



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

APR 15 2013

Gloria Nagle, PhD, MPA
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT (SPA) 13-004

Dear Ms. Nagle,

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 13-004 for your review and approval. This SPA implements the Diagnosis Related Group (DRG) reimbursement methodology for private general acute care hospitals. SPA 13-004 will be effective for inpatient services with dates of admission on or after July 1, 2013.

In 2010, Senate Bill 853 was enacted into law, directing the Department of Health Care Services (DHCS) to develop a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program utilizing a DRG methodology.

Since 1983, private hospitals have been paid under the Selective Provider Contracting Program (SPCP) or received cost-based reimbursement. "Contracted" hospitals negotiated a per diem payment rate with the California Medical Assistance Commission; that role has now been taken on by DHCS in the period before the new method is implemented. Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. Designated public hospitals have a separate payment method and therefore are not included in the DRG project.

Enclosed for your review are the following:

- SPA 13-004 – Attachment 4.19 - A, pages 17.38 -17.53, Appendix 6, pages 1 - 3
- HCFA 179
- Public Notice

Gloria Nagle, PhD, MPA

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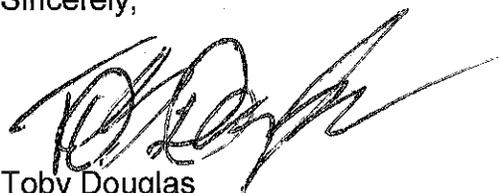
APR 15 2013

A public notice was published by the California Regulatory Notice Register on March 26, 2013, to notify Medi-Cal providers of the pending change in reimbursement methodology.

The Department is seeking approval of SPA 13-004 to implement the changes approved in State law. We are requesting the SPA be approved prior to our implementation date of July 1, 2013.

If you have any questions about the enclosed SPA, please contact Pilar Williams, Chief, Safety Net Financing Division, at (916) 552-9113.

Sincerely,

A handwritten signature in black ink, appearing to read 'Toby Douglas', is written over the typed name.

Toby Douglas
Director

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
13-004

2. STATE
CA

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
**42 CFR Part 447, Subpart C. 1902(a)(13), 1923, 1861(v)(1)(G) of the
Act**

7. FEDERAL BUDGET IMPACT:
a. FFY 2013/14 \$ (44,083,000)
b. FFY 2014/15 \$ (89,621,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19-A, pages 17.38-17.53
Appendix 6 to Attachment 4.19-A pages 1-2**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
None

10. SUBJECT OF AMENDMENT:

11. GOVERNOR'S REVIEW (*Check One*):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
The Governor's Office does not
wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Toby Douglas

14. TITLE:

Director

15. DATE SUBMITTED: **APR 15 2013**

16. RETURN TO:

**Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

**REIMBURSEMENT TO GENERAL ACUTE CARE HOSPITALS FOR ACUTE
INPATIENT SERVICES**

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013 and after, reimbursement to private general acute care hospitals (GACH) for acute inpatient services that are provided to Medi-Cal beneficiaries is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. “APR-DRG” or “All Patient Refined Diagnosis Related Groups” is a specific code assigned to each claim by a grouping algorithm that utilizes the diagnoses code(s), procedure code(s), patient birthdate, patient age, patient gender, admit date, discharge date, and discharge status on that claim.
2. “APR-DRG Base Price” is the statewide base price amount before the relative weight of the APR-DRG, any adjustors, and/or add-on payments are applied. APR-DRG Base Prices are determined by parameters defined in Welfare and Institutions (W&I) Code section 14105.28, as the law was in effect on July 1, 2013.
3. “APR-DRG Grouper” is the software application used to assign the APR-DRG to a DRG Hospital claim.
4. “APR-DRG Payment” is the payment methodology for admissions on or after July 1, 2013 for acute inpatient services provided to Medi-Cal beneficiaries at DRG Hospitals.

