Designated Public Hospital Inpatient Services

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This section contains information for Designated Public Hospitals (DPHs), i.e., those hospitals reimbursed through certified public expenditures (CPE) for acute inpatient care.

Notice: Effective for admissions on or after July 1, 2013, reimbursement for inpatient general acute care hospitals (which do not participate in certified public expenditure reimbursement) is based on a diagnosis-related groups (DRG) reimbursement methodology. Due to DRG, the instructions in this manual section may not pertain to your facility. If your facility is reimbursed according to the DRG model, refer to corresponding DRG instructions in the appropriate Part 2 provider manual. This section will be retained in the provider manual to accommodate claims submitted prior to July 1, 2013, and non-DRG-reimbursed claims, until the Department of Health Care Services (DHCS) directs its removal or update. Some instructions in this section are no longer supported.

Introduction

Designated Public Hospital Information

Welfare and Institutions Code (WIC) Section 14166.1 defines “Designated public hospital” as one of the following hospitals identified in Attachment C, “Government-operated Hospitals to be Reimbursed on a Certified Public Expenditure Basis,” of the Special Terms and Conditions to Medi-Cal’s 2005 Hospital/Uninsured Care Demonstration project (Number 11-W-00193/9) and successor demonstration project approved by the federal Centers for Medicare and Medicaid Services (CMS).

The following DPHs were identified in this demonstration project, and to date, the list remains largely the same.

- UC Davis Medical Center
- UC Irvine Medical Center
- UC San Diego Medical Center
- UC San Francisco Medical Center
- UC Los Angeles Medical Center (also known as Ronald Reagan UCLA Medical Center), including Santa Monica/UCLA Medical Center
- LA County Harbor/UCLA Medical Center
- LA County Martin Luther King Jr.-Harbor Hospital (Closed August 2007)
- LA County Olive View UCLA Medical Center

- LA County Rancho Los Amigos National Rehabilitation Center
- LA County University of Southern California Medical Center
- Alameda Health System
- Arrowhead Regional Medical Center
- Contra Costa Regional Medical Center
- Kern Medical Center
- Natividad Medical Center
- Riverside County Regional Medical Center
- San Francisco General Hospital
- San Joaquin General Hospital
- San Mateo Medical Center
- Santa Clara Valley Medical Center
- Tuolumne General Hospital (Closed June 2007)
- Ventura County Medical Center

Selective Hospital Contracting Information

Medi-Cal's previous Selective Provider Contracting Program (SPCP) began to phase out with the implementation of the 2005 Medi-Cal Hospital/Uninsured Care Demonstration Project. The primary Medi-Cal inpatient acute care reimbursement method for DPHs became CPEs (vs. inpatient contract rates and inter-governmental transfers).

The SPCP was later terminated when the California Legislature directed Medi-Cal to replace the fee-for-service reimbursement method for general acute care hospital inpatient services, both negotiated contract rates and non-contract cost reimbursement, with reimbursement by DRGs (W&I Code, Section 14105.28).

This means that open and closed Health Facility Planning Areas (HFPAs) are no longer a component of fee-for-service general acute care hospital recipient reimbursement. As such, all eligible providers may serve Medi-Cal recipients for both emergency and elective acute inpatient services subject to Medi-Cal specific policy, making it no longer a requirement to transfer a recipient once they are stabilized.

Physician/Outpatient Services

DPHs are reimbursed for certain physician/outpatient services via their CPE per diem rate and should not bill separately for these services. Physician services that are included in a hospital's CPE per diem rate should be billed to the hospital. Questions regarding denials for Remittance Advice Details (RAD) code 348 (procedure billed is not payable in the facility for the date of service billed. Contact the facility.) should first be directed to the DPH. If unresolved, a complaint letter specifying the nature of the problem should be sent to the Department of Health Care Services (DHCS) at Safety Net Financing Division, 1501 Capitol Avenue, MS 4504, P.O. Box 997436 Sacramento, CA 95899-7436.

Separately Reimbursable Services

DPHs must provide additional statements when requesting reimbursement for an outpatient or emergency service that is separately reimbursable from their CPE per diem rate when performed during an inpatient stay. A statement also will be required for outpatient or emergency services rendered more than 24 hours prior to the inpatient admission on the calendar day prior to admission.

