

# Medi-Cal DRG Payment

## Provider Training

### August 2013

W230

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Payment Method Development

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# Topics

- 1. Introduction and Background**
2. DRG Grouping
3. Claims Pricing under DRG Payment
4. Billing, Authorization & Payment Scenarios
5. Financial Impacts
6. Other Impacts
7. Billing Points
8. Provider Education

# First, the Headlines

- Payment by APR-DRG started with dates of admission 7/1/13
  - Authorized by Senate Bill 853 in October 2010
  - NDPHs planned for transition to APR-DRGs as of 1/1/14
- Base Rates to be phased in over four years
- Patients: Medi-Cal fee-for-service, CCS only, GHPP only, not managed care
- Hospitals:
  - Excluded: designated public hospitals, psychiatric hospitals
  - Included: all other general hospitals, including out-of-state, Medicare-designated CAH, Medicare-designated LTAC
- Services: APR-DRGs to be used for almost all care except psych (counties), rehabilitation (per diem), admin days (per diem)
- Major simplification in TAR/SAR requirements
- Important changes in billing (e.g., separate claims for mom and baby claims, limitations on interim claims, requirements for admin/rehab)

## Introduction and Background

# DRG Webpage

- DHCS webpage devoted to APR-DRG information
  - [www.dhcs.ca.gov](http://www.dhcs.ca.gov), “DHCS A-Z Index,” “Diagnosis Related Group” or
  - [www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx)
- Questions to [drg@dhcs.ca.gov](mailto:drg@dhcs.ca.gov)
- Join DRG listserve by emailing [drg@dhcs.ca.gov](mailto:drg@dhcs.ca.gov)



The screenshot shows the header of the California Department of Health Care Services website. The header includes the "CA.GOV" logo, the text "CALIFORNIA DEPARTMENT OF Health Care Services", and a heart icon. Below the header is a navigation menu with links for HOME, SERVICES, INDIVIDUALS, PROVIDERS & PARTNERS, and FORMS. The breadcrumb trail reads: Home > Providers & Partners > **Diagnosis Related Group Hospital Inpatient Payment Methodology**. The main heading of the page is also **Diagnosis Related Group Hospital Inpatient Payment Methodology**.

# Introduction and Background Helpful Documents

## Medi-Cal DRG Project Frequently Asked Questions

Please note that changes remain possible before the implementation date. Changes have been made since the May 3, 2012 version was published on the DHCS website.

### OVERVIEW QUESTIONS

#### 1. What is the Medi-Cal DRG project?

As directed by the California legislature, the Department of Health Care Services (DHCS) is developing a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program. This 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. "Contracted" hospitals negotiate a per diem payment rate with the California Medical Commission. Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. (Note: designated public hospitals have a separate method).

#### 3. What change is being made?

The California Legislature directed the department to replace the current reimbursement method for hospital acute care inpatient services (both negotiated contract rates and non-contract cost) with payment by diagnosis related group (DRG). This would eliminate the current cost-to-charge ratio contract status designation once payments are based upon DRGs. The reference is to a bill 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 of payment 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 date to implement DRG payment was July 1, 2012, as part of the 2012 Budget Act. The new method 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. It will be implemented in the fourth year, similar to what Medicare does with major payment DRGs. It will be paid using the DRG payment method, but some hospitals will see transition DRGs that are lower than they would have been without the transition. In the first year of the transition, that average payments per stay for an individual hospital will increase or decrease relative to what they otherwise would have been. In the second year the range will be plus or minus 10% and in the third year to 15%.

September 14, 2012 Please note that changes remain possible before implementation.

Information	Data	Comments or Formula
<b>Medi-Cal DRG Pricing Calculator</b>		
Note: This calculator does not reflect final decisions on the structure of the Medi-Cal fee-for-service DRG payment method that will be implemented July 1, 2013. Stays for administrative days and rehabilitation services will not be priced via the DRG method.		
Indicates information to be input by the user.		
Indicates payment policy parameters set by Medicaid		
<b>INFORMATION FROM THE HOSPITAL-- TO BE INPUT BY THE USER</b>		
1 Total charges	\$100,000.00	UB-04 Form Locator: 47
2 Hospital-specific cost-to-charge ratio	35.00%	Used to estimate the hospital's cost of this stay
3 Length of stay	41	Used for transfer pricing adjustment
4 Patient discharge status - 02, 05, 65 or 69? (transfer)	No	Used for transfer pricing adjustment
5 Patient age (in years)	15	Used for age adjustor
6 Other health coverage	\$300.00	UB-04 Form Locator: 54 for payments by third parties
7 Patient share of cost	\$300.00	Includes spend-down or copayment
8 Is discharge status equal to 30?	Yes	Indicates an interim claim
9 Designated NICU facility	No	Policy adjustor for designated NICU facilities
10 APR-DRG	001-1	From separate APR-DRG pricing software
<b>APR-DRG INFORMATION</b>		
11 APR-DRG description	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	Look up from DRG table
12 Casemix relative weight--unadjusted	7.0839	Look up from DRG table
13 Service adjustor - hospital with designated NICU	1.0000	Look up from DRG table
14 Service adjustor - all other hospitals	1.0000	Look up from DRG table
15 Age adjustor	1.2500	Look up from DRG table
16 Payment relative weight	8.8549	IF E11<21, then IF (E15="Yes"), then (E19*E20*E22), else (E19*E21*E22), else (E19*E23), then (E19*E23), else (E19*E21)
17 Average length of stay for this APR-DRG	6.93	Look up from DRG table
<b>PAYMENT POLICY PARAMETERS SET BY MEDICAID-- SUBJECT TO CHANGE</b>		
18 DRG base price	\$7,500	Used for DRG base payment--see DRG base price tab
19 Cost outlier threshold 1	\$40,000	Used for cost outlier adjustments
20 Cost outlier threshold 2	\$125,000	Used for cost outlier adjustments
21 Marginal cost percentage_1	60%	Used for cost outlier adjustments
22 Marginal cost percentage_2	80%	Used for cost outlier adjustments
23 Casemix adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00
24 Interim claim threshold	29	Used for pricing interim claims
25 Interim per diem amount	\$600	Used for pricing interim claims
<b>IS THIS AN INTERIM CLAIM?</b>		
26 Is discharge status equal to 30?	Yes	Look up E14
27 Is length of stay > interim claim threshold?	Yes	IF E35="Yes", then IF (E9 > E32), "Yes", else "No", else "N/A"
28 Skip to E65 for final interim claim payment amount	\$24,600.00	IF E36="Yes", (E30*E9) rounded to 2 places, else 0
<b>WHAT IS THE DRG BASE PAYMENT?</b>		
29 DRG base payment for this claim	\$66,411.56	E26*E23*E31
<b>IS A TRANSFER PAYMENT ADJUSTMENT MADE?</b>		
30 Is a transfer adjustment potentially applicable?	No	Look up E10
31 Calculated transfer payment adjustment	N/A	IF E41="Yes", then (E38*E24)/(E9+1) rounded to 2 places, else "N/A"
32 Is transfer payment adjustment < allowed amount so far?	N/A	IF E42="N/A", then "N/A", else IF (E42<E39), then "Yes" else "No"
33 Allowed amount after transfer adjustment	\$66,411.56	IF E43="Yes", then E42, else E39
<b>IS A COST OUTLIER ADJUSTMENT MADE?</b>		
34 Estimated cost of this case	\$35,000.00	E7 * E8
35 Is estimated cost > allowed amount	Gain	IF E46 > E44 then "Loss" else "Gain"
<b>High-Side Outlier Payment When Payment is Much Lower than Cost</b>		
36 Estimated loss on this case	N/A	IF E47 = "Loss", then (E48-E46), else "N/A"
37 Is loss > outlier threshold lower limit	N/A	IF E47 = "Loss", then IF (E48 > E27), then "Yes", else "No", else "N/A"
38 DRG cost outlier payment increase 1	\$0.00	IF E50 = "Yes", then IF (E48<E28), then (E49-E27)*E29, else (E28-E27)*E29, else 0
39 DRG cost outlier payment increase 2	\$0.00	IF E50="Yes", then IF (E49<E28), then (E49-E28)*E30, rounded to 2 places else 0, else 0
<b>Low Side Outlier Payment When Payment is Much Greater than Cost</b>		
40 Estimated gain on this case	\$31,411.56	IF E47="Gain", then (E44-E46), else "N/A"
41 Is gain > outlier threshold	No	IF E47="Gain", then IF (E54<E27), then "Yes", else "No", else "N/A"
42 Calculated transfer payment decrease	\$0.00	IF E47="Gain", then IF (E55="Yes"), then (E54-E27)*E29 rounded to 2 places, else 0
<b>ALLOWED AMOUNT AFTER TRANSFER AND OUTLIER ADJUSTMENTS</b>		
43 DRG payment so far	\$66,411.56	IF E47="Loss", then (E44+E51+E52), else (E44-E56)
<b>CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT</b>		
44 Add-on amount	\$0.00	Hospital-specific payment separate from DRG payment (not used at this time)
45 Allowed amount	\$66,411.56	Allowed amount = E58+E60
46 Other health coverage	\$300.00	E12
47 Patient share of cost	\$300.00	E13
48 "Lesser of" calculation	\$66,411.56	Existing policy ensures that payment amount cannot exceed total charges. IF E61<E7, then E7, else E61
49 Payment amount	\$24,600.00	If interim claim (E35="Yes"), then interim claim (E37) amount as payment amount. Otherwise, subtract other health coverage (E62) and patient share of cost (E63) from "lesser of" (E64) to obtain payment amount.

