Diagnosis-Related Groups (DRG): Inpatient Services

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This section contains information to help providers submit inpatient service claims with adequate detail so the claim will reimburse at the appropriate level under the diagnosis-related groups (DRG) reimbursement methodology.

Introduction

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) model. DRG is a system that uses information on the claim (including revenue, diagnosis and procedure codes, patient's age, discharge status and complications) to classify the hospital stay into an APR-DRG group. A percentage is assigned to the group. Basically, final payment for the hospital stay is calculated by multiplying the percentage associated with the group by the hospital's assigned base price.

Hospital providers do not need to calculate these amounts. Providers submit a claim according to the APR-DRG billing guidelines. Together, the Fiscal Intermediary claims processing system and APR-DRG software calculate the claim amount.

DHCS DRG Website

Information about "Diagnosis Related Group Hospital Inpatient Payment Methodology" is available on the Department of Health Care Services (DHCS) website at *www.dhcs.ca.gov*.

DRG Terminology

For purposes of this provider manual, APR-DRG will be referred to as the DRG reimbursement method or DRG model. Hospitals reimbursed according to DRG guidelines will be referred to as DRG-reimbursed hospitals.

Note: Providers should not confuse references to the DRG method mentioned in this manual with the DRG method applied to Medicare claims. The diagnosis-related grouping algorithms applied to Medi-Cal claims differ from the algorithms applied to Medicare claims. Medi-Cal groupings differ from Medicare groupings because Medi-Cal serves recipients of many different ages, while Medicare serves mostly seniors.

Replaces Selective Provider Contracting Program

With the implementation of DRG reimbursement, the previous Selective Provider Contracting Program standards for billing are discontinued. Open and closed Health Facility Planning Areas (HFPAs) are not a component of DRG. All hospitals may serve Medi-Cal recipients for both emergency and elective acute inpatient services, subject to approved *Treatment Authorization Requests* (TARs) and Medi-Cal specific policy.

Excluded Facilities

Psychiatric hospitals and designated public hospitals are excluded from DRG reimbursement methodology. Claims submitted for these facilities follow the guidelines that were in place prior to implementation of the DRG model.

Excluded Services

Acute intensive inpatient rehabilitation services, including drug and alcohol, and administrative day services are not reimbursed according to the DRG payment method. These services provided at a DRG-reimbursed hospital are reimbursable on a per diem basis.

Administrative Days

For information about requesting authorization for and billing administrative level 1 and level 2 days, refer to the *Administrative Days* section in this provider manual.

OB and Newborn Services

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.

Rehabilitation Services

Refer to the *Inpatient Rehabilitation Services* section in the Part 2 *Inpatient Services* provider manual for instructions to bill acute inpatient intensive rehabilitation (AIIR) services.

Transplant Services

Information for billing inpatient transplant services is included in the *Transplants* section of this provider manual.

Billing Example

For an example of an inpatient claim illustrating a lung transplant, refer to the *Transplants: Billing Examples for Inpatient Services* section in this manual.

Authorization for Inpatient Services

To be reimbursed, most inpatient services require authorization. Claims submitted for services rendered without an approved *Treatment Authorization Request* (TAR) may be denied.

Note: Obstetric admissions associated with a delivery do not require either an admit or daily TAR in cases where both the mom and newborn remain healthy. If the newborn becomes sick, an admit TAR must be submitted for the entire hospital stay, starting the day of admission. Refer to "Admit TAR and Daily TAR" information in this section for more information.

Two separate TAR forms are used to request recipient admission for a hospital stay. In general, the medical services provider submits a 50-1 TAR requesting the initial admission and any planned procedures. The inpatient facility may submit an 18-1 *Request for Extension of Stay in Hospital* TAR or a 50-1 as an admit TAR. The inpatient facility must submit an 18-1 for all emergency admissions.

Important additional TAR instructions

Only one claim may be submitted in connection with each approved *Treatment Authorization Request* (TAR), with the exception of interim claims.

For successful TAR submission, providers must follow appropriate instructions in the *TAR Overview* section of the Part 1 provider manual and the Part 2 *TAR Completion* and *TAR Request for Extension of Stay in Hospital (Form 18-1)* sections.

Admit TAR and Daily TAR

An admit TAR is a TAR that is submitted to request authorization for the entire hospital stay. It differs from a daily TAR that identifies the specific number of hospital days for which authorization is requested.

