CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL DIAGNOSIS RELATED GROUPS PAYMENT METHOD FREQUENTLY ASKED QUESTIONS FOR STATE FISCAL YEAR 2020-21

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MEDI-CAL DRG FAQ FOR STATE FISCAL YEAR 2020-21 JULY 2020

Medi-Cal Diagnosis Related Groups Payment Method

Frequently Asked Questions for State Fiscal Year 2020-21

Beginning July 1, 2013, Medi-Cal has paid for most hospital inpatient services received by fee-for-service beneficiaries using Diagnosis Related Groups (DRG). This Frequently Asked Questions (FAQ) provides updated information applicable to state fiscal year (SFY) 2020-21.

This FAQ captures the current status of DRG payment effective July 1, 2020. For information about previous state fiscal years, or the payment method in general, see the Department of Health Care Services (DHCS) DRG webpage at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

The Medi-Cal DRG payment method uses All Patient Refined Diagnosis Related Groups (APR-DRG) software that is created, owned, and licensed by the 3M™ Company. While we appreciate assistance from 3M™, please note that 3M™ was not involved in developing the Medi-Cal payment method and bears no responsibility for the contents of this document. The FAQs are written by staff from DHCS DRG Section. Please also note that nothing in this document supersedes applicable laws, regulations, or policies.

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Medi-Cal Diagnosis Related Groups Changes for State Fiscal Year 2020-21

1. What changes were made for state fiscal year 2020-21?

For state fiscal year (SFY) 2020-21, several updates and changes were made in payment rates and policy. All Patient Refined Diagnosis Related Groups (APR-DRG) Version 35 grouper and hospital-specific relative value (HSRV) weights will remain in use for SFY 2020-21 (see question 12). Policy adjustor values are also unchanged.

Regular annual updates include:

- Wage area index values, labor share, and wage area index neutrality factor (see questions 14 and 15)
- Cost-to-charge ratios (CCRs) (see question 22)

Policy changes include:

- The cost outlier threshold will remain at $61,000 and the marginal cost (MC) percentage will remain at 55% (see question 16)
- Statewide base rate increase to $6,596 (see question 13)
- Remote rural base rate increase to $15,036

For SFY 2020-21, DHCS chose to again remain on V.35 of the APR-DRG grouper and HSRV weights to sustain maximum stability of payment amounts during the extraordinary pandemic circumstances currently affecting all providers.

See Table 1 for a comparison of Diagnosis Related Groups (DRG) payment policy for the most recent three years. For details about previous years' payment policy, see the Frequently Asked Questions (FAQ) documents on the Department of Health Care Services (DHCS) DRG webpage at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx under the relevant year's Pricing Resources section.

Table 1: Comparison of DRG Payment Policy

Payment Policy	SFY 2018-19 Values	SFY 2019-20 Values	SFY 2020-21 Values
DRG Base Payments			
DRG statewide base rate	$6,507	$6,584	$6,596
DRG statewide base rate (remote rural hospitals)	$12,832	$14,615	$15,036
Hospital base payment adjustment for wage area values	DRG statewide base rate adjusted for Medicare FFY 2018 wage area values	DRG statewide base rate adjusted for Medicare FFY 2019 wage area values	DRG statewide base rate adjusted for Medicare FFY 2020 wage area values
Adjustment for wage area values	Similar to Medicare, reflecting a labor share of 68.3% adjusted by 0.9771 CA wage area neutrality factor	Similar to Medicare, reflecting a labor share of 68.3% adjusted by 0.9731 CA wage area neutrality factor	Similar to Medicare, reflecting a labor share of 68.3% adjusted by 0.9584 CA wage area neutrality factor
Border hospitals	Policy described in SPA 15-020	Policy described in SPA 15-020	Policy described in SPA 15-020
DRG Grouper			
DRG version	APR-DRG V.35	APR-DRG V.35	APR-DRG V.35
DRG relative weights	APR-DRG V.35 national HSRV weights	APR-DRG V.35 national HSRV weights	APR-DRG V.35 national HSRV weights
National average length of stay benchmarks (used in calculating transfer adjustments)	APR-DRG V.35 (arithmetic, untrimmed)	APR-DRG V.35 (arithmetic, untrimmed)	APR-DRG V.35 (arithmetic, untrimmed)
Outlier Policy Factors			

Payment Policy	SFY 2018-19 Values	SFY 2019-20 Values	SFY 2020-21 Values
Hospital-specific cost-to-charge ratios (CCRs)	FYE 2016 cost report (some exceptions may apply)	FYE 2017 cost report (some exceptions may apply)	FYE 2018 cost report (some exceptions may apply)
High side (provider loss) tiers and marginal cost (MC) percentages	$0-$57,000: no outlier payment	$0-$61,000: no outlier payment	$0-$61,000: no outlier payment
	>$57,000: MC=60%	>$61,000: MC=55%	>$61,000: MC=55%
Low side (provider gain) tiers and marginal cost percentages	$0-$57,000: no outlier reduction	$0-$61,000: no outlier reduction	$0-$61,000: no outlier reduction
	>$57,000: MC= 60%	>$61,000: MC= 55%	>$61,000: MC= 55%
Other Payment Policies			
Policy adjustor – neonate at designated Neonatal Intensive Care Unit (NICU) (SOI=1-3)	1.75	1.75 (No change)	1.75 (No change)
Policy adjustor – neonate at designated Neonatal Intensive Care Unit (NICU) (SOI=4)	2.45	2.45 (No change)	2.45 (No change)
Policy adjustor – neonate at other NICU (SOI=1-3)	1.25	1.25 (No change)	1.25 (No change)
Policy adjustor – neonate at other NICU (SOI=4)	1.75	1.75 (No change)	1.75 (No change)
Policy adjustor – obstetric (SOI=1-3)	1.06	1.06 (No change)	1.06 (No change)
Policy adjustor – obstetric (SOI=4)	1.17	1.17 (No change)	1.17 (No change)

Payment Policy	SFY 2018-19 Values	SFY 2019-20 Values	SFY 2020-21 Values
Policy adjustor – pediatric misc, pediatric resp (SOI=1-3)	1.25	1.25 (No change)	1.25 (No change)
Policy adjustor – pediatric misc, pediatric resp (SOI=4)	1.75	1.75 (No change)	1.75 (No change)
Policy adjustor – adult misc, adult gastroent, adult resp, adult circ (SOI=4)	1.10	1.10 (No change)	1.10 (No change)
Pediatric age cutoff	<21	<21 (No change)	<21 (No change)
Discharge status values for the transfer adjustment	02, 05, 63, 65, 66, 82, 85, 91, 93, and 94	02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 (No change)	02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 (No change)

Notes:

1. For hospital-specific DRG base rates, see the Hospital Characteristics File specific to each year of DRG payment under the pricing resources links at www.dhcs.ca.gov/provgovpart/pages/drg.aspx.
2. For details of the pricing logic, APR-DRG groups, and relative weights, see the DRG Pricing Calculators specific to each year of DRG payment under the pricing resources link at www.dhcs.ca.gov/provgovpart/pages/drg.aspx.
3. Border hospital policy is described in SPA 15-020, which is available at https://www.dhcs.ca.gov/provgovpart/Documents/DRG/CA-SPA-15-020-FP-AL-179-PP.pdf.

