

# DRG Pricing Business Requirements

The Department of Health Care Services (DHCS) Safety Net Financing Division is requesting changes to CA-MMIS related to implementation of a new Diagnosis Related Group (DRG) pricing methodology. DRG pricing will be performed on most, but not all inpatient claims. All of the business requirements for this change are included in this document. Software changes are expected to be needed within the mainframe portion of CA-MMIS and within both TAR data entry applications, SURGE and SARS. In addition, data repositories downstream of the claims adjudication process, such as SURS and the ITSD DSS, will need to be updated to capture a few new fields related to DRG pricing. The proposed implementation date for these changes is July 1, 2013.

## Background

### DRG Pricing

The California Legislature has asked Medi-Cal to implement a DRG pricing method by 7/1/2013. The acronym "DRG" stands for Diagnosis Related Grouping and is a method for categorizing the services and resources used in a hospital. DRG pricing is a method used to determine the payment amount to acute care hospitals for inpatient stays. DRG pricing involves determining a DRG code and then calculating a payment amount using a variety of information, most of which is based on the provider or the DRG code.

DRG codes are determined through calls to two off-the-shelf software packages available from 3M Health Information Systems that are offered for a variety of platforms, mainframe, MS Windows-based PCs, and servers running the Unix operating system. Once the DRG code is determined for a given claim, parameters related to that DRG and parameters related to the hospital are used to calculate the price (a.k.a. allowed amount) for the claim. The pricing logic is relatively simple and is described in a flow chart and modeled in a spreadsheet referred to as the "DRG Pricing Calculator".

To support DRG pricing, a small number of data fields must exist within a provider table/file and within a separate DRG reference table/file. Details of these are described in this document.

The DRG pricing implementation is planned as a date-of-service type of implementation. This means claims with admit date prior to the DRG pricing cut-over date will be priced under existing CA-MMIS methods. Claims with admit date on or after the DRG pricing cut-over date will be priced under the new method. In addition, some providers (most notably designated public hospitals) and some services (most notably administrative days) will be exempt from DRG pricing and will continue to be paid under their existing methods. Exclusions include:

- designated public hospitals
- non-designated public hospitals
- free-standing psychiatric hospitals

- hospice providers
- administrative days both level 1 and level 2
- rehabilitation stays, at general acute care facilities and at specialty rehabilitation facility (identified by rehabilitation revenue codes used in the previous payment method)

## Gathering of Business Requirements

Personnel from Health Care Financing and Safety Net Financing Division have been engaged since April 2011, in an extensive effort to establish business requirements for this significant change in the method used to pay inpatient claims. The effort included involvement from numerous divisions within DHCS, consultation from external consultants specializing in claim payment methods, consultation with the California Hospital Association, and models of the new payment method using historical claims data.

The result of this effort is a series of detailed business requirements that are included in this SDN attachment. In addition, a Policy Design Document (PDD) was created that provides extensive background information and explanation for why specific business requirements were selected. Lastly, a DRG pricing calculator was created which is a small spreadsheet that models the DRG payment method.

## Options for Software Implementation

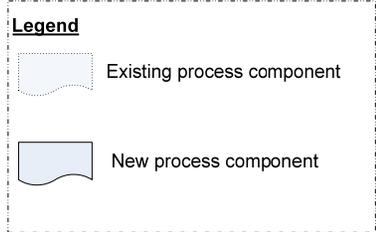
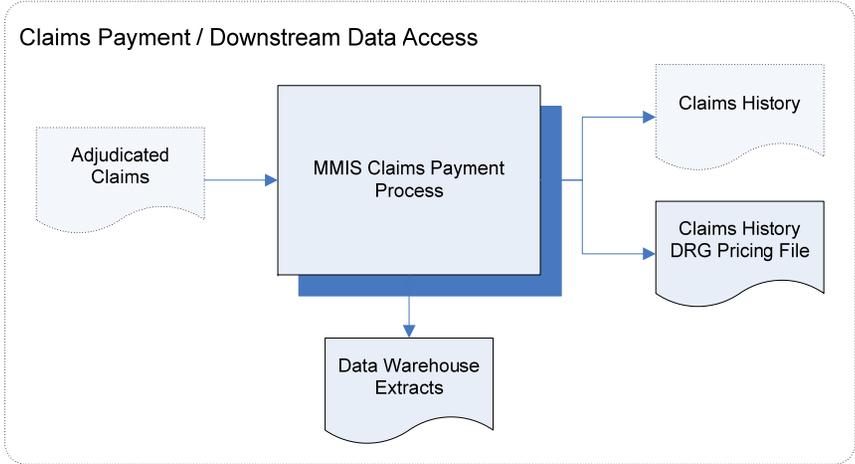
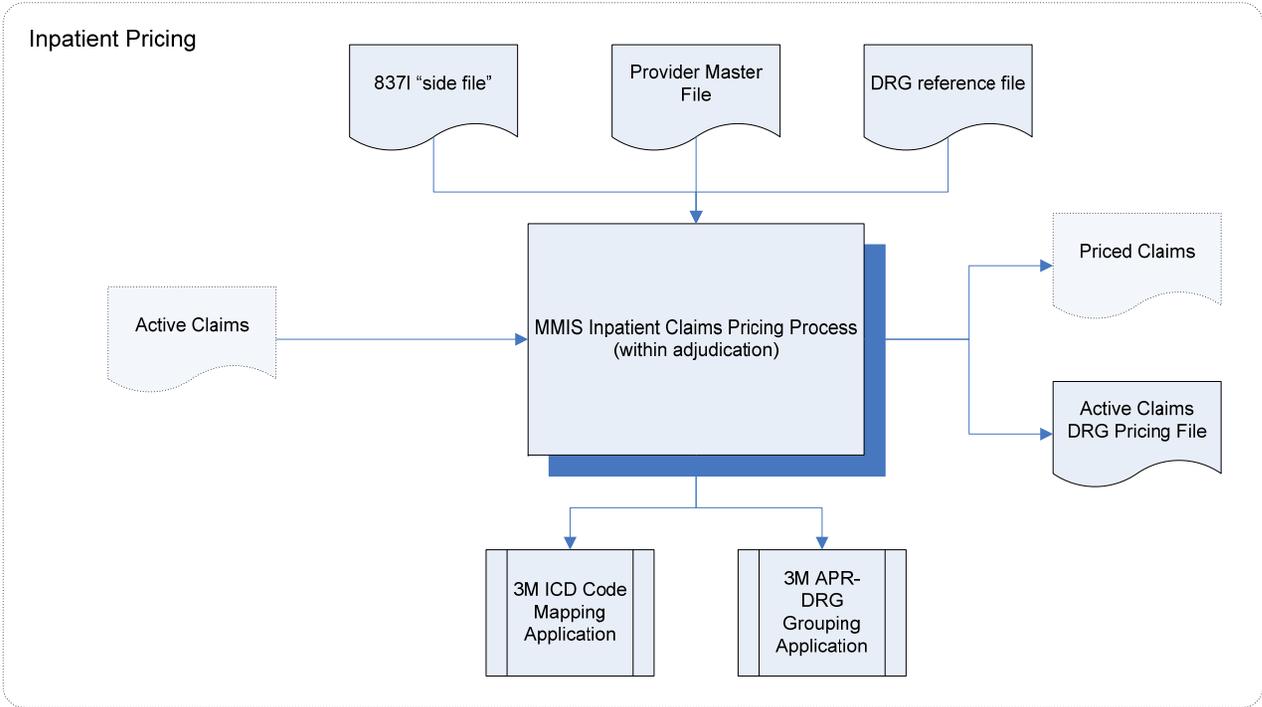
During the process of developing the DRG pricing business requirements, three different options were discussed as possible software implementation strategies. Those options are:

- 1) Perform DRG pricing outside of CA-MMIS
- 2) Perform DRG pricing inside of CA-MMIS
  - a. Implement a bare minimum amount of new functionality to perform APR-DRG pricing
  - b. Implement all changes needed to perform APR-DRG pricing and make details of the pricing on each inpatient claim viewable to online users and accessible to downstream reporting modules
- 3) Execute a complete HIPAA remediation of CA-MMIS so that it can store a sufficient number of diagnosis codes, procedure codes, and detail line items on each claim to enable DRG pricing within CA-MMIS as well as support many other claims processing functions currently handled through work-arounds due to CA-MMIS system limitations.

After conversations with CA-MMIS Division staff and Xerox Fiscal Intermediary staff, it has been decided that option 2, changes directly in mainframe CA-MMIS are the most practical option. More detailed decisions about how many areas of CA-MMIS will be changed for initial implementation will need to be made through coordination between the CA-MMIS Division, Safety Net Financing Division, and Xerox after detailed time estimates have been developed for software changes needed to various areas of CA-MMIS.

The requirements are organized in this document according to the Safety Net Financing Division DRG Pricing Work Group's best estimate of what area of CA-MMIS will be affected by each requirement. Also, a very high level depiction of how DRG pricing will fit within CA-MMIS is shown on the next page.

**System Changes**  
**Areas of MMIS Affected by DRG Pricing**



## Hospital Billing Changes

The following table lists changes in hospital billing practices that will be required under DRG pricing. This table is a subset of the table listed in section 6.3 of the DRG Policy Design Document (PDD). The changes listed in this table are not specifically requirements for CA-MMIS but will be necessary in conjunction with the CA-MMIS software changes to make the new DRG pricing method function correctly. Included in the following table is a reference to a section in the DRG Policy Design Document in which each of these changes is discussed in more detail.

Expected Impacts on Hospital Operations and Finances (Listed in approximate declining order of impact)		
PDD Ref.	Item	Comment
3.6, 6.7	Financial impact of new payment method	Individual hospitals will see increases or decreases.
5.1	Treatment Authorization Request process	TAR/SAR no longer required on length of stay for the vast majority of days. TAR on the admission is still required. SAR is specific to CCS and GHPP beneficiaries. See Table 5.1.1 and 5.1.2 for more detail.
	Payment is per stay	Payment is no longer per day. APR-DRG makes one payment for the hospital stay.
2.2.2	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.
5.7.1	Mother and newborn to be billed on separate claims	Separate payment will be made for each stay.
5.7.2	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 (i.e., sick newborns).	Because payment will be by stay, submission of the mother's beneficiary number on some claims and the baby's beneficiary number on other claims would be problematic.
5.7.2	Newborn weight should be coded using diagnosis codes (not value codes) when applicable. This is important where birth weight is a critical indicator of care.	ICD-9-CM classification uses the 5 <sup>th</sup> digit to indicate birth weight for diagnoses 764 and 765.0-765.1.
5.2.2	Interim bill types 112, 113, and discharge status 30 only accepted for stays exceeding 29 days. Interim bill type 114 not accepted.	For those claims with extended stays (greater than 29 days) and a discharge status code 30, providers will be allowed to submit an interim bill that will be paid at a per diem rate currently being developed by DHCS. Submission of interim claim(s) is voluntary and not mandatory under any circumstance. Payment of interim claims requires an approved TAR/SAR. When the patient is discharged, a single admit-through-discharge claim should be submitted using type of bill 111 (Admit-through-discharge claim) containing the full length of stay, all diagnosis and surgical procedure codes, and all the charges for the entire stay which will be priced using the APR-DRG method. All previous interim claims will be voided and the amount of the interim claims will be removed from the provider's checkwrite Remittance Advice Details.

Expected Impacts on Hospital Operations and Finances (Listed in approximate declining order of impact)		
PDD Ref.	Item	Comment
5.4	Administrative days	<p>A new administrative day level 2 (revenue codes 190, 199) will be created for sub-acute level care.</p> <p>Administrative day level 2 care is defined as care that is less intensive than acute care, and more intensive than the existing administrative day care, which is referred to as administrative day level 1. Administrative day level 2 revenue codes 190 and 199 will be available for payment only to DRG hospitals.</p> <p>Administrative day level 2 claims will flow through the same pricing policy as used for administrative day level 1 (revenue code 169) claims. This existing policy pays a per diem amount which is being developed by DHCS for these specific revenue codes and pays additionally for specific ancillary services. Level 2 administrative day claims will be identified by the presence of one or more lines with revenue code 190 (sub-acute pediatric) or 199 (sub-acute adult).</p> <p>Administrative day level 2 will require TAR every day.</p>
2.2.2	Four-byte APR-DRG code	Impact depends on how the hospital's billing system is configured. APR-DRG = three-bytes for the base DRG and 1 byte for level of severity (format 123-4).
5.5	Rehabilitation stays	A new per diem payment method will be implemented for payment of rehabilitation claims. Rehabilitation claims will be identified by the presence of revenue codes 118, 128, 138, 148, and/or 158 on one or more service lines on the claim, as well as claims grouped to APR-DRG 860. Rehabilitation claims will be paid a per diem rate currently being developed by DHCS. The per diem will be multiplied by the number of days submitted on the claim.
4.10.1	Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnoses codes, which are blank per 5010).
4.7	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 for blood factors.
5.2.1	Late charges (bill type 115) not accepted	Submit a claim adjustment instead.
4.10.1	Health care-acquired conditions (HCACs)	Payment may be reduced if a HCAC is present on the claim. Note: HCACs are also known as provider preventable conditions or PPCs under this federally required payment policy.
	Physician services bundled into SPCP per diem rates	For some hospitals, specific physician services (e.g., laboratory and pathology) were bundled into the inpatient hospital per diem. This will no longer apply. All physician services should be billed as professional claims (i.e., CMS-1500, 837P).

Expected Impacts on Hospital Operations and Finances (Listed in approximate declining order of impact)		
PDD Ref.	Item	Comment
	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.
4.1	Transfers from non-contract hospitals	Hospitals will no longer be required to transfer patients based on their previous non-contract designation in closed Health Facility Planning Areas (HFPAs). Contract or non-contract facility designations will not apply under the DRG payment method. All HFPAs will be considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for both emergency and elective services (subject to approved Treatment Authorization Requests).
<p>Note: Some references to sections of the Policy Design Document are blank since these topics were added as a result of the SDN 12005 development phases (e.g., Specific Functional Design, Technical Systems Design, etc.).</p>		

The business requirements in the following pages were an exact copy of Chapter 7 of the DRG Policy Design Document and used as an attachment to the System Development Notice (SDN) submitted on March 27, 2012. That is why all section numbers begin with "7". The business requirements in this version of the SDN Attachment have been updated based on the business requirements sessions between DHCS and Xerox. For ease of reference, the sections continue to be enumerated with "7". Note that the Operating Instruction Letter (OIL) #246-12 of July 30, 2012 updated the SDN with the DRG Policy Design Document, May 1, 2012.

# 7 Business Requirements for CA-MMIS Changes

This section lists all the business requirements for implementation of APR-DRG pricing for Medi-Cal, with revisions as of December 10, 2012. Software changes are expected to be needed within the mainframe portion of CA-MMIS and within both Treatment Authorization Review (TAR) data entry applications, Service Utilization Review Guidance and Evaluation system (SURGE) and Service Authorization Request system (SAR). In addition, data repositories downstream of the claims adjudication process, such as Surveillance and Utilization Review Subsystem (SURS) and the Information Technology Services Division (ITSD) decision support system (DSS) will need to be updated to capture a few new fields related to DRG pricing.

## 7.1 Summary of Requirements

The business requirements are listed in summary form in Table 7.1.1 below and then explained in more detail in the sections that follow. The requirements are categorized by our best estimate of what area of CA-MMIS will be affected by each requirement.

Table 7.1.1 Summary of APR-DRG Business Requirements		
Requirement Number	CA-MMIS Area /Sub-system	Requirement Description
<b>Reference Sub-System</b>		
BR-Ref-1	Reference sub-system	Add new system parameters and lists
BR-Ref-2	Reference sub-system	Define new adjudication edits
BR-Ref-3	Reference sub-system	View and update new Reference DRG pricing file online
BR-Ref-4	Reference sub-system	Batch update process for DRG pricing file
<b>Provider Master File</b>		
BR-Prov-1	Provider sub-system	Allow new fields to be viewable and updateable by staff who maintain the provider master file
BR-Prov-2	Provider sub-system	Batch update for new fields supporting DRG pricing

Table 7.1.1

## Summary of APR-DRG Business Requirements

Requirement Number	CA-MMIS Area /Sub-system	Requirement Description
<b>TAR Entry – SURGE and SARS</b>		
BR-TAR-1	TAR data entry	TAR the admit only, not individual days of a hospital stay, for most stays priced using DRGs
<b>Claim Data Entry</b>		
BR-Clm-Entry-1	Claim data entry	Capture additional fields on inpatient claims
<b>Adjudication Edits</b>		
BR-Adj-Edit-1	Adjudication	Pricing method edits
BR-Adj-Edit-2	Adjudication	Inpatient claim data validity edits
BR-Adj-Edit-3	Adjudication	Hospital-acquired condition and erroneous surgery edits
BR-Adj-Edit-4	Adjudication	DRG pricing parameter edits
BR-Adj-Edit-5	Adjudication	DRG grouping edits
BR-Adj-Edit-6	Adjudication	Post DRG grouping edits
BR-Adj-Edit-7	Adjudication	TAR edits
<b>Claims Pricing</b>		
BR-Pricing-1	Pricing	Add branching logic
BR-Pricing-2	Pricing	Retrieve additional claim data needed for DRG pricing
BR-Pricing-3	Pricing	Add call to diagnosis and procedure code mapper
BR-Pricing-4	Pricing	Build DRG grouping input record
BR-Pricing-5	Pricing	Call health care-acquired condition utility
BR-Pricing-6	Pricing	Add calls to DRG grouping software
BR-Pricing-7	Pricing	Add logic to perform DRG pricing
BR-Pricing-8	Pricing	Store DRG pricing values
BR-Pricing-9	Pricing	Allow users the ability to view claim DRG pricing fields
BR-Pricing-10	Pricing	Price administrative day level 2 claims similarly to administrative day level 1
BR-Pricing-11	Pricing	Add new rehabilitation service per diem pricing logic
<b>Processing Final Claim After Interim Claims</b>		
BR-Final-Clm-1	Adjudication	Voiding interim claims
<b>Reporting DRG Pricing Information</b>		
BR-Rptng-1	Reporting	Remittance advice
BR-Rptng-2	Reporting	Standard DRG pricing reports
BR-Rptng-3	Reporting	Data warehouse extracts
<b>Database Changes</b>		
BR-DB-1	Database	Reference DRG pricing file
BR-DB-2	Database	Provider Master File
BR-DB-3	Database	Claim input from provider side file
BR-DB-4	Database	Claim DRG pricing file
<b>Data Configuration</b>		
BR-Config-1	Reference and Provider sub-systems	Initial implementation configuration tasks
<b>Data Retention</b>		
BR-Retention-1	Data retention and disaster recovery	Store data for 10 years and add to disaster recovery plan

Table 7.1.1

## Summary of APR-DRG Business Requirements

Requirement Number	CA-MMIS Area /Sub-system	Requirement Description
<b>Other Adjustments</b>		
BR-Other Adjust-1	Share of cost and other health care coverage	Continue to be applicable under DRG payment
BR-Other Adjust-2	Timely filing	Continue s to be applicable under DRG payment
BR-Other Adjust-3:	Various adjustments identified	Applicability of some payment adjustments
BR-Other Adjust-4:	Lesser of paid or billed	Applicability of lesser of paid or billed logic to paid amount
<i>Notes:</i>		
1 Some adjudication edits may get added in daily adjudication, while others may make more sense to add in weekly adjudication. Final decision on placement of these edits will be made during the technical design phase.		

