California Department of Health Care Services
Clinical Assurance Division (CAD)

Frequently Asked Questions (FAQs)

Designated Public Hospital (DPH) TAR-Free Program

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Frequently Asked Questions (FAQs)
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I. General Questions

a. Why did DHCS decide to go TAR-free for inpatient hospital days in Designated Public Hospitals (DPHs)?

Answer: To increase efficiency and effectiveness while still ensuring hospital inpatient days are billed appropriately, DHCS transitioned out of 100% utilization review (UR) and allowed the hospitals to use evidence-based standardized review criteria, such as InterQual® or MCG® for acute inpatient days for fee-for-service (FFS) Medi-Cal beneficiaries.

b. Where can I find information about the TAR-free program on-line?

Answer: The DPH TAR-free program has a webpage available at https://www.dhcs.ca.gov/provgovpart/Pages/PublicHospitalProject.aspx.

The webpage can also be found by starting at the Department of Health Care Services (DHCS) Home Page, https://www.dhcs.ca.gov, clicking on the "Providers & Partners" icon in the banner, and then clicking on "Public Hospital Project" under the heading "Programs for Providers".

c. Even though hospital days no longer require a TAR, will surgeries and medical procedures still need one?

Answer: Yes, elective and emergency surgeries/procedures that previously required a TAR will continue to be required. However, the TAR should not request hospital days associated with the surgery or medical procedure.

Per *California Code of Regulations (CCR) § 51501 (e): (e) Fees shall not be paid to any provider for professional services rendered in a hospital or other facility when such provider is compensated on a salary or contract basis, for performing the same or similar services, by that hospital or facility if the funds used to pay such salary or to discharge the obligation of such contract are subject to reimbursement in whole or in part from the General Fund of the State of California or from taxes or assessments paid to any of its subdivisions.*

d. What are the general steps of the DPH TAR-free UR process?

Answer: The high-level process is as follows:

1. The participating DPH must run all acute inpatient days, weekly for acute rehabilitation (see ***Acute Inpatient Intensive Rehabilitation (AIIR)*** *section below*) through standardized medical review criteria as well as review for Medi-Cal specific policies, such as delays of service, administrative day policies, and aid code restrictions.

2. If all days of a stay meet InterQual/MCG criteria and Medi-Cal policies, DPHs may claim all days.

3. If a day(s) do not meet criteria and the DPH wants to be considered for reimbursement by Medi-Cal for the day(s), DPHs may perform a Secondary Review determination by a facility physician (see ***Secondary Review Process*** section for additional information). If the facility physician approves the Secondary Review, the DPH may claim for the day(s) approved on Secondary Review. If the DPH does not perform a Secondary Review, any day that does not meet standardized medical review criteria should not be claimed. Please note, Secondary Review decisions are subject to DHCS review for medical necessity and conformance to Medi-Cal policies and may be overturned by a DHCS Medical Consultant (MC).

4. DHCS conducts compliance reviews of a statistically valid sample of claims paid during a given period, and issues a Statement of Findings to the DPH detailing any findings (see ***Statement of Findings/Dispute Resolution Process*** section for additional information). If there are no findings noted, then a “No Variance Letter” will be issued.

5. If a DPH chooses to dispute a clinical finding that is deemed recoupable, they have 60 calendar days from the date of the letter transmitting the Statement of Findings to submit the dispute to DHCS (see ***Statement of Findings/Dispute Resolution Process*** section for additional information). DHCS will issue a Dispute Report within 180 calendar days of dispute receipt.

6. Any undisputed findings or findings upheld on dispute will be recouped (see ***Recoupment Process*** section for additional information).

II. DPH Requirements for Using InterQual/MCG and Case Management/UR Documentation

a. Are daily InterQual/MCG reviews required?

Answer: Yes, each acute day that will be billed to Medi-Cal FFS must meet InterQual/MCG criteria or be approved on Secondary Review. Acute administrative days (AAD) and inpatient hospital services for deliveries and well babies as specified in CCR Title 22 Section 51327(a)(1)(A) are exempt from this requirement. DPHs should utilize the most current version of their evidence-based standardized review criteria (InterQual/MCG).