Overview Questions

2. When was payment by Diagnosis Related Groups (DRG) implemented for Medi-Cal? What are the goals of DRG payment?

As directed by the California legislature, on July 1, 2013, the Department of Health Care Services implemented a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program based on All Patient Refined Diagnosis Related Groups. The goals of the DRG methodology are to encourage access to care, reward efficiency, improve transparency, and improve fairness by paying similarly across hospitals for similar care.

3. Which hospitals are paid by Diagnosis Related Groups (DRG)?

DRG payment applies to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals and long-term care hospitals. Non-designated public hospitals transitioned to DRG payment as of January 1, 2014. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals (such as the University of California) are outside the scope of DRG-based payment. With regard to rehabilitation hospitals and services, see question 50.

4. Are Diagnosis Related Groups (DRGs) budget neutral?

Implementation of DRGs required budget neutrality in aggregate for fee-for-service Medi-Cal, not by individual hospital. This requirement ensures that payment for hospital services for each year of DRG payment are not below 2012-13 levels. Base rates are set each state fiscal year with a budget target that is budget neutral.

5. What services are affected?

For affected hospitals, Diagnosis Related Groups payment impacts all inpatient hospital services except:

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Medi-Cal managed care stays (see question 45)
- Physical rehabilitation stays (see question 50)
- Administrative days (see question 50)

6. Do Diagnosis Related Groups (DRG) affect California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) patients?

Yes. Claims for eligible beneficiaries under CCS or the GHPP are priced using the DRG method. This is true regardless of whether the beneficiaries also have Medi-Cal fee-for-service or Medi-Cal Managed Care (in CCS carve out counties only). See questions 41 and 42 for more information on billing and authorizations for CCS and GHPP patients.

7. Who else uses Diagnosis Related Groups (DRG) payment?

The Medicare program implemented payment by DRG on October 1, 1983. About three-quarters of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Half of Medicaid programs use All Patient Refined Diagnosis Related Groups (APR-DRG), rather than Medicare DRGs, because APR-DRGs are much more appropriate for neonatal, pediatric, and obstetric care. Medicare DRGs were designed for a Medicare population, where less than 1% of stays are for obstetrics, pediatrics, or newborn care. In the Medi-Cal fee-for-service population, these categories represent about two-thirds of all stays.

Diagnosis Related Groups Payment

8. What are the characteristics of Diagnosis Related Groups (DRG) payment?

- DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased
- DRG payment alone does not depend on hospital-specific costs or charges, therefore this method rewards hospitals for improving efficiency
- Because higher acuity DRGs receive higher payment rates, this method incentivizes greater access to care
- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers, policymakers, and hospitals better information about services provided

9. How do Diagnosis Related Groups (DRG) payment methods work?

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

The DRG relative weight is multiplied by a DRG base rate and any relevant policy adjustors to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base rate is $6,500, then the payment rate for that DRG is $3,250, before accounting for any policy adjustors.

10. How is the Diagnosis Related Groups (DRG) assigned? How can my hospital replicate DRG assignment?

Medi-Cal's California Medicaid Management Information System claims payment system uses the 3M™ All Patient Refined Diagnosis Related Groups algorithm (APR-DRG) to assign a DRG to each claim. The hospital does not need to include the DRG on the claim. Hospitals are encouraged to comprehensively and accurately document diagnoses and procedures on the claim, which will lead to the most accurate DRG assignment. Each stay is assigned to 1 of 326 or so base APR-DRGs (this number can change due to annual changes in the APR-DRG algorithm). It is then assigned a severity level (minor, moderate, major, or extreme). Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2. Unlike Medicare DRGs, there is no universal list of complications and comorbidities. There are also two error DRGs.

Although hospitals are not required to buy APR-DRG software, some hospitals will choose to buy the software to understand and predict the DRG assignment. The DRG methodology is updated annually, so it is critical to use the appropriate APR-DRG version to assign the DRG as well as apply appropriate policy parameters. Table 2 summarizes the admission date ranges on the claims and links to the appropriate DRG grouper versions. Please see the DRG Grouper Settings documents under each pricing folder for each state fiscal year (SFY) on the Department of Health Care Services' webpage for more detailed information (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx); these documents explain

the correct grouper, mapper, and health care-acquired conditions utility versions to use based on claim dates.

Table 2: Medi-Cal APR-DRG Versions by Claim Admission Date

State Fiscal Year	APR-DRG	State Fiscal Year
2013-14	V.29	7/1/13 – 6/30/14
2014-15	V.31	7/1/14 – 6/30/15
2015-16	V.32	7/1/15 – 6/30/16
2016-17	V.33	7/1/16 – 6/30/17
2017-18	V.34	7/1/17 – 6/30/18
2018-19	V.35	7/1/18 – 6/30/19
2019-20	V.35	7/1/19 – 6/30/20
2020-21	V.35	7/1/20 – 6/30/21

11. Are the Diagnosis Related Groups (DRG) codes published?

Yes. The list of DRGs is available within the DRG Pricing Calculators located within each state fiscal year pricing folder on the Department of Health Care Services' DRG webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx). The DRGs are listed on the "DRG Table" tab of the calculators.

The All Patient Refined Diagnosis Related Groups (APR-DRG) Definition Manual provides detail on how each DRG and severity of illness is assigned; manuals for each version of APR-DRGs are available from 3M™.

12. Where do the Diagnosis Related Groups (DRG) relative weights come from?

The Department of Health Care Services (DHCS) uses All Patient Refined Diagnosis Related Groups (APR-DRG) relative weights calculated by 3M™ from the National Inpatient Sample. Each DRG is assigned a relative weight, which reflects a hospital's typical resources used for the level of care provided. Each DRG also has four levels of severity; the relative weight of the DRG generally increases as severity increases, resulting in a higher payment. There are a few

exceptions – particularly when the most extreme severity indicates that patient death is likely early in the stay.

An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal FFS data. The national weights are updated annually by 3M™ Health Information Systems. For State Fiscal Year 2020-21, the relative weights reflect hospital-specific relative value (HSRV) weights of V.35 of the APR-DRG grouper. HSRV weights are used as they are a more accurate method of calculating relative weights, controlling for differences among hospitals in charge levels.

For SFY 2020-21, DHCS chose to remain on V.35 of the APR-DRG grouper and HSRV weights to sustain maximum stability of payment amounts during the extraordinary pandemic circumstances currently affecting all providers.

13. What is the Diagnosis Related Groups (DRG) base rate?

The DRG base rate is used in the DRG payment calculation as described in question 9. For state fiscal year (SFY) 2020-21, there are two DRG base rates – statewide ($6,596) and remote rural ($15,036) — applied to each hospital based on its remote rural status. The Medi-Cal DRG base rate is the same concept as the Medicare DRG standardized amount.

