

## **Diagnosis Related Groups: Most Common Denial Reasons Anticipated Under DRG Reimbursement Methodology**

### **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).

### **Common Denials Due to Billing Changes**

As the crossover to DRG reimbursement methodology has been implemented, DHCS would like to make providers aware of the most common denial reasons anticipated and the steps providers should take to avoid these common denials. Subsequent bulletins will provide detail regarding other denials that are observed after the transition to DRG reimbursement.

### **Remittance Advice Detail (RAD) 9951**

All claims with mother and baby billed on the same UB-04 will deny with this RAD code. For all admissions on or after July 1, 2013, mother and baby must be billed as separate individual claims for each discharge. Please see the provider manual ***Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals section in the Part 2 Inpatient Services*** provider manual for codes and information necessary to bill inpatient obstetrical and newborn services.

### **Remittance Advice Detail (RAD) 9952**

All claims submitted with a bill type of 114 (final interim claim) and bill type 115 (late charges) will be denied with RAD code 9952. Providers may submit an interim claim for patients whose hospital stay is greater than 29 days and the claim indicates patient status code 30 (still a patient). Interim claims are reimbursable at a per diem rate of \$600. Interim claims submitted with type of bill code 112 or 113 with a patient status code of 30 are allowable only for hospital stays exceeding 29 days, and in increments exceeding 29 days thereafter. Claims submitted with type of bill code 114 will not be accepted. Submission of interim claims is voluntary and is not mandatory under any circumstance. Upon patient discharge, providers submit a final claim (bill type 111) containing charges for the full length of stay and all diagnosis and procedure codes.

Type of bill code 115 is disallowed by Medi-Cal for inpatient claims reimbursed under DRG. This code is designated to bill additional inpatient services rendered to the patient that were not submitted on the initial claim. When billing for ancillary, accommodation, diagnosis or procedure code for any hospital stay that was previously billed and reimbursed, providers must void the original claim and resubmit a new claim for the entire amount.

### **Remittance Advice Detail (RAD) 9953**

All interim claims not exceeding the 29 threshold will be denied with RAD code 9953. Interim billing is allowable only for hospital stays exceeding 29 days, and in increments exceeding 29 days thereafter.

### **Remittance Advice Detail (RAD) 9955**

All claims containing revenue / accommodation codes for rehab services (118, 128, 138, and 158) and administrative day services (169, 190, and 199) must be billed separately from an

acute care stay. Claims containing a mixture of acute care revenue codes with rehab and/or administrative will be denied with RAD code 9955.

**DHCS DRG Web Page**

DHCS encourages providers to visit the [Diagnosis Related Group Hospital Inpatient Payment Methodology](#) Web page on the DHCS website. The Web page is being updated as the DRG project progresses.

To submit questions, or to add your email address to the DRG listserve to receive DRG updates, contact DHCS via the DRG mailbox at [DRG@dhcs.ca.gov](mailto:DRG@dhcs.ca.gov).

Providers interested in receiving email notifications about Medi-Cal news are encouraged to subscribe to the [Medi-Cal Subscription Service \(MCSS\)](#). Providers who would like to receive updates on DRG information should select the Inpatient Services subject matter of interest on the MCSS Subscriber Form.