Questions submitted from the March 29, 2012 Webinar- "Fundamentals of Stop-Loss Part I – Claim Submission Guidelines"

Question # 1

Chemical Dependency Detox - Can you explain and provide an example for the Inpatient Chemical Detox component and Capital Cost Per Diem?

Chemical Dependency Detox will apply only to hospitals certified for medically managed detox and medically supervised inpatient withdrawal by OASAS. When MMD and MSIW services are performed in an Article 28 facility, they must be reported to Stop-Loss under rate code 2299 (inpatient expenditures > $100,000.00 per year) If the Article 28 facility does not appear on the OASAS list, the stay will be processed under the DRG. The list and rates for OASAS certified facilities are listed on the NYS DOH website (http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/ffs/index.htm). Again please remember that all rates are date sensitive.

Only certified OASAS facilities will bill the following rate codes:

1. **Rate Code 4800:** MMD (operating cost) with or without OBS Days

2. **Rate Code 4801:** MSIW (operating cost) without OBS Days

3. **Rate Code 4802:** MSIW (operating cost) with 1 OBS Day

4. **Rate Code 4803:** MSIW (operating cost) with 2 OBS Days

5. **Rate Code 4804:** Inpatient Detox Capital Cost Per Diem ***(add-on rate code only)***

Example

Patient is admitted to an OASAS facility certified for detox (see List). Please note that certification for a facility is very specific, down to the number of beds. Patient is admitted on April 5, 2011 and discharged on April 12, 2011 for a total stay of 7 days. On the 3rd day of the stay, the hospital determines the stay is for detox and bills the stay under Rate Code 4800.

To calculate, go to the appropriate rate sheet (4/1/11-12/31/11), locate the MMD column (RC 4800), scroll down the list of facilities and find the specific facility and find the rate located under rate code 4800. An example from the list of facilities has a rate listed at $872.20 and the amount listed for rate code 4804 is $128.91.

The instructions for a medical managed detox stay with additional days uses the following formula:

Days 1-5 (RC 4800 amount + RC 4804 amount x the number of days 1-5)

$872.20 + $128.91 = $1001.11 x 5 days = $5005.55

Days 6-10 (RC 4800 amount + RC 4804 amount multiplied by 0.5 x the number of days 6-10)

$872.20 + $128.91 = $1001.11 * 0.5 = $500.56 x 2 days (days 6 & 7) = $1001.12

Add $5005.55 + $1001.12 = $6006.67 - Total reimbursement for the stay.

Question # 1, Part II

Can you explain and provide an example for Capital Cost Per Diem?

When calculating an APR-DRG stay on a transfer (disposition code 02), you need to calculate the daily rate for the stay, multiply it by the number of days in the stay and compare that total to the inlier total for the stay (remember that the total transfer payment cannot exceed the amount that would have been paid if the patient had been discharged and the stay calculated as an inlier). In order to calculate the daily rate, you need to multiply the case payment rate for the facility by the SIW for the APR-DRG and then divide the total by the average length of stay (ALOS) associated with the APR-DRG to determine the average inlier cost per day. You will find the average length of stay for each APR-DRG in the SIW APR-DRG table on the NYS DOH website. Multiply the average inlier cost per day by 120%, to that total add the rates for capital cost per Diem (column 11 on the case payment rate sheet) to determine the total per diem transfer cost

EXAMPLE:

Patient is admitted to a facility with a case payment rate of $7231.42 on November 8, 2011. A diagnosis of hepatic coma and other major acute liver disorders is made (APR-DRG 279- Severity Level 2= SIW of 0.8528 and an average length of stay of 7 days). Arrangements are made for the patient to be transferred to a transplant facility for a possible liver transplant. The patient is transferred on the fourth day of their stay at the admitting hospital.

If the patient were discharged versus being transferred, an Inlier would be calculated. The inlier is calculated as: case payment rate for the facility of $7,231.42 for discharge date - 11/11/11 x SIW for APR-DRG 279 with a severity level of 2 + capital per discharge rate + non comparable add-ons x HCRA tax.

