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
Introduction and Background
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/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)

[DHCS webpage](http://www.dhcs.ca.gov)
Introduction and Background

Helpful Documents

December 5, 2013
Introduction and Background

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
Introduction and Background

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: NDPH DRG implementation (by date of admission)
Introduction and Background

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
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

9 December 5, 2013
## DRG Grouping

### How States Pay for Inpatient Care

#### As of July 2013

<table>
<thead>
<tr>
<th>Per Stay -- CMS-DRGs</th>
<th>Per Stay -- AP or Tricare DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO*, IA, IL*, KS**, KY, MN, NC**, UT, VT, WV**</td>
<td>DC*, GA, IN, NE, NJ, VA, WA</td>
</tr>
<tr>
<td>* Moving to APR-DRGs</td>
<td>** Moving to MS-DRGs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Stay -- MS-DRGs</th>
<th>Per Stay -- Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI, NH, NM, OK, OR, SD, WI</td>
<td>DE, MA*, NV, WY</td>
</tr>
<tr>
<td></td>
<td>* Casemix adjustment based on APR-DRGs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Stay -- APR-DRGs</th>
<th>Per Diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA, FL, MT, ND, NY, OH, PA, RI, MS, SC, TX</td>
<td>AK, AZ, HI, LA, MO, TN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Reimbursement</th>
<th>Other (Regulated Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL, AR, CT, ID, ME</td>
<td>MD*</td>
</tr>
<tr>
<td></td>
<td>* Casemix adjustment based on APR-DRGs</td>
</tr>
</tbody>
</table>

December 5, 2013
DRG Grouping

Very Different Populations

Medi-Cal FFS Stays, 2008

- Obstetrics: 28%
- Pediatrics: 5%
- Psych-rehab: 1%
- Newborns: 32%
- Adult med-surg: 34%

Medicare FFS Stays (National), 2008

- Obstetrics: 0%
- Pediatrics: 0%
- Newborns: 0%
- Psych-rehab: 3%
- Adult med-surg: 97%

Source: OSHPD 2008 data
DRG Grouping

**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
# DRG Grouping

## Comparing MS-DRGs and APR-DRGs

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

#### 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 | 16.0270  
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 | 0.3070  
560-2 | Vaginal Delivery | 0.3477  
560-3 | Vaginal Delivery | 0.5057  
560-4 | Vaginal Delivery | 1.3646
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

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

Key Payment Values

<table>
<thead>
<tr>
<th>Payment Policy Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide base price</td>
<td>$6,223</td>
</tr>
<tr>
<td>Statewide base price (remote rural)</td>
<td>$10,218</td>
</tr>
<tr>
<td>APR-DRG algorithm and relative weights</td>
<td>V.29 national</td>
</tr>
<tr>
<td>Policy adjustor -- neonate at designated NICU hospital</td>
<td>1.75</td>
</tr>
<tr>
<td>Policy adjustor -- neonate at other hospital</td>
<td>1.25</td>
</tr>
<tr>
<td>Policy adjustor -- pediatric resp, pediatric misc</td>
<td>1.25</td>
</tr>
<tr>
<td>Pediatric age</td>
<td>&lt; 21 years old</td>
</tr>
<tr>
<td>Transfer discharge statuses</td>
<td>02, 05, 65, 66</td>
</tr>
<tr>
<td>Documentation, coding and capture adjustment</td>
<td>3.50%</td>
</tr>
<tr>
<td>Wage area adjustments</td>
<td>Per Medicare Aug 2012</td>
</tr>
<tr>
<td>Allowed = lesser of calculated payment or charge</td>
<td>Yes</td>
</tr>
<tr>
<td>High-side (provider loss) cost outlier threshold 1</td>
<td>$40,000</td>
</tr>
<tr>
<td>High-side (provider loss) cost outlier threshold 2</td>
<td>$125,000</td>
</tr>
<tr>
<td>Low-side (provider gain) cost outlier threshold</td>
<td>$40,000</td>
</tr>
</tbody>
</table>

Notes
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.
Claims Pricing under DRG