TN No. 13-004
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TN No. None

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Effective Date: July 1, 2013

5. “APR-DRG Relative Weight” is a numeric value representing the average resources utilized per APR-DRG. The relative weights associated with each APR-DRG are calculated from a two-year dataset of 15.5 million stays in the Nationwide Inpatient Sample, which includes general acute care hospitals including freestanding children’s hospitals.
6. “DRG Hospital Specific Transitional APR-DRG Base Price” is a DRG Hospital specific APR-DRG Base Price calculated to assist DRG Hospitals to adapt to the change in payment methodologies. Transitional base prices may be used during the three year implementation phase.
7. “DRG Hospitals” are private general acute care hospitals reimbursed for acute inpatient services based on APR-DRG pricing for admissions dated on or after July 1, 2013. “DRG Hospitals” are currently all private general acute care hospitals not excluded as outlined in (Section B; paragraph 2).
8. “Estimated Gain” is the amount a DRG Hospital is estimated to gain on a final discharge claim for which the final APR-DRG Payment exceeds estimated costs.
9. “Estimated Loss” is the amount a DRG Hospital is estimated to lose on a final discharge claim for which the final APR-DRG Payment does not exceed estimated costs.
10. “Exempt Hospitals, Services, and Claims” are those hospitals, services, and claims as defined in Welfare & Institutions Code section 14105.28, as the law was in effect on July 1, 2013.
11. “High Cost Outlier Threshold 1” is the amount that an estimated loss for a single complete discharge claim must exceed to be paid an outlier payment at the Marginal Cost Factor 1.

12. “High Cost Outlier Threshold 2” is the amount that an estimated loss for a single complete discharge claim must exceed to be paid an outlier payment at the Marginal Cost Factor 2.
13. “Low Cost Outlier Threshold” is the amount that the Estimated Gain needs to be greater than to have the gained amount reduced by Marginal Cost Factor 1.
14. “Marginal Cost Factor 1” is the factor used for payment reductions and for determining outlier payments to DRG Hospitals for claims that have estimated losses between High Cost Outlier Threshold 1 and High Cost Outlier Threshold 2.
15. “Marginal Cost Factor 2” is the factor used for determining outlier payments to DRG Hospitals for claims that have estimated losses greater than High Outlier Threshold 2.
16. “Medi-Cal” is the name of California’s Federal Medicaid program.
17. “Remote Rural Hospital” is a California hospital that is defined as a rural hospital by the Office of Statewide Health Planning and Development (OSHPD), is at least fifteen (15) miles in driving distance from the nearest GAC hospital that has a basic level emergency room, and does not operate under a combined license or bill under a common National Provider Index (NPI) number with a non-remote rural hospital.
18. “State Fiscal Year” (SFY) is California state government’s fiscal year which begins on July 1 and ends the following June 30.

B. Applicability

1. Except as specified below in Paragraph 2, for admissions dated July 1, 2013 and after, the Department of Health Care Services (DHCS) will reimburse “DRG Hospitals” through a prospective payment methodology based upon APR-DRG.
2. The following are “Exempt Hospitals, Services, and Claims” that are not be reimbursed based upon APR-DRG:
 - a. Psychiatric hospitals and psychiatric units
 - b. Rehabilitation hospitals, rehabilitation units, and rehabilitation stays at general acute care hospitals
 - c. Designated Public Hospitals
 - d. Non-Designated Public Hospitals
 - e. Indian Health Services Hospitals
 - f. Inpatient Hospice
 - g. Swing-bed stays
 - h. Managed Care stays
 - i. Administrative Day Reimbursement claims
 - i. Level 1
 - ii. Level 2
3. For Medi-Cal Managed Care, as required by Welfare & Institutions Code 14091.3 (c) (2), emergency out-of-network stays are priced by APR-DRGs.

