

UB-04 Special Billing Instructions for Inpatient Services

This section contains information about billing for day of discharge, private accommodations, emergency room charges and other special billing situations. Instructions for hospitals reimbursed according to the diagnosis-related groups (DRG) model are identified separately from instructions for non-DRG-reimbursed hospitals.

This information is designed to supplement the explanations in the *UB-04 Completion: Inpatient Services* and *Diagnosis-Related Groups (DRG): Inpatient Services* sections of this manual.

Diagnosis-Related Groups (DRG) Reimbursement

Beginning in July 2013 payment for inpatient general acute care for many hospitals is calculated using an all patient refined diagnosis related groups (APR-DRG) reimbursement methodology. For purposes of this manual, APR-DRG is referred to as the DRG reimbursement method or DRG model.

It is important for Inpatient providers to know their reimbursement method because it affects payment and claim completion standards. For example, claims submitted by hospitals reimbursed according to the DRG model should take extra care to enter all ICD-9-CM diagnosis codes and ICD-9-CM Volume 3 procedure codes on a claim to ensure payment at the appropriate level. For help understanding the DRG model, refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in this manual.

DRG Information in the Provider Manuals

Other provider manual sections that contain important DRG-related policy and/or billing examples include, but are not limited to, the following:

Administrative Days

Ancillary Codes

Inpatient Rehabilitation Services

Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals

Obstetrics: UB-04 Billing Examples for Inpatient Services – DRG Payment Method

Transplants: Billing Examples for Inpatient Services

Non-DRG Hospitals

For purposes of this provider manual, non-DRG-reimbursed hospitals are hospitals that are not paid according to the DRG reimbursement methodology. Refer to the *Hospital Directory* section in this manual for a listing of some non-DRG hospitals. Reimbursement for those hospitals may pertain to certified public expenditure (CPE). (Listings in the section are subject to change and may be incomplete.)

**Day of Discharge or Death:
Emergency or Elective
Admission**

If the day of discharge or death occurs with an emergency or elective admission, it is not reimbursable except when the discharge/death occurs on the day of admission. This is true even if the day is approved by the quantity authorized on the *Treatment Authorization Request (TAR)*.

**Discharge/Death on
Day of Admission**

If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of discharge/death is not the same day as admission, the day is not payable because there is no reasonable expectation that the patient will remain and occupy a bed on such a day.

When day of discharge and admission are the same, it is important to bill usual and customary charges for all inpatient services, including ancillary services.

OB Admissions

The above policy about day of discharge/death also applies to two-day (vaginal delivery) or four-day (cesarean delivery) obstetrical claims for those hospitals reimbursed under DRG methodology.

Revenue Codes

When billing for revenue codes hospitals must:

Enter the number of days billed in the *Service Units* field (Box 46)

Enter the usual and customary charges reflecting total charges

Important: The total number of days must not exceed the number of days represented by the “from-through” dates of service.

Abortion Services

Inpatient hospitalization for the performance of an abortion requires authorization under the same criteria as other medical procedures (see *California Code of Regulations*, Title 22, Section 51327).

Split Billing a Revenue Code

The following policy pertains to hospitals whether or not they are reimbursed according to the DRG-reimbursement model.

Charges for a single revenue code may be billed on separate claim lines only:

If the patient is transferred during the stay to an identical accommodation with a different rate (for example, from ward to semi-private), or

If the Total Charges amount for that single line would exceed \$9,999,999.99

When separate lines are required to bill a revenue code, the line charge should be equal to the hospital's daily rate multiplied by the number of days billed on that line.

Split Billing a Hospital Stay

The following policy pertains to hospitals reimbursed according to DRG-reimbursed or non-DRG reimbursed methods, as indicated.

Non-DRG: Separate claim forms must be prepared for a hospital stay:

- If more than 22 claim lines are needed to itemize revenue/ancillary charges, or
- When the Total Charges to be billed would exceed \$9,999,999.99, or
- If the hospital's fiscal year ends during the stay, or
- When the hospital's accommodation rate changes during the stay

Acute and Administration Days

DRG and non-DRG: Acute and administrative days require separate claim forms and separate TARs.

