| Current (C) | Description | Status | |
|---|---|---|---|
| • **C.1** Paper Claims for Appeal/CIF process<br>• Initial Bulletin: 5/19/16<br>• RAD Code: N/A | Due to system limitations, the Appeal/CIF process has to drop to paper claim format, causing claim limits of 18 procedure codes and 6 diagnosis codes | This issue is resolved with a system change effective June 24, 2019 that allows claim resubmission to be performed electronically. The Provider Manual has been updated with specific instructions for the resubmission process that must be followed or the claim will be denied. | • Void and Resubmit (V&R) / EPC: N/A<br>• System Change Date: 6/24/19<br>• Latest Publication Date: N/A |
| • **C.2** Claim admission date outside SAR Authorized dates<br>• Initial Bulletin: 11/28/17<br>• RAD Code: 9970 (No SAR approval on file for CCS/GHPP APR-DRG inpatient admission) | The SAR authorized from and through dates do not include the claim admission date so the system denies the claim. | This issue has been reviewed by the Department of Health Care Services and a fix has been implemented for SAR date not matching admit date issue. As long as the issue date of the SAR is during the stay, the claim will be paid. | • Void and Resubmit (V&R) / EPC: EPC<br>• System Change Date: 8/23/19<br>• Latest Publication Date: TBD |
| • **C.3** Patient discharged and re-admitted the same day<br>• Initial Bulletin: N/A<br>• RAD Code: 9978 (Paid APR-DRG claim in history for same inpatient stay) | Currently, if a patient is discharged and re-admitted the same day, inpatient claims suspend and are denied with Remittance Advice Detail (RAD) 9978. | This issue has been reviewed by the Department of Health Care Services and a fix is in place to allow examiners to override this error and have the claims paid for applicable dates when a patient is discharged and then re-admitted on the same day. | • Void and Resubmit (V&R) / EPC: V&R<br>• System Change Date: 6/24/19<br>• Latest Publication Date: TBD |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.1A** Acute Date Outside of Admission Date<br>• Initial Bulletin: N/A<br>• RAD Code: 509 (adjustment due to an inappropriate payment made for a service rendered on a denied acute inpatient day) | Provider bills the surgery date or outpatient date, which occurs within 24 hours before the Admission date on the inpatient claim. This causes claims to deny when examiners cannot look at hours. | The Department has fixed this issue and is advising affected DRG providers to void and resubmit claims, and continue to adhere to timely filing requirements. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 6/16/2017<br>• Latest Publication Date: 6/16/2017 |
| • **R.1B** Acute Date Outside of Admission Date<br>• Initial Bulletin: N/A<br>• RAD Code: 0076 (The Submitted Documentation Was Not Adequate) | Emergency room outpatient services rendered on the same calendar day or on the day prior to admission are not separately reimbursable. When an outpatient service has been rendered and the patient is then admitted to the hospital within 24 hours and the RTD is not received, the claim is denied. | The Provider Manual ("ub spec ip" page 5) was updated to accurately define such policy. The language states, "DRG and non-DRG: If emergency services are rendered on the same calendar date as the date of admission, the services should be billed on the UB-04 with the appropriate ancillary code, along with the appropriate revenue code."<br>Emergency room outpatient services rendered on the same calendar date as the day of admission, or the day prior to admission, are not separately reimbursable.<br>If emergency services are rendered on a different calendar date and are not the day prior to the date of admission, the services should be billed on the UB-04 claim using the appropriate outpatient facility codes." | • Void and Resubmit (V&R) / EPC: N/A<br>• System Change Date: N/A<br>• Latest Publication Date: 5/15/2016 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.2** Partial Eligibility<br>• Initial Bulletin: 8/31/2015<br>• RAD Code: 0314 (Recipient is Not Eligible for the Month of Service Billed) | The recipient is not eligible for Medi-Cal and has no other insurance on the date of admission, but becomes eligible for FFS the following month. | The Provider Manual ("diagnosis ip" page 12) was updated to accurately define such policy. The language states, "DRG providers may be reimbursed for inpatient services only for dates of stay on or after the date the recipient becomes FFS eligible if the recipient had no other coverage on the date of admission."<br>DRG providers should bill using the:<br>- Correct type of bill<br>- Actual admission date<br>- Actual discharge date<br>- “Statement Covers Period From-Through” dates limited to the recipient’s FFS eligibility dates<br>- Services and supplies incurred only during the recipient’s FFS eligibility dates<br>- Diagnosis and procedure codes associated only to treatment provided during the recipient’s FFS eligibility dates | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: N/A<br>• Latest Publication Date: 4/15/2016 |