## 7.2 Reference Data System

### BR-Ref-1: Add new system parameters and lists

Several new system parameters and four new system lists will need to be added. The parameters and lists are defined in the following table.

A system parameter / list file already exists in CA-MMIS so no database changes are needed for this requirement.

Table 7.2.1			
New System Parameters and Lists			
Parameter	Format	Tentative Initial Value	Notes
<b>System parameters – One Value</b>			
DRG cutover date	Date	07/01/2013	
Casemix adjustment factor	Numeric	1.000	This will be used to reduce or increase all DRG payments by a specific percentage. It is a multiplier that will be applied to all non-interim claims paid via DRGs.
DRG high (provider loss) cost outlier threshold 1	Numeric, dollar amount	\$30,000	All claims with provider loss over this amount will get paid an outlier
DRG high (provider loss) cost outlier threshold 2	Numeric, dollar amount	\$100,000	Claims with provider loss less than this value will receive marginal cost percent 1. Claims with provider loss greater than or equal to this value will also receive marginal cost percent 2.
DRG low (provider gain) cost outlier threshold	Numeric, dollar amount	\$30,000	Value is expected to be equal to DRG high side cost outlier threshold 1.
DRG outlier marginal cost percent 1	Percentage or numeric	0.60	60%

Table 7.2.1 New System Parameters and Lists			
Parameter	Format	Tentative Initial Value	Notes
DRG outlier marginal cost percent 2	Percentage or numeric	0.80	80%
DRG age threshold	Numeric	21	Beneficiaries with age less than this value will get DRG relative weight age adjustors
Installed DRG version number	Character string	290	Version 29.0
Installed HAC version number	Character string	300	Version 30.0
Federal fiscal year begin date for installed DRG version	Date	10/01/2011	
Federal fiscal year end date for installed DRG version	Date	09/30/2012	
Interim claim minimum length	Numeric	29	Only interim claims with a length of stay greater than 29 will be payable.
Interim claim per diem rate	Numeric, Dollar Amount	SNFD to provide value prior to implementation date	One value will exist for all providers.
<b>System lists – multiple values</b>			
DRG transfer status codes	Character string	"02", "05", "65", "66"	
Rehab APR-DRGs	Character string	"860-1", "860-2", "860-3", "860-4"	
Rehab revenue codes	Character string	"118", "128", "138", "148", "158"	
Manual HCAC Categories Pediatric	Character string	07, 08	07 = Vascular Catheter Associated Infection 08 = Surgical Site Infection - CABG

## BR-Ref-2: Define new adjudication edits

Many new claim adjudication edits are required to support DRG pricing. Those edits are described in detail in the section of this document called "Adjudication Edits." Each of these new edits will need to be defined within the Reference sub-system. Generally, definition of an edit involves assigning an edit number, deciding on the description for the edit, mapping the edit to a standard 835 electronic remittance advice adjustment reason code, setting the edit disposition (suspend, deny, etc.), and detailing instructions for working the edits within suspense correction.

## BR-Ref-3: View/update new reference DRG pricing file online

A new Reference DRG pricing file needs to be added to support DRG pricing. This file will need to be viewable and updateable to users who support CA-MMIS reference data. The fields in the file are shown in the following table.

Table 7.2.2 Field Edits for Updates to Reference DRG Pricing File		
Column	Format	Validation
DRG_Code	PIC X(05)	Cannot be blank
Eff_Begin_Dt	Standard CA-MMIS date format	Must be a valid date Also no two rows should be allowed to have overlapping effective dates for the same DRG code.
Eff_End_Dt	Standard CA-MMIS date format	Must be a valid date and must be equal to or greater than the begin date. Also no two rows should be allowed to have overlapping effective dates for the same DRG code.
DRG_Description	PIC X(100)	Cannot be blank
DRG_ALOS	PIC 9(03).9(02)	Must be numeric. A value of zero is only acceptable for DRG values "955-0" and "956-0".
DRG_Casemix_Rel_Wt	PIC 9(03).9(04)	Must be numeric. A value of zero is only acceptable for DRG values "955-0" and "956-0".
DRG_Svc_Adjstr_All_Others	PIC 9(03).9(02)	Must be numeric. A value of zero is NOT acceptable. The default value for this field will be 1.00.
DRG_Svc_Adjstr_Desig_NICU	PIC 9(03).9(02)	Must be numeric. A value of zero is NOT acceptable. The default value for this field will be 1.00.
DRG_Age_Adjstr	PIC 9(03).9(02)	Must be numeric. A value of zero is NOT acceptable. The default value for this field will be 1.00.
Mcaid_Care_Categ_Adult	PIC X(50)	Cannot be blank
Mcaid_Care_Categ_Child	PIC X(50)	Cannot be blank
DRG_On_Review_Ind	PIC X(01)	Valid values will be "Y" and "N". No claims editing occurs with this field at this time. DHCS will establish back-end processes to pull ad-hoc reports based on the indicator code for any claims that were assigned a DRG code that is "on review."  Note: This field allows DHCS to build editing logic in the future. For example, DHCS may decide to build an edit that will post if the claim is going to price via DRGs and the on-review indicator for the DRG is set to "Y" (yes). The claim then may suspend for review by the Department. For implementation, this field will be set to "N" for all DRGs.

## BR-Ref-4: Batch update process for DRG pricing file

A batch update process will need to be created to load the DRG pricing file. The process should support adds of new rows, changes of existing rows based on a key of DRG code and effective-begin-date, and deletes of existing rows, also based on a key of DRG code and effective-begin-date. The batch load should produce two output reports – one describing what records changed, and another, describing input records rejected with a data error.

Please see the Table 7.2.2 for validations that need to occur in the batch load.

# 7.3 Provider Master File

## BR-Prov-1: Allow new fields to be viewable and updateable

A few new fields will need to be added to the provider master file to support DRG pricing. Some of these fields may already exist within the provider master file. If they do, no changes are needed. If they do not, then they will need to be added either to an existing file or to a new file. And logic will need to be added to make the new fields viewable and updateable by users. All of these fields are date sensitive. The fields are shown in Table 7.3.1.

Table 7.3.1		
Edits for Updates to Provider-Specific Fields Supporting DRG Pricing		
Column	Format	Validation
Inpatient payment method	PIC X(1)	Valid values will be "P" for per diem pricing and "D" for DRG pricing. Other values may also be needed to identify other pricing methods (none to date). For most providers of type 016 and 060, this value will be "D" for dates after the cut-over to DRG pricing. However, the value will be "P" for designated public hospitals as they will continue to be paid via a per diem method. It may also be "P" for non-designated public hospitals (decision pending).
Cost-to-charge ratio	PIC 9(1)V9(05)	For a provider being paid via DRGs, this value cannot be zero.
DRG base price	PIC 9(09)V9(02)	For a provider being paid via DRGs, this value cannot be zero.
Per-claim add-on payment	PIC 9(09)V9(02)	This field must contain a numeric value. \$0.00 is a valid value. All providers are expected to have an initial value of \$0.00.
Designated NICU indicator	PIC X(1)	Value must be "Y" or "N".
Administrative day level 1 per diem	Numeric, dollar amount	Values will be hospital-specific and may vary among hospitals. Value will be stored by provider / revenue code combination in the provider master file as done today. This is the current administrative days per diem
Administrative day level 2 per diem	Numeric, dollar amount	Values will be hospital-specific and may vary among hospitals. Value will be stored by provider / revenue code combination in the provider master file as done today for the administrative day level 1 per diem. The revenue code will further distinguish services for pediatric and adult beneficiaries. Accommodation code 0190 (Subacute care, General) will be used for pediatric beneficiaries. Accommodation code 0199 (Subacute care, Other subacute care) will be used for adult beneficiaries.
Rehabilitation per diem	Numeric, dollar amount	Values will be hospital-specific and may vary among hospitals. Value will be stored by provider / revenue code combination in the provider master file similar to how per diems are stored today.
Date	Standard CA-MMIS date format	This field will be displayed at the bottom of the new PMF screen and populated with the current date. Value format MM/DD/YYYY

The key for updates to these fields will be provider number and effective-begin-date.

## BR-Prov-2: Batch update for new fields supporting DRG pricing

A batch update process will need to be created to load the new provider master file fields needed to support DRG pricing. The values will be date sensitive and only one set of values should be in effect on any single day.

The batch load should produce two output reports – one describing what records changed, and another, describing input records rejected with a data error.

Please see Table 7.3.1 for validations that need to occur in the batch load.

## 7.4 TAR Data Entry – SURGE and SAR

The changes to Treatment Authorization Request (TAR) requirements will apply to regular Medi-Cal fee-for-service, GHPP, and CCS beneficiaries. Thus, the TAR entry requirements identified below will apply to both the Service Utilization Review Guidance and Evaluation system (SURGE) and the Service Authorization Request system (SAR).

### BR-TAR-1: TAR only admit on most inpatient stays

With the implementation of DRG pricing, most inpatient stays will require a TAR only for the admission. TARs will no longer need to specify the number of days authorized. The specific business requirements for changes to TAR editing are listed under requirement “BR-Adj-Edit-7: TAR Edits within Claims Adjudication.” These requirements apply both to TAR data entry and TAR edits on claims, as these two processes work in concert.

## 7.5 Inpatient Claim Data Entry

### BR-Clm-Entry-1: Capture additional fields on inpatient claims

Additional data fields from incoming inpatient claims must be captured to support DRG pricing. Those fields are:

- 25 claim header diagnosis codes
- 25 present-on-admission indicators (associated with the diagnosis codes)
- 25 surgical procedure codes

- 25 surgical procedure dates (associated with the procedure codes)

External cause of injury diagnosis codes will not be separately captured (e.g., form locator 72a through 72c on the UB-04 paper claim form). They will be captured only when listed within the primary or secondary diagnosis fields (e.g., form locator 67A through 67Q on the UB-04 paper claim form).

These fields need to be captured on all inpatient claims, whether submitted electronically (837I) or on paper (UB-04).

**Note:** On paper claims, some of these fields have fewer instances.

In addition, DRG payment would depend on a single admit-through-discharge claim. The single DRG claim should include accurate data on all of the fields from incoming inpatient claims that are needed for pricing or editing claims using the new DRG pricing logic. This applies to the additional data listed above as well as claims data currently captured by CA-MMIS. It is important to make certain that only one claim is used for DRG pricing and that all claims data for the whole stay are used. This will ensure accurate DRG assignment (e.g., using all submitted diagnosis and procedures), enable accuracy in applying the DRG pricing logic (e.g., using all submitted charges in outlier pricing), allow enforcement of branching logic (e.g., using revenue codes that identify claims paid by per diem instead of DRG in the case of rehabilitation, administrative day, interim claims), enable claims editing (e.g., POA for HCACs, type of bill, discharge status, etc.), and avoid duplicate payment for the same stay (e.g., submitting more than one claim for a single stay or split billing).

This data must be easily accessible to the inpatient claims pricing process performed within claims adjudication using CCN as the primary key. Once a claim has been paid, the record for that claim can be moved to a historical file that is less easily accessible. However, the claim adjustment process must be able to retrieve these fields when making a new copy of a claim. In addition, the fields will need to be accessible for extracts to data warehouses and accessible for standard claim audits.

Requirements for capture of additional fields on inpatient claims are also described in requirements BR-Pricing-2 and BR-DB-3.

# 7.6 Adjudication Edits

## BR-Adj-Edit-1: Pricing method edit

Nearly all the new edits described in this section apply only to claims that will be priced via DRGs. So one of the first steps in the adjudication of an inpatient claim will need to be determination of whether or not the claim will price via the new DRG methodology. And edits need to be defined to catch the unlikely scenario of being unable to determine how the claim will price. Those two edits are shown in Table 7.6.1 and should apply to all inpatient claims in which the provider type is 016 or 060.

Edit #	Description	Draft Disposition	Logic	Notes
A	Provider inpatient payment method not found	Data validation error message	This edit will post if the inpatient payment method indicator on the provider master file is blank or contains an invalid value.	This will be a data validation error message on the Provider Master File.
B	APR-DRG cutover date not found	Data validation error message	This edit will post if the APR-DRG pricing cutover date in the system parameter table is missing or blank or zero	This will be a data validation error message in the new DRG System Parameter Table that simply says, "DRG cutover date not found".

## BR-Adj-Edit-2: Inpatient claim data validity edits

This section describes edits of basic inpatient claim data that must be valid to price a claim under a DRG methodology. These edits should apply to inpatient claims pricing via DRGs.

Table 7.6.2 Inpatient Claim Data Validity Exceptions				
Edit #	Description	Draft Disposition	Logic	Notes
C	Rehabilitation revenue code not found	Data validation error message	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and the rehabilitation revenue code is not found on the system parameter	This will be a data validation error message in the new DRG System Parameter Table that simply says, "Rehab revenue code not found".
D	Invalid mix of services on the same inpatient claim.	Deny claim	<p>This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and revenue codes are found on the claim line items for more than one of the following 4 categories of service.</p> <p>The 4 categories of service are:</p> <ol style="list-style-type: none"> <li>1. Administrative day level 1 – identified by revenue code 169.</li> <li>2. Administrative day level 2 – identified by revenue codes 190 (for pediatric beneficiaries) or 199 (for adult beneficiaries).</li> <li>3. Rehab service – identified by revenue codes 118, 128, 138, 148, or 158</li> <li>4. Acute care accommodation code – all values between 100 and 219 except 118, 128, 138, 148, 158, 169, 190 and 199.</li> </ol> <p>Claims price differently under each of these categories, so any claim with revenue codes from more than one of these categories cannot be priced and needs to be denied.</p>	Revenue codes 190 and 199 will be used for administrative day level 2
E	Invalid type of bill	Deny claim	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and the type of bill on the claim is invalid. Valid types of bill are available in the UB-04 billing manual	This is an existing edit in CA-MMIS (error code 3029).

Table 7.6.2

## Inpatient Claim Data Validity Exceptions

Edit #	Description	Draft Disposition	Logic	Notes
New	Invalid type of bill code for DRG Claim	Deny claim	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and the type of bill equals blank or any type of bill code other than 111, 112 or 113.	
G	Patient discharge status and bill type mismatch	Deny claim	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and 1. (The type of bill is 112 or 113) AND (discharge status is not 30) OR 2. (Type of bill is 111) AND (discharge status is 30)	
H	Interim claim minimum length of stay not found	Data validation error message	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and the interim claim minimum length of stay value in the system parameter table is missing or blank or zero	This will be an error message in the new DRG System Parameter table that simply says, "Interim claim minimum length of stay not found".
I	Interim claim too short length of stay	Deny claim	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and the discharge status 30 and the length of stay is less than or equal to the length of stay threshold for interim claims, and the type of bill equals 112 or 113. That minimum length of stay threshold will be stored as a new system parameter.	The interim claim length of stay threshold will be set to 29 days. So only interim claims with length of stay greater than 29 days will be payable.  Note: The value of this parameter can be changed by DHCS via an OIL, if needed in the future.
J	Services for mother and newborn not billable on the same claim	Deny claim	This edit will post if the provider is configured to price via DRGs (provider inpatient pricing method code is "D") and a revenue code in the set of 112, 122, 132, 152, and a revenue code in the range of 170 – 179 are billed on different lines on the same claim.	
New	Voided interim claim cannot be adjusted	Suspend	This edit will post when a provider attempts to adjust an interim claim that was voided.	The claim will suspend as duplicate of a previous adjustment claim

## BR-Adj-Edit-3: HCAC and erroneous surgery edits

The Center for Medicare and Medicaid Services (CMS) has come out with a new directive requiring Medicaid programs to avoid paying for health care-acquired conditions (HCACs) and erroneous surgeries. Because DRG pricing is one of the easiest methods for avoiding payment for HCACs, the requirements for meeting CMS' HCAC mandate are being included with this DRG SDN. One of those requirements is to add a few adjudication edits to CA-MMIS.

Edit #	Description	Draft Disposition	Logic	Notes
L	Erroneous surgery performed	Suspend claim	This edit will post if diagnosis code E876.5, E876.6, or E876.7 is found as a principal diagnosis or secondary diagnosis	
M	Identify claims with a HCAC, but no change in DRG	Pay and report	This edit will post when the HCAC utility identifies a health care-acquired condition (HCAC) on the claim, but the HCAC did not cause a change in the DRG (pre-HCAC DRG and post-HCAC DRG are the same).	This will be an indicator added to the claim instead of an edit. "Pre-HCAC" refers to the DRG <u>before</u> the HCAC diagnosis and/or procedures have been disregarded in the DRG assignment. "Post-HCAC" refers to the DRG <u>after</u> the HCAC diagnosis/procedures have been disregarded in the DRG assignment. The HAC Utility is run and returns both of these DRGs.
N	Identify claims with a HCAC and change in the DRG	Pay and report	This edit will post when the HCAC utility identifies a health care-acquired condition (HCAC) on the claim, and the HCAC caused a change in the DRG (pre-HCAC DRG and post-HCAC DRG are different)	This will be an indicator added to the claim instead of an edit. In this case, a new payment RAD code will also be added to the claim. "Pre-HCAC" refers to the DRG <u>before</u> the HCAC diagnosis and/or procedures have been disregarded in the DRG assignment. "Post-HCAC" refers to the DRG <u>after</u> the HCAC diagnosis/procedures have been disregarded in the DRG assignment. The HAC Utility returns both of these DRGs.

