

## **Update: DRG Claims Denied with RAD Code 9968 Will Reprocess      July 2015**

A previously published [NewsFlash](#) announced instructions for the resubmission of diagnosis-related group (DRG) claims including Other Health Coverage (OHC) that were erroneously denied. These instructions have been updated as follows:

The Department of Health Care Services (DHCS) has resolved a claims processing issue that caused DRG claims that included OHC to erroneously deny with Remittance Advice Details (RAD) code **9968: No Approved TAR on File for APR-DRG Inpatient Admission**.

Timeliness will be waived for claims that were previously denied with RAD code 9968 for dates of service from July 1, 2013, through March 1, 2015. Hospital providers may resubmit claims until November 20, 2015.

Claims resubmitted must contain the following on the *UB-04* claim form to receive reimbursement:

Include the following statement in the *Remarks* field (Box 80):

“DRG claim that previously denied with RAD code 9968”

Indicate delay reason code “11” in the appropriate field

Note that OHC must be billed **prior** to Medi-Cal, and any payments received will be indicated in the *Payer Name* (Box 50) and *Prior Payments* (Box 54) sections of the *UB-04* claim form. The final DRG payment will be reduced by payments received by OHC.

### **Reminder:**

Per DRG methodology, upon discharge of the recipient, the provider must submit a final claim, with “111” entered in the *Type of Bill* field (Box 4) of the *UB-04* claim form, which will contain charges for the full length of stay, including for **all** days, diagnosis and procedure codes. This applies even when a recipient has coverage other than Medi-Cal fee-for-service for a portion of the stay.