Diagnosis-Related Groups: Billing for OB and Newborn Services

Reminder
Effective for admissions on or after July 1, 2013, reimbursement for private inpatient general acute care hospitals will be based on a Diagnosis-Related Group (DRG) payment methodology. The specific DRG algorithm chosen by the Department of Health Care Services (DHCS) is All Patient Refined Diagnosis-Related Groups (APR-DRG). This is a change from the current methodology of per diem contract rates for contract hospitals and cost reimbursement for non-contract hospitals.

Separate Claims for Mother/Newborn
The DRG payment methodology requires a separate claim for services provided to the mother and newborn (or to each newborn, in the case of multiple births). Separate claims and separate payments are consistent with the fact that the mother and the newborn are distinct patients with separate diagnoses, treatments, charges, lengths of stay and discharge status codes. This separation will facilitate a better understanding of the course of treatment and the quality of care rendered to obstetric (OB) and neonatology patients.

When submitting claims for newborn services:

- Hospitals must submit the newborn claim separately from the mother’s claim for the delivery. Claims for OB and neonatal services that fail to meet this standard will be denied.
- Hospitals that bill interim claims for stays greater than 29 days for sick babies or neonates must use a single Beneficiary Identification Card (BIC) number. The baby’s unique Medicaid identification number is preferred; however, the mother’s BIC number is acceptable. Claims submitted with both the mother’s and baby’s number on the interim claim for a single related neonatal stay will be denied.
- The primary diagnosis code that supports the newborn’s admission should be placed in the primary diagnosis field (unlabeled Box 67) on the claim. Additionally, hospitals will use an appropriate diagnosis code to indicate the baby’s birth weight or gestational age. Diagnosis related group assignment and acuity level for the newborn will be driven in part by the diagnosis code relating to the baby’s birth weight and/or gestational age. Hospitals are encouraged to list all applicable diagnosis codes in field boxes 67A through 67Q.

New TAR Requirements
TAR requirements for OB stays will change as follows:

**OB stays resulting in delivery**

No TAR will be required for acute inpatient hospital days when the OB hospitalization resulted in a delivery.

**OB stays resulting in no delivery**

An admission TAR will be required for OB admissions with no delivery, for recipients with full-scope Medi-Cal.

TARs for each day, rather than an admission TAR, will be required for recipients with restricted aid codes, for hospital stays with no delivery.

**OB administrative days**

OB administrative days will continue to require an acute administrative day TAR.

**Newborn and NICU Stays**

All well baby stays (revenue code 171) for full-scope and restricted aid codes will be TAR free.
All Neonatal Intensive Care Unit (NICU) hospitalizations for full-scope and restricted aid code recipients will require admission TARs.

DHCS, in conjunction with the Provider Outreach and Education department, is developing detailed training materials to help providers transition to payment by APR-DRG.

DHCS encourages interested parties to visit the Diagnosis Related Group Hospital Inpatient Payment Methodology Web page on the DHCS website frequently, including the DRG Hospital Inpatient TAR Requirements document, which provides more detail regarding TAR requirements. Providers may communicate with DHCS via the DRG mailbox at DRG@dhcs.ca.gov.