Beginning July 1, 2013, Medi-Cal has paid for most hospital inpatient services received by fee-for-service (FFS) beneficiaries using diagnosis related groups (DRGs). This FAQ provides updated information applicable to SFY 2015-16, which is Year 3 of the DRG payment method.

This May 24, 2016, version of the FAQ captures changes announced in fall 2015 via bulletins, as well as the April 25, 2016, upgrade to DRG mapping and HAC software in the Medi-Cal claims payment system. Also, we have merged the billing FAQs into this document for your convenience. For information about SFY 2013-14 and SFY 2014-15 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. Please note that this FAQ document does not supersede applicable laws, regulations or policies.
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OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project? What are the goals of DRG payment? Explain the expectation of budget neutral.

As directed by the California legislature, on July 1, 2013, DHCS implemented a new method of paying for hospital inpatient services in the FFS Medi-Cal program. The new method is based on All Patient Refined Diagnosis Related Groups (APR-DRGs). 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. Implementation of DRGs is budget neutral in aggregate, not by individual hospital. The state’s budget neutral requirement in FFS ensures that payment for hospital services for each year of DRG payment are not below 2012-13 levels.

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

From 1983 to 2013, hospitals were paid under the Selective Provider Contracting Program (SPCP). “Contracted” hospitals negotiated a per diem payment rate with the State (previously, the California Medical Assistance Commission). Non-contracted hospitals were reimbursed based on interim rates using a cost-to-charge ratio (CCR) and subject to a cost settlement process.

3. Is there a transition period?

Yes. The DRG-based payment method is being phased in over a three-year period with the changes fully implemented in the fourth year (SFY 2016-17), similar to what Medicare does with major payment changes. See Question 19 for an overview of the three-year transition policy.

4. Which hospitals are paid by 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. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals (DPHs) (such as the University of California) are outside the scope of DRG-based payment. With regard to rehabilitation hospitals and services, see Question 102. Non-designated public hospitals (NDPH) transitioned to DRG payment as of January 1, 2014.

5. What services are affected?

For affected hospitals, DRG 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 (MC) stays (see Question 90)
- Physical rehabilitation stays (see Question 102)
- Administrative days (see Question 104)

6. Will non-contract hospitals accept Medi-Cal patients?

All hospitals that are allowed to service Medi-Cal beneficiaries will continue to service Medi-Cal patients. References to hospitals as a contract or non-contract hospitals are no longer applicable under DRG payment. This includes the removal of transfer requirements for non-contract facilities in a closed area, as well as the removal of restrictions based on open and closed Health Facilities Planning Areas (HFPAs).
7. **Do DRGs affect CCS and GHPP patients?**

Yes. Claims for eligible beneficiaries under California Children’s Services (CCS) or the Genetically Handicapped Person Program (GHPP) are priced using the DRG method. This is true regardless of whether the beneficiaries also have Medi-Cal FFS or Medi-Cal MC (in CCS carve out counties only). See Question 57 for more information on billing and authorizations for CCS and GHPP patients.

8. **Who else uses 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. California and many other Medicaid programs typically use APR-DRGs, 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, and newborn care. In the Medi-Cal FFS population, these categories represent about two-thirds of all stays.

9. **Is there a different methodology for DRG exempt facilities?**

DPHs are exempt from FFS DRG reimbursement as they are reimbursed via Certified Public Expenditures.

Medi-Cal managed care plans (MCPs) are required to use DRG reimbursement for emergency and post-stabilization services provided by all out-of-network general acute care hospitals, including DPHs and out-of-state hospitals effective July 1, 2013. With the implementation of DRGs, there is no longer an average rate as issued by the previous methodology under the Selective Provider Contracting Program on which the Roger Rates were based. The DRG statewide base rates for these hospitals are available in the Hospital Characteristics Files for the appropriate DRG payment year on the DHCS DRG webpage.

**DRG PAYMENT**

10. **What are the characteristics of DRG payment?**

   - DRG payment defines “the product of a hospital,” thereby enabling greater understanding of the services being provided and purchased.
   - Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.
   - Because 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.

11. **How do DRG payment methods work?**

In general, every complete inpatient stay is assigned to a single diagnosis related group (DRG) using a computerized algorithm that takes into account the patient’s diagnoses, age, procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to 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 $8,000, then the payment rate for that DRG is $4,000, before accounting for any policy adjustors.

12. How is the DRG assigned?

DHCS uses the 3M™ All Patient Refined Diagnosis Related Group algorithm (APR-DRG), to assign a DRG to each claim. First, each stay is assigned to one of 314 base APR-DRGs. Then, each stay is 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.

The DRG methodology is updated annually, so it is critical to use the appropriate APR-DRG version to assign the DRG. Please see the SFY 15/16 DRG Grouper Setting document on the DHCS webpage.

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<td>V.32</td>
<td>SFY 2015-16</td>
<td>Claims with admission dates on or after 7/1/15</td>
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13. Are the DRG groups published?

Yes. The list of DRGs is available within the DRG Pricing Calculator located on the DHCS DRG webpage on the “DRG Table” tab.

14. Where do the DRG relative weights come from?

DHCS uses 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 the patient death is likely early in the stay such as for very low birth weight neonates (under 500 grams).

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 SFY 2015-16, the relative weights reflect hospital-specific relative value (HSRV) weights of V.32 of the APR-DRG grouper. HSRV weights were chosen as they are a more accurate method of calculating relative weights that has been recently made available for APR-DRGs. HSRV weights are similarly calculated from the National Inpatient Sample, but control for differences among hospitals at charge levels.

The APR-DRG Definition Manual provides detail on how each DRG and severity of illness is assigned. Manuals for each version of APR-DRGs can be found on the 3M website.
15. What is the DRG base rate?

The DRG base rate is used in the DRG payment calculation as described in Question 11. Some hospitals are still in a transition period until all hospitals move to a statewide base rate on July 1, 2016. There are two statewide base rates – remote rural and non-remote rural. Hospitals fall into one of three categories for base rates:

- Non-transition hospital at the remote rural base rate
- Non-transition hospital at the non-remote rural base rate
- Transition hospital

In SFY 2015-16, about one-third of California hospitals are paid using the statewide base rate of $6,289 ($12,768 for remote rural hospitals). For each hospital, the statewide base rate is adjusted for differences in local area wages, using the same approach and hospital-specific values as Medicare uses (see Question 16). In the Los Angeles area, for example, a typical SFY 2015-16 statewide base rate is $7,436.

The other two-thirds of California hospitals are paid using hospital-specific transition base rates. The transition is intended to buffer the impact of the change in payment methods over a three-year period before full implementation July 1, 2016. For transition hospitals, rates for SFY 2013-14 were set with the intention that a hospital’s average payment per stay would increase or decrease no more than 5% relative to what it otherwise would have been for the same mix of patients. In SFY 2014-15, DRG base rates were set with the intention that a hospital’s average payment would change no more than 5% relative to Year 1. For SFY 2015-16, a similar mechanism would apply relative to Year 2. (For NDPHs, the transition mechanism is similar, but the percentages are 2.5% in the period January-June 2014, 5% in SFY 2014-15, and 7.5% in SFY 2015-16.) Table 2 depicts the base rates over the first three years of DRG payment.

