

Medi-Cal DRG Project

Provider Billing Frequently Asked Questions

1. Since the implementation date is July 1, 2013, what if patient is admitted on June 28, 2013 and stays through July 3, 2013?

The pricing logic in CA-MMIS will reimburse the claim based on the date of admission. If a patient is admitted on June 28, 2013, and discharged on or after July 1, 2013, the stay will be priced using the contract or non-contract reimbursement methodology. DRG payment will be made only for admissions on or after July 1, 2013.

2. Will non-contract hospitals accept Medi-Cal patients?

All hospitals that are allowed to service Medi-Cal beneficiaries will continue. Current references to hospitals as a contract or non-contract hospital will no longer be applicable. This includes the removal of transfer requirements for non-contract facilities in a closed area, as well as the removal of restrictions based on open and closed Health Facilities Planning Areas (HFPAs).

3. We have different NPIs for non-contract and contract reimbursement. Which should we use?

All hospitals will be able to utilize either NPI number. Rates are specific to each hospital and will no longer have any affiliation with a contract or non-contract status.

4. Currently, only two diagnoses codes are captured. How many are read in the DRG method?

Electronic claims will be able to accept as many as 25 diagnosis codes and 25 procedure codes. Paper claims can accept up to 18 diagnosis codes and 6 procedure codes. Hospitals should bill all diagnosis and procedures related to a hospital stay to ensure that the appropriate base APR-DRG and patient severity of illness are assigned.

5. Are there any changes to the UB-04?

No changes are being made to UB-04 Completion form process. For DRG reimbursed hospitals, the main item to note on the UB-04 is the importance of correctly identifying all procedure and diagnosis codes for each stay.

6. How will DRG implementation affect claims processing?

System changes have been made within the CA Medicaid Management Information System (CA-MMIS) to allow for payment by DRG.

7. How will claim adjustments be processed?

Late charges will not be accepted for DRG payment; the original claim must be voided and resubmitted.

Hospital Characteristics

8. What is the easiest way for a provider to determine if they are a private or public hospital?

Please see the Hospital Characteristics File located on the DHCS DRG web page, which shows the status for Designated Public Hospitals and Non-Designated Public Hospitals, as well as the status for designated NICUs, Remote Rural Hospitals, Wage Area Index, etc.

9. Is the cost-to-charge ratio published?

Yes. Each hospital's cost-to-charge ratio is included on the hospital characteristics file on the DHCS DRG web page.

10. What is the wage area for an out-of-state hospital? Is this Medicare defined?

The Medicare national value of 1.00 % is used for out-of-state hospitals.

Level of Severity

11. What are the dashes after the DRG?

Level of severity. There are four levels of severity for each DRG (minor, moderate, major, and extreme). Severity depends on the number, nature and interaction of complications and comorbidities. This is determined by the interplay between the diagnoses and procedure codes on the claim.

12. Can you explain the differences in DRG weights and severity levels?

Each group, or DRG, is assigned a relative weight, which reflects a hospital's typical resources used for the level of care provided. Each DRG also has four levels of severity; the relative weight of the DRG generally increases as severity increases, resulting in a higher payment. There are a few exceptions – particularly when the most extreme severity indicates that the patient death is likely early in the stay.

13. Is there a place where we can find what determines level of severity for an APR-DRG?

The APR-DRG Definitions can be found on the 3M website.

ICD-10 / Crosswalk

14. Will you be ready for ICD-10?

Yes. ICD-10 is scheduled for implementation on Oct. 1, 2015, and DHCS is on schedule to accept ICD-10 for inpatient claims starting at that time.

15. Is there a DRG to ICD-9 crosswalk?

There is not a simple crosswalk, however you can access the 3M APR-DRG Definitions Manual through the 3M Health Information Systems webpage that will provide information on how combinations of diagnoses and procedures map to DRGs.

What is the name of the manual and where can we find it?

16. Will you have a crosswalk from MS-DRG to APR-DRG?

No, the two groupers are different and no crosswalk is available.

Coding and Grouper Versions/Settings

17. Will there be coding training for a hospital to understand which DRG to use?

There is no particular coding for DRG. Claims submitted for payment will include the DRG assignment. A DRG is not assigned until the diagnoses and procedure codes are run through APR-DRG grouping logic from the final discharge claim after it is submitted. The Medi-Cal claims processing system will determine the DRG for each claim based on the diagnoses, procedures, patient age, patient gender, and other relevant information for each admission. As such, it is critical that coding is complete, accurate, and defensible for each claim.

