



CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

**MEDI-CAL DIAGNOSIS RELATED  
GROUP PAYMENT METHOD  
FREQUENTLY ASKED QUESTIONS  
FOR STATE FISCAL YEAR 2017-18**

Prepared by Conduent for the Medi-Cal DRG Project

Version 1



## FOR STATE FISCAL YEAR 2017-18

### Document Version History

Version	Date	Author	Edits/Comments
1	07/06/2017	DHCS DRG Section / Conduent Payment Method Development	New questions added and brought over from original format to DHCS template

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# Medi-Cal Diagnosis Related Group Payment Method

## Frequently Asked Questions for State Fiscal Year 2017-18

Beginning July 1, 2013, Medi-Cal has paid for most hospital inpatient services received by fee-for-service beneficiaries using Diagnosis Related Groups (DRG). This Frequently Asked Questions (FAQ) provides updated information applicable to State Fiscal Year (SFY) 2017-18, which is Year 5 of the DRG payment method.

This July 2017 version of the FAQ captures the current status of DRG payment effective July 1, 2017. For information about previous SFYs 2013-14, 2014-15, 2015-16, and 2016-17, 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 FAQs are written by staff from DHCS and Conduent, which advises DHCS 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, or policies.

## Contents

<b>Medi-Cal DRG Payment Method</b> .....	<b>iii</b>
Frequently Asked Questions for SFY 2017-18.....	iii
Overview Questions.....	7
1. When was payment by DRGs implemented for Medi-Cal? What are the goals of DRG payment? .....	7
2. Which hospitals are paid by DRG? .....	7
3. Are DRGs budget neutral?.....	7
4. What services are affected? .....	7
5. Do DRGs affect California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP) patients? .....	8
6. Who else uses DRG payment?.....	8
DRG Payment.....	8
7. What are the characteristics of DRG payment? .....	8
8. How do DRG payment methods work? .....	9
9. How is the DRG assigned? How can my hospital replicate DRG assignment? .....	9
10. Are the DRG groups published? .....	10
11. Where do the DRG relative weights come from? .....	10
12. What is the DRG base rate? .....	11
13. What are wage area index values and how are they used?.....	11
14. What is the wage area index neutrality factor and how is it used in the DRG payment method? .....	12
15. What other payment policies affect payment methods?.....	12
16. How can hospitals earn the enhanced designated Neonatal Intensive Care Unit (NICU) policy adjustor for a NICU inpatient admission? .....	13
17. If a patient is transferred, do you get the full DRG payment? .....	13
18. What changes were made for SFY 2017-18? .....	14
Hospital Characteristics .....	21
19. How can a provider determine if a hospital is private or public? .....	21
20. How are CCRs assigned each year and used in ratesetting? Which cost reports are used?.....	21
21. Is the cost-to-charge ratio (CCR) published? .....	21



## FOR STATE FISCAL YEAR 2017-18

22. What is the wage area and CCR for an out-of-state (OOS) hospital? Is this Medicare defined? .....	22
Coding and Billing .....	22
23. What are the most important billing points under DRG payment? .....	22
24. How many diagnoses and procedures are used in DRG assignment? Why is this important? .....	24
25. Did DHCS implement adjustments based on provider-preventable conditions (PPC) concurrent with DRG implementation? .....	25
26. Is the present-on-admission (POA) indicator required? Is the Medi-Cal POA the same as Medicare POA? .....	25
27. How is payment affected if a health care-acquired condition (HCAC) is present on the claim? .....	25
28. Does the reporting of present-on-admission (POA) indicators eliminate the need to complete the Medi-Cal Provider-Preventable Conditions Reporting Form? .....	26
29. Are outpatient services related to the inpatient stay bundled? .....	26
30. In an interim claims scenario, does a provider need to do anything to clarify that it is not double billing? .....	28
31. How does the DRG payment method affect patients dually eligible for Medi-Cal and Medicare? .....	28
Pediatrics/Newborns/Neonatal Intensive Care Units (NICUS) .....	28
32. What is the age definition for pediatric? .....	28
33. What revenue code is required for well newborn claims? .....	28
34. 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? .....	29
35. What defines a neonate at hospitals that are not designated NICUs? .....	29
Treatment Authorization Request (TAR) .....	29
36. How does DRG payment fit with the Treatment Authorization Request (TAR) and Service Authorization Request (SAR) processes? .....	29
37. How should TARs be submitted? .....	31
38. How will DHCS handle restricted benefit aid code stays where at least one day was denied, and payment was affected? .....	31
Service Authorization Request (SAR) For California Children's Services .....	31



## FOR STATE FISCAL YEAR 2017-18

39. Are inpatient claims for CCS-only patients processed using the DRG payment method? .....	31
40. What is the impact on billing and the TAR/SAR process for CCS patients? .	31
41. 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? .....	32
42. 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? .....	32
Managed Care Plans (MCPs) .....	33
43. Are payments by Medi-Cal MCPs affected? .....	33
44. How is payment calculated if a patient has Medi-Cal managed care (MC) in the first part of the stay and later becomes FFS? .....	33
APPEALS .....	34
45. 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? .....	34
46. The APR-DRG Pricing Calculator instructions indicate that in the case of a difference in the APR-DRG assignment, the claims processing system should be considered correct. Is there a process to appeal the APR-DRG assignment if the provider still believes they are correct? .....	34
47. How are interim claims paid? .....	35
48. What other types of services are not paid by DRG? Where is information available on administrative days and rehabilitation days? .....	35
Other Questions.....	36
49. Are hospitals required to submit cost reports? Are DRG payments subject to adjustment after cost reports have been submitted? .....	36
50. What are the cost report submission requirements? What is the cost report used for?.....	36
51. What is outlier recalculation? Why is DHCS pursuing outlier recalculation? .	37
FOR FURTHER INFORMATION: .....	38



### Overview Questions

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

As directed by the California legislature, on July 1, 2013, the Department of Health Care Services implemented a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program based on All Patient Refined Diagnosis Related Groups (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 Diagnosis Related Groups (DRG)?**

DRG payment applies to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals and long-term care hospitals. Non-designated public hospitals transitioned to DRG payment as of January 1, 2014. Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals (such as the University of California) are outside the scope of DRG-based payment. With regard to rehabilitation hospitals and services, see Question 48.