Hospitals can see their SFY 2015-16 DRG base rates on the DHCS DRG webpage. In July 2013, each hospital was advised of its projected SFY 2015-16 base rate. In June 2015, each hospital was advised of its final rate. For non-transition hospitals, the final rates differed slightly from the projections because the SFY 2015-16 rates reflect the latest available Medicare wage area data adjusted by a factor of 0.9797 (see Question 16). For transition hospitals, the final rates were the same as the projected rates.

For SFY 2015-16, all hospitals designated as remote rural – both transition and non-transition – are paid using a base rate 20% higher than it otherwise would have been. This supports access to care for beneficiaries in rural areas while maintaining the efficiency incentives of a DRG payment method. The remote rural base rate (used for non-transition hospitals) is $12,768, up from $10,640 in SFY 2014-15.

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

In implementing payment by DRG, the Department decided to vary the DRG base rate for each California hospital depending on local wage area index values as determined by Medicare.

DHCS uses hospital-specific wage area index values as used by Medicare per the Medicare Impact File. For children’s hospitals, critical access hospitals and other hospitals not included in the Medicare Impact File, DHCS uses the wage area index value (WI) that corresponds to the hospital’s physical location. For SFY 2015-16, the Medicare values have been multiplied by an adjustment factor of 0.9797. 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:

\[
\frac{\text{(Statewide base rate} \times \text{WI} \times \text{labor share of WI} \times \text{adjustment factor}) + \text{(Statewide base rate} \times \text{non-labor share of WI})}{\text{(Statewide base rate} \times \text{WI} \times \text{labor share of WI} \times \text{adjustment factor}) + \text{(Statewide base rate} \times \text{non-labor share of WI})}
\]

\[
(6,289 \times 1.2822 \times 69.6\% \times 0.9797) + (6,289 \times 30.4\%) = 7,436
\]
17. What other payment policies affect payment methods?

Prior to SFY 2015-16, payment for approximately 80% of stays payment was made using a “straight DRG” calculation — that is, payment equals the DRG relative weight times the DRG base rate, as described in Question 11. In special situations, payment may also include other adjustments, for example:

- **Policy adjustors.** Relative weights for neonates and pediatric stays are adjusted upward in order to facilitate access to care. As of July 1, 2015, obstetric stays are also adjusted upward through use of a policy adjustor.

- **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. For details, see Question 18 and the DRG Pricing Calculator on the DHCS DRG webpage. Medi-Cal, unlike Medicare, does not have a post-acute transfer policy.

- **Cost outlier adjustment.** As do Medicare and other DRG payers, Medi-Cal makes additional “outlier” payments on stays that are exceptionally expensive for a hospital. Medi-Cal has a two-tier outlier policy. 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. For details, see the DRG Pricing Calculator on the DHCS DRG webpage.

- **“Lesser Of.”** If the allowed amount exceeds charges, payment is reduced to charges. This is consistent with previous policy.

- **Other health coverage and patient cost-sharing.** The calculations described above determine the allowed amount. From the allowed amount, Medi-Cal deducts payments from other health coverage (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.

18. If a patient is transferred, do you get the full DRG payment?

It depends on when the beneficiary is discharged from the other hospital. Each hospital will get a DRG payment. However, the first hospital may have a transfer adjustment depending on the length of stay. The receiving hospital would receive a full DRG payment. 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 adjustment applies to only the first hospital.

If a beneficiary is not discharged and is sent to a second hospital for a procedure and returns to the original hospital, the original hospital would receive a single DRG payment. The original hospital would negotiate payment to the second hospital; the second hospital would not receive a DRG payment and should not bill Medi-Cal.

19. What changes were made for SFY 2015-16?

See Table 2 for a comparison of DRG payment policy between SFY 2013-14, SFY 2014-15, and SFY 2015-16. The Department has kept the payment method as stable as possible during the three years of transition. For the first annual update impacting Year 2 of DRG payment, the changes were technical in nature rather than policy oriented. For the second annual update, which impacts Year 3 of DRG payment, technical changes as well as a few policy changes were made:

- A policy adjustor of 1.06 is applied to obstetric stays; increasing payments for obstetric stays.

- Remote rural hospitals – both transition and non-transition – are paid using a base rate 20% higher than it otherwise would have been.
• Wage areas for non-transition hospitals were updated and adjusted by a factor of 0.9797. This adjustment retains the relative positions of index values within California while removing the impact of relative changes between California and the rest of the country. Please refer to Question 16.

• HSRV weights are used as of July 1, 2015. Please refer to Question 14.

| Table 2  |
|------------------|------------------|------------------|
| Summary of DRG Payment Policies in Year 1 (SFY 2013-14), Year 2 (SFY 2014-15), and Year 3 (SFY 2015-16) | |
| Payment Policy | Year 1 Value (SFY 2013-14) | Year 2 Value (SFY 2014-15) | Year 3 Value (SFY 2015-16) |
| DRG Base Rates | |
| DRG base rate, statewide | $6,223 | $6,289 | $6,289 |
| DRG base rate, statewide (remote rural hospitals) | $10,218 | $10,640 | $12,768 |
| Payment to non-transition hospitals | Statewide DRG base rate adjusted for Medicare FFY 2013 wage area values | Statewide DRG base rate adjusted for Medicare FFY 2014 wage area values | Statewide DRG base rate adjusted for Medicare FFY 2015 wage area values and the 0.9797 factor |
| Payment to transition hospitals | Hospital-specific, as shown in separate document1 | Hospital-specific, as shown in separate document2 | Hospital-specific, as shown in separate document2 |
| Adjustment for wage area values | Similar to Medicare, reflecting a labor share of 68.8% | Similar to Medicare, reflecting a labor share of 69.6% | Similar to Medicare, reflecting a labor share of 69.6%, then adjusted by a 0.9797 factor to neutralize CA changes compared to U.S. |
| Adjustment to base rates for improved documentation, coding and capture of diagnoses and procedures | -3.5% | None | None |
| DRG Grouper | |
| DRG version | APR-DRG V.29 | APR-DRG V.31 | APR-DRG V.32 |
| DRG relative weights | APR-DRG V.29 (national, charge-based) | APR-DRG V.31 (national, charge-based) | APR-DRG V.32 (national, hospital-specific relative value (HSRV) weights) |
| National average length of stay benchmarks (used in calculating transfer adjustments) | APR-DRG V.29 (arithmetic, untrimmed) | APR-DRG V.31 (arithmetic, untrimmed) | APR-DRG V.32 (arithmetic, untrimmed) |
| Outlier Policy Factors | |
| Hospital-specific cost-to-charge ratios | Most recent available for Year 1, as determined by DHCS | FYE 2012 cost report (some exceptions may apply) | FYE 2013 cost report (some exceptions may apply) |
| High side (provider loss) tiers and marginal cost (MCost) percentages4 | $0-$40,000: no outlier payment | $0-$42,040: no outlier payment | $0-$45,000: no outlier payment |
| | $40,001 to $125,000: MCost = 0.60 | $42,041 to $131,375: MCost = 0.60 | $45,001 to $145,000: MCost = 0.60 |
| | >$125,000: MCost = 0.80 | >$131,375: MCost = 0.80 | >$145,000: MCost = 0.80 |
| Low side (provider gain) tiers and marginal cost percentages | $0-$40,000: no outlier reduction | $0-$42,040: no outlier reduction | $0-$45,000: no outlier reduction |
| | >$40,000: MCost = 0.60 | >$42,040: MCost = 0.60 | >$45,000: MCost = 0.60 |
| Other Payment Policies | |
| Policy adjustor – neonate at designated NICU | 1.75 | 1.75 (No change) | 1.75 (No change) |
| Policy adjustor – neonate at other NICU | 1.25 | 1.25 (No change) | 1.25 (No change) |
| Policy adjustor – obstetric | n/a | n/a | 1.06 |
| Policy adjustor – pediatric miscellaneous, pediatric respiratory | 1.25 | 1.25 (No change) | 1.25 (No change) |
| Pediatric age cutoff | <21 | <21 (No change) | <21 (No change) |
| Discharge status values for the transfer adjustment5 | 02, 05, 65, 66 | 02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 | 02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 |