Inlier Calculation

$7,231.42 x 0.8528 = $8,479.62 + $546.97 + 0.00 =$9026.59 x 1.0704 = $9,662.06 (total inlier payment)

CASE PAYMT RATE SIW CAPITAL PER DISCHG ADD ONS HCRA

Transfer Calculation

$7,231.42 x 0.8528 = $8,479.62 ÷ 7 = $1,211.37 x 120% = $1,453.65 + $96.33 = $1,549.98 x 3 days =

CASE PAYMT RATE SIW AVERAGE LENGTH OF STAY TRANSFER ADJ FACTOR CAPITAL COST PER DIEM LENGTH OF STAY

$4,649.94 x 1.0704 = $4,977.29 (total transfer payment)

HCRA

Stop-Loss would compare the inlier total, the transfer total, and the amount paid by the Plan; and reimburses the lower of three.

QUESTION # 2

On Page 30 of the presentation the least common mistake states: claims submitted using the first of the month as the date of service are denied as a duplicate claim; does this apply to the CSC (eMedNY) file or the new electronic claim submission file in the column titled "ADMIT DATE"?

The comment refers to the CSC or eMedNY file. Capitation payments, which are automated, are paid and go out on the first of the month. When the first of the month is used as the date of service on a Stop-Loss claim, the eMedNY system interprets the Stop-Loss claim as a duplicate and will deny it with system edit 00705 or 00727.

The ADMIT DATE column on the new electronic submission form requires the actual admission date for the inpatient stay.

QUESTION # 2 - Part 2

On Page 27 you refer to a REMIT statement; what is this? Is this the 837 file received from CSC?

The REMIT statement is also referred to as the 837 file.

Question # 3

When Rates Change do we have to resubmit?

Historically, Stop-Loss has always waited until the appropriate rates for a specific time period were published before processing claims.

Between the lag time of submitting claims and the time required to access and adjudicate claims by Stop-Loss, reimbursements were usually based on the latest rate available at the time of payment.

Because claims were reviewed and processed off-line, the only portion of the claims available for review electronically were the recalculated payments for the entire claim recorded in eMedNY. We had no process to do a mass adjustment other than a total resubmission of the claim as an adjustment.

With the implementation of claim documentation being submitted electronically, it will be possible at some point in the future to have a record of all claims paid for a specific rate code, time period and facility. With that information, it will be possible to do a mass adjustment for all claims affected by a rate change. Until that point in time, the only way to process a claim with a rate adjustment would be to resubmit the claim to eMedNY and Stop-Loss as an adjustment to a previously paid claim.

Please keep in mind that post payment audits that change the charges and payments on hospital stays that have been previously submitted to Stop-Loss should be resubmitted as adjustments to the previously paid claim.

Question # 4

Do we void or rebill claims that require changes and have not been adjudicated?

Once a claim is pending there is nothing that allows the provider to cancel or void it.

If a claim has been submitted and requires changes, a Plan can wait until the claim is adjudicated and then file an adjusted claim or it can submit a new claim that includes the changes.

If you are submitting multiple claims for the same charges/dates of service, please notify Stop-Loss with an e-mail.

Question # 5

Are there any recommendations for health plans that continued to use AP-DRG's beyond the State's conversion to APR-DRG's on 12/1/09?

We realize that many institutions continued to bill charges under AP-DRG for a significant period after the implementation of APR-DRG's with an effective date of 12/1/09.

In an effort to inform Plans, hospitals and other service providers of upcoming changes, presentations outlining health care reform in the 2009-2010 budget year, including the change from AP-DRG to APR-DRG methodology on 12/1/09 were held in July of 2009.

Stop-Loss is obligated to compare the Plan's contract rate to the Medicaid rate and pay the lesser of the two. We were also required to recalculate claims with dates of service on or after 12/1/09 with the new rates and methodology as stated in Chapter 58 of the Laws of 2009, Pubic Health Law Section 35.

Question # 6

SSI enrolled members shouldn't be included into Stop-Loss submissions. Is that correct?

Clients enrolled in mainstream managed care plans with SSI coverage are excluded from inpatient mental health claims only. SSI status does not affect claim submission for inpatient claims (rate code 2299) or residential health care claims (rate code 2297).

Clients enrolled in SNPS Plans (Special Needs Plans) are exempt from the exclusion of inpatient mental health claims when SSI coverage is present. This applies only to SNPS Plan enrollees.

Note: Mental health and substance abuse services provided to members who were not classified as SSI or SSI related *at the time of service* are still covered under the stop-loss program even if the enrollee is retroactively classified SSI or SSI related and the retroactive period includes dates when such services were provided. However in this instance, plans are required to submit appropriate documentation (for example the enrollee roster showing the Aid Category at the time of service) along with the attestation and other supporting documentation for the Stop-Loss claim.