**3. Are Diagnosis Related Groups (DRGs) budget neutral?**

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

**4. What services are affected?**

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

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Medi-Cal managed care stays (see Question 43)
- Physical rehabilitation stays (see Question 48)
- Administrative days (see Question 48)

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

Yes. Claims for eligible beneficiaries under CCS or the GHPP are priced using the DRG method. This is true regardless of whether the beneficiaries also have Medi-Cal fee-for-service or Medi-Cal Managed Care (in CCS carve out counties only). See Questions 39 and 40 for more information on billing and authorizations for CCS and GHPP patients.

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

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

## Diagnosis Related Group Payment

### 7. What are the characteristics of Diagnosis Related Group (DRG) payment?

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

Medi-Cal DRG payment has had a two tier outlier policy since inception. Since the outlier policy is dependent on hospital-specific charges, and calculated costs, the outlier policy must be carefully monitored, so it does not skew incentives for efficiency inherent in a DRG payment method. Please see Question 18 for more information on changes to the outlier policy for State Fiscal Year 2017-18.



### **8. How do Diagnosis Related Group (DRG) payment methods work?**

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

The DRG relative weight is multiplied by a DRG base rate and any relevant policy adjustors to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base rate is \$8,000, then the payment rate for that DRG is \$4,000, before accounting for any policy adjustors.

### **9. How is the Diagnosis Related Group (DRG) assigned? How can my hospital replicate DRG assignment?**

Medi-Cal's California Medicaid Management Information System claims payment system uses the 3M™ All Patient Refined Diagnosis Related 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 or so base APR-DRGs (this number can change due to annual changes in the APR-DRG algorithm), 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 Department of Health Care Services' webpage for more detailed information; these documents explain the correct grouper, mapper, and healthcare-acquired conditions utility versions to use based on claim dates.

Table 1

Medi-Cal APR-DRG Versions by Claim Admission 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	7/1/16 – 6/30/17
Year 5	V.34	SFY 2017-18	7/1/17 – 6/30/18

**10. Are the Diagnosis Related Group (DRG) groups published?**

Yes. The list of DRGs is available within the DRG Pricing Calculators located within each state fiscal year pricing folder on the Department of Health Care Services’ DRG webpage on the “DRG Table” tab of the calculators.

The All Patient Refined Diagnosis Related Group (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 Diagnosis Related Group (DRG) relative weights come from?**

The Department of Health Care Services uses All Patient Refined Diagnosis Related Group (APR-DRG) relative weights calculated by 3M from the National Inpatient Sample. Each DRG is assigned a relative weight, which reflects a hospital’s typical resources used for the level of care provided. Each DRG also has four levels of severity; the relative weight of the DRG generally increases as severity increases, resulting in a higher payment. There are a few exceptions – particularly when the most extreme severity indicates that patient death is likely early in the stay.

An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal FFS data. The national weights are updated annually by 3M Health Information Systems. For State Fiscal Year 2017-18, the relative weights reflect hospital-specific relative value (HSRV) weights of V.34 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 Diagnosis Related Group (DRG) base rate?

The DRG base rate is used in the DRG payment calculation as described in Question 8. For State Fiscal Year (SFY) 2017-18, there are two base rates – statewide (\$6,760) and remote rural (\$12,832) — applied to each hospital based on its remote rural status. The Medi-Cal DRG base rate is the same concept as the Medicare DRG standardized amount.

For each hospital, the 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, once adjusted for local area wages, a typical SFY 2017-18 statewide base rate is \$7,936.

Hospitals can see their SFY 2017-18 DRG base rates on the Department of Health Care Services' DRG webpage, under "Pricing Resources: SFY 2017/18."

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

DHCS uses hospital-specific wage area index values (WI) as shown on the Medicare Impact File, including reclassifications where appropriate. For children's hospitals, critical access hospitals, and other hospitals not included in the Medicare Impact File, DHCS uses the WI that corresponds to the hospital's physical location. For State Fiscal Year 2017-18, the Medicare values have been multiplied by an adjustment factor of 0.9792. 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:

***(Statewide base rate x WI x labor share of WI x adjustment factor) +  
(Statewide base rate x non-labor share of WI)***

***(\$6,760 x 1.2766 x 69.6% x 0.9792) + (\$6,760 x 30.4%) = \$7,936***

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

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

### 15. What other payment policies affect payment methods?

For most stays, payment is made using a “straight Diagnosis Related Group (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 17 and the DRG Pricing Calculator on the Department of Health Care Services’ (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. Historically, Medi-Cal had a two-tier outlier policy for Years 1 through 4 of DRG payment. As of Year 5, a single tier outlier policy is in effect. For a small number of stays that are exceptionally profitable for a hospital, Medi-Cal also has a “low-side” outlier policy that reduces payment; this low-side outlier has been single-tiered since Year 1. 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 (OHC) and patient cost-sharing.* The calculations described above determine the allowed amount. From the allowed amount, Medi-Cal deducts payments from OHC (e.g., workers’ compensation, etc.) as well as the patient’s share of cost. Implementation of the DRG payment method did not affect these deductions.

