

Medi-Cal DRG Year 2

Provider Training W397 6/26/14

June 19, 2014

June 26, 2014

Darrell Bullocks, Kevin Quinn, Dawn Weimar



Agenda

1. **Medi-Cal DRG Background**
2. Year 1 Actual
3. Year 2 Updates
4. Year 2 Impacts
5. Billing Points
6. Provider Education

Appendix

Medi-Cal DRG Background

Stay in Touch



Home > Providers & Partners > **Diagnosis Related Group Hospital Inpatient Payment Methodology**

▶ Diagnosis Related Group Hospital Inpatient Payment Methodology

Payment by DRGs encourages access to care, rewards efficiency, improves transparency, and improves fairness by paying similarly across hospitals for similar care. Payment by DRGs also simplifies the payment process, encourages administrative efficiency, and bases payments on patient acuity and hospital resources rather than length of stay.

History of DRG

Senate Bill 853 (Statutes of 2010) added Section 14105.28 to the Welfare and Institutions Code which mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon Diagnosis Related Groups (DRGs).

DRG Payment Method

The DRG reimbursement methodology replaced the previous payment method for all private hospitals

[Find more information about SPCP](#)

To find out about DRG specific information, please select from the pages below.

Contact Information	Billing and TAR Changes
Important Information	Pricing Resources: SFY 2013/14
Provider Education and Bulletins	Pricing Resources: SFY 2014/15

Recorded Webinars on the Medi-Cal Learning Portal

Diagnosis Related Group Overview recorded Webinar (Year 1) 12/20/13

https://learn.medi-cal.ca.gov/_ngcdfw/diagnosis_is_related_group_overview_recorded_webinar.aspx

Diagnosis Related Group ratesetting Recorded Webinar (Year 1) Feb 2013

https://learn.medi-cal.ca.gov/_m07kbnh/diagnosis_is_related_group_ratesetting_recorded_webinar.aspx

Diagnosis Related Group Billing Recorded Webinar July 2013

https://learn.medi-cal.ca.gov/_fl55izi/diagnosis_related_group_billing_recorded_webinar.aspx

Medi-Cal DRG Background

Overview

- **Timeline:**

- 7/1/13 Payment by APR-DRG started with dates of admission 7/1/13; 1/1/14 for NDPHs
 - Base rates phase in over four-year period
- 7/1/14 Year 2 update
- 7/1/15 Year 3 update
- 7/1/16 Year 4 end of transition

- **Programs:** Medi-Cal fee-for-service, CCS only, GHPP only

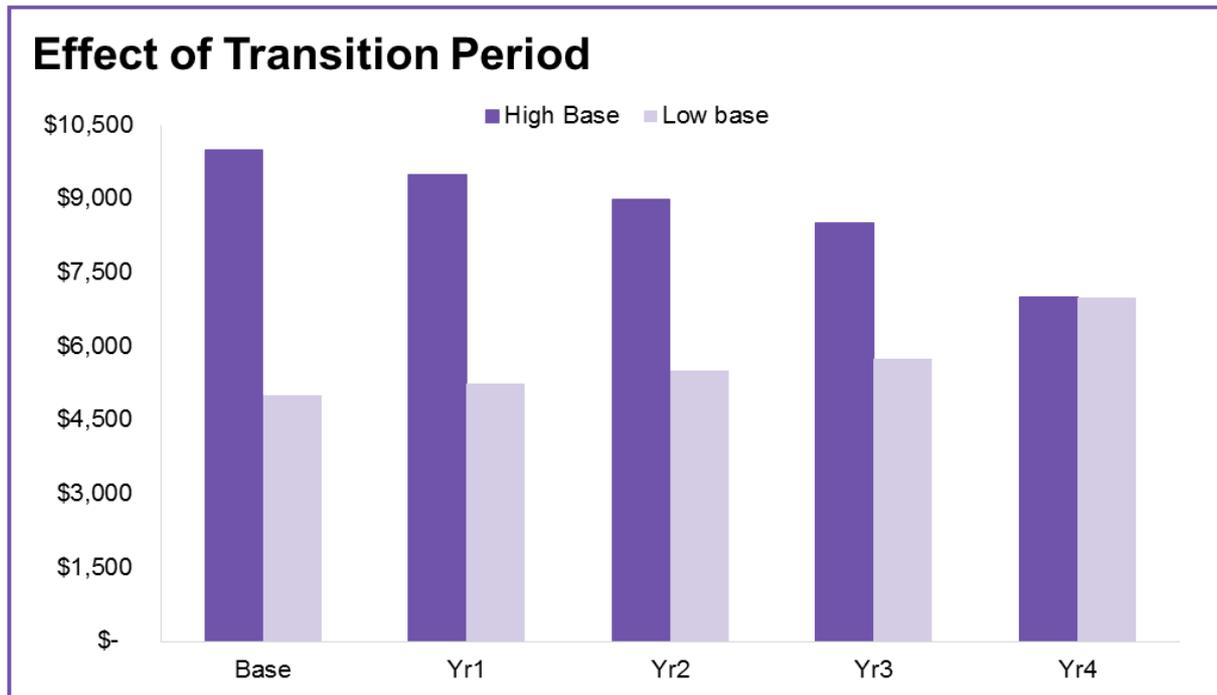
- **Hospitals:** General, acute care hospitals, including out-of-state, Medicare-designated CAH, Medicare-designated LTAC

- **Excluded Hospitals:** designated public hospitals, psychiatric hospitals (county)

- **Excluded Services:** rehabilitation (per diem), admin days (per diem)

Transition Period Moderates Impacts

- DRG payment being phased in over three years, with full impact in SFY 2016/17
- July 1, 2014 is Year 2 of DRG base rate transition
- Of 337 CA hospitals, 227 are transitioning toward the statewide base rates while 110 are considered non-transition and are already at the statewide rate
- Example hospitals depicted moving toward statewide rate from high and low point below:

