

Medi-Cal DRG Payment Method

Frequently Asked Questions for SFY 2016-17

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 2016-17, which is Year 4 of the DRG payment method.

This July 28, 2016, version of the FAQ captures the current status of DRG payment as it reaches full implementation of statewide base rates effective July 1, 2016. For information about SFYs 2013-14, 2014-15, and 2015-16, 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 Group (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 FAQ was written by staff from the California Department of Health Care Services and Xerox, which advises the Department on DRG payment as part of its role as the Medi-Cal fiscal intermediary. Please also note that nothing in this document supersedes applicable laws, regulations, and policies.

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OVERVIEW QUESTIONS

1. When was payment by DRGs implemented for Medi-Cal? 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 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.

2. 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. Non-designated public hospitals (NDPH) transitioned to DRG payment as of January 1, 2014. 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 46.

3. Are DRGs budget neutral?

Implementation of DRGs was 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. Base rates are set each state fiscal year (SFY) with a budget target that is budget neutral.

4. 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 41)
- Physical rehabilitation stays (see Question 46)
- Administrative days (see Question 46)

5. 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 Questions 37 and 38 for more information on billing and authorizations for CCS and GHPP patients.

6. 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. Nearly half of Medicaid programs 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.

DRG PAYMENT

7. 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.

8. 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.

9. How is the DRG assigned? How can my hospital replicate DRG assignment?

Medi-Cal’s CA-MMIS claims payment system uses the 3M™ All Patient Refined Diagnosis Related Group 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 one of 314 base APR-DRGs, 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.

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 1 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 SFY on the DHCS webpage for more detailed information; these documents explain the correct grouper, mapper, and healthcare-acquired conditions (HAC) utility versions to use based on claim dates.

DRG Payment Year	APR-DRG Grouper Version	SFY	Claim Admission Date Ranges
Year 1	V.29	SFY 2013-14	7/1/13 – 6/30/14
Year 2	V.31	SFY 2014-15	7/1/14 – 6/30/15
Year 3	V.32	SFY 2015-16	7/1/15 – 6/30/16
Year 4	V.33	SFY 2016-17	Beginning 7/1/16

10. Are the DRG groups published?

Yes. The list of DRGs is available within the DRG Pricing Calculators located within each SFY pricing folder on the DHCS DRG web page on the “DRG Table” tab of the calculators.

The 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.

11. 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 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 SFY 2016-17, the relative weights reflect hospital-specific relative value (HSRV) weights of V.33 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.

12. What is the DRG base rate?

The DRG base rate is used in the DRG payment calculation as described in Question 8. For SFY 2016-17, there are two base rates – statewide (\$6,320) and remote rural (\$12,832) — applied to each hospital based on its status. The Medi-Cal DRG base rate is the same concept as the Medicare DRG standardized amount.

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 13). In the Los Angeles area, for example, a typical SFY 2016-17 statewide base rate is \$7,468.

Hospitals can see their SFY 2016-17 DRG base rates on the DHCS DRG webpage, under “Pricing Resources: SFY 2016/17.”

For the first three years of DRG payment, over two thirds of California hospitals were paid using hospital-specific transition base rates, which were intended to buffer the impact of the change in payment methods. This transition period ended July 1, 2016.

13. 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. Wage areas are updated by Medicare to reflect differences in wages based on geographic locale.

DHCS uses hospital-specific wage area index values 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 wage area index value (WI) that corresponds to the hospital's physical location. For SFY 2016-17, the Medicare values have been multiplied by an adjustment factor of 0.9690. 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:

$$(\text{Statewide base rate} \times \text{WI} \times \text{labor share of WI} \times \text{adjustment factor}) + (\text{Statewide base rate} \times \text{non-labor share of WI})$$
$$(\$6,320 \times 1.3012 \times 69.6\% \times 0.9690) + (\$6,320 \times 30.4\%) = \$7,468$$

14. What other payment policies affect payment methods?

For most stays, payment is made using a "straight DRG" calculation — that is, payment equals the DRG relative weight times the DRG base rate, as described in Question 8. In special situations, payment may also include other adjustments, for example:

- *Policy adjustors.* Relative weights for neonatal, pediatric, and obstetric stays are adjusted upward in order to facilitate access to care.
- *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 16 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 specific to each SFY in the pricing folders 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.