| • **R.3** SFY 15-16 OB Policy Adjustor for NICU Providers<br>• Initial Bulletin: 9/14/2015<br>• RAD Code: N/A | DRG claims from designated NICU providers are not receiving the Obstetric Policy Adjustor effective July 1, 2015. | Providers should continue to submit their initial claims. An EPC was processed to correct the payments to the specific providers. | • Void and Resubmit (V&R) / EPC: EPC Sept 2016<br>• System Change Date: 11/23/2015<br>• Latest Publication Date: 6/30/2016 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.4** Medicare Part B<br>• Initial Bulletin: 7/14/2014<br>• RAD Code: 9952 (Type of Bill Code for APR-DRG Claim Invalid or Missing) | Medicare Part B claims submitted with bill type 121 are erroneously denying. | Medi-Cal recently implemented a fix for inpatient claims with type of bill code 121 that were erroneously denying with Remittance Advice Details (RAD) code 9952: Type of bill code for APR-DRG Claim Invalid or Missing.<br>Starting July 14, 2014, providers were instructed to resubmit DRG claims with type of bill 121 and dates of service on or after July 1, 2013, through June 30, 2014. Timeliness requirements are being waived for these type of bill 121 claims; therefore, providers do not need to submit a delay reason code, or any other documentation. This one-time timeliness waiver will allow for resubmission of these claims until September 26, 2014.<br>In April 2015, an EPC was issued to catch any claims not resubmitted by providers during the resubmission period for dates of service from July 1, 2013, through June 24, 2014. | • Void and Resubmit (V&R) / EPC: V & R and EPC April 2015<br>• System Change Date: 7/1/2014<br>• Latest Publication Date: 7/14/2014 |
| • **R.5** Other Health Coverage (OHC)<br>• Initial Bulletin: 11/4/2014<br>• RAD Code: 9968 (No Approved TAR on File for APR-DRG Inpatient Admission) | DRG claims that include OHC are denying. | The Department 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 were able to resubmit claims until November 20, 2015.<br>Claims resubmitted must contain the following on the UB-04 claim form to receive reimbursement:<br>- Include the following statement in the Remarks field (Box 80):<br>"DRG claim that previously denied with RAD code 9968"<br>- Indicate delay reason code "11" in the appropriate field<br>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 from OHC. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 9/21/2015<br>• Latest Publication Date: 7/1/2015 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.6** MCP and FFS Billing for Inpatient Stays<br>• Initial Bulletin: 11/4/2015<br>• RAD Code: 0037 (Health Care Plan Enrollee, Capitated Service Not Billable to Medi-Cal) | Recipient has Medi-Cal Managed Care for the first portion of the stay and Medi-Cal FFS for the second part of the stay; due to a system issue the claims are erroneously denying. | 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 MCP and FFS during the same inpatient stay, the hospital must first obtain reimbursement from the MCP. Once payment is received from the MCP, the hospital may then bill 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:<br>**Include prior payment dollar amount (amount paid by MCP) in the Prior Payments field (Box 54)<br>- Include one of the following statements in the Remarks (Box 80):<br>Medi-Cal managed care and fee-for-service stay<br>Medi-Cal MC and FFS stay<br>- Attach the statement of payment from the MCP<br>Timeliness will be waived for claims with dates of service through April 30, 2015, for FFS claims with admission dates on or after July 1, 2013, that previously denied for Remittance Advice Detail (RAD) code 0037: Health Care Plan enrollee, capitated service not billable to Medi-Cal. This billing advice 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 managed care plan with carved-out CCS Services. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 9/21/2015<br>• Latest Publication Date: 5/5/2015 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.7** Restricted Aid Code TARs<br>• Initial Bulletin: 11/4/2015<br>• RAD Code: 0341 (Units of Service Billed Exceed the TAR Authorized Days) | The system views an Admit TAR instead of a Daily TAR on claims billed with a restricted aid code causing claims to deny. | The Department identified a claims processing issue causing diagnosis-related group (DRG) claims for recipients who have a restricted aid code to erroneously deny with Remittance Advice Details (RAD) code 0341: Units of service billed exceed the TAR (Treatment Authorization Request) authorized days. Please resubmit with a new TAR Control Number. This issue has been resolved.<br>Claims resubmitted must contain the following on the UB-04 claim form to receive reimbursement:<br>- Include the following statement in the Remarks field (Box 80):<br>"DRG claim that previously denied with RAD code 0341"<br>- Indicate delay reason code "11" in the appropriate field<br><br>Timeliness for claims that previously denied with RAD code 0341 will be waived for claims with dates of service through February 1, 2015 and for FFS claims with admission dates on or after July 1, 2013. Hospital providers may resubmit claims until November 20, 2015. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 9/21/2015<br>• Latest Publication Date: 7/6/2015 |
