

Medi-Cal DRG Project

Frequently Asked Questions

Please note that changes remain possible before the implementation date.

Changes have been made since the March 1, 2013 version was published on the DHCS webpage.

OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project?

As directed by the California legislature, the Department of Health Care Services (DHCS) will implement a new method of paying for hospital inpatient services in the fee-for-service (FFS) Medi-Cal program. This FAQ document is intended to provide interested parties with periodic updates on the project.

2. How are hospitals currently paid?

Since 1983, hospitals have been paid under the Selective Provider Contracting Program (SPCP). “Contracted” hospitals negotiate a per diem payment rate with the State (previously, the California Medical Assistance Commission, currently DHCS). Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. (Note: designated and non-designated public hospitals have separate payment methods.)

3. What change is being made?

The California Legislature directed the Department to replace the current reimbursement methodology for hospital acute care inpatient services (both negotiated contract rates and non-contract cost reimbursement) with payment by diagnosis related group (DRG). This would eliminate the current contract and non-contract status designation once payments are based upon DRGs. The reference is to Senate Bill 853, passed in October 2010, which added Section 14105.28 to the California Welfare and Institutions Code.

4. What is the timeframe?

A workgroup of staff from DHCS and other state agencies developed the new method, in consultation with a group of hospital managers and other stakeholders convened by the California Hospital Association (CHA). The consultation workgroup finished its work in February 2012. The original target date to implement DRG payment was July 1, 2012; as part of the 2012 Budget Act, implementation is now set for July 1, 2013.

5. Will there be a transition period?

Yes. The DRG-based payment method will be phased in over a three-year period with the changes fully implemented in the fourth year, similar to what Medicare does with major payment changes. Claims will be paid using the DRG payment method, but some hospitals will see transition DRG base prices higher or lower than they would have been without the transition. In the first year of the transition, the intention is that average payments per stay for an individual hospital will increase or decrease by no more than 5% relative to what they otherwise would have been. In the second year, the range would widen to plus or minus 10% and in the third year to 15%. Full implementation at the statewide base price will occur in year four.

Some hospitals did not receive a transition base price, but instead received the statewide base price. Hospitals received the statewide base rate if any of the following criteria were met: 1) Estimated impact (up or down) of DRG payment of less than 5%; 2) Estimated impact (up or down) of DRG payment less than \$50,000; 3) Fewer than 100 Medi-Cal FFS stays and these stays were estimated to represent less than 2% of the hospital's inpatient volume; 4) No stays in the simulation dataset.

At the end of January 2013, year 1 individual hospital base prices were distributed. Estimates of years 2 and 3 base prices will be released by July 2013.

6. How much money will be affected?

In FY 2009, approximately \$4.5 billion was paid to hospitals for FFS inpatient acute care. Of that, approximately \$1 billion was paid to designated public hospitals that are outside the scope of the DRG payment method. Non-designated public hospitals, which will be included in DRG payment starting January 1, 2014, received approximately \$175 million in 2009. Another significant portion—estimated at \$800 million—was paid for services to beneficiaries who likely will be enrolled in managed care by 2013. Total payments to be made by DRG were trended forward to 2012-13 levels and adjusted for the total number of people in Medi-Cal fee-for-service and for legislative appropriations. It is expected that legislative appropriations will be frozen at 2012-13 levels.

7. How will payments change in the future?

The Department plans to do an annual review of what changes, if any, in DRG base prices would be appropriate. However, it is expected that legislative appropriations will initially freeze the statewide base price at the July 1, 2013 level. The combination of base prices, the number of stays, the average casemix per stay, and the service-specific and age-specific policy adjusters will determine the overall level of payments.

In the first year of DRG payment, as the Department and the hospitals gain experience with the new method, it is possible that the Department will make adjustments if it becomes clear that the initial values were set too low or too high. If at all possible, any adjustments would be made on a go-forward basis. DHCS intends to avoid making retroactive adjustments.

8. What providers will be affected?

The new method will apply to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals are outside the scope of the change to a DRG based payment system. These facilities will continue to be paid as they are today. With regard to rehabilitation hospitals and services, please see Question 36. Non-designated Public Hospitals will transition to DRG reimbursement starting with admissions beginning on or after January 1, 2014. For providers excluded from the DRG payment method, payment calculations and treatment authorization requirements will be determined subject to those methodologies.