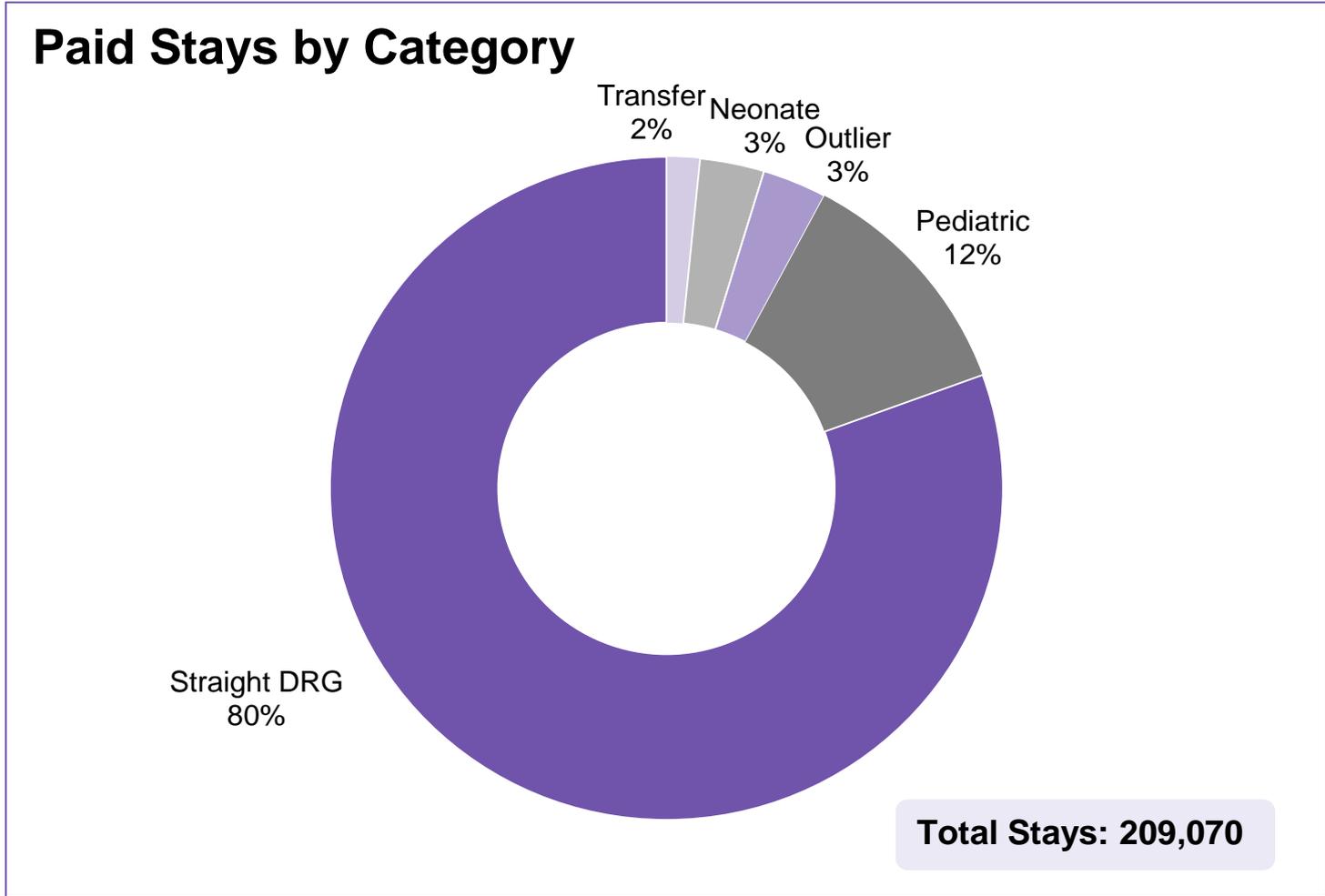


Agenda

1. Medi-Cal DRG Background
- 2. Year 1 Actual**
3. Year 2 Updates
4. Year 2 Impacts
5. Billing Points
6. Provider Education