For each hospital, the DRG statewide base rate is adjusted for differences in local area wages, using the same approach and hospital-specific values as Medicare uses (see question 14). In the Los Angeles area, for example, once adjusted for local area wages, a typical SFY 2020-21 DRG statewide base rate is $7,669.

Hospitals can see their SFY 2019-20 DRG base rates on the Department of Health Care Services' DRG webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx), under "Pricing Resources: SFY 2020-21."

14. What are wage area index values and how are they used?

In implementing payment by Diagnosis Related Groups (DRGs), the Department of Health Care Services (DHCS) decided to vary the DRG base rate for each California hospital depending on local wage area index values as determined by Medicare. Wage areas are updated by Medicare to reflect differences in wages based on geographic locale.

DHCS uses hospital-specific wage area index values (WI) as shown on the Medicare Impact File, including reclassifications where appropriate. For children's hospitals, critical access hospitals, and other hospitals not included in the

Medicare Impact File, DHCS uses the WI that corresponds to the hospital's physical location. For state fiscal year (SFY) 2020-21, the Medicare values have been multiplied by a wage area index neutrality factor of 0.9584. This factor adjusts for the increase in Medicare values for California relative to the rest of the country.

The result is that Medi-Cal base rates are adjusted for changes in relative differences within California. Here is an example of the base rate calculation for a Los Angeles area hospital:

(DRG statewide base rate x WI x labor share of WI x adjustment factor) + (DRG statewide base rate x non-labor share of WI)

($6,596 x 1.2918 x 68.3% x 0.9584) + ($6,596 x 31.7%) = $7,669

15. What is the wage area index neutrality factor and how is it used in the Diagnosis Related Groups (DRG) payment method?

The Department of Health Care Services (DHCS) uses hospital-specific wage area index values to determine hospital-specific base rates which are used to calculate hospital-specific DRG base payments. Since implementing the DRG payment method, DHCS has used the same wage area index values as Medicare per the Medicare Impact File. Relative to the rest of the U.S., California hospitals have higher wage area index values due to higher labor costs. To account for differences in local wage areas without increasing the overall wage area adjustment, California wage areas as measured by the Medicare program must be normalized. Therefore, the Medicare wage area index value is multiplied by a neutrality factor to preserve the internal consistency of California wage area values. This factor adjusts for the increase in Medicare values for California relative to the rest of the country. The result is that Medi-Cal base rates are adjusted for changes in relative differences within California. Medi-Cal has been applying a wage area index neutrality factor since state fiscal year (SFY) 2015-16. The factor is updated annually based on the California Medicare wage index values. See question 1 for the neutrality factors used since SFY 2017-18.

16. How do cost outlier payments affect the Diagnosis Related Groups (DRG) payment method?

As do Medicare and other DRG payers, Medi-Cal makes additional "outlier" payments on stays that are exceptionally expensive for a hospital. Historically, Medi-Cal had a two-tier outlier policy for DRG payment in state fiscal years (SFY) 2013-14 through 2016-17. As of SFY 2017-18, a single tier outlier policy went into

effect. For a small number of stays that are exceptionally profitable for a hospital, Medi-Cal also has a "low-side" outlier policy that reduces payment; this low-side outlier has been single-tiered since the start of the DRG program in SFY 2013-14.

For SFY 2020-21, the outlier threshold remains at $61,000, and the marginal cost percentage remains at 55%. For details on the cost outlier threshold and marginal cost percentage for each year, see the DRG Pricing Calculator specific to each SFY in the pricing folders on the DHCS DRG webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx).

17. How do policy adjustors affect payment by Diagnosis Related Groups (DRG)?

Each DRG is assigned a relative weight based on its expected relative resource use. The relative weight for each base DRG is adjusted for the expected severity of illness, with severity of illness codes ranging from one to four; in general, relative weights are higher for increasing severity of illness codes because the expected resource use is higher. In addition, relative weights for some DRGs are adjusted upward using policy adjustors in order to facilitate access to care. Medi-Cal implemented the DRG payment method in state fiscal year (SFY) 2013-14 with policy adjustors for pediatrics, neonates at Designated Neonatal Intensive Care Units (NICU), and neonates at other hospitals. Starting in SFY 2015-16, a policy adjustor was added for obstetric stays. A high acuity policy adjustor was added in SFY 2018-19 for adult, obstetric, neonate and pediatric DRGs with severity of illness 4. For SFY 2020-21 policy adjustor values remain the same as SFY 2019-20.

Table 3: Medi-Cal APR-DRG SFY 2020-21 Policy Adjustors

Policy Adjustor	Severity of Illness 1-3	Severity of Illness 4
Pediatric	1.45	1.75
Neonate at Designated NICU	1.75	2.45
Neonate at other NICU	1.25	1.75
Adult	1.00	1.10
Obstetric	1.06	1.17

18. What other payment policies affect payment methods?

For most stays, payment is made using a "straight Diagnosis Related Groups (DRG)" calculation — that is, payment equals the DRG relative weight times the DRG base rate, as described in question 9. Cost outliers and policy adjustors are applied as described in questions 16 and 17, respectively. In special situations, payment may also include other adjustments, for example:

- Transfer pricing adjustment. Payment may be reduced when the patient is transferred to another acute care hospital. The calculation is similar to the Medicare program, though the specific discharge status values differ. Medi-Cal, unlike Medicare, does not have a post-acute transfer policy. For details on transfer pricing adjustments, see question 20 and the DRG Pricing Calculator on the Department of Health Care Services' (DHCS) DRG webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx).
- "Lesser Of." If the allowed amount exceeds charges, payment is reduced to charges.
- Other health coverage (OHC) and patient cost-sharing. The calculations described above determine the allowed amount. From the allowed amount, Medi-Cal deducts payments from OHC (e.g., workers' compensation, etc.) as well as the patient's share of cost. Implementation of the DRG payment method did not affect these deductions.

19. How can hospitals earn the enhanced Designated Neonatal Intensive Care Unit (NICU) policy adjustor for a NICU inpatient admission?

For a hospital to receive the enhanced Designated NICU policy adjustors (1.75 for neonatal DRGs with severity of illness [SOI] 1-3 and 2.45 for neonatal DRGs with SOI 4), it must:

- *Perform services assigned to the neonate care category.*
- *Be approved by California Children's Services (CCS) and continue to meet the standards of either a Regional NICU or a Community NICU with neonatal surgery.* CCS conducts reviews annually or as necessary to determine whether a hospital continues to meet all applicable neonatal surgery standards. If the CCS NICU-surgery approval/status of a hospital is revoked or otherwise terminated, the hospital will no longer receive the enhanced designated NICU policy adjustor, effective the date status ceases. Inpatient NICU DRG admissions at non-designated NICUs

receive the 1.25 policy adjustor for neonatal DRGs with SOI 1-3 and 1.75 for neonatal DRGs with SOI 4.

See State Plan Amendment 19-0025 for more information. Check the Hospital Characteristics File on the Department of Health Care Services' Diagnosis Related Groups webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx) to check if a hospital is a designated NICU.