Mother or Newborn: Outpatient and Emergency Services

DPHs must provide a statement when requesting outpatient or emergency service reimbursement for a newborn or mother when one of the two remains an inpatient. When billing for an outpatient or emergency service for a mother and the newborn is still an inpatient, enter "Service separately reimbursable – recipient discharged from inpatient care on (Date)" in the *Remarks* field (Box 80). The same statement will be required if the outpatient or emergency service is performed for the newborn and the mother is still an inpatient.

Hospital Contract Exclusion

DPHs must bill their separately reimbursable services on a separate outpatient claim and include the appropriate statement in the *Remarks* field (Box 80) of the claim as follows:

- For services performed during an inpatient stay, the claim must indicate that “the service is separately reimbursable and is not included in the facility CPE per diem rate.”
- For services rendered more than 24 hours prior to the inpatient admission on the calendar day prior to admission, the claim must indicate that “the service occurred on (Date and Time) which is more than 24 hours prior to the inpatient admission on (Date and Time).

Note: This statement is only required when the service rendered is for the same or related condition as the condition for which the recipient was admitted. See the transplant billing example “Inpatient Provider Billing for Bone Marrow Procurement Submits Outpatient Claim” in the *Transplants: Billing Examples for Inpatient Services* section in the appropriate Part 2 provider manual.

Non-CPE Per Diem Services

DPHs billing for non-CPE per diem services such as administrative days; take-home drugs; applicable, deductible and/or coinsurance for Medicare crossover recipients; and psychiatric care must bill these services on a separate *UB-04* claim form. These services are cost reimbursed, including associated ancillaries.

Billing for Private Rooms

Claims with charges for private accommodations are reviewed to determine if the recipient’s medical condition requires the use of a private room. If there is not enough information submitted on or with the claim to substantiate the private accommodation, reimbursement will be made at the rate justified on file.

DPH Hospital Billing for Subsequent Ancillary Charges

DPHs must provide documentation when billing for additional ancillary charges subsequent to those on the initial claim. Providers must document both of the following in the *Remarks* field of the claim form or on an attachment to the claim:

- Certification that ancillary charges do not duplicate previously billed ancillary services.
- Identification of specific ancillary item(s) being billed that were not included on previous claim(s).

CPE Per Diem Services

All inpatient services provided by a DPH hospital for which a separate NPI subpart has been registered to uniquely identify the services billed must use the subpart NPI when billing for CPE per diem-only services.

If a hospital chooses to register one NPI to bill both inpatient CPE per diem and non-CPE per-diem services, the Medi-Cal claims reimbursement system will distinguish between the two services and services and correctly reimburse using the one NPI submitted.

Billing Usual and Customary Charges

DPHs must continue to bill their usual and customary charges for all inpatient services (revenue codes for accommodations and ancillaries) in order that appropriate federal requirements can be met. The claims processing system will reimburse DPHs for valid inpatient services covered by a CPE per diem rate, at that rate regardless of the amount billed on the claim form. Hourly rates are not allowable and cannot be billed by hospitals. It is imperative that DPHs bill any additional ancillary charges identified after the initial billing, even though it will not result in additional reimbursement. These amounts are part of the hospital's historical cost figures and are used in future determination of the CPE per diem rate. It is to the hospital's advantage to have all charges on file to help determine equitable CPE per diem rates.

CPE Per Diem Hospital Billing

DPHs are identified via WIC Section 14166.1 and the current federally approved Section 1115 Medicaid Waiver are to be reimbursed on a CPE per diem basis for all inpatient services. Refer to the *Revenue Codes for Inpatient Services* section in the appropriate Part 2 manual.

OB and Newborn Revenue Codes

Refer to *Obstetrics: Revenue Codes and Billing Policy for Designated Public Hospitals* instructions in the Part 2 Inpatient Services manual for codes and information necessary to bill inpatient obstetrical and newborn services using revenue codes for all DPH facilities.