Appendix

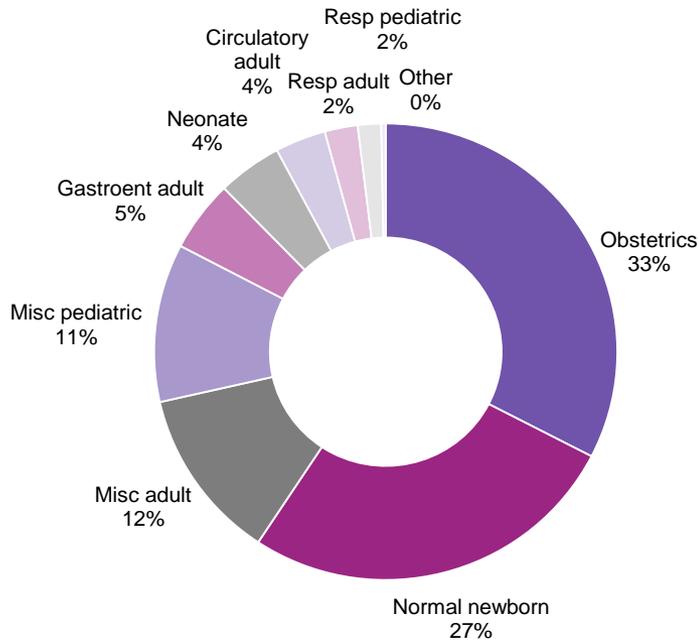
How Claims Were Paid



Stays & Payment by MCC

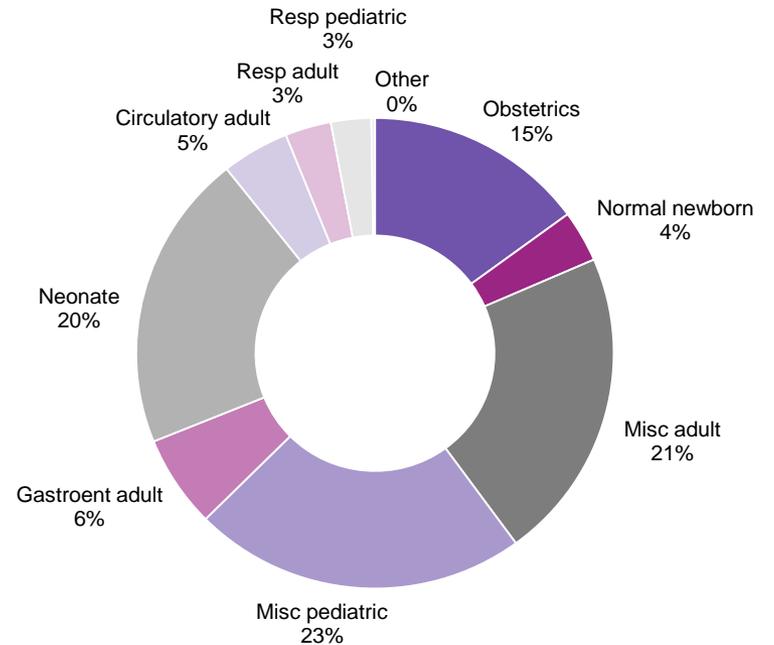
Stays by Medicaid Care Category

Total Stays: 209,070
Paid claims thru 3/10/14



Payment by Medicaid Care Category

Total Stays: 209,070
Paid claims thru 3/10/14



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Appendix

Year 2 Headlines

- Overall approach – stability as we move from Year 1 to Year 2
- Technical updates only; no policy changes
- Technical updates
 - APR-DRG grouper, relative weights, and national average lengths of stay
 - Medicare wage area index values (for non-transition hospitals)
 - Cost-to-charge ratios
 - Cost outlier thresholds to reflect charge inflation
 - Discharge code 63 added as a transfer status code to existing codes 02, 05, 62, and 65
- Payment policies unchanged
 - Policy adjustors for sick newborns and pediatrics
 - Outlier payment formulas
 - Pricing logic overall
- As we continue with DRG, mid-year changes remain possible

Key Payment Values

Base rates		
DRG base rate, non-remote rural	\$6,223	\$6,289
DRG base rate, remote rural	\$10,218	\$10,640
Transition hospital-specific base rates	Year 1 Hospital-specific	Year 2 Hospital-specific
Technical updates		
DRG version	V.29 charge-based weights	V.31 charge-based weights
Inflation factor		5.1% applied to outlier thresholds and charges
Documentation & coding adjustment	3.5% in Year 1	No DCC in year 2
Wage area adjustments	Per Medicare Impact File for FFY 2013, labor share is 68.8%.	Per Medicare Impact File for FFY 2014; labor share is 69.6%.
Transfer Status Codes	02, 05, 65 and 66	02, 05, 63, 65 and 66
Outlier policy factors- Updates		
Cost to charge ratios	Year 1 values	Year 2- updated to FY2012 w some exceptions
High side (provider loss) tiers and marginal cost (MC) percentages	i.e.\$0 - \$40,000: no outlier payment	i.e.\$0 - \$42,040: no outlier payment
	i.e. \$40,000 to \$125,000: MC = 0.60	i.e. \$42,040 to \$131,375: MC = 0.60
	i.e. > \$125,000: MC = 0.80	i.e. > \$131,375: MC = 0.80
Low side (provider gain) tiers and marginal cost (MC) percentages	i.e. \$0 - \$40,000: no outlier reduction	i.e. \$0 - \$42,040: no outlier reduction
	i.e. > \$40,000: MC = 0.60	i.e. > \$42,040: MC = 0.60
Policy adjustors- no change		
Policy adjustor - neonate at designated NICU	1.75	1.75
Policy adjustor - neonate at other NICU	1.25	1.25
Policy adjustor - age - pediatric, misc & resp	1.25	1.25
Pediatric age cutoff	< 21	< 21

For Year 2, Changes Technical in Nature

1. APR-DRG V.29→V.31 with updated relative weights
 - Reduces measured casemix 3.86% from 0.7314 to 0.7032
2. Updated cost-to-charge ratios by hospital
 - Weighted average CCR 24.2% in Year 1 → 23.5% in Year 2
3. Updated wage area index values (affects non-transition statewide base rates)
 - Most recent Medicare values for FFY 2014
 - Wage area labor share increased from 68.8% to 69.6%
4. No additional documentation and coding adjustment

Hospital-Specific DRG Base Rates

- Rate notification letters sent to each hospital CFO May 20, 2014
 - Transition hospitals – same base rate as notified in July 2013
 - Non-transition hospitals – same base rates as notified in July 2013, then adjusted to reflect latest Medicare wage area values



State of California—Health and Human Services Agency
Department of Health Care Services



TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

May 20, 2014

CHIEF FINANCIAL OFFICER
«NAME»
«ADDRESS», «Suite_»
«CITY», «STATE» «ZIP»-«ZIP_4»

RE: Medi-Cal FFS Inpatient DRG Rate Notification for NPI «NPI»

Dear Chief Financial Officer,

This letter serves as the formal communication of your hospital's base rate for Diagnosis Related Group (DRG) inpatient fee-for-service general acute care Medi-Cal admissions for State Fiscal Year (SFY) 2014-15. The base rate is effective for admissions on or after July 1, 2014, through June 30, 2015.

