

Medi-Cal DRG Project

Frequently Asked Questions

All Patient Refined Diagnosis Related Groups (APR-DRGs) were implemented for private hospitals on July 1, 2013, and for non-designated public hospitals (NDPHs) on January 1, 2014. Please check the DRG webpage at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx for updates to the payment method.

This version replaces the June 21, 2013, version of the FAQ.

OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project?

As directed by the California legislature, the Department of Health Care Services (DHCS) implemented a new method of paying for hospital inpatient services in the fee-for-service (FFS) Medi-Cal program. This FAQ document provides interested parties with an overview of the DRG payment method and periodic updates on the project.

2. How were hospitals paid prior to the DRG implementation?

Since 1983, hospitals were paid under the Selective Provider Contracting Program (SPCP). “Contracted” hospitals negotiated a per diem payment rate with the State (previously, the California Medical Assistance Commission). Non-contracted hospitals were reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. (Note: Designated public hospitals, such as the University of California, had and continue to have separate payment methods.)

3. What change was made?

The California Legislature directed the Department to replace the SPCP with payment by diagnosis related group (DRG). This change in inpatient payment method eliminated the previous contract and non-contract status designation. The reference is to Senate Bill 853, passed in October 2010, which added Section 14105.28 to the California Welfare and Institutions Code.

A workgroup of staff from DHCS and other state agencies developed the new method, in consultation with a group of hospital managers and other stakeholders convened by the California Hospital Association (CHA). The consultation workgroup finished its work in February 2012. The original target date to implement DRG payment was July 1, 2012; as part of the 2012 Budget Act, implementation became effective July 1, 2013. Non-designated public hospitals (NDPHs) are reimbursed by DRGs effective for admissions on or after January 1, 2014.

4. Is there a transition period?

Yes. The DRG-based payment method is being phased in over a three-year period with the changes fully implemented in the fourth year, similar to what Medicare does with major payment changes. Some hospitals receive transition DRG base prices higher or lower than they would have been without the transition. In the first year of the transition (FY 2013-14), the intention is that average payments per stay for an individual hospital will increase or decrease by no more than 5% relative to what they otherwise would have been with the same mix of patients. In the second year (FY 2014-15), the range would widen to plus or minus 10% and in the third year (FY 2015-16) to 15%. Full implementation at the statewide base prices will occur July 1, 2016.

For NDPHs, the transition mechanism is similar, but the percentages are 1% in the period January-June 2014, 5% in FY 2014-15, and 7.5% in FY 2015-16.

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

At the end of January 2013, year 1 individual hospital base prices were distributed (in June 2013 for NDPH hospitals). Estimates of years 2 and 3 base prices were released to hospitals in July of 2013. The actual statewide and remote rural base prices applicable in year 2 will be distributed to hospitals to take effect July 1, 2014.

5. How will payments change in the future?

The Department plans to do an annual review of what changes, if any, in DRG base prices would be appropriate. Funding also depends on legislative appropriations. The combination of base prices, the number of stays, the average casemix per stay, and the service-specific and age-specific policy adjusters determines the overall level of payments.

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

6. What providers are affected?

The new method applies to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals and long-term care hospitals. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals are outside the scope of the DRG-based payment system. These facilities continue to be paid under previous reimbursement methodologies. With regard to rehabilitation hospitals and services, see Question 36. NDPHs transitioned to DRG reimbursement starting with admissions on January 1, 2014.

7. What services are affected?

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

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Physical rehabilitation stays (see Question 36)
- Medi-Cal managed care stays (see Question 9)
- Administrative days (see Question 37)

8. Do DRGs affect CCS and GHPP patients? Do DRGs affect Healthy Families patients?

Claims for beneficiaries who have eligibility under California Children's Services (CCS) or the Genetically Handicapped Person Program (GHPP) are priced using the DRG method. This is true for all CCS or GHPP beneficiaries regardless of whether they also have Medi-Cal FFS, Medi-Cal managed care

(CCS carve out counties only) or Healthy Families coverage. See Questions 35 and 38 for more information on claims submission for CCS patients.

