HCRA CLAIMS PROCESSING

Reimbursement: HCRA is not Medicaid; however, HCRA covered services are reimbursed at the hospital's outpatient or inpatient reimbursement rate allowed for Florida Medicaid.

The Medicaid inpatient diagnosis-related groups (DRG) rates and Medicaid outpatient Enhanced Ambulatory Patient Grouping (EAPG) rates are posted to the Agency's HCRA website each July. A hospital inpatient DRG Pricing Calculator and outpatient EAPG Pricing Calculator will be posted instead of per diems.

For more information on Hospital Rates, please visit the following website: http://www.ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml

Per 59H-1.0055(7), F.A.C., the county shall not be liable for payment unless the hospital is able to provide the necessary information to the counties (i.e. APR-DRG code) required to calculate the rate of reimbursement.

INPATIENT HOSPITAL REIMBURSEMENT

To ensure all hospitals receive the same payment for rendering the same service, the 2012 Legislature directed the Agency for Health Care Administration (Agency) to develop a plan to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG).

Effective July 1, 2013, the Agency implemented a new hospital inpatient payment method utilizing DRG for Florida Medicaid. With this reimbursement change, there will no longer be any hospital inpatient per diem rates posted. The only exception is for the State Mental Health Hospitals which will continue to be reimbursed per diem. It was estimated to be budget neutral at a statewide level, so some counties may pay more and others less.

What is a DRG?

- Each discharge is assigned a DRG code based on information routinely submitted on medical claims (diagnosis codes, procedure codes, age, gender, and birth weight)
- Each DRG has a relative weight factor, which recognizes the differences in resource requirements for patients assigned to the DRG
- The DRG relative weight and a hospital base rate are the primary components in calculating payment, which is per discharge

HCRA defines inpatient as: A patient of a hospital who (1) receives professional services in the hospital for a 24-hour period or longer, or (2) is expected by the hospital to receive professional services in the hospital for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the hospital for 24 hours.

Chapter 6-12 of the HCRA Handbook states that inpatient care under this program is primarily provided for the purpose of treatment for emergency conditions. Therefore, the claim must identify the

type of admission as a '1' which indicates that the patient was admitted under an emergency situation. A claim may be denied for a code other than '1' in this field.

In order to process payment on HCRA eligible UB-04 claim forms, follow the steps below:

1. First verify that the provider is participating with the HCRA program.
2. Next, you will need to gather the following information:

Submitted charges	=	Also referred to as "covered charges." Generally this equals the hospital billed amount because there are rarely non-covered charges on a claim. But technically, this field equals Field Locator 47 minus Field Locator 48 on the UB-04 claim provided by the hospital.
Length of stay	=	Equals discharge date minus admit date.
Medicaid payment eligible days	=	The county must reimburse participating hospitals through HCRA for up to a maximum of 45 days of inpatient services per applicant, per fiscal year (October 1-September 30). **If an applicant has at least one day of coverage remaining within his/her 45-day benefit limit at the time of admission, then the eligible days shall be equal to the full length of stay.** Inpatient hospital days not certified as medically necessary and the day of discharge are not reimbursable through HCRA. (For prior authorizations, remove length of stay limitations for admissions that will be reimbursed under the DRG method. The only exception will be approved applicants who have reached the 45 day benefit limit prior to admission.)
Was patient transferred - discharge status	=	This is a "Yes/No" field indicating whether or not the patient was transferred from one acute care hospital to another. Acute-to-acute transfers are identified by patient discharge status values "02", "05", "65", "66", "82", "85", "93", and "94".
Patient age (in years)	=	This is a numerical value. This should be the applicant's age at the time of admission.
Other health coverage	=	Amount of money paid by private insurance or other coverage prior to submission of a claim. Third party coverage may affect an applicant's eligibility with HCRA.
Medicaid copayment	=	Amount of applicant's share of cost, if applicable.
Provider primary Medicaid ID	=	Use the Provider Medicaid ID in column A under the Provider Table tab of the DRG Pricing Calculator posted on the HCRA website. If the hospital is considered participating in the HCRA program and it is not listed under the Provider Table tab of the DRG Pricing Calculator or does not have a nine-digit Provider Primary Medicaid ID # in column D of the Participating Hospital List posted on the HCRA website, then enter the value "Non-Par".
APR-DRG	=	Equals Field Locator 71 on the UB-04 claim provided by the hospital. Please note that the APR-DRG code must be four-digits. Participating hospitals must provide HCRA eligible inpatient UB 04 claim forms to the applicant's county of residence using the APR-DRG grouping method (not Medicare). If the DRG code provided in Field Locator 71 on the UB 04 claim form is not a four-digit code from the DRG Table tab of the DRG Pricing Calculator posted on the HCRA website, it is

		not reimbursable through HCRA. If a hospital's billing system is not able to provide the APR-DRG code in Field Locator 71 on the UB 04 claim form at time services were rendered, it is not reimbursable through HCRA. Handwritten modifications are not acceptable and may be considered fraudulent.

3. Go to the HCRA website: http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index.shtml

4. Click on the "APR-DRG Inpatient Hospital Reimbursement Calculator" link or go to the DRG Inpatient Payment Review website at http://www.ahca.myflorida.com/Medicaid/cost_reim/drg.shtml

5. Select the calculator effective at the time services were rendered. For example, if services were rendered April 5-8, 2016, you would open the "Florida DRG Calculator SFY 2015-2016" (effective March 1, 2016).