### **16. How can hospitals earn the enhanced designated Neonatal Intensive Care Unit (NICU) policy adjustor for a NICU inpatient admission?**

For a hospital to receive the enhanced designated NICU policy 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 reviews annually or as necessary to determine whether a hospital continues to meet all applicable neonatal surgery standards. If the CCS NICU-surgery approval/status of a hospital is revoked or otherwise terminated, the hospital will no longer receive the enhanced designated NICU policy adjustor, effective the date status ceases. Inpatient NICU DRG admissions at non-designated NICUs receive the 1.25 policy adjustor.

See State Plan Amendment 17-015 for more information. Check the Hospital Characteristics File on the Department of Health Care Services’ Diagnosis Related Group webpage to check if a hospital is a designated NICU.

### **17. If a patient is transferred, do you get the full Diagnosis Related Group (DRG) payment?**

It depends on when the beneficiary is discharged from the other hospital. Each hospital will receive a DRG payment. However, payment to the first hospital may be subject to a transfer adjustment depending on the length of stay. The receiving hospital would receive full DRG payment. If a beneficiary is not discharged, sent to a second hospital for a procedure and then returns to the original hospital, the original hospital would receive a single DRG payment. It would be the responsibility of the original hospital to negotiate payment to the second hospital; the second hospital would not receive a DRG payment and should not bill

## FOR STATE FISCAL YEAR 2017-18

Medi-Cal. See the DRG Pricing Calculator on the DHCS DRG 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. Additional information on TARs/SARs, see Questions 36 and 37.

### **18. What changes were made for State Fiscal Year (SFY) 2017-18?**

See Table 2 for a comparison of Diagnosis Related Group (DRG) payment policy between SFYs 2013-14, 2014-15, 2015-16, 2016-17, and 2017-18. The Department of Health Care Services kept the payment method as stable as possible over the first four years. Policy changes for SFY 2017-18 address the upward trend of payment made for outliers by simplifying to a single-tier high outlier policy and increasing non-remote rural base rates. (The remote rural base rate is already higher to address the unique needs of those hospitals.) Because outliers also rely on hospital-specific cost-to-charge ratios, this reduces the sensitivity of the payment method to hospital cost reports and charge practices. Additionally, the pediatric policy adjustor was raised to 1.45 from 1.25, which offset the change to the outlier policy on payment for pediatric stays.

Table 2

Summary of Five Years of Diagnosis Related Group (DRG) Payment Policy					
Payment Policy	Year 1 Values (State Fiscal Year [SFY] 2013- 14)	Year 2 Values (SFY 2014-15)	Year 3 Values (SFY 2015-16)	Year 4 Values (SFY 2016-17)	Year 5 Values (SFY 2017-18)
<b>DRG Base Rates</b>					
DRG base rate, statewide	\$6,223	\$6,289	\$6,289	\$6,320	\$6,760
DRG base rate, statewide (remote rural hospitals)	\$10,218	\$10,640	\$12,768 (Set at 95% of aggregate cost)	\$12,832 (Set at 95% of aggregate cost)	\$12,832 (Still achieves 95% of aggregate cost)
Payment to non-transition hospitals	Statewide DRG base rate adjusted for Medicare Federal Fiscal Year (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 wage area neutrality factor	Statewide DRG base rate adjusted for Medicare FFY 2016 wage area values and the 0.9690 wage area neutrality factor	Statewide DRG base rate adjusted for Medicare FFY 2017 wage area values and the 0.9792 wage area neutrality factor
Payment to transition hospitals	Hospital-specific, as shown in separate document <sup>1</sup>	Hospital-specific, as shown in separate document <sup>2</sup>	Hospital-specific, as shown in separate document <sup>3</sup>	Transition has ended as expected; all hospitals at non- remote rural and remote rural statewide rates	n/a



**FOR STATE FISCAL YEAR 2017-18**

<b>Summary of Five Years of Diagnosis Related Group (DRG) Payment Policy</b>					
<b>Payment Policy</b>	<b>Year 1 Values (State Fiscal Year [SFY] 2013- 14)</b>	<b>Year 2 Values (SFY 2014-15)</b>	<b>Year 3 Values (SFY 2015-16)</b>	<b>Year 4 Values (SFY 2016-17)</b>	<b>Year 5 Values (SFY 2017-18)</b>
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 0.9797 to neutralize CA changes compared to U.S.	Similar to Medicare, reflecting a labor share of 69.6%, adjusted by 0.9690 to neutralize CA changes compared to U.S.	Similar to Medicare, reflecting a labor share of 69.6%, adjusted by 0.9792 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	None	None