20. If a patient is transferred, do you get the full Diagnosis Related Groups (DRG) payment?

It depends on when the beneficiary is discharged from the other hospital. Each hospital will receive a DRG payment. However, payment to the first hospital may be subject to a transfer adjustment depending on the length of stay. The receiving hospital would receive full DRG payment. If a beneficiary is not discharged, sent to a second hospital for a procedure and then returns to the original hospital, the original hospital would receive a single DRG payment. It would be the responsibility of the original hospital to negotiate payment to the second hospital; the second hospital would not receive a DRG payment and should not bill Medi-Cal. See the DRG Pricing Calculator on the DHCS DRG webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx) for more information on how payments for transfers are calculated.

Treatment Authorization Requests (TAR) and Service Authorization Requests (SAR) requirements apply to transfers. When a beneficiary is discharged from one hospital and transferred to another, there will be two claims and two TARs/SARs. The transfer payment adjustment applies to only the first hospital. For additional information on TARs/SARs, see questions 38 and 39.

Hospital Characteristics

21. How can a provider determine if a hospital is private or public?

Please see the state fiscal year-specific Hospital Characteristics Files in the pricing folders located on the Department of Health Care Services Diagnosis Related Groups webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx). These files show the status for Designated Public Hospitals and Non-Designated Public Hospitals, as well as the status for designated Neonatal Intensive Care Units, and remote rural hospitals.

22. How are cost-to-charge ratios (CCRs) assigned each year and used in ratesetting? Which cost reports are used?

The Cost Report Tracking Section (CRTS) at the Department of Health Care Services (DHCS) calculates the CCR according to this formula based on fields on the cost report:

$$CCR = \frac{\text{Total Medi-Cal costs (Worksheet E-3 part VII Line 7 of cost report)}}{\text{Total Medi-Cal charges (Worksheet E-3 part VII Line 12 of cost report)}}$$

In California, hospitals generally have fiscal years ending June 30 or December 31. Hospitals submit cost reports depending on their fiscal year end (FYE), so some cost reports will be for July-June and others will be for January-December (or, rarely, other time periods). For a given year, the "reported" or "as filed" CCR is from the cost report as submitted by the hospital, subject to preliminary review and acceptance by the CRTS of DHCS.

The common practice is to use the reported CCR to pay Diagnosis Related Groups claims. In state fiscal year (SFY) 2020-21, for example, the reported CCR from FYE 2018 was commonly used for claim payment.

CCRs from the most recently available fiscal year are used in the ratesetting process. For example, the FYE 2018 CCRs were used for SFY 2020-21 ratesetting. CRTS provides the Safety Net Financing Division with CCRs in October to begin ratesetting simulations for the next fiscal year. Any revised CCRs received by December 31 will be included in the final ratesetting process.

Closely adhering to the cost reporting submission requirements outlined in question 52 will minimize inaccuracies and time spent in related audit requirements, including outlier recalculation.

23. Is the cost-to-charge ratio (CCR) published?

Yes. Each hospital's CCR is included in the state fiscal year-specific Hospital Characteristics Files on the Department of Health Care Services Diagnosis Related Groups webpage (http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx). See question 10 for the dates of admission that correspond to each year of DRG payment.

24. What are the wage area and cost-to-charge ratio (CCR) for an out-of-state (OOS) hospital? Is this Medicare defined?

Wage area index values for OOS hospitals are set at the Medicare national average of 1.0000. The Department of Health Care Services applies the California

default CCR calculated by Medicare to OOS hospitals. The OOS CCR for federal fiscal year (FFY) 2020 is 21.1%, decreased 0.2% from FFY 2019.

Coding and Billing

25. What are the most important billing points under Diagnosis Related Groups (DRG) payment?

Table 4 shows the most significant billing changes that occurred July 1, 2013, when DRG payment was implemented.

Table 4: Impacts on Hospital Billing and Operations Due to Change in Diagnosis Related Groups (DRG) Payment July 1, 2013 (Listed in Approximate Declining Order of Impact)

Item	Comment
Payment is per stay	Under DRG payment, one payment is made per stay. Under the previous method, payment was per day for contract hospitals and at a percentage of cost for non-contract hospitals.
Treatment Authorization Request (TAR)/Service Authorization Request (SAR) process	As of July 1, 2013, TAR/SAR is no longer required on length of stay for the vast majority of days. SAR is specific to California Children's Services and Genetically Handicapped Persons Program beneficiaries. For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR, not a daily TAR. As of January 2016, TAR requirements began to change. See questions 38 and 39.
Increased importance of diagnosis and procedure coding	Assignment of the base All Patient Refined Diagnosis Related Groups and level of severity is driven by the number, nature, and interaction of diagnoses and comorbidities as well as procedure codes. See question 26.
Mother and newborn billed on separate claims	Separate payment is made for each patient. Under the previous method, normal newborns were billed on their mothers' claims.

Item	Comment
Newborns with long lengths of stay and multiple claims must be billed with the same Medicaid number on each claim, preferably the baby's number	Because payment is by stay, submission of the mother's beneficiary number on some claims and the baby's beneficiary number on other claims would be problematic.
Newborn weight should be coded using diagnosis codes (not value codes) when applicable	This is important as birthweight is a critical input to the All Patient Refined Diagnosis Related Groups (APR-DRG) assignment. Diagnosis codes should also be used to report gestational age where applicable. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes include the ability to indicate birthweight and gestational age.
Interim bill types 112, 113, and discharge status 30 only accepted for stays exceeding 29 days. Interim bill type 114 not accepted	When the patient is discharged, a single admit-through-discharge claim should be submitted. See question 49. For newborn claims, please be sure to consistently use the mother's or baby's beneficiary identification number for all claims related to a single stay. See question 36.
Split billing a hospital stay (multiple-page paper claims)	This applies only to multiple-page paper claims. Each page of the claim must show all diagnosis and procedure codes. The provider number, beneficiary identification number, dates of admission, and all diagnosis and procedure codes should be the same on all pages.
Administrative days	Administrative days must be billed on a separate claim, identified by revenue code. Effective July 1, 2013, a new Level 2 administrative day was created. See question 50.
Four-byte APR-DRG code	A hospital's billing system should accept a four-byte DRG code. An APR-DRG has three bytes for the base DRG and 1 byte for level of severity without the hyphen (e.g., format 1234 for DRG 123-4).
Physical rehabilitation stays	Physical rehabilitation days must be billed on a separate claim, identified by revenue code. Payment is per diem. See question 50.