The goal for Year 2 of DRG payment, which begins July 1, 2014, is to keep the method as stable as possible. The statewide base rate is \$6,289 (\$10,640 for remote rural hospitals). In Year 2 of the transition to DRG payment, some hospitals will receive their Year 2 transition base rate instead of the statewide base rate. Previously delivered Year 2 transition base rates to transition hospitals have not changed.

Your hospital is a transition hospital. The applicable base rate for July 1, 2014 is the same as you were advised in August 2013. Your rate is «FY_1415_Transitional_Base_Rate_».

Hospital-Specific DRG Base Rates

- To see hospital-specific base rates, go to DRG webpage/DRG Pricing Resources for SFY 2014/15:
 - SFY 14/15 DRG Pricing Calculator
 - SFY 14/15 Hospital Characteristics File
 - SFY 14/15 Transition Base Rates for Admissions



DRG Pricing Resources for SFY 2014/15

Below is information about DRG Pricing Resources for SFY 2014/15

[SFY 14/15 DRG Pricing Calculator \(Excel\)](#)

[SFY 14/15 DRG Pricing Calculator \(PDF\)](#)

[SFY14/15 Hospital Characteristics File \(PDF\)](#)

[SFY14/15 Transition Base Rates \(PDF\)](#)

[Back to DRG Main Page](#)

Update Wage Area and Index Values

- Policy is to follow Medicare
- Applies to non-transition hospitals only
- Labor portion of cost updated by Medicare
 - Now 69.6% in FFY 2014, up from 68.8% in FFY 2013
 - Calculation (e.g., if statewide base rate = \$6,289 and wage area index = 1.2477)
 - $(\$6,289 \times 0.696 \times 1.2477) + (\$6,289 \times 0.304) = \$7,373.22$
- Each year the Medicare Impact File updates wage area assignments and index values for Medicare prospective payment hospitals
 - www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
 - For FFY 2014, most California hospitals saw an increase in the Medicare wage area value
- For children's hospitals, Medicare CAHs and others not listed on the Medicare Impact file, we assign wage areas and index values by geographic location

Wage Area Index Values

Wage Area Description	FFY 2013	FFY 2014	Wage Area Description	FFY 2013	FFY 2014
Bakersfield-Delano	1.2282	1.2477	Sacramento-Arden-Arcade-Roseville	1.4203	1.4887
California (Rural)	1.2282	1.2477	Salinas	1.5968	1.5678
Chico	1.2282	1.2477	San Diego-Carlsbad-San Marcos	1.2282	1.2477
El Centro	1.2282	1.2477	San Francisco-San Mateo-Redwood City	1.5889	1.6269
Fresno	1.2282	1.2477	San Jose-Sunnyvale-Santa Clara	1.6801	1.6650
Hanford-Corcoran	1.2282	1.2477	San Luis Obispo-Paso Robles	1.2461	1.2559
Los Angeles-Long Beach-Glendale	1.2282	1.2477	Santa Ana-Anaheim-Irvine	1.2282	1.2508
Madera-Chowchilla	1.2282	1.2477	Santa Barbara-Santa Maria-Goleta	1.2359	1.2488
Merced	1.2613	1.2879	Santa Cruz-Watsonville	1.7471	1.7276
Modesto	1.2880	1.3401	Santa Rosa-Petaluma	1.6082	1.6337
Napa		1.5215	Stockton	1.3148	1.3505
Oakland-Fremont-Hayward	1.6090	1.6439	Vallejo-Fairfield	1.5353	1.5558
Oxnard-Thousand Oaks-Ventura	1.2815	1.3019	Visalia-Porterville	1.2282	1.2477
Redding	1.3822	1.4390	Yuba City	1.2282	1.2799
Riverside-San Bernardino-Ontario	1.2282	1.2477			

Note:

1. Individual hospitals may not receive the specific value for the wage area that they are assigned to by Medicare. Medi-Cal follows Medicare, which sometimes adjusts hospital-specific values for various reasons.

Update Outlier Thresholds

- In general, outlier payments depend on estimated cost = hospital charges x CCR relative to cost outlier threshold
- Hospital charges tend to rise faster than CCRs decline, so it is important to update cost outlier thresholds
- For this simulation, cost outlier thresholds increased by 5.1%
 - Reflects charge inflation per stay for Medi-Cal FFS stays in most recent year of OSHPD data, from \$61,165 in 2011 to \$64,285 in 2012

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APR-DRG Grouper Update V.29 to V.31

- Important to update APR-DRG version to keep pace with changes in medicine and practice
- No major change in DRG logic moving from V.29 to V.31
 - Changes from V.29 to V.30 is the most significant change in 10 years; nevertheless, not a major change
 - No logic changes between versions 30, 31 and 32
- Still 314 base DRGs, each with 4 levels of severity
- We compared APR-DRG assignments on 209,070 CA DRG stays that were paid using V.29, then regrouped to V.31
 - 94% of stays did not change DRG assignment
 - 0.3% of stays changed base APR-DRG
 - 5% of stays changed severity of illness within the same base APR-DRG
 - 1% increased severity
 - 4% decreased severity
- Relative weights calculated by 3M from 15 million stays from the Nationwide Inpatient Sample