9. What services will be affected?

For affected hospitals, the new DRG method will apply to all inpatient hospital fee-for-service claims except the following:

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Physical rehabilitation stays (see Question 36)
- Managed care stays (see Question 11)

- Administrative days (see Question 37)
- Other services as may be determined by DHCS (none are currently proposed)

10. Will DRGs affect CCS and GHPP patients? Will DRGs affect Healthy Families patients?

Claims for beneficiaries who have eligibility under the California Children’s Services (CCS) or the Genetically Handicapped Person Program (GHPP) will be priced using the new DRG method. This is true for all CCS or GHPP beneficiaries regardless of whether they also have Medi-Cal or Healthy Families coverage.

Claims for inpatient services for a Healthy Families subscriber with a CCS eligible condition that are not authorized by CCS to treat the CCS client’s CCS eligible condition are the responsibility of the Healthy Families Health Plan and are not paid by DRGs.

11. Will the change affect payments by Medi-Cal managed care plans?

The primary impact to Medi-Cal managed care plans (MCPs) relates to payment for emergency and post-stabilization inpatient services provided to MCP enrollees by general acute care hospitals which are not part of the MCP’s contracted provider network. MCPs are responsible to calculate out-of-network rates consistent with DRG pricing utilized in Medi-Cal fee-for-service inpatient acute care reimbursement. Consistent with current policy, MCPs may negotiate a different payment amount with out-of-network hospitals. This new method does not impact contracts with network hospitals or arrangements for elective admissions to out-of-network hospitals. An All Plan Letter 2/12/13 was mailed to MCPs and posted to the DHCS DRG webpage which provides more detailed information regarding MCPs and payment for emergency and post stabilization inpatient services provided to MCP enrollees by out-of-network facilities.

DRG PAYMENT

12. How do DRG payment methods work?

In general, every complete inpatient stay is assigned to a single diagnosis related group (DRG) using a computerized algorithm that takes into account the patient’s diagnoses, age, procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient. For example, if a DRG has a relative weight of 0.50 then that patient is expected to be about half as expensive as the average patient.

The DRG relative weight is multiplied by a DRG base price to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base price is \$8,000, then the payment rate for that DRG is \$4,000.

13. Who uses DRG payment?

The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Many hospitals in the U.S. use DRGs for internal management purposes.

14. What are the characteristics of DRG payment?

- DRG payment defines “the product of a hospital,” thereby enabling greater understanding of the services being provided and purchased.

- Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.
- Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.
- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers, policymakers and hospitals better information about services provided.

15. What other payment policies are typically included in DRG payment methods?

For approximately 80% of stays, it is likely that payment will be made using a “straight DRG” calculation—that is, payment will equal the DRG relative weight times the DRG base price, as described in Question 12. In special situations, payment may also include other adjustments, for example:

- *Transfer pricing adjustment.* Payment may be reduced when the patient is transferred to another acute care hospital.
- *Cost outlier adjustment.* Medicare and other DRG payers typically make additional “outlier” payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Nationally, outlier adjustments typically affect 1% to 2% of all stays and a higher percentage of all DRG payments. Medi-Cal will employ a two-tier outlier policy to provide higher payment for the most costly stays.
- *“Lesser Of”.* Payment cannot exceed charges. If the allowed amount exceeds charges, payment will be reduced to charges. This is consistent with current policy, which is not impacted by a change in payment method.
- *Other health coverage and patient cost-sharing.* The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct payments from other health coverage (e.g., workers’ compensation) as well as the patient’s share of cost. No changes are planned to current Medi-Cal policies or procedures on other health coverage or share of cost.

16. How will the DRG be assigned?

DHCS acquired the 3M™ All Patient Refined Diagnosis Related Groups (APR-DRGs), Version 29, and will use it to assign the DRGs to claims. Hospitals who would like more detail on use of the APR-DRG grouper can refer to question 48.

17. Where do the DRG relative weights come from?

DHCS will use APR-DRG relative weights calculated from the Nationwide Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal fee-for-service data. The national weights are updated annually by 3M Health Information Systems.