| • **R.8** RTDs for DRG Organ Procurement Claims<br>• Initial Bulletin: 11/14/2014<br>• RAD Code: N/A | Hospitals reimbursed by DRG are erroneously issued a RTD when billing organ procurement claims with ancillary codes 810, 811, 812, 813, 814, 815, and 819. | Previously affected hospital providers should no longer receive erroneously issued RTDs when billing organ procurement claims for ancillary codes 810, 811, 812, 813, 814, 815 and 819, as this issue has been resolved.<br><br>Questions related to this past issue should be directed to the Telephone Service Center at 1-800-541-5555. | • Void and Resubmit (V&R) / EPC: N/A<br>• System Change Date: N/A<br>• Latest Publication Date: 11/17/2015 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.9** Admin/Rehab Claims - Length of Stay Invalid for Interim Claim<br>• Initial Bulletin: 9/17/2015<br>• RAD Code: 9953 (APR-DRG - Length of Stay Invalid for Interim Claim) | The system is not allowing interim admin/rehab claims (per diem claims) to pay if the stay does not exceed 29 days. | Hospital providers may resubmit Level 1 or Level 2 administrative day claims (with revenue code 169, 190 or 199) and rehabilitation claims (with revenue code 118, 128, 138 or 158) that were previously denied with Remittance Advice Detail (RAD) code 9953: APR-DRG – Length of Stay Invalid for Interim Claim, with admission dates on or after July 1, 2013, through November 13, 2015.<br><br>Type of Bill Code for Acute Inpatient Intensive Rehabilitation (AIIR), Administrative Day, and Medicare Crossover Claims:111, 112, 113, 114 Type of Bill Code for Inpatient Claims with Medicare Part B:<br>121, 122, 123, 124,<br>Resubmission claims must contain the following information to receive reimbursement:<br>Appropriate revenue code: 169, 190, 199, 118, 128, 138, or 158 in Box 42 (Rev. CD field)<br>Appropriate delay reason code<br>− Delay Reason Code “11” in Box 37 if the claim is submitted more than six months but less than 12 months from the date of admission<br>− Delay reason code “10” in Box 37 if the claim is submitted more than 12 months from the date of admission<br><br>The following statement in the Remarks field: “DRG claim that previously denied with RAD code 9953”<br>Timeliness will be waived for claims previously denied with Remittance Advice Details (RAD) code 9953: APR-DRG – Length of Stay Invalid for Interim Claim with admission dates on or after July 1, 2013, through November 13, 2015.<br><br>Timeliness for resubmitted claims that meet the above criteria will be waived through June 1, 2016. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: Estimated 5/23/2016<br>• Latest Publication Date: 5/15/2016 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.10** 22 Line Limit on Electronic Claims<br>• Initial Bulletin: 4/2/2015<br>• RAD Code: N/A | Providers are unable to submit electronic claims exceeding 22 revenue lines and are attempting to split bill. The second page of the claim submitted is denying. In some cases, the second page of the claim is received and processed for payment and the first page of the claim is denying. | Providers should complete a Claims Inquiry Form (CIF) void for all paid claims that were split-billed due to the 22 line restriction before July 28, 2014, where one of the following criteria exists:<br>- First page paid, second page denied; or<br>- Second page paid, first page denied; or<br>- First and second page paid separately (please make sure to void both pages)<br><br>Once the void appears on a future Remittance Advice Details (RAD) form, these claims may be resubmitted via Computer Media Claims (CMC) as a single claim.<br>Timeliness for claims that exceed 22 lines and meet one of the above criteria will be waived through April 1, 2016.<br>When resubmitting the claims via CMC, providers must do the following:<br>- Indicate delay reason code “10” in the appropriate field<br>- Use the following comment in the remarks area: “Claim exceeds 22 lines prior to July 28, 2014”<br>Failure to follow the above instructions could result in claims being denied or processed incorrectly. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 8/1/2015<br>• Latest Publication Date: 2/5/2016 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.11** DRG Claims Exceed $9,999,999.99<br>• Initial Bulletin: N/A<br>• RAD Code: N/A | Under DRG reimbursement, providers cannot split claims with total charges exceeding $9,999,999.99; splitting claims will cause claims to price incorrectly. | The Department has created a work around resolution to a claim processing issue that caused DRG claims with total charges exceeding $9,999,999.99 to pay inaccurately.<br>-To begin the process providers should submit a final claim using type of bill 111, actual admit and discharge dates, all procedures and diagnosis codes, and as many charges that can be accepted and remain below but as close to the $9,999,999.99 maximum allowed. Once the claim has adjudicated, the provider should contact the Department through the DRG mailbox, drg@dhcs.ca.gov, and submit a paper claim where the first page is identical to the original billed charges that were submitted and the second page is the remaining billable charges. Both pages should reflect the complete total charges. The subject line of the email should begin with the text: >$10M CLAIM.