Item	Comment
Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes). See question 28.
Separately payable services, supplies, and devices	In the few situations where separate payment is allowed, a separate outpatient claim should be submitted. See question 31.
Late charges (bill type 115) not accepted	Void and resubmit the original claim instead.
Health care-acquired conditions (HCACs)	Payment may be reduced if a HCAC is present on the claim. HCACs are also known as provider-preventable conditions or PPCs under this federally required payment policy. See question 29.
Transfers from non-contract hospitals under the previous payment method	Under the DRG payment method, there is no distinction between contract and non-contract hospitals. All Health Facility Planning Areas are considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for all services (subject to approved Treatment Authorization Requests [TAR]).
California Children's Services (CCS) Patients with Medi-Cal Fee-for-Service (FFS)	Most CCS patients also have Medi-Cal FFS. CCS inpatient stays are paid by DRG. Submit a single claim for a single payment; only an admission Service Authorization Request or TAR is required. Daily authorization is required if the patient has a restricted benefit aid code. See questions 41 and 42.
CCS patients with Medi-Cal Managed Care (MC)	For a CCS client enrolled in a Medi-Cal MC plan with "carved-out" CCS services, CCS authorizes inpatient admissions for the treatment of the client's CCS eligible condition. If a patient is treated for a CCS eligible inpatient admission, submit the claim to Medi-Cal FFS and not the Medi-Cal managed care plan. See questions 41 and 42.

26. How many diagnoses and procedures are used in Diagnosis Related Groups (DRG) assignment? Why is this important?

The Medi-Cal claims processing system, California Medicaid Management Information System, accepts up to 25 diagnosis codes and 25 procedure codes for electronic claims (18 diagnosis codes and six procedure codes for paper claims). Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate base All Patient Refined DRG and patient severity of illness are assigned.

27. Did the Department of Health Care Services (DHCS) implement adjustments based on provider-preventable conditions (PPC) concurrent with DRG implementation?

Consistent with federal requirements, DHCS implemented Version 30 of the hospital-acquired condition (HAC) utility on July 1, 2013, to ensure payments are only made for PPCs that were present on admission. The HAC utility was most recently upgraded to Version 37.1 on April 1, 2020. Hospitals should continue reporting all provider-preventable conditions to the Audits and Investigations Division, consistent with current reporting guidelines, which can be found at http://www.dhcs.ca.gov/individuals/pages/ai_ppc.aspx.

28. Is the present-on-admission (POA) indicator required? Is the Medi-Cal POA the same as the Medicare POA?

Yes. POA indicators are a national standard and the same for both Medi-Cal and Medicare. Acceptable POA indicators are: Y, N, U, W, or blank. Hospitals are required to include the POA indicator associated with the principal and secondary diagnosis codes when submitting paper and electronic claims. These values are used to identify health care-acquired conditions (HCAC) by the HAC utility (see question 29). For the official guidelines on how to apply the POA indicator as well as information on complete and accurate documentation, code assignment and reporting of diagnoses and procedures, see the ICD-10-CM FY 2020 Guidelines link at https://www.cdc.gov/nchs/icd/icd10cm.htm.

29. How is payment affected if a health care-acquired condition (HCAC) is present on the claim?

Federal law requires Medicaid programs to demonstrate that they are not paying for HCACs, as defined specifically by the Centers for Medicare & Medicaid Services (CMS). The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with. The Medi-Cal claims

processing system uses the 3M™ HAC utility to identify HCACs from the diagnosis, procedure and present-on-admission information on the claim and disregards the HCAC in assigning the All Patient Refined Diagnosis Related Groups (APR-DRG). As of July 1, 2017, the system identifies and accommodates up to five HCACs. Payment for the stay would be affected only if the presence of the HCAC(s) would otherwise have pushed the stay into a higher-paying APR-DRG. Based on an analysis of Medi-Cal data, Medicare and other states, we expect payment to be reduced on less than 1% of stays. (This figure could change if CMS expands the list of HCACs.)

30. Does the reporting of present-on-admission indicators eliminate the need to complete the Medi-Cal Provider-Preventable Conditions Reporting Form?

No. This report continues to be required.

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

In general, the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission) is the same under Diagnosis Related Groups (DRG) payment as it was under the previous payment method. Under the DRG payment method, all hospitals are able to bill the items in Table 5 on an outpatient claim for separate payment during an inpatient stay. All other services provided to an inpatient are bundled with the DRG payment.

Table 5: Separately Payable Services That Can Be Billed on an Outpatient Claim

Description	Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Code
Bone Marrow Search and Acquisition Costs	
Management of beneficiary hematopoietic progenitor cell donor search and cell acquisition	38204
Unrelated bone marrow donor	38204
Blood Factors	
Blood Factor XIII (antihemophilic factor, Corifact)	J7180
Blood Factor XIII (antihemophilic factor, Tretten)	C9134
Blood Factor Von Willebrand - Injection	J7183
Blood Factor VIII	J7185 / J7190 / J7192
Blood Factor VIII/Von Willebrand	J7186
Blood Factor Von Willebrand	J7187
Blood Factor VIIa	J7189
Blood Factor IX	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197
Blood Factor Antiinhibitor	J7198
Hemophilia clotting factor, not otherwise classified	J7199
Long-Acting Reversible Contraceptive (LARC) Methods	
Intrauterine copper (Paraguard)	J7300

Description	Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Code
Skyla	J7301
Levonorgestrel-releasing intrauterine contraceptive system (Mirena)	J7302
Etonogestrel (Implanon, Nexplanon)	J7307
Car T-Cell Therapies	
Tisagenlecleucel (Kymriah™)	Q2040
Axicabtagene ciloleucel (Yescarta™)	Q2041
Tisagenlecleucel (Kymriah™)	Q2042

32. In an interim claims scenario, does a provider need to do anything to clarify that it is not double billing?

No. When a final discharge claim is processed, it will be priced for the entire stay including all charges, diagnosis and procedure codes from date of admission. Payment is made based on the assigned Diagnosis Related Groups for the entire stay. If interim claims were paid, the payments for the interim claims will be removed from the provider's next checkwrite through the Remittance Advice Details. See question 49 for a detailed explanation of interim claim billing.

33. How does the Diagnosis Related Groups (DRG) payment method affect patients dually eligible for Medi-Cal and Medicare?

In the common Medicare crossover situation—when Medicare is the primary payer and Medi-Cal is the secondary payer—there is no impact. Adjudication of crossover claims was unaffected by the implementation of the DRG payment method July 1, 2013.

It occasionally happens that a dually eligible beneficiary either does not have Medicare Part A coverage for the inpatient stay or loses that coverage during the stay (for example, because Part A coverage days are exhausted). In this situation,

if Medi-Cal would otherwise cover the stay then Medi-Cal becomes the primary payer for all or part of the stay. Submit the claim showing the original admission date and discharge data. Show only the charges, diagnoses, and procedure codes related to the portion of the stay not covered by Medicare Part A. Show also any applicable payments made to the hospital by Medicare Part B. The Department of Health Care Services will use this information in pricing the claim under the DRG payment method.

Pediatrics/Newborns/Neonatal Intensive Care Units (NICUs)

34. What is the age definition for pediatric?

Medi-Cal defines pediatric as under the age of 21.

35. What revenue code is required for well newborn claims?

The revenue/accommodation codes used for billing well newborn claims have not changed under Diagnosis Related Groups payment. Use revenue/accommodation code 171 or 170 for well newborn claims and 170 when the mother has no Medi-Cal coverage. Babies must be billed on separate claims from their mothers; this includes multiple births. Using twins as an example, the claim should indicate for which twin the claim applies (e.g., “Twin 1” or “Twin 2”).

