

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES



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DATE: AUGUST 27, 2008
TO: OUT-OF-STATE MONTANA MEDICAID PARTICIPATING HOSPITALS
FROM: DEPARTMENT OF HEALTH AND HUMAN SERVICES, MONTANA MEDICAID
RE: CHANGE IN MONTANA ADMINISTRATIVE RULE (MAR NOTICE NO. 37-445)
PRIOR AUTHORIZATION AND REIMBURSEMENT METHODOLOGY FOR
OUT-OF-STATE FACILITIES

Effective October 1, 2008, the Department of Public Health and Human Services (the Department) is changing its inpatient reimbursement methodology for all hospitals to ensure client access to services unavailable in Montana. The Department believes that while it is better for clients to use in-state services, because of local family support, accessible community resources, and continuous medical aftercare, this is not always possible. The Department strives to ensure client access to services unavailable in Montana.

Since January 1, 2007, the Department has had in place two reimbursement methodologies for out-of-state facilities (excluding Residential Treatment Facilities). Out-of-state hospitals are paid a DRG rate unless they are a "Preferred Hospital" with the Department.

On October 1, 2008, Montana Medicaid will implement a new reimbursement methodology, which will be based on "All Patient Refined Diagnosis Related Groups" (APR-DRGs). No out-of-state hospitals will be paid percent of charges using their cost-to-charge ratio. The Department will assign an APR-DRG to each Medicaid patient discharge in accordance with the current APR-grouper program version as developed by 3M Health Information Systems. The assignment of each APR-DRG is based on the ICD-9 –CM principal diagnoses, all ICD-9-CM secondary diagnoses and all ICD-9-CM medical procedures performed during the recipient's hospital stay. For each APR-DRG, the Department determines a relative weight using a national database from 3M that reflects the cost of hospital resources used to treat similar cases. The relative weight, average national length of stay and outlier thresholds for each APR-DRG will be available online at <http://medicaidprovider.hhs.mt.gov/providerpages/providertype/01pmnt.shtml>. Effective October 1, 2008, the average base price, including capital expenses, is \$4,129 for all hospitals. The average base for distinct part rehabilitation units and long-term care hospitals (LTCH), including capital expenses, is \$9,092. Disproportionate share payments are paid to in-state hospitals only. LTACs must use a rehab taxonomy when they enroll in order to get this enhanced payment.

Other additional changes to our reimbursement policy are as follows:

- 1. All out-of-state hospitals will require prior authorization (PA). Those hospitals that do not obtain PA but provide emergent or medically necessary inpatient services will be reimbursed at 50% of APR-DRG payment. Transplant stays, mental health stays & specific stays that currently require PA (i.e., gastric bypass) require PA both in and out-of-state. If PA is not received, then no payment will be made.**

2. Any hospital may now interim bill for inpatient stays of at least 30 days. The hospital may bill every 30 days and will receive the current flat per diem rate of \$400/day. At discharge, the hospital may adjust the interim bills and submit one bill for payment under APR-DRG.
 - a. Hospitals first call the Department representative at 1-800-262-1545 ext. 5850 for PA for inpatient admission.
 - b. Hospitals may call this number at any time they realize the patient will be inpatient for more than 30 days and will require a retroreview. PA spans, for billing purposes, must be 30 days. Continued stays will be based on medical necessity.
 - c. Hospitals must notify the Department representative of discharge as a new PA number will be issued for admission through discharge.
3. The Department is moving away from CMS bundling rules and instead will simplify the rule by requiring that any service on the day before or the day of the inpatient stay be bundled when the outpatient and inpatient provider's NPI are the same, except dialysis services. Services that are performed at a second hospital because the services are not available at the first hospital (i.e., a CT scan) are included in the first hospital's payment. This includes transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital where the services were actually performed must be between the first and second hospital and the transportation provider.
4. The Present on Admission (POA) indicator will be required effective 10/1/2008 for all principle & secondary diagnosis codes. A valid value must be present, however Montana Medicaid will not adjust payments for hospital acquired conditions at this time.

To review the applicable Montana Administrative Rule (MAR), please go to the Montana Medicaid website at <http://www.dphhs.mt.gov/legalresources/ruleproposals/index.shtml> then click on **MAR 37-445 Notice of Public Hearing on Proposed Adoption, Amendment and Repeal pertaining to Medicaid inpatient hospital reimbursement (6/27/08)**. A Montana Medicaid Notice will be posted and will provide you with further information.

We look forward to continue working with you and are thankful for your medical healthcare services and expertise available to our clients.

Thank you for your attention and please don't hesitate to contact me should you have any questions.

Sincerely,

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