

Diagnosis Related Groups: Cost-to-Charge Ratios and Service Authorization Requests

Reminder

Effective for admissions on or after July 1, 2013, reimbursement for private inpatient general acute care hospitals will be based on a Diagnosis-Related Group (DRG) payment methodology. The specific DRG algorithm chosen by the Department of Health Care Services (DHCS) is All Patient Refined Diagnosis-Related Groups (APR-DRG).

Cost-to-Charge Ratios

Cost-to-charge ratios (CCRs) are utilized in the DRG reimbursement methodology in relation to outlier payments. CCRs are derived from the Medicare cost report (CMS 2552-10) filed by each facility. All inpatient hospitals' cost reports are due five months after the end of the hospital's fiscal year. The filed CCRs are used to calculate an interim rate for payments to non-contract hospitals for an estimate of their Medi-Cal allowable costs and then reconciled during the hospital's annual audit. This has been a historical practice for Medi-Cal inpatient fee-for-service reimbursement in California and will continue after DRG implementation, however, cost reports will go through an initial review before the updated CCR is accepted for use in claims processing to determine outliers.

DHCS is in the process of creating a detailed description and timeline to further explain updates to hospitals' CCR. Please look for this information in the coming weeks on the DHCS website at the [Diagnosis Related Group Hospital Inpatient Payment Methodology](#) Web page.

California Children's Services and Service Authorization Requests

All California Children's Services (CCS) claims for full-scope clients will require an approved Service Authorization Request (SAR) for a hospital admission. Hospitals will no longer submit separate claims (split bill) when a CCS-only condition changes to a Medi-Cal CCS covered service during an inpatient stay. If the recipient is enrolled in a Medi-Cal Managed Care Plan (MCP), the hospital will split bill and submit a bill for the CCS treatment to fee-for-service and submit a bill for the other aspects of the admission to the MCP.

Admission SARs require documentation that establishes medical necessity for the acute inpatient admission. If the admission SAR is approved, it is not necessary to submit a *Treatment Authorization Request* for necessary non-CCS services provided during the admission. If the client is identified by a restricted aid code, then the hospital must document medical necessity for each day of the hospital stay. Further information about CCS services and DRG reimbursement is available in the [DRG Provider Billing FAQ](#), pages 8 and 9, which is available at the [Diagnosis Related Group Hospital Inpatient Payment Methodology](#) Web page.

Provider Manual Updates

DRG policy is being added to the *Inpatient Services* provider manual. The manual is slated to be released in the June 2013 *Medi-Cal Update*.

DHCS DRG Web Page

DHCS encourages providers to visit the [Diagnosis Related Group Hospital Inpatient Payment Methodology](#) Web page on the DHCS website. The Web page is being updated as the DRG project progresses.

To submit questions, or to add your email address to the DRG listserv to receive DRG updates, contact DHCS via the DRG mailbox at DRG@dhcs.ca.gov.

Providers interested in receiving email notifications about Medi-Cal news are encouraged to subscribe to the [Medi-Cal Subscription Service \(MCSS\)](#). Providers who would like to receive updates on DRG information should select the Inpatient Services subject matter of interest on the MCSS Subscriber Form.