6. Go to the Interactive Calculator tab of the DRG Pricing Calculator.

7. Enter the data from step 2 into the highlighted fields in cells E7 through E15 of the Interactive Calculator tab of the DRG Pricing Calculator.

8. Payment due is determined by entering the data in the highlighted fields. Once all required fields have been entered, scroll down to cell E65…that is the amount reimbursable through HCRA (counties at their 10 Mill Cap on Ad Valorem Taxes as of October 1, 1991, whose residents are NOT eligible for the HCRA spend-down provision, reimburse the HCRA participating hospitals at 80% of this amount).

For example, if you received a UB-04 claim with an APR-DRG code of 1352 from Orlando Regional Medical Center (Provider Medicaid ID#: 010133800) for a 31 year-old applicant who has no third party coverage or share of cost with dates of service from 7/8/2014 through 7/10/2014, was not transferred and the total submitted charges equals $9,670.00, the allowable reimbursement through HCRA should equal $5,068.23.

NOTE: Please be advised that if the DRG code in field 71 on the UB 04 claim form is not a four-digit code, you may be calculating reimbursement incorrectly as Medicare DRG codes are three-digits and have some duplication. Please see example below:

Grouping Method	DRG Code	Description
APR	0011	Liver &/or Intest Transpl
Medicare	011	MDC,P,TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC

OUTPATIENT HOSPITAL REIMBURSEMENT

During the 2015 Legislative Session, the Agency was directed to contract with a vendor to develop a plan to convert outpatient hospital reimbursement to a prospective payment system that classifies claim lines for outpatient visits by assigning an Enhanced Ambulatory Patient Grouping (EAPG) Code to each line.

Mandatory in Florida beginning July 1, 2017 (for all claims with first date of service on or after July 1st). Payments are made on a per visit basis. A separate EAPG code is assigned to each line item on a claim. Pricing is performed at the line level with interaction between separate lines.

What is EAPG?

- Outpatient visit-based patient classification system encompassing the full range of outpatient services (including laboratory and therapies) for all outpatient settings (including same day surgery units and emergency rooms)
- Determines a line price based on a combination of diagnosis, classification of visit, patient age/gender, provider and location
- Payment is directed to the main significant procedure or treatment provided during an outpatient visit, which allows for higher payment for the main procedure, rather than diluting the payment across individual services

HCRA defines outpatient as: A patient of a hospital who receives professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the hospital past midnight. Only one day's services are billable on one outpatient claim.

In order to process payment on HCRA eligible UB-04 claim forms, follow the steps below:

1. First verify that the provider is participating with the HCRA program.
2. Next, you will need to gather the following information:

Provider primary Medicaid ID (cell D5)	=	Use the Provider Medicaid ID in column A under the Provider Attributes tab of the EAPG Pricing Calculator posted on the HCRA website. If the hospital is considered participating in the HCRA program and it is not listed under the Provider Table tab of the DRG Pricing Calculator or does not have a nine-digit Provider Primary Medicaid ID # in column D of the Participating Hospital List posted on the HCRA website, then enter the value "Non-Par-Hosp". Once entered, cells D6 through D11 will automatically populate.
Revenue Code (column B)	=	Enter the claim detail line revenue code (not all revenue codes are covered). Please note that the revenue code must be four-digits, including the leading "0". If the revenue code provided on the UB 04 claim form is not a four-digit code from the Covered Rev Codes tab of the EAPG Pricing Calculator posted on the HCRA website, it is not reimbursable through HCRA. Handwritten modifications are not acceptable and may be considered fraudulent.
EAPG Code (column C)	=	Enter the EAPG code based on claim detail line revenue code (not all revenue codes are covered). Please note that the EAPG code must be five-digits, including the leading "00". If the EAPG code provided on the UB 04 claim form is not a five-digit code from the EAPG Weight Table tab of the EAPG Pricing Calculator posted on the HCRA website, it is not reimbursable through HCRA. If a hospital's billing system is not able to provide the EAPG code on the UB 04 claim form at time services were rendered, it is not reimbursable through HCRA. Handwritten modifications are not acceptable and may be considered

		fraudulent.
EAPG Grouping Indicators (columns H-N)	=	If applicable, enter the EAPG grouping indicators based on the combination of services being performed to determine is a service is payable or paid at an adjusted rate.

3. Go to the HCRA website:
   http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index.shtml
4. Click on the "EAPG Outpatient Hospital Reimbursement Calculator" link or go to the Hospital Outpatient Prospective Payment Reimbursement Methodology/ASC website at
   http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml
5. Select the calculator effective at the time services were rendered. For example, if services were rendered July 7, 2017, you would open the "Florida EAPG Calculator SFY 2017-2018" (Updated May 23, 2017).
6. Go to the Interactive Calculator tab of the EAPG Pricing Calculator.
7. Enter the data from step 2 into the highlighted fields in cells D5, column B, column C (and columns H-N, if applicable) of the Interactive Calculator tab of the EAPG Pricing Calculator.
8. Payment due is determined by entering the data in the highlighted fields. Once all required fields have been entered, scroll to cell AE13…that is the amount reimbursable through HCRA.

Maximum covered emergency services are $1,500 for outpatient per applicant per fiscal year (October 1 – September 30).

Time Standards: The hospital has six months from the date of the Notification of Eligibility (NOE), approving an applicant's eligibility, to submit a completed UB-04 claim for payment to the appropriate county claims processing agent. The county has 90 days from the date it receives the claim to complete its adjudication and transmit its reimbursement, if appropriate, to the hospital. (The hospital may resubmit a claim denied by a county as long as the corrected claim is resubmitted within six months of the date of the NOE.)