C. APR-DRG Reimbursement

TN No. 13-004
Supersedes
TN No. None

Approval Date _____

Effective Date: July 1, 2013

For admissions dated July 1, 2013 and after, reimbursement to DRG Hospitals for services provided to Medi-Cal beneficiaries are based on APR-DRG. APR-DRG Payment is determined by multiplying a specific APR-DRG relative weight by a DRG Hospital's specific APR-DRG Base Price with the application of adjustors and add-on payments, as applicable. Provided all requirements for a treatment authorization request (TAR) or a service authorization request (SAR) have been approved by DHCS, APR-DRG Payment is for each admit through discharge claim, unless otherwise specified in this segment of Attachment 4.19-A.

1. APR-DRG Relative Weight

The assigned APR-DRG code is determined from the information contained on a DRG Hospital's submitted UB-04 or 837I acute inpatient claim. The grouping algorithm utilizes the diagnoses codes, procedure codes, admit date, discharge date, patient birthdate, patient age, patient gender, and discharge status present on the submitted claim to group the claim to one of 314 specific APR-DRG groups. Within each specific group of 314, there are four severities of illness and risk of mortality sub classes: minor (1), moderate (2), major (3), and extreme (4). This equates to a total of 1256 different APR-DRG (with two error code possibilities). Each discharge claim is assigned only one APR-DRG code. For each of the 1256 APR-DRG codes there is a specific APR-DRG Relative Weight assigned to it by the APR-DRG grouping algorithm. The APR-DRG Relative Weights are calculated from a Nationwide Inpatient Sample. Each version of the APR-DRG grouping algorithm has its own set of APR-DRG specific relative weights assigned to it.

2. APR-DRG Statewide Base Prices Beginning SFY 2016-17

- i. The estimated impact (up or down) of APR-DRG Payment is less than five percent.
 - ii. If the estimated impact (up or down) of APR-DRG Payment is less than \$50,000.
 - iii. If the DRG Hospital had fewer than 100 Medi-Cal Fee for Service stays and these stays were estimated to represent less than two percent of the DRG Hospital's total inpatient volume based on data submitted to OSHPD.
 - iv. If there were no stays in the simulation dataset for a particular DRG Hospital.
- d. DRG Hospital Specific Transition APR-DRG Base Prices will be adjusted using the same criteria outlined in subparagraphs C.3. (b) and (c) after each transitional year (SFYs 2013-14, 2014-15, and 2015-16), or when DHCS deems it necessary, to ensure efficient program delivery.

4. Wage Area Adjustor

The "Wage Area Adjustor" adjusts the APR-DRG Base Price of a DRG Hospital depending on the wage area Medicare has assigned to them. DHCS will utilize the same wage area boundaries, wage area index values, labor share calculation, and any other wage area or index value adjustments as Medicare. DHCS will also use the Medicare reclassifications of DRG Hospitals into adjacent wage areas. Out of state hospitals will receive a wage area adjustor of 1.00.

5. Policy Adjustors

The implementation of APR-DRG Payment includes the functionality of policy adjustors. These adjustors are created to allow the DHCS to address any current, or future, policy goals and to ensure access to care is preserved. Policy adjustors may be used to enhance payment for services where Medi-Cal plays a major role. This functionality of policy adjustors allows DHCS the ability to ensure access to quality care is available for all

services. A list of the current policy adjustors is reflected in Appendix 6 of Attachment 4.19-A.

6. Cost Outlier Payments

Outlier payments are determined by calculating the DRG Hospital's estimated cost and comparing it to the APR-DRG Payment to see if there is a loss or gain for the hospital for a discharge claim. The DRG Hospital's estimated cost on a discharge claim is determined by multiplying the Medi-Cal covered charges by the DRG Hospital's most currently accepted CMS 2552-10 cost-to-charge ratio (CCR).