When separate claims are required to bill a stay:

- Complete all data items, as applicable, on each claim
- Attach appropriate proof of recipient eligibility to each claim
- Itemize accommodation/ancillary charges, as appropriate, on each claim
- Enter the *Total Charges* and *Estimated Amount Due* according to the charges itemized on each claim (that is, do not enter the *Total Charges* and *Estimated Amount Due* for the entire stay on each separate billing)
- Enter a statement in the *Remarks* field (Box 80) of each claim that this is a split billing and the reason for the split billing

Split Paper Claims

DRG: For additional information about split paper claims for DRG-reimbursed hospitals, refer to “Split Paper Claims” in the *Diagnosis-Related Groups (DRG): Inpatient Services* section of this manual.

Split Billing Coinsurance Charges

DRG and non-DRG: Refer to the *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section of this manual.

Denied Inpatient Days

Non-DRG: If a Medi-Cal consultant denies any portion of an inpatient stay, the claim must include only those charges applicable to the authorized days. Do not bill accommodation/ancillary charges for denied days.

DRG: If a Medi-Cal consultant denies any portion of an inpatient stay for a recipient with a restricted aid code, the claim must include all charges applicable to the authorized and denied days. Providers are to bill all accommodation/ancillary charges for denied days.

Denied Services

Non-DRG: If a Medi-Cal consultant denies any services of an inpatient stay, the claim must include only those charges applicable to the authorized services. Do not bill ancillary charges for denied services.

DRG: If a Medi-Cal consultant denies any services of an inpatient stay for a recipient with a restricted aid code, the claim must include all charges applicable to the authorized and denied services. Providers are to bill ancillary charges for denied services.

**Newborn Infant
Using Mother's ID**

DRG: Refer to the *Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals* section in the Part 2 *Inpatient Services* provider manual for codes and information necessary to bill inpatient obstetrical and newborn services.

Non-DRG: May also refer to the instructions noted in the previous paragraph. The instructions for entering the newborn infant number on the claim is the same for DRG and non-DRG-reimbursed hospitals.

Emergency Room Charges

DRG and non-DRG: If emergency services are rendered on the same calendar date as the date of admission, the services should be billed on the *UB-04* with the appropriate ancillary code, along with the appropriate revenue code (length of stay). Emergency room outpatient services rendered on the same calendar date as the day of admission, or within 24 hours prior to admission, are not separately reimbursable.

If emergency services are rendered on a different calendar date and are not within 24 hours from the date of admission, the services should be billed on the *UB-04* claim using the appropriate outpatient facility codes.

Billing for Private Rooms

Non-DRG: Claims with charges for private accommodations are reviewed to determine if the patient's medical condition requires the use of a private room. If there is not enough information submitted on or with the claim to substantiate the private accommodation, payment will be made at the rate justified on file.

Disproportionate Share Payments: Inpatient Hospital Care

Non-DRG: Eligible hospitals serving a disproportionate share of Medi-Cal recipients receive special disproportionate share payments for approved inpatient admit days in compliance with federal law, Section 1923 of the Social Security Act.

All disproportionate share providers may not bill for disproportionate share payments. Payments for disproportionate share are automated, except for certain sick-newborn services rendered in select hospitals and billed with revenue code 172 in conjunction with revenue code 112, 122, 132 or 152. Refer to the *Obstetrics: Revenue Codes and Billing Policy* section in this manual for code 172 billing instructions.

Important: Revenue code 172 has multiple purposes. Providers are cautioned to bill appropriately.

Identical Services Billed for the Same Date of Service

DRG and non-DRG: Identical services billed for the same date of service are considered duplicate billings and only one service will be reimbursed.

When a service is legitimately rendered more than once on the same date of the service (before-and-after X-rays, glucose tolerance testing, ova and parasite tests, etc.), providers must include documentation with the claim, or a statement in the *Remarks* field (Box 80), explaining why the service was rendered more than once.

Providers who receive a denial for duplicate services may submit a *Claims Inquiry Form* (CIF) for claim reconsideration. The CIF must include documentation or a statement in the *Remarks* area explaining why the service was rendered more than once.