18. What will be the DRG base price?

The final rates for 2013-14 were released at the end of January 2013. Medi-Cal uses wage areas to adjust the hospital-specific base price, in much the same way as Medicare does. In addition, in order to facilitate access to beneficiaries living in remote rural areas, there are higher base prices for these hospitals as defined by DHCS.

19. How will transfers be paid?

Medi-Cal will follow the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital would be paid the lesser of:

- The DRG base payment
- A per diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per diem amount would be the DRG base payment divided by the DRG-specific average length of stay.

The effect would be to reduce the DRG base payment if the actual length of stay at the transferring hospital is less than overall average length of stay minus one day. The receiving hospital would receive the full DRG payment. Medi-Cal would define a transfer as UB-04 discharge status values 02, 05, 65, and 66. Medi-Cal, unlike Medicare, would not have a post-acute transfer policy.

20. How would the hospital indicate a situation of partial eligibility?

A situation of partial eligibility during a hospital stay is not affected by DRG payment. Hospitals should bill for the portion of a stay that is eligible for Medi-Cal.

21. How will interim claims be paid?

Interim claims will be accepted for stays that exceed 29 days. In these situations, the hospital will be paid a per diem amount (\$600). When the patient is discharged, the hospital will submit a single, admit-through-discharge claim. Hospitals are not to send void claims. Final payment will be calculated by the DRG method and then will be reduced by the interim claim amounts that were previously submitted. Payment of interim claims is unusual among DRG payers but is being put in place to help ensure access to care for sick newborns and other patients with unusually lengthy stays. Payment of interim claims requires an approved admission TAR/SAR.

22. How is payment made for the most expensive patients?

DHCS will utilize a two tiered outlier policy and a two tiered neonatal intensive care unit (NICU) policy adjustor to provide additional payment for the most costly patients. A DRG Pricing Calculator interactive spreadsheet, which shows the mechanics of these calculations, is posted on the DHCS DRG webpage.

23. How have decisions been made about the new payment method?

A baseline dataset was created using actual data extracted from the CA-MMIS Medi-Cal claims payment system. This data was matched to Office of Statewide Health Planning and Development (OSHPD) data to increase the number of diagnosis and procedure codes available for DRG pricing. 2009 paid claims were selected by discharge date, interim claims were chained together, and many other claim validation and improvement techniques were used to create a baseline dataset for analysis. DRGs were assigned to the dataset using V.29 of the 3M™ APR-DRG grouper software. This dataset has been used to simulate results by applying policy adjustors, age adjustors, outlier limits, etc.

Using this process, DHCS modeled the impact of policy decisions on claims data overall and by hospital. These results were shared within the CHA consultation group.

ALL PATIENT REFINED DRGs

24. Why were APR-DRGs chosen? Why not the same DRG algorithm as Medicare uses?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal, pediatric and obstetric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

MS-DRGs—the algorithm now used by Medicare—were designed for a Medicare population using only Medicare claims. In Medicare, less than 1% of stays are for obstetrics, pediatrics, and newborn care. In the Medi-Cal fee-for-service population, these categories represent about two-thirds of all stays.

25. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M and the Children’s Hospital Association (formerly the National Association of Children’s Hospitals and Related Institutions (NACHRI)). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are state “report cards” such as www.floridahealthfinder.gov and analysis done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

APR-DRGs are also in use or planned for use in calculating payment by the State of Maryland; Medicaid programs in Colorado, Florida, Illinois, Mississippi, Montana, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Washington, D.C.; and Wellmark, the BlueCross BlueShield plan in Iowa.

26. In order to be paid, would my hospital need to buy APR-DRG software?

No. The Medi-Cal claims processing system will assign the APR-DRG to the claim and calculate the payment.

27. What version of APR-DRGs will be implemented?

The Department intends to implement Version 29 (V.29) of APR-DRGs, which was released October 1, 2011. Version 30 was released October 1, 2012, but the Department plans to implement V.29 because all policy decisions and impact simulations are being done using V.29. Version 29 will accept all diagnosis and procedure codes effective in 2013-14. Version 30 of the health-care acquired conditions utility is being used because it includes the conditions added by CMS effective October 1, 2012.