- a. Subtracting the APR-DRG Payment from the DRG Hospital's estimated cost on a given discharge claim gives the estimated loss. If the Estimated Loss is greater than the High Cost Outlier Threshold 1, then the Cost Outlier Payment is the Estimated Loss less the High Cost Outlier Threshold 1 (but to a maximum of High Cost Outlier Threshold 2 less High Cost Outlier Threshold 1) multiplied by the Marginal Cost Factor 1.
- b. For extreme outlier cases, if the Estimated Loss on a discharge claim is greater than the High Cost Outlier Threshold 2, then the Cost Outlier Payment is the Estimated Loss less the High Cost Outlier Threshold 1 (but to a maximum of High Cost Outlier Threshold 2 less High Cost Outlier Threshold 1) multiplied by the Marginal Cost Factor 1, plus the Estimated Loss less High Cost Outlier Threshold 2 multiplied by the Marginal Cost Factor 2.
- c. APR-DRG Payment also utilizes a low-side outlier similar to the high side outlier adjustment calculations. The estimated gain is determined by subtracting the APR-DRG Payment from the DRG Hospital's estimated cost . If the Estimated Gain is

greater than the Low Cost Outlier Threshold, payment will be decreased by the Estimated Gain less the Low Cost Outlier Threshold, and then multiplied by the Marginal Cost Factor 1.

- d. Values for High Cost Outlier Threshold 1, High Cost Outlier Threshold 2, Low Cost Outlier Threshold, Marginal Cost Factor 1, and Marginal Cost Factor 2 are reflected in Appendix 6 of Attachment 4.19-A.

7. Transfer Adjustments

When a Medi-Cal beneficiary is transferred from a DRG Hospital (DRG Hospital 1), to another hospital, DRG Hospital 1's payment for the transfer is determined by calculating a per diem payment amount for the assigned APR-DRG and multiplying it by: one plus the actual length of stay. The per diem amount is calculated by pricing the stay at its assigned APR-DRG payment and dividing by the nationwide average length of stay for the assigned APR-DRG. If DRG Hospital 1's actual length of stay plus one is greater than the nationwide average length of stay, payment for this particular transfer would pay the full DRG. If the receiving hospital is a DRG Hospital, they would receive an APR-DRG payment based on a final discharge claim. Discharge status values defining an acute care transfer are reflected in Appendix 6 of Attachment 4.19-A.

8. Interim Payments

For stays exceeding twenty- nine (29) days, a DRG Hospital may submit an interim claim for payment every thirty (30) days. For example, if a stay is for sixty-one (61) days, two interim claims may be submitted for payment, as well as one final claim. Interim claims are paid a per diem amount for each day of service. When the Medi-Cal beneficiary is discharged, the DRG Hospital submits a full admit through discharge claim. The final discharge claim is priced as any other final discharge claim and will be paid accordingly.

All previously paid interim payments related to the final discharge claim are removed from the DRG Hospital's next check-write through the remittance advice detail (RAD). The interim per diem amount is reflected in Appendix 6 of Attachment 4.19-A.

9. Separately Payable Services, Supplies, and Devices

A separate outpatient claim may be submitted for certain services, supplies, and devices as determined by DHCS, reflected in Appendix 6 of Attachment 4.19-A.

10. Out-of-State Hospital Reimbursement

- a. For admissions beginning July 1, 2013, when acute inpatient medical services are provided out-of-state pursuant to Section 2.7 of the State Plan and have been certified for payment at the acute level of an emergency nature for which prior Medi-Cal authorization has been obtained, then such inpatient services are reimbursed utilizing the statewide APR-DRG Base Price for the services provided.
- b. When Medi-Cal is required to provide acute inpatient services that are not available in the State to comply with paragraph (3) of part 431.52(b) of Title 42 of the Code of Federal Regulations, and the out-of-state hospital refuses to accept the APR-DRG rate, then DHCS may negotiate payment in excess of the APR-DRG rate for the acute inpatient services provided but no more than what the out-of-state hospital charges the general public.
- c. DHCS will adjust payment to out-of-state inpatient hospitals for provider preventable conditions, as described in Attachment 4.19-A. When treating a Medi-Cal beneficiary, out-of-state providers must comply with the reporting provisions for

provider preventable conditions described in Attachment 4.19-A pages 52 through 54, OMB No. 0938-1136.