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
Claims Pricing under DRG

How Claims Will Be Paid

Stays by Category

- Transfer 1%
- Outlier 2.5%
- Neonate 1.6%
- Pediatric 12%
- Straight DRG 83%

December 5, 2013
Claims Pricing under DRG

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
Claims Pricing under DRG

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

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

2. Pediatric Adjustor

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

<table>
<thead>
<tr>
<th>Straight DRG</th>
<th>Pediatric Adjustor Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG</td>
<td>Description</td>
</tr>
<tr>
<td>139-1</td>
<td>Oth Pneumonia</td>
</tr>
<tr>
<td>139-2</td>
<td>Oth Pneumonia</td>
</tr>
<tr>
<td>139-3</td>
<td>Oth Pneumonia</td>
</tr>
<tr>
<td>139-4</td>
<td>Oth Pneumonia</td>
</tr>
</tbody>
</table>
3. Transfer Cases

- Payment adjustment follows Medicare model

- Applies to short-stay patients transferred from acute care to acute care; (“Transfer” status codes: 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

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG base payment</td>
<td>$7,200 x 1.0665</td>
<td>$7,679</td>
</tr>
<tr>
<td>Transfer case</td>
<td>Discharge status = 02</td>
<td>Yes</td>
</tr>
<tr>
<td>National ALOS</td>
<td>Look up from DRG table</td>
<td>4.87</td>
</tr>
<tr>
<td>Tsf adjustment</td>
<td>($7,679/4.87) * (2+1)</td>
<td>$4,730</td>
</tr>
<tr>
<td>DRG payment</td>
<td>$4,730 &lt; $7,679</td>
<td>$4,730</td>
</tr>
</tbody>
</table>

December 5, 2013
Claims Pricing under DRG

Transfers

• Same Day Stays- A long standing rule is that CAMMIS does not pay for the date of discharge. This has a direct impact on the Transfer Payment calculation for same-day stays. The current calculation is as follows:

\[(\text{DRG Base Payment} \times (0 + 1))\]

National ALOS

• 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
Claims Pricing under DRG

4. Cost Outlier Case: Tier 1

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

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG base payment</td>
<td>$7,200 x 2.7338</td>
<td>$19,683</td>
</tr>
<tr>
<td>Estimated cost</td>
<td>$180,000 x 39%</td>
<td>$70,200</td>
</tr>
<tr>
<td>Estimated loss</td>
<td>$70,200 - $19,683</td>
<td>$50,517</td>
</tr>
<tr>
<td>Cost outlier case</td>
<td>$50,517 &gt; $40,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Est. loss - cost outlier</td>
<td>$50,517 - $40,000</td>
<td>$10,517</td>
</tr>
<tr>
<td>Cost outlier payment</td>
<td>$10,517 x 0.60</td>
<td>$6,310</td>
</tr>
<tr>
<td>DRG payment</td>
<td>$19,683 + $6,310</td>
<td>$25,993</td>
</tr>
</tbody>
</table>

Example: DRG 720-4 Septicemia with Charges of $180,000

December 5, 2013
## 5. Cost Outlier Case: Tier 1 & 2

### Example: DRG 720-4 Septicemia with Charges of $600,000

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG base payment</td>
<td>$7,200 \times 2.7338</td>
<td>$19,683</td>
</tr>
<tr>
<td>Estimated cost</td>
<td>$600,000 \times 39%</td>
<td>$234,000</td>
</tr>
<tr>
<td>Estimated loss</td>
<td>$234,000 - $19,683</td>
<td>$214,317</td>
</tr>
<tr>
<td>Cost outlier case</td>
<td>$214,317 &gt; $40,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost outlier payment Tier 1 for loss</td>
<td>($125,000 - $40,000) \times 60%</td>
<td>$51,000</td>
</tr>
<tr>
<td>Tier 2 loss over $125,000</td>
<td>$214,317 - $125,000</td>
<td>$89,317</td>
</tr>
<tr>
<td>Cost outlier payment Tier 2</td>
<td>$89,317 \times 80%</td>
<td>$71,453</td>
</tr>
<tr>
<td>DRG payment</td>
<td>$19,683 + $51,000 + $71,453</td>
<td>$142,137</td>
</tr>
</tbody>
</table>