28. What is the APR-DRG format?

Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG. Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2. Unlike MS-DRGs, there is no universal list of complications and comorbidities. For hospitals that choose to acquire APR-DRG software, staff should note that the software outputs the base APR-DRG and the severity of illness as two different fields. Medi-Cal would concatenate these fields for purposes of calculating payment. The APR-DRG is therefore four bytes (ignoring the hyphen), in contrast to the three-byte MS-DRG field.

CODING AND BILLING

29. Would the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction?

No. DHCS will assign the APR-DRG based on the diagnoses, procedures, patient age, and patient discharge status as submitted by the hospital on the claim. The UB-04 field for “PPS Code” (Form Locator 71) is not read by the Medi-Cal claims processing system. The PPS Code field is used when, for example, the hospital needs to advise a commercial insurer of the DRG for a stay. This situation would not apply to Medi-Cal.

30. How many diagnoses and procedures will be used in DRG assignment? Why is this important?

Currently, the California claims processing system (CA-MMIS) stores two diagnoses and two procedure codes. Enhancements will be made to the system to accept as many as 25 diagnosis codes and 25 procedure codes for electronic claims (18 diagnosis codes and 6 procedure codes for paper claims). Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate base APR-DRG and patient severity of illness (SOI) are assigned. This will ensure accurate capture of patient acuity. Each four-digit APR-DRG has an assigned relative weight. This relative weight directly affects payment. The DRG Pricing Calculator spreadsheet, posted to the DHCS webpage, contains the list of APR-DRG relative weights.

Although claims will continue to be paid based on the current methodology through June 30, 2013, we encourage hospitals to begin including all diagnoses and procedure codes on their claims as soon as possible to ensure they are prepared for the July 1, 2013, transition.

31. How will ICD-10 affect the DRG payment method?

When ICD-10 is implemented nationwide, the Medi-Cal claims processing system will accept ICD-10 diagnosis and procedure codes and will utilize ICD-10 codes for internal processing. Hospitals should follow national guidelines in submitting ICD-10 codes to Medi-Cal. The ICD-10 implementation date has been delayed from October 1, 2013, until October 1, 2014.

32. Will the present-on-admission indicator be used?

Yes. Hospitals are required to include the present-on-admission (POA) indicator associated with the principal and secondary diagnosis codes when submitting paper and electronic claims. Hospitals should submit valid values of the POA indicator. The claims processing system will be enhanced to accept, edit and store these values, which will be used in identifying health care-acquired conditions (Question 45).

For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, please see the ICD-9-CM Official Guidelines for Coding and Reporting at <http://www.cdc.gov/nchs/icd/icd9cm.htm>.

33. Will outpatient services related to the inpatient stay be bundled?

In general, there will be no change to the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission). One exception is that under the current SPCP, a few hospitals can bill for a short list of specialized, high-cost services (e.g., blood factors) on an outpatient claim even when provided on an inpatient basis. Once the new payment system is implemented, all hospitals will be able to bill the following items in Table 1 on an outpatient claim for separate payment.

Table 1 Specialized Services that can be Billed on an Outpatient Claim	
Bone Marrow Search and Acquisition Costs	
Management of recipient hematopoietic progenitor cell donor search and cell acquisition	38204
Unrelated bone marrow donor	38204
Blood Factors	
Blood Factor XIII	J7180
Blood Factor Von Willebrand- Injection	J7183 / J7184 / Q2041
Blood Factor VIII	J7185 / J7190 / J7192
Blood Factor VIII/Von Willebrand	J7186
Blood Factor Von Willebrand	J7187
Blood Factor VIIa	J7189
Blood Factor IX	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197
Blood Factor Antiinhibitor	J7198

34. How does this affect contracted SPCP rates that bundled the physician component of hospital services with the hospital component?

The physician component will become separately billable on a professional (e.g., CMS-1500) claim. This situation only affects a few hospitals that previously had negotiated bundled physician/hospital payments for specific services.

35. Will there be changes in billing requirements?

Yes, there will be some changes in billing requirements and business practices; see Table 2. Hospitals should wait for official notification from DHCS before making any changes in claims submission.