D. Treatment Authorization Requests and Service Authorization Request

1. Notwithstanding any other segment of the State Plan, DRG Hospitals follow one of three processes for a TAR or SAR:
 - a. Approval of an admission TAR/SAR by DHCS for authorization of services provided to full-scope Medi-Cal beneficiaries. Submission of any TAR/SAR requires justification of an admission.
 - b. All acute rehabilitation days as well as administrative days (Level 1 and 2) require a daily approved TAR/SAR.
 - c. Daily approved TARs/SARs continue to be required for all aid codes that have restrictions.
2. For any stay that requires a daily TAR/SAR, if one or more days are denied, claims may be re-priced based upon how a claim would price by removing services provided on a denied day.

E. Updating Parameters

1. DHCS will review all base prices, policy adjustors, and other payment parameters as needed to ensure projected payments for any given year are kept within the parameters as defined in Welfare & Institutions Code section 14105.28, as the law was in effect on July 1, 2013. Any needed changes may be implemented as outlined in paragraph 4 of this section.

2. The APR-DRG Relative Weights are specific to the APR-DRG Grouper version and are released annually. DHCS will perform a review of each released version to determine if an update to the current grouper and hospital acquired condition (HAC) utility are necessary. The APR-DRG Grouper version and HAC Utility version DHCS is utilizing is reflected in Appendix 6 of Attachment 4.19-A. Changes to the APR-DRG Grouper version and HAC Utility version may be implemented as outlined in paragraph 4 of this section.
3. DHCS will review and update Appendix 6 of Attachment 4.19-A as necessary. When reviewing and updating, DHCS shall consider: access to care for specific and overall care categories, hospital coding trends, and any other issues warranting review.
4. The effect of all transition base rates, policy adjustors and values as referenced in Appendix 6 of Attachment 4.19A will be monitored by DHCs on a quarterly basis. If DHCS determines that adjustments to any values or parameters specified in Appendix 6 of Attachment 4.19-A are necessary to ensure access for all Medi-Cal beneficiaries, or program integrity, following public notification, DHCS may implement the changes. Changes implemented pursuant to this paragraph shall only be valid for up to 90 days. To maintain the changes, DHCS must submit a SPA within 90 days of the effective date of the changes.

F. Pre-Payment and Post-Payment Review

All claims paid using the APR-DRG Payment methodology are subject to DHCS' TAR/SAR pre-payment medical necessity review and discretionary post-payment review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO DRG HOSPITALS FOR ADMINISTRATIVE LEVEL 2 SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013 and after, reimbursement for Diagnosis Related Group (DRG) Hospital Administration Level 2 Services that are provided to Medi-Cal beneficiaries by DRG Hospitals is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. “Administrative Level 2 Services” are defined as services provided by a DRG Hospital requiring more services, supplies, and/or resources than needed for the current administrative day that are billed under the existing methodology and criteria associated with revenue code 169, as outlined in the Medi-Cal Provider Manual’s Inpatient Services “Administrative Days,” but less than or equal to those required for a Sub-Acute environment as outlined in Attachment 4.19-D of the State Plan.
2. “DRG Hospitals” as defined in Attachment 4.19-A.

B. Applicability

For admissions dated July 1, 2013 and after, the Department of Health Care Services (DHCS) will reimburse DRG Hospitals for Administrative Level 2 Services through an Administrative Day Level 2 per diem payment.

C. Administrative Day Level 2 Reimbursement

Payment for Administrative Day Level 2 Services follow the current Sub-Acute payment methodology used for distinct part sub-acute facilities providing sub-acute services for both pediatric and adult Medi-Cal beneficiaries as outlined in Attachment 4.19-D of the State Plan at the average rate for ventilator and non-ventilator days.

