Participating Hospital Responsibilities for Participation in the Superior Systems Waiver Public Hospital Project

I. Hospital Primary Contact

Provide hospital name and address. Also provide a single hospital contact person's name, phone number, and e-mail address. This person will be the primary contact for the California Department of Health Care Services' (DHCS) Public Hospital Project (PHP).

Hospital Name: _____

National Provider Identification (NPI) Number : _____

Street Address:_____ Suite/Unit: _____

City:_____ State_____ Zip Code: _____

Primary Contact: _____ Title: _____

Phone: _____ E-mail: _____

II. Organizational Chart

Please attach the Utilization Review (UR)/Case Management department's organizational chart along with primary contacts of the hospital's UR/Case Management, Medical Records and Billing departments.

To ensure the participating hospital receives the appropriate DHCS documentation it is the responsibility of the hospital to notify DHCS within ten (10) business days of any modifications.

To verify current hospital representatives receiving correspondence/documentation related to the PHP for your hospital, please contact DHCS at PublicHospitalProject@dhcs.ca.gov.

III. Utilization Review Process

As the single state Medicaid agency, DHCS is required to provide technical assistance, oversight and monitoring of state and federal funds. The Superior Systems Waiver (SSW) outlines additional guidelines regarding the PHP, including DHCS' role for monitoring and oversight of the hospital evidence-based standardized medical review criteria processes and outcomes in lieu of requiring 100 percent review and prior authorization of acute inpatient hospital days.

The participating hospital must submit evidence that each hospital day was individually reviewed through a standard utilization review (UR) tool including daily decisions and daily case management notes. Grouping of a range of days is not permitted. No claims shall be submitted until the utilization review process is completed for each hospital day to be billed. The Clinical Assurance Division (CAD) may ask the participating hospital to amend claims that do not fulfill these requirements. An authorized day under any standardized utilization tool does not guarantee approval by DHCS.

For acute inpatient claims associated with Medi-Cal beneficiaries with restricted aid codes, one of the following phrases must be indicated in the "Comments" field of the UB04 and/or UB92 claim form (box 80):

"Hospital certifies providing emer svcs to unverified citizen"

OR

"Hospital certifies providing emer or pregnancy related svcs to unverified citizen"

Use of a current evidence-based standardized medical review criteria tool is required for participation in the SSW's DRG TAR-Free process. Please indicate below which system your hospital uses:

☐ InterQual; Version: _____

☐ MCG – formerly Milliman Care Guidelines; Edition: _____

☐ Other (Please Specify): _____

If your hospital changes its evidence-based standardized medical review criteria system, then the participating hospital shall notify DHCS at least 90 calendar days prior to the planned implementation date of the change via email or by telephone:

PublicHospitalProject@dhcs.ca.gov
(916) 552-9100

IV. Utilization Review Committee

As Medi-Cal providers, each hospital is required to have a utilization review (UR) committee.

Code of Federal Regulations Title 42, section 482.30(b) requires a hospital's UR committee to be composed of two or more practitioners who carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in section 482.12(c)(1).

For further information, please refer to Code of Federal Regulations Title 42, sections 456.1 through 456.51, 482.12, and 482.30.

V. Requirements

As a participant in the SSW's PHP, the hospital is required to:

- Use the current version of evidence-based standardized medical review criteria for acute inpatient care. (Please note – your hospital determines which product it will use.)
- Ensure UR staff is trained on the use of evidence-based standardized medical review criteria.
- Include all DHCS submission criteria requirements in your hospital's evidence-based standardized medical review criteria documentation. These requirements include but are not limited to:
    - Utilization of an Episode Day ("Initial Review" not permitted; *requirement applicable to InterQual only*)
    - Version/Edition used
    - Criteria/Guideline Status (Observation status is not permitted)
    - Subset/Guideline(s) used
    - Criteria Point(s)/Clinical Indication(s)
    - Date of the hospital stay that was reviewed
    - Date the review was created
- Receive training by DHCS staff for applicable hospital UR staff on the new UR process, requirements, and relevant Medi-Cal policies prior to beginning the new UR process, and ongoing training as needed.
- Provide a process for resolving Medi-Cal beneficiary grievances including recording of all grievances received, date of receipt, nature of problem, date and resolution or disposition of the grievance.