## BR-Adj-Edit-4: DRG pricing parameter edits

Table 7.6.4 lists edits that should post if configuration fields needed to price via DRGs cannot be found. These edits are expected to be handled via entry error messages because they are all an indication that some configuration data has not been loaded correctly in CA-MMIS. A claim should never deny for any of these edits. Instead, when these post, the appropriate configuration data should be loaded. There are a few exceptions and those are mentioned in the Logic column.

Table 7.6.4 Inpatient Claim DRG Pricing Parameter Exceptions				
Edit #	Description	Draft Disposition	Logic	Notes
O	DRG base price not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and the DRG base price on the provider master file is missing, blank, zero, or non-numeric.	This field will be added to the PMF File as a separate DRG provider-specific screen.
P	Provider cost-to-charge ratio not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and the cost-to-charge ratio on the provider master file for the provider is missing, blank, zero, or non-numeric.	This field will be added to the PMF File on the separate DRG provider-specific screen.
Q	DRG age threshold not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and DRG age in the system parameter table is missing, blank, zero, or non-numeric.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG age threshold not found".
R	DRG provider loss outlier threshold 1 not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and DRG provider loss outlier threshold 1 in the system parameter table is missing, blank, zero, or non-numeric.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG provider loss outlier threshold 1 not found not found".
S	DRG provider loss outlier threshold 2 not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and DRG provider loss outlier threshold 2 in the system parameter table is missing, blank, zero, or non-numeric.	This will be a new edit (error message), on the new DRG System Parameter Table that simply says, "DRG provider loss outlier threshold 2 not found".

Table 7.6.4

## Inpatient Claim DRG Pricing Parameter Exceptions

Edit #	Description	Draft Disposition	Logic	Notes
T	DRG casemix adjustment factor not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and the DRG casemix adjustment factor in the system parameter table is missing, blank, zero, or non-numeric.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG casemix adjustment factor not found".
U	DRG provider gain outlier threshold not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and the DRG provider gain outlier threshold in the system parameter table is missing, blank, zero, or non-numeric.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG provider gain outlier threshold not found".
V	DRG marginal cost percent 1 is not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and DRG marginal cost percent 1 in the system parameter table is missing, blank, zero, or non-numeric.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG marginal cost percent 1 not found".
W	DRG marginal cost percent 2 is not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and DRG marginal cost percent 2 in the system parameter table is missing, blank, zero, or non-numeric.	This can be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG marginal cost percent 2 not found".
X	DRG transfer status code list is not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and the DRG transfer codes in the system parameter are not found.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "DRG transfer status codes not found".

Table 7.6.4

## Inpatient Claim DRG Pricing Parameter Exceptions

Edit #	Description	Draft Disposition	Logic	Notes
Y	Manual HCAC categories, pediatric not found	Data validation error message	This edit will post if the provider is configured to price via DRGs and the manual HCAC category in the system parameter is not found.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "Manual HCAC Categories Pediatric codes not found".
Z	Installed DRG version parameter not found	Data validation error message	This edit will post if the provider type is 016 or 060 and the installed DRG version system parameter is not found or is blank.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "Installed DRG version number not found".
New	Installed HAC version parameter not found	Data validation error message	This edit will post if the provider type is 016 or 060 and the installed HAC utility version system parameter is not found or is blank.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "Installed HAC version number not found".
AA	DRG fiscal year begin date parameter not found	Data validation error message	This edit will post if the provider is 016 or 060 and the installed DRG grouper fiscal year begin date system parameter is not found or is blank or is not a valid date.	This will be a new edit, (error message) on the new DRG System Parameter Table that simply says, "Federal fiscal year begin date not found".
AB	DRG fiscal year end date parameter not found	Data validation error message	This edit will post if the provider is 016 or 060 and the installed DRG grouper fiscal year end date system parameter is not found or is blank or is not a valid date.	This will be a new edit (error message) on the new DRG System Parameter Table that simply says, "Federal fiscal year end date not found".
AC	Rehab DRG system parameter is not found	Data validation error message	This edit will post if the provider is configured to price via DRGs, the claim is inpatient (not inpatient crossover) and the rehabilitation DRG system parameter is not found.	This will be a new edit on the new DRG System Parameter Table that simply says, "Rehab APR-DRGs codes not found".

## BR-Adj-Edit-5: DRG grouping edits

There are a series of edits performed by the DRG grouper that when triggered will cause a non-zero value to be sent back in the return code. These non-zero return codes will need to be translated into CA-MMIS error codes. The mapping of non-zero return codes to CA-MMIS edits is shown in Table 7.6.5. These edits should apply to inpatient claims for providers with provider type 016 or 060.

Table 7.6.5 Inpatient Claim DRG Grouping Exceptions				
Edit #	Description	Draft Disposition	Logic	Notes
AG	ICD code mapping error	Suspend	This edit will post if the claim is going to price via DRGs and the ICD code mapping software sends back a non-zero return code.	This is not really a DRG grouping error, but has been included in the DRG grouping category of edits as the ICD code mapping is only performed to enable accurate DRG grouping. Mapping errors are extremely rare and generally are an indication that the mapping software is not installed correctly. This will be a 'SYSOUT' error message.
AH	Invalid principal diagnosis code	Deny claim	This edit will post if the claim is going to price via DRGs and the APR-DRG assigned to the claim is 955-0 or the DRG grouper return code is 1.	
AI	Valid DRG code could not be determined	Deny claim	This edit will post if the claim is going to price via DRGs and the APR-DRG assigned to the claim is 956-0 and the return code is zero, or the return code is 2, or the return code is 11, or the return code is non-zero and there is no mapping of the return code to a DRG specific edit.	
AJ	DRG invalid beneficiary age	Deny claim	This edit will post if the claim is going to price via DRGs and the return code from the grouper is 3 or 9.	
AK	DRG invalid beneficiary gender	Deny claim	This edit will post if the claim is going to price via DRGs and the return code from the grouper is 4.	
AL	DRG invalid discharge status	Deny claim	This edit will post if the claim is going to price via DRGs and the return code from the grouper is 5.	
AM	DRG invalid birth weight	Deny claim	This edit will post if the claim is going to price via DRGs and the return code from the grouper is 6.	

Table 7.6.5

Inpatient Claim DRG Grouping Exceptions

Edit #	Description	Draft Disposition	Logic	Notes
AN	DRG gestational age and birth weight conflict	Deny claim	This edit will post if the claim is going to price via DRGs and the return code from the grouper is 12.	

## BR-Adj-Edit-6: Post DRG grouping edits

Four new edits need to be performed after the DRG is assigned to the claim. These edits are shown in Table 7.6.6 and should apply to inpatient claims for providers with type 016 and 060.

Table 7.6.6

Inpatient Claim Post DRG Grouping Exceptions

Edit #	Description	Draft Disposition	Logic	Notes
AO	Rehab claim without rehab revenue code	Deny claim	Post if the claim groups to a rehab APR-DRG (stored in a system parameter table) and does not contain a rehab revenue code (also stored in a system parameter table).	The rehab APR-DRGs will be 860-1, 860-2, 860-3, and 860-4, and the list of rehab revenue codes is 118, 128, 138, 148, and 158. Both the rehab DRGs and the rehab revenue codes will be stored in the new DRG System Parameter Table.
AP	DRG not on file	Auto-deny	This edit will post if the claim is going to price via DRGs and the DRG returned from the grouper is not found in the Reference DRG pricing file.	Auto-deny with error code. Provider training and billing tips will include this and other DRG-related edits.
AR	DRG relative weight missing	Data validation error message	This edit will post if the claims is going to price via DRGs, and the DRG codes is NOT equal to "955-0" and NOT equal to "956-0" and any of the following fields are blank, zero, or non-numeric: DRG_Casemix_Rel_Wt DRG_Svc_Adjstr_All_Others DRG_Svc_Adjstr_Desig_NICU DRG_Age_Adjstr	This is a data validation error message on the DRG Reference File

*Note:* Two other edits that must be performed after DRG grouping are related to health care-acquired conditions (HCACs) and are listed in Table 7.6.3.

## BR-Adj-Edit-7: TAR edits within claims adjudication

Today a TAR is required for each day of every inpatient hospital stay except those for vaginal deliveries with length of stay less than 3 days and cesarean deliveries with length of stay less than 5 days. When DRG pricing is implemented, most inpatient stays will only require a TAR for the admission, not for each individual day the beneficiary is in the hospital. However, there will be a variety of exceptions to this rule. For each exception the existing TAR process will apply, which, in most or all cases, involves a TAR for each day of a hospital stay. The specific exceptions to this change requiring a TAR only on the admission are listed below.

1. Providers that are not being paid under the DRG method will continue their current daily TAR process. This includes designated public hospitals and possibly non-designated public hospitals. (A Provider Payment Indicator “D” or “P” will be stored on the provider master file identifying those providers paid via DRGs or per diem, respectively.)
2. Some services will not be paid via DRGs even if they are performed at a general acute care facility in which most services will be paid via DRGs. These services include administrative day level 1, administrative day level 2, and rehabilitation. For these services, the existing process including daily TARs will continue to be required. Claims for level 1 administrative day will be identified by the presence of revenue code 169. Claims for level 2 administrative days will be identified by the presence of revenue code 190 or 199. Claims for rehabilitation services will be identified by the presence of revenue code 118, 128, 138, 148, and/or 158.
3. Claims for beneficiaries with restricted benefit aid codes will continue to require daily TARs if the hospital stay is unrelated to delivery of a baby. Claims for these beneficiaries need a daily TAR because Federal Financial Participation rules require no payment for procedures that are non-emergency. A daily audit through the TAR process is needed to ensure that only emergency services get reimbursed. Claims with restricted benefit aid codes will be identified as any claim assigned a beneficiary benefit aid code whose description is not “Full” or “Full benefits”.
4. Obstetric admissions for the delivery of a baby will not require any authorization. This is similar to current TAR rules. However, under current TAR rules obstetric admissions including induction that start the day before a baby is born and unusually long obstetric stays (greater than 2 days for a vaginal delivery and greater than 4 days for a cesarean section delivery) required a TAR. For facilities being priced using DRGs, no obstetric admissions for the delivery of a baby will require any authorization.

A summary of the TAR/SAR requirements for inpatient claims is shown in Table 7.6.7.

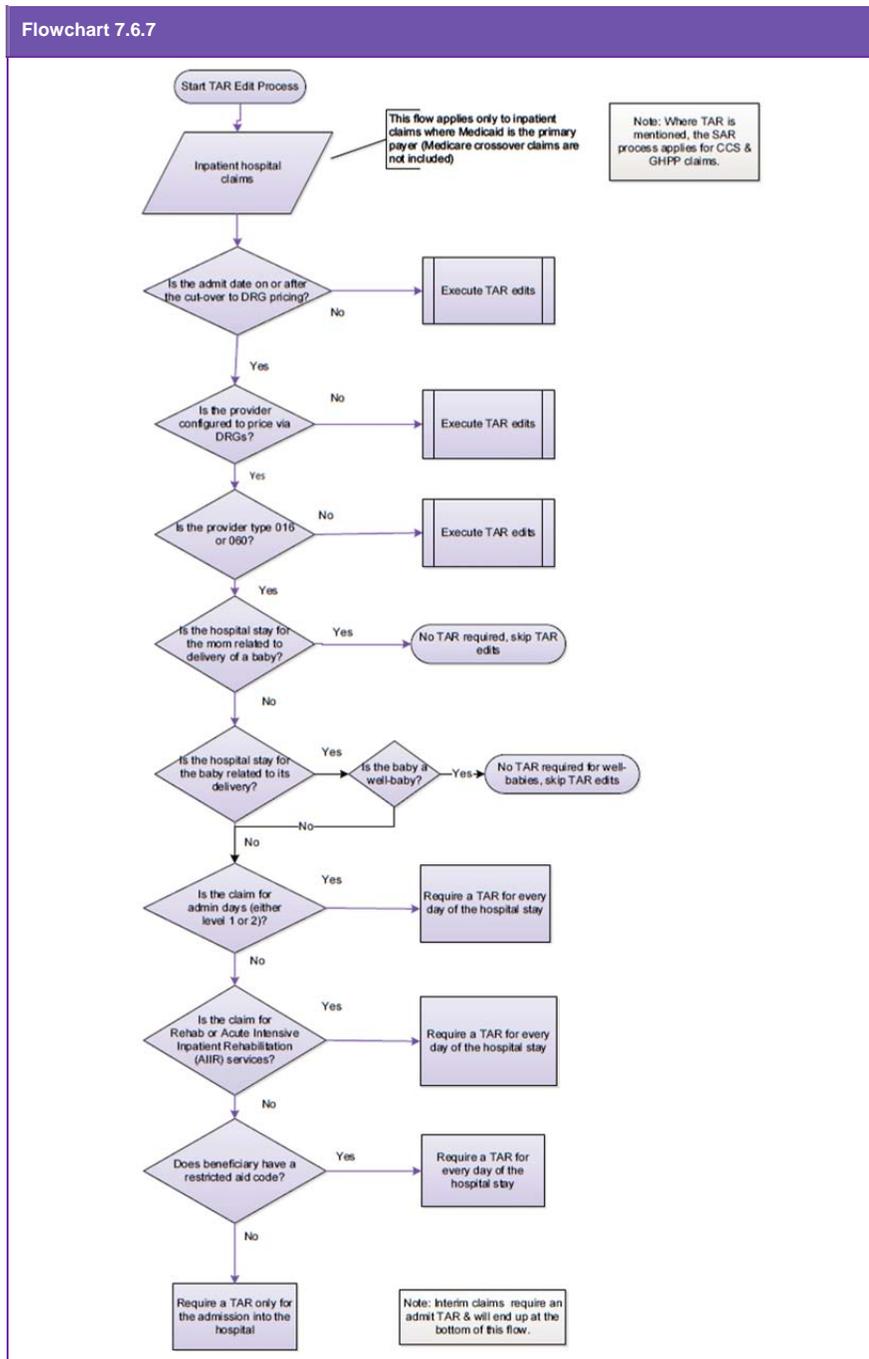
Table 7.6.7 TAR/SAR Entry Business Requirements for Inpatient Claims after DRG Pricing is Implemented			
Type of Stay	TAR/SAR Approach Current	TAR/SAR Approach New	Paid under DRGs
<b>General Acute Care – Full Scope</b>			
General acute care inpatient stay – complete stay	TAR every day	<b>TAR admission only</b>	Yes

Table 7.6.7

## TAR/SAR Entry Business Requirements for Inpatient Claims after DRG Pricing is Implemented

Type of Stay	TAR/SAR Approach Current	TAR/SAR Approach New	Paid under DRGs
General acute care inpatient stay – interim claim	TAR every day	<b>TAR admission only</b>	Paid per diem (until final claim is submitted), then paid by DRG for final payment
<b>CCS and GHPP</b>			
CCS and GHPP beneficiaries – complete stay	SAR every day	<b>SAR admission only</b>	Yes
CCS and GHPP beneficiaries – interim claim	SAR every day	<b>SAR admission only</b>	Paid per diem (until final claim is submitted), then paid by DRG for final payment.
<b>General Acute Care- Restricted Aid Codes</b>			
General acute care inpatient stay – complete stay	TAR every day, including review to ensure all services are emergency services.	No change; TAR every day, including review to ensure all services are emergency services.	Yes – With review for potential payment cutback if any days are denied.
General acute care inpatient stay – interim claim	TAR every day, including review to ensure all services are emergency services.	No change; TAR every day, including review to ensure all services are emergency services.	Paid per diem (until final claim is submitted), then paid by DRG for final payment. With review for potential payment cutback if any days are denied.
<b>Obstetrics (OB) with Delivery – Full Scope or Restricted</b>			
OB admission with delivery	No TAR required	No TAR required	Yes
OB with induction day before delivery	TAR every day	<b>No TAR required</b>	Yes
OB prolonged stays- vaginal greater than 2 days; c-section greater than 4 days	TAR every day	<b>No TAR required</b>	Yes
<b>Obstetrics (OB) non-delivery</b>			
OB admission non-delivery – full scope	<b>TAR everyday</b>	<b>TAR admission only</b>	Yes
OB admission non-delivery with restricted aid codes	<b>TAR everyday</b>	<b>TAR every day</b>	Yes
<b>Other</b>			
Well-baby stays admission - full scope and restricted aid codes (maternal aid codes used)	Not applicable – well-baby (newborns) were billed on the mother's claim	<b>No TAR required</b>	Yes – separate claim
Neonate (sick-baby) stays admission – full scope and restricted aid codes (maternal aid codes used)	<b>TAR everyday</b>	<b>TAR admission only</b>	Yes
Designated public hospitals and non-designated public hospitals	Separate process	Continue separate process	No
Administrative day level 1	TAR every day	TAR every day	No - paid per diem
Administrative day level 2 (referred to as subacute)	TAR every day (acute days currently given)	TAR every day	No – paid per diem
Rehabilitation stays - Acute Intensive Inpatient Rehab (AIIR)	TAR every day	TAR every day	No – paid per diem
<b>Notes:</b>			
1 The SAR system is a DHCS-supported system and system modifications are the responsibility of DHCS staff.			
2 Outliers will be monitored using an analytical oversight process. DHCS may decide to focus TAR review for outliers as the findings indicate.			

These TAR requirements are also depicted in the following flowchart 7.6.7.



The logic for editing the claim against the specifics of the TAR will be as shown in Table 7.6.8 and should apply to inpatient claims pricing via DRGs. For these claims a TAR not on file edit should also be executed. This is undoubtedly an existing edit within CA-MMIS and matches the TAR number the provider ID and the beneficiary ID on the claim against TARs in the TAR file.

Table 7.6.8 Inpatient Claim TAR Exceptions				
Edit #	Description	Draft Disposition	Logic	Notes
AS	Date of admission not covered within the dates of service on the TAR	Deny claim	This edit will post if: <ul style="list-style-type: none"> <li>The claim is going to price via DRGs and</li> <li>The beneficiary has full benefits (as defined by the benefit aid code) and</li> <li>The claim is not for delivery of a baby and</li> <li>The claim is not for a well-baby and</li> <li>The date of admission on the claim is outside the dates of service on the TAR.</li> </ul>	The list of procedure codes used to identify delivery stays already exists in CA-MMIS and is shown in Table 7.6.9.

A well baby is identified by revenue code 171 which does not require a TAR if that is the only revenue code on the claim. If a baby claim must document a sick baby, then revenue codes 172, 173 or 174 are used, which require a TAR. If a well-baby becomes a sick baby, then revenue code 171 will be on the claim in addition to another revenue code for the sick baby – any revenue code could be used even though 172, 173 or 174 is preferred. This situation still requires a TAR.