<br>-Upon submitting the total claim to the DRG mailbox, it should be submitted on two pages with the total charges of the entire stay. Also, all diagnosis and procedure codes and dates of service should match the first claim that was submitted and paid. The DRG Section will be responsible to price the claim with the full charges, subtract the DRG payment from the first claim and request for the remaining portion to be sent to providers.<br>This process allows the DRG assignment to be correctly captured resulting in an accurate DRG payment, as well as capture the Medi-Cal days which is utilized in other Medi-Cal programs.<br>For further information or questions regarding DRG claims exceeding $9,999,999.99 maximum allowed amount in total charge, contact the Department at drg@dhcs.ca.gov. | • Void and Resubmit (V&R) / EPC: N/A<br>• System Change Date: N/A<br>• Latest Publication Date: N/A |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.12** DRG Claims Erroneously Grouping to APR-DRG 951 and 952<br>• Initial Bulletin: 12/2/2015<br>• RAD Code: N/A | The Department has identified a mapping issue causing some APR-DRG claims for vaginal deliveries with a day of discharge on or after October 1, 2015, to group to APR-DRG 951 or 952. This is resulting in incorrect payments based on an incorrect DRG assignment. Affected DRG providers should continue to adhere to timely filing requirements. | For claims coded with ICD-10 codes, the Department upgraded to 3M Mapper Version 33, HAC Version 33, and Grouper Version 32 to resolve this issue. For claims coded with ICD-9 codes, the Department also upgraded to HAC Version 32. All upgrades occurred on April 25, 2016. | • Void and Resubmit (V&R) / EPC: EPC August 2017<br>• System Change Date: 4/25/2016<br>• Latest Publication Date: 9/8/2016 |
| • **R.13** Rehab Room and Board Payment Cap<br>• Initial Bulletin: N/A<br>• RAD Code: N/A | Provider billed their room and board and the charges are less than their rate on file and are paid at the lesser amount based on current Medi-Cal system design. | The system is working as intended and the Department has provided policy clarification regarding this issue. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: N/A<br>• Latest Publication Date: 2/7/2017 |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.14** Share of Cost Issue<br>• Initial Bulletin: N/A<br>• RAD Code: N/A | Issue 1- Baby using mom's ID, the SOC is being taking out twice from mom's claims and baby's claims.<br>Issue 2- Claim with a From and Through date longer than 30 days (final) claim is only deducting the 1st month SOC. | The Department has fixed this issue and affected DRG providers should void and resubmit claims that were kept timely | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 7/24/2017<br>• Latest Publication Date: 11/14/2016 |
| • **R.15** DRG Interim Claims Issue<br>• Initial Bulletin: N/A<br>• RAD Code: 9969 (No Approved TAR on File for APR-DRG Inpatient Interim Claim Admission) | The system is looking for a TAR with from and thru dates that overlap the claim service dates. Only an admit TAR is required, therefore the denial is erroneous. | The Department has fixed this issue and affected DRG providers were notified to void and resubmit claims that were kept timely. | • Void and Resubmit (V&R) / EPC: V & R<br>• System Change Date: 6/16/2017<br>• Latest Publication Date: N/A |
| • **R.16** Acute and Admin Days<br>• Initial Bulletin: N/A<br>• RAD Code: N/A | Provider bills for Acute days, however there are no billing instructions on how to bill for acute transfers. | The Department has updated the Medi-Cal provider manual, UB-04 Completion: Inpatient Services Billing Examples (ub comp ip ex) for billing inpatient services when transferring a patient between acute level of care and administrative level of care in the same (DRG) hospital. | • Void and Resubmit (V&R) / EPC: N/A<br>• System Change Date: N/A<br>• Latest Publication Date: 3/19/2018 |
| • **R.17** Surgical codes not recognized<br>• Initial Bulletin: N/A<br>• RAD Code: 67 (The primary/secondary surgical code has no match on the procedure file) | Claims submitted using specific ICD-10 surgical codes are not recognized by the system and claims are being denied. | The codes are now valid in the system and claims with this issue will be processed correctly. An EPC will be run for claims denied only for this reason. | • Void and Resubmit (V&R) / EPC: EPC<br>• System Change Date: 11/16/2018<br>• Latest Publication Date: N/A |

| Resolved (R) | Description | Status | |
|---|---|---|---|
| • **R.18** Revenue Codes Not Available in CA-MMIS<br>• Initial Bulletin: N/A<br>• RAD Code: N/A | Claims billed with invalid ancillary codes are denied because some revenue codes are NOT allowed by Medi-Cal, but still used by other payers. | This item was moved to resolved as revenue codes are documented in the Provider Manual. | • Void and Resubmit (V&R) / EPC: N/A<br>• System Change Date: N/A<br>• Latest Publication Date: N/A |