Question # 7:

How Do We Handle Out of State Claims?

Please Provide an Example

Out of state hospital APR-DRG rate chart

Rate Period	Downstate Rate 2953 DRG Rate-Teaching Hospital only	Downstate Rate 2953 DRG Rate – Non Teaching Hospital only	Upstate Rate 2953 DRG Rate-Teaching Hospital only	Upstate Rate 2953 DRG Rate – Non Teaching Hospital only	Capital Add-On per discharge-Rate Code 2990 Upstate	Capital Add-On per discharge-Rate Code 2990 Downstate	Capital Add-on per diem Rate Code 2991 -Upstate	Capital Add-on per diem Rate Code 2991 - Downstate	HCO Converter Upstate	HCO convertor Downstate	WEF Upstate*	WEF Downstate*	ALC Rates 2950 & 2951 All Hospitals Upstate	ALC Rates 2950 & 2951 All Hospitals Downstate
12/1/09	$8121.24	$6779.56	$5936.68	$5345.47	$398.08	$622.41	$81.37	$121.27	0.476642	0.379209	0.8424	1.0684	$171.74	$261.20
1/1/10	$8121.24	$6779.56	$5936..68	$5345.47	$427.24	$638.30	$89.13	$127.53	0.476642	0.379209	0.8424	1.0684	$171.74	$261.20
10/01/10	$8109.64	$6736.14	$5917.25	$5311.24	$427.24	$638.30	$89.13	$127.53	0.476642	0.379209	0.8424	1.0684	$171.74	$261.20
1/1/11	$8593.66	$7138.18	$6270.42	$5628.23	$466.08	$674.25	$100.25	$136.06	0.476642	0.379209	0.8424	1.0684	$173.45	$263.81
4/1/11	$8508.57	$7067.51	$6208.33	$5572.51	$466.08	$674.25	$100.25	$136.06	0.476642	0.379209	0.8424	1.0684	$171.74	$261.20
10/1/11	$8391.64	$6970.38	$6123.01	$5495.93	$466.08	$674.25	$100.25	$136.06	0.476642	0.379209	0.8424	1.0684	$171.74	$261.20

Calculating an out of state Inlier

Case payment rate upstate hospital (upstate teaching or non-teaching {rate code 2953}) x SIW +Capital per discharge (Rate code 2990) = Inlier reimbursement

Case payment rate downstate hospital (downstate teaching or non-teaching {rate code 2953}) x SIW + Capital per discharge (Rate code 2990) = Inlier reimbursement

- Downstate facilities are providers located in areas that surround NYC- in New Jersey, the counties of Sussex, Passaic, Bergin, Hudson, Essex, Union, Middlesex and Monmouth. In Connecticut it applies to Fairfield and Litchfield and in Pennsylvania, the county of Pike. Rates for facilities in these areas should be taken from "downstate" rates. All other areas fall under "upstate" rates. The case payment rate chart for out of state facilities located at: http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/outstate/index.htm contains a list of more than 1,000 out of state hospitals. If you match the case payment rate from the facility to the above rate chart, you can determine whether the facility is an upstate or downstate teaching/non-teaching facility.

- For HCO calculations, use the HCO thresholds found in the Cost outlier tables found on the NYS DOH website (http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/tresholds/). Follow the instructions for DOH HMO claims payment calculations at the same website (http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/ffs/2011/index.htm). Make sure they are date appropriate for the claim discharge date. The WEF column on the out of state rate sheet corresponds to the Institution specific adjustment factor (ISAF) - column 5 on the NYS inpatient rate sheet. The WEF value should be used on Line 18 on the high cost outlier page of the claims calculation when calculating out of state rates.

  Example:

  Admission to a Non-teaching downstate facility - Admit date 2/1/10- Discharge 2/14/10, APR-DRG 140 Severity Level 4 (SIW- 2.3575) Plan's payment $21,450.75.

  Stop-Loss calculation:

  Downstate non-teaching rate code 2953 (2/14/10) - $6779.56 x 2.3575 (SIW) = $15,982.86 + $638.30 (Capital add-on per discharge Rate code 2990 downstate) = $16,621.16.

  Stop-Loss total $16,621.16 compared to Plan's payment of $21,450.75= Maximum Stop-Loss reimbursement is $16,621.16