Table 7.6.9 shows a tentative list of the procedure codes used to identify delivery hospital stays.

Table 7.6.9 Procedure Codes Identifying Delivery Stays			
Omit Diagnostic Code ID	Admitting Procedure Code	Description	Vaginal / Cesarean Indicator
<b>Procedure Codes</b>			
1	72	Forceps, vacuum, and breech delivery	1
2	72.0	Low forceps operation	1
3	72.1	Low forceps operation with episiotomy	1
4	72.2	Mid forceps operation	1
5	72.21	Mid forceps operation with episiotomy	1
6	72.29	Other mid forceps operation	1
7	72.3	High forceps operation	1
8	72.31	High forceps operation with episiotomy	1
9	72.39	Other high forceps operation	1
10	72.4	Forceps rotation of fetal head	1

Table 7.6.9

## Procedure Codes Identifying Delivery Stays

Omit Diagnostic Code ID	Admitting Procedure Code	Description	Vaginal / Cesarean Indicator
11	72.5	Breech extraction	1
12	72.51	Partial breech extraction with forceps to aftercoming head	1
13	72.52	Other partial breech extraction	1
14	72.53	Total breech extraction with forceps to aftercoming head	1
15	72.54	Other total breech extraction	1
16	72.6	Forceps application to aftercoming head	1
17	72.7	Vacuum extraction	1
18	72.71	Vacuum extraction with episiotomy	1
19	72.79	Other vacuum extraction	1
20	72.8	Other specified instrumental delivery	1
21	72.9	Unspecified instrumental delivery	1
22	73	Other procedures inducing or assisting delivery	1
23	73.0	Artificial rupture of membranes	1
24	73.01	Induction of labor by artificial rupture of membranes	1
25	73.09	Other artificial rupture of membranes	1
26	73.1	Other surgical induction of labor	1
27	73.2	Internal and combined version and extraction	1
28	73.21	Internal and combined version without extraction	1
29	73.22	Internal and combined version with extraction	1
30	73.3	Failed forceps	1
31	73.4	Medical induction of labor	1
32	73.5	Manually assisted delivery	1
33	73.51	Manually rotation of fetal head	1
34	73.59	Other manually assisted delivery	1
35	73.6	Episiotomy	1
36	73.8	Operations on fetus to facilitate delivery	1
37	73.9	Other operations assisting delivery	1
38	73.91	External version	1
39	73.92	Replacement of prolapsed umbilical cord	1
40	73.93	Incision of cervix to assist delivery	1
41	73.94	Pubiotomy to assist delivery	1
42	73.99	Other	1
43	74	Cesarean section and removal of fetus	2
44	74.0	Classical cesarean section	2
45	74.1	Low cervical cesarean section	2

Table 7.6.9 Procedure Codes Identifying Delivery Stays			
Omit Diagnostic Code ID	Admitting Procedure Code	Description	Vaginal / Cesarean Indicator
46	74.2	Extraperitoneal cesarean section	2
47	74.3	Removal of extratubal ectopic pregnancy	2
48	74.4	Cesarean section of other specified type	2
49	74.99	Other cesarean section of unspecified type	2

*Note:* The list of procedure codes used to identify delivery stays already exists in CA-MMIS and is shown here. Procedure codes 68.3 and 68.4 have been removed from this table. These procedures can be listed and do not currently require a TAR in addition to a delivery code. In the future, DHCS may decide to change the current TAR logic for these codes via a separate SDN.

## 7.7 Claims Pricing

### BR-Pricing-1: Add branching logic

Branching logic will need to be added to ensure claims price under appropriate methods. After implementation of DRG pricing, most inpatient claims, but not all, will price via the DRG method. Some claims will continue to price under their current method and others will price under new methods that will take effect only after DRG pricing is implemented. So logic will need to be added to ensure claims flow down the appropriate path of logic in order to be priced correctly. Table 7.7.1 shows the different scenarios and the pricing method that will apply under each scenario. These scenarios only apply to claims from providers whose provider type is 016 or 060.

Table 7.7.1 Pricing Methods for Types of Inpatient Claims		
Scenario	How Identified	Pricing Method
Claim admit date is prior to cutover to DRG pricing	Claim admit date is less than the DRG pricing cutover date stored in a system parameter	Under contract or non-contract reimbursement methodology.
For all the following scenarios, the admit date on the claim is on or after the DRG pricing cut-over date		
Provider is a designated public hospital or non-designated public hospital	The new payment method indicator field stored on each provider record will be a value "P" for per diem hospitals.	Pricing method under certified public expenditures (CPE) reimbursement methodology  (DRG pricing will not be used for designated public hospitals and possibly for non-designated public hospitals)

Table 7.7.1

## Pricing Methods for Types of Inpatient Claims

Scenario	How Identified	Pricing Method
Claim is for administrative days, level 1 or 2	Claim contains revenue code 169, 190 or 199	This applies to DRG reimbursed hospitals only (payment method "D"). Current pricing method including per diem payment for revenue code 169 and separate payment for ancillary services. Administrative day level 2 claims will receive a different per diem than level 1 claims, but will otherwise price the same as level 1 including payment for select ancillary services. Administrative day level 2 will be identified by the presence of revenue codes 190 or 199. The new administrative days level 2 services will be further distinguished by the specific revenue code: administrative day level 2– Subacute Pediatric (0190) and administrative day level 2 – Subacute Adult (0199).
Claim is for rehabilitation services	Claim contains revenue code 118, 128, 138, 148, and/or 158	This applies to DRG reimbursed hospitals only (payment method "D"). Claim will price under a per diem payment method with the per diem applied only to service lines with revenue code 118, 128, 138, 148, or 158. No other revenue codes on the claim will be payable on rehab claims.
Interim stay claim	Patient discharge status is 30 and type of bill 112 or 113	This applies to DRG reimbursed hospitals only (payment method "D"). Claim will price under a per diem payment method with the per diem multiplied by the length of stay for all services within the "from-through" dates on the claim.
All other scenarios	None of the above scenarios hit	This applies to DRG reimbursed hospitals only (payment method "D"). Claim will price under the new DRG pricing method.
<p><b>Notes:</b></p> <p>1 These scenarios only apply to claims from providers whose provider type is 016 or 060.</p> <p>2 A new edit will be added to deny any claim that falls into more than one pricing category, where the pricing categories are: DRG, administrative day level 1, administrative day level 2, and rehabilitation (Table 7.6.2).</p>		

## BR-Pricing-2: Retrieve additional claim data for DRG pricing

Additional claim data submitted by providers and needed for DRG pricing will be stored in a file separate from the claim activity file/record. This data will need to be retrieved in order to perform DRG pricing. The data includes:

- Up to 25 claim header diagnosis codes
- Up to 25 present-on-admission indicators (associated with the diagnosis codes)
- Up to 25 surgical procedure codes
- Up to 25 surgical procedure dates (associated with the procedure codes)

External cause of injury diagnosis codes will not be separately captured (e.g., form locator 72a through 72c on the UB-04 paper claim form). They will be captured only when listed within the secondary diagnosis fields (e.g., form locator 67A through 67Q on the UB-04 paper claim form).

The external cause of injury diagnosis codes are not actually needed for DRG pricing. They are only needed for the new erroneous surgery edit. It may make sense to retrieve these diagnosis codes during claim pricing and perform the erroneous surgery edit in claim pricing, but it would certainly also be acceptable to retrieve this data and perform this edit elsewhere within the adjudication cycle. The new erroneous surgery edit will apply when the E-codes are present in the principal or first secondary diagnosis code fields.

These fields need to be captured on all inpatient claims, whether submitted electronically (837I) or on paper (UB-04).

**Note:** On paper claims, some of these fields have fewer instances.

In addition, DRG payment would depend on a single admit-through-discharge claim. The single DRG claim should include accurate data on all of the fields from incoming inpatient claims that are needed for pricing or editing claims using the new DRG pricing logic. This applies to the additional data listed above as well as claims data currently captured by CA-MMIS. It is important to make certain that only one claim is used for DRG pricing and that all claims data for the whole stay is used. This will ensure accurate DRG assignment (e.g., using all submitted diagnosis and procedures), enable accuracy in applying the DRG pricing logic (e.g., using all submitted charges in outlier pricing), allow enforcement of branching logic (e.g., using revenue codes that identify claims paid by per diem instead of DRG in the case of rehabilitation, administrative day, interim claims), enable claims editing (e.g., POA for HCACs, type of bill, discharge status, etc.), and avoid duplicate payment for the same stay (e.g., submitting more than one claim for a single stay or split billing).

The current expectation is that this additional claim data will be stored and retrieved much the same way the electronic remittance advice (835) process under EDI 5010 will retrieve fields from the 837I to populate the 835.

## BR-Pricing-3: Add call to diagnosis/procedure code mapper

A call to a mainframe-based third-party software application called the diagnosis and procedure code mapper will need to be added. This software is written by 3M. If the software sends back a non-zero return code, an MMIS edit should post to the claim, as mentioned in Table 7.6.5.

The ICD mapping software only needs to be called if the admit date on the claim is outside of the federal fiscal year recognized by the DRG grouper. For example, when DRG pricing is implemented the version of the DRG grouper that will be installed is version 29. Version 29 was released in federal fiscal year 2012, which started on October 1, 2011 and ended on September 30, 2012. If the claim has an admit date in this federal fiscal year, the ICD mapping software does not need to be called. If on the other hand, the claim's admit date is outside this 12-month period (less than October 1, 2011 or greater than September 30, 2012), then the ICD mapping software does need to be called.

The begin and end dates of the federal fiscal year recognized by the installed version of the DRG grouper and of the HAC Utility will be stored in system parameters to support the decision on whether or not the ICD mapping software needs to be called. And these system parameters will need to be updated each time a new version of the APR-DRG grouping software or of the HAC Utility is installed.

## BR-Pricing-4: Build DRG grouping input record

The DRG grouping input record is used in both the call to the health care-acquired condition (HCAC) utility and to the DRG grouper. The list of fields included in the DRG grouper input record is shown in Table 7.7.2.

Table 7.7.2 Input to DRG Grouper
CCN
First date of service
Last date of service
Patient discharge status
Source of admission (optional)
Type of admission (optional)
Beneficiary gender
Beneficiary age
Age in days – admission (if age is zero, populate the age in days).
Admit diagnosis code (optional)
Principal diagnosis code
All diagnosis codes submitted on the claim
Present-on-admission indicators for each diagnosis code

Table 7.7.2

Input to DRG Grouper

All surgical procedure codes submitted on the claim

ICD version indicator

## BR-Pricing-5: Call health care-acquired condition (HCAC) utility

A call must be made to a mainframe based third party software application called the health care-acquired condition (HCAC) utility. This utility is also referred to as the hospital-acquired condition (HAC) utility. This utility will identify any diagnosis codes and/or diagnosis code / surgical procedure code combinations that are classified as health care-acquired conditions (HCACs). The utility also returns a separate list of diagnosis and surgical procedure codes removing those codes identified as HCACs for pricing.

## BR-Pricing-6: Add calls to DRG grouping software

Two calls to a mainframe-based third party software application written by 3M Health Information Systems called the APR-DRG grouper will need to be added. This software will assign the APR-DRG code. The first call should be performed using all the diagnosis and surgical procedure codes on the claim. The DRG assigned from this call is generally referred to as the pre-HCAC DRG (because it reflects the DRG assignment before the HCAC Utility is run. During this first call the HCAC diagnoses and/or procedures are identified). The second call should include only those diagnosis and surgical procedure codes that are not defined as HCACs. The 3M HCAC utility returns a list of all the diagnosis and surgical procedure codes on the claims except those defined as HCACs, making the removal of HCAC codes very easy. The DRG returned from the second call to the DRG grouper is generally referred to as the post-HCAC DRG (because it reflects the DRG assignment after running the HCAC Utility).

On ninety-nine percent (99%) or more of the claims, there will be no diagnosis or surgical procedure codes defined as HCACs. So it would be worthwhile to compare the list of codes sent to the HCAC utility against the list of codes returned from the HCAC utility. If the two lists are the same, then it is safe to assume the pre-HCAC and post-HCAC DRGs will be the same, and the second call to the DRG grouper can be skipped. Even in cases where there are codes defined as HCACs, the pre-HCAC and post-HCAC DRG codes may still turn out to be the same. But the only way to know for sure is to perform a second call to the DRG grouper.

In cases where the pre-HCAC DRG and the post-HCAC DRG differ, CA-MMIS will price the claim using the post-HCAC DRG; however, two calls to the HCAC Utility will still be needed to obtain the post-HCAC DRG.

If the DRG grouping software sends back a non-zero return code, an MMIS edit should post to the claim. The APR-DRG grouping software has about a dozen return codes, and those codes need to be mapped to specific MMIS edits. (Table 7.6.5)

## BR-Pricing-7: Add logic to perform DRG pricing

New DRG pricing logic will need to be added to CA-MMIS, as shown in Table 7.7.3A. This logic is also shown in the flow chart included in section 7.15 of this document and in the separate DRG calculator spreadsheet. Please refer to the separate DRG Calculator spreadsheet to understand the formulae below. The “line” column in Table 7.7.3A refers to the line in the DRG Pricing Calculator.

Table 7.7.3A				
DRG Pricing Logic				
Line	Information	Comments	Formula (Column E) from DRG Calculator	Expressed Formula
6	<b>CLAIM-SPECIFIC INFORMATION USED IN PRICING</b>			
7	Total charges	From claim (UB-04 Form Locator 47)		
8	Hospital-specific cost-to-charge ratio	From provider master file		
9	Length of stay	From claim		
10	Patient discharge status = 02, 05, 65 or 66? (transfer)	Check claim against system list		
11	Patient age (in years)	From claim		
12	Other health coverage	No change from current calculation		
13	Patient share of cost	No change from current calculation		
14	Is discharge status equal to 30?	From claim		
15	Designated NICU facility	From provider master file		
16	APR-DRG	From APR-DRG grouping software		
17	<b>APR-DRG INFORMATION USED IN PRICING</b>			
18	APR-DRG description	Look up from DRG Reference file. The description itself does not affect pricing.		
19	Casemix relative weight--unadjusted	Look up from DRG Reference file		
20	Service adjustor - hospital with designated NICU	Look up from DRG Reference file		

**Table 7.7.3A  
DRG Pricing Logic**

Line	Information	Comments	Formula (Column E) from DRG Calculator	Expressed Formula
21	Service adjustor - all other hospitals	Look up from DRG Reference file		
22	Age adjustor	Look up from DRG Reference file		
23	Payment relative weight	21 is the cut-off age for pediatric age adjustor	=+IF(E11<21,IF(E15="Yes", (E19*E20*E22), (E19*E21*E22)), IF(E15="Yes", (E19*E20), (E19*E21)))	If the patient age <21 years old and if this is a designated NICU facility, then Casemix relative weight—unadjusted * designated NICU policy adjustor * age adjustor, else Casemix relative weight—unadjusted * Service adjustor all other hospitals * age adjustor, else Service adjustor all other hospitals * age adjustor, else
24	Average length of stay for this APR-DRG	Look up from DRG Reference file		
25	<b>PAYMENT POLICY PARAMETERS USED IN DRG PRICING</b>			
26	DRG base price	From provider master file		
27	Cost outlier threshold 1	From parameter table		
28	Cost outlier threshold 2	From parameter table		
29	Marginal cost percentage_1	From parameter table		
30	Marginal cost percentage_2	From parameter table		
31	Casemix adjustment factor	From parameter table		
32	Interim claim threshold	From parameter table		
33	Interim per diem amount	From parameter table		
34	<b>DETERMINE WHETHER THIS IS AN INTERIM CLAIM</b>			
35	Is discharge status equal to 30?		=E14	Continue if the discharge status (E14) is equal to 30 signaling this as an interim claim; otherwise skip to line 39.
36	Is length of stay > interim claim threshold?		=IF(E35="Yes", IF(E9>E32, "Yes", "No"), "N/A")	Is the claim's length of stay (LOS) (E9) greater than the interim claim threshold of 29 (E32) days?
37	Skip to E65 for final interim claim payment amount		=IF(E36="Yes", ROUND((E33*E9),2),0)	If the response to line 36 is yes, then calculate the interim claims price by multiplying the DRG per diem amount (E33) by the LOS (E9). This is the payment amount for an interim claim. Go to E65.

Table 7.7.3A

## DRG Pricing Logic

Line	Information	Comments	Formula (Column E) from DRG Calculator	Expressed Formula
38	<b>DETERMINE THE DRG BASE PAYMENT</b>			
39	DRG base payment for this claim		=E26*E23*E31	Calculate the DRG base price by multiplying DRG base price (E26) * Payment relative weight (E23) * Casemix adjustment factor (E31)
40	<b>DETERMINE TRANSFER-ADJUSTED BASE PRICE, IF APPLICABLE</b>			
41	Is a transfer adjustment potentially applicable?		=+E10	Does the patient discharge status (E10) indicate that this is a transfer claim? If no, skip to line 45; otherwise, proceed with calculating transfer-adjusted base price.
42	Calculated transfer payment adjustment		=IF(E41="Yes",ROUND((E39/E24)*(E9+1),2),"N/A")	Divide DRG Base Payment (E39) by ALOS (E24) for the DRG then multiply by the LOS for this claim plus 1 day. Round to 2 places.
43	Is transfer payment adjustment < allowed amount so far?		=IF(E42="N/A","N/A",IF(E42<E39,"Yes","No"))	Is the transfer payment (E42) less than the DRG base payment (E39)?
44	Allowed amount after transfer adjustment		=+IF(E43="Yes",E42,E39)	If E43 is yes and the transfer payment (E42) is less than the DRG base payment (E39), then pay the transfer adjustment (E42); otherwise pay the DRG Base Price (E39). Go to E45.
45	<b>DETERMINE COST OUTLIER PAYMENT, IF APPLICABLE</b>			
46	Estimated cost of this case		=E7*E8	Calculate the estimated cost of this case by multiplying covered charges (E7) by the hospital-specific Cost-to-charge (CCR) ratio (E8). Use this to determine if an outlier payment qualifies.
47	Is estimated cost > allowed amount		=IF(E46>E44,"Loss","Gain")	If the estimated cost of this case (E46) is greater than the allowed amount (E44) (the transfer adjustment is calculated and either the base price or transfer adjusted base price is used), then label this a loss and go to (E48) to calculate High-side outlier payment. If the estimated cost of this case (E47) is less than the allowed amount (E45) then label a "gain" and go to E54 to calculate low side outlier payment.
48	<b>Calculate High-Side Outlier Payment When Payment Is Much Lower than Cost</b>			
49	Estimated loss on this case		=IF(E47="Loss",(E46-E44),"N/A")	If E47 is a "loss", then calculate the loss by subtracting the allowed amount (E44) from the estimated cost of this case (E46).