15. How can hospitals earn the enhanced designated NICU policy adjustor for a NICU inpatient admission?

For a hospital to receive the enhanced designated NICU policy adjustor of 1.75 (vs. the 1.25 adjustor at other hospitals performing inpatient NICU services), 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 annual or as necessary reviews 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, then 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.

See SPA 16-011 for more information (pending federal approval). Check the hospital characteristics file on the DRG webpage to check if a hospital is a designated NICU.

16. 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. 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. See the DRG calculator on the DHCS webpage 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 adjustment applies to only the first hospital.

17. What changes were made for SFY 2016-17?

See Table 2 for a comparison of DRG payment policy between SFYs 2013-14, 2014-15, 2015-16, and 2016-17. The Department has kept the payment method as stable as possible over these four years. The changes for SFY 2016-17 are technical in nature rather than policy oriented.

Table 2 Summary of DRG Payment Policies from Year 1 (SFY 2013-14) to Year 4 (SFY 2016-17)				
Payment Policy	Year 1 Value (SFY 2013-14)	Year 2 Value (SFY 2014-15)	Year 3 Value (SFY 2015-16)	Year 4 Value (SFY 2016-17)
DRG Base Rates				
DRG base rate, statewide	\$6,223	\$6,289	\$6,289	\$6,320
DRG base rate, remote rural hospitals	\$10,218	\$10,640	\$12,768	\$12,832
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	Statewide DRG base rate adjusted for Medicare FFY 2016 wage area values and the 0.9690 factor
Payment to transition hospitals	Hospital-specific, as shown in separate document ¹	Hospital-specific, as shown in separate document ²	Hospital-specific, as shown in separate document ³	No longer applicable ⁴
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.	Similar to Medicare, reflecting a labor share of 69.6%, then adjusted by a 0.9690 factor to neutralize CA changes compared to U.S.
Adjustment to base rates for improved documentation, coding and capture of diagnoses and procedures	-3.50%	None	None	None
DRG Grouper				
DRG version	APR-DRG V.29	APR-DRG V.31	APR-DRG V.32	APR-DRG V.33
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)	APR-DRG V.33 (national, HSRV)

Table 2 Summary of DRG Payment Policies from Year 1 (SFY 2013-14) to Year 4 (SFY 2016-17)				
Payment Policy	Year 1 Value (SFY 2013-14)	Year 2 Value (SFY 2014-15)	Year 3 Value (SFY 2015-16)	Year 4 Value (SFY 2016-17)
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)	APR-DRG V.33 (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)	FYE 2014 cost report (some exceptions may apply)
High side (provider loss) tiers and marginal cost (MCoSt) percentages ⁵	\$0-\$40,000: no outlier payment	\$0-\$42,040: no outlier payment	\$0-\$45,000: no outlier payment	\$0-\$46,800: 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	\$46,801 to \$150,800: MCoSt = 0.60
	>\$125,000: MCoSt = 0.80	>\$131,375: MCoSt = 0.80	>\$145,000: MCoSt = 0.80	>\$150,800: 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	\$0-\$46,800: no outlier reduction
	>\$40,000: MCoSt = 0.60	>\$42,040: MCoSt = 0.60	>\$45,000: MCoSt = 0.60	>\$46,800: MCoSt = 0.60
Other Payment Policies				
Policy adjustor – neonate at designated NICU	1.75	1.75 (No change)	1.75 (No change)	1.75 (No change)
Policy adjustor – neonate at other NICU	1.25	1.25 (No change)	1.25 (No change)	1.25 (No change)
Policy adjustor – obstetric	n/a	n/a	1.06	1.06
Policy adjustor – pediatric miscellaneous, pediatric respiratory	1.25	1.25 (No change)	1.25 (No change)	1.25 (No change)
Pediatric age cutoff	<21	<21 (No change)	<21 (No change)	<21 (No change)
Discharge status values for the transfer adjustment ⁵	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 ⁶	02, 05, 63, 65, 66, 82, 85, 91, 93, and 94
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. For SFY 2016-17, all California DRG hospitals receive the statewide of remote rural base rate, adjusted for wage area. For hospital-specific DRG base rates, see “SFY 16/17 Hospital Characteristics File.”				
5. Outlier thresholds have been increased to reflect the latest available data on hospital charge inflation.				
6. 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.				
7. 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 .				
8. FYE = Fiscal year ending				

