DHCS Designated Public Hospital TAR-Free Process

Variance Descriptions and Authorities

Hospital Utilization Review Process

DPH Utilization Process	
Description	The DPHP allows for the use of a standardized screening tool to determine medical necessity. The decision to admit, retain, or discharge a beneficiary is a physician decision. When a beneficiary is admitted to an acute inpatient hospital and the standardized reviewcriteria has determined that the primary review did not meet criteria, a secondary review may be performed by the utilization review nurse and a physician. The secondary review may be completed by a physician adviser, physician on the UR Committee or any other California licensed physician that is not the attending/ordering physician. If the DPH chooses to perform a secondary review and to authorize additional days, then this secondary review determination must be performed and signed off by a doctor of medicine or osteopathy with a current active license in the State of California. The secondary review should include the physician review date, signature, contact information (phone number) and a summary outlining the medical rationale for authorization of each day of the stay through secondary review (reason for decision/outcome).
Authority	• Title 42,4 CFR, Section 482.30
Medical Necessity	
Description	Medical necessity for an acute inpatient day is met if approved by the standardized utilization review tool criteria. If an acute day falls out of the criteria of the UR tool a secondary review is required. DHCS will review secondary review decisions to determine if Medi-Cal acute inpatient level of care criteria is met. Approval of acute inpatient hospital days requires that the care rendered is medically necessary and the Medi-Cal beneficiary remains at the acute level of care as documented in the medical record. Acute hospital services, including specific physician services, procedures and consultations are to be available 24 hours per day, 7 days per week, in order to meet the medical needs of the beneficiary.
Authority	• W&I Code, Section 14059.5 • W&I Code, Section 14133.25(a) • W&I Code, Section 14133.3(a) • Manual of Criteria For Medi-Cal Authorization Chapter 5.1, I

Variance Descriptions and Authorities

Limited/Restricted Aid Codes

Aid Code Discrepancy	
Description	Aid Codes are meant to assist providers in identifying the types of services for which Medi- Cal and Public Health Program recipients are eligible. Aid Codes were developed for use inconjunction with the Medi-Cal Eligibility Verification System (EVS). Providers must verify eligibility every month. They must submit an inquiry to the EVS to verify a recipient's eligibility for services. Eligibility verified at the first of the month is valid for the entire month of service. A Point of Service (POS) printout or Internet eligibility response may be kept as evidence of proof of eligibility for the month. When a provider verifies that an individual is eligible to receive Medi-Cal benefits; the provider is accepting the individual as a Medi-Cal recipient. The Designated Public Hospital Project (DPHP) instructs the provider to submit a monthly inpatient admission list for Medi-Cal fee-for-service beneficiaries. One of the mandatory data requirements for this list includes a valid Aid Code for each beneficiary. The Aid Code provided in the monthly admissions data should match DHCS verification of the recipient's Aid Code.
Authority	• W&I Code, Section 14018.2
Restricted Aid Code	
Description	Medi-Cal funds can be paid only for services that the beneficiary qualifies for under their assigned aid code. Some aid codes have limited or restricted eligibility. These aid codes limit reimbursement to medical care that is directly related to the emergent condition for which they were admitted or for services that are medically necessary services related to a pregnancy. A beneficiary with a restricted aid code has coverage for services that are medically necessary and related to the emergent condition. (Examples of some of these aid codes are 3V, 58).
Authority	• W&I Code, Section 14007.5 • Title 22, CCR, Section 51056

Variance Descriptions and Authorities

Delay

Delay of Services	
Description	Delay in Rendering Acute Care: A delay in rendering acute care occurs when a service or procedure has not been supplied or performed in a timely manner, the patient's hospital discharge is delayed, and there is nodocumented medical reason for the delay. Slow Progression of Acute Care: Slow progression of acute care occurs when progress in reaching therapeutic goals is delayed beyond generally accepted standards of medical practice that causes a delay in the patient's hospital discharge, and there is no documented medical reason for the delay.
Authority	• Social Security Act Section 1902[42 U.S.C. 1396a(a)(30)(A)] • Welfare & Institutions Code (W&I), Section 14133.3

