MSA
MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

3/23/11 - Sentence revised per bulletin MSA 11-13
3/31 – Effective Date revised to July 1, 2011 per bulletin MSA 11-15

Bulletin Number: MSA 11-08

Distribution: Hospitals, Medicaid Health Plans (MHP)

Issued: March 1, 2011

Subject: Rebasing Diagnosis Related Group (DRG) Rates; DRG Grouper Update; Per Diem Rates Update; Present on Admission Indicators and Non-Payment for Hospital Acquired Conditions

Effective: ~~April 1, 2011~~ July 1, 2011

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

Effective April 1, 2011, claims for inpatient hospital admissions reimbursed using the DRG methodology will be processed using the Medicare Grouper Version 28.0. The Michigan Department of Community Health (MDCH) has established its own relative weights, average lengths of stay, and high and low day outlier thresholds for each DRG based on paid claims data taken from Medicaid and CSHCS hospital admissions and MHP encounter claims. The DRG hospital prices and relative weights will be rebased with the following changes:

- Two years of Fee-for-Service (FFS) and MHP encounter paid claims data will be used. The base period for inpatient hospital admissions is from September 1, 2007 through August 31, 2009.
- Two years of hospital cost report data will be used. The data used to calculate the hospital cost to charge ratios and Indirect Medical Education (IME) adjustors will be taken from hospital cost reports ending between September 1, 2007 and August 31, 2009, and are specific to FFS and MHP populations. The wage data will be drawn from the Centers for Medicare and Medicaid Services (CMS) audited wage data as published in the Federal Register and includes the two most recent periods available for hospital cost reports ending between September 1, 2006 and August 31, 2008. Filed wage data will be used for hospitals where audited data are not available. All hospital cost report and wage data are weighted 60% for the most recent period and 40% for the oldest period.
- Hospitals will be grouped by U.S. Census Core Based Statistical Areas (CBSA) as determined by CMS for the Medicare program for wage data.
- A budget neutrality factor will continue to be included in the hospital price calculation. Hospital prices will be reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The estimate will be based on one year's paid claims, including MHP data with FFS rates applied for the period of September 1, 2008 through August 31, 2009, paid by June 30, 2010. The calculated DRG prices will be deflated by the percentage necessary for the total payments to equal the amount currently paid.
- The 2011 DRG Rebasing will include a $2 million adjustment to overall budget neutrality to adjust for the adoption of the three day outpatient payment rule. Overall budget neutrality will continue to be evaluated in future rate setting and adjusted accordingly.
- For payment purposes, a single cost to charge ratio will be published on the MDCH website. The single cost to charge ratio will be used for calculating payments paid a percent of charge, cost outliers, and low-day outliers. This ratio will be calculated from the averages of FFS and MHP ratios, net of IME.

- Hospitals identified with Medicare Critical Access Hospital (CAH) status as of April 1, 2011, will be grouped and paid a single DRG price. The DRG price is the truncated mean of the hospital specific base prices of all CAHs adjusted by the rural cost adjustor and budget neutrality. This is the sum of the product of the hospitals' specific base price times discharges divided by the sum of all the group discharges. In the event a hospital status changes from prospective payment system (PPS) to a CAH status, MDCH would recognize the hospital under CAH status as of the CMS effective date. Budget neutrality for CAHs will be determined as a group, independent of non-CAHs.
- The truncated mean component of the statewide operating cost limit calculation ~~and incentive components~~ of the DRG price will be eliminated. The State limit for each group is the mean plus 0.5 standard deviation of the groups' hospital specific base prices.
- To calculate an incentive for non-CAH hospitals with base DRG prices below the truncated mean, the hospital's base DRG price is increased by adding 50 percent of the difference between the hospital's limited base price and the truncated mean.

Hospital Cost Report Data

Data used to develop the hospital cost to charge ratios and hospital IME adjustors will be taken from filed cost reports submitted to and accepted by MDCH. In the development of the relative weights, MDCH applies a ratio specific to each component of data (FFS and MHP). The most recent data available to MDCH will be used. For the current rebasing, data will be taken from hospital cost reports for fiscal years ending in the following two periods:

1. September 1, 2007 to August 31, 2008
2. September 1, 2008 to August 31, 2009

Inflation and weighting factors are applied to bring all periods up to a common point in time. The following factors, with inflation derived from the 1st Quarter 2010 Global Insight PPS -Type Hospital Market Basket Index, will be used.

Fiscal Year Ending	Cost Inflation Factors	Weighting Factors
9/30/07	1.0731	0.40
12/31/07	1.0612	0.40
3/31/08	1.0471	0.40
6/30/08	1.0311	0.40
9/30/08	1.0138	0.60
12/31/08	1.0048	0.60
3/31/09	1.0008	0.60
6/30/09	1.0000	0.60
8/31/09	1.0000	0.60

Rates will be adjusted by an inflation factor of 1.0405 for the period from August 31, 2009 to January 1, 2011.