- Allow DHCS staff electronic access to fee-for-service (FFS) Medi-Cal beneficiary medical records, evidence-based standardized medical review criteria determinations and secondary review decisions at least five (5) business days prior to scheduled review.
- Submit requested missing documentation within 24 hours of notification.
- Notify DHCS of anticipated system changes (i.e. firewalls, updates, new systems such as Cerner, EPIC, etc.) 90 days prior to changes as well as provide training for DHCS staff in regards to system changes.
- Notify DHCS within ten (10) business days of any organization personnel changes.
- Notify DHCS of changes in ownership and/or NPI numbers at least 90 days prior to the effective date. A change of ownership does not guarantee TAR-Free participation for the new entity. Failure to notify DHCS of changes in NPI numbers may result in a claims processing delay.

VI. Secondary Review Process

If an acute hospital day does not meet evidence-based standardized medical review criteria, and the hospital wants to be considered for reimbursement by Medi-Cal, the hospital must perform a secondary review and include:

- A written discussion of the medical necessity indicating the need for acute inpatient level of care
- Physician contact name and phone number
- Date of review
- Physician's signature of approval

An authorized day approved via secondary review does not guarantee approval by DHCS.

This secondary review determination must be performed by a doctor of medicine or osteopathy with a current active medical license in the State of California. This physician may be a member of the UR committee, but may not be one of the attending physicians for the case under review.

Hospital days approved through the secondary review process must be individually justified by the physician. Grouping approval of a range of days is not permitted.

VII. TAR-Free Claiming

TARs will no longer be required for most acute inpatient days prior to claim submission with participation in the PHP. This excludes the following:

- Hospice General Inpatient Care
- Surgical Procedures (Hospital days associated with surgical procedures will not require a TAR and can be billed using the TAR-Free process with the required utilization review process defined above.)

After the hospital's own UR process is completed, and a secondary review has been performed if necessary, the participating hospital may then submit a claim form directly to the DHCS fiscal intermediary.

Evidence-based standardized medical review criteria must be utilized before submitting a claim for acute inpatient days. Medical records, evidence based-decisions, access to the evidence-based standardized review acute criteria system, and secondary reviews shall be available to DHCS upon request; if these requirements are not met, DHCS will instruct the participating hospital to adjust claims.

VIII. Acute Inpatient Rehabilitation (as applicable)

This section only applies to hospitals that provide Acute Inpatient Rehabilitation (acute rehab) services.

For acute rehab services, DPHs will also perform their own UR using evidence-based standardized medical review criteria, such as InterQual or MCG. Medi-Cal FFS acute rehab criteria for DPHs in the PHP are as follows:

- The participating hospital is required to document InterQual or MCG outcomes on a weekly basis.
- All acute rehab services for Medi-Cal FFS beneficiaries must be provided in an acute care bed (certified pursuant to 42 CFR Part 482) in a rehabilitation center (licensed in accordance with Title 22, CCR, sections 70595-70603).
- Only the identified acute rehab revenue codes shall be used when billing for acute rehab day(s), i.e. 118, 128, and/or 138.
- DHCS requires patients to be in an Intensive Rehab Program, consisting of 15 hours per week of treatment therapies as directed in the standardized medical review criteria (except in circumstances where temporary changes in the patient's condition preclude administration of this level of therapy) and this can consist of individual and group therapy if the beneficiary is deemed medically appropriate for group therapy. Of the provided hours, no less than 75% of the 15 hours per week (11.25 hours) shall be individual therapy. Any additional therapy may consist of group or individual based upon the clinical determination of the treating physician.
- Care/treatment must be supervised by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation.

