MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

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Distribution: Hospitals, Medicaid Health Plans

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Subject: Inpatient and Outpatient Hospital Short Stay Reimbursement

Effective: July 1, 2015

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS)

Introduction

The Michigan Department of Health and Human Services (MDHHS) will establish a new Short Hospital Stay rate of reimbursement for certain outpatient and inpatient hospital stays effective for outpatient dates of service or inpatient discharges on and after July 1, 2015. This will affect roughly one percent of total inpatient and outpatient hospital claims. The Short Hospital Stay rate will encompass funding for both operating and capital costs. This rate will be identical for inpatient and outpatient services, and will apply to all services billed on the claim. If a claim does not qualify for the Short Hospital Stay rate based on the criteria described below, it will be reimbursed using the normally applicable inpatient or outpatient reimbursement logic. Inpatient and outpatient hospital claims categorized as Short Hospital Stay under this policy will be used in the calculation of the Medicaid Access to Care Initiative pools, Graduate Medical Education pools and Disproportionate Share Hospital pools as supplemental payments using current policy for these programs. This policy will reduce administrative efforts for both hospitals and Medicaid Health Plans regarding the status of a patient as the payment rate for inpatient and outpatient services that meet the Short Hospital Stay criteria will be identical.

Current policy requires Medicaid Health Plans to reimburse non-contracted hospitals at Medicaid Fee-for-Service prices where the Hospital Access Agreement is utilized for payment determinations. This policy will not supersede existing contracts between Medicaid Health Plans and hospitals.

This policy will not modify MDHHS's inpatient or outpatient billing requirements for hospitals. Rather, the impact is being limited to reimbursement to ensure that healthcare services are provided to Michigan Medicaid beneficiaries in the most clinically appropriate setting. If the patient meets criteria for an inpatient admission, the invoice must be submitted as an inpatient claim. Conversely, if the patient does not meet criteria for an inpatient admission, the invoice must be submitted as an outpatient claim. In either situation, the hospital will receive the same rate for services rendered. The Short Hospital Stay rate will not include an area wage adjustment or any other relative weight adjustment.

The Short Hospital Stay logic will apply to both emergent and elective claims. For purposes of this reimbursement structure, Short Hospital Stays will be defined using the following criteria.

Outpatient Hospital Claims Qualification

An outpatient hospital claim will qualify for the Short Hospital Stay reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the outpatient claim is listed in the diagnosis table below.
- The claim does not include a surgical revenue code (36x) billed on any line of the outpatient claim.
- The claim does not include cardiac catheterization lab revenue code 481.
- The claim includes observation revenue code 762.

- The claim must include discharge status codes 01, 06, 09, 21, 30, 50 or 51.

Inpatient Hospital Claims Qualification

An inpatient hospital claim will qualify for the Short Hospital Stay reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the inpatient claim is listed in the diagnosis table below.
- The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim.
- The claim has a date of discharge equal to or one day greater than the date of admission.
- The claim does not include cardiac catheterization lab revenue code 481.
- The claim must include discharge status codes 01, 06, 09, 21, 30, 50 or 51.

Exclusions

The Short Hospital Stay logic will not apply to inpatient or outpatient claims with the following conditions:

- Claims where Medicaid is the secondary payer. MDHHS will follow the rules of the primary payer, and MDHHS will be responsible for payment up to co-insurance and/or deductible.
- Claims for patients who leave the hospital Against Medical Advice (AMA).
- Claims for deceased patients.
- Claims that include primary diagnoses that are not on the table listed below, including claims for births and deliveries, for example.

Diagnoses

As indicated, in order to qualify for a Short Hospital Stay rate, a claim must include one of the primary diagnosis codes listed in the table below. This table will be maintained and updated on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. The list of eligible codes will be evaluated annually and updated as necessary. Additional information regarding ICD-10 will be forthcoming.

CODE	DESCRIPTION
038.9	Unspecified septicemia
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
250.11	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled
250.80	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
250.81	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled
250.82	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
250.83	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled
276.50	Volume depletion, unspecified
276.51	Dehydration
276.52	Hypovolemia
345.90	Epilepsy, unspecified, without mention of intractable epilepsy
401.9	Unspecified essential hypertension
414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft

CODE	DESCRIPTION
414.01	Coronary atherosclerosis of native coronary artery
466.11	Acute bronchiolitis due to Respiratory Syncytial Virus (RSV)
466.19	Acute bronchiolitis due to other infectious organisms
486	Pneumonia, organism unspecified
491.21	Obstructive chronic bronchitis with (acute) exacerbation
491.22	Obstructive chronic bronchitis with acute bronchitis
493.22	Chronic obstructive asthma with (acute) exacerbation
493.91	Asthma, unspecified type, with status asthmaticus
493.92	Asthma, unspecified type, with (acute) exacerbation
558.9	Other and unspecified noninfectious gastroenteritis and colitis
577.0	Acute pancreatitis
682.1	Cellulitis and abscess of neck
682.2	Cellulitis and abscess of trunk
682.3	Cellulitis and abscess of upper arm and forearm
682.4	Cellulitis and abscess of hand, except fingers and thumb
682.5	Cellulitis and abscess of buttock
682.6	Cellulitis and abscess of leg, except foot
682.7	Cellulitis and abscess of foot, except toes
682.8	Cellulitis and abscess of other specified sites
682.9	Cellulitis and abscess of unspecified sites
780.2	Syncope and collapse
780.39	Other convulsions
786.50	Chest pain, unspecified
786.59	Other chest pain

Short Hospital Stay Rate and Methodology

A single Short Hospital Stay rate will be developed for certain outpatient and inpatient hospital stays. This rate will encompass funding for both operating and capital costs, will be identical for inpatient and outpatient services, and will encompass all services billed on the claim.

The Short Hospital Stay rate will be $1,314. The Short Hospital Stay rate will be implemented in a manner that is budget neutral to the State of Michigan.

The rate will be established using Medicaid hospital fee-for-service paid claims and managed care encounters that meet the Short Hospital Stay criteria. To calculate the rate, the following process will be employed:

- Aggregate Fee-for-Service operating payments on qualifying claims with dates of service during the second previous fiscal year will be identified.
- Aggregate Fee-for-Service capital payments will be calculated by multiplying the Fee-for-Service inpatient claims count for qualifying claims with dates of service during the second previous fiscal year by the current year statewide capital rate.
- Aggregate managed care operating and capital payments on qualifying encounters with dates of service during the second previous fiscal year will be identified.
- Fee-for-Service and managed care operating and capital payments will be aggregated and divided by the number of claims and encounters that meet the Short Hospital Stay criteria. The resulting quotient will be the Short Hospital Stay rate.

MDHHS will monitor the diagnosis code sets and reimbursement to ensure budget neutrality is maintained or to maintain consistency with future reimbursement changes. As a result, future changes to this policy are possible.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, 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
Medical Services Administration