D. Treatment Authorization Request (TAR) and Service Authorization Request (SAR)

1. A daily approved TAR/SAR is required for all Administrative Day Level 2 Services days.

E. Updating Parameters

Pediatric and adult sub-acute rates paid to distinct part facilities providing sub-acute services to Medi-Cal beneficiaries are currently reviewed and updated by DHCS in accordance with Attachment 4.19-D. Administrative Day Level 2 rates will be updated concurrently when DHCS releases subsequent state fiscal year sub-acute rates.

F. Pre-Payment and Post Payment Review

All claims paid under Administrative Day Level 2 are subject to DHCS' TAR/SAR pre-payment medical necessity review and discretionary post-payment review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO DRG HOSPITALS FOR REHABILITATION SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013 and after, reimbursement for Rehabilitation Services that are provided to Medi-Cal beneficiaries by Diagnosis Related Group (DRG) Hospitals is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. “DRG Hospitals” as defined in Attachment 4.19-A.
2. “Rehabilitation Services” are defined as acute inpatient intensive rehabilitation services provided to Medi-Cal beneficiaries, in accordance with Sections 14064 and 14132.8 of the Welfare and Institutions Code as the laws were in effect on July 1, 2013.

B. Applicability

For admissions dated July 1, 2013 and after, the Department of Health Care Services’ (DHCS) will reimburse Rehabilitation Services rendered by DRG Hospitals, through a hospital specific per diem rate for Rehabilitation Services provided to a Medi-Cal beneficiary.

C. Rehabilitation Reimbursement

Provided all requirements for a treatment authorization request (TAR) and/or a service authorization request (SAR) have been approved by DHCS, Rehabilitation Services are paid a

per diem amount for each day of service that is authorized, unless otherwise specified in Attachment 4.19-A.

D. Treatment Authorization Request (TAR) and Service Authorization Request (SAR)

1. A daily approved TAR/SAR is required for all Rehabilitation Services' days.

E. Updating Parameters

DHCS will review and update the Rehabilitation Services per diems as necessary. When reviewing and updating, DHCS shall consider: access to care related to Rehabilitation Services provided at a DRG Hospital, and any other issues warranting review.

F. Pre-Payment and Post Payment Review

All claims paid under the rehabilitation per diem are subject to DHCS' TAR/SAR pre-payment medical necessity review and discretionary post-payment review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Appendix 6