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## Table 2
Summary of DRG Payment Policies in Year 1 (SFY 2013-14), Year 2 (SFY 2014-15), and Year 3 (SFY 2015-16)

<table>
<thead>
<tr>
<th>Payment Policy</th>
<th>Year 1 Value (SFY 2013-14)</th>
<th>Year 2 Value (SFY 2014-15)</th>
<th>Year 3 Value (SFY 2015-16)</th>
</tr>
</thead>
</table>

Notes:
1. For SFY 2013-14 hospital-specific DRG base rates, see “SPCP Contract Rates” at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
2. For SFY 2014-15 hospital-specific DRG base rates, see “SFY 14/15 Hospital Characteristics File” for non-transition hospitals and “SFY 14/15 Transition Base Rates for Admissions” for transition hospitals at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
3. For SFY 2015-16 hospital-specific DRG base rates, see SFY 15/16 Hospital Characteristics File” for non-transitional hospitals and transitional hospitals base rates at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
4. Outlier thresholds have been increased to reflect the latest available data on hospital charge inflation.
5. Discharge status values 82, 85, 91, 93, and 94 became effective nationally October 1, 2013. They became effective for Medi-Cal inpatient FFS stays September 21, 2015, retroactive to July 1, 2014. These values parallel the other values that indicate a transfer adjustment, with the difference being a planned acute care readmission. Discharge status value 70 became effective nationally in 2008, but implemented for Medi-Cal inpatient FFS stays September 21, 2015, retroactive to July 1, 2014. Note that discharge status value 70 will not trigger a transfer pricing adjustment.
6. For details of the pricing logic, APR-DRG groups, and relative weights, see the SFY 2015-16 DRG Pricing Calculator at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

20. How will payments change in the future?

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

In the early years of DRG payment, as the Department and the hospitals gain experience with the new method, it is possible that the Department will make adjustments to the payment method mid-year if necessary. If at all possible, any adjustments would be made on a go-forward basis. As of July 1, 2015, no retroactive adjustments have been necessary.

## Hospital Characteristics

21. What is the easiest way for a provider to determine if they are a private or public hospital?

Please see the Hospital Characteristics Files located on the DHCS DRG webpage, which shows the status for DPHs and NDPHs, as well as the status for designated neonatal intensive care units (NICUs), and remote rural hospitals.

22. Is the cost-to-charge ratio published?

Yes. Each hospital’s cost-to-charge ratio (CCR) is included on the Hospital Characteristics Files on the DHCS DRG webpage specific to each year of DRG payment. See Question 12 for the dates of admission that correspond to each year of DRG payment.

23. What is the wage area and CCR for an out-of-state (OOS) hospital? Is this Medicare defined?

Wage area index values for all non-border hospitals are set at the Medicare national average of 1.000. CCRs for OOS hospitals are set at the California default CCR, as determined by Medicare. The OOS CCR for FFY 2016 is 21.6%, down from 21.8% in FFY 2015.
CODING AND BILLING

24. What are the most important billing points under DRG payment?

Table 3 shows the most significant billing changes under the DRG payment method, with specifics where appropriate to billing requirements, Treatment Authorization Requests (TAR), Service Authorization Requests (SAR) and business practices under the previous method.

<table>
<thead>
<tr>
<th>Item</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment is per stay</td>
<td>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.</td>
</tr>
<tr>
<td>TAR/SAR process</td>
<td>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 CCS and GHPP recipients. For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR, not a daily TAR. See Questions 57 and 72. As of January 2016, TAR requirements began to change; please see Question 58 for details</td>
</tr>
<tr>
<td>Increased importance of diagnosis and procedure coding</td>
<td>Assignment of the base APR-DRG and level of severity is driven by the number, nature and interaction of diagnoses and comorbidities as well as procedure codes. See Question 27.</td>
</tr>
<tr>
<td>Mother and newborn billed on separate claims</td>
<td>Separate payment is made for each patient. Under the previous method, normal newborns were billed on their mothers’ claims.</td>
</tr>
<tr>
<td>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</td>
<td>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.</td>
</tr>
<tr>
<td>Newborn weight should be coded using diagnosis codes (not value codes) when applicable</td>
<td>This is important as birth weight is a critical input to the APR-DRG assignment. ICD-9-CM classification uses the 5th digit to indicate birth weight for diagnoses 764 and 765.0-765.1. Diagnosis codes should also be used to report gestational age where applicable. ICD-10-CM codes also include the ability to indicate birthweight and gestational age.</td>
</tr>
<tr>
<td>Interim bill types 112, 113, and discharge status 30 only accepted for stays exceeding 29 days</td>
<td>When the patient is discharged, a single admit-through-discharge claim should be submitted. See Question 101. 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.</td>
</tr>
<tr>
<td>Interim bill type 114 not accepted</td>
<td>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.</td>
</tr>
<tr>
<td>Split billing a hospital stay (multiple-page paper claims)</td>
<td>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 to pay more than the existing Level 1 administrative day for sub-acute patients who require more care than Level 1. See Question 104.</td>
</tr>
<tr>
<td>Four-byte APR-DRG code</td>
<td>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 (format 1234 for DRG 123-4).</td>
</tr>
<tr>
<td>Physical rehabilitation stays</td>
<td>Physical rehabilitation days must be billed on separate claim, identified by revenue code. Payment is per diem. See Question 102.</td>
</tr>
<tr>
<td>Present-on-admission indicator</td>
<td>Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes). See Question 33.</td>
</tr>
<tr>
<td>Separately payable services, supplies, and devices</td>
<td>In the few situations where separate payment is allowed, a separate outpatient claim should be submitted. See Question 36.</td>
</tr>
<tr>
<td>Late charges (bill type 115) not accepted</td>
<td>Void and resubmit the original claim instead.</td>
</tr>
<tr>
<td>Health care-acquired conditions (HCACs)</td>
<td>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 32.</td>
</tr>
<tr>
<td>Physician services bundled into SPCP per diem rates</td>
<td>All physician services should be billed as professional claims (i.e., CMS-1500, 837P). Under the previous payment method, some hospitals had specific physician services bundled into the inpatient hospital per diem payment. See Question 37.</td>
</tr>
</tbody>
</table>
Table 3
Impacts on Hospital Billing and Operations because of the Change to DRG Payment July 1, 2013 (Listed in approximate declining order of impact)

<table>
<thead>
<tr>
<th>Item</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers from non-contract hospitals</td>
<td>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).</td>
</tr>
<tr>
<td>CCS Patients with Medi-Cal FFS</td>
<td>Most CCS patients also have Medi-Cal FFS. CCS inpatient stays are paid by DRG. Submit a single claim for a single payment; only an admission SAR or TAR is required. Daily authorization is required if the patient has a restricted benefit aid code. See Questions 7 and 39.</td>
</tr>
<tr>
<td>CCS patients with Medi-Cal MC</td>
<td>For a CCS client enrolled in a Medi-Cal managed care plan with “carved-out” CCS services, CCS authorizes inpatient admissions for the treatment of the client’s CCS eligible condition. If a patient is treated for a CCS-eligible inpatient admission, submit the claim to Medi-Cal FFS and not the Medi-Cal managed care plan. See Questions 7 and 38.</td>
</tr>
</tbody>
</table>

25. Will there be coding training for a hospital to understand which DRG to use?

Claims submitted for payment do not include the DRG assignment; rather a DRG is assigned when the APR-DRG grouper within the Medi-Cal claims processing system processes the final claim. Hospitals should follow national coding standards. The DRG for each claim is determined based on the diagnoses, procedures, patient age, patient gender, and other relevant information for each admission. As such, it is critical that coding is complete, accurate, and defensible for each claim.