12/19/2012  
This calculator spreadsheet is intended to be helpful to users, but it cannot capture all the editing and pricing complexity of the Medicaid claims processing system. In cases of difference, the claims processing system is correct.  
CALCULATOR VALUES ARE SUBJECT TO CHANGE BEFORE IMPLEMENTATION JULY 1, 2013.

## Diagnosis Related Group (DRG) Reimbursed Hospital Inpatient Paper TAR Requirements

(for eTAR submission please see eTutorial on line at [www.dhcs.ca.gov](http://www.dhcs.ca.gov))

Physicians, podiatrists, pharmacies, medical supply dealers, outpatient clinics and laboratories use the *Treatment Authorization Request* (TAR, 50-1) to request approval from a Medi-Cal field office consultant for certain procedures/services. List section in the appropriate numbers of designations.

For addresses and telephone numbers for a geographic area or specific addresses section of this manual.

For DRG methodology this section discusses and the specific TAR types that should be used to establish medical necessity.

When a Beneficiary Has a Full Scope Aid Code: No TAR is required. An Admission TAR is required.

When Delivery - No Admission TAR is required.

When Delivery - No TAR is required.

When (All) Stays - Each day requires a diem and dependent upon the number of admissions, Whether Elective Or d. Reimbursement is based on a

Each day requires approval on TAR. When the number of approved days is less than 14, the provider submits this TAR.

When the number of approved days is 14 or more, approval on TAR is required for each day of services.



# Previous Payment Method

- In CY 2009, \$4.5 billion was paid for Medi-Cal FFS inpatient care
- Generally referred to as Selective Provider Contracting Program (SPCP)
- In place almost 30 years

### 1. Contract hospitals

- Signed contracts with California Medical Assistance Commission
- Flat-rate per diem rates for all care (with some exceptions)
- Rates confidential

### 2. Non-contract hospitals

- Paid at 100% of allowed cost, with cost settlement process
- In closed areas, could only accept emergency patients

### 3. Designated public hospitals

- Separate method outside the SPCP

# Policy Development Process

- DHCS instructions: an open, transparent process
- April 2011 to February 2012
  - Monthly meetings of state workgroup, hospital consultation group
- “Policy design document (PDD)” was key document
  - Set the structure of the payment method
- July 1, 2012: Contracting program transferred from CMAC to DHCS
- Early February 2013: Hospital-specific base prices sent effective 7/1/13
  - Sent by U.S. mail to hospital CFO
  - For explanation, see sample and presentation on DRG webpage
- July 1, 2013: DRG implementation (by date of admission)
- January 1, 2014: DRG implementation for NDPHs

# Aspects of DRG Payment

- **Value purchasing:** DRGs define “the product of a hospital,” enabling greater understanding of the services provided and purchased
  - DRGs reward better diagnosis and procedure coding, which should be complete, accurate and defensible
- **Fairness:** Moving toward statewide base rates with outlier policy for expensive patients
- **Efficiency:** Because payment does not depend on hospital-specific costs or charges, hospitals are rewarded for improving efficiency
  - Reductions in length of stay, where appropriate, generate savings
- **Access:** Higher DRG payment for sicker patients encourages access to care across the full range of patient conditions
  - Non-contract hospitals in closed areas may increase Medi-Cal volume
- **Transparency:** Payment methods and calculations on the Internet
  - But note re: SPCP confidentiality before DRG implementation
- **Administrative ease:** Day-by-day TAR no longer required (except some limited-benefit beneficiaries)
- **Quality:** Sets foundation for improvement of outcomes

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# How States Pay for Inpatient Care

As of July 2013

## Per Stay -- CMS-DRGs

CO\*, IA, IL\*, KS\*\*, KY, MN, NC\*\*, UT, VT, WV\*\*

\* Moving to APR-DRGs

\*\* Moving to MS-DRGs

## Per Stay -- AP or Tricare DRGs

DC,\* GA, IN, NE, NJ, VA, WA

\* Moving to APR-DRGs

## Per Stay -- MS-DRGs

MI, NH, NM, OK, OR, SD, WI

## Per Stay -- Other

DE, MA\*, NV, WY

\* Casemix adjustment based on APR-DRGs

## Per Stay -- APR-DRGs

CA, FL, MT, ND, NY, OH, PA, RI, MS, SC, TX

## Per Diem

AK, AZ, HI, LA, MO, TN

## Cost Reimbursement

AL, AR, CT, ID, ME

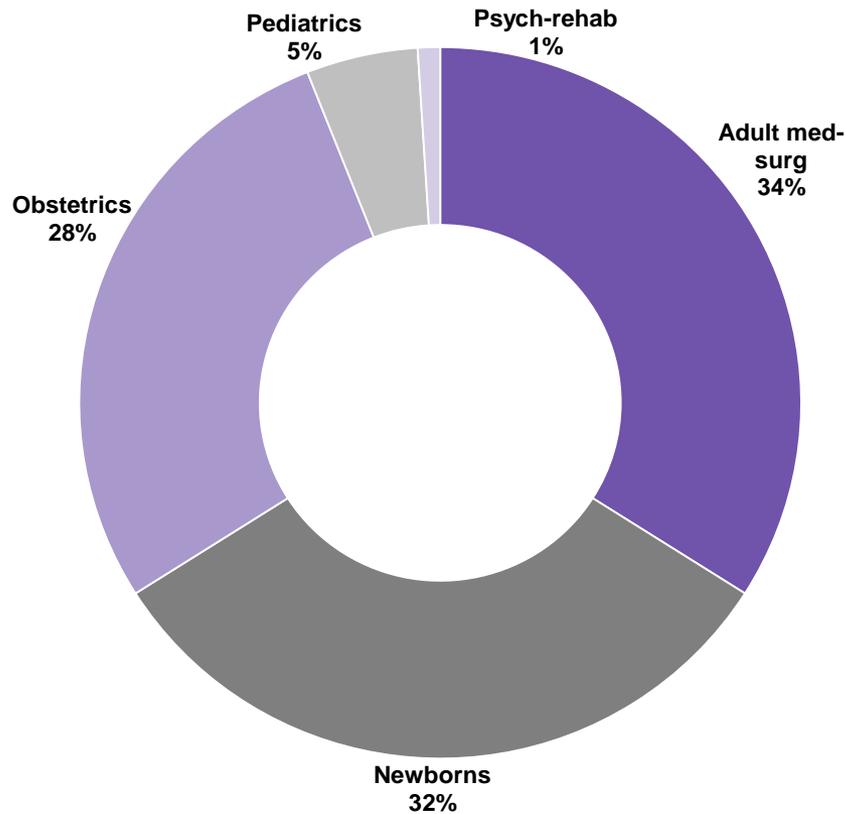
## Other (Regulated Charges)