36. If a baby has not been issued his or her own Benefits Identification Card and Client Identification Number (BIC/CIN) in the first 30 days, can the first interim claim be billed under the mother’s BIC/CIN?

Yes. But if an interim claim for a baby is billed with the mother’s BIC/CIN, then all subsequent claims for the baby should continue to use the mother’s BIC/CIN through final discharge of the baby. A comment should be noted on the claim, “Baby using mother’s BIC/CIN.” If possible, hospitals should hold claims and submit a single admit-through-discharge claim under the baby’s identity.

37. What defines a neonate at hospitals that are not designated Neonatal Intensive Care Units (NICUs)?

The baby is a normal newborn or a neonate (sick baby). The Diagnosis Related Groups (DRG) table in the DRG Pricing Calculator specifies which DRGs are in the “Neonate” category and which are in the “Normal newborn” category. Categories are defined as the Medicaid Care Category, a clinically based categorization scheme that makes it easy to group related DRGs.

Many hospitals with newborn services are not designated NICUs. NICU designations can be found in the Hospital Characteristics Files on the Department of Health Care Services' DRG webpage at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx.

Treatment Authorization Request (TAR)

38. How does Diagnosis Related Groups (DRG) payment fit with the Treatment Authorization Request (TAR) and Service Authorization Request (SAR) processes?

Simplification of the TAR/SAR process was a major benefit of DRG implementation on July 1, 2013, with further simplification continuing through a piloted program in February 2016. Note that SAR is specific to California Children's Services (CCS) and Genetically Handicapped Person's Program (GHPP) beneficiaries.

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

- Continuation of the previous TAR/SAR requirements on the medical necessity of the admission, including CCS and GHPP admissions. That is, authorization is required for all admissions except for deliveries and care of well newborns (i.e., normal newborns), regardless of aid code. If a well newborn becomes sick, an admission TAR/SAR is required.
- Discontinuation in almost all cases of the previous TAR/SAR requirement on the length of stay, meaning an admit TAR is sufficient to authorize a stay regardless of length. For beneficiaries with a full-scope aid code (regardless of age), only a single admission TAR/SAR is required.
- However, beneficiaries with restricted benefit aid codes (regardless of age) who have an admission that does not involve a delivery or well newborn care, acute intensive rehabilitation days, or acute administrative days (Levels 1 and 2) still require a TAR for daily review of all hospital days.
- For a delivery outside the hospital, a TAR is not required for either the mother or normal newborn.
- Continuation of the previous TAR requirement for a short list of specific procedures for all beneficiaries.

- Prior to submission of an interim claim, please submit a TAR/SAR for approval. Payment of interim claims requires an approved admission TAR/SAR.
- Either a SAR or TAR, based on eligibility at admission, is required if a patient has a stay that is covered by CCS and Medi-Cal (see question 42).
- Claims in which Medi-Cal is the secondary payer with Other Health Coverage as the primary payer also require a TAR.

For stays not paid by DRG:

- TAR requirements on both the admission and the length of stay continue as they were previously for rehabilitation and administrative days (see question 50).
- For interim claim billing, hospitals need an approved TAR before the interim claim can be processed for payment.

A facility/provider can submit an admit TAR either before, upon, or after the admission. Retroactive TARs will still be accepted. However, it is the provider that risks loss of payment if the service is provided and the TAR is denied. For emergency admissions, the admit TAR would be submitted after the admission. Hospitals must submit medical information supporting the type of TAR required.

As of February 2016, Non-Designated Public Hospitals and private hospitals that serve fee-for service Medi-Cal patients also began to move away from TAR requirements to an internal utilization management process using nationally recognized evidence-based medical criteria software such as InterQual® and/or MCG. In this approach, DHCS conducts post-payment clinical and administrative monitoring oversight of participating hospitals. Additional information on this pilot can be found on the TAR-Free Process webpage at http://www.dhcs.ca.gov/services/medi-cal/pages/tarfreeprocess.aspx.

39. How should Treatment Authorization Requests (TARs) be submitted?

There are no new paper TAR forms. Use the 18-1 TAR for emergency admissions and the 50-1 TAR for non-emergency elective admissions. If an elective inpatient stay requires a 50-1 TAR, an 18-1 does not need to be generated upon continued stay.

40. How will the Department of Health Care Services (DHCS) handle restricted benefit aid code stays where at least one day was denied, and payment was affected?

As long as one day is approved on a TAR, providers should bill with all of the charges, procedure codes, and diagnosis codes that otherwise would have been billed. DHCS will review the cases where at least one day was denied to see if there is any reason that the Diagnosis Related Groups grouping should be different based on removing the procedures performed on the Treatment Authorization Request-denied days. If the claim was eligible for an outlier payment, there could also be an impact if charges associated with denied days are removed. If there is a payment offset or recoupment, the provider then knows that the denied days did in fact have a financial effect. The provider can submit an appeal against the denied days. It is possible that denied days may not actually affect payment.

Service Authorization Request (SAR) For California Children's Services

41. Are inpatient claims for California Children's Services (CCS)-only patients processed using the Diagnosis Related Groups (DRG) payment method?

Yes. CCS-only claims are paid by DRG using Medi-Cal payment methodology and rates. Inpatient admissions for CCS-only clients at hospitals participating in DRG payment are authorized by CCS using the same methodology that is used for CCS/Medi-Cal clients.

42. What is the impact on billing and the Treatment Authorization Request (TAR)/Service Authorization Request (SAR) process for California Children's Services (CCS) patients?

CCS and Medi-Cal Fee-for-Service (FFS): As mentioned in question 6, claims for beneficiaries under CCS are priced using the Diagnosis Related Groups (DRG) methodology. Most CCS patients also have Medi-Cal coverage. CCS and Medi-Cal billing and the SAR/TAR process have been streamlined for these patients. If the beneficiary has Medi-Cal FFS, separate claims and authorizations for the CCS and Medi-Cal parts of the stay are no longer required. Only one claim should be submitted, and only one admission SAR or TAR should be requested for a CCS client, including clients with a restricted benefit aid code. An example of a

restricted benefit aid code is, “pregnancy related and emergency services only.” One DRG payment is made for the stay.

CCS and Medi-Cal Managed Care: For a CCS client enrolled in a Medi-Cal managed care plan (MCP) with “carved-out” CCS services, CCS will issue a SAR for inpatient admissions for the treatment of the client’s CCS eligible condition. If CCS authorizes the admission with a SAR, Medi-Cal FFS should be billed pursuant to the CCS SAR and the services will be reimbursed using the DRG methodology. If the client is not CCS medically eligible on admission and CCS subsequently determines that the client is CCS medically eligible at any point in the inpatient episode, CCS will issue a SAR covering the entire inpatient episode (retroactive to the date of admission).

The resulting claim should be submitted to Medi-Cal FFS and not to the Medi-Cal MCP. A CCS-ineligible stay should be billed entirely to the managed care plan.