18. Does the calculator on the DRG web page help determine if the correct DRG was billed?

No. The purpose of the DRG calculator on the DRG web page is for pricing; it is not a grouper. It assumes you know which APR-DRG to use in order to estimate payment. It is not used to validate diagnoses, procedures, etc. The appropriate DRG is determined through the use of the APR-DRG grouper algorithm within the claims processing system; all the hospital needs to provide is accurate diagnoses and procedure codes, as well as current billing requirements (revenue codes, ancillary charges, etc.).

19. Do we need to purchase the 3M grouping software to submit claims?

No. Hospitals are not required to purchase the grouping software. The Medi-Cal claims processing system will assign the DRG based, in part, on the diagnoses and procedures on the final discharge claim form.

20. Are you going to publish the groupings?

Yes. This is available within the DRG Pricing Calculator located on the DHCS DRG web page.

21. The v29.0 APR-DRG will be used for implementation, when does CA plan on updating to a newer version?

Version 31 of the grouper was implemented for admissions after July 1, 2014. The DHCS plans to implement version 32 on July 1, 2015.

22. What version of Healthcare Acquired Conditions (HAC) does California plan on using?

HAC version 30.

23. Is DHCS implementing adjustments based on Provider-Preventable Conditions (PPC) concurrent with DRG implementation?

Consistent with federal requirements, DHCS implemented version 30 of the health-care acquired conditions utility to ensure payments are only made for provider preventable conditions that are present-on-admission. Hospitals should continue reporting all provider preventable conditions to Audits and Investigations consistent with current reporting guidelines.

24. Will the reporting of present-on-admission (POA) indicators eliminate the need to complete the Medi-Cal Provider-Preventable Conditions Reporting Form?

No. This report continues to be required.

25. Is the Medi-Cal POA the same as Medicare POA?

POA indicators are a national standard and the same for both Medi-Cal and Medicare. Acceptable POA indicators are: Y, N, U, W, or blank.

Dual Eligibility

26. What if there is a Medicare crossover? What comparison payment method will be used?

Transition to APR-DRGs changes the allowed amount for each Fee-For-Service inpatient admission, but does not change any policies regarding crossover claims.

27. When a Medicare patient is in a long term acute care facility and their Medicare days exhaust, how is Medi-Cal payment calculated?

A claim for Medi-Cal services will be submitted using the original admit date for the stay and will include all charges, diagnoses, and procedure codes applicable to the entire stay. Medicare payments will be deducted from the DRG payment.

28. Will DRGs affect secondary billing?

If a patient has workers comp, Blue Cross, etc., and Medi-Cal is secondary, the claim will go through DRG pricing to determine the allowed amount, but other coverage is subtracted to arrive at final payment. There is no change from the current pricing system.

29. How will the share of cost affect DRG payment?

Other health coverage and share of cost is deducted from DRG payment, which has not changed from the previous methodology.

Pediatrics / Newborns / Neonate Intensive Care Units (NICUs)

30. What is the age definition for pediatric?

Under the age of 21.

31. What revenue code will be required for well newborn claims?

Revenue/Accommodation code 171 or 170 for a mom with no Medi-Cal coverage. The DRG payment methodology does not change any revenue/accommodation codes used for billing purposes.

32. Are well babies going to be reimbursed separately from the mother?

Yes, all babies must be billed on separate claims from their mothers. Claims that include both nursery revenue/accommodation codes and labor and delivery revenue/accommodation codes will be denied. Separate claims and separate payments are consistent with the fact that the mother and the baby are separate patients with separate diagnoses, treatments, charges, length of stay, and discharge statuses.

33. Some well babies were previously billed on their own claim (i.e. mother is in jail) using four special revenue codes. Will the use of those special revenue codes be discontinued under DRGs?

Revenue codes used to bill for all babies are 0170, 0171, 0172, 0173 and 0174. Each code correlates to the severity of the condition.

34. If a baby has not been issued its own BIC/CIN in the first 30 days, can we bill the first interim claim under the mother's BIC/CIN?

Yes. If an interim claim for a baby that is billed with the mother's ID, then all subsequent claims for the baby should continue to use the mother's ID through final discharge of the baby.

35. How will multiple births be processed?

There will be a separate claim for every patient who is admitted; submit a claim for each baby born.