AIIR services have different requirements (see ***Acute Inpatient Intensive Rehabilitation (AIIR)*** section below for specific InterQual/MCG requirements), with the exception of acute days while awaiting acute rehabilitation or subacute/LTAC placement (see ***Acute Administrative Days (AAD)*** and ***Awaiting Subacute/Long-term Acute Care (LTAC) Placement*** sections below for more information).

b. If a beneficiary is admitted with an order indicating an admission to observation, does the admission need to meet InterQual/MCG acute criteria?

Answer: Yes, if there are Medi-Cal FFS billed days associated with an admission to observation, the admit order date will be used as the admit date. Each day that the hospital plans to bill as acute inpatient days would need to meet InterQual/MCG acute criteria or referred for Secondary Review. Observation is not a status that Medi-Cal recognizes and, therefore, Medi-Cal does not honor InterQual/MCG observation criteria. If referred for Secondary Review, the reviewer must approve as acute inpatient status and not for observation only.

c. If InterQual/MCG indicated that a beneficiary qualified for multiple consecutive acute days based on their diagnosis, am I still required to perform a daily review?

Answer: Yes, all acute days billed to Medi-Cal must be individually evaluated using InterQual/MCG acute criteria along with Medi-Cal policies. If it is for an ICU stay, UR notes may be grouped in segments of three or four days but each individual day must still be evaluated through InterQual/MCG.

d. If a beneficiary exhausts Medicare Part A coverage in the middle of the stay and Medi-Cal becomes responsible for coverage, does the Case Management/UR staff start using InterQual Initial Review criteria or do they start with the Continued Stay review?

Answer: The Case Management/UR staff would not use the Initial Review criteria. They would go to the appropriate Episode Day for the hospitalization and the condition-specific subset. Once the episode days within a subset have been exhausted and continued stay is necessary, the Extended Stay subset should be used.

e. Does the physician admission order have to have the word "admit" in it? For instance, if the physician's order reads "Move to outpatient bed (observation)" or "Outpatient for Observation Services" and acute criteria are met, can we bill for acute days?

Answer: The term "admit" is not necessary, however the order needs to clearly illustrate that the patient was being admitted to a bed in the inpatient hospital (observation or acute). What is most important is that the acute InterQual/MCG criteria are used to review all observation days or a Secondary Review is performed. Medi-Cal does not recognize observation status and, therefore, does not honor the InterQual/MCG observation criteria. Those orders with additional documentation establishing that the beneficiary was admitted under observation status and did in fact meet the InterQual/MCG acute criteria would allow a facility, in most cases, to bill for the appropriate acute hospital day(s). Also, if the day did not meet InterQual/MCG acute criteria and a Secondary Review approved the day or days, these could be billed as long as this determination follows the Secondary Review requirements (see ***Secondary Review Process*** section for additional information).

f. If a beneficiary is admitted for an outpatient procedure but later must be admitted as an inpatient, does the stay need to meet InterQual/MCG criteria?

Answer: Yes. Please note that outpatient billing within 24-hours of an inpatient admission paid by Medi-Cal is not allowable.

g. What documentation is required from the Case Management/UR staff?

Answer: Case Management/UR notes should include the following information:

- Header, to include hospital name and address.
- Discharge diagnosis.
- Beneficiary name, date of birth, Medi-Cal number, and hospital medical record number.
- Type and version of the evidence-based standardized UR tool used.
- Dates of service including admission and discharge dates, if applicable, total length of stay, and indication of the specific days that will be billed to Medi-Cal FFS.
- Case Management/UR summaries for each day of the standardized medical review that clearly indicate the date of care being reviewed. These should contain the Case Manager/UR staff's name with the corresponding hospital day that was reviewed, documentation that acute criteria was met or not met and a brief medical comment**.**
- If acute criteria were not met, document those dates of service and indicate if a Secondary Review was performed and include the outcome.
- If the beneficiary is at a lower level of care and NF placement is sought, in order to approve AAD, include the dates when administrative days started and stopped.
- Document the disposition of all beneficiaries, including transfers to another acute hospital, long-term acute care, subacute facility, or acute inpatient rehabilitation facility and discharges to home, a NF, shelter, respite care, etc.

III. Secondary Review Process

a. What is the purpose of the Secondary Review and what are the requirements?

Answer: For acute days, when a hospital day does not meet InterQual/MCG acute criteria and the Case Management/UR staff believes that acute hospital day may be warranted, they can request the day be referred for Secondary Review, who can recommend approval of the day if acute care is medically necessary. 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.

The physician must document the rationale for the approval of the acute day and sign-off on the decision. The physician's contact information must be included with the documentation.