OB Admissions

OB Authorization Free Days

Inpatient delivery services are reimbursable without post reimbursement review for medical necessity up to a maximum of two consecutive days, regardless of the type of delivery, beginning the day the mother is admitted to the hospital, if delivery occurs within that two-day period. WIC Section 14132.42 mandates that a minimum of 48 hours of inpatient hospital care following a normal vaginal delivery and 96 hours following a delivery by cesarean section are reimbursable without authorization. For claims processing purposes, it is necessary to use calendar days instead of hours to implement these requirements.

Therefore, a maximum of two consecutive days following a vaginal delivery using any of the following ICD-10-PCS codes is reimbursable without a post reimbursement review:

0U7C7ZZ

0Q820ZZ thru 0Q832ZZ

0W8NXZZ

10907ZA

10908ZA

10900ZC

10903ZC

10904ZC

10907ZC

10908ZC

10D07Z3 thru 10D07Z8

10E0XZZ

10S07ZZ

10S0XZZ

Or, four consecutive days following a delivery by cesarean section using any of the following ICD-10-PCS codes is reimbursable without a post reimbursement review:

10A00ZZ thru 10A04ZZ

10D00Z0 thru 10D00Z2

10T20ZZ thru 10T24ZZ

The post-delivery period begins at midnight after the mother delivers.

If delivery does not occur within two consecutive days of admission, post reimbursement review is possible for all days of hospitalization prior to and including the delivery day to support the medical necessity of each day of the stay. If the delivery does not occur at all during the hospital stay, post reimbursement review is possible for all days of that hospital stay.

Continued medically necessary hospitalization beyond two consecutive days following vaginal delivery, or four consecutive days following delivery by cesarean section, will allow for possible post reimbursement review for medical necessity.

DPHs Billing Per Diem: Well Baby

DPHs billing CPE per diem are reimbursed for post-delivery inpatient care of a well-baby who remains in the hospital during the mother's unused OB authorization-free period after the mother is discharged or expires. Any inpatient days after the OB authorization-free period may be reviewed post reimbursement for medical necessity.

Split Billing OB Authorization-free Days

DPHs must not split-bill (submit on two or more claims) OB inpatient stays that fall under the OB authorization-free period. Hospital stays that are reimbursed on a CPE per diem basis that extend beyond the OB authorization-free period may be billed on one claim. For example, a provider should submit one claim for a mother who delivered vaginally on the second day of her hospital stay but then experienced a complication that required her to spend five hospital days, with discharge on the sixth day. The total hospital stay of five days that is partially OB authorization-free should be billed on one claim.

Delivery Prior to Hospital Admission

When a vaginal delivery occurs outside the hospital, the mother and baby may receive up to a maximum of three OB authorization-free days for the hospitalization including the day of admission (if the delivery occurs on the same day as the day of admission) and two consecutive days. Any stay past two days following the delivery may be subject to post-reimbursement review for medical necessity. The actual time and day of delivery will be established from a combination of the mother's statement, records of auxiliary personnel involved in the care and transport of the mother, and the attending physician's assessment.

Revenue code 119, 129, 139 or 159 in conjunction with admit type code "4" (newborn), admit source code "4" (extramural birth) and ICD-10-PCS code 10D07Z8 (extraction of products of conception, other via natural or artificial opening) is used to bill OB-related room and board services when vaginal delivery occurs prior to the mother's admission to a hospital. Providers should bill revenue code 171 (nursery, newborn, level I) for disproportionate share reimbursement adjustments for the well-baby services on the same claim used to bill the mother's stay.

Following are some billing examples when a delivery occurs on 072522.

Example 1

Mother and baby were admitted to the hospital later that same day (072522) and discharged 072822.

072522 (Day 1): OB authorization-free.

072622 (Day 2): OB authorization-free.

072722 (Day 3): OB authorization-free.

072822 (Day 4): OB authorization not applicable.

Example 2

Mother and baby were admitted to the hospital on 072622 and discharged 072822:

072622 (Day 1): OB authorization-free.

072722 (Day 2): OB authorization-free.

072822 (Day 3): OB authorization not applicable.

Example 3

Mother and baby were admitted to the hospital on 072722 and discharged on 072822:

072722 (Day 1): OB authorization-free.