MD\*

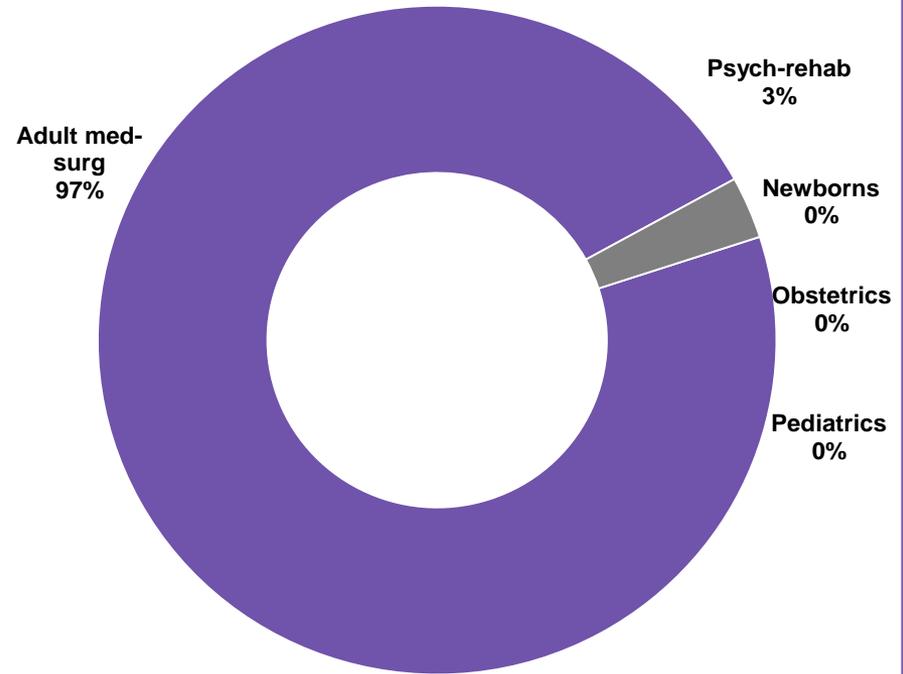
\* Casemix adjustment based on APR-DRGs

# Very Different Populations

**Medi-Cal FFS Stays, 2008**



**Medicare FFS Stays (National), 2008**



Source: OSHPD 2008 data

# DRG Algorithm: APR-DRGs

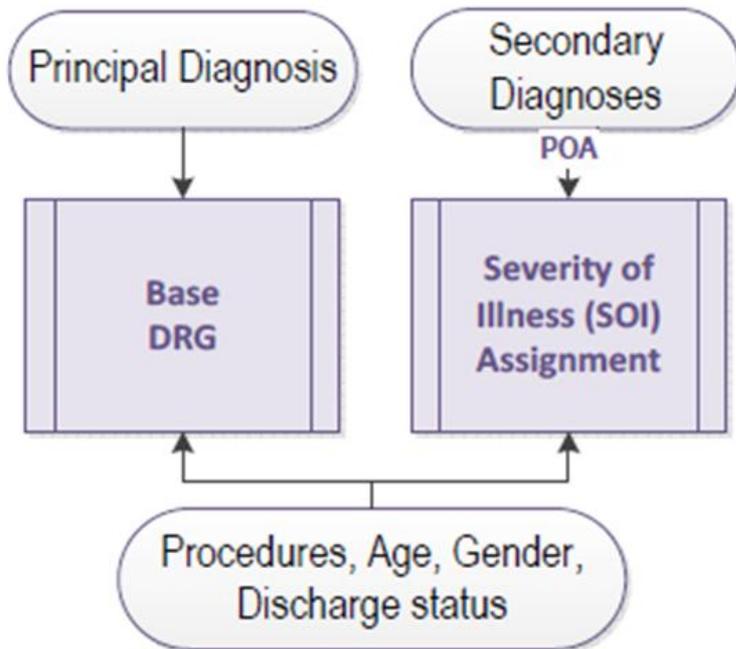
- All Patient Refined (APR- DRGS)
- Developed in early 1990s by 3M and the Children's Hospital Association (formerly NACHRI)
- Intended to be suitable for all patients, especially obstetrics, newborns, NICU babies, general pediatrics, and medically complex children
- Widely used for research, analysis and payment
- Hospitals do not need to buy APR-DRG software
  - DRG grouping and pricing will be done by Medi-Cal

# Comparing MS-DRGs and APR-DRGs

	Medicare MS-DRGs	Medi-Cal APR-DRGs
Developer	Medicare (3M contractor)	3M and Children's Hospital Association (formerly NACHRI)
Genesis	2007--adaptation of CMS-DRGs to improve capture of complications and comorbidities (CC)	Early 1990s--new model
Patient population	Medicare only	All-patient, using the Nationwide Inpatient Sample (NIS)
Total DRGs	751	1,258
DRG Structure	334 base DRGs; many conditions split "with CC" or "with major CC"	316 base DRGs, each with 4 severity of illness (SOI) levels. No CC list.
Newborn DRGs	7 DRGs; birthweight not used	29 x 4 = 116 DRGs; birthweight used
Obstetric DRGs	Unchanged since 1983	4 x 4 = 16 delivery DRGs, plus other obstetric DRGs
Pediatric DRGs	Previous CMS-DRG logic discontinued; now, pediatric age not considered	Pediatric age reflected in base DRGs (e.g., RSV) and severity
Version	V.30 for federal fiscal year 2013	V.29 for state fiscal year 2013-14
Relative weights	Calculated from Medicare population	Calculated from NIS; validated using Medi-Cal data

# Structure of APR-DRGs

## DRG 002-4 Base DRG - SOI



APR-DRG	APR-DRG Description	Relative Weight
002-1	Heart &/Or Lung Transplant	9.5322
002-2	Heart &/Or Lung Transplant	11.3558
002-3	Heart &/Or Lung Transplant	16.027
002-4	Heart &/Or Lung Transplant	24.7273
141-1	Asthma	0.3506
141-2	Asthma	0.4946
141-3	Asthma	0.7464
141-4	Asthma	1.4218
560-1	Vaginal Delivery	0.307
560-2	Vaginal Delivery	0.3477
560-3	Vaginal Delivery	0.5057
560-4	Vaginal Delivery	1.3646

# Diagnosis and Procedure Coding

- Increased importance of diagnosis/procedure coding
- APR-DRG severity assignment:
  - No single complications/comorbidities list
  - Depends on interaction of primary diagnosis with multiple secondary diagnoses and procedures
  - APR-DRG granularity => opportunities to increase severity of illness
- Logic and experience (e.g., Medicare, MD, PA) => measured casemix will increase
  - Newborn casemix expected to increase in particular (due to birth weight coding, inferred newborn claims)
  - Overall, documentation and coding adjustment built into DRG base price
- Hospitals must ensure that coding is complete, accurate and defensible