For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR, not a daily TAR. However, there are exceptions. Refer to the TAR Requirements charts in this section for details.

50-1 admit TAR

A “1” is entered in the *Quantity* fields (Boxes 12, 16, 20, etc.), as appropriate.

50-1 daily TAR

The number of hospital-stay days requested (for example, 3) is entered in the *Quantity* fields (Boxes 12, 16, 20, etc.), as appropriate.

18-1 admit TAR

Used for emergency or elective admits. When used for emergency admits, an “X” is entered in the *Emer. Admit* field (Box 9). A “1” is entered in the *Number of Days Requested* field (Box 17).

18-1 daily TAR

The number of hospital-stay days requested (for example, 3) is entered in the *Number of Days* Requested field (Box 17).

TARs: Facility Numbers Required

Physicians submitting 50-1 TARs for elective admissions must show the admitting inpatient hospital provider number in Box 3. Additionally, the name and address of the admitting inpatient hospital must be entered on the last line of the *Medical Justification* section of the TAR. These requirements apply to all TARs.

TAR Charts: Inpatient Services

The following charts identify whether an inpatient service requires an approved TAR for the service to be reimbursed. The first chart shows TAR requirements for recipients covered by full-scope Medi-Cal. The second chart shows TAR requirements for recipients identified by restricted aid codes. (For a listing of aid codes, refer to the *Aid Codes Master Chart* in the Part 1 provider manual.)

If the service requires TAR approval, the chart indicates which TAR form must be submitted, either the 50-1 (*Treatment Authorization Request*) or 18-1 (*Request for Extension of Stay in Hospital*). The table includes information about how the TAR-approved services are reimbursed, according to the DRG reimbursement method or on a per diem basis. Additionally, the chart includes some TAR tips.

TAR Requirements Chart for Recipients with Full-Scope Medi-Cal

Service	**TAR Required**	**TAR Form**	**Reimbursed**	**TAR Tip**
Healthy baby (associated with delivery)	No TAR required	NA	DRG model	NA
Sick baby (associated with delivery)	Yes, admit TAR	50-1	DRG model	Typically physician or podiatrist submits the 50-1.
Pregnancy-related admit with delivery, healthy mom and newborn	No TAR Required	NA	DRG model	NA
Pregnancy-related admit without delivery	Yes, admit TAR	50-1	DRG model	Typically physician or podiatrist submits the 50-1.
Other medical/surgical admit – elective	Yes, admit TAR	50-1	DRG model	Typically physician or podiatrist submits the 50-1.
Other medical/surgical admit – emergency	Yes, admit TAR	18-1	DRG model	Emergency admissions are requested on the 18-1 TAR. Authorization for associated surgical procedures are requested on the 50-1 TAR.
Rehabilitation stay (acute inpatient days)	Yes, TAR required for each day	50-1	Per diem	Typically physician or podiatrist submits the 50-1.

TAR Requirements Chart for Recipients with Full-Scope Medi-Cal (continued)

Service	TAR Required	TAR Form	Reimbursed	TAR Tip
Hospice general inpatient care **(0656/T2045)**	Yes, TAR required for each day	50-1	Per diem	Hospice provider generally submits TAR **with procedure code T2045**.
Administrative day, level 1 ∞	Yes, TAR required for each day	18-1	Per diem, for both DRG and non-DRG hospitals	Reimbursement allowable for approved ancillary services submitted on claims with administrative level 1 day(s).
Administrative day, level 2 ∞	Yes, TAR required for each day	18-1	Per diem, for DRG hospitals only	Reimbursement allowable for approved ancillary services submitted on claims with administrative level 2 day(s).

∞Refer to the Administrative Days section in this manual for additional information.

TAR Requirements Chart for Recipients with Restricted Aid Codes

Service	TAR Required	TAR Form	Reimbursed	TAR Tip
Healthy baby (associated with delivery)	No TAR required	NA	DRG model	NA
Sick baby (associated with delivery)	Yes, admit TAR	50-1	DRG model	Typically physician or podiatrist submits the 50-1.
Pregnancy-related admit with delivery, healthy mom and newborn	No TAR required	NA	DRG model	NA

TAR Requirements Chart for Recipients with Restricted Aid Codes (continued)

