

Diagnosis Related Groups – Part 1: APR-DRG Reimbursement Implementation

Senate Bill 853 (Statutes of 2010) added Section 14105.28 to the California *Welfare and Institutions Code* (W&I Code), which directed the Department of Health Care Services (the Department or DHCS) to replace the current Medi-Cal fee-for-service reimbursement methodology for hospital acute care inpatient services (both negotiated contract rates and non-contract cost reimbursement) with payment by diagnosis related group (DRG).

As set forth in California W&I Code, Section 14105.28:

“(b) (1) (A) (i) The department shall develop and implement a payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals in state and out of state, including Medicare critical access hospitals, but excluding public hospitals, psychiatric hospitals, and rehabilitation hospitals, which include alcohol and drug rehabilitation hospitals.”

The specific DRG algorithm chosen by DHCS is the All Patient Refined Diagnosis Related Groups (APR-DRG). DHCS is implementing version 29 of APR-DRGs.

In accordance with W&I Code, Section 14105.28(b)(1)(A)(ii), this bulletin serves as the DHCS Director's execution of declaration certifying that all necessary federal approvals have been obtained and the DRG methodology is sufficient for formal implementation. The Director has determined that effective July 1, 2013, all private hospital (W&I Code, Section 14166.1(j).) admissions for acute inpatient services on or after this date shall be reimbursed under the DRG methodology provided by W&I Code, Section 14105.28. All acute inpatient stays at private hospitals with dates of admission prior to July 1, 2013 will continue to be paid at the reimbursement methodology in place on the date of such admission. Designated public hospitals (W&I Code, Section 14166.1(d).) reimbursed under the certified public expenditure (CPE) methodology, will continue to be reimbursed under the CPE methodology.

A non-designated public hospital (W&I Code, Section 14166.1(f).) in a closed health facility planning area that does not have an SPCP contract on July 1, 2013, solely for the purposes of W&I Code, Sections 14103.5 and 14087, shall continue to be considered a noncontract hospital in a closed health facility planning area and all other acute inpatient hospitals in the area shall be considered contract hospitals.

This bulletin incorporates the DRG State Plan Amendment (CA 13-004), the California Medi-Cal Provider Manual as amended to reflect implementation of the DRG reimbursement project, the Medi-Cal Managed Care All Plan Letter issued February 12, 2013 (APL 13-004), and DRG provider bulletins issued previously or in conjunction with this bulletin.

This declaration provides for the additional changes to current reimbursement policies.

Medi-Cal Selective Provider Contracting Program – Inactivation

Effective upon DHCS' implementation of the DRG private hospital acute inpatient reimbursement as described in W&I Code, Section 14105.28, the Medi-Cal Selective Provider Contracting Program (SPCP) as set forth in Article 2.6 of the California W&I Code (commencing with Section 14160) shall be discontinued for designated public hospitals and private hospitals in accordance with Paragraph 29 of the Special Terms and Conditions for the 1115 Medicaid Demonstration, entitled "California's Bridge to Reform" (Waiver II-WOO 193/9). Designated public hospitals will continue to be reimbursed under the CPE methodology.

This provider bulletin is published under the authority specified in paragraph (2) of subdivision (f) of section 14105.28 of the *Welfare and Institutions Code*, which provides in part:

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Except as provided by W&I Code, Section 14165 (b)(3), upon the discontinuance of the SPCP under the Demonstration as provided above, DHCS shall no longer exercise, recognize, or require SPCP contracting status for designated public hospitals and private hospitals for programs or requirements previously associated with the SPCP, including, but not limited to, supplemental programs (W&I Code, Section 14166.12, and Sections 14085 through 14085.57), open/closed health facility planning areas (W&I Code, Section 14087 and Section 14103.5), open staffing (W&I Code, Section 14087.28), and designated public hospital reimbursement (W&I Code, Section 14166.2 (f)).

Acute Inpatient Intensive Rehabilitation Services

For admissions on or after July 1, 2013, the Department will reimburse Rehabilitation Services rendered by DRG hospitals through a hospital specific per diem rate for acute rehabilitation inpatient days provided to Medi-Cal beneficiaries. For admissions prior to July 1, 2013 to DRG hospitals, regardless of the date of discharge, claims will be paid at the reimbursement methodology in place on the date of such admission.