## DRG Grouping

# Top 20 Medi-Cal Stays by Total Cost 2009

APR-DRG	Description	Stays	Days	Charges	Est. Cost	Casemix	National ALOS	Average Cost per Stay
540-1	Cesarean Del	36,767	116,578	\$895,069,993	\$206,357,005	0.52	3.0	\$5,613
560-1	Vaginal Del	68,222	133,236	\$829,993,929	\$191,713,182	0.31	2.0	\$2,810
720-4	Septicemia & Disseminated Inf	4,855	56,175	\$763,063,878	\$167,482,211	2.73	9.6	\$34,497
640-1	Normal Newborn, Bwt >2499G	139,196	297,543	\$631,929,500	\$146,658,208	0.10	2.1	\$1,054
005-4	Trach, MV 96+ Hrs, w/o Ext Proc	678	33,055	\$475,513,784	\$100,128,923	11.47	34.1	\$147,683
560-2	Vaginal Del	20,946	48,125	\$320,122,814	\$75,595,806	0.35	2.4	\$3,609
540-2	Cesarean Del	8,714	35,322	\$275,245,556	\$63,960,846	0.63	4.1	\$7,340
130-4	Resp Sys Diag w MV 96+ Hrs	878	20,146	\$254,667,446	\$57,615,744	5.39	17.4	\$65,622
710-4	Inf & Parasit Dis Incl HIV w O.R. Proc	720	18,267	\$231,849,292	\$49,418,135	6.09	18.8	\$68,636
634-1	Neo, Bwt >2499G w Maj Resp Cond	1,165	30,436	\$204,226,884	\$44,176,471	0.55	4.5	\$37,920
720-3	Septicemia & Disseminated Inf	2,742	18,924	\$176,718,683	\$40,100,616	1.17	6.3	\$14,625
194-3	Heart Failure	2,945	15,233	\$153,063,934	\$33,288,623	0.94	5.6	\$11,303
139-3	Oth Pneumonia	2,804	15,583	\$144,338,588	\$32,838,843	0.89	5.5	\$11,711
139-2	Oth Pneumonia	3,899	14,941	\$117,597,728	\$28,379,777	0.58	3.8	\$7,279
133-4	Pulmon Edema & Resp Failure	1,175	8,392	\$114,031,279	\$25,568,272	1.97	7.1	\$21,760
460-3	Renal Failure	2,191	11,643	\$108,423,344	\$24,436,578	0.85	5.1	\$11,153
540-3	Cesarean Del	2,163	13,335	\$106,424,329	\$24,081,373	0.93	6.8	\$11,133
194-2	Heart Failure	3,282	11,883	\$108,817,664	\$24,030,415	0.63	3.8	\$7,322
140-3	COPD	2,351	11,628	\$108,543,395	\$23,845,083	0.85	5.2	\$10,143
140-2	COPD	3,266	12,400	\$103,554,831	\$23,665,712	0.62	4.0	\$7,246
<b>Top 20 Total</b>		<b>308,959</b>	<b>922,845</b>	<b>\$6,123,196,853</b>	<b>\$1,383,341,821</b>	<b>0.58</b>	<b>3.9</b>	<b>\$4,477</b>
<b>Top 20 as Percent of All</b>		<b>57%</b>	<b>42%</b>	<b>31%</b>	<b>30%</b>			



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## Claims Pricing under DRG

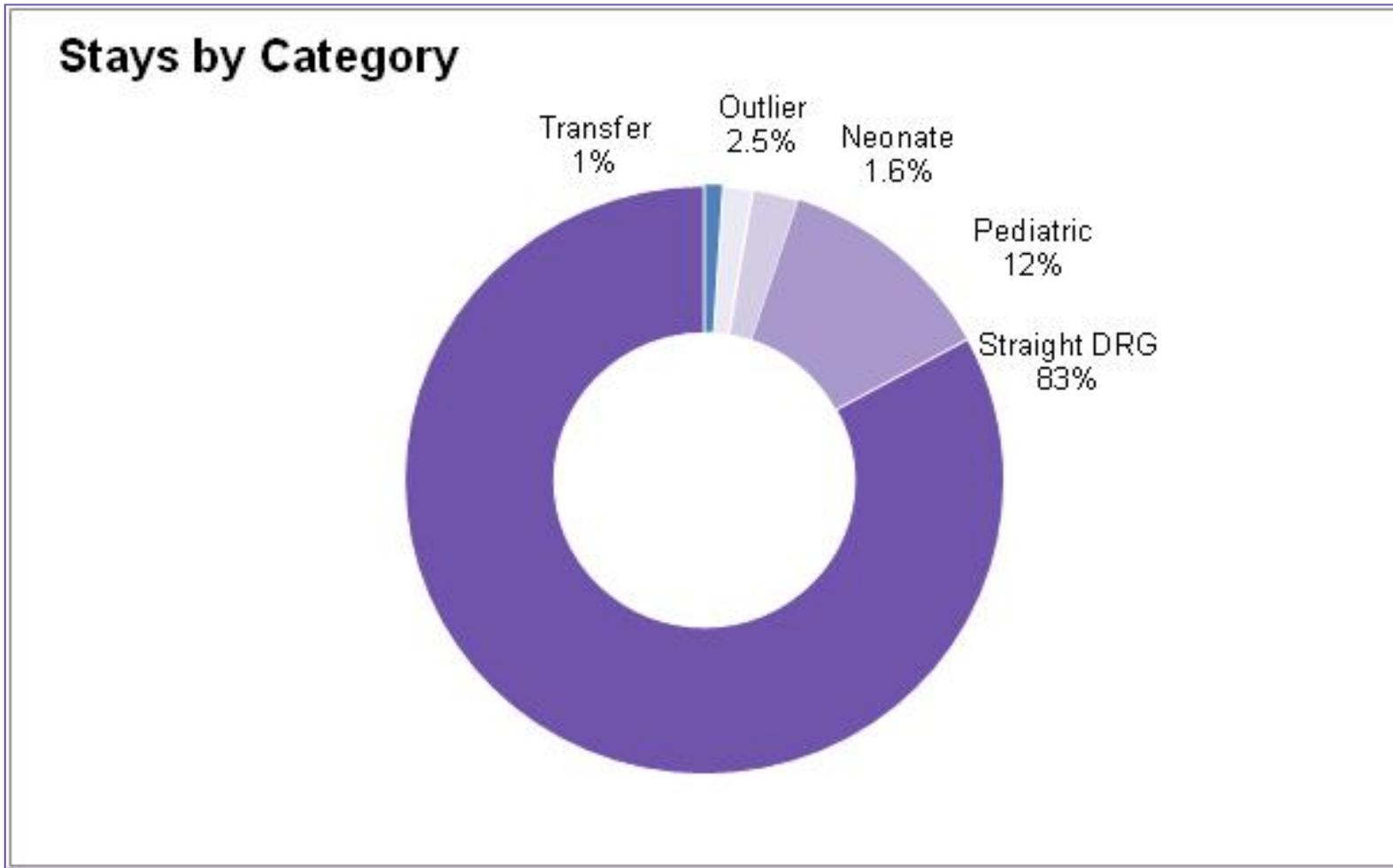
# Key Payment Values

Payment Policy Parameter	Value
Statewide base price	\$6,223
Statewide base price (remote rural)	\$10,218
APR-DRG algorithm and relative weights	V.29 national
Policy adjustor -- neonate at designated NICU hospital	1.75
Policy adjustor -- neonate at other hospital	1.25
Policy adjustor -- pediatric resp, pediatric misc	1.25
Pediatric age	< 21 years old
Transfer discharge statuses	02, 05, 65, 66
Documentation, coding and capture adjustment	3.50%
Wage area adjustments	Per Medicare Aug 2012
Allowed = lesser of calculated payment or charge	Yes
High-side (provider loss) cost outlier threshold 1	\$40,000
Marginal cost percentage	60%
High-side (provider loss) cost outlier threshold 2	\$125,000
Marginal cost percentage	80%
Low-side (provider gain) cost outlier threshold	\$40,000
Marginal cost percentage	60%
<b>Notes</b>	
1. Policy adjustors are applied to the relative weight for specific DRGs, with the effect of increasing the relative weight used for calculating payment. "Neonate" refers to specific APR-DRGs for sick newborns.	
2. The statewide base price for remote rural hospitals was calculated to equal 95% of cost for remote rural hospitals in aggregate. The statewide base price for all other hospitals was then calculated so that aggregate payments statewide equalled the budget target.	