FOR STATE FISCAL YEAR 2017-18

Summary of Five Years of Diagnosis Related Group (DRG) Payment Policy					
Payment Policy	Year 1 Values (State Fiscal Year [SFY] 2013- 14)	Year 2 Values (SFY 2014-15)	Year 3 Values (SFY 2015-16)	Year 4 Values (SFY 2016-17)	Year 5 Values (SFY 2017-18)
Border hospitals	Treated as out-of-state hospitals with default statewide rates, CCR and wage areas	Treated as out-of-state hospitals with default statewide rates, CCR and wage areas	State Plan Amendment (SPA) 15-020 for all border hospitals for 7/1/15 to 12/20/15. Court order for Asante plaintiffs and SPA-15-020 for other border hospitals for 12/21/15 to 6/30/16.	Court order for Asante plaintiffs; SPA-15-020 for other border hospitals	Court order for Asante plaintiffs; SPA15-020 for other border hospitals
<b>DRG Grouper</b>					
DRG version	All Patient Refined Diagnosis Related Group (APR-DRG) V.29	APR-DRG V.31	APR-DRG V.32	APR-DRG V.33	APR-DRG V.34
DRG relative weights	All Patient Refined Diagnosis Related Group (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 weights are unchanged from V.32	APR-DRG V.34 national HSRV weights



## FOR STATE FISCAL YEAR 2017-18

Summary of Five Years of Diagnosis Related Group (DRG) Payment Policy					
Payment Policy	Year 1 Values (State Fiscal Year [SFY] 2013- 14)	Year 2 Values (SFY 2014-15)	Year 3 Values (SFY 2015-16)	Year 4 Values (SFY 2016-17)	Year 5 Values (SFY 2017-18)
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), unchanged from V.32	APR-DRG V.34 (arithmetic, untrimmed)
<b>Outlier Policy Factors</b>					
Hospital-specific cost-to-charge ratios (CCR)	Most recent CCR 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)	FYE 2015 cost report (some exceptions may apply)
High side (provider loss) tiers and marginal cost (MCost) percentages <sup>3</sup>	\$0-\$40,000: no outlier payment	\$0-\$42,040: no outlier payment	\$0-\$45,000: no outlier payment	\$0-\$46,800: no outlier payment	\$0-\$60,000: no outlier payment
	\$40,001 to \$125,000: MC=0.60	\$42,041 to \$131,375: MC=0.60	\$45,001 to \$145,000: MC=0.60	\$46,801 to \$150,800: MC=0.60	>\$60,000; MC=0.50
	>\$125,000: MCost = 0.80	>\$131,375: MCost = 0.80	>\$145,000: MCost = 0.80	>\$150,800: MCost = 0.80	n/a (paid at MC=0.50)
Low side (provider gain) tiers and marginal cost percentages <sup>3</sup>	\$0-\$40,000: no outlier reduction	\$0-\$42,040: no outlier reduction	\$0-\$45,000: no outlier reduction	\$0-\$46,800: no outlier reduction	\$0-\$60,000: no outlier reduction
	>\$40,000: MCost=0.60	>\$42,040: MCost=0.60	>\$45,000: MCost=0.60	>\$46,800: MCost=0.60	>\$60,000; MC=0.50



FOR STATE FISCAL YEAR 2017-18

Summary of Five Years of Diagnosis Related Group (DRG) Payment Policy					
Payment Policy	Year 1 Values (State Fiscal Year [SFY] 2013- 14)	Year 2 Values (SFY 2014-15)	Year 3 Values (SFY 2015-16)	Year 4 Values (SFY 2016-17)	Year 5 Values (SFY 2017-18)
<b>Other Payment Policies</b>					
Policy adjustor – neonate at designated Neonatal Intensive Care Unit (NICU)	1.75	1.75 (No change)	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)	1.25 (No change)
Policy adjustor – obstetric	n/a	n/a	1.06	1.06 (No change)	1.06 (No change)
Policy adjustor – pediatric miscellaneous, pediatric respiratory	1.25	1.25 (No change)	1.25 (No change)	1.25 (No change)	1.45
Pediatric age cutoff	<21	<21 (No change)	<21 (No change)	<21 (No change)	<21 (No change)
Discharge status values for the transfer adjustment	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 <sup>5</sup>	02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 (No change)	02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 (No change)



Summary of Five Years of Diagnosis Related Group (DRG) Payment Policy

Payment Policy	Year 1 Values (State Fiscal Year [SFY] 2013- 14)	Year 2 Values (SFY 2014-15)	Year 3 Values (SFY 2015-16)	Year 4 Values (SFY 2016-17)	Year 5 Values (SFY 2017-18)
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**Notes:**

1. For SFY 2013-14 hospital-specific DRG base rates, see “SPCP Contract Rates” at [WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX](http://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](http://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 transitional and non-transitional hospitals base rates at [WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX](http://WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX).
4. For SFY 2016-17 hospital-specific DRG base rates, see SFY 16/17 Hospital Characteristics File for California, border, and Asante hospitals at [WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX](http://WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX).
5. For SFY 2017-18 hospital-specific DRG base rates, the SFY 17/18 Hospital Characteristics File is available at [WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX](http://WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX).
6. DRG out-of-state border hospital policy per SPA 10-020 and Asante court judgement changed during Year 4; some changes were retroactive and affected Year 3. Current policy is reflected in the table.
7. 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.
8. For details of the pricing logic, APR-DRG groups, and relative weights, see the DRG Pricing Calculators specific to each year of DRG payment at [WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX](http://WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX).



## Hospital Characteristics

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

Please see the State Fiscal Year-specific Hospital Characteristics Files in the pricing folders located on the Department of Health Care Services Diagnosis Related Group webpage, which shows the status for Designated Public Hospitals and Non-Designated Public Hospitals, as well as the status for designated Neonatal Intensive Care Units , and remote rural hospitals.

### 20. How are Cost-to-Charge Ratios (CCRs) assigned each year and used in ratesetting? Which cost reports are used?

The Audit and Review Analysis Division (ARAS) calculates the CCR according to this formula based on fields on the cost report:

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

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

The common practice is to use the reported CCR to pay Diagnosis Related Group claims. In State Fiscal Year (SFY) 2016-17, or year 4 of DRG payment, for example, the reported CCR from FYE 2014 was commonly used for claim payment.

