---	--	---------------	--	---	--	----------	--	--------	--

12 BIRTH DATE		13 SEX		14 MBS		15 DATE 010691		16 HR		17 TYPE		18 SEC		19 AN		20 DN		21 STAT		22 STATEMENT COVERS PERIOD FROM 010691 THROUGH 011491		23 COV D		24 NCD		25 C10		26 L R D		27	
31 OCCURRENCE		32 DATE		33 DATE		34 DATE		35 DATE		36 DATE		37 DATE		38 DATE		39 DATE		40 DATE		41 DATE		42 DATE		43 DATE		44 DATE		45 DATE			

34		35		36		37		38		39		40		41		42		43		44		45		46		47		48		49		50	
48 VALUE		49 VALUE		50 VALUE		51 VALUE		52 VALUE		53 VALUE		54 VALUE		55 VALUE		56 VALUE		57 VALUE		58 VALUE		59 VALUE		60 VALUE		61 VALUE		62 VALUE		63 VALUE			
85		5:00																															

50 DESCRIPTION	51 R CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56
Neonatal ICU	179	8	XXXX XX			
Pharmacy	250	300	XXX XX			
Med-Sur Supplies	279	25	XX XX			
Laboratory	300	43	XXX XX			
Dx X-Ray	320	2	XXX XX			
Respiratory Svc	410	5	XXX XX			
Telemetry	732	120	XXX XX			
<b>Total Charges</b>	<b>001</b>		<b>XXXX XX</b>			

57 PAYER T-19 01		58 REL 59 ASC INCC DFN		60 DEDUCTIBLE		61 CO-INSURANCE		62 EST RESPONSIBILITY		63 PRIOR PAYMENTS		64 EST AMOUNT DUE	
<b>DUE FROM PATIENT</b>													

65 INSURED'S NAME Mother Ina Recipient MM/DD/YY		66 SEX		67 PREL		68 CERT SSN-INC ID NO 0987654321		69 GROUP NAME		70 INSURANCE GROUP NO	
---	--	--------	--	---------	--	-------------------------------------	--	---------------	--	-----------------------	--

71 EID		72 ESC		73 EMPLOYER NAME		74 EMPLOYEE ID		75 EMPLOYER LOCATION	
--------	--	--------	--	------------------	--	----------------	--	----------------------	--

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS Respiratory Distress Syndrome						77 PRIN CODE 769		78		79 OTHER DIAGNOSES CODES 7650 76404		80		81	
--	--	--	--	--	--	---------------------	--	----	--	--	--	----	--	----	--

82 PC 83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS Mechanical Respiratory Assist NEC						84 PRINCIPAL PROCEDURE 9392		85 DATE 010691		86 OTHER PROCEDURE		87		88 DATE	
---	--	--	--	--	--	--------------------------------	--	-------------------	--	--------------------	--	----	--	---------	--

89 PERIOD DATA			90 GRC			91 TREATMENT AUTH			92 ATTENDING PHYSICIAN ID 12345678 IM Provider			93 OTHER PHYSICIAN ID		
----------------	--	--	--------	--	--	-------------------	--	--	---	--	--	-----------------------	--	--

94 REMARKS															
FROM				VERIFIED N-C STAY DATES THROUGH				95 INTERIM DIAMT USE ONLY PR PSC D				V300			
AMT REIMBURSED				N-PYM CD				APPROV BY				DATE APPROV			

I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF  
 PROVIDER REPRESENTATIVE X IM Billing MM/DD/YY

## DRG Grouper and Payment Problem Solving

Following is a check list of questions and answers that you should carefully examine before calling EDS or the Bureau of Health Care Financing.

Statement 1. My DRG grouper software or logic did not assign the same DRG to claim # (claim specs, ICN, DOS, etc.) as the DRG that appeared on the Remittance and Status Report from EDS.

- A. Did you use the same claim data that was used by EDS to group the claim? Are the diagnoses and procedure codes, etc. the same?

If no, then correct data input into your software. If you sent incorrect data to EDS and want to correct it, submit an adjustment to the claim in question, indicating what data elements should be corrected.

- B. Is the DRG that your software logic assigned to the claim in the Medicare DRG range 385 through 391?

If yes, then your program logic for WMAP neonates and newborns is incorrect. We have completely redefined Medicare DRGs 385 through 391 into Medical Assistance DRGs 601 through 678. Check your program logic and refer to Section XII and Attachments 2, 3, and 4 of this MAPB.