Table 2 Expected Impacts on Hospital Billing and Operations (Listed in approximate declining order of impact)	
Item	Comment
Payment is per stay	Payment is no longer per day. APR-DRG makes one payment for the hospital stay.
Treatment Authorization Request process	TAR/SAR no longer required on length of stay for the vast majority of days. SAR is specific to CCS and GHPP recipients.
Increased importance of diagnosis and procedure coding	Assignment of base APR-DRG and level of severity is driven by the number, nature and interaction of diagnoses and comorbidities as well as procedure codes. Refer to Question 30.
Mother and newborn to be billed on separate claims	Separate payment will be made for each stay.
Newborns with long lengths of stay and multiple claims must be billed with the same Medicaid number on each claim, preferably the baby's number.	Because payment will be by stay, submission of the mother's beneficiary number on some claims and the baby's beneficiary number on other claims would be problematic.
Newborn weight should be coded using diagnosis codes (not value codes) when applicable. This is important as birthweight is a critical indicator of care.	ICD-9-CM classification uses the 5 th digit to indicate birth weight for diagnoses 764 and 765.0-765.1.
Interim bill types 112, 113, and discharge status 30 only accepted for stays exceeding 29 days. Interim bill type 114 not accepted.	When the patient is discharged, a single admit-through-discharge claim should be submitted. Refer to Question 21. For newborn claims, please be sure to consistently use the mother's or baby's beneficiary identification number for all claims related to a single stay.
Split billing a hospital stay	This specifically applies only to paper claims that are submitted on more than one page. Each page of the claim must show all diagnosis and procedure codes. The provider number, the beneficiary identification number, the dates of admission, and all diagnosis and procedure codes should be the same on all pages.
Administrative days	Administrative days must be billed on a separate claim, identified by revenue code. A new Level 2 administrative day will be created to pay more than the existing Level 1 administrative day for sub-acute patients who require more care than Level 1. Refer to Question 37.

Table 2 Expected Impacts on Hospital Billing and Operations (Listed in approximate declining order of impact)	
Item	Comment
Four-byte APR-DRG code	Impact depends on how the hospital's billing system is configured. An APR-DRG has three-bytes for the base DRG and 1 byte for level of severity without the hyphen (format 1234 for DRG 123-4).
Physical rehabilitation stays	Physical rehabilitation days to be billed on separate claim, identified by revenue code. Payment will be per diem.
Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes).
Separately payable services, supplies and devices	In the few situations where separate payment is allowed, a separate outpatient claim should be submitted for bone marrow search and acquisition as well as blood factors. Refer to Question 33.
Late charges (bill type 115) not accepted	Submit a claim adjustment instead.
Health care-acquired conditions (HCACs)	Payment may be reduced if a HCAC is present on the claim. HCACs are also known as provider preventable conditions or PPCs under this federally required payment policy.
Physician services bundled into SPCP per diem rates	For some hospitals, specific physician services (e.g., laboratory and pathology) were bundled into the inpatient hospital per diem. This will no longer apply. All physician services should be billed as professional claims (i.e., CMS-1500, 837P). Refer to Question 34.
Transfers from non-contract hospitals	All HFPAs will be considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for both emergency and elective services (subject to approved Treatment Authorization Requests). Hospitals will no longer be required to transfer patients based on their previous non-contract designation in closed Health Facility Planning Areas (HFPAs). Contract or non-contract facility designations will not apply under the DRG payment method.
<i>Note:</i> These impacts are anticipated as of July 2013, but hospitals should wait for official notification from DHCS before making any changes in claims submission.	

OTHER QUESTIONS

36. What impact will there be on physical rehabilitation care?

Physical rehabilitation services—either within a general acute care hospital or a specialty rehabilitation facility—are currently paid under the SPCP, that is, at a negotiated hospital-specific per diem rate or, for noncontract hospitals, at 100% of allowable cost. Rehabilitation services will not be priced by DRG. Instead, DHCS has established per diem rates for each hospital. Each hospital will have a specific rate based on its historical blend of pediatric and adult days using statewide rates of \$1,841 (pediatric) and \$1,032 (adult), adjusted for the hospital's Medicare wage area. Hospital-specific rates are available on the DRG webpage in the hospital-specific characteristics document.