9. Are payments by Medi-Cal managed care plans affected?

The primary impact to Medi-Cal managed care plans (MCPs) relates to payment for emergency and post-stabilization inpatient services provided to MCP enrollees by general acute care hospitals that are not part of the MCP's contracted provider network. MCPs are responsible for calculating out-of-network rates consistent with DRG pricing utilized in Medi-Cal fee-for-service inpatient acute care reimbursement. This DRG-based method does not affect contracts with network hospitals or arrangements for elective admissions to out-of-network hospitals. An All Plan Letter dated February 12, 2013, was mailed to MCPs and posted to the DHCS DRG webpage. It provides more detailed information regarding MCPs and payment for emergency and post-stabilization inpatient services provided to MCP enrollees by out-of-network hospitals.

10. How is payment calculated if a patient is both fee-for-service and Medi-Cal managed care in the same stay?

If the beneficiary is fee-for service for any part of an acute care stay, then the entire claim should be billed to fee-for-service Medi-Cal.

DRG PAYMENT

11. How do DRG payment methods work?

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

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

12. Who uses DRG payment?

The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Many hospitals in the U.S. use DRGs for internal management purposes. Please note that California uses APR-DRGs, which differ from MS-DRGs used by Medicare.

13. What are the characteristics of DRG payment?

- DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased.
- Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.
- Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.

- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers, policymakers, and hospitals better information about services provided.

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

For approximately 80% of stays, payment is made using a “straight DRG” calculation — that is, payment equals the DRG relative weight times the DRG base price, as described in Question 11. In special situations, payment may also include other adjustments, for example:

- *Transfer pricing adjustment.* Payment may be reduced when the patient is transferred to another acute care hospital.
- *Cost outlier adjustment.* Medicare and other DRG payers typically make additional “outlier” payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Nationally, outlier adjustments typically affect 1% to 2% of all stays and a higher percentage of all DRG payments. Medi-Cal employs a two-tier outlier policy to provide higher payment for the most costly stays.
- *“Lesser Of”.* Payment cannot exceed charges. If the allowed amount exceeds charges, payment is reduced to charges. This is consistent with previous policy.
- *Other health coverage and patient cost-sharing.* The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct payments from other health coverage (e.g., workers’ compensation) as well as the patient’s share of cost. Implementation of the DRG payment method did not affect calculations of other health coverage and patient share of cost.

15. How is the DRG assigned?

DHCS acquired the 3M™ All Patient Refined Diagnosis Related Group algorithm (APR-DRG), Version 29, to assign the DRGs to claims. Hospitals that would like more detail on use of the APR-DRG grouper can refer to Question 30. On July 1, 2014, the APR-DRG grouper will be updated to V.31.

16. Where do the DRG relative weights come from?

DHCS uses APR-DRG relative weights calculated from the Nationwide Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal fee-for-service data. The national weights are updated annually by 3M Health Information Systems. On July 1, 2014, the relative weights will be updated when V.31 of the APR-DRG grouper is installed.

17. What is the DRG base price?

The final base prices for 2013-14 were released at the end of January 2013. Many hospitals have a transition base price. Others are paid using the statewide base price, adjusted for differences in local area wages.

DRG base prices effective July 1, 2014, will be released in the late spring of 2014.

18. How are transfers paid?

Medi-Cal follows the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital is paid the lesser of:

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

This reduces the DRG base payment if the actual LOS at the transferring hospital is less than overall national average LOS minus one day. The receiving hospital receives the full DRG payment. Medi-Cal defines a transfer as UB-04 discharge status values 02, 05, 65, and 66. Medi-Cal, unlike Medicare, does not have a post-acute transfer policy. Please note that Medi-Cal calculates length of stay as the discharge date minus the admission date, so if a patient is admitted and transferred to another hospital then the calculated LOS equals zero. In this case, the payment adjusted for the transfer would be the per diem amount times the LOS (zero) plus one day.

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

A situation of partial eligibility during a hospital stay is not affected by DRG payment. Hospitals should bill for the portion of the stay for which the patient has Medicaid eligibility.