26. In order to be paid, does each hospital need to buy APR-DRG software or put the DRG on the claim?

No. The DRG grouper assigns the APR-DRG to the claim. The CA Medicaid Management Information System (CA-MMIS) uses the DRG assignment to calculate payment for the stay.

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

The Medi-Cal claims processing system accepts up to 25 diagnosis codes and 25 procedure codes for electronic claims (18 diagnosis codes and 6 procedure codes for paper claims). Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate base APR-DRG and patient severity of illness (SOI) are assigned.

28. Does the calculator on the DHCS DRG webpage help determine if the correct DRG was billed?

No. The purpose of the DRG Pricing Calculator on the DHCS DRG webpage is for pricing; it is not a grouper. It assumes you know which APR-DRG to use (e.g. from Remittance Advice Details) in order to estimate payment. See Question 12 for more information.

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

Please see the SFY 2015-16 Grouper Settings document on the DHCS DRG webpage for APR-DRG grouper software settings. The document explains the correct grouper, mapper, and HAC utility versions to use based on admission and discharge dates. It also explains how the grouper settings are affected by the implementation of ICD-10.
30. When and how will ICD-10 affect the DRG payment method?

ICD-10 was implemented nationwide October 1, 2015. At that time, the Medi-Cal claims processing system began accepting ICD-10 diagnosis and procedure codes and utilizing ICD-10 codes for internal processing. Beginning on October 1, 2015, ICD-10 codes were mapped to ICD-9 codes using the 3M APR-DRG mapper. As of April 25, 2016, DRG assignment is made based on submitted ICD-10 codes without mapping to ICD-9 codes. Hospitals should follow national guidelines in submitting ICD-10 codes to Medi-Cal.

31. Is there an ICD-10 to ICD-9 crosswalk?

Prior to April 25, 2016, the 3M™ APR-DRG Mapper crosswalked ICD-10 to ICD-9 codes for DRG assignment to after October 1, 2015.

32. Did DHCS implement adjustments based on provider-preventable conditions (PPC) concurrent with DRG implementation?

Consistent with federal requirements, DHCS implemented V.30 of the health-care acquired conditions (HAC) utility in July 1, 2013, to ensure payments are only made for provider-preventable conditions that are present-on-admission. The HAC utility was upgraded to V.33 on April 25, 2016. Hospitals should continue reporting all provider-preventable conditions to Audits and Investigations consistent with current reporting guidelines.

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

Yes. Present-on-admission (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. Hospitals are required to include the POA indicator associated with the principal diagnosis code. 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 http://www.cdc.gov/nchs/icd/icd10cm.htm.

34. 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 HCACs, as defined specifically by CMS. The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with. The Medi-Cal claims processing system uses the 3M HAC utility to identify HCACs from the diagnosis, procedure and POA information on the claim and disregards the HCAC in assigning the APR-DRG. Therefore, payment for the stay would be affected only if the presence of the HCAC 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.)

35. Will the reporting of present-on-admission (POA) indicators eliminate the need to complete the Medi-Cal Provider-Preventable Conditions Reporting Form?

No. This report continues to be required.
**36. 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 DRG payment as it was previously. One exception is that prior to July 1, 2013, a few hospitals could bill for a short list of specialized, high-cost services (e.g., blood factors) on an outpatient claim even when provided on an inpatient basis. Under the DRG payment method, all hospitals are able to bill the items in Table 4 on an outpatient claim for separate payment during an inpatient stay; please note the additions to this list can be billed on an outpatient claim as of July 1, 2015.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Separately Payable Services That Can Be Billed on an Outpatient Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>CPT / HCPCS Code Effective July 1, 2013-June 30, 2015</td>
</tr>
<tr>
<td><strong>Bone Marrow Search and Acquisition Costs</strong></td>
<td></td>
</tr>
<tr>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
<td>38204</td>
</tr>
<tr>
<td>Unrelated bone marrow donor</td>
<td>38204</td>
</tr>
<tr>
<td><strong>Blood Factors</strong></td>
<td></td>
</tr>
<tr>
<td>Blood Factor XIII (antihemophilic factor, Corifact)</td>
<td>J7180</td>
</tr>
<tr>
<td>Blood Factor XIII (antihemophilic factor, Tretten)</td>
<td>C9134</td>
</tr>
<tr>
<td>Blood Factor Von Willebrand- Injection</td>
<td>J7183 / J7184 / Q2041</td>
</tr>
<tr>
<td>Blood Factor VIII</td>
<td>J7185 / J7190 / J7192</td>
</tr>
<tr>
<td>Blood Factor VIII/Von Willebrand</td>
<td>J7186</td>
</tr>
<tr>
<td>Blood Factor Von Willebrand</td>
<td>J7187</td>
</tr>
<tr>
<td>Blood Factor Vila</td>
<td>J7189</td>
</tr>
<tr>
<td>Blood Factor Antithrombin III</td>
<td>J7197</td>
</tr>
<tr>
<td>Blood Factor Antinhibitor</td>
<td>J7198</td>
</tr>
<tr>
<td>Hemophilia clotting factor, not otherwise classified</td>
<td>J7199</td>
</tr>
<tr>
<td><strong>Long-Acting Reversible Contraception (LARC) Methods</strong></td>
<td></td>
</tr>
<tr>
<td>Intrauterine copper (Paraguard)</td>
<td>J7300</td>
</tr>
<tr>
<td>Skyla</td>
<td>J7301</td>
</tr>
<tr>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Mirena)</td>
<td>J7302</td>
</tr>
<tr>
<td>Etonogestrel (Implanon, Nexplanon)</td>
<td>J7307</td>
</tr>
</tbody>
</table>

Note: 1. These services can be billed separately as of July 1, 2015. Please watch for a bulletin that may address instructions for retroactive adjustment of claims for these new LARC codes beginning January 1, 2015.
37. How did the implementation of DRG pricing affect contracted SPCP rates that bundled the physician component of hospital services with the hospital component?

Effective July 1, 2013, the physician component always should be separately billed on a professional (e.g., CMS-1500, 837P) claim. This situation only affects a few hospitals that previously had negotiated bundled physician/hospital payments for specific services.