CCRs from the most recently available fiscal year are used in the ratesetting process. For example, the FYE 2016 “as filed” CCR will be used for Year 6 (SFY 2018-19) ratesetting. ARAS provides Safety Net Financing Division with CCRs in October to begin ratesetting simulations for the next fiscal year. Any revised CCRs received by December 31st will be included in the final ratesetting process.

Closely adhering to the cost reporting submission requirements outlined in Question 50 will minimize inaccuracies and time spent in related audit requirements, including outlier recalculation.

### 21. Is the Cost-to-Charge Ratio (CCR) published?

Yes. Each hospital’s CCR is included in the state fiscal year-specific Hospital Characteristics Files on the Department of Health Care Services Diagnosis Related Group webpage. See Question 9 for the dates of admission that correspond to each year of DRG payment.

**22. What is the wage area and Cost-to-Charge Ratio (CCR) for an out-of-state (OOS) hospital? Is this Medicare defined?**

Wage area index values for OOS hospitals are set at the Medicare national average of 1.000. The Department of Health Care Services applies the California default CCR calculated by Medicare to OOS hospitals. The OOS CCR for Federal Fiscal Year (FFY) 2017 is 21.3%, down from 21.6% in FFY 2016.

**Coding and Billing**

**23. What are the most important billing points under Diagnosis Related Group (DRG) payment?**

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

**Table 3**

<b>Impacts on Hospital Billing and Operations Because of the Change to Diagnosis Related Group (DRG) Payment July 1, 2013 (Listed in approximate declining order of impact)</b>	
<b>Item</b>	<b>Comment</b>
Payment is per stay	Under DRG payment, one payment is made per stay. Under the previous method, payment was per day for contract hospitals and at a percentage of cost for non-contract hospitals.
Treatment Authorization Request (TAR)/Service Authorization Request (SAR) process	As of July 1, 2013, TAR/SAR is no longer required on length of stay for the vast majority of days. SAR is specific to California Children’s Services and Genetically Handicapped Persons Program 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 36 and 37.
Increased importance of diagnosis and procedure coding	Assignment of the base All Patient Refined Diagnosis Related Group and level of severity is driven by the number, nature, and interaction of diagnoses and comorbidities as well as procedure codes. See Question 24.
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.

Impacts on Hospital Billing and Operations Because of the Change to Diagnosis Related Group (DRG) Payment July 1, 2013 (Listed in approximate declining order of impact)	
Item	Comment
Newborns with long lengths of stay and multiple claims must be billed with the same Medicaid number on each claim, preferably the baby's number	Because payment is by stay, submission of the mother's beneficiary number on some claims and the baby's beneficiary number on other claims would be problematic.
Newborn weight should be coded using diagnosis codes (not value codes) when applicable	This is important as birth weight is a critical input to the All Patient Refined Diagnosis Related Group (APR-DRG) assignment. Diagnosis codes should also be used to report gestational age where applicable. International Classification of Diseases-10-Clinical Modification 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 47. 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 35.
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 48.
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 48.

Impacts on Hospital Billing and Operations Because of the Change to Diagnosis Related Group (DRG) Payment July 1, 2013 (Listed in approximate declining order of impact)	
Item	Comment
Present-on-admission indicator	Submit claims with a valid present-on-admission value for each diagnosis (except for exempt diagnosis codes). See Question 26.
Separately payable services, supplies, and devices	In the few situations where separate payment is allowed, a separate outpatient claim should be submitted. See Question 29.
Late charges (bill type 115) not accepted	Void and resubmit the original claim instead.
Healthcare-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 27.
Transfers from non-contract hospitals under the previous payment method	Under the DRG payment method, there is no distinction between contract and non-contract hospitals. All Health Facility Planning Areas are considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for all services (subject to approved Treatment Authorization Requests [TAR]).
California Children's Services (CCS) Patients with Medi-Cal Fee-for-Service (FFS)	Most CCS patients also have Medi-Cal FFS. CCS inpatient stays are paid by DRG. Submit a single claim for a single payment; only an admission Service Authorization Request or TAR is required. Daily authorization is required if the patient has a restricted benefit aid code. See Questions 39 and 40.
CCS patients with Medi-Cal Managed Care (MC)	For a CCS client enrolled in a Medi-Cal MC plan with "carved-out" CCS services, CCS authorizes inpatient admissions for the treatment of the client's CCS eligible condition. If a patient is treated for a CCS eligible inpatient admission, submit the claim to Medi-Cal FFS and not the Medi-Cal managed care plan. See Questions 39 and 40.

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

The Medi-Cal claims processing system, California Medicaid Management Information System, accepts up to 25 diagnosis codes and 25 procedure codes for electronic claims (18 diagnosis codes and 6 procedure codes for paper claims).





Hospitals should bill all diagnoses and procedures related to a hospital stay to ensure that the appropriate base All Patient Refined-DRG and patient severity of illness are assigned.

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

Consistent with federal requirements, DHCS implemented V.30 of the hospital-acquired condition (HAC) utility on July 1, 2013, to ensure payments are only made for PPC that were present on admission. The HAC utility was upgraded to V.33 on April 25, 2016 and will be upgraded to V.34 on July 1, 2017. 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](http://www.dhcs.ca.gov/individuals/PAGES/AI_PPC.ASPX).