36. If you have multiple births billing with two or more claims and each of those claims are using the mom's BIC number is there a probability of claims being denied as duplicate claims?

No.

37. Will the newborn hearing screening still be able to be billed separately and reimbursed in addition to the DRG?

Newborn screening is not changing, please follow the current procedure.

38. What defines neonate at other hospitals that are not designated NICUs?

The NICU policy adjustor is based on the hospital admission grouping to a DRG in the 'Neonate' Medicaid care category. You can see on the DRG pricing calculator in the DRG table which DRGs are in the 'Neonate' Medicaid care category and which are in the 'Normal newborn' category. Many hospitals with newborn services are not designated NICUs; that classification is included on the letter that went out to hospital CFOs and can also be found in the Hospital Characteristics File on the DRG web page.

39. Will the TAR process for pediatrics remain the same?

It is a similar process. If a well-baby becomes sick, an admission TAR/SAR is required. For beneficiaries with a full-scope aid code (regardless of age), a single admission TAR/SAR is required. For beneficiaries with a limited benefit aid code (regardless of age), daily authorization is required, consistent with the current process. No TAR is required for obstetric admissions and normal newborns, regardless of aid code.

40. Is a TAR required if mom delivered outside of hospital?

No, a healthy baby delivery outside of the hospital does not require a TAR.

Treatment Authorization Requests / Service Authorization Requests (TAR / SARs)

41. What criteria for TARs are used to determine medical necessity?

The criteria currently used for Fee-For-Service will continue to be used. For admission TARs, medical necessity will be evaluated for the patient requiring inpatient hospitalization. Medical professionals will continue to review these TARs. The Manual of Criteria is on the DHCS website.

42. When DRGs are implemented, will we lose our on-site nurse?

The field offices are committed to working with providers and meeting their needs for on-site, eTAR, virtual record reviews, and FAX submissions. Once a hospital determines what it needs based upon the Fee-For-Service population, the field offices will look more closely at what works best for both the facility and the field office.

43. Do we do ADMIT TARs for everyone?

No, there are certain exceptions. In general, full-scope Fee-For-Service Medi-Cal beneficiaries will require an ADMIT TAR for payment unless it is an admission for an obstetrical delivery or a normal newborn. Restricted Aid Code recipients, acute intensive rehabilitation admissions or stays, or acute administrative days will continue to require a TAR for daily review of the stay.

44. Can I still submit electronic TARs?

Yes, please do. DHCS is working to make submission as easy as possible for the providers and eTAR is still the fastest way to get your TAR submitted to DHCS and adjudicated. ADMIT TARs require less documentation, so e-submission should cut down the paper workload as well. Paper TARs are still being accepted. Those hospitals interested in becoming an eTAR provider can contact either their local field office or Xerox at 1-800-541-5555.

45. Will we still be using the 18-1 TAR or will there be new TARs?

There are no new TARs. Continue to use the 18-1 TAR for emergency admissions and the 50-1 TAR for non-emergency elective admissions.

46. If it is an elective inpatient stay requiring a 50-1 TAR, will we need to generate an 18-1 upon continued stay?

No.

**47. Are admission TARs for elective procedures done prior to admission only?
Are we going back to prior authorization?**

Nothing is changing as far as the timing for submission of a TAR. A facility/provider can submit an ADMIT TAR either before admission if they think medical necessity may be in debate, or after admission. Retroactive TARs will still be accepted. As always, it is the provider that risks loss of payment, if the service is provided and then the TAR is submitted for review, and denied. For emergency admissions, the ADMIT TAR would be submitted after admission.

48. Will the entire medical record be required for the admission TAR/SAR? Is there a list of supporting documentation that is required when submitting an admission TAR/SAR versus a length of stay TAR/SAR?

Types of documentation will remain the same. Hospitals will need to submit the information that will support the medical necessity of acute inpatient admission. For services that will still require a daily TAR/SAR (Acute Inpatient Intensive Rehabilitation, Administrative Days Level 1 and 2, Restricted Aid Codes) hospitals will be required to submit medical documentation consistent with the current requirements to establish medical necessity for each requested day and to establish the level of care (acute vs. administrative level 1 or 2).

49. How does it work when you get TARs in 30 day increments? Say you have a patient for 90 days; TARs are for 30 day increments and there are denied days between.