Table 7.7.3A  
DRG Pricing Logic

Line	Information	Comments	Formula (Column E) from DRG Calculator	Expressed Formula
50	Is loss > outlier threshold lower limit		=IF((E47="Loss"),IF((E49>E27),"Yes", "No"),"N/A")	Is the loss (E49) greater than Cost outlier threshold 1 (E27)? If no, skip to (E53). else N/A.
51	DRG cost outlier payment increase 1		=IF(E50="Yes",IF(E49<E28,(E49-E27)*MC_1,(E28-E27)*MC_1),0)	<p>If the loss (E49) is less than the Cost outlier threshold 2 (E28), subtract the loss (E49) by Cost outlier threshold 1 (E27) then multiply by Marginal cost percentage_1 (E29) to get the DRG cost outlier payment increase 1 (E51).</p> <p>If the loss (E49) is more than the Cost outlier threshold 2 (E28), then calculate the difference, between Cost outlier threshold 2 (E28) and Cost outlier threshold 1 (E27) and multiply by the Marginal cost percentage_1 (E29) to get the DRG cost outlier payment increase 1 (E51).</p>
52	DRG cost outlier payment increase 2		=IF(E50="Yes",IF(E49>E28,(E49-E28)*MC_2,0),0)	If the loss (E49) is greater than the Cost outlier threshold 2 (E28), then calculate the difference between loss (E49) and the Cost outlier threshold 2 (E28), then multiply by Marginal cost percentage_2 (E30) to calculate the DRG cost outlier payment increase 2 (E52). Otherwise, no DRG cost outlier payment increase 2 (E52).
53	<b>Calculate Low Side Outlier Payment When Payment Is Much Greater than Cost</b>			
54	Estimated gain on this case		=IF(E47="Gain",(E44-E46),"N/A")	If a "gain" is indicate (E47), then calculate the estimated gain by subtracting estimated cost of this case (E46) from the allowed amount (E44). Otherwise, "N/A".
55	Is gain > outlier threshold		=IF((E47="Gain"),IF((E54>E27),"Yes","No"),"N/A")	Is the "gain" (E54) greater than Cost outlier threshold 1 (E27)? If yes, continue, If no, skip to E57. Else N/A.
56	DRG cost outlier payment decrease		=IF((E47="Gain"),(ROUND(IF(E55="Yes",((E54-E27)*E29),0),2)),0)	If E55 is "yes", then subtract the Cost outlier threshold 1 (E27) from the "gain" (E54), then multiply by the Marginal cost percentage_1 (E29) to calculate the DRG cost outlier payment decrease (E56). Round to 2 places Otherwise Zero.

Table 7.7.3A  
DRG Pricing Logic

Line	Information	Comments	Formula (Column E) from DRG Calculator	Expressed Formula
57	<b>CALCULATE ALLOWED AMOUNT AFTER TRANSFER AND OUTLIER ADJUSTMENTS</b>			
58	DRG payment so far		=IF(E47="Loss", (E44+E51+E52), (E44-E56))	Calculate the DRG payment so far (E58) including any transfer adjustment and outlier payments by:  If E47 is a "loss", then Allowed amount after transfer adjustment (E44) plus DRG cost outlier payment increase 1 (E51) plus DRG cost outlier payment increase 2 (E52).  If E47 is a "gain", then Allowed amount after transfer adjustment (E44) minus the DRG cost outlier payment decrease 2 (E56).
59	<b>CALCULATE ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT</b>			
60	Add-on amount	Look up provider master file. Not used at this time, so value is zero		
61	Allowed amount		E58 + E60	
62	Other health coverage	No change from current CA-MMIS logic in moving from the allowed amount to the reimbursed amount logic.	IF E12 > 0, then E12, else 0	Process the payment from E61 along with any other current logic from the allowed amount to the reimbursed amount logic.  Existing policy ensures that payment amount cannot exceed total charges. If allowed amount is greater than charges (E61>E7), then use charges (E7), otherwise, use allowed amount (E61).
63	Patient share of cost		IF E13 > 0, then E13, else 0	
64	"Lesser of" calculation		IF E61>E7, then E7, else E61	
65	Payment amount		IF(E35="Yes", E37, (E64-(E62+E63)))	If interim claim (E35="Yes"), then final interim claim amount (E37) as payment amount. Otherwise, subtract other health coverage (E62) and patient share of cost (E63) from "Lesser of" (E64) to obtain payment amount.

Note: The DRG pricing calculator spreadsheet shows this same logic, with examples.

This table is intended to be helpful with the DRG pricing logic, but it cannot capture all the editing and pricing complexity of the Medicaid claims processing system. In cases of difference, the claims processing system is correct.

## BR-Pricing-8: Store DRG pricing values

At the completion of DRG pricing, the values calculated will need to be stored in the CA-MMIS database. All of these values will be stored in the new claim DRG pricing file.

Those values are shown in Table 7.7.4.

DRG Pricing Fields	Notes	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
The first set of fields contains the values used in pricing the claim using the post-HCAC DRG.		
CCN		DRG, Per Diem
NPI	Copied from the provider master file	DRG, Per Diem
CIN	Client Index Number	DRG, Per Diem
DRG_Code	Determined by DRG grouper	DRG, Per Diem
DRG_MDC_Code	Determined by DRG grouper	DRG, Per Diem
Prov_DRG_Base_Price	Copied from the provider master file	DRG
DRG_Casemix_Rel_Wt	Copied from DRG pricing file	DRG, Per Diem
DRG_Pymt_Rel_Wt	If the beneficiary age is greater than or equal to the value in the age cutoff parameter, then this field equals (DRG_Casemix_Rel_Wt) * (the DRG service adjustor, either the NICU or "all other" service adjustor).  If the beneficiary age is less than the value in the age cutoff parameter, then this field equals (DRG_Casemix_Rel_Wt) * (the DRG service adjustor, either the NICU or "all other" service adjustor) * (DRG age adjustor).	DRG
Casemix_Adjstmnt_Factor	Found in a system parameter	DRG
DRG_Base_Pymt	Equals Prov_DRG_Base_Price * DRG_Pymt_Rel_Wt * Casemix_Adjstmnt_Factor	DRG
DRG_ALOS	Copied from DRG pricing record	DRG, Per Diem
Transfer_Pymt_Amt	Calculated value – in the flowchart this is referred to as "transfer payment"	DRG
Prov_CCR	Copied from the provider master file	DRG
Estimate_Gain_Loss	Calculated value	DRG
Est_Gain_Loss_Ind	"G" or "L"	DRG
DRG_Outlier_Amt	Calculated value	DRG
DRG_Outlier_Ind	Calculated value	DRG
Add_On_Pymt_Amt	Copied from the provider master file	DRG
DRG_Price_Full_Stay	Calculated value	DRG

Table 7.7.4

DRG Pricing Fields Stored with Each Claim

DRG Pricing Fields	Notes	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
<p>The second set of fields contains the values generally referred to as the "pre-HCAC" values although in practice they are the values determined using the DRG code with the higher relative weight between the "pre-HCAC" and "post-HCAC" DRGs. Also, extremely few claims will have any HCAC conditions. So the "pre-HCAC" values will equal the "post-HCAC" values on over 99% of the inpatient claims.</p>		
Pre_HCAC_DRG_Cd	Determined by DRG grouper	DRG, Per Diem
Pre_HCAC_DRG_Casemix_Rel_Wt	Copied from DRG pricing file	DRG, Per Diem
Pre_HCAC_Pymt_Rel_Wt	<p>If the beneficiary age is greater than or equal to the value in the age cutoff parameter, then this field equals (Pre_HCAC_DRG_Casemix_Rel_Wt) * (the DRG service adjustor, either the NICU or "all other" service adjustor).</p> <p>If the beneficiary age is less than the value in the age cutoff parameter, then this field equals (Pre_HCAC_DRG_Casemix_Rel_Wt) * (the DRG service adjustor, either the NICU or "all other" service adjustor) * (DRG age adjustor).</p>	DRG
Pre_HCAC_Final_Price	Calculated value	DRG
HCAC_Category	<p>Returned by the HCAC utility. There can be multiple categories identified on a single claim, although this will be very rare. Recording the first category identified will be sufficient.</p> <p>Valid values for this field are:</p> <ul style="list-style-type: none"> <li>00 = No HCAC assigned</li> <li>01 = Foreign Object Retained After Surgery</li> <li>02 = Air Embolism</li> <li>03 = Blood Incompatibility</li> <li>04 = Stage III &amp; IV Pressure Ulcers</li> <li>05 = Falls and Trauma</li> <li>06 = Catheter Associated Urinary Tract Infection</li> <li>07 = Vascular Catheter Associated Infection</li> <li>08 = Surgical Site Infection - CABG</li> <li>09 = Manifestations of Poor Glycemic Control</li> <li>10 = DVT/PE after certain orthopedic procedures</li> <li>11 = Surgical Site Infection - Bariatric Surgery</li> <li>12 = Surgical Site Infection - Certain Orthopedic procedures</li> <li>13 = Surgical site infection - Cardiac implantation (CIED)</li> <li>14 = Iatrogenic pneumothorax w venous catheterization</li> </ul>	DRG, Per Diem

Table 7.7.4 DRG Pricing Fields Stored with Each Claim		
DRG Pricing Fields	Notes	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
<p><i>Note:</i></p> <p>** Reference is to the "inpatient payment method" field that has hospital-specific valid values of D=DRG and P=Per Diem. For the per diem hospitals, the goal is to report clinical information about the stay (e.g., DRG code, DRG casemix relative weight calculated from national data, national average length of stay, HCAC presence) but not pricing information that does not pertain to per diem hospitals (e.g., DRG payment relative weight, DRG base price),</p>		

In addition, the DRG pricing indicator will need be stored in the DRG Pricing file instead of the Activity Record. The final claim price will be stored in the Activity Record.

The new pricing method indicator values for DRG pricing should be:

- Standard DRG pricing (value code = 'DST')
- Transfer claim; DRG price reduced (value code = 'TFA')
- Transfer claim; DRG price not reduced (value code = 'TFN')
- Outlier claim, DRG price adjusted for loss (value code = 'OLA')
- Outlier claim, DRG price adjusted for gain (value code = 'OGA')
- Transfer claim, DRG price reduced, outlier loss adjusted (value code = 'TLA')
- Transfer claim, DRG price reduced, outlier gain adjusted (value code = 'TGA')
- Transfer claim, DRG price not reduced, outlier loss adjusted (value code = 'TLN')
- Transfer claim, DRG price not reduced, outlier gain adjusted (value code = 'TGN')
- DRG interim claim (value code = 'DIN')
- Rehabilitation claim (value code = 'DRB')
- DRG Admin Level Claim – 'DAD'

The presence of outlier payments will be identified with a separate DRG outlier indicator stored on the new claim DRG pricing file.

## BR-Pricing-9: Allow users to view claim DRG pricing fields

DRG pricing file will not be viewable online (Customer Information Control System [CICS]), but the required information can be extracted through ITSD Medi-Cal Information System/Decision Support System (MIS/DSS) or SURS Prospector.

The final claim header price will be stored in the same place as it is stored for all other claims, in the field called CF1-ALLOWABLE-PROC-PAYMT. The DRG pricing indicator will be stored in the DRG Pricing side file.

## BR-Pricing-10: Price admin level 2 claims like admin level 1

Level 2 administrative day claims should flow through the same pricing logic as used for administrative day level 1 claims. This is existing logic within CA-MMIS that pays a per diem amount for specific revenue codes and pays additionally for specific ancillary services. Level 2 administrative day claims will be identified by the presence of one or more lines with revenue code 190 or 199. And the per diem rate will be paid to the lines with revenue code 190 or 199. The logic used to pay certain ancillary services will be the same logic currently used for administrative day level 1 claims (claims with revenue code 169).

Administrative day level 2 care is care that is less intensive than acute care, and more intensive than the existing administrative day care, which is referred to in this document as administrative day level 1.

Administrative day level 2 and revenue codes 190 and 199 will be available for payment only to DRG hospitals. Revenue codes 190 and 199 will be added to the provider master file for these providers.

Revenue codes 190 and 199 will require a daily TAR. Payment will work the same as revenue code 169, such as bundling policies, separately payable ancillary services. Administrative day level 1 and level 2 services will require a separate claim to be billed.

Administrative day level 1 and level 2 per diem rates will reside in the PMF.

The new administrative day level 2 services will be further distinguished by the specific revenue code to identify services provided to pediatric and adult beneficiaries:

- Administrative day level 2 – Subacute Pediatric will be identified by revenue code 0190
- Administrative day Level 2 – Subacute Adult will be identified by revenue code 0199

**Note:** A new edit will be added to deny any claim that falls into more than one pricing category, where the pricing categories are: DRG, administrative day level 1, administrative day level 2, and rehabilitation (Table 7.6.2).

## BR-Pricing-11: Add new rehabilitation service pricing logic

A new per diem payment method will be implemented for payment of rehabilitation claims. Rehabilitation claims will be identified by the presence of revenue codes 118, 128, 138, 148, and/or 158 on one or more service lines on the claim. Rehabilitation claims will be paid a per diem. The per diem will be multiplied by the number of units for

each of these five revenue codes on the claim to get the total claim price. All other lines on the claim should price at zero.

Rehabilitation rates will reside in the Provider Master File.

**Note:** A new edit will be added to deny any claim that falls into more than one pricing category, where the pricing categories are: DRG, administrative day level 1, administrative day level 2, and rehabilitation (Table 7.6.2).

## 7.8 Processing Final Claim after Interim Claims

### BR-Final-Clm-1: Voiding interim claims

A particularly complicated piece of the DRG pricing process is handling long hospital stays in which interim claims are billed followed by a final claim. For these types of stays the interim claims will be paid a per diem rate, which is intended to help the providers with their cash flow. Then when the beneficiary is finally discharged, a final claim will be submitted that will be priced under the normal DRG method. To perform DRG pricing on the final claim, providers will be expected to bill all the information for the full stay on the final claim. The final claim will contain the full length of stay, all diagnosis and surgical procedure codes, and all the charges for the stay.

The final bill will also need to include all the accommodation codes from each interim claim to be voided, just like if they had submitted a final bill and only a final bill. This will ensure processing the final bill as a complete final bill and that the claim used for repricing includes all the accommodation codes and ancillary services as applicable.

The basic business requirement in this scenario is to ensure that the overall payment for this stay is the full DRG payment. When a provider submits a claim with type of bill 111 (Admit-through-discharge claim), then all previous interim claims will be voided and the final claim will be reimbursed using DRG pricing methodology.

The final claim has to be suspended until all the voids have been entered. The interim per diem rate will be on the DRG System Parameter Table. Interim claims will meet the minimum number of days which will also be on the DRG System Parameter table as the "interim claim threshold". Only interim claims with length of stay greater than 29 days will be payable.

## 7.9 Reporting DRG Pricing Information

No changes to the Claim Activity Record are anticipated. As a result, no changes are anticipated for the CMS 64 report or the MARS 145 and 154 reports.

## BR-Rptng-1: Remittance advice

The DRG code assigned to each inpatient claim priced via DRGs will need to be output on the electronic (835) and paper remittance advices.

Price reductions caused by HCACs need to be communicated to providers. These claims will be identified either through a new indicator or through an exception posted to the claim.

## BR-Rptng-2: Standard DRG pricing reports

Standard DRG pricing reports will need to be built to help UMD, Safety Net Financing, and other organizations monitor payments made for inpatient acute care services.

No reports will be generated through CA-MMIS. Reports will be generated from a data warehouse. See Section 6.6 of the Policy Design Document (May 1, 2012) for a suggested list of DRG reports.

New mainframe reports associated with modifications to the DRG data, however, will be added. Examples are: DRG Reference File audit report and batch update/reject reports, DRG System Parameter Table report, and DRG Provider data batch update/reject report, and transaction audit trail report.

