Billing Guidelines

Article 1
Invoicing of DRGs

(1) Diagnosis-related lump sum fees shall be invoiced by the treating hospital in accordance with the DRG catalogue and the corresponding billing guidelines valid at the time of hospitalisation. In the event of a patient transfer to or from another hospital, each participating hospital charges a DRG. According to Article 3, the DRG revenue can be reduced. This regulation does not apply to DRGs listed in column 11 of the DRG catalogue. In these cases, the transferring hospital shall apply the regulations as set forth in Paragraph 3. A transfer is classified as such if no more than 24 hours have passed between a patient's discharge from one hospital and his/her admission to another.

(2) If the length of a hospital stay exceeds the DRG specific maximum length of stay (high trim point), an additional day-based fee is charged for the day stated in column 8 of the DRG catalogue and for each additional day of hospitalisation. This fee is calculated from the cost weight as stated in column 9 of the DRG catalogue multiplied by the base rate. The number of additional billable hospital days is calculated as follows:

(actual length of stay as set forth in paragraph 6) + 1

./. high trim point (column 8 of the DRG catalogue)

= additional billable hospital days

(3) If the length of stay of non-transferred patients is shorter than the DRG specific minimum length of stay (low trim point), a daily deduction is made for the day stated in column 6 of the DRG catalogue and for each additional day of hospitalisation that was not required. Notwithstanding sentence 1, the deduction regulation shall also pertain to the invoicing of DRGs listed in column 11 of the DRG catalogue by the transferring hospital. The daily deduction is calculated from the cost weight as stated in column 7 of the DRG catalogue multiplied by the base rate. The number of deducted days shall be calculated as follows:

low trim point (column 6 of the DRG catalogue) + 1

./. actual length of stay pursuant to Paragraph 6

= number of day-based deductions

(4) Each neonate receiving continued hospital treatment after being cared for in the delivery room is to be assigned to and invoiced by a DRG. If the DRG catalogue states a minimum length of stay in connection with a DRG and the length of stay (Paragraph 6) in the hospital in which the birth took place does not achieve this minimum length of stay, the neonate's care shall be deemed satisfied with the mother's DRG. In the event of a transfer, paragraph 1, sentences 2 to 4 shall apply.

(5) Certified programs (DRG grouper software) shall assign hospital cases to the relevant DRG. The day of admission to the hospital determines the DRG catalogue to be used for billing. If the age of a patient is essential for the allocation of a treatment to the corresponding DRG, the patient's age on the day of his/her admission to the hospital must be used.

(6) The number of inpatient days is essential when calculating the length of stay. Inpatient days include the day of admission and every day of hospitalisation excluding the day of a patient's transfer to another hospital or the day of a patient's discharge from hospital. If hospital admission and transfer or discharge take place on the same day, this day is deemed an inpatient day. Article 2, paragraph 4, sentence 4 shall apply in the event of a re-admission. A full-day leave of absence from hospital shall be identified separately in the invoice and is not considered an inpatient day. A leave of absence is the day on which a patient temporarily interrupts his/her inpatient treatment with the approval of the treating clinician, but does not conclude inpatient treatment. The day the patient returns to the hospital from a leave of absence to continue treatment is not regarded as re-admission within the meaning of Article 2.

Article 2
Readmission to the same hospital

(1) The hospital shall regroup all services that occur between hospital admission and discharge and reassign them to a DRG if

1. a patient is readmitted within the specified maximum length of stay (high trim point), calculated from the number of calendar days from the date of the patient's first hospital admission;

2. and the patient is assigned to the same adjacent DRG on readmission.

Data regrouping and reclassification according to sentence 1 shall not be performed if the adjacent DRG is listed in column 12 of the DRG catalogue.

(2) The regrouping of a patient's data and the re-assignment of the case to a new DRG shall also be performed if

1. a patient is readmitted within 30 calendar days from the date of the patient's first hospital admission;

2. and if the previously billable DRG is to be grouped into the „medical partition“ or „other partition“ and the subsequently billable DRG is to be grouped into the “surgical partition” within the same Major Diagnosis Category (MDC).