### 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
 Claims Pricing under DRG

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)

<table>
<thead>
<tr>
<th>Claim</th>
<th>Type of Bill</th>
<th>Days</th>
<th>Interim Per Diem</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st interim claim</td>
<td>112</td>
<td>30</td>
<td>$600</td>
<td>$18,000</td>
</tr>
<tr>
<td>2nd interim claim</td>
<td>113</td>
<td>30</td>
<td>$600</td>
<td>$18,000</td>
</tr>
<tr>
<td>Final complete claim</td>
<td>111</td>
<td>80</td>
<td>DRG Payment</td>
<td>$131,412</td>
</tr>
<tr>
<td>System adjusts next week's remittance</td>
<td></td>
<td></td>
<td></td>
<td>($36,000)</td>
</tr>
</tbody>
</table>

**Note:**

1. APR-DRG 602-4 base rate is $7,200 x 18.2517 = $131,412.
2. $600 is the per diem rate for interim claims.
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
This section brings together billing, TAR/SAR and payment changes for five of the most common billing 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 prior to 7/1/2013, but with modifications to accommodate admission only TAR for a significant number of stays per year. Daily TAR remains in effect 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
Billing, Authorization & Payment

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
Billing, Authorization & Payment

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 are located in the 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
Billing, Authorization & Payment

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.
## Deliveries

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

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

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

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

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

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.
Billing, Authorization & Payment

Sick Babies

<table>
<thead>
<tr>
<th>Sick Babies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If accommodation revenue codes 172, 173 or 174 appear on the claim, the</td>
<td>baby is defined as a sick baby. This is true even if the claim</td>
</tr>
<tr>
<td>baby is defined as a sick baby. This is true even if the claim also</td>
<td>includes revenue code 171.</td>
</tr>
<tr>
<td>includes revenue code 171.</td>
<td></td>
</tr>
</tbody>
</table>

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

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**

This information applies to all stays except deliveries and newborns.

<table>
<thead>
<tr>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing</strong></td>
<td>Same</td>
</tr>
<tr>
<td>Following standard practice</td>
<td>Same</td>
</tr>
<tr>
<td><strong>TAR / SAR</strong></td>
<td>Admission only</td>
</tr>
<tr>
<td>Admission and each day</td>
<td>Admission only</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>By DRG for the entire stay of charges</td>
</tr>
<tr>
<td>For authorized days, per diem or at percent of charges</td>
<td>By DRG for the entire stay of charges</td>
</tr>
</tbody>
</table>
General Acute Care -- Patients with Limited Benefits

This information applies to all stays except deliveries and newborns.

<table>
<thead>
<tr>
<th>General Acute Care -- Patients with Limited Benefits</th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing</td>
<td>Following standard practice</td>
<td>Same</td>
</tr>
<tr>
<td>TAR / SAR</td>
<td>Admission and each day</td>
<td>Same</td>
</tr>
<tr>
<td>Payment</td>
<td>For authorized days, per diem or at percent of charges</td>
<td>By DRG for the entire stay. Payment for stays with unauthorized services may be recalculated to remove the impact of the unauthorized services.</td>
</tr>
</tbody>
</table>

TAR will continue to be reviewed as they are today

Claim Payment Process:

- As long as there is 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
## Billing, Authorization & Payment

### Major Reduction in Daily TAR/SARs

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

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.
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
Financial Impacts

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

Effect of Transition Period

- High Base
- Low base

<table>
<thead>
<tr>
<th>Year</th>
<th>High Base</th>
<th>Low Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base</td>
<td>$10,500</td>
<td>$4,500</td>
</tr>
<tr>
<td>Yr1</td>
<td>$9,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Yr2</td>
<td>$7,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Yr3</td>
<td>$6,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Yr4</td>
<td>$4,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

December 5, 2013
Financial Impacts

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
Financial Impacts

All HFPAs Are Open Areas

• All Health Facility Planning Areas (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 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
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
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

