

Update: MCP and Fee-For-Service Billing for Inpatient Stays at DRG Hospitals

A previously published [Medi-Cal NewsFlash](#) announced instructions for the resubmission of Managed Care Plan (MCP) and fee-for-service (FFS) claims for inpatient stays at diagnosis-related group (DRG) hospitals. These instructions have been updated below.

Effective retroactively for dates of service on or after July 1, 2013, 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
- Indicate delay reason code “11” in the appropriate field

For acute inpatient stays where the beneficiary has Medi-Cal MC enrollment for all of the stay, but the stay should pay through FFS Medi-Cal, an additional carve out that should be paid is:

Voluntary Inpatient Detoxification (carve-out from MC)

Note:

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

Timeliness will be waived for claims that were previously denied for *Remittance Advice Details* (RAD) code **0037: Health Care Plan enrollee, capitated service not billable to Medi-Cal** for dates of service from July 1, 2013, through May 30, 2015. Hospital providers may resubmit claims until January 31, 2016.

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 beneficiary 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 beneficiary who is covered by FFS for the first part of the stay and Medi-Cal MC the second part of the same inpatient stay. These claims are currently billed the entire stay to FFS and reimbursed under DRG payment methodology.

For additional information about recent updates to electronic transactions, including specific processing instructions for inpatient claims submitted with more than 22 claim lines, providers should refer to the [HIPAA 5010 Medi-Cal Companion Guide Update](#) article on the Medi-Cal website.

For more information regarding Computer Media Claims (CMC), please refer to the [Medi-Cal Computer Media Claims \(CMC\) Billing and Technical Manual](#) page of the Medi-Cal website. If you have any questions regarding the instructions above, please call the Telephone Service Center (TSC) at 1-800-541-5555 and select the option for POS, Internet, LSRS and CMC inquiries.

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