## BR-Rptng-3: Data warehouse extracts

Some of the new claim DRG pricing fields, new reference DRG pricing fields, and new provider pricing fields will need to be extracted and made available for data warehouses. The claim fields that should be made available to data warehouses are:

Table 7.9.2 Additional Claim Fields for Data Warehouse
<b>DRG Pricing Fields</b>
DRG_Code
DRG_Code_Desc
DRG_MDC_Code
DRG_MDC_Code_Desc
Prov_DRG_Base_Price
DRG_Casemix_Rel_Wt
DRG_Svc_Adjstr_All_Others
DRG_Svc_Adjstr_Desig_NICU
DRG_Age_Adjstr

**Table 7.9.2**

**Additional Claim Fields for Data Warehouse**

DRG_Pymt_Rel_Wt
Casemix_Adjstmnt_Factor
DRG_Base_Pymt
Estimate_Gain_Loss
Est_Gain_Loss_Ind
DRG_Outlier_Amt
Add_On_Pymt_Amt
Claim final price
DRG pricing method indicator
Pre_HCAC_DRG_Cd
Pre_HCAC_DRG_Casemix_Rel_Wt
Pre_HCAC_Pymt_Rel_Wt
Pre_HCAC_Final_Price
HCAC_Category
<b>Fields Submitted on Claims</b>
Diag_Cd_1
POA_Cd_1
Diag_Cd_2
POA_Cd_2
Diag_Cd_3
POA_Cd_3
Diag_Cd_4
POA_Cd_4
Diag_Cd_5
POA_Cd_5
Diag_Cd_6
POA_Cd_6
Diag_Cd_7
POA_Cd_7
Diag_Cd_8
POA_Cd_8
Diag_Cd_9
POA_Cd_9
Diag_Cd_10
POA_Cd_10
Diag_Cd_11
POA_Cd_11
Diag_Cd_12
POA_Cd_12

Table 7.9.2 Additional Claim Fields for Data Warehouse
Diag_Cd_13
POA_Cd_13
Diag_Cd_14
POA_Cd_14
Diag_Cd_15
POA_Cd_15
Diag_Cd_16
POA_Cd_16
Diag_Cd_17
POA_Cd_17
Diag_Cd_18
POA_Cd_18
Diag_Cd_19
POA_Cd_19
Diag_Cd_20
POA_Cd_20
Diag_Cd_21
POA_Cd_21
Diag_Cd_22
POA_Cd_22
Diag_Cd_23
POA_Cd_23
Diag_Cd_24
POA_Cd_24
Diag_Cd_25
POA_Cd_25
Surg_Proc_Cd_1
Surg_Proc_Dt_1
Surg_Proc_Cd_2
Surg_Proc_Dt_2
Surg_Proc_Cd_3
Surg_Proc_Dt_3
Surg_Proc_Cd_4
Surg_Proc_Dt_4
Surg_Proc_Cd_5
Surg_Proc_Dt_5
Surg_Proc_Cd_6
Surg_Proc_Dt_6

Table 7.9.2 Additional Claim Fields for Data Warehouse	
Surg_Proc_Cd_7	
Surg_Proc_Dt_7	
Surg_Proc_Cd_8	
Surg_Proc_Dt_8	
Surg_Proc_Cd_9	
Surg_Proc_Dt_9	
Surg_Proc_Cd_10	
Surg_Proc_Dt_10	
Surg_Proc_Cd_11	
Surg_Proc_Dt_11	
Surg_Proc_Cd_12	
Surg_Proc_Dt_12	
Surg_Proc_Cd_13	
Surg_Proc_Dt_13	
Surg_Proc_Cd_14	
Surg_Proc_Dt_14	
Surg_Proc_Cd_15	
Surg_Proc_Dt_15	
Surg_Proc_Cd_16	
Surg_Proc_Dt_16	
Surg_Proc_Cd_17	
Surg_Proc_Dt_17	
Surg_Proc_Cd_18	
Surg_Proc_Dt_18	
Surg_Proc_Cd_19	
Surg_Proc_Dt_19	
Surg_Proc_Cd_20	
Surg_Proc_Dt_20	
Surg_Proc_Cd_21	
Surg_Proc_Dt_21	
Surg_Proc_Cd_22	
Surg_Proc_Dt_22	
Surg_Proc_Cd_23	
Surg_Proc_Dt_23	
Surg_Proc_Cd_24	
Surg_Proc_Dt_24	
Surg_Proc_Cd_25	
Surg_Proc_Dt_25	

The reference DRG pricing fields that should be made available to data warehouses are:

Table 7.9.3 Reference DRG Pricing Fields Available to Data Warehouses
DRG_Code
Eff_Begin_Dt
Eff_End_Dt
DRG_Description
DRG_ALOS
DRG_Casemix_Rel_Wt
DRG_Svc_Adjstr_All_Others
DRG_Svc_Adjstr_Desig_NICU
DRG_Age_Adjstr
Mcaid_Care_Categ_Adult
Mcaid_Care_Categ_Child

The provider-specific DRG pricing fields that should be made available to data warehouses are:

Table 7.9.4 Provider DRG Pricing Fields Available to Data Warehouses
Eff_Begin_Dt
Eff_End_Dt
Cost-to-charge ratio
Provider DRG base price
Per-claim add-on payment
Designated NICU indicator
Administrative day level 1 per diem rate
Administrative day level 2 per diem rate (adult)
Administrative day level 2 per diem rate (pediatric)
Rehabilitation per diem rate

## 7.10 Database Changes

### BR-DB-1: Add a reference DRG pricing file

A new Reference DRG pricing file needs to be created. This file will be updated once a year and about 1,300 rows will be added each year. The file needs to be accessible to

the inpatient pricing logic within the adjudication process. The file should also be viewable and updateable online in CA-MMIS. Fields in this file are:

Table 7.10.1 New Reference DRG pricing file		
Column	Format	Description
DRG_Code	PIC X(05)	Unique key is DRG_Code and Begin_Dt
Eff_Begin_Dt	Standard CA-MMIS date format	Unique key is DRG_Code and Begin_Dt
Eff_End_Dt	Standard CA-MMIS date format	
DRG_Description	PIC X(100)	
DRG_ALOS	PIC 9(03)V9(02)	Average length of stay
DRG_Casemix_Rel_Wt	PIC 9(03)V9(04)	Relative weight
DRG_Svc_Adjstr_All_Others	PIC 9(03)V9(02)	Relative weight adjustor based on the type of service. Also known as the "policy adjustor". Applicable to all providers except those operating a designated NICU (defined by DHCS as a NICU certified by the California Children's Services program for neonatal surgery. See Table 7.10.2 below for the 'designated NICU indicator' field and values on the PMF).
DRG_Svc_Adjstr_Desig_NICU	PIC 9(03)V9(02)	Relative weight adjustor based on the type of service. Also known as the "policy adjustor". Applicable to providers operating a designated NICU (defined by DHCS as a NICU certified by the California Children's Services program for neonatal surgery. See Table 7.10.2 below for the 'designated NICU indicator' field and values on the PMF).
DRG_Age_Adjstr	PIC 9(03)V9(02)	Relative weight adjustor based on the beneficiary age. Only beneficiaries younger than the age threshold get the age adjustor applied.
Mcaid_Care_Categ_Adult	PIC X(50)	A categorization of DRGs applicable for claims where the beneficiary is an adult
Mcaid_Care_Categ_Child	PIC X(50)	A categorization of DRGs applicable for claims where the beneficiary is a child
DRG_On_Review_Ind	PIC X(01)	DRG-specific indicator that may be used by DHCS Audits & Investigations for post-payment ad-hoc reporting. No editing occurs with this field at this time. Note. This field allows DHCS to build editing logic in the future. For example, this functionality may be used by DHCS to suspend a claim for review prior to payment based on the DRG indicator.
Last_Updt_User_ID	Standard CA-MMIS format	
Last_Updt_Date_Time	Standard CA-MMIS format	

## BR-DB-2: Provider master file

The following provider-specific fields need to exist in the provider master file to support APR-DRG pricing. These fields may already exist within the provider master file. If they do, no changes are needed. If they do not, then they will need to be added either to an existing file or to a new file. These fields are all date sensitive. Each needs to be “bracketed” with begin and end effective dates.

Column	Format	Description
Cost-to-charge ratio	PIC 9(1)V9(05)	This value is calculated by the Audits and Investigations division. It is the same thing as the interim rate currently loaded for non-contract hospitals.
Inpatient payment method	PIC X(1)	Valid values will be “P” for per diem pricing and “D” for DRG pricing. Other values may also be needed to identify other pricing methods. For most providers of type 016 and 060, this value will be “D” for dates after the cut-over to DRG pricing. However, the value will be “P” for designated public hospitals and possibly non-designated public hospitals because they will be paid via a per diem method.
DRG base price	PIC 9(09)V9(02)	Provider-specific value used in DRG pricing
Per-claim add-on payment	PIC 9(09)V9(02)	Provider-specific payment amount added to the DRG payment for claims priced under the DRG method.
Designated NICU indicator	PIC X(1)	Value must be “Y” or “N”. This field is on the provider master file and is used in determining the service adjustor value used to increase payment to hospitals identified with a “Y” indicator value.  Note: “Designated NICU” hospital is defined by DHCS as a NICU certified by the California Children’s Services program for neonatal surgery.
Administrative day level 1 per diem	Numeric, dollar amount	Values will be hospital-specific and may vary among hospitals. Value will be stored by provider / revenue code combination in the provider master file as done today. This is the current administrative days per diem
Administrative day level 2 per diem	Numeric, dollar amount	Values will be hospital-specific and may vary among hospitals. Value will be stored by provider / revenue code combination in the provider master file as done today for the administrative day level 1 per diem. Note: The new administrative days level 2 services will be further distinguished by the specific revenue code: administrative day level 2 – Subacute Pediatric (0190) and administrative day level 2 – Subacute Adult (0199).
Rehabilitation per diem	Numeric, dollar amount	Values will be hospital-specific and may vary among hospitals. Value will be stored by provider / revenue code combination in the provider master file similar to how per

Table 7.10.2 Provider-Specific Fields Supporting DRG Pricing		
Column	Format	Description
		diems are stored today.

### BR-DB-3: Claims entry side file

A new file will be needed to capture claim data submitted by providers that is not currently captured or used in CA-MMIS. This data will likely be captured in a process very similar to the one built to capture data under the EDI 5010 project. However, for the DRG project, these additional fields will need to be captured on both electronic and paper claims. Also, the fields will only be needed on hospital inpatient claims.

Fields in this new file are shown in Table 7.10.3.

Table 7.10.3 Additional Submitted Claim Fields Needed for DRG Pricing		
Column	Format	Description / Notes
CCN	PIC X(13)	Primary key to this file
Diag_Cd_1	PIC X(07)	
POA_Cd_1	PIC X(01)	
Diag_Cd_2	PIC X(07)	
POA_Cd_2	PIC X(01)	
Diag_Cd_3	PIC X(07)	
POA_Cd_3	PIC X(01)	
Diag_Cd_4	PIC X(07)	
POA_Cd_4	PIC X(01)	
Diag_Cd_5	PIC X(07)	
POA_Cd_5	PIC X(01)	
Diag_Cd_6	PIC X(07)	
POA_Cd_6	PIC X(01)	
Diag_Cd_7	PIC X(07)	
POA_Cd_7	PIC X(01)	
Diag_Cd_8	PIC X(07)	
POA_Cd_8	PIC X(01)	
Diag_Cd_9	PIC X(07)	
POA_Cd_9	PIC X(01)	
Diag_Cd_10	PIC X(07)	
POA_Cd_10	PIC X(01)	
Diag_Cd_11	PIC X(07)	
POA_Cd_11	PIC X(01)	
Diag_Cd_12	PIC X(07)	

Table 7.10.3

## Additional Submitted Claim Fields Needed for DRG Pricing

Column	Format	Description / Notes
POA_Cd_12	PIC X(01)	
Diag_Cd_13	PIC X(07)	
POA_Cd_13	PIC X(01)	
Diag_Cd_14	PIC X(07)	
POA_Cd_14	PIC X(01)	
Diag_Cd_15	PIC X(07)	
POA_Cd_15	PIC X(01)	
Diag_Cd_16	PIC X(07)	
POA_Cd_16	PIC X(01)	
Diag_Cd_17	PIC X(07)	
POA_Cd_17	PIC X(01)	
Diag_Cd_18	PIC X(07)	
POA_Cd_18	PIC X(01)	
Diag_Cd_19	PIC X(07)	
POA_Cd_19	PIC X(01)	
Diag_Cd_20	PIC X(07)	
POA_Cd_20	PIC X(01)	
Diag_Cd_21	PIC X(07)	
POA_Cd_21	PIC X(01)	
Diag_Cd_22	PIC X(07)	
POA_Cd_22	PIC X(01)	
Diag_Cd_23	PIC X(07)	
POA_Cd_23	PIC X(01)	
Diag_Cd_24	PIC X(07)	
POA_Cd_24	PIC X(01)	
Diag_Cd_25	PIC X(07)	
POA_Cd_25	PIC X(01)	
Surg_Proc_Cd-1	PIC X(07)	
Surg_Proc_Dt-1	Standard CA-MMIS date format	
Surg_Proc_Cd-2	PIC X(07)	
Surg_Proc_Dt-2	Standard CA-MMIS date format	
Surg_Proc_Cd-3	PIC X(07)	
Surg_Proc_Dt-3	Standard CA-MMIS date format	
Surg_Proc_Cd-4	PIC X(07)	
Surg_Proc_Dt-4	Standard CA-MMIS date format	
Surg_Proc_Cd-5	PIC X(07)	
Surg_Proc_Dt-5	Standard CA-MMIS date format	

Table 7.10.3

## Additional Submitted Claim Fields Needed for DRG Pricing

Column	Format	Description / Notes
Surg_Proc_Cd-6	PIC X(07)	
Surg_Proc_Dt-6	Standard CA-MMIS date format	
Surg_Proc_Cd-7	PIC X(07)	
Surg_Proc_Dt-7	Standard CA-MMIS date format	
Surg_Proc_Cd-8	PIC X(07)	
Surg_Proc_Dt-8	Standard CA-MMIS date format	
Surg_Proc_Cd-9	PIC X(07)	
Surg_Proc_Dt-9	Standard CA-MMIS date format	
Surg_Proc_Cd-10	PIC X(07)	
Surg_Proc_Dt-10	Standard CA-MMIS date format	
Surg_Proc_Cd-11	PIC X(07)	
Surg_Proc_Dt-11	Standard CA-MMIS date format	
Surg_Proc_Cd-12	PIC X(07)	
Surg_Proc_Dt-12	Standard CA-MMIS date format	
Surg_Proc_Cd-13	PIC X(07)	
Surg_Proc_Dt-13	Standard CA-MMIS date format	
Surg_Proc_Cd-14	PIC X(07)	
Surg_Proc_Dt-14	Standard CA-MMIS date format	
Surg_Proc_Cd-15	PIC X(07)	
Surg_Proc_Dt-15	Standard CA-MMIS date format	
Surg_Proc_Cd-16	PIC X(07)	
Surg_Proc_Dt-16	Standard CA-MMIS date format	
Surg_Proc_Cd-17	PIC X(07)	
Surg_Proc_Dt-17	Standard CA-MMIS date format	
Surg_Proc_Cd-18	PIC X(07)	
Surg_Proc_Dt-18	Standard CA-MMIS date format	
Surg_Proc_Cd-19	PIC X(07)	
Surg_Proc_Dt-19	Standard CA-MMIS date format	
Surg_Proc_Cd-20	PIC X(07)	
Surg_Proc_Dt-20	Standard CA-MMIS date format	
Surg_Proc_Cd-21	PIC X(07)	
Surg_Proc_Dt-21	Standard CA-MMIS date format	
Surg_Proc_Cd-22	PIC X(07)	
Surg_Proc_Dt-22	Standard CA-MMIS date format	
Surg_Proc_Cd-23	PIC X(07)	
Surg_Proc_Dt-23	Standard CA-MMIS date format	
Surg_Proc_Cd-24	PIC X(07)	
Surg_Proc_Dt-24	Standard CA-MMIS date format	
Surg_Proc_Cd-25	PIC X(07)	

Table 7.10.3 Additional Submitted Claim Fields Needed for DRG Pricing		
Column	Format	Description / Notes
Surg_Proc_Dt-25	Standard CA-MMIS date format	

This data must be easily accessible to the inpatient claims pricing process performed within claims adjudication using CCN as the primary key. Once a claim has been paid, the record for that claim can be moved to a historical file that is less easily accessible. However, the claim adjustment process must be able to retrieve these fields when making a new copy of a claim. In addition, the fields will need to be accessible for extracts to data warehouses and accessible for standard claim audits.

These fields need to be captured on all inpatient claims, whether submitted electronically (837I) or on paper (UB-04).

**Note:** On paper claims, some of these fields have fewer instances.

In addition, DRG payment would depend on a single admit-through-discharge claim. The single DRG claim should include accurate data on all of the fields from incoming inpatient claims that are needed for pricing or editing claims using the new DRG pricing logic. This applies to the additional data in Table 7.10.3 as well as claims data currently captured by CA-MMIS. It is important to make certain that only one claim is used for DRG pricing and that all claims data for the whole stay is used. This will ensure accurate DRG assignment (e.g., using all submitted diagnosis and procedures), enable accuracy in applying the DRG pricing logic (e.g., using all submitted charges in outlier pricing), allow enforcement of branching logic (e.g., using revenue codes that identify claims paid by per diem instead of DRG in the case of rehabilitation, administrative day, interim claims), enable claims editing (e.g., POA for HCACs, type of bill, discharge status, etc.), and avoid duplicate payment for the same stay (e.g., submitting more than one claim for a single stay or split billing).

## BR-DB-4: Claim DRG pricing file

Several new fields will need to be added at the claim header level in support of DRG pricing. This document assumes that these fields will be added in a new claims DRG pricing “side file” because as a separate side file it is expected to require less development effort than adding all these fields to the existing claim activity record.

For claims not pricing via DRGs, this record will only be used to support HCAC requirements. So the DRG codes and their associated parameters will be populated, but none of the payment fields will be populated.

Fields in the new claim DRG pricing file are shown in Table 7.10.4.

