DRG Billing and Reimbursement Update for AIIR Services

February 07, 2017

For admissions beginning on or after July 1, 2013, the Department of Health Care Services (DHCS) has reimbursed fee-for-service (FFS) acute inpatient intensive rehabilitation (AIIR) services rendered by diagnosis-related group (DRG) hospitals to Medi-Cal recipients through a hospital-specific, all-inclusive per diem rate in accordance with the APR-DRG Reimbursement Implementation.

For the purposes of FFS reimbursement to DRG hospitals, “Rehabilitation Services” are defined as AIIR services in accordance with Welfare and Institutions Code (W&I Code), Sections 14064 and 14132.8. Rehabilitation services are identified by the presence of revenue codes 118, 128, 138 or 158 in the Revenue Code field (Box 42) of the UB-04 form on one or more service lines on the claim and include the ancillary services provided during the stay in accordance with W&I Code, Sections 14064 and 14132.8.

To receive accurate reimbursement for rehabilitation services, DRG hospitals should indicate in the Total Charges field (Box 47) at a minimum the all-inclusive, hospital-specific per diem rates in the HCPCS/Rate field (Box 44) multiplied by the number of authorized days in the Service Units field (Box 46) for the service period on the required Treatment Authorization Request or Service Authorization Request. If the charges reflected for the rehabilitation services on the claim are lesser than the all-inclusive, hospital-specific calculation, it will pay at the lesser of the two.

The all-inclusive, hospital-specific per diem rate for rehabilitation services is available on the Diagnosis Related Group Hospital Inpatient Payment Methodology Web page of the DHCS website.

Retroactive Application of Billing at the All-Inclusive Per Diem for Rehabilitation Services

If the reimbursement for rehabilitation services was less than the calculated amount based on the all-inclusive, hospital-specific per diem rates, resubmit the claim through a Claims Inquiry Form (CIF) and appeal for claim reimbursement reprocessing by taking the following steps:

1. Void claims through a CIF, mark the “Overpayment” box and include the statement “Please void claim, not an overpayment but an acute inpatient intensive rehabilitation service correction to increase payment” in the remarks area. (Please note, in order to waive timeliness guidelines providers must check the “Overpayment” box on the CIF, not the “Underpayment” box.)
2. Once the voided claim appears on a Remittance Advice Details (RAD), resubmit the corrected claim with an Appeal Form and request reprocessing. Attach the RAD of the voided claim to show timeliness filing. The claim must be resubmitted within 90 days from the RAD date.

All corrected claims must be submitted by March 31, 2017.

For further information or questions regarding AIIR service reimbursement, contact DHCS at drg@dhcs.ca.gov.

This provider bulletin is published under the authority specified in paragraph (2) of subdivision (f) of section 14105.28 of the W&I Code, which provides in part:

“[N]otwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action.”

This provider bulletin governs should there be a conflict between this provider bulletin and any previous Department published provider bulletins relating to W&I Code section 14105.28.