Most claims will only need an admission TAR/SAR. Hospitals will submit TARs/SARs as they do today. The TAR/SAR will need approval for the admission. For full scope beneficiaries, the system will see at least one TAR-approved day and then the whole stay will be approved. For Restricted Aid Code beneficiary stays that are not newborn or delivery related, each day will be looked at and if days are denied there is the potential for re-pricing. For services related to Acute Inpatient Intensive Rehabilitation, Administrative Days Level 1 and 2, and Restricted Aid Codes, daily TAR/SAR requirements apply.

50. For an extended length of stay, which TAR is accepted?

The stay only requires a TAR/SAR authorization for the admission. Subsequent interim payments and final discharge bill will use the initial admission TAR/SAR. Please note this requirement differs for Acute Inpatient Intensive Rehabilitation, Administrative Days Level 1 and 2 and Restricted Aid Codes.

51. On extended stays do we have to wait 30 days to send the admission TAR?

No, as soon as a beneficiary is admitted, a hospital can submit a TAR. For full scope beneficiaries, the admission TAR needs to contain documentation establishing the medical necessity for the acute hospitalization. For Restricted Aid Code beneficiary

stays that require a day by day TAR, for the submitted TAR there will need to be documentation supporting medical necessity and an emergency condition for each day being requested. If the TAR/SAR is denied, the hospital may appeal consistent with the current TAR/SAR appeals process.

52. Do you have procedure regarding denials for claims?

If there's a denial of a TAR/SAR, there is a documented reason on the TAR/SAR. If it's a claims processing reason (ineligible patient, incomplete codes), the first step is to contact the call center to understand the denial. DRG rates and group assignments are not appealable, but other aspects of the denial could be appealed depending on circumstances.

53. Which codes require daily TAR reviews?

Any Restricted Aid Codes require daily TAR/SARS as well as the administrative day level of care and all rehabilitation stays.

54. If we don't submit the TAR daily, how can you determine which day is denied?

For admission TARs, the determination is whether the admission was medically necessary at an acute level of care. The claim may be submitted with an authorized admission TAR. If the admission TAR is approved, the whole stay is approved for beneficiaries with a Full-Scope Aid Code.

55. How will DHCS handle Restricted Aid Code stays where at least one day was denied and this affected payment?

As long as one day was approved on a TAR, go ahead and bill with all of the charges, procedure codes, and diagnoses codes that you would otherwise have billed with. DHCS will look at the cases where at least one day was denied to see if there is any reason that the DRG grouping should be different based on removing the procedures performed on the TAR denied days. If the claim was eligible for an outlier payment, there could also be an impact if charges associated with denied days are removed. If there is a payment offset or recoupment, the provider then knows that the denied days did in fact have a financial effect. The provider can submit an Appeal against the denied days if they wish, but it is possible that denied days may not actually affect payment.

56. Can I still appeal a denied TAR?

Yes, appeals for denied or modified TARs are still allowed. A denied ADMIT TAR or a denied or modified daily review TAR may be appealed. These will follow the current

process and timeliness. The only difference will be for the ADMIT TAR the submitted documentation will focus on the medical necessity for the admission.

57. Currently, the TAR Appeal process can take over a year to process. Will there be a reduction in the time limit due to the simplified TAR process?

Since the Fee-For-Service TAR volume is decreasing, we expect to see a reduction in the time to process, but there is no set limit.

58. Currently, when requesting a TAR for an emergency acute admission, we wait for the patient to discharge, and then send the TAR and complete records to the field office. With an admission TAR, do we no longer have to wait for the patient to discharge and send the entire chart?

Hospitals can submit after discharge or sooner at their discretion. An admission TAR/SAR will require documentation to establish the medical necessity for an acute inpatient admission. If it's a Restricted Aid Code, hospitals will need documentation for each day of the hospitalization. For interim claim billing, hospitals would need an approved TAR/SAR before the interim claim can be approved for payment.

59. How long do we have to get an admission TAR if a baby goes from newborn to NICU?

Today, most TARs/SARS are submitted after admission and done retrospectively. Hospitals don't need an admission TAR/SAR to be approved before admission. A unique circumstance is if a stay is particularly long and hospitals want to bill an interim claim; in that case an approved TAR/SAR is needed before the interim claim will be paid.

60. In an interim claims scenario, does a provider need to do anything to clarify that it is not double billing?

No. When a final discharge claim is processed, it will be priced for the entire stay including all charges, diagnosis and procedure codes from date of admission. Payment will be made based on the assigned DRG for the entire stay. If interim claims were paid, the payments for the interim claims will be removed from the provider's next check write through the Remittance Advice Detail (RAD).