072822 (Day 2): OB authorization not applicable.

Example 4

Mother and baby were admitted to the hospital on 072722 and discharged on 073022:

072722 (Day 1): OB authorization-free.

072822 (Day 2): Exceeds OB authorization-Free Period.

072922 (Day 3): Exceeds OB authorization-Free Period.

073022 (Day 4): OB authorization not applicable.

Example 5

If mother and baby were admitted to the hospital on or after 072822, the entire hospital stay would be subject to post reimbursement review for medical necessity.

Fetal Demise

All OB authorization-free days for pre-delivery and post-delivery days apply in the event of fetal demise, if the physician determines the event constituted delivery. Once a delivery for fetal demise has been determined, providers should use the following ICD-10-PCS codes for vaginal deliveries:

0U7C7ZZ

0Q820ZZ thru 0Q834ZZ

0W8NXZZ

10907ZA

10908ZA

10900ZC

10903ZC

10904ZC

10907ZC

10908ZC

10D07Z3 thru 10D07Z8

10E0XZZ

10S07ZZ

10S0XZZ

Providers use the following ICD-10-PCS codes for cesarean deliveries:

10A00ZZ thru 10A04ZZ

10D00Z0 thru 10D00Z2

10T20ZZ thru 10T24ZZ

Claims also must include either admit type code “1” (emergency) or “3” (elective).

Day of Discharge or Death: OB Admission

The day of discharge or day of death is not reimbursable even though the day may be an OB authorization-free day. It is reimbursable only when the discharge/death occurs on the day of admission.

Emergency Services

Emergency hospital services do not require authorization prior to admission if hospitalization is for services that meet the definition of emergency services. All hospitalizations resulting from emergency admissions, however, are subject to post reimbursement review by the Medi-Cal consultant and require justification for medical necessity.

Emergency Transfers

If the recipient was transferred from another facility, enter in the *Source of Admission* field (Box 15), “4,” “5” or “6” to indicate the source of emergency transfer.

No Delivery

If hospitalization does not result in delivery (false labor or failed induction) and the recipient is discharged on the same day as admitted (that is, before midnight), services should be billed following the outpatient billing instructions in *UB-04 Completion: Outpatient Services* section in the appropriate Part 2 provider manual.

When billing for this admission the provider must not bill with a delivery ICD-10-PCS Code. This admit must be billed with a procedure code other than the following codes:

0U7C7ZZ

0Q820ZZ thru 0Q834ZZ

0W8NXZZ

10900ZC

10903ZC

10904ZC

10907ZA

10907ZC

10908ZA

10908ZC

10A00ZZ thru 10A04ZZ

10D00Z0 thru 10D00Z2

10D07Z3 thru 10D07Z8

10E0XZZ

10S07ZZ

10S0XZZ

10T20ZZ thru 10T24ZZ

If no delivery occurs but it is medically necessary for the recipient to remain at the acute level of care for a second day, for each day of the hospital stay post reimbursement review for medical necessity is possible. These claims must be billed with Type of Admission code “3” (elective). If the recipient was transferred from another facility, enter in the *Source Admission* field (Box 15) “4”, “5” or “6” to indicate the source of the elective transfer.

Place of Service

All services provided by the hospital to inpatient recipients, regardless of the site of service, must be billed as inpatient services. Hospitals rendering services to inpatient recipients in the hospital outpatient department or emergency room may not bill these services separately as outpatient services. Hospital outpatient departments, surgical clinics and organized outpatient clinics may be reimbursed only for services provided to outpatient recipients at the department or clinic site.

Low Birth Weight Newborns May Qualify for SSI and SSI Linked Medi-Cal

Providers can assist parents of premature newborns in applying for immediate Supplemental Security Income (SSI) benefits and related SSI-linked Medi-Cal benefits. Premature infants born before or at 37 weeks and weighing less than 2 pounds and 10 ounces, regardless of medical impairment, qualify for the Social Security Administration (SSA) “Presumptive Disability” (PD) category. Though subject to SSA review, PD infants usually qualify for benefits.