Payment for all inpatient services for a CCS client enrolled in a Medi-Cal MCP with “carved-in” CCS services, i.e., the County Organized Health System (CHOS) health plans, with the exception of the COHS in Ventura County, are the responsibility of the Medi-Cal MCP and should not be billed to Medi-Cal FFS.

Well newborn stays do not require an admission SAR; however, if a well newborn becomes sick, an admission SAR is required.

Acute inpatient intensive rehabilitation stays require daily SARs (see question 50).

43. Is the entire medical record required for the admission Service Authorization Request (SAR)? Is there a list of supporting documentation that is required when submitting an admission SAR versus a length of stay SAR?

For admission SARs, hospitals must submit the information that will support the medical necessity for an acute inpatient admission.

For acute inpatient intensive rehabilitation stays, hospitals must submit medical documentation consistent with the current requirements to establish medical necessity for each requested day and to establish the level of care.

44. If a newborn is using the mother's Benefits Identification Card/Client Identification Number (ID) number, but the mother does not have Medi-Cal eligibility on the date of admission and California Children's Services (CCS) does not authorize the stay for dates of service (DOS) prior to the Medi-Cal eligibility, how are providers to get paid for the stay?

Medi-Cal fee-for-service and the CCS payment system will not pay the Diagnosis Related Groups claim if there is no eligibility on the date of admission. In such a circumstance Medi-Cal CCS will not pay for the inpatient episode. If the baby has eligibility, then submit the claim under the newborn's ID.

Managed Care Plans (MCPs)

45. Are payments by Medi-Cal Managed Care Plans (MCPs) affected?

Medi-Cal MCPs use the Diagnosis Related Groups (DRG) payment method to pay for emergency and post-stabilization inpatient services provided to MCP enrollees by general acute care hospitals that are not part of the MCP's contracted provider network. MCPs are responsible for calculating out-of-network rates consistent with DRG pricing using the DRG statewide or remote rural base rate (wage adjusted). The hospital-specific base rates are shown on the Hospital Characteristics Files on the Department of Health Care Services' (DHCS) DRG webpage at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx. For previous fiscal years, see the Hospital Characteristics Files on the DRG webpage under the Pricing Resources folder specific to each DRG payment year; these files list each hospital's base rates used for emergency and post-stabilization services for out-of-network stays. Calculation of DRG payment, then follows the same logic described in question 9.

MCPs should also use the DRG payment method in pricing emergency and post-stabilization services provided by University of California hospitals and other Designated Public Hospitals (DPHs) if those hospitals are outside the MCP's network. This is the only situation in which the DRG payment method affects DPHs.

The DRG-based method does not affect MCP contracts with in-network hospitals or arrangements for elective admissions to out-of-network hospitals. (Note that some plans have chosen to adopt the Medi-Cal fee-for-service DRG payment method, though this is not required by DHCS.)

An *All Plan Letter Replacement of Rogers Rate 13-004* dated February 12, 2013, is posted to the DHCS Managed Care webpage at https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. It provides more detailed information regarding MCP payment for emergency and post-stabilization inpatient services by out-of-network hospitals.

46. How is payment calculated if a patient has Medi-Cal managed care (MC) in the first part of the stay and later becomes fee-for-service (FFS)?

When billing a stay at a Diagnosis Related Groups hospital for a beneficiary who is covered by a Managed Care Plan (MCP) in the first part of the stay and later becomes FFS, the hospital must first obtain reimbursement from the MCP. When payment is received from the MCP, the hospital then bills the entire stay to FFS. The payment received from the MCP will be deducted from the total payment amount from FFS. Claims submitted for MCP and FFS must contain the following on the UB-04 claim form to receive reimbursement:

- Include prior payment dollar amount (amount paid by MCP) in the Prior Payments field (Box 54)
- Include one of the following statements in the Remarks field (Box 80):
    - MC and FFS stay
    - Medi-Cal MC and FFS stay
- Attach the statement of payment from the MCP

Appeals

47. If initially a claim is billed electronically with 25 diagnosis codes, but an appeal is later submitted in paper form, will the diagnosis codes not included on the paper appeal affect the All Patient Refined Diagnosis Related Groups due to not having all the original diagnosis codes?

The paper claim form submitted with the appeal will not be able to carry all 25 diagnosis codes. Appeals are no longer required to be submitted on paper and can be submitted electronically including the full 25 diagnosis and procedure codes. See the Medi-Cal Provider Manual at http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp for special instructions that must be followed or the claim will be denied.

48. The All Patient Refined Diagnosis Related Groups (APR-DRG) Pricing Calculator instructions indicate that in the case of a difference in the APR-DRG assignment, the claims processing system should be considered correct. Is there a process to appeal the APR-DRG assignment if the provider still believes they are correct?

There is no process to appeal the Diagnosis Related Groups (DRG) assignment or calculations. DRG assignment discrepancies often are resolved once grouper settings and diagnosis, procedure, and patient information are verified for accuracy. If diagnosis or procedure codes were omitted from the initial claim, the hospital can rebill and no appeal is needed to add the full set of codes. Please contact the DRG inbox at drg@dhcs.ca.gov if you need assistance with grouper settings or continue to see discrepancies after verifying the grouper settings and information on the claim form. The grouper settings documents for each state fiscal year (SFY) are located in the Pricing Resources folder for each SFY on the DRG webpage at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx.

49. How are interim claims paid?

Hospitals are never required to submit interim claims but can choose to do so if the date span exceeds 29 days. In these situations, the hospital is paid a per diem amount ($600). When the patient is discharged, the hospital submits a single, admit-through-discharge claim. Hospitals should not send void claims. Final payment is calculated by the Diagnosis Related Groups (DRG) method and then reduced by the interim claim amounts that were previously submitted. Payment of interim claims is unusual among DRG payers, but helps ensure access to care for sick newborns and other patients with unusually lengthy stays. Payment of interim claims requires an approved admission Treatment Authorization Request/Service Authorization Request.

50. What other types of services are not paid by Diagnosis Related Groups (DRG)? Where is information available on administrative days and rehabilitation days?

Administrative days and physical rehabilitation services are not paid by DRG, but are subject to Treatment Authorization Request (TAR)/Service Authorization Request (SAR) requirements. Below are the state fiscal year (SFY) 2020-21 Medi-Cal payment rates for rehabilitation services and Level 2 administrative days.

- Adult rehabilitation service base rate: $1,032.00
- Pediatric rehabilitation service base rate: $1,841.00

- Administrative day Level 2 revenue codes 190 (sub-acute pediatric): $1,112.71
- Administrative day Level 2 revenue codes 199 (sub-acute adult): $1,097.37

More information on administrative days Levels 1 and 2 can be found in Medi-Cal's "Provider Manual Part 2- Inpatient Services" (IPS-Administrative Days (admin) section) in the Publications tab of the Medi-Cal webpage or directly at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/admin_i00.doc for up to date information. Hospital-specific Level 2 rates can be found in each SFY-specific Hospital Characteristics File on the Department of Health Care Services (DHCS) DRG webpage at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx.