38. What is the impact on billing and the TAR/SAR process for CCS patients?

CCS and Medi-Cal FFS: As mentioned in Question 7, claims for beneficiaries under CCS are priced using the 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. Separate claims and authorizations for the CCS and Medi-Cal parts of the stay are no longer required if the beneficiary has Medi-Cal FFS. Only one claim should be submitted, and only one admission SAR or TAR should be requested for a CCS client, including clients with restricted benefit aid code Medi-Cal, i.e., pregnancy related and emergency services only. One DRG payment is made for the stay.

CCS and Medi-Cal MC: For a CCS client enrolled in a Medi-Cal 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 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 health plans in San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa counties, are the responsibility of the Medi-Cal MCP and should not be billed to Medi-Cal FFS.

39. Since the implementation date of DRG payment is July 1, 2013, what if a patient is admitted on June 28, 2013, and stays through July 3, 2013?

The pricing logic in CA-MMIS reimburses the claim based on the date of admission. If a patient is admitted on June 28, 2013, and discharged on or after July 1, 2013, the stay will be priced using the contract or non-contract reimbursement methodology. DRG payment is made only for admissions on or after July 1, 2013.

40. We have different NPIs for non-contract and contract reimbursement. Which should we use?

All hospitals are able to utilize either NPI number. DRG rates are specific to each hospital and will no longer have any affiliation with a contract or non-contract status.

41. 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 DRG for the entire stay. If interim claims were paid, the payments for the interim claims will be removed from the provider’s next check write through the RAD. See Question 101 for a detailed explanation of interim claim billing.
42. Are there any changes to the UB-04?

No changes are being made to UB-04 completion form process due to the DRG payment method. For DRG reimbursed hospitals, the main item to note on the UB-04 is the importance of correctly identifying all procedure and diagnosis codes for each stay.

43. How are claim adjustments processed under the DRG payment method?

When requesting a claim adjustment, submit a copy of the RAD on which the claim line was paid and all other pertinent attachments, including timeliness documentation. Further information can be found in the Provider Manual on the Medi-Cal website.

DUAL ELIGIBILITY

44. What if there is a Medicare crossover? What comparison payment method will be used?

Transition to APR-DRGs changes the pricing methodology for each Medi-Cal FFS inpatient admission, but does not change any policies regarding crossover claims.

45. When a Medicare patient is in a general acute care facility and their Medicare days exhaust, how is Medi-Cal payment calculated?

A claim for Medi-Cal services should be submitted using the original admit date and discharge date for the stay and should include only charges, diagnoses, and procedure codes related to the portion of the stay not covered by Medicare, as well as the Part B payment on the claim. Medicare payments are deducted from the DRG payment.

46. Will DRGs affect secondary billing or other health care coverage?

There is no change from the current pricing system. Refer to the Provider Manual, Other Health Care Coverage (OHC) for further information. If a patient has workers’ compensation, Blue Cross, etc., and Medi-Cal is secondary, the claim will go through DRG pricing to determine the allowed amount, but other coverage is subtracted to arrive at final payment.

47. How will the share of cost affect DRG payment?

Other health coverage and share of cost are deducted from DRG payment; this practice has not changed under the DRG payment method.

PEDIATRICS/NEWBORNS/NEONATAL INTENSIVE CARE UNITS (NICUs)

48. What is the age definition for pediatric?

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

49. What revenue code will be required for well newborn claims?

The revenue/accommodation codes used for billing well newborn claims have not changed under DRG payment. Use revenue/accommodation code 171 or 170 for well newborn claims and 170 for when the mother has no Medi-Cal coverage.
50. Are well babies going to be reimbursed separately from the mother?

Yes, all babies must be billed on separate claims from their mothers. Claims that include both nursery revenue/accommodation codes and labor and delivery revenue/accommodation codes will be denied. Separate claims and separate payments are consistent with the fact that the mother and the baby are distinct patients with unique diagnoses, treatments, charges, length of stay, and discharge statuses.

51. Some well babies were previously billed on their own claim (e.g., mother is in jail) using four special revenue codes. Will the use of those special revenue codes be discontinued under DRGs?

The revenue codes used to bill for babies are 170, 171, 172, 173, and 174 and each code correlates to the severity of a baby’s condition.

52. If a baby has not been issued its own Benefits Identification Card and Client Identification Number (BIC/CIN) in the first 30 days, can we bill the first interim claim under the mother’s BIC/CIN?

Yes. 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.

53. How will multiple births be processed?

There will be a separate claim for every patient who is admitted; submit a claim for each baby born.

54. If you have multiple births billing with two or more claims and each of those claims are using the mother's BIC/CIN number, is there a probability of claims being denied as duplicate claims?

No. The claim should indicate for which twin the billing applies. For example, if the claim indicates “Baby using mother’s BIC/CIN”, the comment should also specify if it is for Twin 1 or Twin 2.

55. Will the newborn hearing screening still be able to be billed separately and reimbursed in addition to the DRG?

Yes, newborn screening is not changing; please follow the current procedure.

56. What defines a neonate at hospitals that are not designated NICUs?

The NICU policy adjustor is based on the hospital admission grouping to a DRG in the “Neonate” Medicaid care category. The DRG table in the DRG Pricing Calculator specifies which DRGs are in the “Neonate” Medicaid care category and which are in the “Normal newborn” category. Many hospitals with newborn services are not designated NICUs; that classification is included on the DRG rate letter that went out to hospital Chief Financial Officers (CFOs) and can also be found in the Hospital Characteristics Files on the DHCS DRG webpage.

TREATMENT AUTHORIZATION REQUEST (TAR)

57. How does 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 with a piloted program in January 2016. Note: SAR is specific to California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP) recipients.
For stays paid by DRG, the TAR/SAR process from July 1, 2013, 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 babies (i.e., normal newborns).

- Discontinuation in almost all cases of the previous TAR/SAR requirement on the length of stay. However, beneficiaries with restricted benefit aid codes who have an admission that does not involve a delivery or well-baby care continue to require a TAR with review of all hospital days. (For beneficiaries with restricted aid codes, this is a continuation of the previous process.)

- Continuation of the previous TAR requirement for a short list of specific procedures for all beneficiaries.

- Prior to submission of an interim claim, please submit a TAR/SAR for approval. Payment of interim claims requires an approved admission TAR/SAR.

- Either a SAR or TAR, based on eligibility at admission, is required if a patient has a stay that is covered by CCS and Medi-Cal. See Question 38.

For stays not paid by DRG:

- TAR requirements on both the admission and the length of stay continue as they were previously for rehabilitation and administrative days (see Questions 102 and 104).

As of January 2016, NDPHs and private hospitals that serve FFS Medi-Cal patients also began to move away from TAR to internal management by each hospital using their own utilization management systems and nationally recognized evidence-based medical criteria. In this new approach, DHCS will conduct post-payment clinical and administrative monitoring and oversight. Additional information on this pilot and the incremental transition plan will be communicated via bulletins as it becomes available.

58. **Will the TAR process for pediatrics remain the same?**

It is a similar process. If a well-baby becomes sick, an admission TAR/SAR is required. For beneficiaries with a full-scope aid code (regardless of age), a single admission TAR/SAR is required. For beneficiaries with a restricted benefit aid code (regardless of age), daily authorization is required, consistent with the current process. No TAR is required for obstetric admissions and normal newborns, regardless of aid code.

59. **Is a TAR required if the mother delivered outside of hospital?**

No, a TAR is not required for the mother’s delivery stay or the healthy baby delivered outside of the hospital.