Service	TAR Required	TAR Form	Reimbursed	TAR Tip
Pregnancy-related admit without delivery	Yes, TAR required for each day	50-1	DRG model	When one or more days is denied, there is a potential for repricing of claim. Days may be denied because care is not related to emergency or pregnancy, etc. *
Other medical/surgical admit – elective	Yes, TAR required for each day	50-1	DRG model	Typically physician or podiatrist submits the 50-1.
Other medical/surgical admit – emergency	Yes, TAR required for each day	18-1	DRG model	Emergency admissions are requested on the 18-1 TAR. Authorization for associated surgical procedures are requested on the 50-1 TAR. When one or more days is denied, there is a potential for repricing of claim. Days may be denied because care is not related to emergency.*

*Additional information about emergency and pregnancy-related care is available in the *Manual of Criteria for Medi-Cal Authorization*, Chapter 4 and the *Code of Federal Regulations*, Section 440.255.

Increased Importance of Diagnosis/Procedure Codes

Providers may submit up to 18 diagnosis codes and six procedure codes on paper claims. Entering all applicable diagnosis and procedure codes on the claim allows the claim to be reimbursed at the appropriate level. All diagnosis codes should be complete and accurate.

Present on Admission Indicators Required

Hospitals are required to include a present on admission (POA) indicator for the principal and each secondary diagnosis code submitted on a claim, unless the code is exempt from POA reporting. POA information is stored and used to identify health care acquired conditions. Providers should refer to the *ICD-10-CM Official Guidelines for Coding and Reporting* for national POA coding standards, which apply also to Medi-Cal.

Claim examples showing ICD-10-CM diagnosis codes with associated POA codes are included in the O*bstetrics: UB-04 Billing Examples for Inpatient Services – DRG Payment Method* section in this provider manual.

Bill Usual and Customary Charges

Hospitals must bill their usual and customary charges for all inpatient services (revenue codes for accommodations and ancillaries) in order that appropriate federal requirements can be met. Usual and customary charges are monitored for use in overall hospital reimbursement research. The claims will be reimbursed at the appropriate DRG-calculated amount regardless of the amount billed on the claim form. Hourly rates are not allowable and must not be billed.

Physician Services: Must Be Separately Billed

Charges for physician services may not be included in the amounts billed on inpatient claims. Such bundling of services is disallowed. All physician services must be billed separately on the appropriate claim form, for example an outpatient *UB-04* or *CMS-1500*.

Separately Reimbursable: Bone Marrow and Blood Factors

Claims for acute inpatient services generally bill for all services rendered to the inpatient recipient. Bone marrow and contract blood factors are exceptions. Therefore, the following bone marrow and blood factors codes must be separately billed on an outpatient claim.

> Bone marrow code 38204 (management of recipient hematopoietic progenitor cell donor search and cell acquisition) and (unrelated bone marrow donor).
>
> Blood factor codes ‹‹J7175, J7179 thru J7183,›› J7185 thru J7190, J7192 thru J7195, J7197, J7198, ‹‹J7200 thru J7205, J7207 thru J7212, J3399,›› Q2041 and Q2042. Refer to the Blood and Blood Derivatives section in the Part 2 Clinics and Hospitals provider manual for code descriptions.

Ancillary Services

When the day of admission is the same as the day of discharge or death, DRG-reimbursed hospitals are paid at the appropriate level under the DRG model. However, hospitals must continue to bill their usual and customary charges for all inpatient services, including ancillary charges.

Revenue Codes

When billing for revenue codes, DRG-reimbursed 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.

Multiple Revenue Codes

Multiple revenue codes may be billed on one claim form. DHCS uses all revenue codes billed on a claim for utilization review purposes.

Exceptions: Revenue codes for administrative days (level 1 administrative day revenue code 169 or level 2 administrative day revenue codes 190 and 199) may not be billed on a claim with other revenue codes. Revenue codes for acute inpatient intensive rehabilitation (AIIR) services (revenue codes 118, 128, 138 and/or 158) may not be billed on a claim with other revenue codes. Though a combination of codes 118, 128, 138 and/or 158 is allowed on the same claim, as appropriate.

Late Charges

Type of bill code 115 (used to designate late charges) is not allowed by Medi-Cal for inpatient claims. This code is designated to bill additional inpatient services rendered to the patient that were not submitted on the initial claim.

When billing for ancillary, accommodation, diagnosis or procedure codes for any hospital stay that was previously billed and reimbursed, providers must void the original claim and submit a new claim for the entire amount. These amounts are part of the hospital's historical cost figures. It is to the hospital's advantage to have all charges on file.