<table>
<thead>
<tr>
<th>Bone Marrow Search and Acquisition Costs</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
<td>38204</td>
</tr>
<tr>
<td>Unrelated bone marrow donor</td>
<td>38204</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Factors</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Factor XIII</td>
<td>J7180</td>
</tr>
<tr>
<td>Blood Factor Von Willebrand - Injection</td>
<td>J7183 / J7184 / Q2041</td>
</tr>
<tr>
<td>Blood Factor VIII</td>
<td>J7185 / J7190 / J7192</td>
</tr>
<tr>
<td>Blood Factor VIII / Von Willebrand</td>
<td>J7186</td>
</tr>
<tr>
<td>Blood Factor Von Willebrand</td>
<td>J7187</td>
</tr>
<tr>
<td>Blood Factor VIIa</td>
<td>J7189</td>
</tr>
<tr>
<td>Blood Factor IX</td>
<td>J7193 / J7194 / J7195</td>
</tr>
<tr>
<td>Blood Factor Antithrombin III</td>
<td>J7197</td>
</tr>
<tr>
<td>Blood Factor Antiinhibitor</td>
<td>J7198</td>
</tr>
</tbody>
</table>
Other Impacts

California Children’s Services

- 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

<table>
<thead>
<tr>
<th>Medi-Cal FFS and California Children's Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario: Patient has CCS coverage for part of the stay and Medi-Cal FFS coverage for the rest of the stay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing</td>
<td>Separate claims to CCS and Medi-Cal FFS</td>
<td>Single claim</td>
</tr>
<tr>
<td>TAR / SAR</td>
<td>SAR for CCS days and TAR for Medi-Cal FFS days</td>
<td>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.</td>
</tr>
<tr>
<td>Payment</td>
<td>CCS payment for CCS days and Medi-Cal FFS payment for Medi-Cal FFS stays</td>
<td>Single DRG payment</td>
</tr>
</tbody>
</table>

December 5, 2013
Other Impacts

California Children's Services

Billing for Beneficiaries with CCS Eligible Conditions and Managed Care

1. If a beneficiary is admitted to a hospital for a CCS-eligible condition

2. If a beneficiary is admitted to a hospital for a non-CCS eligible condition and subsequently receives services during the stay for a CCS-eligible condition. A SAR will be authorized back to the day of admission.

3. When a beneficiary stay includes delivery and well-baby coverage under a MCP, the entire claim will be billed to the MCP. If, during the stay, the baby develops a CCS-eligible condition, the entire stay for the baby will require a SAR from the date of admission. In this case, the hospital will receive two payments, one payment from the MCP for the mom’s delivery stay and one payment for the baby reimbursed from Medi-Cal FFS based on the DRG.

These examples should be billed through the FFS system. MCPs should not be billed for these stays.
Other Impacts

Rehabilitation – Paid Per Diem

• Defined as a claim that includes accommodation revenue code 118, 128, 138, 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
Other Impacts

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
Other Impacts

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
Other Impacts

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.
Other Impacts

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.
Other Impacts

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
  - However, Rogers Rate has been replaced; DRG based payment per stay is the FFS standard; Per diem pricing no longer applies
  - MCPs can reference the DRG Pricing Calculator on DRG webpage
  - MCPs should use the statewide base price adjusted by wage area to calculate payment for out-of-network emergency post stabilization services
  - 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
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
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
Billing Points

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 5th digit to indicate bwt for diagnoses 764 & 765.0-765.1
  - ICD-9-CM codes exist for gestational age
Billing Points

Other Billing Topics

- CA-MMIS will accept up to 25 diagnoses and procedure codes
- Four byte APR-DRG code will be provided on remittance advice
- 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
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
Provider Education

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
Provider Education

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
Provider Education

Many Training Opportunities Offered

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

For More Information

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

Some results in this presentation were produced using data obtained through the use of proprietary computer software created, owned and licensed by the 3M Company. All copyrights in and to the 3M™ Software are owned by 3M. All rights reserved. 3M had no role in the development of the Medi-Cal DRG payment method or the calculation of DRG base prices.