# Hospital Characteristics

- **“Designated NICU”** as determined by California Children’s Services based on neonatal surgical capacity
- **“Designated remote rural hospital”** - rural per OSHPD list and at least 15 miles from the nearest hospital with a basic emergency room
- **Cost-to-charge ratio** used for calculating outlier payments - (1) from the hospital’s most recent cost report accepted by DHCS or, if need be, (2) most recent Provider Master File
- **Wage area** - from Medicare impact file for FFY 2013, including reclassifications where appropriate

# How Claims Will Be Paid



# Calculating the Allowed Amount

1. Group each stay to APR-DRG and use relative weight
  - Relative weights from a national database that fits CA well
  - CA-MMIS will use up to 25 diagnoses and procedure codes
  
2. Hospital-specific base price
  - Higher base price for remote rural hospitals
  - Transition rates in effect 2013-14, 2014-15, 2015-16
  - Adjust by Medicare Wage Area
  
3. Incorporate specific payment adjustments
  - Age adjustor, NICU adjustor, outlier payments, transfers

# 1. Straight DRG

- 314 base APR-DRGs, each with four levels of severity
- DRG base price = statewide base price adjusted for wage area
  - L.A. area:  $(\$6,223 \times 68.8\% \times 1.2282) + (\$6,223 \times 31.2\%) = \$7,200$
- Individual hospitals will have different base prices due to the transition

DRG	Description	Rel Wt	DRG Base Price	DRG Base Payment
139-1	Oth Pneumonia	0.3886	\$7,200	\$2,798
139-2	Oth Pneumonia	0.5773	\$7,200	\$4,157
139-3	Oth Pneumonia	0.8937	\$7,200	\$6,435
139-4	Oth Pneumonia	1.7342	\$7,200	\$12,486
166-1	Coronary Bypass w/o Cath	2.5684	\$7,200	\$18,492
166-2	Coronary Bypass w/o Cath	2.8429	\$7,200	\$20,469
166-3	Coronary Bypass w/o Cath	3.6188	\$7,200	\$26,055
166-4	Coronary Bypass w/o Cath	6.1761	\$7,200	\$44,468

## 2. Pediatric Adjustor

- Illustrates the Straight DRG modified for a pediatric patient
- Pediatric adjustor of 1.25 is applied

Straight DRG					Pediatric Adjustor Applied		
DRG	Description	Casemix Rel. Wt.	DRG Base Price	DRG Base Payment	Pediatric Adjustor	Payment Rel. Wt.	DRG Base Payment
139-1	Oth Pneumonia	0.3886	\$7,200	\$2,798	1.25	0.48575	\$3,497
139-2	Oth Pneumonia	0.5773	\$7,200	\$4,157	1.25	0.721625	\$5,196
139-3	Oth Pneumonia	0.8937	\$7,200	\$6,435	1.25	1.117125	\$8,043
139-4	Oth Pneumonia	1.7342	\$7,200	\$12,486	1.25	2.16775	\$15,608

# 3. Transfer Cases

- Payment adjustment follows Medicare model
- Applies to short-stay patients transferred from acute care to acute care; (“Transfer” statuses 02-general hospital, 05-children’s or cancer, 65-psych, 66-critical access)
- Transfer adjustment made only if LOS less than national ALOS - 1 day
- No post-acute transfer policy

**Example: DRG 190-3, Heart-attack  
LOS= 2 days; Transferred to another general hospital**

Step	Explanation	Amount
DRG base payment	$\$7,200 \times 1.0665$	\$7,679
Transfer case	Discharge status = 02	Yes
National ALOS	Look up from DRG table	4.87
Tsf adjustment	$(\$7,679/4.87) * (2+1)$	\$4,730
DRG payment	$\$4,730 < \$7,679$	\$4,730

# Transfers

- If a beneficiary is discharged from one hospital and readmitted to another hospital, there will need to be two TARs, one for each hospital admission.
- If a beneficiary is only transported to another hospital for a procedure and returns to the originating hospital, there only needs to be one Admit TAR for the initial hospital admission.

# 4. Cost Outlier Case: Tier 1

- Cost outlier payments supplement base payments in exceptional cases
- Cost is calculated using charges and CCR
- Same calculation model as Medicare 5% of payments as outliers; CA 17%

Example: DRG 720-4 Septicemia with charges of \$180,000		
Step	Explanation	Amount
DRG base payment	$\$7,200 \times 2.7338$	\$19,683
Estimated cost	$\$180,000 \times 39\%$	\$70,200
Estimated loss	$\$70,200 - \$19,683$	\$50,517
Cost outlier case	$\$50,517 > \$40,000$	Yes
Est. loss - cost outlier	$\$50,517 - \$40,000$	\$10,517
Cost outlier payment	$\$10,517 \times 0.60$	\$6,310
DRG payment	$\$19,683 + \$6,310$	\$25,993

# 5. Cost Outlier Case: Tier 1 & 2

Example: DRG 720-4 Septicemia with charges of \$600,000		
Step	Explanation	Amount
DRG base payment	$\$7,200 \times 2.7338$	\$19,683
Estimated cost	$\$600,000 \times 39\%$	\$234,000
Estimated loss	$\$234,000 - \$19,683$	\$214,317
Cost outlier case	$\$214,317 > \$40,000$	Yes
Cost outlier payment Tier 1 for loss between \$40,000 & \$125,000	$(\$125,000 - \$40,000) \times 60\%$	\$51,000
Tier 2 loss over \$125,000	$\$214,317 - \$125,000$	\$89,317
Cost outlier payment Tier 2	$\$89,317 \times 80\%$	\$71,453
DRG payment	$\$19,683 + \$51,000 + \$71,453$	\$142,137

Example of two-tier cost outlier threshold:

\$40,000 and \$125,000

- Tier 1 paid at 60% for losses between \$40,000 and \$125,000
- Tier 2 paid at 80% for losses greater than \$125,000

# 6. Interim Claims

- Hospitals are not required to submit interim claims under any circumstances
- Hospitals can choose to submit interim claims if a stay exceeds 29 days
- The Interim per diem amount of \$600 is intended to provide cash flow for long stays
- Hospitals should not adjust their final claim based on interim claim payments, void interim payments, or try to return interim payments
- Hospitals should submit the final admit through discharge claim, including all ICD-9-CM diagnosis and procedure codes related to the entire stay
- The System, CA-MMIS, will pay the admit through discharge claim, and deduct previously paid interim claim amounts from the subsequent payment remittance
- Authorization, TAR/SAR is required for the admission before the interim claim will be paid

## Claims Pricing under DRGs

# Interim Claim Payment

Example: Neonate 1200 g with respiratory distress syndrome (APR-DRG 602-4)				
Claim	Type of Bill	Days	Interim Per Diem	Payment
1st interim claim	112	30	\$600	\$18,000
2nd interim claim	113	30	\$600	\$18,000
Final complete claim	111	80	DRG Payment	\$131,412
System adjusts next week's remittance				(\$36,000)

Note:

1. APR-DRG 602-4 base rate is  $\$7,200 \times 18.2517 = \$131,412$ .
2. \$600 is the per diem rate for interim claims.

# Topics

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# Deliveries, Babies, General Acute

This section brings together billing, TAR/SAR and payment changes for the five most common scenarios:

- Deliveries
- Well babies
- Sick babies
- General acute care – patients with full benefits
- General acute care – patients with limited benefits

Same TAR submission process as in place currently, with changes to accommodate admission only TAR. Daily TAR remains for

- acute inpatient rehabilitation
- restricted aid code-assigned beneficiaries
- acute administrative days-Level 1 or Level 2

Reduction in TAR/SAR requirements-

- Reduces administrative burden, a major benefit for hospitals

# TAR Process

Required documentation still needed to establish the medical necessity of the Admission (Admit TAR and Principal Diagnosis)

Providers can still use

- 50-1 TAR for elective non-emergency admission
- 18-1 TAR for emergency admissions, or
- the electronic (eTAR)

Designated public hospitals are unaffected by the DRG-related changes in TAR/SAR

Non-designated public hospitals will be affected by the DRG-related changes in TAR/SAR effective with dates of admission 1/1/14

# Deliveries

## Deliveries

Deliveries are identified by the presence of specific ICD-9-CM procedure codes on the claim.