Rehabilitation services will be identified by claims that include revenue codes 118, 128, 138, or 158. For hospital stays without these revenue codes that group to the rehabilitation DRG (860), the claim will be denied and the hospital will need to resubmit with the appropriate revenue codes or primary diagnosis (if rehabilitation was incorrectly listed as the primary diagnosis on the original claim). No claims will be priced using DRG code 860. Daily treatment authorization requests (TAR) will be required for rehabilitation services.

37. What impact will there be on administrative days?

Under the existing payment method, which will continue as is, administrative days were approved through the TAR/SAR process and paid at a lesser of the average statewide per diem equivalent to the cost of DP-SNF services or the hospital's actual DP-SNF cost. Generally, administrative days are defined as days of service provided to beneficiaries who no longer require acute hospital care, but need nursing home placement or other subacute or post-acute care that is not available at the time. With the transition to a new payment method the Department is implementing two levels of administrative days.

Administrative Days – Level 1: These would be days which are paid under the existing system and will continue to be treated the same under the new policy. These days will continue to require a daily TAR, be billed and paid under the existing methodology, and continue to be billed using revenue code 169.

Administrative Days – Level 2: This is a new level, similar to Level 1, except at a higher rate for higher acuity patients. Administrative day level 2 care is defined as care that is less intensive than acute care, and more intensive than the existing administrative day care, which is referred to as administrative day level 1.

Administrative day level 2 revenue codes 190 (sub-acute pediatric) and 199 (sub-acute adult) will be available for payment only to DRG hospitals. The pediatric level should be used when the age of the beneficiary is less than 21 years old. Revenue codes 190 and 199 will be added to the provider master file. Administrative day level 2 will require a TAR and will require submission of a separate claim. Payment for administrative day level 2 will be the lower of the hospital-specific rate already established and statewide rate. The statewide per diem rates are pediatric– \$895.60 and adult– \$896.67. Payment will work the same as revenue code 169 relative to bundling policies and separate payment for ancillary services. The previous list of separately payable services that can be billed in conjunction with administrative days is unchanged.

38. What impact will there be on billing for CCS patients?

As mentioned in question 10, claims for beneficiaries under CCS will be priced using the new DRG method. Most CCS patients also have Medi-Cal coverage. Billing and TAR have been streamlined for these patients; Separate claims and authorizations for the CCS and Medi-Cal parts of the stay are no longer required if the beneficiary has Medi-Cal fee-for-service. Only one claim should be submitted and only one admission SAR should be requested for a CCS client, including clients with limited scope Medi-Cal, i.e., pregnancy related and emergency services only. One DRG payment will be made for the stay.

For a CCS client enrolled in a Medi-Cal managed care plan with “carved-out” CCS services, CCS will authorize inpatient admissions for the treatment of the client’s CCS eligible condition. Such services billed pursuant to a CCS SAR will be paid by DRGs. Payment for all inpatient services for a CCS client enrolled in a Medi-Cal managed care plan with “carved-in” CCS services, i.e., the County Organized Health System health plans in San Mateo, Santa Barbara, Solano, Yolo, Marin and Napa counties, will be the responsibility of the health plan.

39. What changes, if any, will be made to supplemental payments?

Medi-Cal has several programs under which it makes supplementary payments to hospitals, e.g., disproportionate share hospital replacement payments, hospital fee payments, and private hospital supplemental fund payments. These payments are unaffected by the transition to DRG payment.

40. How will this affect the overall payment level?

The change to DRGs is a change in payment method, not payment level. The overall payment level will continue to be determined each year through the legislative appropriation process. The statute that required DRG implementation also required that implementation be budget-neutral in aggregate.

It is expected that legislative appropriations will be frozen at 2012-13 levels. Future increases will be subject to legislative appropriations.

41. How will the change affect funding to each hospital?

Because there will be a major change in the payment method, some hospitals will see decreases in payments while other hospitals will see increases. There will be a transition period of three years; see Question 5. In January 2013, DHCS distributed estimated impacts of the change to each hospital, while maintaining the confidentiality of previous hospital-specific payment levels under the SPCP.

42. Will payments be subject to adjustment after cost reports have been submitted?

No, payments will not be subject to adjustment after cost reports have been submitted except for limited circumstances, as cost-settlement will no longer occur. The focus of audits will change upon implementation of the new payment system. The Department may audit stays that receive an outlier payment among other items that could be subject to adjustment.