Audited Wage Data

Salary and wage data used to develop the base and update cost adjustors are taken from the CMS website, public use files. All data were subject to appeal through the hospital's Medicare Fiscal Intermediary. The most recent data available to MDCH will be used. This includes hospital cost report data for fiscal years included in the following two years:

1. September 1, 2006 through August 31, 2007
2. September 1, 2007 through August 31, 2008

Fiscal Year Ending	Wage Inflation Factors	Weighting Factors
9/30/06	1.0718	0.40
12/31/06	1.0632	0.40
3/31/07	1.0541	0.40
6/30/07	1.0500	0.40
9/30/07	1.0422	0.60
12/31/07	1.0334	0.60
3/31/08	1.0187	0.60
6/30/08	1.0117	0.60
8/31/08	1.0000	0.60

Cost Data for Distinct Part Rehabilitation Units and Rehabilitation Hospitals

The three-year cost report data (for hospital fiscal years ending between September 1, 2005 and August 31, 2008) used to complete the January 1, 2010, per diem rate rebasing were used to complete the April 1, 2011 per diem rate update. Rates were adjusted by an inflation factor of 1.0549 for the period from August 31, 2008 to December 31, 2010.

Wage Data for Distinct Part Rehabilitation Units and Rehabilitation Hospitals

Medicare-audited wage data, as published on the CMS website for hospital fiscal years ending between September 1, 2004 and August 31, 2008, were used for the base and updated wage adjustor. Hospitals are grouped by U.S. CBSAs as published in the most recent Federal Register for wage data.

Fiscal Year Ending	Wage Inflation Factors	Base Weighting Factors	Update Weighting Factors
9/30/04	1.1762	0.16	
12/31/04	1.1613	0.16	
3/31/05	1.1472	0.16	
6/30/05	1.1333	0.16	
9/30/05	1.1193	0.24	0.16
12/31/05	1.1062	0.24	0.16
3/31/06	1.0932	0.24	0.16
6/30/06	1.0818	0.24	0.16
9/30/06	1.0718	0.60	0.24
12/31/06	1.0632	0.60	0.24
3/31/07	1.0541	0.60	0.24
6/30/07	1.0500	0.60	0.24
9/30/07	1.0422		0.60
12/31/07	1.0334		0.60
3/31/08	1.0187		0.60
6/30/08	1.0117		0.60
8/31/08	1.0000		0.60

Present on Admission Indicator for Hospital Acquired Conditions

Effective upon implementation of DRG Grouper 28.0, MDCH will adopt Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for Hospital Acquired Conditions (HAC). Acute care hospitals and CAHs will be required to report whether a diagnosis on a Medicaid claim was present on admission. **Claims submitted without the required POA indicators will be denied**. For claims containing secondary diagnoses that are included on Medicare's most recent list of HACs and for which the condition was not present on admission, the HAC secondary diagnosis will not be used for DRG grouping. That is, the claim will be paid as though any secondary diagnoses (HAC) were not present on the claim.

POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Note that

beginning on October 1, 2010, MDCH **began** capturing POA edits on inpatient claims for **informational** purposes only.

Table 1 – POA Indicators and Definitions

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. MDCH will pay the CC/MCC DRG for those selected HACs that are coded as "Y" for the POA Indicator.
N	Diagnosis was not present at time of inpatient admission. MDCH will **not** pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. MDCH will **not** pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. MDCH will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.
1	Unreported/Not used. Exempt from POA reporting. MDCH will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list.

The current list of HACs was published by CMS in the August 16, 2010, *FFY 2011 Inpatient Prospective Payment System* final rule and includes diagnoses listed in Table 2. MDCH will continue to follow CMS' HAC determinations, including any future additions or changes to the current list of HAC conditions, as well as diagnosis codes that are exempt from HAC reporting.

Table 2 – Hospital Acquired Conditions

Description	CC/MCC (ICD-9-CM code)
Foreign Object Retained After Surgery	CC - 998.4, 998.7
Air Embolism	MCC - 999.1
Blood Incompatibility	CC - 999.60, 999.61, 999.62, 999.63, 999.69
Pressure Ulcer States III & IV	MCC - 707.23, 707.24
Falls and Trauma -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	CC/MCC codes within these ranges: - 800-829 - 830-839 - 850-854 - 925-929 - 940-949 - 991-994
Catheter –Associated Urinary Tract Infection (UTI)	CC - 996.64 and excludes the following from acting as a CC/MCC: CC - 112.2, 590.10, 590.3,590.80,590.81, 595.0, 597.0, 599.0 MCC - 590.11, 590.2
Vascular Catheter – Associated Infection	CC - 999.31

Description	CC/MCC (ICD-9-CM code)
Manifestations of Poor Glycemic Control	MCC - - 250.10-250.13 - 250.20-250.23 - 249.10-249.11 - 249.20-249.21 CC - 251.0
Surgical Site Infection, Mediastinitis After Coronary Artery Bypass Graft (CABG)	MCC - 519.2 and one of the following procedure codes: - 36.10 - 36.19
Surgical Site Infection Following Certain Orthopedic Procedures	CC - 999.67 and 998.59, and one of the following procedure codes: - 81.01-81.08 - 81.23-81.24 - 81.31-81.38 - 81.83 - 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	CC - 278.01 and 998.59, and one of the following procedure codes: - 44.38 - 44.39 - 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	MCC - 453.40-453.42, or 415.11, or 415.19, and one of the following procedure codes: - 00.85-00.87 - 81.51-81.52 - 81.54

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
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