60. **What criteria for TARs are used to determine medical necessity?**

The FFS criteria currently in use will continue to be used. For admission TARs, medical necessity will be used to evaluate if the patient requires an inpatient hospitalization. Medical professionals continue to review these TARs.

61. **Will on-site nurse review continue?**

The field offices are committed to working with providers and meeting their needs for on-site, eTAR, virtual record reviews, and fax submissions. Once a hospital determines what it needs based upon the FFS population, the field offices will determine what works best for both the facility and the Medi-Cal field office.
62. Are admit TARs used for all Medi-Cal beneficiaries?

No, there are certain exceptions. In general, full-scope FFS Medi-Cal beneficiaries will require an admit TAR for payment unless it is an admission for an obstetrical delivery or a normal newborn. Restricted benefit aid code beneficiaries, acute intensive rehabilitation days, and acute administrative days (Level 1 and 2) will continue to require a TAR for daily review of the stay.

63. Can TARs still be submitted electronically?

Yes, please do. DHCS is working to make submission as easy as possible for the providers and eTAR is still the fastest way to get your TAR submitted to DHCS and adjudicated. Admit TARs require less documentation, so electronic submission will reduce your workload as well. Paper TARs will be accepted until July 1, 2016. Those hospitals interested in becoming an eTAR provider can contact either their local field office or Xerox at 1-800-541-5555.

Effective July 1, 2016, eTARs must be submitted; Paper TARs will no longer be accepted after July 1, 2016.

64. Will the 18-1 TAR still be used or will there be new TAR forms?

There are no new TAR forms. Continue to use the 18-1 TAR for emergency admissions and the 50-1 TAR for non-emergency elective admissions.

65. If an elective inpatient stay requires a 50-1 TAR, will an 18-1 still need to be generated upon continued stay?

No.

66. Are admission TARs for elective procedures done prior to admission only? Will the need for prior authorization be returning?

Nothing is changing as far as the timing for submission of a TAR. A facility/provider can submit an admit TAR either before admission if they prefer, or after the admission. Retroactive TARs will still be accepted. As always, it is the provider that risks loss of payment, if the service is provided and then the TAR is submitted for review, and denied. For emergency admissions, the admit TAR would be submitted after the admission.

67. Will the entire medical record be required for the admit TAR? Is there a list of supporting documentation that is required when submitting an admit TAR/SAR versus a length of stay TAR?

Types of required documentation will remain the same. For an admit TAR, hospitals will need to submit the information that will support the medical necessity for an acute inpatient admission.

For services that require a daily TAR/SAR (acute inpatient intensive rehabilitation, administrative days levels 1 and 2, restricted benefit aid codes) hospitals will be required to submit medical documentation consistent with the current requirements to establish medical necessity for each requested day and to establish the level of care (acute vs. administrative levels 1 or 2).
68. What is the process for submitting TARs in 30-day increments? Say you have a patient for 90 days; TARs are for 30 day increments and there are denied days in between.

Most claims will only need an admit TAR. Hospitals will submit TARs as they do today. The purpose of the TAR is to approve the admission. For full scope beneficiaries, the system requires at least one TAR-approved day and then the entire stay is approved.

For restricted benefit aid code beneficiary stays that are not newborn or delivery related, each day is reviewed and if any days are denied, then there is potential for re-pricing. For services related to acute inpatient intensive rehabilitation, administrative days levels 1 and 2, and restricted benefit aid codes, the daily TAR requirements apply.

69. Which TAR is accepted for an extended length of stay?

The stay only requires an admit TAR to authorize the admission. Subsequent interim payments and the final discharge bill will use the admit TAR. Please note this requirement differs for acute inpatient intensive rehabilitation, administrative days levels 1 and 2 and restricted benefit aid codes.

70. Must 30 days pass before submitting the admit TAR on extended stays?

No, as soon as a beneficiary is admitted, a hospital can submit a TAR. For full scope beneficiaries, the admit TAR needs to contain documentation establishing the medical necessity for the acute hospitalization. For restricted benefit aid code beneficiary stays that require a daily TAR, the TAR requires documentation supporting the emergent condition being treated for each day requested on the TAR. If the TAR is denied, the hospital may appeal consistent with the current TAR appeals process.

71. What is the procedure to appeal a denied TAR?

If a TAR is denied, a documented reason is provided. If it is a claims processing reason (ineligible patient, incomplete codes), the first step is to contact the call center to understand the denial. DRG rates and group assignments are not appealable, but other aspects of the denial could be appealed depending on circumstances.

72. Which codes require daily TAR reviews?

Administrative day level of care, all rehabilitation stays and admissions for a restricted benefit aid code beneficiary except for well newborn and OB delivery stays require daily TARs.

73. If TARs are not submitted daily, what is the process for determining which day is denied?

For admit TARs, the determination is whether the admission was medically necessary at an acute level of care. The claim may be submitted with an authorized admit TAR. If the admit TAR is approved, the whole stay is approved for beneficiaries with a full-scope aid code.

74. How will DHCS handle restricted benefit aid code stays where at least one day was denied, and payment was affected?

As long as one day was approved on a TAR, go ahead and bill with all of the charges, procedure codes, and diagnoses codes that you would otherwise have billed. DHCS will review the cases where at least one day was denied to see if there is any reason that the DRG grouping should be different based on removing the procedures performed on the TAR 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 if they wish. It is possible that denied days may not actually affect payment.
75. Can denied TARs be appealed?

Yes, appeals for denied or modified TARs are still allowed. A denied admit TAR or a denied or modified daily review TAR may be appealed. Follow the current appeal process and timeliness requirements. The only difference for the admit TAR is that the submitted documentation will focus on the medical necessity for the admission.

76. Currently, when requesting a TAR for an emergency acute admission the TAR and complete records are submitted to the field office after the patient is discharged. What is the procedure for submitting an admit TAR?

Hospitals can submit an admit TAR after discharge or sooner at their discretion. An admit TAR will require documentation to establish the medical necessity for an acute inpatient admission. If the stay is for a beneficiary with a restricted benefit aid code, hospitals will need documentation for each day of the hospitalization. For interim claim billing, hospitals need an approved TAR before the interim claim can be processed for payment.

77. Will claims in which Medi-Cal is the secondary claims, after other health coverage (OHC) as primary, still require a TAR?

Yes.

78. Will the SAR process for a well-baby that becomes sick remain the same?

It is a similar process. If a well-baby becomes sick, an admission SAR is required. For beneficiaries with a full-scope aid code (regardless of age), a single admission SAR is required.

79. Will the entire medical record be required for the admission SAR? Is there a list of supporting documentation that is required when submitting an admission SAR versus a length of stay SAR?

Types of required documentation will remain the same. Hospitals will need to submit the information that will support the medical necessity for an acute inpatient admission.

Acute Inpatient Intensive Rehabilitation requires a daily SAR; hospitals will be required to submit medical documentation consistent with the current requirements to establish medical necessity for each requested day and to establish the level of care.

80. For an extended length of stay, which SAR is accepted?

The stay only requires a SAR authorization for the admission. Subsequent interim payments and final discharge bill use the initial admission SAR. Please note this requirement differs for acute inpatient intensive rehabilitation. See Question 83.