More information on physical rehabilitation services can be found in the Rehabilitation and Admin Level 2 provider bulletin on the DHCS DRG webpage under Provider Education and Bulletins. Hospital-specific rehabilitation rates can be found in each SFY-specific Hospital Characteristics File on the DHCS DRG webpage.

Other Questions

51. Are hospitals required to submit cost reports? Are Diagnosis Related Groups (DRG) payments subject to adjustment after cost reports have been submitted?

Hospitals are required to submit cost reports, which the Department of Health Care Services uses for a variety of purposes, including calculation of hospital utilization fees, establishing a cost-to-charge ratio (CCR) used in DRG outlier payment policy, and review of hospital payments overall. It is important that "submitted" cost reports be accurate and defensible in order to ensure hospitals receive accurate payments.

The Medi-Cal Program uses the Medicare cost report Centers for Medicare & Medicaid Services (CMS) 2552-10 and it is subject to federal and state regulations.

Centers for Medicare & Medicaid Services (CMS) Publication (Pub) 15-1 section 2413 and Pub. 15-2 section 100 states:

Providers of service participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered

to Medicare beneficiaries (42 U.S.C. l395g (Section l8l5(a) of the Social Security Act)). Regulations state that cost reports "will be required from providers on an annual basis..." (42 Code of Federal Regulations (C.F.R.) 405.406(b)). When you fail to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments (see Part II, §l00).

Per California Welfare and Institutions Code Section 14170, providers must submit cost reports and other data to a state agency for the purpose of determining reasonable costs for services or establishing rates of payment. For DRG purposes, the cost report data is used for calculating hospital utilization fees, and establishing the hospital CCR which is an element in the calculation of the reimbursement of outlier claims.

California Welfare and Institutions Code Section 14170 states in part…

> *(a)(1) "Amounts paid for services provided to Medi-Cal Beneficiaries shall be audited by the department in the manner and form prescribed by the department."*

52. What are the cost report submission requirements? What is the cost report used for?

Hospital-specific cost-to-charge ratios (CCRs) are necessary to calculate outlier payments sometimes made in addition to the Diagnosis Related Groups (DRG) base payment. The necessary documents required for calculation of a hospital's CCR by the Cost Report Tracking Section (CRTS) are listed below in Table 6. All documents should be submitted to acute.submissions@dhcs.ca.gov.

Table 6: Cost Report Submission Requirements

Hospital Submits	Comments by DHCS' CRTS
Cover letter	Detail special circumstances, contact personnel, etc.
Signed copy of Centers for Medicare & Medicaid Services (CMS) 2552-10	Federally Qualified Health Centers (FQHC) must have "Provider Based" status approved by CMS to be included on CMS 2552-10
Signed copy of Department of Health Care Services (DHCS) 3092	If applicable, include Medi-Cal supplemental Sections 6 and 7
Audited financial statements	Must cover the entire cost reporting period
Working papers and trial balance used to support the entire cost report, A-6 reclassifications, and A-8 adjustments	If the hospital participated in the Medi-Cal Quality Assurance Fee Program, any payments made must be removed on A-8

Accurate cost reporting is imperative because the contents are used by CRTS to calculate the hospital-specific CCR which affects DRG outlier payments for each claim payment as well as DRG statewide base rates during annual ratesetting. Additionally, CRTS reviews hospital CCRs for continuity from year to year. If a hospital experiences a change in CCR that is greater than five percent the hospital must provide written explanation for the cause of the change (e.g., reporting error the previous year, changes in services provided, changes in utilization).

We encourage hospitals to strive for accuracy in reported CCRs in order to avoid future payment adjustments under outlier recalculation (see question 53).

53. What is outlier recalculation? Why is the Department of Health Care Services (DHCS) pursuing outlier recalculation?

Diagnosis Related Groups (DRG) payment is final, but outlier payment is subject to recalculation based on the audited cost-to-charge ratio (CCR). Outlier recalculation is performed during the audit process: the reported and the audited CCRs are compared specific to the applicable DRG outlier payments from paid claims, with date of service that align with the hospital's cost reporting period of the fiscal year end being audited.

The DHCS is pursuing DRG outlier recalculation per State Plan Amendment 13-004 dated May 31, 2013:

> *When there is a material change between the reported CCR and the final audited CCR, outlier payments may be subject to recalculation based upon the audited CCR. A material change is defined as a change that would result in outlier payment adjustments exceeding $10,000.00 for a hospital during a state fiscal year.*

The DRG outlier recalculation policy began state fiscal year (SFY) 2016-17.

For Further Information:

The DHCS webpage at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx is the best source for information. Resources include:

- ***FAQ.*** Updates to this Frequently Asked Questions (FAQ) document are made available as changes are needed. This version of the FAQ represents the policies, rates, and decisions for state fiscal year (SFY) 2020-21. For versions of the FAQ that apply to previous years of DRG payment, see the Department of Health Care Services DRG webpage under Pricing Resources for the relevant year.
- ***DRG pricing calculator.*** The DRG Pricing Calculator interactive spreadsheet does not assign the All Patient Refined Diagnosis Related Groups (APR-DRG), but it demonstrates how a given APR-DRG is priced in different circumstances.

  The calculator includes a complete list of APR-DRGs and related information for use in California. Please select the appropriate DRG calculator based on the admission date for each appropriate fiscal year.
- ***Hospital characteristics.*** The Hospital Characteristics File provides relevant information about all California DRG hospitals, including Designated Public Hospital/Non-Designated Public Hospital status, Neonatal Intensive Care Unit designation, remote rural status, wage area assignment, base rates, CCRs, and rates for rehabilitation and administrative days Level 2. The files for each state fiscal year are available in the pricing resources page for that year. As an added convenience, this file is also included as a separate tab in the DRG Pricing Calculator.

- ***Grouper settings.*** The grouper settings documents for each state fiscal year are useful to providers who want to verify DRG assignment of the claims. Medi-Cal assigns APR-DRGs using the 3M™ algorithm. Providers may choose, but are not required, to purchase the 3M™ grouper to check how their claims are being grouped. The grouper settings documents describe what settings to use in the software for claims in a specific time period based on admission and discharge dates.
- ***Provider bulletins.*** Provider bulletins contain additional details on specific areas of DRG billing, payment, and Treatment Authorization Request/Service Authorization Request authorizations.

Other key resources are as follows:

- ***Questions:*** For policy questions, please email the DRG mailbox at drg@dhcs.ca.gov. Never send any patient-specific information by email.
- ***DRG listserv:*** To subscribe to the DRG listserv, email drg@dhcs.ca.gov.
- ***Medi-Cal Provider Manual.*** The manual was updated to show billing details for the DRG-based payment method and is available on the DHCS webpage at https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx under "Inpatient services (IPS)."
- ***Recorded trainings.*** Providers may access recorded trainings on the Medi-Cal learning portal at https://learn.medi-cal.ca.gov/home.aspx (login, then go to OPS > Recorded Webinars).