- C. Is the DRG assigned by your software or logic in the WMAP neonatal DRG range 601 through 678?

If yes, and low birth weight was a factor in the stay, check to ensure either the claim submitted to EDS contained the appropriate low birth weight ICD-9-CM diagnosis code or you entered the appropriate low birth weight data into your software or logic.

(Note: If low birth weight is not a factor, a diagnosis code for birth weight is not necessary on the claim submitted to EDS. EDS logic establishing DRGs 601 through 678 assumes a normal birth weight if a low birth weight code is not indicated on the claim form.)

If the error is not the above, check your program logic used to establish DRGs 601 through 678 to ensure it is consistent with that provided in Section XII and Attachments 2, 3, and 4 in this MAPB.

- D. Is the DRG that your software logic assigned to the claim in the Medicare DRG range 424 through 432?

If yes, then your program logic for psychiatric discharges is incorrect. We have completely redefined Medicare DRGs 424 through 432 into Medical Assistance DRGs 701 through 778. See Section XIII and Attachment 5 of this MAPB.

- E. Is the DRG that your software logic assigned to the claim in DRG range 701 through 778?

If yes, ensure that your program logic has placed your hospital in the correct group of psychiatric DRG codes. There are four groups. See Section XIII and Attachment 5 of this MAPB.

If the group is correct, check to ensure that the age of the recipient is consistent with the birth date on EDS' file and/or check the age logic of your software.

- F. Is the DRG that your software logic assigned to the claim in any other range than those listed above?

If yes, ensure that you are using the same version of the Medicare base grouper that we are. See Section XI of this MAPB concerning the versions and update cycle which the WMAP will use.

Statement 2: The DRG assigned by the hospital and the DRG assigned by EDS is the same but EDS paid an amount different than the payment we calculated for the claim in question.

Ensure that you are using the correct DRG weight and the correct rate for your hospital for the date of service.

If the weight and rate are the same, ensure you have deducted other insurance payments, copayment amounts and/or spenddown amounts.

Statement 3: According to hospital calculations, the claim should have qualified for an outlier payment, but the Remittance and Status Report from EDS does not indicate an outlier payment.

Outlier payments are made for allowed costs only. Ensure that all charges that you indicated on the claim submitted to EDS are allowed Medical Assistance services, and that your charges were adjusted by the appropriate cost to charge ratio to derive allowable costs.

Statement 4: The claim I submitted was denied because the diagnosis or procedure code on the claim form conflicted with the sex of the patient (Medicare code edit #6). However, we have verified that the correct sex and diagnosis were indicated on the claim.

The recipient's certifying agency may have provided EDS with an incorrect sex code. Contact the recipient's certifying agency (either the county social services agency or the local social security office) to ensure they have the correct sex code. If not, the certifying agency should correct the sex code, and send the correction to EDS.

ATTACHMENT 11  
PAPERLESS CLAIMS REQUEST FORM

MAPB-090-027-B  
Date: 09/25/90

Please complete this form if you want additional information on electronic billing.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Phone #: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Type of Service(s) Provided: \_\_\_\_\_

Estimated Monthly Medicaid Claims Filed: \_\_\_\_\_

.....

1. Do you currently submit your Medicaid claims on paper?  YES  NO

2. Are your Medicaid claims computer generated on paper  YES  NO

3. Do you use a billing service?  YES  NO

If the answer is YES to #2 or #3, please complete the following:

Name: \_\_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_

4. Do you have an in-house computer system?  YES  NO

If YES, type of computer system:

a. Large main frame  Manufacturer: \_\_\_\_\_  
(e.g., IBM 360, Burroughs 3800)  Model #: \_\_\_\_\_

b. Mini-Computer  Manufacturer: \_\_\_\_\_  
(e.g., IBM System 34, or 36 TI 990)  Model #: \_\_\_\_\_

c. Micro-Computer  Manufacturer: \_\_\_\_\_  
(e.g., IBM PC, COMPAQ, TRS 1000)  Model #: \_\_\_\_\_

5. Please send the paperless claims manual for:



magnetic tape submission



telephone transmission (EDS free software)  3-1/2"  5-1/2"

(NOTE: EDS does not supply the 3-1/2" diskette. If you need this size, please send a blank formatted diskette with your request.)



telephone transmission (3780 protocol transmission)

Return To: EDS  
Attn: EMC Department  
6406 Bridge Road  
Madison, WI 53784-0009