61. Will the secondary claims after other health coverage (OHC) primary still require a TAR?

Yes.

California Children's Services (CCS)

62. Today, when a SAR is issued by the CCS Office, it includes a "from & through" date, the number of days being approved for a patient stay. How will the SAR look under the new methodology?

Whether it's a TAR or SAR, as long as one day is approved, it's considered an approved admission for DRG payment with regards to full aid code beneficiaries, non-rehabilitation stays and non-administrative day stays. There are no changes to the TAR/SAR forms. If a beneficiary is admitted to a hospital for a non-CCS eligible condition and subsequently receives services during the stay for a CCS-eligible condition, a SAR will be authorized back to the day of admission.

63. Currently, a SAR covers the first 10 days and a TAR covers the remainder. Should we do one TAR upon admission?

Beginning July 1, 2013, only one admission SAR/TAR is required. If the admission or any part of the stay is CCS based, an admission SAR is required; otherwise an admission TAR is required.

64. For CCS patients, will we continue to send medical records to CCS every 3-4 days to obtain more days or just the initial SAR?

No. The stay is priced by DRG, so an admission SAR is only required with regards to full aid code beneficiaries, non-rehabilitation stays and non-administrative day stays. However, daily CCS eligibility will still need to be established through the existing process. If the beneficiary is also in Medi-Cal Fee-For-Service, there would be no impact in billing. However, if the beneficiary is not Medi-Cal eligible, the procedures, charges, and other relevant claim information associated with non-CCS days should not be on the claim.

65. For CCS and Managed Care patients at a CCS approved hospital, when a hospital does not have an on-site nurse to determine days carved out, how will we determine CCS days versus Managed Care?

If a beneficiary is admitted to a hospital for a CCS-eligible condition or receives services for a CCS-eligible condition during any part of the stay, the entire stay will be billed through fee-for-service. Managed Care should not be billed for any part of the stay. The hospital will receive one payment based on the DRG for the stay.

66. For the hospitals that do not have a CCS on-site nurse, will we then need a SAR for each day? Originally, SAR is for admission.

DRGs do not change whether or not a hospital is an eligible CCS provider. All stays (except as noted previously – restricted aid codes, acute inpatient intensive

rehabilitation and/or administrative days level 1 and 2) will require only a SAR for the admission.

67. What will happen in the case of split billing between CCS and Managed Care plans for Managed Care beneficiaries who have their CCS benefits carved out? How will these cases be paid?

Hospitals should submit one claim through fee-for-service for the full stay if any part of the stay was CCS-eligible, and Managed Care should not be billed. A CCS-ineligible stay would be billed entirely to the Managed Care plan.

68. Is there an issue where some days are authorized by CCS and some are not, if the first day is approved?

As long as an admission SAR is approved, the entire stay is approved (with the exception of Restricted Aid Codes, Acute Inpatient Intensive Rehabilitation and/or Administrative Days Level 1 and 2).

Administrative Days

69. How are acute administrative days paid?

Current acute administrative days with revenue/accommodation code 169 will see no change in how they are paid or billed. These days will continue a per diem reimbursement as well as a cost reimbursement for allowed ancillaries.

70. What is the Administrative Day Level 1 rate?

This rate is set at the lower of the individual facilities projected cost or the median projected cost. The median rate effective December 28, 2011 is \$416.95.

71. Is there another administrative day being added?

Yes, Administrative Day Level 2. This is for pediatric and adult patients that require a subacute level of care and placement cannot be found. Placement efforts, just as for Level 1 days, need to be documented by the hospital. These days require a TAR for review and approval of each day before a claim can be submitted. Level 2 days are only available to hospitals reimbursed through DRG methodology and will be identified by revenue/accommodation codes 190 for subacute pediatric and 199 for subacute adult.

72. Are ancillaries all-inclusive for the Administrative Day Level 2?

Payment will work the same as the Administrative Day Level 1 with cost reimbursement for allowable ancillary services.

73. What is the determination for an acute patient to be transferred to administrative days and an admission TAR submitted?

These days may be authorized for patients awaiting placement in skilled nursing facilities (SNFs), or intermediate care facilities (ICFs). The patient must be a lower level of care from acute and placement efforts must be documented.