“Rehabilitation Services” are defined as acute inpatient intensive rehabilitation stays for Medi-Cal beneficiaries, in accordance with W&I Code, Sections 14064 and 14132.8.

A per diem payment method will be used for payment of rehabilitation claims. Rehabilitation claims will be identified by the presence of one or more of revenue codes 118, 128, 138, or 158 on one or more service lines on the claim. Rehabilitation claims will be paid a hospital specific per diem amount. The per diem will be multiplied by the number of days authorized on the required *Treatment Authorization Request (TAR)* or Service Authorization Request (SAR). Rehabilitation Services will continue to require a daily TAR or SAR.

Hospital specific base rates have been established as follows: for Rehabilitation Services provided to beneficiaries age 21 and over, a per diem rate of \$1,032 will be assigned to a DRG hospital. This per diem rate is then adjusted by the wage index of each specific hospital in the same manner as the DRG base price is adjusted. The wage area adjustment applies to 68.8 percent of the rate.

For Rehabilitation Services provided to beneficiaries under the age 21, a per diem rate of \$1,841 will be assigned to a DRG hospital. This per diem rate is then adjusted by the wage index of each specific hospital in the same manner as the DRG base price is adjusted.

For DRG hospitals that provided services to both an adult and pediatric population, a specific per diem has been calculated to blend both rates above based on the allocation of days provided to each age category. This per diem rate is then adjusted by the wage index of each specific hospital. Effective July 1 of each year, the hospital specific blend of pediatric and adult rehabilitation services will be updated based on the blend in the most recent year for which data is available. Rates will not be retroactively reconciled based on actual experience.

In developing the above referenced rates, DHCS utilized a comprehensive paid claims dataset representing all days billed and paid with the revenue codes 118, 128, 138, and 158 for the calendar year 2011. Payments for such claims were then trended forward to July 1, 2013, based upon hospital-specific increases in SPCP contract rates or non-contract trend factors as utilized in the Quality Assurance Fee (QAF) model. Claims for hospital stays that do not list one of the identified revenue codes and group to DRG code 860 (Rehabilitation) will be denied. Hospitals are advised to resubmit these denied claims with the appropriate revenue code(s) to ensure rehabilitation pricing, or to indicate the correct primary diagnosis, if it is not rehabilitation, to ensure the claim is assigned the appropriate DRG group.

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Hospitals that provide such services will receive their hospital's specific per diem rate. For further questions please contact the DRG mailbox at DRG@dhcs.ca.gov.

Administrative Day Level 2

For admissions on or after July 1, 2013, the Department will reimburse administrative day level 2 services rendered by DRG hospitals through a per diem rate for Subacute Care provided to Medi-Cal beneficiaries. For admissions prior to July 1, 2013, regardless of the date of discharge, claims will be paid at the reimbursement methodology in place on the date of such admission.

Administrative day level 2 services for pediatric patients are billed with revenue code 190 (room and board, pediatric subacute). The appropriate pediatric patient is younger than 21 years of age with a fragile medical condition with medical and nursing care needs which meet the requirements outlined in the *Subacute Care Programs: Pediatric* section in the appropriate Part 2 Medi-Cal Provider Manual and Chapter 7 of the *Manual of Criteria for Medi-Cal Authorization*.

Administrative day level 2 services for adult patients are billed with revenue code 199 (room and board, adult subacute). The appropriate adult patient is 21 years of age or older and has a fragile medical condition with medical and nursing care needs which meet the requirements outlined in the *Subacute Care Programs: Adult* section in the appropriate Part 2 Medi-Cal Provider Manual and Chapter 7 of the *Manual of Criteria for Medi-Cal Authorization*.

A per diem payment method will be used for payment of administrative day level 2 claims. Administrative day level 2 claims will be identified by the presence of revenue codes 190 or 199 on one or more service lines on the claim. Administrative day level 2 claims will be paid a per diem amount as follows:

The Subacute Pediatric Administrative Day Level 2 (Revenue/Accommodation Code 190) rate is \$894.60, which is the average of the established Distinct Part Pediatric Subacute rate for vent and non-vent services. However, hospitals with an established rate that is lower will continue to receive their facility-specific rate.