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

Yes. POA indicators are a national standard and the same for both Medi-Cal and Medicare. Acceptable POA indicators are: Y, N, U, W, or blank. Hospitals are required to include the POA indicator associated with the principal and secondary diagnosis codes when submitting paper and electronic claims. These values are used to identify health care-acquired conditions (HCAC) by the HAC utility (see Question 27). 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 [HTTPS://WWW.CDC.GOV/NCHS/ICD/ICD10CM.HTM](https://www.cdc.gov/nchs/icd/icd10cm.htm).

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

Federal law requires Medicaid programs to demonstrate that they are not paying for HCACs, as defined specifically by the Centers for Medicare & Medicaid Services (CMS). The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with. The Medi-Cal claims processing system uses the 3M HAC utility to identify HCACs from the diagnosis, procedure and present-on-admission information on the claim and disregards the HCAC in assigning the All Patient Refined-Diagnosis Related Group (APR-DRG). As of July 1, 2017, the system will identify and accommodate up to five HCACs. Therefore, payment for the stay would be affected only if the presence of the HCAC(s) would otherwise have pushed the stay into a higher-paying APR-DRG. Based on an analysis of Medi-Cal data, Medicare and other states, we expect payment to be reduced on less than 1% of stays.

(This figure could change if CMS expands the list of HCACs.)

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

No. This report continues to be required.

**29. Are outpatient services related to the inpatient stay bundled?**

In general, the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission) is the same under Diagnosis Related Group (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 admitted patient. 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

<b>Separately Payable Services That Can Be Billed on an Outpatient Claim</b>		
<b>Description</b>	<b>Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Code Effective July 1, 2013-June 30, 2015</b>	<b>CPT / HCPCS Code Effective July 1, 2015<sup>1</sup></b>
<b>Bone Marrow Search and Acquisition Costs</b>		
Management of recipient hematopoietic progenitor cell donor search and cell acquisition	38204	38204
Unrelated bone marrow donor	38204	38204
<b>Blood Factors</b>		
Blood Factor XIII (antihemophilic factor, Corifact)	J7180	J7180
Blood Factor XIII (antihemophilic factor, Tretten)		C9134

## FOR STATE FISCAL YEAR 2017-18

Separately Payable Services That Can Be Billed on an Outpatient Claim		
Description	Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Code Effective July 1, 2013-June 30, 2015	CPT / HCPCS Code Effective July 1, 2015 <sup>1</sup>
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
<b>Long-Acting Reversible Contraception (LARC) Methods</b>		
Intrauterine copper (Paraguard)		J7300
Skyla		J7301
Levonorgestrel-releasing intrauterine contraceptive system (Mirena)		J7302
Etonogestrel (Implanon, Nexplanon)		J7307
<b>Note:</b>		
1. Procedure codes C9134, J7199, J7300, J7301, J7302, and J7037, can be billed separately as of July 1, 2015.		

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

No. When a final discharge claim is processed, it will be priced for the entire stay including all charges, diagnosis and procedure codes from date of admission. Payment is made based on the assigned Diagnosis Related Group for the entire stay. If interim claims were paid, the payments for the interim claims will be removed from the provider's next checkwrite through the Remittance Advice Details. See Question 47 for a detailed explanation of interim claim billing.

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

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

It occasionally happens that a dually eligible beneficiary either does not have Medicare Part A coverage for the inpatient stay or loses that coverage during the stay (for example, because Part A coverage days are exhausted). In this situation, if Medi-Cal would otherwise cover the stay then Medi-Cal becomes the primary payer for all or part of the stay. Submit the claim showing the original admission date and discharge data. Show only the charges, diagnoses, and procedure codes related to the portion of the stay not covered by Medicare Part A. Show also any applicable payments made to the hospital by Medicare Part B. The Department of Health Care Services will use this information in pricing the claim under the DRG payment method.

### **Pediatrics/Newborns/Neonatal Intensive Care Units (NICUs)**

**32. What is the age definition for pediatric?**

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

**33. What revenue code is required for well newborn claims?**

The revenue/accommodation codes used for billing well newborn claims have not changed under Diagnosis Related Group 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").

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

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

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

The baby is a normal newborn or a neonate (sick baby). The Diagnosis Related Group (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 Department of Health Care Services' DRG webpage.

### Treatment Authorization Request (TAR)

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

Simplification of the TAR/SAR process was a major benefit of DRG implementation on July 1, 2013, with further simplification continuing through a piloted program in February 2016. Note that SAR is specific to California Children's Services (CCS) and Genetically Handicapped Person's Program (GHPP) 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 newborns (i.e., normal newborns), regardless of aid code. If a well newborn becomes sick, an admission TAR/SAR is required.
- Discontinuation in almost all cases of the previous TAR/SAR requirement on the length of stay, meaning an admit TAR is sufficient to authorize a stay regardless of length. For beneficiaries with a full-scope aid code (regardless of age), only a single admission TAR/SAR is required.

## FOR STATE FISCAL YEAR 2017-18

- However, beneficiaries with restricted benefit aid codes (regardless of age) who have an admission that does not involve a delivery or well newborn care, acute intensive rehabilitation days, or acute administrative days (Levels 1 and 2) still require a TAR for daily review of all hospital days.
- For a delivery outside the hospital, a TAR is not required for either the mother or normal newborn.
- Continuation of the previous TAR requirement for a short list of specific procedures for all beneficiaries.
- Prior to submission of an interim claim, please submit a TAR/SAR for approval. Payment of interim claims requires an approved admission TAR/SAR.
- Either a SAR or TAR, based on eligibility at admission, is required if a patient has a stay that is covered by CCS and Medi-Cal (see Questions 40 and 41).
- Claims in which Medi-Cal is the secondary payer with Other Health Coverage as the primary payer also require a TAR.