Data regrouping and reclassification according to sentence 1 may not be performed if a DRG listed in column 12 of the DRG catalogue can be charged for at least one of the hospital stays.

(3) If a patient assigned to a certain DRG is re-admitted owing to complications in connection with a medical procedure that falls within the hospital’s area of responsibility, the hospital shall group all services that occur between hospital admission and discharge into one single case and assign the data to a new DRG. The medical procedure/service must have been provided within the specified maximum length of stay calculated from the number of calendar days from the day of the patient’s first hospital admission. Data regrouping and reclassification shall not be performed in the event of unavoidable side effects in connection with chemotherapy and radiation therapy within the scope of oncological treatments. The provisions of paragraphs 1 and 2 shall prevail over the provisions of sentence 1 and 2.

(4) When applying paragraphs 1 to 3, each inpatient hospital stay shall be assigned to a DRG. On this basis, the hospital shall perform a chronological reclassification grouping the case-related data of all hospital stays into one DRG. The length of stay is calculated by adding the number of inpatient days (Art. 1, paragraph 6). In accordance with paragraph 1, sentence 1, number 1, the high trim point essential to the grouping of cases is calculated from the day of admission and the DRG for the first hospitalisation. If the length of stay of the regrouped case exceeds the high trim point of the reassigned DRG Art. 1, paragraph 2 applies.

Article 3
Deductions following a patient’s transfer to/from another hospital

(1) If a patient is transferred to another hospital, the transferring hospital shall make a deduction if the length of stay is shorter than the average length of stay stated in column 5 of the DRG catalogue. The day-based deduction is calculated from the cost weight featured in column 10 in the DRG catalogue multiplied by the base rate. The number of days for which a deduction must be made is calculated as follows:

The average length of stay (column 5 of the DRG catalogue) rounded up to the next round figure

./. actual length of stay in accordance with Art. 1, paragraph 6

= number of day-based deductions

(2) In the event of a patient’s interhospital transfer, the patient-receiving hospital shall make a deduction in accordance with the requirements as set forth in Paragraph 1, if the length of stay in the patient-receiving hospital falls below the average length

of stay (column 5 of the DRG catalogue). If treatment in the patient-transferring hospital does not exceed 24 hours, the patient-receiving hospital may not make a transfer deduction as set forth in Sentence 1. In the event of early patient discharge by the patient-receiving hospital, the rule on the low trim point as set forth in Article 1, Paragraph 3 shall apply. In the event of a further transfer, the day-based deduction rule as set out in Paragraph 1 shall apply accordingly.

(3) If a patient is transferred from one hospital to others and transferred back to the first hospital within 30 calendar days from the day of the first hospital admission (re-transfer), the first (readmitting) hospital shall group the patient's data from the first and all following stays in the same hospital within said period. Reclassification into a DRG is subsequently performed in accordance with the stipulations as set forth in Article 2, paragraph 4 and paragraph 2, sentence 1. Combinations of re-admissions and retransfers are possible. In this case, a chronological review is mandatory. The review period shall always pertain to the first case leading to a grouping of data. Sentences 1 to 4 shall not apply to cases for neonates (MDC 15).

Article 4
Other reimbursements

(1) EUR [amount] per day shall be charged for procedures/services in accordance with Appendix 1.

(2) In accordance with paragraph 1, day-based fees shall be charged for the day of admission and for each additional day of hospitalisation according to Art. 1, paragraph 6.

Article 5
Case recording

(1) Each DRG shall count as one hospital episode of care in the year of discharge. In the event of readmission according to Article 2 and retransfer according to Article 3, paragraph 3, only the DRG charged after regrouping shall be taken into account.

(2) In accordance with Article 4, every hospital admission counts as one hospital episode of care when invoicing day-based fees.

Article 6
Period of validity

The Billing Guidelines shall come into force on [date] and shall remain in force until new billing guidelines take effect.