The Subacute Adult Administrative Day Level 2 (Revenue/Accommodation Code 199) rate is \$896.67, which is an average of the median rate for vent and non-vent services for Distinct Part Adult Subacute. However, hospitals with an established rate that is lower will continue to receive their facility-specific rate.

The per diem amount will be multiplied by the number of days authorized on the required TAR or SAR. All administrative day level 2 services will require a daily TAR or SAR.

In addition to the per diem payment noted above, DHCS has established limits on reimbursement of ancillary services provided during administrative day level 2 days. Only codes listed with a dagger (†) in the *Ancillary Codes* section of the provider manual are reimbursable when billed with administrative day level 2 days. If ancillary codes that are not marked with a dagger are billed with administrative day level 2 days, the ancillary services will be denied. The allowed ancillaries will be reimbursed on a cost to charge methodology.

The existing Administrative Day will be known as Administrative Day Level 1 effective with admissions on or after July 1, 2013 and will be billed and paid consistent with the current method.

Audits and Appeals

Payments made to providers for services reimbursed pursuant to the DRG methodology in W&I Code, Section 14105.28 are subject to examination or audit as provided under current State law. The DRG

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methodology does not change the provider's obligation to file an annual cost report (Form 2552) and to comply with the Department's audit authority, which includes, but is not limited to:

- W&I Code, Sections 14170, 14171, and 14124
- *California Code of Regulations*, Title 22, Sections 51015 to 51024

Post-Payment Review

Upon request, the DRG hospital shall submit to the Medi-Cal Review Branch, audit records substantiating medical necessity and medical justification for services rendered and billed to Medi-Cal. Payment of a claim is not proof of a valid claim. The hospital is required to retain records readily producible for a minimum of three years and producible within a reasonable period of time for seven years. If a dispute arises based on the Department's findings, the hospital may seek a formal hearing through either the Office of Administrative Hearing and Appeals (OAHA) or through Superior Court. The hospital may seek an Appellate Court ruling if unsuccessful in Superior Court.

Exit Conference and Audit Report

Notwithstanding any other law, pursuant to the authority granted to the Department in paragraph (2) of subdivision (f) of W&I Code, Section 14105.28, and only with regards to the services reimbursed by the APR-DRG methodology, *California Code of Regulations*, Title 22, Section 51021 is modified to read:

§ 51021. Exit Conference and Audit Report.

- (a) The provider shall be afforded a reasonable opportunity to participate in an exit conference after the conclusion of any field audit or examination of records or reports of a provider, by or on behalf of the Department, and prior to the issuance of the Audit Report. The purpose of the exit conference is to:
 - (1) Inform the provider of the audit or examination findings and the supporting reasons and evidence.
 - (2) Inform the provider of the specific instances in which no records were found to substantiate claims billed to the program which was the subject of the audit or examination.
 - (3) Allow the provider an opportunity to present relevant information concerning the audit or examination findings.
- (b) The provider must make available to the Department any records which were identified as unavailable for review or missing, or that provide additional information regarding the audit or examination findings within 15 calendar days of the exit conference to be included in the Audit Report. Except as provided in Section 51040, this subsection (b) shall conclude the provider's record and information submission for the audit or examination.
- (c) Where the audit or examination involves the records or reports of a provider of pharmaceutical services:
 - (1) The auditor or reviewer shall identify missing prescriptions by beneficiary name, beneficiary number, prescription number and date of service to the provider at the exit conference.
 - (2) The audit worksheets relating to exceptions taken shall be furnished to the provider subsequent to the submission of missing prescriptions pursuant to subsection (b), in the event that a request for repayment of an overpayment is made
- (d) An audit or examination findings issued by or on behalf of the Department shall include the following:

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- (1) A complete copy of the Audit Report which identifies all items to which exception has been taken, the monetary value of each and the reason for the exception, including citation to the appropriate statutory or regulatory authority.
- (2) Notice of the provider's right to a hearing pursuant to the provisions of this article. A copy of the provisions of this article shall accompany such notice.

Note: Authority cited: Sections 14105, 14105.28 and 14124.5, *Welfare and Institutions Code*. Reference: Sections 14105.28, 14170 and 14171, *Welfare and Institutions Code*.