81. What is the procedure regarding claim denials?

There is a documented denial reason on the SAR. If it is a claims processing reason (ineligible patient, incomplete codes), the first step is to contact the call center to understand the denial. DRG rates and group assignments are not appealable, but you may informally appeal other aspects of the denial to the State CCS program depending on circumstances.
82. Which codes require daily SAR review?

Daily SARs are required for Acute Inpatient Intensive Rehabilitation stays.

83. What is the timeframe for submitting an admission SAR if a baby goes from newborn to NICU?

Today, most SARs are submitted after admission and done retrospectively. Hospitals do not need an admission SAR to be approved before admission. If a stay is particularly long and hospitals want to bill an interim claim, an approved SAR is needed before the interim claim will be paid.

84. Today, when a SAR is issued by the CCS Office, it includes a "from and through" date, and the number of days being approved for a patient stay. How will the SAR look under the new methodology?

A DRG inpatient admission SAR is approved for one day only and covers the entire DRG inpatient episode. There is no change to the SAR forms. If a CCS/Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan with carved out CCS services is admitted to a hospital for a non-CCS eligible condition and subsequently develops a CCS eligible condition during the stay, a SAR is authorized back to the date of admission.

85. For CCS patients, will medical records continue to be sent to CCS every 3-4 days to obtain more days, or just the initial SAR?

No. The stay is priced by DRG, so only an admission SAR is required for both non-rehabilitation stays or full scope aid beneficiary stays.

86. For CCS and managed care patients at a CCS approved hospital, when a hospital does not have an on-site nurse to determine days carved out, how will CCS days versus managed care days be determined?

If a CCS-only or CCS/Medi-Cal beneficiary is admitted to a hospital for a CCS-eligible condition the entire stay should be billed on a FFS basis. If the CCS/Medi-Cal beneficiary is enrolled in a Medi-Cal managed care plan with carved out CCS services and develops a CCS-eligible condition during the inpatient episode, CCS issues a SAR retroactive to the date of admission. If the CCS/Medi-Cal client is enrolled in a Medi-Cal managed care plan with carved-in CCS services, the managed care plan is responsible for reimbursement of the inpatient episode; no claim should be submitted to FFS Medi-Cal. Please refer to Question 38.

87. For hospitals without a CCS on-site nurse, will a SAR be required for each day? Originally, SARs were only for admission.

Only a SAR for the admission is required.

88. Are inpatient claims for CCS-only clients processed using the DRG payment method? If not, at what rate are the claims processed?

Yes, CCS-only claims are paid by DRG using Medi-Cal reimbursement methodology and rates. Inpatient admissions for CCS-only clients at hospitals participating in DRG reimbursement are authorized by CCS using the same methodology that is used for CCS/Medi-Cal clients.
89. If a newborn is using the mother’s BIC/CIN ID number, but the mother does not have Medi-Cal eligibility on the date of admission and 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?

CCS cannot authorize a service including an inpatient admission if there is no eligibility for the beneficiary (or in this case the mother) on the Medi-Cal Eligibility System (either eligibility for Medi-Cal or state-only CCS eligibility). Therefore, CCS cannot authorize an inpatient admission for a newborn on the mother’s Medi-Cal if there is no Medi-Cal eligibility for the mother on the date of admission. Also, Medi-Cal FFS and the CCS payment system will not pay the DRG claim if there is no eligibility on the date of admission. In such a circumstance Medi-Cal or state-only CCS will not pay for the inpatient episode.

**MANAGED CARE PLANS**

90. Are payments by Medi-Cal managed care plans (MCPs) affected?

There is no change for contracts with network hospitals or for elective out-of-network admissions. The primary impact to Medi-Cal MCPs is on payment for emergency and post-stabilization inpatient services provided to MCP enrollees by general acute care hospitals that are not part of the MCP’s contracted provider network. MCPs are responsible for calculating out-of-network rates consistent with DRG pricing utilized in Medi-Cal FFS inpatient acute care reimbursement rather than Roger’s Rate which no longer exists. For each hospital, MCPs should use the statewide (wage adjusted) DRG base rate, regardless of whether a hospital receives a transition rate for Medi-Cal FFS payment. The statewide DRG rates are shown on the Hospital Characteristics Files in the DRG Pricing Calculator available on the DHCS DRG webpage at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx. Calculation of DRG payment then follows the same logic described in Question 11.

MCPs should also use the DRG payment method in pricing emergency and post-stabilization services provided by University of California hospitals and other 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.

An *All Plan Letter Replacement of Rogers Rate 13-004* dated February 12, 2013, was mailed to MCPs and posted to the DHCS DRG webpage. It provides more detailed information regarding MCP payment for emergency and post-stabilization inpatient services by out-of-network hospitals.

91. Can MCPs receive confirmation that the wage-adjusted base rates published in the Hospital Characteristics File are required to pay for “Non-Contracted” hospitals versus hospital-specific APR-DRG base rates?

Please see the Hospital Characteristics Files on the DRG webpage at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx under the Pricing Resources folder specific to each DRG payment year; these files list the hospitals’ base rates used for emergency and post-stabilization services for out-of-network stays. MCPs are obligated to utilize the wage-adjusted statewide rate in determining final DRG reimbursement based on the DRG assignment and any policy adjustors. MCPs are not required or authorized to use hospital-specific transitional base rates. The hospital-specific transition base rates listed in the Hospital Characteristics’s files, are not used to price emergency admissions to out-of-network hospitals.
92. On a 5-day emergency admission, will APR-DRG amounts be affected if the Medi-Cal MCPs approve 3 days and deny 2 days?

Per Welfare and Institutions Code section 14091.3, hospitals must accept as full payment the payment amount established pursuant to the methodology developed under Section 14105.28. Because DRG payment is not based on length of stay, disallowing two days at the end of the stay would not necessarily affect payment unless a procedure was performed on one of those days. The health plan may still disallow a procedure if it is unrelated to the emergency. Please note that there is no change to the dispute resolution process regarding disputed days or procedures and whether they are necessary to treat the emergency condition.

93. Will the MCP’s topside capitation rates be built upon Rate Development Template (RDT) submitted data on network inpatient hospital costs, or be built upon the hospital-specific DRGs for those network hospitals?

It is built on RDT-submitted data along with the supplemental data request.

94. Are MCPs required to translate (from Rogers Rate to APR-DRG if the MCPs do not have the software) and pay with an APR-DRG, since hospitals are not required to bill with an APR-DRG?

MCPs are responsible for pricing the claims. The plans will need the APR-DRG software to group the claims and assign the DRG. However, MCPs may have alternatives to DRG pricing depending on the hospital’s agreement with the MCPs. All the information needed to price a claim once the DRG is assigned is available on the DRG webpage.

95. How will MCPs obtain the software to assign a DRG?

Please seek guidance from the California Association of Health Plans.

96. Should MCPs download and save the DRG Pricing Calculator to be able to enter DRG codes into the Calculator and get a hospital’s payment amount or should the Medi-Cal website be used every time to price a DRG claim?

It is advisable for MCPs to download and save the DRG Pricing Calculator that is available on the DHCS DRG webpage. The calculator is used as a tool to estimate the DRG payment based on the data that is input. Note that the DRG Pricing Calculator will change with each state fiscal year, so you will need to ensure that you are using the appropriate calculator for each year of DRG payment based on the claim’s admission date.

97. How is payment calculated if a patient has Medi-Cal managed care in the first part of the stay and later becomes FFS?