For days while awaiting acute rehabilitation and subacute/LTAC placement, see ***Acute Inpatient Intensive Rehabilitation (AIIR)*** and ***Awaiting Subacute/Long-term Acute Care (LTAC) Placement*** sections below for specific Secondary Review requirements.

b. When the physician approves (or denies) a day(s) on Secondary Review, where should the physician document his/her decision?

Answer: The physician should document the decision in the case management InterQual/ MCG notes. If the physician does not have access to the InterQual/MCG notes, the decision can be documented in an email or other note sent to the Case Management/UR staff. The documentation should be presented at the TAR-free review along with the case management notes.

c. If a beneficiary does not meet InterQual/MCG acute criteria and the attending physician believes that acute care is warranted but the Secondary Review physician disagrees, do we have to deny the day?

Answer: Yes, if acute criteria are not met and the day is denied on Secondary Review, the day should be denied and not billed to FFS Medi-Cal.

IV. Compliance Reviews and DPH Data Reporting Responsibilities

a. What are the paid claims compliance reviews?

Answer: DHCS derives a statistically valid sample from Medi-Cal FFS paid claims data that will be reviewed by DHCS Nurse Evaluators and Medical Consultants in a compliance review to ensure that DPHs are in compliance with Medi-Cal policy and the appropriate use of InterQual or MCG.

b. Does DHCS eliminate any paid claims prior to creating the statistically valid sample?

Answer: Yes, DHCS removes from the sample well baby stays and any obstetric claims that fall under CCR Title 22 Section 51327(a)(1)(A). Additionally, any days paid via a Service Authorization Request (SAR) are removed from sampling.

c. What documentation does DHCS require for the paid claims compliance reviews?

Answer: Required additional documentation in addition to the medical record includes:

1. The InterQual/MCG Case Management Summary (summary notes that capture decisions for the length of stay, level of care, approved or denied days and Secondary Reviews) for each day the hospital plans to bill as an acute hospital day.

2. **Nursing Facility (NF) placement Call List, if applicable, for any days that were approved for AAD.**

3. Point-of-Service (POS) eligibility sheet when the beneficiary had retroactive Medi-Cal eligibility, the hospital billed administrative days and no Call Lists are available.

d. When do the DPHs need to provide DHCS with the required documentation for the reviews?

Answer: DHCS sends a paid claims list of records for review approximately six weeks before the first day of the scheduled review. All medical records and additional required documentation must be made available at least 5 business days before the first day of the scheduled review in accordance with Welfare and Institutions Code (WIC) Section 14124.1 and CCR Title 22 Section 51476. During the review, if a medical record for the admission or Call Lists cannot be located for the entire administrative day(s) claim requested for review, DHCS will reach out to hospital staff requesting the documentation be made available within 24 hours, or the proceeding business day. If the requested documentation still cannot be located, a variance will be cited along with a recoupment directive. These variances will be non-disputable.

e. What data reporting requirements must DPHs follow?

Answer: DPHs are required to submit, on a quarterly basis, limited data for any denied days. In this context, denied days are any acute or administrative days where a Medi-Cal FFS beneficiary was an inpatient and the DPH did not approve the day.

The following is a link to the DPH Denied Medi-Cal Days Template Excel spreadsheet. This spreadsheet shall be used for this data submission. https://www.dhcs.ca.gov/provgovpart/Pages/DPH-Denied-Medi-Cal-Days-Template.aspx.

Please use this spreadsheet to capture cases with any denied days. Denied days must be reported no later than the last day of the following calendar quarter, i.e.:

Calendar Quarter	Dates	Submit Data by:
Summer	July 1 - September 30	December 31
Fall	October 1 - December 31	March 31
Winter	January 1 – March 31	June 30
Spring	April 1 – June 30	September 30

f. Where do DPHs submit the denied Medi-Cal Days Template?

Answer: The denied Medi-Cal Days Template should be submitted through the secure file transfer website at https://etransfer.ca.gov. Please contact the TAR-Free Oversight Unit to request a username and password to upload this spreadsheet: PublicHospitalProject@dhcs.ca.gov.

g. What can DPHs do to ensure that the medical record number associated with cases selected for review appear on the master list?

Answer: In order for DHCS to have access to the medical record number to provide to DPHs in association with compliance reviews, DPHs should indicate the medical record number in box 3A of the UB04 claim form.