74. Who determines administrative days? An onsite nurse?

If an onsite nurse is available, they will be able to determine administrative days. Otherwise, administrative days will be authorized by a daily TAR.

75. If we have to have a daily TAR for administrative days and there is a 14-30 day wait time for TARs what is the risk of having a patient in an administrative day and not receiving the TAR?

Although the Fee-For-Service TAR volume is decreasing which may allow the turnaround time to decrease, we anticipate the risk the same as it is now.

76. You refer to "discharge from acute" and readmit to "admin", do you really mean and actual discharge and readmit in the hospital HIS/EHR systems?

No. It is considered one continual hospital stay with different levels of care within it. However, it is two separate claims and two separate TARs.

Rehabilitation Days

77. Which accommodation codes are used for a rehabilitation claim?

Rehabilitation codes include 0118 (private), 0128 (semi-private), 0138 (3/4) and 0158 (ward).

78. If an acute stay transfers to rehab within the same admission, do we bill separately?

Yes, you would bill separately. One claim for the general acute care stay and one claim for the rehabilitation portion of the stay. Please note that rehabilitation days require a TAR for daily review and approval of each day requested.

Cost Reporting

79. How do you anticipate the impact to Medi-Cal cost reporting and cost report audits?

Today, cost reports, among other uses, are utilized during the audit process for all hospitals. Under DRG payment methodology, individual claim payment will be based on APR-DRGs, with some cases where individual claims may be adjusted. But more broadly, there will not be cost settlement as it is done today. Hospitals will continue to be required to submit timely and correct cost reports.

Organ Acquisition

80. How will organs be paid?

Organ acquisition costs were previously allowed reimbursement under an outpatient claim if carved out of the Selective Provider Contracting Program contract. Organ acquisition is now included via the DRG reimbursement. There is a select list of services that will be reimbursed separately under DRGs and this list is uniform for all hospitals (see Question 56).

81. It was noted that bone marrow acquisition will continue on the excluded list for separate outpatient billing, but what about organ procurements such as hearts and lungs?

Overall DRG payment includes acquisition of other organs. Blood factors and bone marrow search and acquisition are the only services separately payable from the inpatient stay.

Transfers

82. If a patient is transferred, do you get the full DRG payment?

It depends on whether the beneficiary is discharged from the other hospital. If yes, the first hospital will get a DRG payment which may have a transfer adjustment depending on the length of stay. The receiving hospital would receive a full DRG payment. TAR/SAR requirements apply to transfers. When a beneficiary is discharged and transferred, there will be two claims and two TARs/SARs. The transfer adjustment applies to only the first hospital. If a beneficiary is not discharged and is sent to a second hospital for a procedure and returns to the original hospital, the original hospital would receive a single DRG payment. The original hospital would negotiate payment to the second hospital.

Managed Care

83. How will DRG implementation affect Medi-Cal Managed Care?

There is no change for contracts with network hospitals or for elective out-of-network admissions, but the Roger's Rate for emergency out-of-network admissions will be based on DRGs.

84. What is the appropriate reimbursement for elective admissions by the Medi-Cal Managed Care plans?

The implementation of DRGs does not change reimbursement arrangement for elective admissions to out-of-network hospitals.

85. What payment methodology will MCPs use to pay inpatient claim for in-network hospitals in the absence of Rogers Rates?

The DRG payment methodology applies to emergency and post-stabilization services provided at out-of-network hospitals (including DPHs and NDPHs) to the extent such services are provided at those hospitals and they are not in the plan's network. This policy has no effect on contracts with network hospitals.

86. Can MCPs receive confirmation that the wage-adjusted base rates published in the Hospital Characteristics File are required to pay for “Non-Contracted” hospitals verse hospital specific APR-DRG base rates?

Please see the Hospital Characteristics File on the DRG web page at <http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx> which lists the hospitals base rates to be utilized for emergency and post-stabilization services for out of network stays. MCPs are only obligated to utilize the wage-adjusted statewide rate in determining final DRG reimbursement based on the DRG assignment and any policy adjusters. MCPs are not required or authorized to use hospital-specific transitional base rates. The hospital specific transition base prices made public July 1, 2013, but are not used to price emergency admissions to out-of-outwork hospitals.

87. On a 5 day emergency admission, if the Medi-Cal Managed Care plans approve 3 days and deny 2 days, will that affect the APR-DRG amounts?