Acute Administrative Days

Acute Administrative Days (AAD)	
Description	Medi-Cal funds cannot be paid at an acute level of care rate when the patient is receiving alower level of care. There are instances when a patient's level of care is not at the acute level, but they must remain in an acute setting due to: • An inability to find nursing facility placement (NF AAD) ➢ Documentation of attempts at placement is required for payment of acuteadministrative days for nursing facility placement. • Patients with tuberculosis (TB) in isolation awaiting negative TB sputum tests followinginitiation of treatment (TB AAD) • Monitoring of an at-risk obstetrical patient. (OB AAD)
Authority	• CCR, Title 22, Section 51173 • CCR, Title 22, Section 51342 • Manual of Criteria for Medi-Cal Authorization, Chapter 5.3, III.(A)

Variance Descriptions and Authorities

Length of Stay

Day of Admission	
Description	The day of admission is determined by the time and date the physician writes the order inthe medical record to admit the patient to the hospital. This order can be written in the MD orders, progress notes or Emergency Department notes. There must also be the intent to admit with the expectation of an overnight hospital stay.
Authority	• California Code of Regulations(CCR), Title 22 , Section 51108
The Physician's Discharge Order Date	
Description	The day of discharge is determined by the time and date the physician writes the order in the medical record to discharge the patient from the hospital. Patients shall be discharged from the hospital only upon the order of the credentialed practitioner. To determine the length of the hospitalization, the reviewer will verify the admission anddischarge order dates on the medical record. Each hospital should have policies that ensure uniformity of both content and format of thepatient record based on all applicable accreditation standards, federal and state regulations, payer requirements, and professional practice standards.
Authority	• Title 42 Code of Federal Regulations (CFR), Section 482.24

Variance Descriptions and Authorities

Mental Health

Psychiatric Inpatient Hospital Services	
Description	Mental Health Plans (MHP) are responsible for the authorization and payment of all medically necessary specialty mental health services for Medi-Cal recipient of that county in accordance with federal and state Medicaid requirements. Each MHP is financially responsible for payment of emergency psychiatric services provided to it recipients within California and specified border communities. MHPs may not restrict recipient access to emergency services. Emergency psychiatric services are covered by the MHP when the recipient has been admitted to a hospital or a psychiatric health facility. Psychiatric inpatient hospital services are covered by the County Mental Health Departments. If a beneficiary with a psychiatric diagnosis is admitted to a medical unit as an emergency admission, the stay is evaluated for medical necessity for his/her medical condition. If the beneficiary's condition is medically stable, then the provider will refer the beneficiary to the local managed mental health care plan. Medi-Cal recipients are enrolled automatically in the Mental Health Plans (MHP) in each of the 58 counties. In most cases, the MHP is the county mental health department.
Authority	• Welfare and Institutions Code, Sections 14680 through 14685 • CCR, Title 9, Sections 1820.205 and 1820.225(b)

Variance Descriptions and Authorities

Rehab: Admission Documentation, Active Participation, IDT Conferences, Face-to-Face Visits, and Therapy Documentation

Acute Inpatient Intensive Rehabilitation Services	
Description	Acute inpatient intensive rehabilitation is a service intended to help the physically or cognitively impaired patient achieve or regain his/her maximum potential for mobility, self-care, and independent living by restoring maximum independent function, resulting in a sustained higher level of self-care to be able to discharge home/other community setting/lower level of care, in the shortest possible time. It is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. Requirements for intensive rehabilitation therapy include specific admission documentation such as the pre-admission screening, individualized overall plan of care, and the CMS IRF-PAI, which consist of the following medical necessity criteria: multiple therapy disciplines, active patient participation, rehabilitation physician supervision, intense therapy program, and interdisciplinary team conferences.
Authority	• CMS Medicare Benefit Policy Manual, Chapter 1, Section 110 • W&I Code, Section 14064, *except Subsection (C) related to trial periods* • W&I Code, Section 14132.8 • CCR, Sections 70595-70603