43. Will hospitals still have to submit cost reports?

Yes. The Department will continue to utilize cost reports for a variety of reasons, including calculation of hospital utilization fees and review of hospital payments overall.

44. Will there be changes to the Treatment Authorization Request (TAR) or the Service Authorization Request (SAR) Process?

Yes. Simplification of the TAR/SAR process will be a major benefit of DRG payment. Note: SAR is specific to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) recipients.

For stays paid by DRG, the expected TAR/SAR process would be as follows:

- Continuation of the current TAR/SAR requirements on the medical necessity of the admission, including CCS and GHPP admissions. That is, authorization would be required for all admissions except for those involving a delivery and for well baby hospital stays.
- Discontinuation in almost all cases of the current TAR/SAR requirement on the length of stay. However, beneficiaries with restricted aid codes who have an admission that does not involve a delivery or well baby care will continue to require a TAR with review of all hospital days. (For beneficiaries with restricted aid codes, this is a continuation of the current process.)
- Continuation of the current TAR requirement for a short list of specific procedures for all beneficiaries.
- Prior to submission of an interim claim, please submit a TAR/SAR for approval. Payment of interim claims requires an approved admission TAR/SAR.
- Either a SAR or TAR is required if a patient has a stay that is covered by CCS and Medi-Cal. See question 38.

For stays not paid by DRG:

- Current TAR requirements on both the admission and the length of stay would continue as they are today for administrative days and rehabilitation (see Questions 36 and 37).
- Designated public hospitals and non-designated public hospitals will follow their current process.

45. How will payment be affected if a hospital-acquired condition is present on the claim?

Medicaid programs nationwide are required by federal law to demonstrate that they are not paying for “health care-acquired conditions (HCACs),” as defined specifically by CMS. The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with.

Based on an analysis of data from Medi-Cal, Medicare and other states, we expect payment to be reduced on less than 1% of stays. (This figure could change if CMS expands the list of HCACs.)

The Medi-Cal claims processing system would identify HCACs from the diagnosis, procedure and present-on-admission information on the claim and disregard the HCAC in assigning the APR-DRG. Payment for the stay would therefore be affected only if the presence of the HCAC would otherwise have pushed the stay into a higher-paying APR-DRG.

46. What is the relationship between DRG payments and hearing or other screenings hospitals are required to perform on all newborns?

DRG payments replace baseline Medi-Cal reimbursement for hospital services; negotiated per diem payments for contract hospitals and cost-based reimbursement for non-contract hospitals. The transition to DRG reimbursement does not change any existing health screening requirements for newborns.

47. What is the correct billing procedure for an obstetric and child birth stay where the mother is admitted before July 1, 2013 and the baby is born on or after July 1, 2013?

Under DRGs, hospitals submit separate claims for the mom and baby. In this scenario, the hospital will be reimbursed for the mom’s hospital admission under the current methodology because the admission was before July 1, 2013. For admissions on and after July 1, 2013, the hospital must submit a separate claim for the baby and the mom. The baby’s claim with admission date on or after July 1, 2013 will be paid by DRG. If a baby is born in your hospital, the date of birth is the date of admission.

48. For hospitals that are interested in using the APR-DRG grouper, what are some key grouper software settings used by Medi-Cal?

Please see Table 3 for common APR-DRG V.29 grouper settings used by the Department of Health Care Services (DHCS) for reimbursement of general acute care inpatient services to Medi-Cal beneficiaries at DRG designated hospitals. This information is provided specifically for hospitals that have the grouper and HAC Utility software and need the settings used by DHCS to generate the APR-DRG assignment. Hospitals do not need this information in order to submit claims to Medi-Cal; this is only for hospitals who want to understand the APR-DRG grouper settings in order to assign the APR-DRG to each claim similar to the Medi-Cal claims processing system.

