

Division of Medicaid  
APR-DRG (Inpatient) Quick Tips  
Effective October 1, 2012

**KEY CONTACTS:**

- Medicaid website: [www.medicaid.ms.gov](http://www.medicaid.ms.gov).
- For Provider Relations assistance call 1-800-884-3222
- The main website for APR-DRG inpatient pricing information is:  
<https://www.medicaid.ms.gov/HospitalInpatientAPR-DRGPayment.aspx>  
This site contains:
  - Training materials
  - FAQ
  - DRG pricing calculator
  - Other helpful information
- A list of APR-DRG codes is located on the 3<sup>rd</sup> tab ("DRG table") of the DRG pricing calculator.

**KEY POINTS to CONSIDER:**

1. All claims must contain a gender code; otherwise the claim will be suspended.
2. Payments for medical education will be made on the claim, as a flat amount per stay. Medical education payments will not be made to out-of-state hospitals.
3. Outpatient services within three (3) days prior to the admission date that are considered to be part of the inpatient stay will not be paid separately. As with Medicare payment methodology, hospitals may indicate that outpatient services are unrelated to the inpatient stay through the appropriate use of condition code 51 on the outpatient claim. Please take care not to bill Medicaid or the Medicaid managed care plans for outpatient services that are defined to be within the window.
4. Interim claims (bill types 112 and 113) are not required but may be submitted if the stay exceeds 30 days. Hospitals should ensure proper use of the correct discharge status code when an interim claim is filed. When a patient is discharged, the interim claims should be voided or adjusted and the hospital should submit a single claim for the entire stay.
5. Interim claims for admit DOS prior to 10/01/12 should not be billed. For admit dates prior to 10/01/12 the entire claim should be billed upon discharge from the hospital; the claim will be paid under the per diem methodology.
6. All newborns will be paid on his or her own claim. Well babies will no longer be billed on a mother's claim.
7. Inpatient claims processed using APR-DRG methodology will not be subject to a 30-day service limit. If the patient meets existing criteria for medically necessary care, appropriate care will be reimbursed.
8. Frequency codes 4 (last claim) and 5 (late charge) should no longer be used. Claims will deny if these frequency codes are filed.
9. Treatment Authorization Number (TAN):
  - Requirements for continued stay review (i.e., the length of stay) that exceed 19 days will require continued stay review.
  - The TAN begin date must equal the admit date.
  - Hospitals should only contact HSM for a TAN on a NEWBORN only if the length of stay will exceed six (6) days (including the discharge date).
10. Hospitals do not need to buy APR-DRG software and need not show the APR-DRG on the claim. The APR-DRG will be assigned by the Medicaid claims processing system based on the diagnoses, procedures and other information submitted by the hospital. Designating the APR-DRG on the claim is not necessary.
11. Hospitals are required to submit valid values for the Present on Admission (POA) indicator.