Request for Formal Hearing

Notwithstanding any other law, pursuant to the authority granted to the Department in paragraph (2) of subdivision (f) of W&I Code, Section 14105.28, and only with regards to the services reimbursed by the APR-DRG methodology, *California Code of Regulations*, Title 22, Section 51024 is modified to read:

§ 51024. Request for Formal Hearing.

- (a) The form and content of the request shall be as specified in Section 51022(d).
- (b) ~~A Party An Institutional provider~~ shall have 30 calendar days following the receipt of the written Report of Findings within which to file a request for formal hearing with the Director. The request shall be deemed filed on the date mailed to the ~~Director~~Department. The audit findings, as amended by the Report of Findings, shall be considered final and deemed dispositive of all issues raised in the Statement of Disputed Issues filed pursuant to Section 51022 at the end of this period unless good cause for late filing is found.
- (c) A request for formal hearing filed after the time permitted in subsection (b) shall be rejected unless the ~~Party provider~~ establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.
- (d) A formal hearing shall routinely be scheduled in each case involving a Non-institutional provider. No separate request for formal hearing shall be required.

Note: Authority cited: Sections 14105, 14105.28, 14124.5 and 14171, *Welfare and Institutions Code*. Reference: Sections 14105.28, 14171, *Welfare and Institutions Code*.

Changes to Out-of-State Hospital Acute Care Inpatient Services Reimbursement Methodology

Currently, out-of-state acute care facilities are reimbursed the average per diem SPCP contract rate in effect on December 1 in a particular calendar year for California SPCP contract hospitals with at least 300 beds. Upon DRG implementation, California hospitals will no longer be designated as SPCP contract or non-contract facilities and will not be reimbursed based on negotiated per diem contract rate or on a cost basis.

For in-state stays at DRG hospitals, the Department is utilizing hospital-specific transition prices for the first three fiscal years of DRG implementation. A statewide base price will be used in year four that will be effective July 1, 2016. Consistent with the current methodology of using a statewide average SPCP contract rate for out-of-state facilities, out-of-state facilities will be paid utilizing the DRG statewide base price effective July 1, 2013. There will be no hospital-specific three-year transition for out-of-state hospitals.

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When out-of-state medical care is authorized pursuant to paragraph (5) of subdivision (a) of Section 51006 of Title 22 of the *California Code of Regulations* for non-emergency acute inpatient admissions, then prior to admission, the Department may negotiate reimbursement on a case-by-case basis for the non-emergency acute inpatient services provided, but no higher than what the out-of-state hospital charges the general public.

Out-of-State Hospital Inpatient Services Reimbursement

Notwithstanding any other law, pursuant to the authority granted to the Department in paragraph (2) of subdivision (f) of Section 14105.28 of W&I Code, *California Code of Regulations*, Title 22, Section 51543 is modified to read:

§ 51543. Out-of-State Hospital Inpatient Services Reimbursement.

Out-of-state hospital inpatient services which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained, effective July 1, 2013 shall be reimbursed under the All Patient Refined Diagnosis Related Groups (APR-DRG) statewide base price pursuant to *Welfare and Institutions Code*, Section 14105.28. ~~the current statewide per diem average of contract rates for acute inpatient hospital services provided by California hospitals with at least 300 beds or the out-of-state hospital's actual billed charges, whichever is less. The term, "current," as used in this paragraph means the most recent per diem average as of December 1 of the prior calendar year of the contract rates for California hospitals with at least 300 beds that the California Medical Assistance Commission has reported to the Legislature pursuant to *Welfare and Institutions Code*, Section 14165.9. Therefore, the average per diem contract rate in effect on December 1 in a particular calendar year for California contract hospitals with at least 300 beds shall be the maximum rate paid to out-of-state hospitals for dates of service beginning January 1 of the following calendar year.~~

Note: Authority cited: Section 20, *Health and Safety Code*; and Sections 14105, 14105.15, 14105.28, and 14124.5, *Welfare and Institutions Code*. Reference: Sections 14086, 14105, 14105.15, and 14105.28, *Welfare and Institutions Code*; Chandler Regional Medical Center, et al., v. California Department of Health Services; Diana M. Bontá, et al. and Arizona Burn Center, et al., v. California Department of Health Services; Diana M. Bontá, et al. City and County of San Francisco, Case Nos. CGC-01-324400 and CGS-02-408260.

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