Table 3 Selected Grouper Settings for Medi-Cal		
Grouper Field	Setting	Comments
APR-DRG Grouper Settings		
Grouper Version	V.29	On July, 1, 2013, Medi-Cal will implement V.29 of the APR-DRG grouper (released by 3M October 1, 2011).
Mapping Type	Historical	APR-DRG V.29 was released October 1, 2011, reflecting the ICD-9-CM diagnosis and procedure code set that was used between October 1, 2011 and September 30, 2012. Because the ICD-9-CM code set in use today differs slightly from that code set, a “mapper” utility is used to map current ICD-9-CM code values to values in effect between October 1, 2011 and September 30, 2012. Between October 1, 2011, and October 1, 2012, the only change to the national ICD-9-CM codeset was the addition of one procedure code. Few if any changes are expected on October 1, 2013.
Birthweight Option	Option 5	Medi-Cal will read the diagnosis codes (not the value codes) to identify birthweight and/or gestational age if coded using appropriate diagnosis codes on the claim. If the claim does not include a diagnosis

Table 3 Selected Grouper Settings for Medi-Cal		
Grouper Field	Setting	Comments
		code indicating birthweight or gestational age, then the default is "normal newborn."
Discharge DRG Option	Compute admission DRG/Discharge DRG	Excluding non-POA Complication of Care (default) is used.
Hospital-Acquired Condition (HAC) Utility Settings		
HAC Version	V.30	On July 1, 2013, Medi-Cal will implement V.30 of the HAC utility (released by 3M October 1, 2012).
Agency Indicator	CMS Medicaid	The HAC category for deep vein thrombosis/pulmonary embolism (DVT/PE) refers to pediatric age. The HAC utility implemented by Medi-Cal July 1, 2013, will define pediatric as under age 18. However, because Medi-Cal policy is to define pediatric as under age 21, the utility will be updated after July 1 st to include a new agency indicator of California Medicaid that will reflect the definition of pediatric as under age 21. In the months following APR-DRG implementation, Medi-Cal will monitor the application of HAC category (DVT/PE) through post payment audit and review of HAC adjusted claims with the goal of ensuring that the HAC rule is applied appropriately. If DHCS finds that the rule for the DVT/PE HAC category is applied inconsistent with policy, the appropriate action will be taken to ensure correct claims adjudication and payment.
Suppress HAC Categories	No HAC suppression is needed	If a beneficiary is a pregnant woman or of pediatric age (see above), no HAC payment reduction will be applied to the claim for HAC category Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE).
POA Indicators		For the present-on-admission (POA) diagnosis fields, no POA value (blank) is acceptable for exempt diagnosis codes. POA values W (clinically undetermined) and U (documentation insufficient) are treated in the claims processing system the same as value N (not present on admission).

49. Where can I go for more information?

The DHCS webpage is the source for information on the DRG payment method. Key resources can be accessed on the webpage is available at <http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx>. Resources include:

- *FAQ*. Updates of this *Frequently Asked Questions* will be made available as changes are needed. In addition, DHCS has compiled an additional FAQ specific to billing and TAR/SAR issues from the questions asked during the provider training sessions.
- *PDD*. The Policy Design Document (PDD) provides more detail on the change in payment methodology to APR-DRG.
- *DRG Pricing Calculator*. The DRG Pricing Calculator interactive spreadsheet will not assign the APR-DRG but it will show how a given APR-DRG will be priced in different circumstances. The calculator includes a complete list of APR-DRGs and related information for use in California.
- *Hospital training sessions*. Hospital trainings will be held across the state in early 2013. Several hospital training sessions have been held in 2012 and February 2013. Additional sessions will be scheduled as necessary. Access the DHCS webpage for details on future sessions.
- *Provider Bulletins*. Provider bulletins contain additional details on specific areas of DRG billing, payment, and TAR/SAR authorizations.

FOR FURTHER INFORMATION:

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

- *Questions*: For questions, please email the DRG mailbox at DRG@dhcs.ca.gov.
- *DRG listserv*: To subscribe to the DRG listserv, email DRG@dhcs.ca.gov

- *Hospital provider manual.* The hospital provider manual will be updated to show billing details for the DRG based payment method and will be 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 directly for the following sessions below:
 - June 2013 Provider training webinar:
https://learn.medi-cal.ca.gov/ngcdfvw/diagnosis_related_group_overview_recorded_webinar.aspx
 - February 2013 Ratesetting Webinar:
https://learn.medi-cal.ca.gov/m07kbnh/diagnosis_related_group_ratesetting_recorded_webinar.aspx