Table 7.10.4

## Fields in New Claim DRG Pricing File

Column	Format	Description	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
CCN	PIC X(13)	Claim control number – unique key to this file	DRG, Per Diem
NPI	PIC X(10)	National provider identification	DRG, Per Diem
CIN	PIC X(xx)	Client index number	DRG, Per Diem
DRG_Code	PIC X(05)	Diagnosis related grouping code	DRG, Per Diem
DRG_Code_Desc	PIC X(xx)	Diagnosis related grouping code description	DRG, Per Diem
DRG_MDC_Code	PIC X(02)	Major diagnostic category	DRG, Per Diem
DRG_MDC_Code_Desc	PIC X(xx)	Major diagnostic category description	DRG, Per Diem
Prov_DRG_Base_Price	PIC 9(09)V9(02)	Per claim provider specific base price for DRG payments	DRG
DRG_Casemix_Rel_Wt	PIC 9(03)V9(04)	Casemix relative weight – prior to applying policy and age adjustors	DRG, Per Diem
DRG_Pymt_Rel_Wt	PIC 9(03)V9(04)	Relative weight actually used in pricing – equals casemix relative weight times policy adjustor and times age adjustor if beneficiary is a child	DRG
Casemix_Adjstmnt_Factor	PIC 9(01)V9(03)	A payment multiplier applied to all non-interim claims paid via DRG method.	DRG
DRG_Base_Pymt	PIC 9(09)V9(02)	Provider base price times DRG payment relative weight	DRG
DRG_ALOS	PIC 9(03)V9(02)	Average length of stay	DRG, Per Diem
Transfer_Pymt_Amt	PIC 9(09)V9(02)	Only populated on transfer claims	DRG
Prov_CCR	PIC 9(03)V9(03)	Provider cost to charge ratio	DRG
Estimate_Gain_Loss	PIC 9(09)V9(02)	Estimate of provider's gain or loss	DRG
Est_Gain_Loss_Ind	PIC X(01)	"G" = gain "L" = loss	DRG
DRG_Outlier_Amt	PIC 9(09)V9(02)	Outlier payment amount	DRG

Table 7.10.4

## Fields in New Claim DRG Pricing File

Column	Format	Description	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
DRG_Outlier_Ind	PIC X(01)	"N" – none "G" – provider gain outlier "L" – provider loss outlier	DRG
DRG_Price_Full_Stay	PIC 9(09)V9(02)	Price before considering partial eligibility	DRG
Add_On_Pymt_Amt	PIC 9(09)V9(02)	Per claim provider-specific add-on payment	DRG
Pre_HCAC_DRG_Cd	PIC X(05)	DRG code with higher relative weight. In most cases the "pre-HCAC" and "post-HCAC" DRGs will be the same in which case the value in this field will equal the value in field DRG_Code	DRG, Per Diem
Pre_HCAC_DRG_Casemix_Rel_Wt	PIC 9(03)V9(04)	Casemix relative weight for the DRG code with higher relative weight. In most cases the "pre-HCAC" and "post-HCAC" DRGs will be the same in which case the value in this field will equal the value in field DRG_Casemix_Rel_Wt.	DRG, Per Diem
Pre_HCAC_Pymt_Rel_Wt	PIC 9(03)V9(04)	Payment relative weight for the DRG code with higher relative weight. This value equals the Pre_HCAC_DRG_Cd's casemix relative weight times policy adjustor and times age adjustor if beneficiary is a child. In most cases the "pre-HCAC" and "post-HCAC" DRGs will be the same in which case the value in this field will equal the value in field DRG_Pymt_Rel_Wt.	DRG
Pre_HCAC_Final_Price	PIC 9(09)V9(02)	Price determined using the pre-HCAC DRG code and all its associated parameters. In most cases the "pre-HCAC" and "post-HCAC" DRGs will be the same in which case the value in this field will equal the value in field CF1-ALLOWABLE-PROC-PAYMT.	DRG

Table 7.10.4

Fields in New Claim DRG Pricing File

Column	Format	Description	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
HCAC_Category	PIC X(03)	<p>Value returned from HCAC utility. Currently the value is two characters in length, but a 3 character field is being recommended in CA-MMIS in case the width of this field changes over time. Additional categories may be added in the future by CMS.</p> <p>More than one HCAC category can be assigned to a single claim because the HCAC categories are assigned to individual diagnosis codes. But claims with more than one category will be extremely rare. It will be acceptable to store the first HCAC category found on the claim – that is the one from the diagnosis code closest to the principal diagnosis code.</p> <p>Valid values for this field are:</p> <p>00 = No HCAC assigned</p> <p>01 = Foreign Object Retained After Surgery</p> <p>02 = Air Embolism</p> <p>03 = Blood Incompatibility</p> <p>04 = Stage III &amp; IV Pressure Ulcers</p> <p>05 = Falls and Trauma</p> <p>06 = Catheter Associated Urinary Tract Infection</p> <p>07 = Vascular Catheter Associated Infection</p> <p>08 = Surgical Site Infection - CABG</p> <p>09 = Manifestations of Poor Glycemic Control</p> <p>10 = DVT/PE after certain orthopedic procedures</p> <p>11 = Surgical Site Infection - Bariatric Surgery</p> <p>12 = Surgical Site Infection - Certain Orthopedic procedures</p>	DRG, Per Diem

**Table 7.10.4**  
**Fields in New Claim DRG Pricing File**

Column	Format	Description	Field Filled for DRG Hospitals (D) or Per Diem Hospitals (P)**
		13 = Surgical site infection - Cardiac implantation (CIED) 14 = Iatrogenic pneumothorax w venous catheterization	
<p><i>Note:</i></p> <p>** Reference is to the "inpatient payment method" field that has hospital-specific valid values of D=DRG and P=Per Diem. For the per diem hospitals, the goal is to report clinical information about the stay (e.g., DRG code, DRG casemix relative weight calculated from national data, national average length of stay, HCAC presence) but not pricing information that does not pertain to per diem hospitals (e.g., DRG payment relative weight, DRG base price),</p>			

Records in this file will be added during the daily adjudication process. The DRGs will be assigned to claims prior to pricing. Then claims will move through the pricing logic. During the pricing process, the "allowed amount" is calculated using the DRG pricing logic. The DRG final price or the "allowed amount" will be stored in the CF1-ALLOWABLE-PROC-PAYMT field on the Activity Record. Any applicable deductions will be applied on the "allowed amount" for determining the payment amount. The DRG pricing indicator and other DRG pricing fields will be stored in the new DRG Pricing side file instead of using existing fields in the Activity Record. The DRG pricing indicator will be used to store values indicating how the claim priced (such as straight DRG, DRG with a transfer reduction, or DRG with an outlier payment).

This topic is also discussed in requirement BR-Pricing-8.

The new claim DRG pricing side file will not need to be accessible when building adjustment claims. This is because the final claim price and the DRG pricing method indicator will exist on the claim activity record and not on the side file. When creating a new copy of a claim during the adjustment process, none of the fields in this file will need to be copied from the original claim. All of these fields will get recalculated when the new adjustment claim goes through adjudication. Whether or not a record will need to be created in this side file for credits/voids of inpatient claims will need to be determined during the technical design phase of this implementation.

Records in this file will need to be accessible as long as the claim is processing through adjudication and payment. Once payment is complete, the data will need to be accessible for standard data warehouse extracts. The data will also need to be accessible for standard claim audits.

# 7.11 Data Configuration

## BR-Config-1: Initial implementation data configuration

The following tasks will need to be performed in each test environment and in production just prior to implementing DRG pricing.

- Enter all the system parameters and system lists
- Load initial values for all DRG codes into the DRG pricing reference file
- Identify hospitals of type 016 and 060 that are active in 2013 but are not in the DRG simulation dataset.
- Load and/or confirm cost-to-charge ratios for all providers getting paid via DRGs. In the past, cost-to-charge ratios were only updated in CA-MMIS if they changed by more than 3 percentage points. With DRG pricing, cost-to-charge ratios are more critical to the pricing calculations and will need to be updated annually, no matter how small values change year-to-year.
- Load the inpatient claim payment method on all providers that bill inpatient claims
- Load the following values on all providers that will be paid via DRGs:
  - DRG base price
  - Designated NICU indicator
  - Per-claim add-on payment (expected to be zero for all providers)
- End date the rate on some of the provider procedure code rate records. Some procedure codes will continue to be billable separately on outpatient claims for inpatient hospital stays. So some records will remain in effect. But the list of procedure codes separately payable will be smaller thus requiring many records to be end dated.
- Add new provider procedure records. Under the current Selective Provider Contracting Program, only certain contract providers are allowed to bill separately on outpatient claims for specific services provided in an inpatient setting. Also, the list of billable services could differ from one contract hospital to another. Under DRG pricing, the list of separately billable services will be smaller and will apply only to all hospitals being paid via DRGs. In addition, the list of separately billable services will be the same for every provider. So the appropriate records will need to be added to all hospitals and an analysis will need to be performed to ensure this list of procedures exists on all contract providers.

Table 7.11.1 lists the services that may be billed separately by hospitals paid by DRG (providers with inpatient payment method value = "D" for DRG pricing).

**Note:** Data configuration for separately billable services is subject to change prior to testing and move to production.

Table 7.11.1 Separately Payable Services, Supplies and Device Codes	
Code	Description
Bone Marrow	
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38204	Unrelated bone marrow donor
Blood Factors	
J7180	Blood factor XIII
J7183/J7184/Q2041	Blood factor Von Willebrand –injection
J7185	Blood factor VIII
J7186	Blood factor VIII / Von Willebrand
J7187	Blood factor Von Willebrand
J7189	Blood factor VIIa
J7190	Blood factor VIII
J7192	Blood factor VIII
J7193	Blood factor IX
J7194	Blood factor IX
J7195	Blood factor IX
J7197	Blood factor antithrombin III
J7198	Blood factor antiinhibitor
<i>Note:</i> This list of services that may be billed separately on an outpatient claim applies only to hospitals paid by DRG (providers with inpatient payment method value = "D" for DRG pricing)	

## 7.12 Data Retention

### BR-Retention-1: Data retention and disaster recovery

The Claims Entry Side File and the DRG Pricing Side File will be stored for 10 years. Existing CA-MMIS data retention requirements will apply to any new data and files created as a result of SDN 12005, Diagnosis Related Group Pricing Methodology for Inpatient Claims.

The Disaster Recovery requirements will be updated to include the new data, files and transactions created as a result of SDN 12005, Diagnosis Related Group Pricing Methodology for Inpatient Claims.

## 7.13 Other Adjustments

### BR-Other Adjust-1: Share of cost and other health care coverage

Share-of-cost (SOC) and other health care coverage (OHC) payments will continue to be applied under the DRG payment method as was previously done. No changes are anticipated to the CA-MMIS logic that calculates the reimbursement amounts.

### BR-Other Adjust-2: Timely filing

Timely filing rules will continue to be applied under the DRG payment method as was previously done. Some exceptions will be made such as for extended stays and final bills submitted with interim claims.

### BR-Other Adjust-3: Various adjustments identified

Payment adjustments for the day of discharge or death will not be applied to claims paid by DRG. The DRG payment method makes the necessary adjustments when assigning the DRG to the claim or through the various payment calculations (e.g., transfers and outliers).

The day of discharge or death payment adjustments will continue to be applied to hospitals paid based on a per diem reimbursement methodology. No reductions will be made on the DRG claims. All inpatient reductions should be turned off including CCS/GHPP/and Healthy Family. DRG claims will not be subject to payment reductions managed through the following tables:

- Table 2074: Claim Reduction Inclusions and Reduction Percent. This table is implemented through SDN S08005, (TEN PERCENT PROVIDER PAYMENT REDUCTION – BUDGET TRAILER BILL OF 2008), effective for claims with Dates of Service beginning July 1, 2008.
- Table 2075: Claim Reduction Exemptions and Reduction Percent. This table was implemented through SDN S02075, (2004 PAYMENT ADJUSTMENTS – 5 PERCENT REDUCTION), effective for claims with Dates of Service beginning January 1, 2004

### BR-Other Adjust-4: Lesser of paid or billed

The lesser of paid or billed logic will continue to be applied under the DRG payment method as was previously done so that final payment does not exceed total charges on the claim.

# 7.14 Payment Policy Flowchart

The following flowchart describes the DRG pricing logic in detail.