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Typically billed together with the baby	The mother and baby must be billed on separate claims.
<b>TAR / SAR</b>	No TAR/SAR required for admission. TAR/SAR required for induction days and any days over 2 (vaginal delivery) or 4 (cesarean delivery)	None
<b>Payment</b>	Single payment typically made for both the mother and the baby combined	Separate DRG-based payments to be made for the mother and the baby

1. This information applies to all patients, regardless of aid code.  
2. For other obstetric stays (e.g., false labor), see General Acute Care.

# Well Babies

## Well Babies

If the only accommodation revenue code is 170 or 171, the baby is defined as a well baby

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Almost always billed on the mother's claim	The mother and baby must be billed on separate claims.
<b>TAR / SAR</b>	None	Same
<b>Payment</b>	Included within payment for the mother	Separate DRG-based payments to be made for the mother and the baby

1. DRG-based payment will reflect the baby's diagnoses and procedures, regardless of the revenue codes billed on the claim. The revenue codes are used only to determine the applicability of TAR/SAR requirements.
2. This information applies to all patients, regardless of aid code.

# Sick Babies

## Sick Babies

If accommodation revenue codes 172, 173 or 174 appear on the claim, the baby is defined as a sick baby. This is true even if the claim also includes revenue code 171.

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Typically billed separately	The baby should continue to be billed separately from the mother
<b>TAR / SAR</b>	Admission and each day	Admission only
<b>Payment</b>	Typically paid separately	Separate DRG-based payments to be made for the mother and the baby

1. DRG-based payment will reflect the baby's diagnoses and procedures, regardless of the revenue codes billed on the claim. The revenue codes are used only to determine the applicability of TAR/SAR requirements.

2. This information applies to all patients, regardless of aid code.

# General Acute Care—Full Benefits

## General Acute Care -- Patients with Full Benefits

This information applies to all stays except deliveries and newborns.

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Following standard practice	Same
<b>TAR / SAR</b>	Admission and each day	Admission only
<b>Payment</b>	For authorized days, per diem or at percent of charges	By DRG for the entire stay

# General Acute Care—Limited Benefits

## General Acute Care -- Patients with Limited Benefits

This information applies to all stays except deliveries and newborns.

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Following standard practice	Same
<b>TAR / SAR</b>	Admission and each day	Same
<b>Payment</b>	For authorized days, per diem or at percent of charges	By DRG for the entire stay. Payment for stays with unauthorized services may be recalculated to remove the impact of the unauthorized services.

**TAR will continue to be reviewed as they are today.**

### Claim Payment Process:

- As long as there at least one approved day, the claim will pay via the DRG grouper
- After payment is made, stays with at least one denied day will be reviewed, verifying diagnosis and procedures occur on approved days. If not, those diagnoses and procedures will be removed for DRG reassignment.
- Claim will be run through the grouper for DRG reassignment . This reassigned DRG will determine if there is a reduction in payment.
- Audits & Investigation will handle recoupment, as necessary.

# Major Reduction in Daily TAR/SARs

	Total Admissions	Admissions Requiring TAR	Total Days	Days Requiring TAR/SAR-- Previous Payment Method	Days Requiring TAR/SAR-- Effective 7/1/13	Change in Days Requiring TAR/SAR
Deliveries	138,265	-	353,406	8,333	-	(8,333)
Well babies	138,742	-	319,108	-	-	-
Sick babies	10,260	10,260	206,890	206,890	-	(206,890)
General acute--full benefits	130,514	130,514	731,360	731,360	-	(731,360)
General acute--limited benefits	27,982	27,982	104,933	104,933	104,933	-
<b>Total</b>	<b>445,763</b>	<b>168,756</b>	<b>1,715,697</b>	<b>1,051,516</b>	<b>104,933</b>	<b>(946,583)</b>

1. The estimate was done before non-designated public hospitals were excluded from DRG payment. NDPHs represented about 9% of the 445,763 stays shown here. Without NDPHs, impacts would be essentially identical in percentage terms.

2. The estimate was done by Xerox for DHCS, assuming that the volume and mix of stays in FY 2013-14 would be similar to the CY 2009 baseline after adjustment for beneficiaries transitioning to managed care.

# TAR Process

- Refer to “DRG Hospital Inpatient TAR Requirements” on webpage
  - Use the TAR, 50-1 for elective non-emergency admission
  - Use the 18-1 TAR for emergency admissions
  - For a list of CPT-4 procedures requiring TAR, refer to the TAR and non-Benefit List section in the appropriate Part 2 manual
  - TAR field Office Addresses of same manual
- Required documentation – necessary documentation to establish the medical necessity of the
  - Admission – admit TAR
  - Each day – current process of authorizing each day as well as the admit

# Additional TAR Information

**Onsite TAR Nurses-** The field office will be working with providers to assess the need for onsite TAR support based on the volume for each provider's FFS population.

**eTAR-** We encourage Providers to become eTAR providers. Interested hospitals can contact either their local Medi-Cal Field Office or Xerox at 1-800-541-5555.

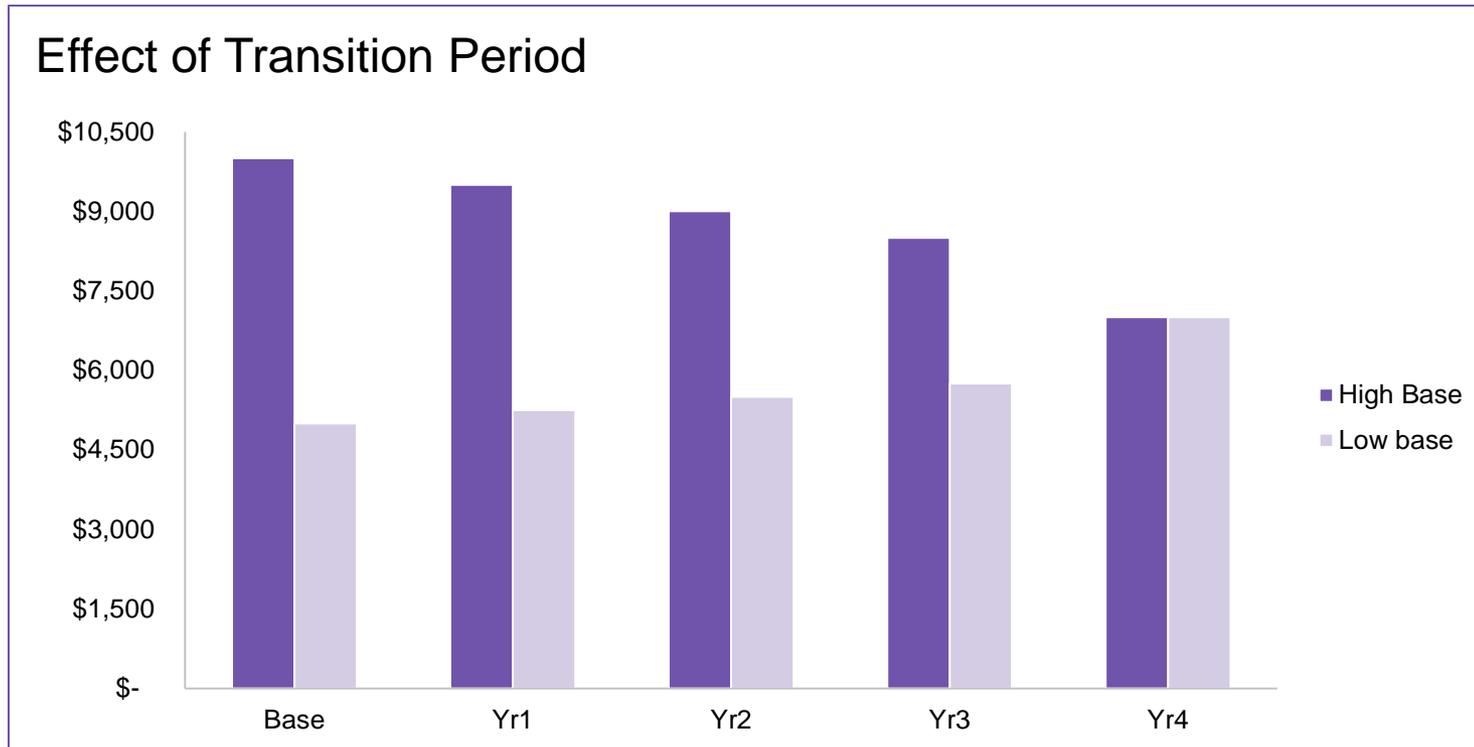
**Appeals-** Appeals for denied or modified TARs will continue. The current process and timelines will remain in place. For ADMIT TARs, the focus of appeals will change as the submitted documentation will focus upon the medical necessity for the admission.