Parents must file an SSI application through the SSA office. Since SSI reimbursements and SSI-linked Medi-Cal benefits are not retroactive to dates prior to the SSI application date, providers should encourage parents to apply for SSI benefits as soon as it is determined their newborn meets PD standards.

The parent’s income and resources are not used to determine SSI benefit eligibility until the month following the month that the infant is released from the hospital. The infant’s independent income and resources, however, are used to determine benefits. For example, an infant bequeathed a legacy may not qualify for these SSI benefits.

Admissions

Emergency Neonatal Intensive Care Services

Neonatal intensive care services performed within the first 24 hours of life are to be considered emergency services and processed as such. This includes hospital admissions (Type of Admission code “1”), transfers, ambulance and other related services otherwise requiring authorization. This policy includes transfers from one acute hospital to another which has the level of care necessary to meet the recipient’s medical needs.

Facilities

Except for OB authorization days all paid claims are subject to possible post reimbursement review for medical necessity as well as proper Medi-Cal procedures.

Day of Discharge or Death: Emergency or Elective Admission

If the day of discharge or death occurs with an emergency or elective admission, it is not reimbursable except when the discharge/death occurs on the day of admission.

Discharge/Death on Day of Admission

If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of discharge/death is not the same day as admission, the day is not payable because there is no reasonable expectation that the recipient will remain and occupy a bed on such a day.

OB Day of Discharge or Death

Refer to “Day of Discharge or Death: OB Admission” on a previous page in this section for more information.

Ancillary Services

When the day of admission is the same as the day of discharge or death, DPHs are reimbursed for a day of service in accordance with their CPE per diem rate. However, DPHs must continue to bill their usual and customary charges for all inpatient services, including ancillary charges.

Revenue Codes

When billing for revenue codes, DPHs must:

- Enter the number of days billed in the *Service Units* box
- Enter the usual and customary charges reflecting total charges

Important: The total number of days must not exceed the number of days represented by the “from-through” dates of service.

Recipient Death

No Reimbursement After Declaration of Death

Medical care provided after a Medi-Cal recipient has been declared dead is not considered acute care services and Medi-Cal will not provide reimbursement under that recipient's Client Identification Number (CIN) or Benefits Identification Card (BIC).

Organ Preservation

Refer to the *Transplants: Donor Protocol* section in the appropriate Part 2 manual for information about medical care provided for organ preservation services.

Reminders

The following items are important:

- Medicare/Medi-Cal crossover recipients are not affected by the fee-for-service process until their Medicare benefits are exhausted, at which time they become Medi-Cal-only recipients. These services are then billed to Medi-Cal using the applicable provider NPI number.
- Medically Indigent Adults (MIAs) who are no longer Medi-Cal recipients must be billed using the hospital inpatient NPI number.

Verifying Eligibility

Providers must verify eligibility on admission and for each subsequent month that the hospital stay includes, if applicable.

Provider Preventable Conditions (PPCs)

As of July 1, 2012, providers must identify Provider Preventable Conditions (PPCs) and report them to DHCS, even if the provider does not intend to bill Medi-Cal. Any DHCS staff aware of potential PPCs may also refer providers to Audits and Investigations. CMS has directed that state Medicaid agencies like Medi-Cal prohibit reimbursement for specified PPCs.

‹‹Split Billing for Managed Care Plan and Fee-for-Service Claims

When billing a stay at a DPH for a recipient who is covered by a Medi-Cal Managed Care Plan (MCP) for the first part of the stay and covered by fee-for-service 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 fee-for-service. The payment received from the MCP will be deducted from the total payment amount from FFS. Claims submitted for MCP and fee-for-service 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

For acute inpatient stays where the recipient has Medi-Cal managed care enrollment for all of the stay, but the stay should pay through fee-for-service Medi-Cal, an additional carve out should be paid for Voluntary Inpatient Detoxification (carve-out from managed care).

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

While not required for a medical necessity review of the *Treatment Authorization Request* (TAR), providers are encouraged to note “Voluntary Inpatient Detoxification” in the *Medical Justification* field of the paper TAR or “VID” in the special handling option of the eTAR. The documentation ensures that DHCS can track service utilization. For TAR criteria, refer to the *Voluntary Inpatient Detoxification* section of this manual.››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.