Per Welfare and Institutions Code section 14091.3, hospitals must accept as full payment the payment amount established pursuant to the methodology developed under Section 14105.28. Because DRG payment is not based on length of stay, disallowing two days at the end would not necessarily affect payment unless a procedure was performed on one of those days. The health plan may still disallow a procedure if it is unrelated to the emergency. Please note that is a change in payment methodology only, so there is no change to the dispute resolution process regarding disputed days or procedures and whether they are necessary to treat the emergency condition.

88. Will the Medi-Cal Managed Care Plans need to be contacted for authorization for emergency admissions in order to be reimbursable at the APR-DRG amounts?

There is no change to the current policy.

89. Will the MCP's topside capitation rates be built upon RDT-submitted data on network inpatient hospital costs, or be built upon the hospital-specific DRGs for those network hospitals?

It is built on RDT-submitted data along with the supplemental data request.

90. When a baby is in a Neonate Intensive Care Unit and payment shifts between CCS and the MCP, what is DHCS expectation in terms of DRG and who is ultimately responsible for payment if CCS is carved out?

If any part of the stay is CCS-eligible and there is an approved SAR, the entire stay would be billed through fee-for-service and no part of the stay should be billed to the managed care plan; the hospital will receive one payment for the full stay by DRG.

91. Are MCPs required to translate (from Rogers to APR DRG if no software) and pay with an APR-DRG, since hospitals are not required to bill with an APR-DRG?

MCPs are responsible for pricing the claims. The plans will need the APR-DRG software to group the claims. However, MCPs may work out something different than DRG pricing with the agreement of the hospital. All the information needed to price a claim (once it has been grouped) is available on the DRG webpage.

92. How will the Managed Care plans obtain the software to assign a DRG?

Please seek guidance from the California Association of Health Plans.

93. Should MCPs download and save the DRG Pricing Calculator, so we can put the DRG codes into the Calculator and get hospital's payment amount or should we go to the Medi-Cal website every time we want to price a DRG claim?

It is advisable for MCPs to download and save the DRG Pricing Calculator that is available on the DHCS DRG web page. The calculator is used as a tool to estimate the DRG payment based on the data that is inputted. Thus, hospitals will need to provide accurate diagnoses and procedure codes, as well as current billing requirements (revenue codes, ancillary charges, etc.). NOTE: The DRG Pricing Calculator will change with each fiscal year, so you will need to ensure that you are using the appropriate calculator by admission date.

94. Since Public Hospitals are not required to use the APR-DRG pricing, do they use their CMAC rate for calculations?

Designated public hospitals are exempt from DRGs in fee-for-service and non-designated public hospitals transitioned to DRGs on January 1, 2014. However, all out-of-network hospitals are paid by DRGs for emergency and post-stabilization services. The DRG statewide base rate for these hospitals is available in the Hospital Characteristics File on the DHCS DRG webpage.

95. What is the basic goal of the DRG? Was it budget neutral in aggregate and related to individual hospitals or just the former? How could it impact us from a contracting standpoint?

The basic goals of the DRG methodology are to encourage access to care, reward efficiency, improve transparency, and improve fairness by paying similarly across hospitals for similar care. Implementation of DRGs is budget neutral in aggregate and not by individual hospital. The state's budget neutral requirement in fee-for-service was to ensure that payment for hospital services in 2013-14 was not below 2012-13 levels. The DRG methodology is replacing per diem rates in fee-for-service and the per diem Roger's rates. Because this is a change to a methodology that is not generally used by the MCPs today, it is unclear how it might affect contracting.

Appeal Process

96. If initially we bill a claim electronically with 25 diagnosis codes but then we have to send an appeal in paper form, will the diagnosis codes not included on the paper appeal affect the APR-DRG due to not having all the original diagnosis codes?

The paper claim form submitted with the Appeal will not be able to carry all 25 diagnosis codes. In this case, we would encourage providers to request a void through CIF or Appeal and then once the void goes through resubmit the claim electronically. However, the void and resubmission would have to take place within six months from the month of service.

97. The APR DRG Calculator instructions indicates that in cases of difference in the APR-DRG assignment, the claims processing system should be considered correct. Is there a process to appeal the APR-DRG assignment if the provider still believes they are correct?

Our experience to date is that all DRG assignment discrepancies are resolved once grouper settings and diagnosis, procedure, and patient information are verified for consistency. If diagnosis or procedure codes were omitted from the initial claim, the hospital can rebill and no appeal is needed to add the full set of codes. Please contact the DRG inbox if you need assistance with grouper settings or continue to see discrepancies after verifying the grouper settings and information on the claim form.