V. Statement of Findings

a. When do DPHs receive Statement of Findings?

Answer: DPHs should receive a Statement of Findings approximately 60 days after DHCS conducts a compliance review. The Statement of Findings will detail any variances identified during the compliance review, and instructions will be provided on those variances where recoupment may occur.

b. Is there a way to identify if a hospital has any outstanding Statement of Findings?

Answer: Yes, please send an email request to the TAR-Free Oversight Unit mailbox at PublicHospitalProject@dhcs.ca.gov. DHCS staff will identify any outstanding reports.

c. What if the hospital does not agree with the findings of the DHCS Statement of Findings?

Answer: The provider may submit a dispute within 60 calendar days of the date of the letter transmitting the Statement of Findings.

VI. Dispute Resolution Process

a. How do I submit a dispute?

Answer: To submit a dispute, the provider should follow these steps:

1. **Request access to the e-transfer website**
   - Disputes must be submitted to the DHCS secure website at https://etransfer.ca.gov.
   - The provider will need to request access from DHCS to upload disputes to this website. To request access to this website, please submit an email to PHPDispute@dhcs.ca.gov.
   - Once the request for access is processed, the provider will receive a username and password.

2. **Submit the dispute within the allowable timeframe**
   - The provider must submit the dispute within 60 calendar days from the date of the Statement of Findings letter.
   - The provider may submit an optional email to DHCS notifying staff that a dispute has been uploaded to the website. The email should be sent to: PHPDispute@dhcs.ca.gov.

3. **Include all required documentation with the dispute**
   - Please submit all disputes for a given Statement of Findings report together.
   - The provider must submit a dispute resolution form for each variance that is disputed.
   - The dispute form must clearly identify what variance and dates of service are being disputed.
   - It is helpful if the provider indicates a reason why the dispute should be approved.
   - Include all relevant medical records with the dispute.
     At this time, the staff who review disputes do not have access to the hospital's electronic medical record system. Please note that the medical review conducted for the dispute is independent of the medical review completed by field office staff; therefore, the provider should submit all relevant clinical documentation with the dispute to ensure a thorough medical review can be completed by the DHCS Medical Consultant. The DHCS Medical Consultant will review the documentation and make an independent determination to either uphold the decision on the Statement of Findings report or reverse it.

b. Can all variance types be disputed?

Answer: No, a provider should only dispute variances in which they disagree with the clinical findings from the Statement of Findings. There are some administrative variances that should not be disputed, including:

- 1H-2 variance (no medical records)
- 4D-1 variance (no call lists) and 4D-2 variance (incomplete call lists)
    - Call lists and medical records should be available at the time of the scheduled field office review. Providers are given an advanced notice of at least a six-weeks for records that will be reviewed.
    - If the field office staff determine call lists and/or medical records were not submitted for the scheduled review, then the provider will be given a 24-hour notice to submit them before the scheduled review closes.
- In addition, variances from the Statement of Findings that do not require the provider to amend or void the claim should not be disputed.

c. How will DHCS notify me when a dispute decision is finalized?

Answer: The provider will receive notification via email when the dispute review has been completed.

- DHCS has 60 calendar days to respond to the dispute.
- All dispute findings are included on the Dispute Outcome Report.
- DHCS will upload the Dispute Outcome Report to the e-transfer website.
- DHCS will also send a courtesy email notifying the provider that the Dispute Outcome Report is available on the e-transfer website.
- The dispute findings will provide the decision for the variance at issue in addition to an extended rationale for the decision and whether the provider will be required to amend or void the claim.
- The dispute process is one level; a second level review is not available at this time for disputes.

d. How can I check the status of a dispute?

Answer: Providers may send an email to PHPDispute@dhcs.ca.gov to confirm that DHCS has received a dispute and to check the status of a dispute.

e. If a beneficiary disagrees with the number of hospital days granted by the provider, can they submit a dispute?

Answer: The dispute process is utilized by the hospital when the hospital disagrees with any DHCS decision on the Statement of Findings report. Each hospital should have an established grievance process for the beneficiary. If a beneficiary disagrees with the hospital about days granted, then the grievance process established by the hospital should be used. If the beneficiary's primary care physician does not believe their condition warrants additional hospital days, then the beneficiary should raise the issue with the hospital's Ombudsman's office. If the beneficiary disagrees with any DHCS decision regarding hospital days granted, they can initiate the Fair Hearing process through the Department of Social Services.

f. If the Statement of Findings report indicates a variance for missing documentation, can the missing documents be submitted through the dispute resolution process once they are found?