20. How are interim claims paid?

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

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

APR-DRG relative weights are higher for patients with higher acuity, resulting in a higher DRG base payment. In addition, DHCS utilizes a two tiered outlier policy and a two tiered neonatal intensive care unit (NICU) policy adjustor to provide additional payment for the most costly patients. A DRG Pricing Calculator interactive spreadsheet, which shows the mechanics of these calculations, is posted on the DHCS DRG webpage.

22. How were decisions made about the new DRG payment method?

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

Using this process, DHCS modeled the impact of policy decisions on claims data overall and by hospital. These results were shared within the CHA consultation group. In addition, individual hospitals could request and receive their claims data.

ALL PATIENT REFINED DRGs

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

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

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

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

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

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

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

No. The Medi-Cal claims processing system assigns the APR-DRG to the claim and calculates the payment.

26. What version of APR-DRGs was implemented? What is the plan for maintaining versions of APR-DRGs?

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

Version 31 of APR-DRGs, which was released October 1, 2013, will be implemented July 1, 2014. Implementation of Version 32 of APR-DRGs is tentatively planned for July 1, 2015.

27. What is the APR-DRG format?

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

CODING AND BILLING

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

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

29. How many diagnoses and procedures are used in DRG assignment? Why is this important?

Prior to DRG implementation on July 1, 2013, the California claims processing system (CA-MMIS) stored two diagnoses and two procedure codes. Enhancements were made to the system to accept up to 25 diagnosis codes and 25 procedure codes for electronic claims (18 diagnosis codes and 6 procedure codes for paper claims). Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate base APR-DRG and patient severity of illness (SOI) are assigned. This ensures accurate capture of patient acuity. Each four-digit APR-DRG has an assigned relative weight. This relative weight directly affects payment. The DRG Pricing Calculator spreadsheet, posted to the DHCS webpage, contains the list of APR-DRG relative weights.

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

Please see Table 1 for common APR-DRG V.29 grouper settings used by Medi-Cal for reimbursement of general acute care inpatient services to Medi-Cal beneficiaries at DRG designated hospitals. This information is provided specifically for hospitals that have the grouper and HAC Utility software and need the settings used by DHCS to generate the APR-DRG assignment. Hospitals do not need this information in order to submit claims to Medi-Cal; this is only for hospitals that want to understand the APR-DRG grouper settings in order to assign the APR-DRG to each claim similar to the Medi-Cal claims processing system.

Table 1		
Grouper Version	V.29	Effective July, 1, 2013
Mapping Type	Historical	APR-DRG V.29 was released October 1, 2011, reflecting the ICD-9-CM diagnosis and procedure code set that was used between October 1, 2011 and September 30, 2012. Because the ICD-9-CM code set in use today differs slightly from that code set, a “mapper” utility is used to map current ICD-9-CM code values to values in effect between October 1, 2011 and September 30, 2012. Between October 1, 2011, and October 1, 2012, the only change to the national ICD-9-CM codeset was the addition of one procedure code. Four procedure codes were implemented on October 1, 2013.
Birthweight Option	Option 5	Medi-Cal reads the diagnosis codes (not the value codes) to identify birthweight and/or gestational age if coded using appropriate diagnosis codes on the claim. If the claim does not include a diagnosis code indicating birthweight or gestational age, then the default is “normal newborn.”
Discharge DRG Option	Compute admission DRG/Discharge DRG	Excluding non-POA Complication of Care (default) is used.
HAC Version	V.30	On July 1, 2013, Medi-Cal implemented V.30 of the HAC utility (released by 3M October 1, 2012).
Agency Indicator	CMS Medicaid	The HAC category for deep vein thrombosis/pulmonary embolism (DVT/PE) refers to pediatric age. The HAC utility implemented by Medi-Cal July 1, 2013, defines pediatric as under age 18. However, because Medi-Cal policy is to define pediatric as under age 21, the utility will be updated on July 1, 2014, to include a new agency indicator of California Medicaid that will reflect the definition of pediatric as under age 21.

