State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: OCTOBER 4, 2013

ALL PLAN LETTER 13-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DIAGNOSIS RELATED GROUPS: BILLING FOR BENEFICIARIES WITH CALIFORNIA CHILDREN'S SERVICES ELIGIBLE CONDITIONS AND/OR MEDI-CAL MANAGED CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) regarding the Diagnosis Related Groups (DRG) implementation and the billing of inpatient services at private hospitals for beneficiaries with California Children's Services (CCS) eligible conditions who are also enrolled in a MCP.

BACKGROUND:
CCS reimburses providers for services provided to Medi-Cal eligible children with specified conditions through Medi-Cal fee-for-service (FFS), with some exceptions. Payments to hospitals for these services align with the payment methodology utilized for all other Medi-Cal FFS providers.

Many Medi-Cal beneficiaries with CCS eligible conditions are also enrolled in a MCP. Most MCP contracts do not cover CCS services, which are generally carved-out of the MCP contracts. However, the MCPs are responsible for providing medically necessary services that are not related to the CCS condition. For those MCPs in which CCS services are carved-in, the MCPs are responsible for covering CCS services in addition to all medically necessary services not related to the CCS condition.

Until the implementation of the DRG payment methodology, inpatient services provided at private hospitals to MCP beneficiaries for CCS eligible conditions that were not covered by the MCPs were paid through Medi-Cal FFS. Payments were based on the number of days authorized on a CCS Service Authorization Request (SAR). If a MCP beneficiary were hospitalized for a CCS eligible condition, as well as a condition covered by the MCP, a provider was required to bill Medi-Cal FFS for the days covered by the CCS SAR and bill the MCP for the days covered by the MCP. This is called billing by payer source.

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REQUIREMENTS:
Effective July 1, 2013, private hospitals are no longer reimbursed by Medi-Cal FFS on a per diem basis. The DRG methodology now reimburses hospitals for the entire stay of the beneficiary, with payments being higher or lower based on acuity and not on length of stay. Under the DRG system, only an admission SAR or Treatment Authorization Request is required to approve an inpatient stay for beneficiaries with full-scope Medi-Cal aid codes. Therefore, providers cannot bill multiple payers for an inpatient stay that includes both managed care and CCS days. Non-Designated Public Hospitals (NDPHs), currently paid under a per diem, will switch to the DRG payment methodology effective January 1, 2014. At that time, this policy will also apply to NDPHs.

Effective July 1, 2013, for days of service and for private hospital stays, the following billing policy will apply for services provided to a Medi-Cal beneficiary with a CCS eligible condition that is enrolled in a MCP in which CCS services are carved-out:

- If a beneficiary is admitted to a hospital for a CCS eligible condition, the entire stay will be billed to Medi-Cal FFS, regardless of whether any services provided during that stay are covered by the MCP. The hospital will receive one payment for the entire stay based on the DRG for that stay. No billing will be allowed to the MCP.

- If a beneficiary is admitted to a hospital for a non-CCS eligible condition, and subsequently receives services during the stay for a CCS eligible condition, the full stay will be billed to Medi-Cal FFS. A SAR will be authorized back to the day of admission. The hospital will receive one payment for the entire stay based on the DRG for that stay. No billing will be allowed to the MCP.

- When a beneficiary stay includes delivery and well-baby coverage under a MCP, the entire claim will be billed to the MCP. If, during the stay, the baby develops a CCS eligible condition, the entire stay for the baby will require a SAR from the date of admission and will be billed to Medi-Cal FFS. MCPs will not be billed for the baby's stay. In this case, the hospital will receive two payments. One for the delivery and well-baby stay from the MCP and one for the baby under the DRG.

Effective July 1, 2013, for days of service and for private hospital stays, the following billing policy will apply for services provided to a Medi-Cal beneficiary with a CCS eligible condition that is enrolled in a MCP in which CCS services are carved-in:

- If a beneficiary is admitted to a hospital for either a CCS eligible condition or a non-CCS eligible condition, the entire claim will be billed to the MCP. The hospital will receive one payment for the entire stay from the MCP.

For further information regarding the DRG implementation and rates for emergency and post-stabilization acute inpatient services provided by out-of-network general acute care hospitals, please see APL 13-004 at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-004.pdf

The Department of Health Care Services (DHCS) appreciates your continued patience and feedback as we progress into this new DRG reimbursement methodology. If you have any questions regarding this policy, or any other DRG policy, please contact DHCS at DRG@dhcs.ca.gov or visit the DRG web page at: http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Chief
Medi-Cal Managed Care Division