Year 2 Impacts

Grouper Update and Impact

Changes in Severity of Illness from APR DRG V.29 to V.31				
APR DRG Description	V.29	V.31	Stays	Change
Cesarean delivery	540-1	540-2	1,142	Increase
Vaginal delivery	560-2	560-1	937	Decrease
Septicemia & disseminated infections	720-4	720-3	377	Decrease
Vaginal delivery	560-1	560-2	370	Increase
Cesarean delivery	540-2	540-3	252	Increase
Vaginal delivery	560-3	560-2	238	Decrease
Septicemia & disseminated infections	720-3	720-2	194	Decrease
Kidney & urinary tract infections	463-3	463-2	144	Decrease
Heart failure	194-3	194-2	143	Decrease
Cesarean delivery	540-2	540-1	118	Decrease
Cellulitis & other bacterial skin infections	383-3	383-2	110	Decrease
Diabetes	420-3	420-2	105	Decrease
Other pneumonia	139-3	139-2	96	Decrease
Other antepartum diagnoses	566-2	566-1	84	Decrease
Chest pain	203-3	203-2	84	Decrease
Other pneumonia	139-4	139-3	80	Decrease
Chronic obstructive pulmonary disease	140-3	140-2	79	Decrease
Electrolyte disorders except hypovolemia related	425-3	425-2	78	Decrease
Heart failure	194-4	194-3	78	Decrease
Angina pectoris & coronary atherosclerosis	198-3	198-2	75	Decrease
Subtotal			4,784	
All other increase			715	Increase
All other decrease			5,915	Decrease
Total			11,414	

Notes:

1. Based on DRG paid claims 7/1/13-3/10/14; stays = 209,070.

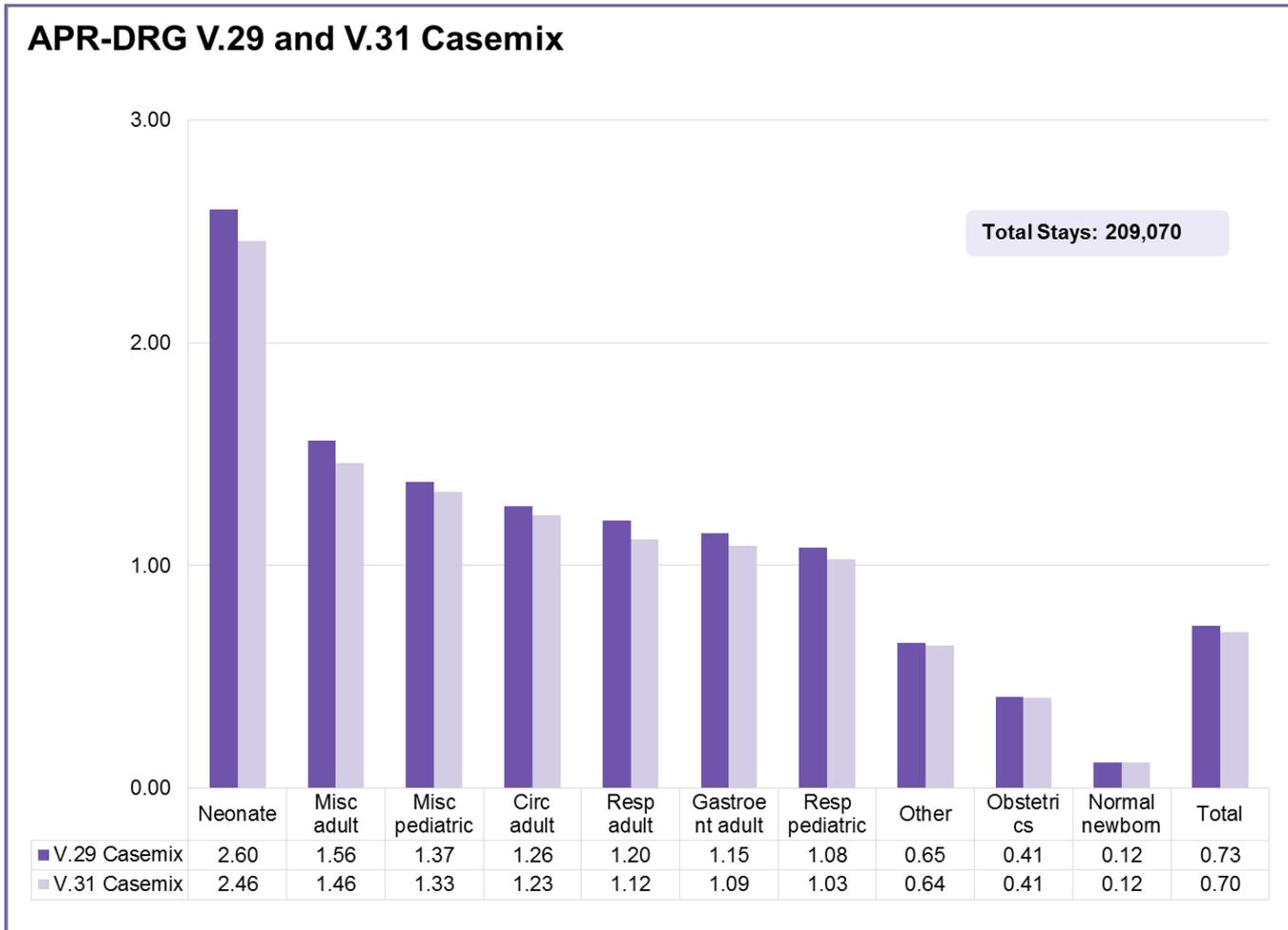


Grouper Update and Impact (Cont.)

Base DRG Changes from APR-DRG V.29 to V.31		
V.29 APR-DRG & Description	V.31 APR-DRG & Description	Stays
639 Neonate Birthwt >2499G W Other Sig Conditio	640 Neonate Bwt >2499G, Norm NB Or Neonate W Other Prob	149
283 Other Disorders Of The Liver	640 Neonate Bwt >2499G, Norm NB Or Neonate W Other Prob	145
169 Major Thoracic & Abdominal Vascular Procedu	160 Major Cardiothoracic Repair Of Heart Anomaly	26
640 Neonate Bwt >2499G, Norm NB Or Neonate W	639 Neonate Birthwt >2499G W Other Significant Condition	24
	All Others	102
	Total	446

Notes:
 1. Based on DRG claims paid between 7/1/13-3/10/14.

Impact by Medicaid Care Category



Grouper Software Settings

- Hospitals need not buy APR-DRG software or put the DRG on the claim
- Hospitals that try to mimic Medi-Cal DRG pricing must be sure to use the appropriate software settings.