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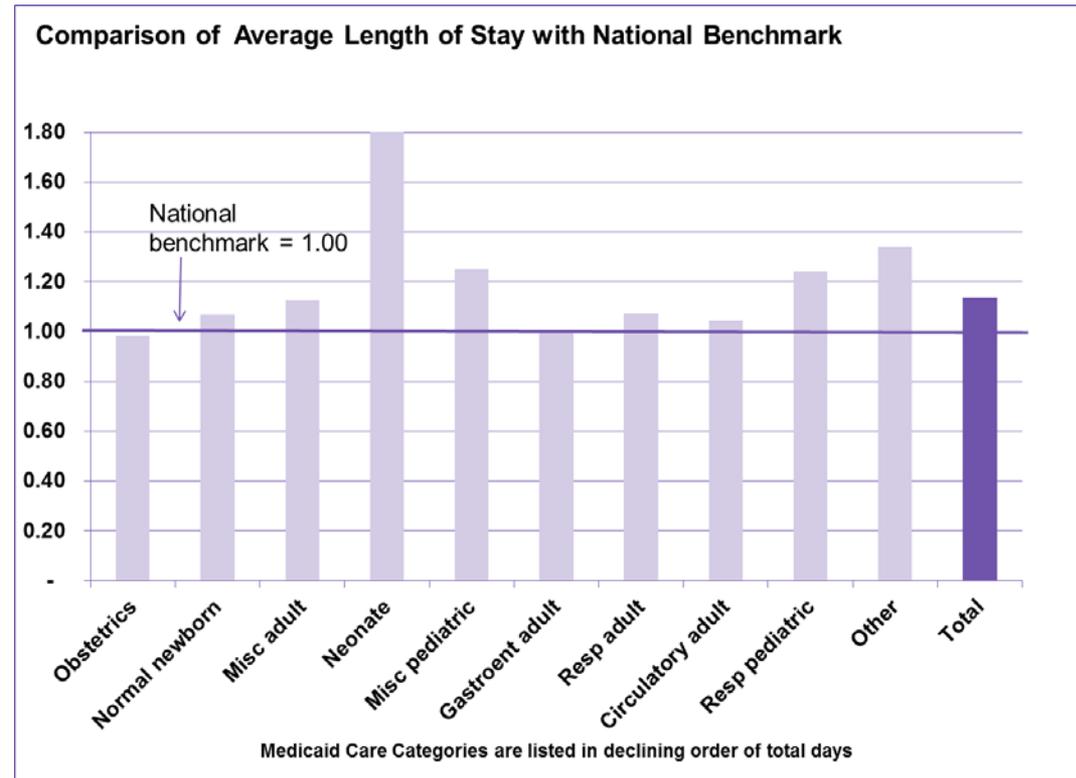
# Transition Period Moderates Impacts

- DRG payment to be phased in over three years, with full impact in FY 2016-17
- Transition put into effect through DRG base prices



# Financial Management

- Change in payment per hospital – up or down
  - Managing LOS and cost per day are rewarded
  - Increase revenue by increasing casemix and volume
  - Increase margins by increasing efficiency
  - In general, no cost settlement process under DRGs



# All HFPAs Are Open Areas

- 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 TAR)
- Hospitals will no longer be required to transfer patients based on their previous non-contract designation in closed Health Facility Planning Areas (HFPAs) . This eliminates the need to assess whether a patient is stable for transfer.
- Contract or non-contract facility designations will not apply under the DRG payment methodology
- NPIs are not “contract” or “noncontract”; any NPI you use now can be used to bill under DRGs.

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## Other Impacts

# Related Outpatient Services

- No change to the Medi-Cal outpatient “window” for inpatient stays
- No change to separate payment for newborn hearing screening
- Blood factors and bone marrow search and acquisition services are the only services separately payable from the inpatient stay

### 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
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Unrelated bone marrow donor	38204
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#### Blood Factors

Blood Factor XIII	J7180
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Blood Factor Von Willebrand - Injection	J7183 / J7184 / Q2041
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Blood Factor VIII	J7185 / J7190 / J7192
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Blood Factor VIII / Von Willebrand	J7186
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Blood Factor Von Willebrand	J7187
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Blood Factor VIIa	J7189
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Blood Factor IX	J7193 / J7194 / J7195
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Blood Factor Antithrombin III	J7197
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Blood Factor Antiinhibitor	J7198
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# California Children's Services (1)

- Most CCS children also have Medi-Cal FFS
- Patients with CCS only will be paid by the Medi-Cal DRG method
- Policy now simplified for Medi-Cal FFS patients who previously had CCS coverage for only part of the stay

## Medi-Cal FFS and California Children's Services

Scenario: Patient has CCS coverage for part of the stay and Medi-Cal FFS coverage for the rest of the stay

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Separate claims to CCS and Medi-Cal FFS	Single claim
<b>TAR / SAR</b>	SAR for CCS days and TAR for Medi-Cal FFS days	Single admission SAR or TAR, depending on aid code (CCS or Medi-Cal only). Daily authorization required if the patient has a limited benefit aid code.
<b>Payment</b>	CCS payment for CCS days and Medi-Cal FFS payment for Medi-Cal FFS stays	Single DRG payment

# California Children's Services (2)

- For children with both Medi-Cal managed care (MCO) and CCS coverage, no change in policy on billing and authorization
- CCS payment to be by DRG

## Medi-Cal FFS and Medi-Cal Managed Care

Scenario: Patient has CCS coverage for part of the stay and Medi-Cal managed care coverage for the rest of the stay

	Previous Payment Method	Effective July 1, 2013
<b>Billing</b>	Separate claims to CCS and Medi-Cal MCO	Same
<b>TAR / SAR</b>	SAR for CCS services	Same
<b>Payment</b>	CCS payment per diem or % of charges	CCS payment by DRG

# Rehabilitation – Paid Per Diem

- Defined as a claim that includes accommodation revenue code 118, 128, 138, 148, or 158 (can be more than one within list)
  - Inclusion of any other accommodation revenue code => denial
- To be paid per diem, outside DRG method
  - Hospital must be licensed to be reimbursed for rehab
  - Statewide rates of \$1,841 (pediatric) and \$1,032 (adult), adjusted for the hospital's Medicare wage area
  - Each hospital will have a specific rate based on its historical blend of pediatric and adult days
  - Rates available on DRG webpage under hospital-specific characteristics