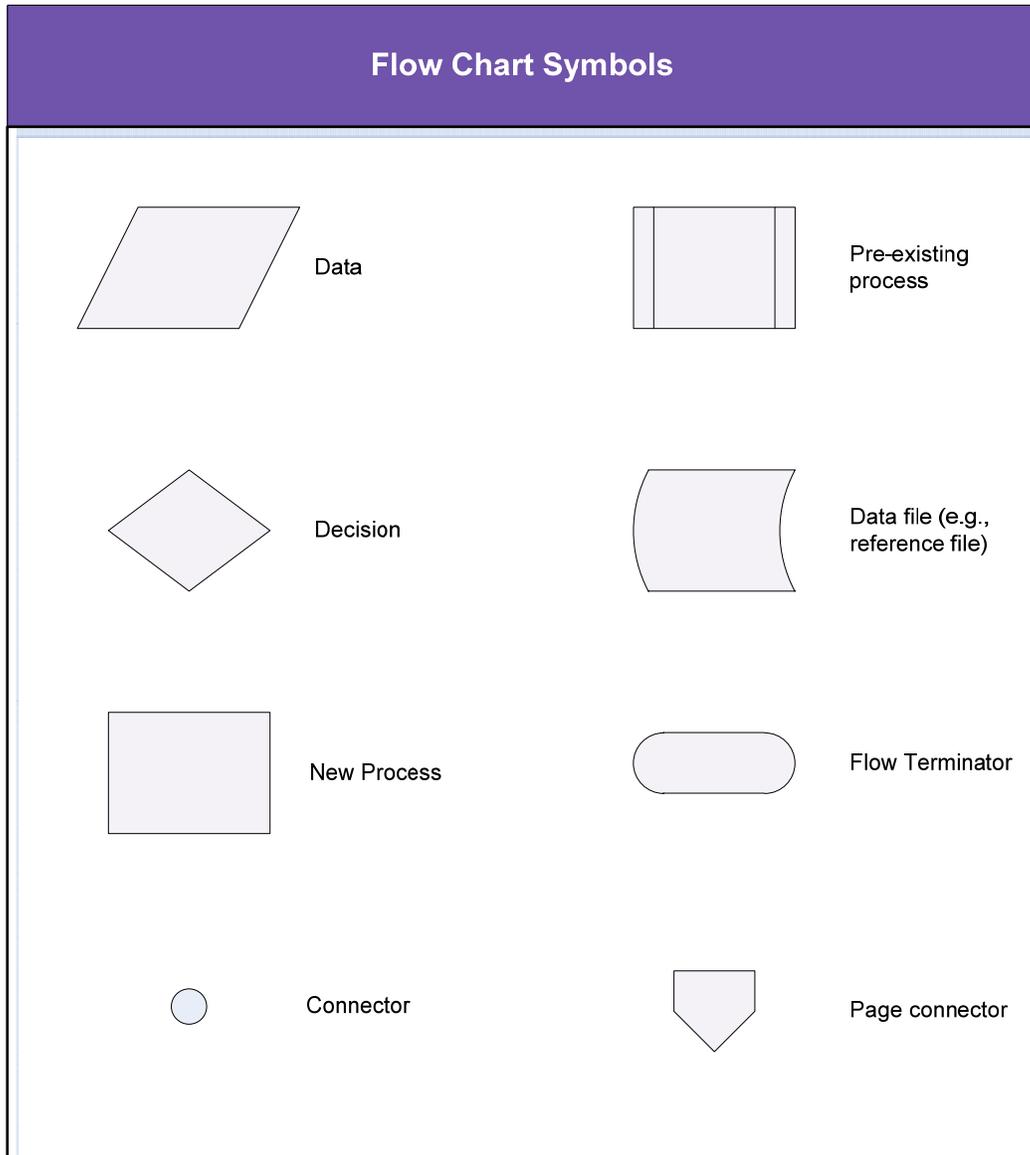
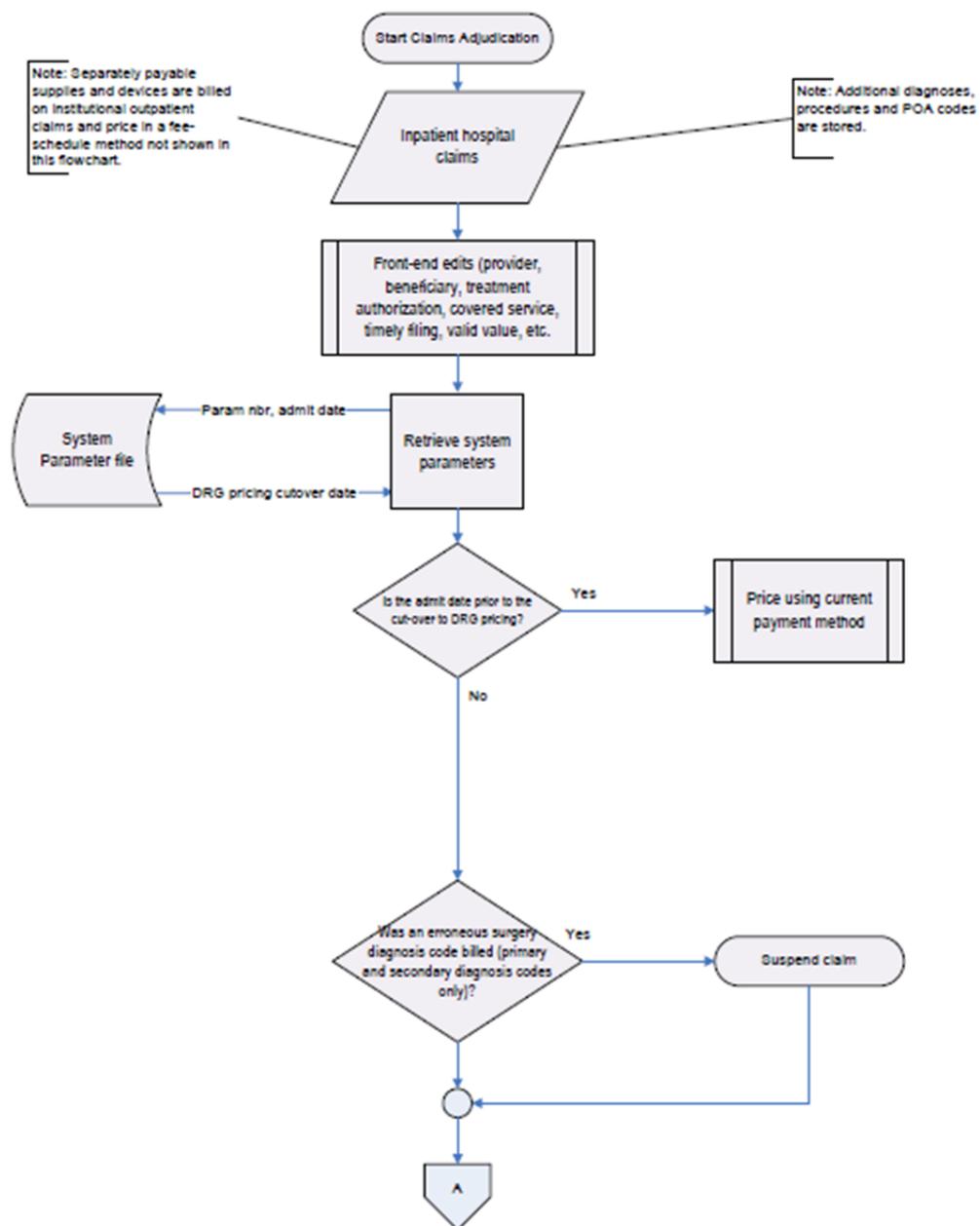
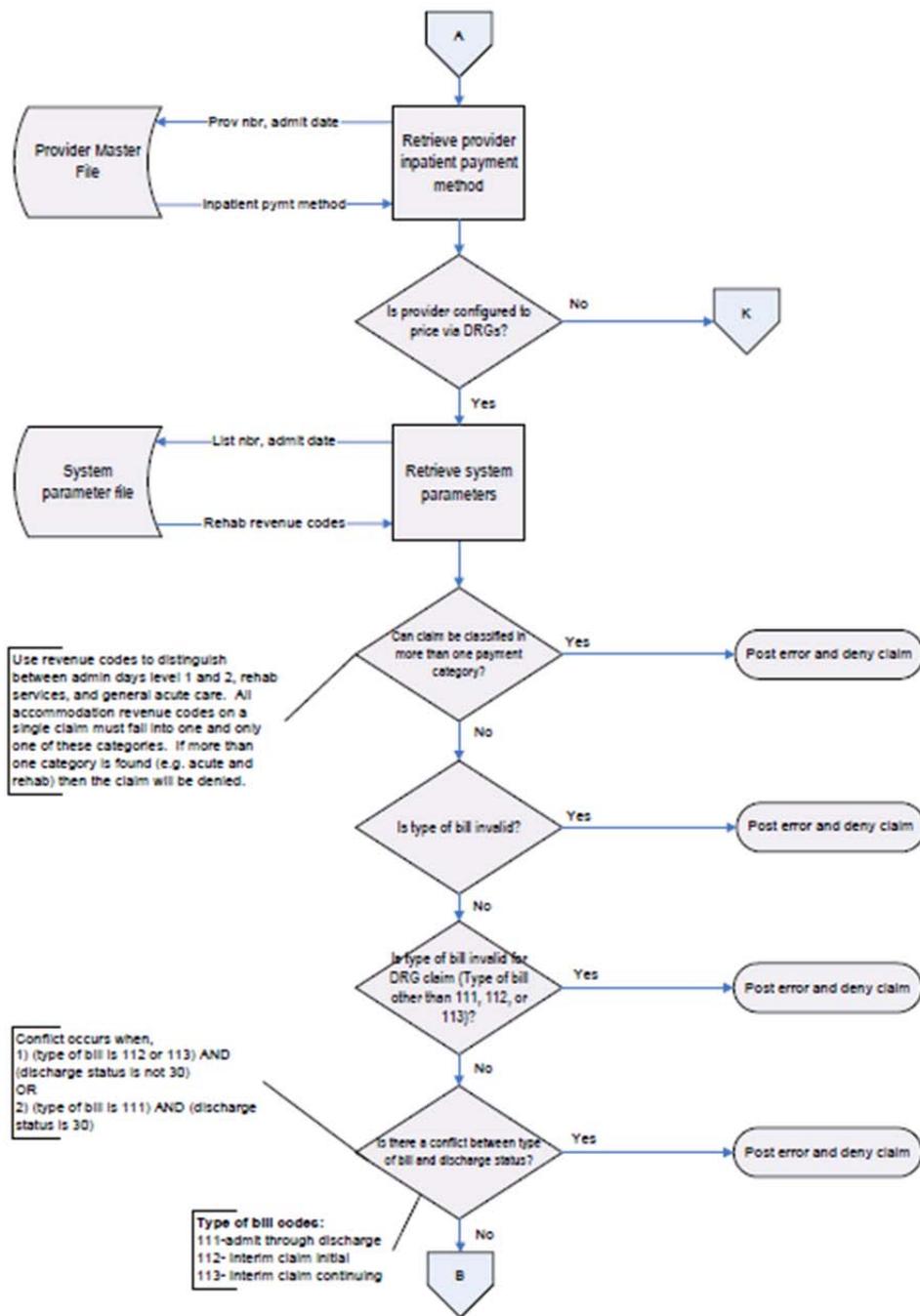
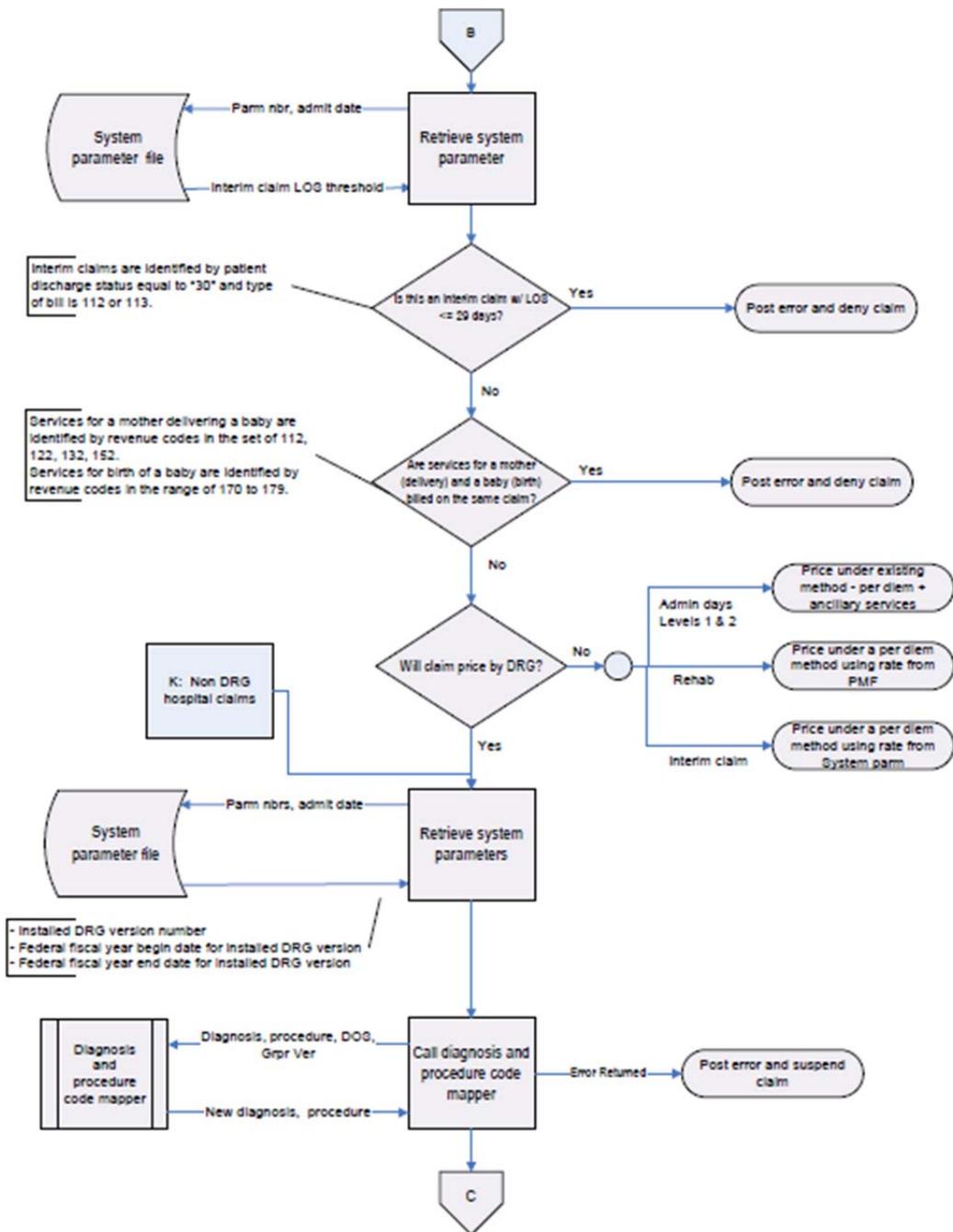
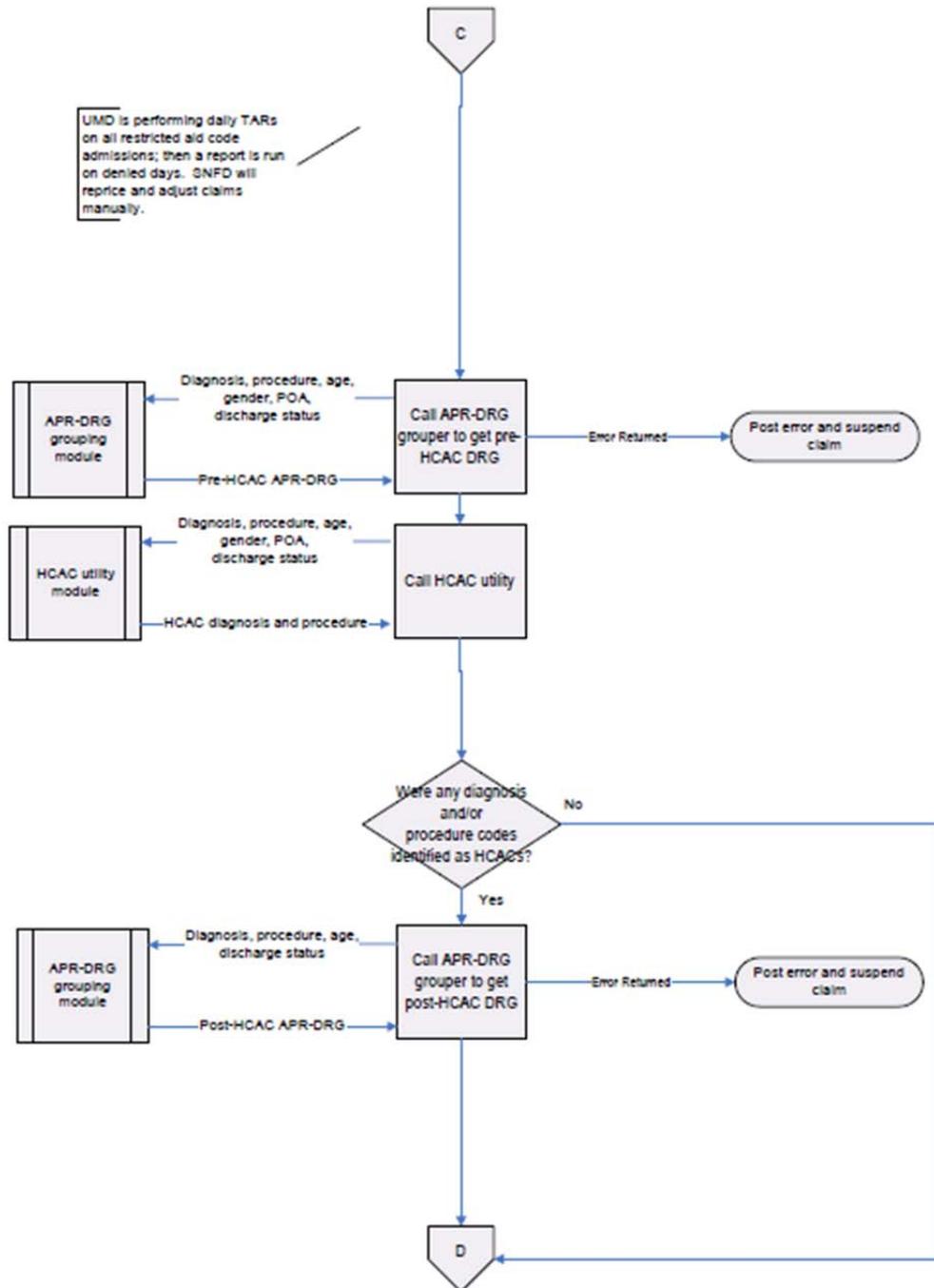


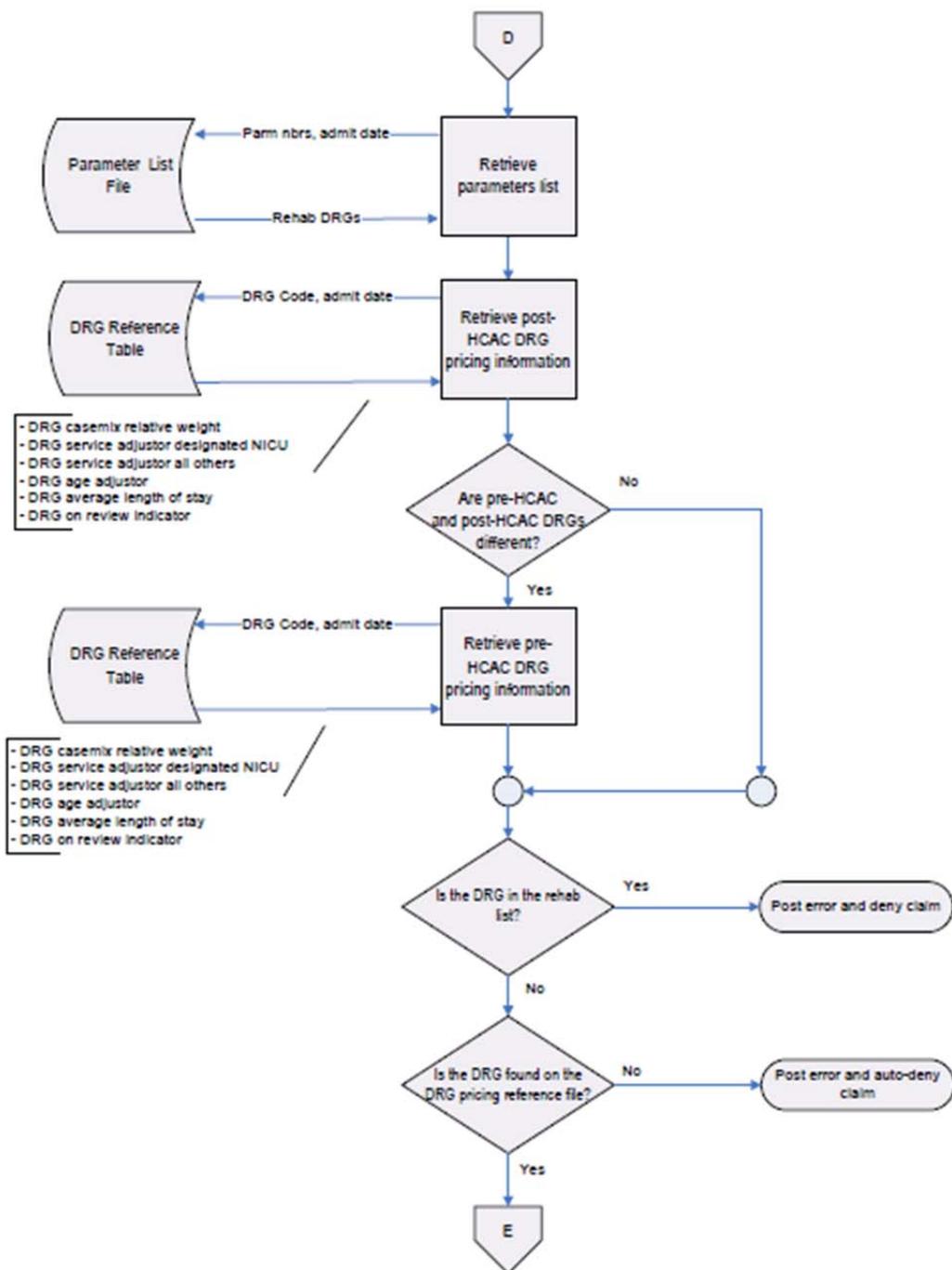
Chart 7.14.1 DRG Pricing Flowchart

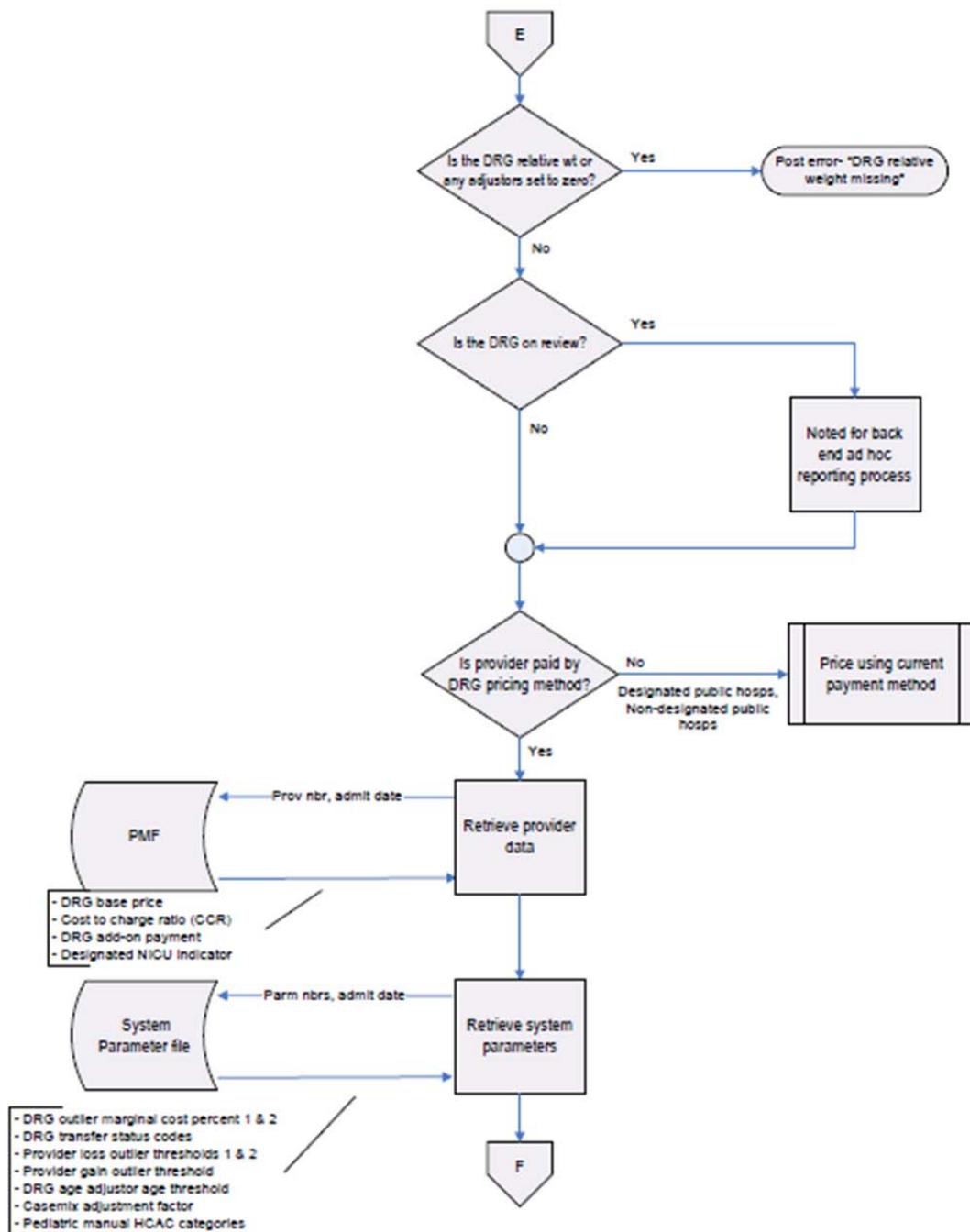












Note: Values of DRG\_Svc\_Adjstr\_Desig\_NICU, DRG\_Svc\_Adjstr\_All\_Others, and DRG\_Age\_Adjstr in the DRG Pricing File would be set carefully to ensure the desired interaction by DRG between NICU status, patient age, and service policy adjustor level. Though the DRG\_Age\_Adjstr appears in the equation for hospitals that are designated NICUs, the DRG\_Age\_Adjstr would be set at 1 for neonate DRGs. This ensures that both NICU and pediatric age policy adjustors do not increase the base price simultaneously.

Note: If the pre-HCAC and post-HCAC DRGs have different relative weights, then the pricing logic from this point through determination of "Final Price" (a.k.a. allowed amount) must be run twice, once for the pre-HCAC DRG and once for the post-HCAC DRG. The price used for payment to the hospital will be the post-HCAC DRG.