Selected APR DRG Grouper Settings for Medi Cal			
Grouper Field	Year 1 Setting (7/1/13 6/30/14)	Year 2 Setting (7/1/14 6/30/15)	Comments
Grouper Version	V.29	V.31	V.29 effective July 1, 2013; V.31 effective July 1, 2014
Mapping Type	Historical	N/A for admission dates 7/1-9/30/14 Historical for admission dates 10/1/14-6/30/15	APR-DRG V.31 was released October 1, 2013, reflecting the ICD-9-CM diagnosis and procedure code set that is effective between October 1, 2013 and September 30, 2014. Mapping is required when the admission date of the claim is outside of the date range of the mapper per 3M Health Information Systems.
Birthweight Option	Option 5 Coded weight with default	Option 5 Coded weight with default	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 grouper default, for claim grouping purposes, is to a birthweight which indicates "normal newborn."
Discharge DRG Option	Excluding non-POA Complication of Care	Excluding non-POA Complication of Care	Excluding non-POA Complication of Care (default) is used.

Grouper Software Settings Year 1

Schedule - New

User key1:	<input type="text"/>	User key2:	<input type="text"/>
Begin date:	07/01/2013	End date:	06/30/2014
Description:	CA V29		
Modified date:	<input type="text"/>		

Grouper version:	APR DRG Grouper version 29.0 (10/01/2011)
PPC version:	None
HAC version:	HAC Version 30.0 for Medicaid (10/01/2012)
Payer Logic Indicator:	None (Standard 3M APR DRG)
Birth weight option:	Coded weight with default
Discharge DRG option:	Compute excluding only non-POA Complication of Care codes
Keyed by:	Admit date
Entered code mapping:	ICD-9-CM Version 30.0 effective 10/01/2012
Mapping type:	Historical
Reimbursement scheme:	None

What's This?
Print
Clear
Cancel
Save
Save as...

Grouper Software Settings Year 2

Schedule - New

User key1:	<input type="text"/>	User key2:	<input type="text"/>
Begin date:	07/01/2014	End date:	09/30/2014
Description:	CA V31		
Modified date:	<input type="text"/>		

Grouper version: APR DRG Grouper version 31.0 (10/01/2013)

PPC version: None

HAC version: HAC Version 30.0 for Medicaid (10/01/2012)

Payer Logic Indicator: None (Standard 3M APR DRG)

Birth weight option: Coded weight with default

Discharge DRG option: Compute excluding only non-POA Complication of Care codes

Keyed by: Admit date

Entered code mapping: None

Mapping type:

Reimbursement scheme: None

What's This?
Print
Clear
Cancel
Save
Save as...

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Billing for Newborns – Refresh

- Code diagnoses and procedures completely, accurately and defensibly
- Newborns should be billed on their own claims
- Sick newborns should be billed with single client ID
 - Either mother's Beneficiary Identification Card (BIC) or newborn's
 - Especially important 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, an admission TAR/SAR is required.
 - Please bill both the well and sick part of the stay on the same claim, this is one hospital stay
- 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 birthweight for diagnoses 764 & 765.0-765.1
 - ICD-9-CM codes exist for gestational age

Other Billing Topics – Refresh

- For electronic (CMC) billing, CA-MMIS will accept up to 25 diagnosis and procedure codes; paper claims allow up to 18 diagnosis codes and 6 procedure codes
- Four-byte APR-DRG code is provided on remittance advice detail
- Physician services should be billed as separate claims
 - Before July 1, 2013, 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
- Split paper bills (multiple-page paper claims): 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 should be submitted for the entire stay instead
- Bill type 115 (late charges) not accepted – void and resubmit the original claim instead
- Use the applicable DRG pricing calculator to understand payment calculations and to estimate payment; calculator varies by SFY

California Children's Services (CCS)

- 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 only part of the stay and is Medi Cal FFS for the rest of the stay.

	Previous Payment Method	Effective July 1, 2013
Billing	Separate claims to CCS and Medi-Cal FFS	Single claim
TAR / SAR	SAR for CCS days and TAR for Medi-Cal FFS days	Single SAR or TAR, depending on aid code on admission (CCS or Medi-Cal only)
Payment	CCS payment for CCS days and Medi-Cal FFS payment for Medi-Cal FFS stays	Single DRG payment

California Children's Services (CCS)

Billing for Beneficiaries with CCS Eligible Conditions and Managed Care

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

FFS Medi-Cal will pay:

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 for CCS authorized providers
3. If, during a newborn stay, a newborn develops a CCS-eligible condition, the entire stay for the newborn will require a SAR from the date of admission (The MCP will pay for the mom's delivery stay only)

Direction from Provider Enrollment

Prior to DRG, Contract and Non Contract hospital providers completed a DHCS 6004 to request a revenue rate change to the provider's master file. With DRG, all reimbursement base rates are loaded in the provider's master file by the SNFD and therefore *hospitals are no longer required* to complete and submit this form to Provider Enrollment Division.