HOSPITAL CHARACTERISTICS

18. What is the easiest way for a provider to determine if it is a private or public hospital?

Please see the Hospital Characteristics Files in the pricing folders specific to each SFY 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.

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

Yes. Each hospital's cost-to-charge ratio (CCR) is included in the Hospital Characteristics Files on the DHCS DRG webpage specific to each year of DRG payment. See Question 9 for the dates of admission that correspond to each year of DRG payment.

20. What is the wage area and 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 1.000. DHCS applies the California default CCR calculated by Medicare to hospitals. The OOS CCR for FFY 2016 is 21.6%, down from 21.8% in FFY 2015.

CODING AND BILLING

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

Table 3 shows the most significant billing changes that occurred July 1, 2013, when DRG payment was implemented.

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)	
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.
TAR/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 CCS and GHPP recipients. 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 Question 34 and 38.
Increased importance of diagnosis and procedure coding	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 22.
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.
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 birth weight is a critical input to the APR-DRG assignment. Diagnosis codes should also be used to report gestational age where applicable. ICD-10-CM codes include the ability to indicate birth weight 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 45. For newborn claims, please be sure to consistently use the mother's or baby's beneficiary identification number <u>for all claims related to a single stay</u> . See Question 32.
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 46.
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 46.
Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes). See Question 24.
Separately payable services, supplies, and devices	In the few situations where separate payment is allowed, a separate outpatient claim should be submitted. See Question 27.
Late charges (bill type 115) not accepted	Void and resubmit the original claim instead.

Table 3 Impacts on Hospital Billing and Operations Because of the Change to DRG Payment July 1, 2013	
Item	Comment
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 25.
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).
CCS Patients with Medi-Cal 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 SAR or TAR is required. Daily authorization is required if the patient has a restricted benefit aid code. See Questions 37 and 38.
CCS patients with Medi-Cal MC	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 37 and 38.

22. 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.

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

Consistent with federal requirements, DHCS implemented V.30 of the HAC utility on July 1, 2013, to ensure payments are only made for provider-preventable conditions that were 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, which can be found at http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.

24. 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. These values are used to identify health care-acquired conditions (HCAC) by the HAC utility (Question 25). 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>.

25. 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 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.)

26. Does 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.

27. 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 under the previous payment method. 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 to an inpatient. 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; note that the additions to this list effective July 1, 2015, can be billed on an outpatient claim. All other services provided to an inpatient are bundled with the DRG payment.

Table 4		
Separately Payable Services That Can Be Billed on an Outpatient Claim		
Description	CPT / HCPCS Code Effective July 1, 2013-June 30, 2015	CPT / HCPCS Code Effective July 1, 2015 ¹
Bone Marrow Search and Acquisition Costs		
Management of recipient hematopoietic progenitor cell donor search and cell acquisition	38204	38204
Unrelated bone marrow donor	38204	38204
Blood Factors		
Blood Factor XIII (antihemophilic factor, Corifact)	J7180	J7180
Blood Factor XIII (antihemophilic factor, Tretten)		C9134
Blood Factor Von Willebrand- Injection	J7183 / J7184 / Q2041	J7183 / J7184 / Q2041
Blood Factor VIII	J7185 / J7190 / J7192	J7185 / J7190 / J7192
Blood Factor VIII/Von Willebrand	J7186	J7186
Blood Factor Von Willebrand	J7187	J7187
Blood Factor VIIa	J7189	J7189
Blood Factor IX	J7193 / J7194 / J7195	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197	J7197
Blood Factor Antiinhibitor	J7198	J7198
Hemophilia clotting factor, not otherwise classified		J7199
Long-Acting Reversible Contraception (LARC) Methods		
Intrauterine copper (Paraguard)		J7300
Skyla		J7301
Levonorgestrel-releasing intrauterine contraceptive system (Mirena)		J7302
Etonogestrel (Implanon, Nexplanon)		J7307
Note: 1. Procedure codes C9134, J7199, J7300, J7301, J7302, and J7037, can be billed separately as of July 1, 2015.		