For stays not paid by DRG:

- TAR requirements on both the admission and the length of stay continue as they were previously for rehabilitation and administrative days (see Question 48).
- For interim claim billing, hospitals need an approved TAR before the interim claim can be processed for payment.

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

As of February 2016, Non-Designated Public Hospitals and private hospitals that serve fee-for service Medi-Cal patients also began to move away from TAR 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 and on the [TAR-FREE PROCESS WEBPAGE](http://www.dhcs.ca.gov/services/medi-cal/pages/tarfreeprocess.aspx) at [HTTP://WWW.DHCS.CA.GOV/SERVICES/MEDI-CAL/PAGES/TARFREEPROCESS.ASPX](http://www.dhcs.ca.gov/services/medi-cal/pages/tarfreeprocess.aspx) as it becomes available.

### **37. How should Treatment Authorization Requests (TARs) be submitted?**

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

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

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

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

### **39. Are inpatient claims for California Children's Services (CCS)-only patients processed using the Diagnosis Related Group (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.

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

CCS and Medi-Cal Fee-for-Service (FFS): As mentioned in Question 5, claims for beneficiaries under CCS are priced using the Diagnosis Related Group (DRG) methodology. Most CCS patients also have Medi-Cal coverage. CCS and Medi-Cal billing and the SAR/TAR process have been streamlined for these patients. If the beneficiary has Medi-Cal FFS, separate claims and authorizations for the CCS and Medi-Cal parts of the stay are no longer required. Only one claim should be submitted, and only one admission SAR or TAR should be requested for a CCS

client, including clients with a restricted benefit aid code. An example of a restricted benefit aid code is, “pregnancy related and emergency services only.” One DRG payment is made for the stay.

CCS and Medi-Cal Managed Care: For a CCS client enrolled in a Medi-Cal managed care plan (MCP) with “carved-out” CCS services, CCS will issue a SAR for inpatient admissions for the treatment of the client’s CCS eligible condition. If CCS authorizes the admission with a SAR, Medi-Cal FFS should be billed pursuant to the CCS SAR and the services will be reimbursed using 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 newborn stays do not require an admission SAR; however, if a well newborn becomes sick, an admission SAR is required.

Acute inpatient intensive rehabilitation stays require daily SARs (see Question 46).

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

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

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

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

Medi-Cal fee-for-service and the CCS payment system will not pay the Diagnosis Related Group 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 newborn's ID.

### Managed Care Plans (MCPs)

#### **43. Are payments by Medi-Cal Managed Care Plans (MCPs) affected?**

Medi-Cal MCPs use the Diagnosis Related Group (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 Files on the Department of Health Care Services' (DHCS) DRG webpage. For previous fiscal years, see the Hospital Characteristics Files on the DRG webpage under the Pricing Resources folder specific to each DRG payment year; these files list each hospital's base rates used for emergency and post-stabilization services for out-of-network stays. Calculation of DRG payment, then follows the same logic described in Question 8.

MCPs should also use the DRG payment method in pricing emergency and post-stabilization services provided by University of California hospitals and other Designated Public Hospitals (DPHs) if those hospitals are outside the MCP's network. This is the only situation in which the DRG payment method affects DPHs. The DRG-based method does not affect MCP contracts with in-network hospitals or arrangements for elective admissions to out-of-network hospitals. (Note that some plans have chosen to adopt the Medi-Cal fee-for-service DRG payment method, though this is not required by DHCS.)

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

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

When billing a stay at a Diagnosis Related Group hospital for a beneficiary who is covered by a Managed Care Plan (MCP) in the first part of the stay and later becomes FFS, the hospital must first obtain reimbursement from the MCP. When payment is received from the MCP, the hospital then bills the entire stay to FFS. The payment received from the MCP will be deducted from the total payment

## FOR STATE FISCAL YEAR 2017-18

amount from FFS. Claims submitted for MCP and FFS must contain the following on the UB-04 claim form to receive reimbursement:

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

## APPEALS

- 45. If initially a claim is billed electronically with 25 diagnosis codes, but an appeal is later submitted in paper form, will the diagnosis codes not included on the paper appeal affect the All Patient Refined-Diagnosis Related Group 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.

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

There is no process to appeal the Diagnosis Related Group (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](mailto: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 SFY are located in the Pricing Resources folder for each state fiscal year on the [DRG WEBPAGE](#).

### 47. How are interim claims paid?

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

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

Administrative days and physical rehabilitation services are not paid by DRG, but are subject to Treatment Authorization Request (TAR)/Service Authorization Request (SAR) requirements. Below are the State Fiscal Year (SFY) 2017-18 Medi-Cal payment rates for rehabilitation services and Level 2 administrative days.

- Adult rehabilitation service rate: \$1,032.00
- Pediatric rehabilitation service rate: \$1,841.00
- Administrative day Level 2 revenue codes 190 (sub-acute pediatric): \$1,027.07
- Administrative day Level 2 revenue codes 199 (sub-acute adult): \$912.90

More information on administrative days Levels 1 and 2 can be found in Medi-Cal's "Provider Manual Part 2- Inpatient Services" (IPS-Administrative Days (admin) section) in the Publications tab of the Medi-Cal webpage or directly at [HTTP://FILES.MEDI-CAL.CA.GOV/PUBSDOCO/PUBLICATIONS/MASTERS-MTP/PART2/ADMIN\\_100.DOC](http://files.medi-cal.ca.gov/pubsdoco/publications/MASTERS-MTP/PART2/ADMIN_100.DOC) for up to date information. Hospital-specific Level 2 rates can be found in each SFY-specific Hospital Characteristics File on the Department of Health Care Services (DHCS) DRG webpage.