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/revcdipfrm6004_i00.doc

State of California—Health and Human Services Agency

Return completed form to: Department of Health Care Services
 Provider Enrollment Division
 MS 4704
 P.O. Box 997413
 Sacramento, CA 95899-7413
 (916) 323-1945

REVENUE RATE CHANGE REQUEST

Hospital name		Provider number	Date	
Address (number, street)		City	State	ZIP code

REVENUE CODE	DESCRIPTION	NEW RATE	EFFECTIVE DATE
<input type="checkbox"/> 119	Room and Board, Private (Medical or General), Other		
<input type="checkbox"/> 129	Room and Board, Semi-Private Two Beds (Medical or General), Other		
<input type="checkbox"/> 139	Room and Board, Semi-Private Three or Four Beds, Other		
<input type="checkbox"/> 159	Room and Board, Ward (Medical or General), Other		
<input type="checkbox"/> 170	Nursery, General Classification		
<input type="checkbox"/> 171	Nursery, Newborn—Level 1		
<input type="checkbox"/> 172	Nursery, Newborn—Level II (When billed with non-OB-delivery-related ICD-9-CM Volume 3 Procedure Code; formerly this was local code 085)		
<input type="checkbox"/> 172	Nursery, Newborn—Level II (When billed with OB-delivery-related ICD-9-CM Volume 3 Procedure Code; formerly this was local code 095)		

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Looking Ahead to Year 3

- Regular annual updates to the APR-DRG grouper are expected
 - APR-DRG V.32 to be released by 3M 10/1/14 and implemented by Medi-Cal 7/1/15
 - Relative weights and average length of stay parameters change with every version
- Annual update planned to hospital-specific cost-to-charge ratios and wage area indices
- ICD-10 delayed; no sooner than October 1, 2015
- DHCS will continue to monitor the payment method, access to care, hospital documentation and coding, and other policy topics throughout Year 2
- Mid-year changes to DRG payment policies are possible

From the Medi-Cal approved Medicaid State Plan

The effect of all transition base rates, policy adjustors and values as referenced in Appendix 6 of Attachment 4.19 A will be monitored by DHCS on a quarterly basis. If DHCS determines that adjustments to any values or parameters specified in Appendix 6 of Attachment 4.19-A are necessary to ensure access for all Medi-Cal beneficiaries, program integrity, or budget neutrality, DHCS may adjust those values or parameters upon approval of a State Plan Amendment. (P.18)

For Further Information

- DHCS webpage devoted to APR-DRG information
 - Reorganized year 1 vs. year 2: www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx
- Join DRG listserv by emailing drg@dhcs.ca.gov
- Policy questions (NOT patient-specific information) to drg@dhcs.ca.gov
- Medi-Cal Learning Portal: <https://learn.medi-cal.ca.gov/Training/TrainingCalendar.aspx>
- Provider bulletins at files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20872_1.asp
- Medi-Cal Telephone Service Center 1-800-541-5555 from 8 a.m. to 5 p.m.

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Agenda

1. Medi-Cal DRG Background
2. Year 1 Actual
3. Year 2 Updates
4. Year 2 Impacts
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6. Provider Education

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Training

DRG Refresher

Recorded Webinars on the Medi-Cal Learning Portal

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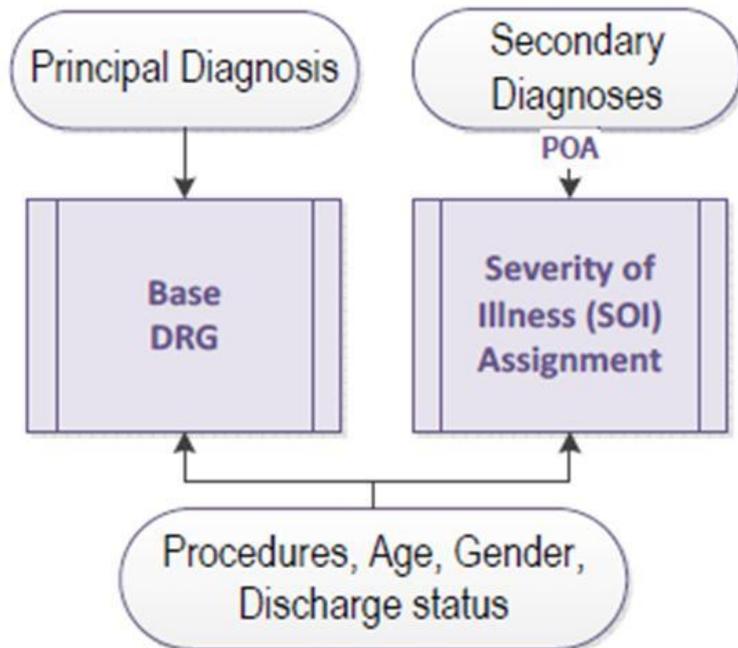
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Diagnosis Related Group Billing Recorded Webinar July 2013

https://learn.medi-cal.ca.gov/fl55izi/diagnosis_related_group_billing_recorded_webinar.aspx

Structure of APR-DRGs

DRG 002-4 Base DRG - SOI



APR DRG	APR DRG Description	Relative Weight
002-1	Heart &/Or Lung Transplant	9.0557
002-2	Heart &/Or Lung Transplant	10.0846
002-3	Heart &/Or Lung Transplant	13.0086
002-4	Heart &/Or Lung Transplant	21.2277
141-1	Asthma	0.3450
141-2	Asthma	0.5100
141-3	Asthma	0.7777
141-4	Asthma	1.4124
560-1	Vaginal Delivery	0.3027
560-2	Vaginal Delivery	0.3445
560-3	Vaginal Delivery	0.5115
560-4	Vaginal Delivery	1.7983

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 – from the FY 2013 cost report with some exceptions
- **Wage area** - from Medicare impact file for FFY14, including reclassifications where appropriate

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
 - For electronic claims, CA-MMIS will use up to 25 diagnoses and procedure codes; for paper claims, 18 diagnoses and 6 procedure codes are accommodated.
2. Hospital-specific base rate
 - Higher base rate for remote rural hospitals
 - Transition rates in effect SFY13/14, SFY 14/15, SFY15/16
 - Adjust by Medicare Wage Area
3. Incorporate specific payment adjustments
 - Age adjustor, NICU adjustor, outlier payments, transfers

Claims Pricing under DRG

Straight DRG

- 314 base APR-DRGs, each with four levels of severity
- DRG base rate = statewide base rate adjusted for wage area
 - L.A. area: $(\$6,289 \times 69.6\% \times 1.2477) + (\$6,289 \times 30.4\%) = \$7,373$
- Individual hospitals will have different base rates due to the transition and Medicare wage index for non-transition hospitals