1. APR-DRG Payment Parameters

| <u>Parameter</u> | <u>Value</u> | <u>Description</u> |
|--|------------------|---|
| <u>Remote Rural APR-DRG Base Price</u> | <u>\$10,218</u> | <u>Statewide Remote Rural APR-DRG Base Price</u> |
| <u>Statewide APR-DRG Base Price</u> | <u>\$6,223</u> | <u>Statewide APR-DRG Base Price (non-Remote Rural)</u> |
| <u>Policy Adjustor - Age</u> | <u>1.25</u> | <u>Policy Adjustor for claims whose patients are less than 21 years old. Mutually exclusive from the Policy Adjustors for Neonatal Intensive Care Unit (NICU) services and NICU surgery</u> |
| <u>Policy Adjustor – NICU services</u> | <u>1.25</u> | <u>Policy Adjustor for all NICU DRGs. Mutually exclusive from the Policy Adjustors for Age and NICU surgery</u> |
| <u>Policy Adjustor – NICU surgery</u> | <u>1.75</u> | <u>Enhanced Policy Adjustor for all designated NICU facilities and surgery sites recognized by California Children’s Services Program to perform neonatal surgery. Mutually exclusive from Policy Adjustors for Age and NICU services</u> |
| <u>High Cost Outlier Threshold 1</u> | <u>\$40,000</u> | <u>Used to determine Cost Outlier payments</u> |
| <u>High Cost Outlier Threshold 2</u> | <u>\$125,000</u> | <u>Used to determine Cost Outlier payments</u> |
| <u>Low Cost Outlier Threshold 1</u> | <u>\$40,000</u> | <u>Used to determine Cost Outlier payments</u> |
| <u>Marginal Cost Factor 1</u> | <u>60%</u> | <u>Used to determine Cost Outlier payments</u> |
| <u>Marginal Cost Factor 2</u> | <u>80%</u> | <u>Used to determine Cost Outlier payments</u> |
| <u>Discharge Status Value 02</u> | <u>02</u> | <u>Transfer to a short term hospital</u> |
| <u>Discharge Status Value 05</u> | <u>05</u> | <u>Transfer to a designated cancer center</u> |
| <u>Discharge Status Value 65</u> | <u>65</u> | <u>Transfer to a psychiatric hospital</u> |
| <u>Discharge Status Value 66</u> | <u>66</u> | <u>Transfer to a critical access hospital</u> |
| <u>Interim Payment</u> | <u>\$600</u> | <u>Per diem amount for Interim Claims</u> |
| <u>APR-DRG Grouper Version</u> | <u>V29</u> | <u>3M Software version used to group claims to a DRG</u> |
| <u>HAC Utility Version</u> | <u>V30</u> | <u>3M Software version of the Healthcare Acquired Conditions Utility</u> |

2. Separately Payable Services, Devices, and Supplies

TN No. 13-004

Supersedes

TN No. None

Approval Date _____

Effective Date: July 1, 2013

| <u>Code</u> | <u>Description</u> |
|--------------------------|---|
| <u>Bone Marrow</u> | |
| <u>38204</u> | <u>Management of recipient hematopoietic progenitor cell donor search and acquisition</u> |
| <u>38204</u> | <u>Unrelated bone marrow donor</u> |
| <u>Blood Factors</u> | |
| <u>J7180</u> | <u>Blood factor XIII</u> |
| <u>J7183/J7184/Q2041</u> | <u>Blood factor Von Willebrand –injection</u> |
| <u>J7185/J7190/J7192</u> | <u>Blood factor VIII</u> |
| <u>J7186</u> | <u>Blood factor VIII/ Von Willebrand</u> |
| <u>J7187</u> | <u>Blood factor Von Willebrand</u> |
| <u>J7189</u> | <u>Blood factor VIIa</u> |
| <u>J7193/J7194/J7195</u> | <u>Blood factor IX</u> |
| <u>J7197</u> | <u>Blood factor Anti-thrombin III</u> |
| <u>J7198</u> | <u>Blood factor Anti-inhibitor</u> |

3. **List of Hospitals to receive the “Policy Adjustor – NICU Surgery”**

- 1) California Hosp Medical Center of Los Angeles
- 2) California Pacific Medical Center - Pacific
- 3) Cedars Sinai Medical Center
- 4) Children’s Hospital & Research Center of Oakland
- 5) Children’s Hospital of Central California
- 6) Children’s Hospital of Los Angeles
- 7) Children’s Hospital of Orange County
- 8) Citrus Valley Medical Central – Queen of the Valley
- 9) Earl & Lorraine Miller Children’s Hospital
- 10) Good Samaritan – Los Angeles
- 11) Good Samaritan - San Jose
- 12) Huntington Memorial Hospital
- 13) Kaiser Permanente Medical Center - Oakland
- 14) Kaiser Foundation Hospital - Roseville
- 15) Loma Linda University Medical Center
- 16) Lucille Salter Packard Children’s Hospital - Stanford
- 17) Pomona Valley Hospital Medical Center
- 18) Providence Tarzana
- 19) Rady Children’s Hospital - San Diego
- 20) Santa Barbara Cottage Hospital
- 21) Sutter Memorial Hospital