Grouper Field	Setting	Comments
		Medi-Cal is monitoring the application of HAC category (DVT/PE) through post payment audit and review of HAC adjusted claims with the goal of ensuring that the HAC rule is applied appropriately. If DHCS finds that the rule for the DVT/PE HAC category is applied inconsistent with policy, the appropriate action is taken to ensure correct claims adjudication and payment.
Suppress HAC Categories	No HAC suppression is needed	If a beneficiary is a pregnant woman or of pediatric age (see above), no HAC payment reduction is applied to the claim for HAC category Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE).
POA Indicators		For the present-on-admission (POA) diagnosis fields, no POA value (blank) is acceptable for exempt diagnosis codes. POA values W (clinically undetermined) and U (documentation insufficient) are treated in the claims processing system the same as value N (not present on admission).

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

When ICD-10 is implemented nationwide, the Medi-Cal claims processing system will accept ICD-10 diagnosis and procedure codes and will utilize ICD-10 codes for internal processing. ICD-10 codes will be mapped to ICD-9 codes using the V.31 3M APR-DRG mapper, and then the DRG will be assigned. Hospitals should follow national guidelines in submitting ICD-10 codes to Medi-Cal.

32. Is the present-on-admission indicator used?

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

For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, please see the ICD-9-CM, ICD-10-CM, and ICD-10-PCS official guidelines for coding and reporting at <http://www.cdc.gov/nchs/icd/icd9cm.htm>.

33. Are outpatient services related to the inpatient stay bundled?

In general, there is no change to the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission). One exception is that under the previous SPCP payment method, a few hospitals could bill for a short list of specialized, high-cost services (e.g., blood factors) on an outpatient claim even when provided on an inpatient basis. Upon DRG payment implementation, all hospitals are able to bill the items in Table 2 on an outpatient claim for separate payment during an inpatient stay.

Management of recipient hematopoietic progenitor cell donor search and cell acquisition	38204
Unrelated bone marrow donor	38204
Blood Factor XIII	J7180
Blood Factor Von Willebrand- Injection	J7183 / J7184 / Q2041
Blood Factor VIII	J7185 / J7190 / J7192
Blood Factor VIII/Von Willebrand	J7186
Blood Factor Von Willebrand	J7187

Table 2

Blood Factor VIIa	J7189
Blood Factor IX	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197
Blood Factor Antiinhibitor	J7198

34. How did the implementation of DRG pricing affect contracted SPCP rates that bundled the physician component of hospital services with the hospital component?

Effective July 1, 2013, the physician component always should be separately billed on a professional (e.g., CMS-1500) claim. This situation only affects a few hospitals that previously had negotiated bundled physician/hospital payments for specific services.

35. Were there changes in billing requirements?

Yes, effective July 1, 2013, there were changes in billing requirements and business practices; see Table 3. Hospitals received official notification from DHCS and Xerox via webinars and in-person trainings on changes in claims submission.

Table 3

Payment is per stay	Payment is no longer per day as under SPCP. APR-DRG makes one payment for the hospital stay.
Treatment Authorization Request process	TAR/SAR no longer required on length of stay for the vast majority of days. SAR is specific to CCS and GHPP recipients.
Increased importance of diagnosis and procedure coding	Assignment of base APR-DRG and level of severity is driven by the number, nature and interaction of diagnoses and comorbidities as well as procedure codes. Refer to Question 29.
Mother and newborn to be billed on separate claims	Separate payment is made for each stay.
Newborns with long lengths of stay and multiple claims must be billed with the same Medicaid number on each claim, preferably the baby's number.	Because payment is by stay, submission of the mother's beneficiary number on some claims and the baby's beneficiary number on other claims would be problematic.
Newborn weight should be coded using diagnosis codes (not value codes) when applicable. This is important as birthweight is a critical indicator of care.	ICD-9-CM classification uses the 5 th digit to indicate birth weight for diagnoses 764 and 765.0-765.1.
Interim bill types 112, 113, and discharge status 30 only accepted for stays exceeding 29 days. Interim bill type 114 not accepted.	When the patient is discharged, a single admit-through-discharge claim should be submitted. Refer to Question 20. For newborn claims, please be sure to consistently use the mother's or baby's beneficiary identification number for all claims related to a single stay.
Split billing a hospital stay	This specifically applies only to paper claims that are submitted on more than one page. Each page of the claim must show all diagnosis and procedure codes. The provider number, the beneficiary identification number, the dates of admission, and all diagnosis and procedure codes should be the same on all pages.
Administrative days	Administrative days must be billed on a separate claim, identified by revenue code. A new Level 2 administrative day was created to pay more than the existing Level 1 administrative day for sub-acute patients who require more care than Level 1. Refer to Question 37.
Four-byte APR-DRG code	Impact depends on how the hospital's billing system is configured. An APR-DRG has three bytes for the base DRG and 1 byte for level of severity without the hyphen (format 1234 for DRG 123-4).
Physical rehabilitation stays	Physical rehabilitation days to be billed on separate claim, identified by revenue code. Payment is by per diem.
Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes).
Separately payable services, supplies, and devices	In the few situations where separate payment is allowed, a separate outpatient claim should be submitted for bone marrow search and acquisition as well as blood factors. Refer to Question 33.
Late charges (bill type 115) not accepted	Submit a claim adjustment instead.
Health care-acquired conditions (HCACs)	Payment may be reduced if a HCAC is present on the claim. HCACs are also known as provider preventable conditions or PPCs under this federally required payment policy.