IX. DHCS Oversight

DHCS will review statistically valid samples from Medi-Cal FFS inpatient paid claims and associated medical records as well as perform, as applicable, focused reviews to validate the hospital's UR process and adherence to Medi-Cal policy. DHCS shall prepare and issue a Statement of Findings (SOF) report after each review period. The SOF will identify any and all variances cited by DHCS. For variances identified as recoupable, the hospital will be instructed to correct the claim through the Claims Inquiry Form (CIF) process. The CIF process is a two- step process (CIF and claim Appeal through the DHCS fiscal intermediary) that results in a correction of the claim for proper payment history. This process includes the coding of the claim as instructed in the CIF links below:

CIF Overview -

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/cif.pdf

and

CIF Completion -

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/cifco.pdf

Claims must be corrected through the CIF process within 60 days from the date of the SOF notice, or if disputed, within 30 days following the final resolution of any applicable dispute.

For variances identified in the SOF as recoupable only: The appeal form overview and completion process is identified in the links below for claim adjustments:

Appeal Overview -

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/appeal.pdf

and

Appeal Completion -
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/appealform.pdf

A dispute process is available to hospitals for variances identified in the SOF as recoupable only. A recoupable variance is one that includes a CIF directive in the variance comments along with the specific claim information.

If after 60 days of the issuance of the SOF, or within 30 days following the final resolution of any applicable disputes, the identified recoupable variances (days) were not corrected through the CIF and appeal processes, this information shall be submitted to the DHCS A&I office for recoupments of overpayments to the provider that are subject to recovery pursuant to Section 51458.1, Article 6 of Division 3, Title 22, California Code of Regulations.

If you choose to dispute any of the findings in the enclosed report, you must submit a Dispute Resolution Form to DHCS within 60 days from the date of this letter. Dispute forms are available on the DHCS website at: http://www.dhcs.ca.gov/provgovpart/Pages/PublicHospitalProject.aspx. Completed dispute forms and any additional documentation in support of the dispute must be submitted on-line to the hospital's dispute folder at: https://etransfer.dhcs.ca.gov. The finalization of findings will be postponed until resolution of the dispute.

One purpose of the DHCS monitoring and oversight process is to provide information and additional training in order to correct variances in the hospital's UR process as well as adherence to Medi-Cal policies. The hospital is also required to provide ongoing training on the TAR-Free UR process to current and new staff. If information sharing and training does not correct a hospital's variances, a referral to DHCS Audits and Investigations (A&I) may occur for further follow up. This referral to A&I would only occur after the DHCS CAD provided training and technical assistance and worked with a hospital to correct issues to meet a measurable level of, and timeframe to come into, compliance, determined by DHCS and communicated to the hospital in writing. If a hospital is deemed non-compliant with the requirements that govern the utilization management process as well as adherence to Medi-Cal policy, DHCS may require another method of utilization review, such as the TAR process, until such time that the hospital can demonstrate compliance. The DHCS oversight and monitoring/audit process may lead to recoupment from the hospital and/or civil money penalties. Civil money penalties may be imposed as permitted by Welfare and Institutions Code, Section 14123.25. These penalties range from $100 to $1,000 per adjustment to reported costs, up to three times the amount for each item or service improperly claimed, whichever is greater.

X. Electronic Medical Record System Access

The participating hospital agrees to make its electronic medical records system (EMR) accessible to authorized DHCS users for the sole and specific purpose of conducting utilization reviews.

DHCS will provide the participating hospital with a list of authorized users who have been properly screened by DHCS, and who will comply with all federal and state laws and regulations which protect the confidentiality of Protected Health Information (PHI) as defined by 45 C.F.R. 160.501. The list of authorized users will contain the names, e-mail addresses, and contact telephone numbers of all DHCS individuals authorized to access EMRs. DHCS will regularly update the list of authorized users as changes occur.

DHCS authorized users will only review cases involving Medi-Cal beneficiaries. DHCS will provide the participating hospital with the list of sample cases in advance of each review. DHCS authorized users will not use or disclose PHI other than as permitted or required by law.

XI. Acknowledgement

I have read and understand the hospital responsibilities outlined above. This document is intended to provide general information about hospital responsibilities for participation in the PHP. It is not a complete or exhaustive list of all hospital responsibilities. This agreement shall be updated annually from the date signed. By signing, the authorized representative acknowledges his/her authority to enter into this agreement.

Hospital Representative (Print Name)	Hospital Representative Signature	Title	Date
Hospital Representative Email:	Hospital Representative Phone:		
DHCS Representative (Print Name)	DHCS Representative Signature	Title	Date