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

## Other Questions

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

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

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

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

Providers of service participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries (42 U.S.C. 1395g (Section 1815(a) of the Social Security Act). Regulations state that cost reports "will be required from providers on an annual basis..." (42 Code of Federal Regulations (C.F.R.) 405.406(b)). When you fail to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments (see Part II, §100).

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

*California Welfare and Institutions Code Section 14170 states in part “(a)(1) “Amounts paid for services provided to Medi-Cal Beneficiaries shall be audited by the department in the manner and form prescribed by the department.”*

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

Hospital-specific cost-to-charge ratios (CCRs) are necessary to calculate outlier payments sometimes made in addition to the Diagnosis Related Group (DRG) base payment. The necessary documents required for calculation of a hospital's

CCR by the Audit and Review Analysis Division (ARAS) are listed below in Table 5. All documents should be submitted to [ACUTE.SUBMISSIONS@DHCS.CA.GOV](mailto:ACUTE.SUBMISSIONS@DHCS.CA.GOV).

**Table 5**

<b>Cost Report Submission Requirements</b>	
<b>Hospital Submits</b>	<b>Comments by DHCS' ARAS</b>
Cover letter	Detail special circumstances, contact personnel, etc.
Signed copy of Centers for Medicare & Medicaid Services (CMS) 2552-10	Federally Qualified Health Centers (FQHC) must have "Provider Based" status approved by CMS to be included on CMS 2552-10
Signed copy of Department of Health care Services (DHCS) 3092	If applicable, include Medi-Cal supplemental sections 6 and 7
Audited financial statements	
Working papers used to support A-6 and A-8 adjustments	If the hospital participated in the Medi-Cal Quality Assurance Fee Program, any payments made must be removed on A-8

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

We encourage hospitals for your sake and that of other California hospitals to strive for accuracy in reported CCRs in order to avoid future payment adjustments under outlier recalculation (see Question 51).

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

In the May/June 2017 provider training for Year 5 Diagnosis Related Group (DRG) payment policy, we highlighted the concerning trend of the increase in outliers as a percentage of payment from 17% in Year 1 to 22% in Year 3, as well as the criticality for accuracy of submitted and reported cost-to-charge ratios (CCRs).



## FOR STATE FISCAL YEAR 2017-18

Hospitals are eligible for additional payment for certain high cost claims when estimated cost exceeds the outlier payment threshold (see Question 18 for the outlier policy details for each state fiscal year [SFY]). Estimated cost is calculated as the hospital charges for a claim times the hospital-specific CCR. Estimated cost exceeding the threshold is then multiplied by the applicable marginal cost factor to calculate the outlier payment amount. Any applicable outlier payment is made in addition to the DRG base payment calculated for the claim.

A key principle of the DRG payment method is prospective payment. However, DHCS has announced intent to perform DRG recalculation per State Plan Amendment 13-004 dated May 31, 2013,

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

When outlier recalculation is performed, the reported and the audited CCRs are compared (specific to the applicable date of service and DRG payment year) and outlier payments are recalculated. DRG payment is final, but outlier payment is subject to recalculation according to DHCS audit.

Details on outlier recalculation beginning in Year 4 will be released when available, but must be based upon audited SFY 2016-17 cost reports which will be available as audits are finalized in 2018.

### FOR FURTHER INFORMATION:

The DHCS webpage at [HTTP://WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/DRG.ASPX](http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx) is the best source for information. Resources include:

- **FAQ.** Updates to this Frequently Asked Questions (FAQ) document are made available as changes are needed. This version of the FAQ represents the policies, rates, and decisions for Year 5 of Diagnosis Related Group (DRG) payment. For previous versions of the FAQ that apply to the first four years of DRG payment, see the Year 4 FAQ on the Department of Health Care Services DRG webpage under “Pricing Resources: 2016/17.”
- **DRG pricing calculator.** The DRG Pricing Calculator interactive spreadsheet does not assign the All Patient Refined-Diagnosis Related Group (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.



## FOR STATE FISCAL YEAR 2017-18

- **Hospital characteristics.** The Hospital Characteristics File provides relevant information about all California DRG hospitals, including Designated Public Hospital/Non-Designated Public Hospital status, Neonatal Intensive Care Unit designation, remote rural status, wage area assignment, base rates, CCRs, and rates for rehabilitation and administrative days Level 2. The files for each state fiscal year (SFY) are available in the Pricing Resources pages. As an added convenience, this file is also included as a separate tab in the DRG Pricing Calculator.
- **Grouper settings.** The grouper settings documents for each 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 Treatment Authorization Request/Service Authorization Request authorizations.

Other key resources are as follows:

- **Questions:** For policy questions, please email the DRG mailbox at [DRG@DHCS.CA.GOV](mailto: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](mailto: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](http://files.medi-cal.ca.gov/pubdoco/manuals_menu.asp).
- **Recorded trainings.** Providers may access recorded trainings on the Conduent provider training site (login, then go to Training > Recorded Webinars) or go to [HTTPS://LEARN.MEDI-CAL.CA.GOV/HOME.ASPX](https://learn.medi-cal.ca.gov/home.aspx).