Table 3
Impacts on Hospital Billing and Operations of the Change to DRG Payment July 1, 2013
 (Listed in approximate declining order of impact)

Item	Comment
Physician services bundled into SPCP per diem rates	For some hospitals, specific physician services (e.g., laboratory and pathology) were bundled into the inpatient hospital per diem under the SPCP prior to July 1, 2013. This no longer applies under the DRG payment method. All physician services should be billed as professional claims (i.e., CMS-1500, 837P). Refer to Question 34.
Transfers from non-contract hospitals	All Health Facility Planning Areas (HFA) are considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for both emergency and elective services (subject to approved Treatment Authorization Requests). Hospitals are no longer required to transfer patients based on their previous non-contract designation in closed HFAs. Contract or non-contract facility designations are eliminated and do not apply under the DRG payment method.
Patients with FFS and Medi-Cal managed care in the same stay	If the beneficiary is fee-for service for any part of an acute-care stay, then the entire claim should be billed through fee-for-service Medi-Cal. Refer to Question 10.
CCS Patients with Medi-Cal fee-for-service	Most CCS patients also have Medi-Cal FFS. CCS inpatient stays are paid by DRG. Submit a single claim for a single payment; only an admission SAR or TAR is required. Daily authorization is required if the patient has a limited benefit aid code. Refer to Questions 8 and 38.
CCS patients with Medi-Cal managed care	For a CCS client enrolled in a Medi-Cal managed care plan with “carved-out” CCS services, CCS authorizes inpatient admissions for the treatment of the client’s CCS eligible condition. If a patient is treated for a CCS-eligible inpatient admission, submit the claim to Medi-Cal FFS and not the Medi-Cal managed care organization. Refer to Questions 8 and 38.

OTHER QUESTIONS

36. How was physical rehabilitation care affected?

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

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

37. How were administrative days affected?

Under the previous payment method and as of July 1, 2013, forward, administrative days are approved through the TAR/SAR process and paid at a lesser of the average statewide per diem equivalent to the cost of Distinct Part-Skilled Nursing Facility (DP-SNF) services or the hospital’s actual DP-SNF cost. Generally, administrative days are defined as days of service provided to beneficiaries who no longer require acute hospital care, but need nursing home placement or other subacute or post-acute care that is not available at the time. With the transition to a new payment method on July 1, 2013, the Department implemented two levels of administrative days.

Administrative Days – Level 1: These days are treated the same as they were prior to July 1, 2013. These days continue to require a daily TAR, are billed and paid under the previous per diem methodology, and continue to be billed using revenue code 169.

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

Administrative day level 2 revenue codes 190 (sub-acute pediatric) and 199 (sub-acute adult) are available for payment only to DRG hospitals. The pediatric level is used when the beneficiary is less than 21 years old. Administrative day level 2 requires a daily TAR and submission of a claim separate from the DRG claim. Payment for administrative day level 2 is the lower of the hospital-specific rate already established and the statewide rate. As of July 1, 2013, the statewide per diem rates are \$894.60 (pediatric) and \$896.67 (adult). Payment works the same as revenue code 169 relative to bundling policies and separate payment for ancillary services. The previous list of separately payable services that can be billed in conjunction with administrative days is unchanged.