DRG	Description	Rel Wt	DRG Base Rate	DRG Base Payment
139-1	Oth Pneumonia	0.3915	\$7,373	\$2,887
139-2	Oth Pneumonia	0.5640	\$7,373	\$4,158
139-3	Oth Pneumonia	0.9394	\$7,373	\$6,926
139-4	Oth Pneumonia	1.8747	\$7,373	\$13,822
166-1	Coronary Bypass w/o Cath	2.6441	\$7,373	\$19,495
166-2	Coronary Bypass w/o Cath	3.0517	\$7,373	\$22,500
166-3	Coronary Bypass w/o Cath	4.0194	\$7,373	\$29,635
166-4	Coronary Bypass w/o Cath	7.0219	\$7,373	\$51,772

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 Rate	DRG Base Payment	Pediatric Adjustor	Payment Rel. Wt.	DRG Base Payment
139-1	Oth Pneumonia	0.3915	\$7,373	\$2,886	1.25	0.4893	\$3,608
139-2	Oth Pneumonia	0.5640	\$7,373	\$4,158	1.25	0.7050	\$5,198
139-3	Oth Pneumonia	0.9394	\$7,373	\$6,926	1.25	1.1743	\$8,658
139-4	Oth Pneumonia	1.8747	\$7,373	\$13,822	1.25	2.3434	\$17,278

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		
Step	Explanation	Amount
DRG base payment	$\$7,373 \times 1.1342$	\$8,362
Transfer case	Discharge status = 02	Yes
National ALOS	Look up from DRG table	5.18
Tsf adjustment	$(\$8,362/5.18) * (3+1)$	\$6,457
DRG payment	$\$6,457 < \$8,362$	\$6,457

Transfers

- Same Day Stays- LOS for a same day stay is zero; therefore, the Transfer Payment calculation for same-day stays is as follows:

$$\frac{(\text{DRG Base Payment}) * (0 + 1)}{\text{National ALOS}}$$

- 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

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%
- Tier 1 Threshold \$42,040

Example: DRG 720 4 Septicemia with Charges of \$180,000		
Step	Explanation	Amount
DRG base payment	$\$7,373 \times 2.8127$	\$20,738
Estimated cost	$\$180,000 \times 39\%$	\$70,200
Estimated loss	$\$70,200 - \$20,738$	\$49,462
Cost outlier case	$\$49,462 > \$42,040$	Yes
Est. loss - cost outlier	$\$49,462 - \$42,040$	\$7,422
Cost outlier payment	$\$7,422 \times 60\%$	\$4,453
DRG payment	$\$20,738 + \$4,453$	\$25,191

Cost Outlier Case: Tier 1 & 2

- Example of two-tier cost outlier threshold: \$42,040 and \$131,375
 - Tier 1 paid at 60% for losses between \$42,040 and \$131,375
 - Tier 2 paid at 80% for losses greater than \$131,375

Example: DRG 720 4 Septicemia with charges of \$600,000

Step	Explanation	Amount
DRG base payment	$\$7,373 \times 2.8127$	\$20,738
Estimated cost	$\$600,000 \times 39\%$	\$234,000
Estimated loss	$\$234,000 - \$20,738$	\$213,262
Cost outlier case	$\$213,262 > \$42,040$	Yes
Est. loss - cost outlier	$\$213,262 - \$42,040$	\$171,221
Cost Outlier Payment tier 1 for loss between \$42,041 & \$131,375	$(\$131,375 - \$42,040) \times 60\%$	\$53,601
Tier 2 loss over \$131,375	$\$213,262 - \$131,375$	\$81,887
Cost outlier payment tier 2	$\$81,887 \times 80\%$	\$65,510
DRG payment	$\$20,738 + \$53,601 + \$65,510$	\$139,849

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

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		\$94,118
System adjusts next week's remittance					\$58,118
Notes:					
1. APR-DRG 602-4 base rate is $\$7,373 \times 12.7652 = \$94,118$.					
2. \$600 is the per diem rate for interim claims.					

Deliveries, Babies, General Acute

- 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

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

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

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
Billing	Typically billed together with the baby	The mother and baby must be billed on separate claims
TAR / SAR	No TAR/SAR required for admission. TAR/SAR required for induction days and any days over 2 (vaginal delivery) or 4 (cesarean delivery)	None
Payment	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
Notes:		
1. This information applies to all patients, regardless of aid code.		

Billing, Authorization & Payment

Well Babies

Well Babies

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

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

Notes:

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

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
Billing	Typically billed separately	The baby should continue to be billed separately from the mother
TAR / SAR	Admission and each day	Admission only
Payment	Typically paid separately	Separate DRG-based payments to be made for the mother and the baby

Notes:

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
Billing	Following standard practice	Admission through discharge claim
TAR / SAR	Admission and each day	Admission only
Payment	For authorized days, per diem or at percent of charges	By DRG for the entire stay

General Acute Care—Restricted Benefits

General Acute Care Patients with Restricted Benefits		
This information applies to all stays except deliveries and newborns.		
	Previous Payment Method	Effective July 1, 2013
Billing	Following standard practice	Admission through discharge claim
TAR / SAR	Admission and each day	Same
Payment	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 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
 - The department will recoup payment difference

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
Unrelated bone marrow donor	38204
Blood Factors	
Blood Factor XIII	J7180
Blood Factor Von Willebrand - Injection	J7183 / J7184 / Q2041
Blood Factor VIII	J7185 / J7190 / J7192
Blood Factor VIII / Von Willebrand	J7186
Blood Factor Von Willebrand	J7187
Blood Factor VIIa	J7189
Blood Factor IX	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197
Blood Factor Antiinhibitor	J7198