Interim Claims

Interim claims are accepted for hospital stays that exceed 29 days. These claims are reimbursable only with a patient status code of 30 (still a patient). For reimbursement, an interim claim requires an approved admit TAR. Interim claims submitted with type of bill code 112 or 113 are allowable. Interim claims submitted with type of bill code 114 will be denied.

Submission of interim claims is voluntary and not mandatory under any circumstance.

Payment

Interim claim(s) are reimbursed on a per diem basis. Upon discharge of the patient, the provider submits a final claim using type of bill 111 and containing charges for the full length of stay, including all diagnosis and procedure codes for the entire stay. The claim is priced using the DRG method. All previous interim claims are voided. The voided interim claims will appear in the provider checkwrite released immediately following the week in which the final claim pays.

Split Paper Claims

A claim for a single hospital stay that must be submitted on multiple pages requires accurate entry of all the following on each page of the paper claim:

- All diagnosis codes
- All procedure codes
- Provider number
- Recipient identification number
- Dates of admission

Day of Discharge or Death

Refer to “Day of Discharge or Death” entries in the *UB-04 Special Billing Instructions for Inpatient Services* section of this provider manual.

No Reimbursement After Recipient Death

Medical care provided after a Medi-Cal recipient has been declared dead is not considered an acute care service and Medi-Cal will not provide reimbursement under that recipient's Client Identification Number (CIN) or Benefits Identification Card (BIC).

Organ Preservation

Refer to the *Transplants: Donor Protocol* section in the appropriate Part 2 manual for information about medical care provided for organ preservation services.

Medicare/Medi-Cal Crossover Recipients

Medicare/Medi-Cal crossover recipients are not affected by the DRG-reimbursement payment methodology until their Medicare benefits are exhausted, at which time they become Medi-Cal only recipients. Providers then submit claims according to standard Medi-Cal billing practices.

Split Billing for Managed Care Plan and Fee-for-Service Claims

When billing a stay at a DRG hospital for a beneficiary who is covered by a Medi-Cal MCP for the first part of the stay and covered by FFS for the second part of the same inpatient stay, the hospital (provider) must first obtain reimbursement from the MCP.

When payment is received from the MCP, the hospital then bills the entire stay to FFS. The payment received from the MCP will be deducted from the total payment amount from FFS. Claims submitted for MCP and FFS must contain the following on the *UB-04* claim form to receive reimbursement:

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

For acute inpatient stays where the recipient has Medi-Cal managed care enrollment for all of the stay, but the stay should pay through fee-for-service Medi-Cal, an additional carve out that should be paid is:

Voluntary Inpatient Detoxification (carve-out from managed care)

Note: Identification on the claim in the *Remarks* field (Box 80) as "Voluntary Inpatient Detox," or "Voluntary Inpatient Detoxification," or "VID" is required.

While not required for a medical necessity review of the *Treatment Authorization Request* (TAR), providers are encouraged to note "Voluntary Inpatient Detoxification" in the *Medical Justification* field of the paper TAR or "VID" in the special handling option of the eTAR. The documentation ensures the Department of Health Care Services (DHCS) is able to track service utilization.

This billing instruction does not apply to inpatient stays authorized by a California Children's Services (CCS) Service Authorization Request (SAR) for a CCS client who is a Medi-Cal recipient enrolled in a Medi-Cal MCP with carved-out CCS Services.

This billing instruction does not apply when billing a stay at a DRG hospital for a recipient who is covered by fee-for-service for the first part of the stay and Medi-Cal managed care for the second part of the same inpatient stay. These claims are currently billed the entire stay to fee-for-service and reimbursed under DRG payment methodology.

Billing When Recipient Becomes Fee-for-Service Eligible During Stay

DRG providers may be reimbursed for inpatient services only for dates of stay on or after the date the recipient becomes fee-for-service eligible if the recipient had no other coverage on the date of admission.

DRG providers should bill using the:

- Correct type of bill
- Actual admission date
- Actual discharge date
- "Statement Covers Period From-Through" dates limited to the recipient's fee-for-service eligibility dates
- Services and supplies incurred only during the recipient's fee-for-service eligibility dates
- Diagnosis and procedure codes associated only to treatment provided during the recipient's fee-for-service eligibility dates

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	This is a symbol denoting additional information
∞	This is a symbol denoting an additional section reference