38. What is the impact on billing for CCS patients?

As mentioned in Question 8, claims for beneficiaries under CCS are priced using the new DRG method. Most CCS patients also have Medi-Cal coverage. Billing and SAR/TAR have been streamlined for these patients. Separate claims and authorizations for the CCS and Medi-Cal parts of the stay are no longer required if the beneficiary has Medi-Cal fee-for-service. Only one claim should be submitted and only one admission SAR should be requested for a CCS client, including clients with limited scope Medi-Cal, i.e., pregnancy related and emergency services only. One DRG payment is made for the stay.

For a CCS client enrolled in a Medi-Cal managed care plan with “carved-out” CCS services, CCS authorizes inpatient admissions for the treatment of the client’s CCS eligible condition. If a patient is treated for a CCS-eligible inpatient admission, Medi-Cal FFS should be billed and these services pursuant to a CCS SAR are paid by DRGs. Submit the claim to Medi-Cal FFS and not the Medi-Cal managed care organization regardless of the reason for admission as long as a CCS condition is treated during the admission. For example, submit the bill to Medi-Cal if the patient is:

- Admitted for a CCS-eligible condition,
- Admitted for a non-CCS-eligible condition, but receives services for an existing CCS condition, or
- Develops a CCS condition during the stay that requires treatment.

Payment for all inpatient services for a CCS client enrolled in a Medi-Cal managed care plan with “carved-in” CCS services, i.e., the County Organized Health System health plans in San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa counties, are the responsibility of the Medi-Cal managed care plan and should not be billed to the Medi-Cal.

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

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

40. How does the change to DRG payment affect the overall payment level?

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

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

Because there was a major change in the payment method, some hospitals saw decreases in payments while other hospitals saw increases. There is a transition period of three years; see Question 4..

42. Are payments to hospitals previously considered “noncontract” subject to adjustment after cost reports have been submitted?

In general, payments are not subject to adjustment after cost reports have been submitted. The Department does reserve the right to audit claims if appropriate. For example, the Department may audit stays that receive an outlier payment, have restricted aid codes, or inappropriate coding.

43. Do hospitals still have to submit cost reports?

Yes. The Department utilizes cost reports for a variety of purposes, including calculation of hospital utilization fees and review of hospital payments overall.

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

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

For stays paid by DRG, the TAR/SAR process is as follows:

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

For stays not paid by DRG:

- TAR requirements on both the admission and the length of stay continue as they were previously for administrative and rehabilitation days (see Questions 36 and 37).
- Designated public hospitals follow their current process.

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

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

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

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

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

DRG payments replace the SPCP but does not change any existing health screening requirements for newborns.

47. Where can I go for more information?

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

- *FAQ*. Updates of this *Frequently Asked Questions* are made available as changes are needed. In addition, DHCS has compiled an additional Provider Billing FAQ specific to billing and TAR/SAR issues compiled from questions asked during provider training sessions or sent to the DRG mailbox.
- *PDD*. The Policy Design Document (PDD) provides more detail on the change in payment methodology to APR-DRG. An updated September 27, 2013, version has been posted to the DHCS webpage.
- *DRG Pricing Calculator*. The DRG Pricing Calculator interactive spreadsheet does not assign the APR-DRG, but it demonstrates how a given APR-DRG is priced in different circumstances. The calculator includes a complete list of APR-DRGs and related information for use in California.
- *Hospital training sessions*. Hospital trainings were held across the state in 2013 prior to DRG implementation and since implementation. If additional training is needed, please contact the Telephone Services Center (TSC) or email DRG@dhcs.ca.gov.
- *Provider Bulletins*. Provider bulletins contain additional details on specific areas of DRG billing, payment, and TAR/SAR authorizations.

FOR FURTHER INFORMATION:

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

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

https://learn.medi-cal.ca.gov/_ngcdfvw/diagnosis_related_group_overview_recorded_webinar.aspx