28. 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 checkwrite through the Remittance Advice Details (RAD). See Question 45 for a detailed explanation of interim claim billing.

29. How does the 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 will use this information in pricing the claim under the DRG payment method.

PEDIATRICS/NEWBORNS/NEONATAL INTENSIVE CARE UNITS (NICUs)

30. What is the age definition for pediatric?

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

31. What revenue code is 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 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").

32. 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-thru-discharge claim under the baby's ID.

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

The baby is a normal newborn or a neonate (sick baby). 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. NICU designations can be found in the Hospital Characteristics Files on the DHCS DRG webpage.

TREATMENT AUTHORIZATION REQUEST (TAR)

34. 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 that SAR is specific to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) recipients.

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

- Continuation of the 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), regardless of aid code. If a well-baby 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-baby 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 38.
- Claims in which Medi-Cal is the secondary payer with other health coverage (OHC) as primary 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 46).
- 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 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 its own utilization management system 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.

35. How should 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.

36. 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 is approved on a TAR, providers should bill with all of the charges, procedure codes, and diagnoses 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 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. It is possible that denied days may not actually affect payment.

SERVICE AUTHORIZATION REQUEST (SAR) FOR CALIFORNIA CHILDREN'S SERVICES (CCS)

37. Are inpatient claims for CCS-only patients processed using the 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.

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

CCS and Medi-Cal FFS: As mentioned in Question 5, 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. 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 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.

Well-baby stays do not require an admission SAR; however, If a well-baby becomes sick, an admission SAR is required.

Acute inpatient intensive rehabilitation stays require daily SARs. See Question 46.

39. Is the entire medical record 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?

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.

40. If a newborn is using the mother's BIC/CINID 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?

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. If the baby has eligibility, then submit the claim under the baby's ID.

MANAGED CARE PLANS

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

Medi-Cal MCPs use the 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 statewide or remote rural DRG base rate (wage adjusted). The hospital-specific base rates are shown on the Hospital Characteristics tab in the DRG Pricing Calculator available on the DHCS DRG webpage. For previous fiscal years, see the Hospital Characteristics Files on the DRG web page 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. Calculation of DRG payment, then follows the same logic described in Question 8.

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. (Note that some plans have chosen to adopt the Medi-Cal FFS 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 DRG webpage. It provides more detailed information regarding MCP payment for emergency and post-stabilization inpatient services by out-of-network hospitals.

42. 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 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

43. 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. 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.

44. 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?

There is no process to appeal the 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 fiscal year are located on the DRG website under the Pricing Resources folder for each fiscal year.

45. 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.

46. What other types of services are not paid by 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 TAR/SAR requirements.

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 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's hospital characteristics file.

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's hospital characteristics file.

OTHER QUESTIONS

47. Are hospitals required to submit cost reports? Are DRG payments subject to adjustment after cost reports have been submitted?

Hospitals are required to submit cost reports, which the Department uses for a variety of purposes, including calculation of hospital utilization fees, establishing a 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 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.

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. This version of the FAQ represents the policies, rates, and decisions for Year 4 of DRG payment. For previous versions of the FAQ that applies to the first three years of DRG payment, see the Year 3 FAQ on the DHCS DRG web page under “Pricing Resources: 2015/16.”
- *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 by appropriate fiscal year.
- *Hospital characteristics.* The Hospital Characteristics File, which can also be found as a separate tab on the DRG Pricing Calculator, provides relevant information about all California DRG hospitals, including DPH/NDPH status, NICU designation, remote rural status, wage area assignment, base rates, CCRs, and rates for rehabilitation and administrative days Level 2. The files for each fiscal year are available in the Pricing Resources pages.
- *Grouper settings.* The grouper settings documents for each SFY 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 TAR/SAR 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 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>.