Answer: No, the dispute resolution process is designed to resolve only disputes involving clinical findings for which recoupment language is identified on the Statement of Findings, including level of care, emergency conditions, and delays of service/discharge. The dispute process should not be used for administrative findings. See subsection b above.

VII. Claims Adjustment / Recoupment Processes

a. Why would a DPH need to initiate a Claims Adjustment?

Answer: If a DPH does not dispute findings listed on the Statement of Findings, or if findings are upheld through the dispute process, DPHs must use the Claims Inquiry Form (CIF) process to resubmit the claims that have been paid.

b. How many steps are there to the CIF process?

Answer: There are two (2) steps to the CIF process – 1) voiding the original claim; and 2) an appeal for the corrected payment. These processes are outlined in the two links below:

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

CIF Submission and Timeliness Instructions
https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/cifsub.pdf

c. What happens if DPHs do not use the Claims Adjustment process?

Answer: All findings that do not follow the Claims Adjustment process will be recouped by the DHCS Audits and Investigations (A&I) Division.

d. How can a DPH find a final recoupment amount?

Answer: DPHs will be notified by A&I of the final recoupment amount via the *Notice of Proposed Adjustment to Designated Public Hospital Project Review of Medical Necessity and Recovery* letter.

e. What is the A&I Division and what is their role in the TAR-free program?

Answer: A&I is a division of DHCS that is responsible for ensuring the fiscal integrity of the health programs administered by DHCS as well as ensuring quality of care provided to the beneficiaries of these programs. For the DPH TAR-free process, A&I is responsible for recouping identified variances on Statement of Findings that were not disputed or were upheld on dispute and were not repaid through the CIF process. In addition, A&I may investigate a provider if a trend of non-compliance to the UR process is identified during compliance reviews.

f. If a hospital is referred to A&I, is there a penalty at that point? Are there additional penalties that can be invoked?

Answer: No, A&I will launch an independent investigation of the referral. There is no penalty until A&I has finished the investigation and has determined that non-compliance has occurred. However, the DHCS oversight and monitoring/audit process may lead to recoupment from the facility and/or civil money penalties. Civil money penalties may be imposed as permitted by WIC 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.

g. If DHCS disagrees with an acute inpatient day that has been authorized and billed, will payment be denied?

Answer: No, generally the claim will have already been paid. However, discrepancies may to be referred to A&I once the provider has had the opportunity to follow the direction from DHCS to void and resubmit claims or file a dispute for clinical variances.

VIII. Restricted Aid Codes

a. How are aid codes restricted to emergency services handled?

Answer: The hospital stay must be related to an emergency medical condition and meet InterQual/MCG acute criteria or be authorized on Secondary Review. Claims for beneficiaries with restricted aid codes must include one of the following statements in the Remarks Section (Box 80) of the claim form:

"*Hospital certifies providing emer svcs to unverified citizen*"

or

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

b. What is Medi-Cal's definition of an emergency medical condition?

Answer: Per the definition in the WIC Section 14007.5, an emergency medical condition is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction to any bodily organ or part.

c. Can a beneficiary with a restricted aid code ask to be re-evaluated for a full aid code?

Answer: Yes, the beneficiary can contact the Medi-Cal eligibility office in their county and request re-evaluation. Aid code determination in general is made at the county level. The name of the eligibility office varies from county to county. The DHCS staff performs reviews with a beneficiary's specific aid code taken into consideration.

d. How do we handle beneficiaries that are admitted with a restricted aid code and during the stay, are converted to a full scope aid code?

Answer: Aid codes are generally valid for the entire month of eligibility. For example, if a beneficiary is admitted on October 30 with a restricted aid code and received full scope eligibility on November 5, the restricted aid code would be in effect through October 31 and the full scope aid code would be effective as of November 1. Medi-Cal policy on restricted aid codes would need to be considered for October 30-31 but not for any days in November. It is important that hospital staff are aware of current aid codes to ensure correct determinations are made for the TAR-free process. For extended stays, eligibility should be confirmed on the first day of each subsequent month.

e. If a beneficiary with a restricted aid code has a high risk pregnancy that could be managed at home but home health nursing is not available or her physician believes it is not an option, could she then qualify for OB administrative days?