98. What impact will DRG payments have on CIF and technical appeal process?

There is an appeals process hospitals currently utilize; this process will not change under DRG methodology.

Other Questions

99. Which CA hospitals rates have not been adjusted with regard to Medi-Cal DRGs? The State indicated there is a phase in period and some hospitals may have rates higher than their State contracted rate.

Hospitals may be receiving hospital-specific rates for three years. These rates are intended to limit the financial impact to the hospital to less than an estimated 5% in year one, 10% in year two and 15% in year three. For hospitals that met certain criteria, their base rate effective year one is equal to the statewide base rate adjusted for their wage area value. The statewide rates are currently available within the Hospital Characteristics File on the DRG web page. This is the rate all hospitals will receive in year four and the rate used to price out-of-network admissions for emergency and post-stabilization acute care services. Please note that this rate can vary by hospital for two potential reasons: (1) differences in the Medicare wage index value and (2) if the hospital qualifies as Remote Rural. hospital. The statewide rate was updated on July 1, 2014.

100. What determines the casemix?

Casemix refers to the type or mix of patients treated at a hospital and is used in developing the relative weights of DRGs. Casemix values are calculated from the National Inpatient Sample by 3M Health Information Systems for APR-DRG v.29

101. Does the length of stay impact pricing? If not, is it necessary to recalculate based on unauthorized days?

Under DRG payment, if an admission TAR is approved for beneficiaries with a full scope aid code, the whole stay is approved. The only scenario in which length of stay will impact pricing is if the patient was transferred and the length of stay at the transferring hospital was less than the national average.

102. What is out-of-state base rate?

\$6,223.00 for admissions on or after July 1, 2013 – June 30, 2014 and \$6,289.00 for admissions on or after July 1, 2014 – June 30, 2015. Out of state hospitals will utilize a cost to charge ratio of 22% and a wage index factor of 1.00.

103. How will the doctor payments be affected for inpatient stays?

For physicians at previously contracted hospitals that were not allowed to separately bill, this restriction will no longer be for physicians that are not employed by the hospital. Otherwise physician payments do not change under DRGs.

104. Would the 3-day rule that Medicare has also apply to APR-DRGs?

No. In addition, there is no change to the definition of the current outpatient payment window. Any outpatient services on the day of admission cannot be billed separately.

105. Will observation stay status be recognized with the new DRG system?

Observation is a Medicare outpatient status. Medi-Cal does not recognize Observation status. Medi-Cal recognizes a beneficiary as being acute, outpatient or at a lower level of care (Admin Level 1 or 2). DRG payment only applies to acute inpatient care.

106. Are there any charges that will not be considered for an outlier payment, i.e., nitric oxide?

All Medi-Cal allowable services rendered during an inpatient stay should be submitted for payment on the claim form associated with the stay.

107. Is there a different methodology for DRG exempt facilities?

Inpatient services provided by designated public hospitals are exempt from DRG reimbursement methodology. These hospitals will receive reimbursement based on Certified Public Expenditures (CPE). Non-designated public hospitals transitioned to DRGs on January 1, 2014.

108. Why are designated public hospitals (DPHs) excluded from APR-DRG reimbursement for Medi-Cal FFS, but not from Medi-Cal Managed Care plan reimbursement for out-of-network emergency admission?

DPHs are exempt from DRG reimbursement as they are reimbursed via certified public expenditures. The out-of-network emergency admissions must now follow DRG reimbursement as there is no longer an average rate as issued by the previous methodology under the Selective Provider Contracting Program of which the roger rates were based.

FOR MORE INFORMATION:

Visit our webpage: <http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx>

- Questions: For policy related questions, please email the DRG mailbox at DRG@dhcs.ca.gov.

- DRG listserve: To subscribe to the DRG listserve, email DRG@dhcs.ca.gov
- Hospital provider manual: The hospital provider manual was updated to show billing details for the DRG based payment method and is available on the DHCS webpage in its existing location.
- Recorded trainings. Providers may access recorded trainings on the Xerox Provider training site (login, then go to Training > Recorded Webinars) or follow this link for the latest sessions:

https://learn.medical.ca.gov/_ngcdfvw/diagnosis_related_group_overview_recorded_webinar.aspx