# Rehabilitation- Licensure & TAR

- A hospital must be licensed to provide acute rehab in order to get paid for the service and the Category of Service listed on the Provider Master File.
- Contact DPHS Licensing if you have questions on your hospital's licensure status.
- The Medi-Cal Manual of Criteria, Acute Inpatient Intensive Rehabilitation contains criteria
  - Treatment authorization: TAR for medical necessity of admission and length of stay (i.e., daily TAR)
  - Patient must have a condition meeting the medical necessity criteria for acute care.
- Transfer from acute care to rehab days within the same hospital would be billed, authorized and paid as two separate stays

# Admin Days – Paid Per Diem

- Defined as a claim that includes an admin day revenue code
  - Inclusion of any other accommodation revenue code => denial
- Admin day level 1 – revenue code 169
  - Same policy and practice as in the past
- Admin day level 2 – revenue codes 190 (pediatric) or 199 (adult)
  - A new sub-acute level between Level 1 and acute
  - Payment will be lower of hospital-specific rate already established and statewide rate:
    - Pediatric (revenue code 190) – \$895.60 per diem
    - Adult (revenue code 199) – \$896.67 per diem
  - Separately payable services – list same as Admin level 1.
- Transfer from acute care unit to admin days within the same hospital would be billed, authorized (TAR) and paid as two separate stays
  - inpatient stay and
  - administrative days

# Acute Administrative Days- Level I

- An acute administrative day is used to reimburse acute inpatient providers for services rendered to a patient awaiting placement in a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B).
- The patient's medical and nursing care needs must meet the requirements for placement in a Level A or Level B facility, including a call list indicating placement efforts.
- Acute administrative days-level 1 need to be individually reviewed and a separate authorization of each day (current process) issued in addition to the Admit TAR.

# Acute Administrative Days- Level II

- An acute administrative day is used to reimburse acute inpatient providers for services rendered to a patient awaiting placement in a subacute nursing facility, either adult or pediatric.
- The patient's medical needs must meet the requirements for placement in a subacute facility, including a call list indicating placement efforts.
- Acute administrative days-level 2 need to be individually reviewed and a separate authorization of each day (current process) issued in addition to the Admit TAR

# Impact on Managed Care Sector

- DRGs apply to the fee-for-service sector
  - MCPs continue to choose their own payment methods
- Out-of-network emergency and post-stabilization services
  - In general, previous policy not changing
  - But Rogers Rate has been replaced by what FFS would pay under DRG-based payment
  - MCPs can reference the DRG Pricing Calculator on DRG webpage
  - Hospital-specific DRG base price for this purpose will be the base price without transition as published in the DRG Pricing Calculator
  - MCPs must use DRG payment calculations for both DRG hospitals and for public hospitals that are otherwise outside DRG payment
- See All Plan Letter 13-004, dated 2/12/13, on DRG webpage

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# Billing Points Highlights

- Discharge status
- Type of bill
- Rev codes for newborns, rehab, admin days
- Medi-Cal client ID
- Diagnoses and POA
- ICD-9-CM procedures

The form is a standard medical billing statement with various sections. Key fields highlighted include:

- Field 4 (TYPE OF BILL):** Located at the top right, circled in purple.
- Field 16 (DHR):** Located in the patient information section, circled in purple.
- Fields 42-43 (REV CD, DESCRIPTION):** A large table in the middle section, with a large purple oval around it.
- Field 59 (INSURED'S UNIQUE ID):** Located in the patient/insurer information section, circled in purple.
- Fields 67-70 (ICD-9-CM codes):** A row of boxes for diagnosis codes, circled in purple.
- Fields 71-74 (ICD-9-CM procedure codes):** A row of boxes for procedure codes, circled in purple.

# Billing for Newborns

- Sick newborns should be billed with single client ID
  - Either mother's Beneficiary Identification Card (BIC) or newborn's
  - Critical for interim claims when hospital stays > 29 days
  - Revenue codes 172, 173, or 174
- If a well baby (rev code 170 or 171) becomes sick, admit TAR is required
- Reporting birthweight
  - Birthweight is important in accurate DRG grouping, especially for premature babies
  - APR-DRG grouper in the Medi-Cal claims processing system has been configured to check diagnosis codes, not value codes, for birthweight
  - ICD-9-CM uses 5<sup>th</sup> digit to indicate bwt for diagnoses 764 & 765.0-765.1
  - ICD-9-CM codes exist for gestational age

# Other Billing Topics

- CA-MMIS will accept up to 25 diagnoses and procedure codes
- Physician services should be billed as separate claims (under SPCP a few hospitals had lab & pathology bundled in)
- Present-on-admission indicators required except for exempt diagnosis codes
  - CA-MMIS will use V.30 of the Healthcare Acquired Conditions (HAC) utility
  - Payment will be reduced if a HAC is present and the HAC affects DRG assignment
  - Low incidence expected (<1%); fiscal impact expected to be negligible
- Split paper bills: all diagnosis and procedure codes should be completely recorded on each page. The first page will be used to pay the claim.
- Bill type 114 (final interim claim) not accepted – submit TOB 111 instead
- Bill type 115 (late charges) not accepted – submit adjustment instead



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# Summary of Impacts

- Importance of diagnosis and procedure coding
- Billing impact
  - Importance of complete coding
  - Mother and newborn billed on separate claims
  - Consistent ID for newborn interim claims
  - Importance of coding newborn birthweight in diagnosis
- TAR/SAR impact
- Financial impact
  - Payment is per stay
  - Efficiency is rewarded
- All HFPAs are open areas
- Related outpatient services
  - Bone marrow search and acquisition
  - Blood factors

# Summary of Impacts

- Rehabilitation (Acute Inpatient Intensive Rehab) per diem
- Administrative level 2 new subacute levels for pediatric and adult
- CCS / Medi-Cal FFS simplified
- MCO impact
- Interim claims
- Late charges
- Four-byte APR-DRG code
- Physician services billed separately, no longer bundled
- Use of present on admission indicator (POA)
- HAC payment adjustment
- Split paper bills – all diagnosis and procedure codes on each page

# Many Training Opportunities Offered

- DRG webpage (especially “DRG Provider Training List”)
  - [www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx)
- Medi-Cal Learning Portal
  - <https://learn.medi-cal.ca.gov/Training/TrainingCalendar.aspx>

The screenshot shows the California Department of Health Care Services (DHCS) website. The header includes the CA.GOV logo and navigation links for HOME, SERVICES, INDIVIDUALS, PROVIDERS & PARTNERS, FORMS, LAWS & PUBLICATIONS, and DATA & STATISTICS. The main content area is titled "Diagnosis Related Group Hospital Inpatient Payment Methodology". It features a "Data Distribution" section explaining the process of calculating rates and a "Statute Link" for current regulations. A sidebar on the right contains "QUICK LINKS" such as "Medi-Cal Helpline" and "About DHCS", and "RELATED LINKS" including "California Health and Human Services Agency".

The screenshot displays the Medi-Cal Learning Portal. The header features the portal logo, a search bar, and navigation links for HOME, TRAINING, and RESOURCES. The main content area is titled "Provider Training" and includes a "Get Started" section with three steps: creating an account, logging in to view eLearning tutorials and sign-up for seminars, and receiving an email confirmation. Below this is a "Register for Training" section with a calendar for November 2013. The calendar shows a play button icon on the 1st, indicating a training session. A "Provider Training Schedule" table lists various seminars and webinars.

Training Title	Schedule
Diagnosis Related Group Overview Webinars	Monthly from April 5, 2013 through September 5, 2013
Diagnosis Related Group Billing Webinars	Several sessions in May, June and July, 2013
Anaheim Provider Seminars	April 16 through 17, 2013
Redding Provider Seminar	May 8, 2013

# For More Information

- DRG webpage
- Medi-Cal Learning Portal
- Provider bulletins at [files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom\\_20872\\_1.asp](http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20872_1.asp)
- Sign up for DRG-specific listserve through [drg@dhcs.ca.gov](mailto:drg@dhcs.ca.gov)
- Questions to [drg@dhcs.ca.gov](mailto:drg@dhcs.ca.gov)
- Updated provider manual released in June 2013

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