Answer: Yes, OB administrative days may be available.

f. Can patients who are restricted to pregnancy-related services receive pregnancy-related postnatal care?

Answer: Yes, pregnancy-related postnatal care is covered to the end of the month in which the 60th day following delivery occurs.

g. If a hospital denies a stay for a restricted aid code beneficiary because there was no emergency condition present, does the stay need to be evaluated using InterQual/MCG criteria?

Answer: No, denied stays do not need to be run though InterQual/MCG. However, if a restricted aid code stay is approved it must be related to an emergency and be authorized using InterQual/MCG acute criteria or upon Secondary Review.

h. Are beneficiaries with restricted aid codes eligible for AAD?

Answer: Certain restricted aid codes with coverage for Long-Term Care (LTC) services qualify for NF administrative days. Certain restricted aid codes with coverage for pregnancy-related services qualify for OB administrative days. Furthermore, restricted aid codes with emergency services qualify for TB administrative days. Pregnant beneficiaries may be eligible for TB administrative days if TB is suspected and treatment/isolation is required. *For additional information on AAD, please refer to the ***Acute Administrative Days (AAD)*** section below. The Medi-Cal Provider Manual for Aid Codes can be referenced for further detail at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes.pdf.

IX. OB Days with Delivery during Stay

a. Do OB delivery days that fall under CCR Title 22 Section 51327(a)(1)(A) need to meet InterQual/MCG criteria?

Answer: No, as long as the beneficiary is admitted and delivers within the normal delivery period per Title 22 Section 51327 (a)(1)(A). These OB days are covered without the use of InterQual/MCG criteria up to a maximum of two consecutive days prior to delivery, beginning at midnight at the beginning of the day the mother is admitted, if delivery occurs within that two-day period, and up to a maximum of two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, beginning at midnight at the end of the day the mother delivers.

b. How are OB days that fall outside the delivery period handled?

Answer: If the stay is longer than permitted by CCR Title 22 Section 51327 (a)(1)(A), InterQual/MCG criteria must be used for all days that exceed the OB delivery period.

c. If there is a fetal demise, is it covered under OB delivery period or must InterQual/MCG be used?

Answer: If the physician determines that there was a delivery, it is covered under OB delivery days as long as the stay falls within CCR Title 22 Section 51327(a)(1)(A).

d. If a newborn infant is admitted to the NICU for 2 days but is discharged home within the OB delivery period, would the days need to meet InterQual/MCG acute criteria?

Answer: Yes, OB delivery days only apply to well-babies. If a baby becomes sick and goes to the NICU, then all NICU days must be evaluated using the InterQual/MCG acute criteria.

e. If a pregnant, diabetic patient restricted to pregnancy-related services only is admitted for out of control, non-gestational diabetes, could this admission be covered?

Answer: Yes, any condition that could adversely affect the fetus may be covered, as long as InterQual/MCG acute criteria are met or the day(s) is approved on Secondary Review.

X. Acute Administrative Days (AAD)

a. Are AAD required to be evaluated with InterQual/MCG criteria?

Answer: No, only acute or acute rehabilitation days that will be billed to FFS Medi-Cal must be evaluated. However, AAD must meet Medi-Cal criteria for administrative days including NF Call List requirements.

b. What are the Call List requirements for AAD?

Answer: Ten NF calls are required per day, except weekends and state observed holidays. Each call must include the facility name, contact date, and response (i.e., reason facility cannot accept patient). Calls must be made on the Friday before the weekend to cover the Saturday and Sunday and the day before a holiday to cover that holiday.

c. Our hospital has two holiday days for Thanksgiving, Christmas and New Year's Day. Do I need to make NF placement calls on the second day? Will calls made on the Wednesday before Thanksgiving cover the Friday and weekend after Thanksgiving?

Answer: Christmas Day and New Year's Day are exempt from NF calls but any other days that the hospital chooses to designate as a holiday would still require the calls. NF calls made on the Wednesday before Thanksgiving would cover Thanksgiving, the Friday after, and the proceeding weekend.

d. If a state observed holiday falls on a Sunday, is a floater day allowed?

Answer: No, a floater day is not permitted.

e. What if Call Lists are not available when AAD were billed for a retroactive Medi-Cal eligible beneficiary awaiting NF placement?

Answer: DHCS requires a Point-of-Service (POS) eligibility sheet for AAD with retroactive Medi-Cal eligibility and when there is no evidence of 10 placement calls per day.

f. Can the same NFs be called daily or is there a requirement that different NFs be called?