When billing a stay at a DRG hospital for a beneficiary who is covered by a MCP in the first part of the stay and later becomes FFS, the hospital (provider) 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):
  - Medi-Cal managed care (MC) and FFS stay
  - Medi-Cal MC and FFS stay
- Attach the statement of payment from the MCP
APPEALS

98. 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 APR-DRG 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. In this case, we would encourage providers to request a void through Claims Inquiry Form (CIF) or an appeal and then once the void goes through resubmit the claim electronically. The void and resubmission would have to take place within six months from the month of service.

99. The APR-DRG Calculator instructions indicate that in case of 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?

Our experience is that DRG assignment discrepancies 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 document is also located on the DRG website under Pricing Resources: http://www.dhcs.ca.gov/provgovpart/pages/DRG.aspx.

100. What impact will DRG payments have on the Claims Inquiry Form (CIF) and technical appeal process?

There is an appeals process hospitals currently utilize; this process will not change under DRG methodology.

SERVICES NOT PAID BY DRG

101. 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 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 TAR/SAR.

102. How are physical rehabilitation services paid?

Physical rehabilitation services — either within a general acute care hospital or a specialty rehabilitation facility — are not paid by DRG. Instead, DHCS has established per diem rates for each hospital. Each hospital has a specific rate based on its historical blend of pediatric and adult days using statewide rates of $1,841 (pediatric) and $1,032 (adult), adjusted for the hospital’s Medicare wage area. These rates are the same for Year 3 as in Year 2, although hospital-specific rehabilitation rates in Year 3 were affected by a change to neutralize the increase in California wage area values. For SFY 2015-16, the wage index values have been multiplied by an adjustment factor of 0.9797. This factor adjusts for the increase in Medicare values for California relative to the rest of the country. The result is that Medi-Cal rates are adjusted for changes in relative differences within California.
For SFY 2015-16, these rates are the same as SFY 2014-15, though the update in wage area index values will affect rates for individual hospitals. Hospital-specific rates are available on the hospital characteristics tab of the DRG Pricing Calculator that is available on the DRG webpage.

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

103. If an acute stay transfers to rehabilitation within the same admission, should these be billed separately?

Yes, you would bill separately, one claim for the general acute care stay and one claim for the rehabilitation portion of the stay. Please note that rehabilitation days require a daily TAR review and approval of each day requested.

104. How are administrative days paid?

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

• Level 1: Current acute administrative days with revenue/accommodation code 169 have not changed in how they are paid or billed. Please refer to the Administrative Days Level 1 document from the Medi-Cal’s Provider Manual Part 2- Inpatient Services (IPS-Administrative Days (admin) section) in the Publications tab or directly at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/admin_i00.doc for up to date information.

• Level 2: This is a new level, similar to level 1, except at a higher rate for higher acuity patients. Administrative day level 2 care is defined as care that is less intensive than acute care, and more intensive than level 1. Placement efforts, just as for Level 1 days, must be documented by the hospital:

  Administrative day level 2 revenue codes 190 (sub-acute pediatric) and 199 (sub-acute adult) are available for payment only to DRG hospitals. The pediatric level is used when the beneficiary is less than 21 years old. Administrative day level 2 requires a daily TAR and submission of a claim separate from the DRG claim. Payment for administrative day level 2 is the lower of the hospital-specific rate already established and the statewide rate. As of July 1, 2015, Year 3 statewide per diem rates are $981.63 (pediatric) and $805.82 (adult). Payment works the same as revenue code 169 relative to bundling policies and separate payment for ancillary services.

Refer to the Provider Manual, Administrative Days section for rate information.

The previous list of separately payable services that can be billed in conjunction with administrative days is unchanged.

105. Who determines administrative days? An onsite nurse?

If available, an onsite nurse will determine administrative days. Otherwise, administrative days will be authorized by a daily TAR.
106. If a daily TAR is required for administrative days and there is a 14-30 day wait time for TARs, what is the risk of having a patient in an administrative day and not receiving an approved TAR?

The TAR volume is decreasing, which may allow the turnaround time to decrease. Risk of a denial is the same as it was previously.

107. "Discharge from acute" and readmit are referred to as "admin." Does this mean an actual discharge and readmit in the hospital electronic health record (EHR) systems?

No. The stay is considered one continual hospital stay with different levels of care within it. However, it is two separate claims for billing purposes and requires two separate TARs.

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

Implementation of DRG payment did not affect health screening requirements for newborns. Additional information on the existing process for newborn health screens is available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/newborn_a02a08i00o03o11m01.doc.

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

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

OTHER QUESTIONS

110. How did the change to DRG payment affect the overall payment level?

The change to DRGs was a change in payment method, not payment level. The overall payment level continues to be determined each year through the legislative appropriation process.

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

Because there was a major change in the payment method, some hospitals saw decreases in payments while other hospitals saw increases. There is a transition period of three years. See Questions 3 and 19.

112. Are DRG payments subject to adjustment after cost reports have been submitted?

In general, payments are not subject to adjustment after the DRG payment has been made. That also applies to hospitals that were non-contract prior to July 1, 2013, and to hospitals classified by Medicare as critical access. The Department reserves the right to audit claims if appropriate. For example, the Department may audit stays that receive an outlier payment, have restricted benefit aid codes, or inappropriate coding.

113. Do hospitals still have to submit cost reports?

Yes. The Department utilizes cost reports for a variety of purposes, including calculation of hospital utilization fees, establishing a cost-to-charge ratio (CCR) used in DRG outlier payment policy, and review of hospital payments overall.
114. Does the Medicare 3-day rule also apply to APR-DRGs?

No. In addition, there is no change to the definition of the current outpatient payment window. Any outpatient acute care services on or within one day of admission cannot be billed separately.

115. Is observation stay status recognized under DRG payment?

Observation is a Medicare outpatient status. Medi-Cal does not recognize observation status. Medi-Cal recognizes a beneficiary as being acute, outpatient or at a lower level of care (Admin Level 1 or 2). DRG payment only applies to acute inpatient care.

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* document are made available, as changes are needed. DHCS has merged the Provider Billing FAQ that contained information specific to billing and TAR/SAR issues FAQ into this FAQ.

- **DRG Pricing Calculator.** The DRG Pricing Calculator interactive spreadsheet does not assign the APR-DRG, but it demonstrates how a given APR-DRG is priced in different circumstances. The calculator includes a complete list of APR-DRGs and related information for use in California. Please select the appropriate DRG calculator based on admission date within the appropriate fiscal year.

- **Hospital training sessions.** Hospital trainings were held across the state prior to DRG implementation and since implementation. If additional training is needed, please contact the Medi-Cal Telephone Service Center (TSC) 1-800-541-5555 or email DRG@dhcs.ca.gov.

- **Provider Bulletins.** Provider bulletins contain additional details on specific areas of DRG billing, payment, and TAR/SAR authorizations.

Other key resources are as follows:

- **Questions:** For policy questions, please email the DRG mailbox at DRG@dhcs.ca.gov. Please be sure not to 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 http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp.

- **Recorded trainings.** Providers may access recorded trainings on the Xerox Provider training site (login, then go to Training > Recorded Webinars) or go to https://learn.medical.ca.gov/Login/tabid/87/Default.aspx?returnurl=%2fTraining%2fRecordedWebinars.aspx.