Answer: No, there is no requirement that different NFs be called each day. However, the response from each NF must be documented for every call.

g. There are only eight NFs in our hospital's immediate area. Are we still required to contact 10 NFs daily?

Answer: No, if there are geographical limitations (e.g., rural area), the number of calls should equal the number of NFs in the immediate area. If there are less than 10, the Call List should include all NFs in the area. To prevent any discrepancies during the review process, the Field Office should be notified prior to the scheduled review.

h. If NF placement is found but the beneficiary or family refuses transfer, do they continue to qualify for AAD?

Answer: No, AAD cannot be approved when there is a delay in discharge due to social reasons.

i. Can a hospital request AAD while attempting to find placement in an acute psychiatric hospital?

Answer: No, AAD can only be approved through Medi-Cal while awaiting placement in a NF or for NF Waiver services. AAD for psychiatric patients may be available through the county. The local county mental health agency should be contacted for information.

j. Do beneficiaries awaiting transfer to an acute inpatient rehabilitation facility qualify for AAD?

Answer: Per Medi-Cal policy, AAD is not allowable for beneficiaries awaiting placement in an acute inpatient rehabilitation facility. However, they do qualify for acute days, with the following stipulations:

- Documentation must indicate that the beneficiary is still receiving therapy services (e.g., PT, OT, and ST), that does not need to total 15 hours per week.
- Documentation must also indicate that continued acute rehabilitation placement efforts are being made, although a Call List is not required.
- Daily UR documentation (i.e., InterQual/MCG) is not required, however, an initial Secondary Review approving acute status must be present if InterQual/MCG acute criteria is either not met or not submitted. No further Secondary Reviews are required if the beneficiary continues to require acute rehabilitation prior to transfer.

k. What other placement facilities do not qualify for AAD?

Answer: Only placement intended to a NF-A (ICF) or NF-B (SNF) qualify for AAD. Other placement facilities and scenarios that do not qualify for AAD include, but are not limited to:

- Discharge to an inpatient psychiatric facility
- Discharge to a homeless shelter
- Discharge to a respite care center
- Discharge to a board and care facility
- Discharge to an acute rehabilitation facility
- Discharge to outpatient dialysis clinic for ongoing treatment
- Discharge plan is for home health services
- If Hospice is elected, and the NF stay is for the Hospice-qualifying condition
- A NF swing bed is available, and the NF is not at full capacity
- Patient is on seven-day bed hold from transferring (sending) NF

For additional information on AAD criteria, please refer to the *TAR Criteria for Acute Administrative Days (AAD)* section in the Inpatient Services Provider Manual.

l. Can we request AAD for beneficiaries admitted for NF placement only and who have no acute issues?

Answer: Yes, as long as the beneficiary is at a NF level of care and there were appropriate placement attempts documented, including 10 calls daily with responses. There is no requirement that the beneficiary must be at an acute level of care on admission.

m. I have a beneficiary that requires NF placement for six to eight weeks of IV antibiotics for endocarditis. No NF will accept him because he is a known IV drug abuser with drug seeking behavior. Do I still need to continue to make 10 NF calls every day to qualify for AAD?

Answer: Yes, 10 daily calls are still required. In situations where a beneficiary is difficult to place, hospitals are expected to broaden their search radius to include additional NFs.

n. Can I consolidate calls to NFs for placement? For example, if I have five patients needing placement, can I make one call to each of 10 NFs, tell them I have five patients for placement and ask if any beds are available?

Answer: Yes, as long as the calls are documented individually on a Call List for each patient.

o. If a beneficiary is pending NF placement and the days are denied by the hospital or meet AAD criteria, is any Secondary Review required?

Answer: No, any days that are denied or will be billed as AAD do not require the use of InterQual/MCG acute criteria or a Secondary Review.

p. If a beneficiary is admitted from a NF and is stable for discharge while the seven-day NF bed hold is still in effect, can AAD be claimed?

Answer: No, if the beneficiary is stable for a lower level of care and a NF bed is available, the beneficiary should be transferred to the NF and no AAD should be claimed.

q. Can a hospital request AAD once the beneficiary has elected hospice care?

Answer: No, once a beneficiary elects hospice care, the hospice organization is responsible for paying for care. Hospice-elected patients do not qualify for AAD.

r. Is a Call List required for OB or TB administrative days?

Answer: No, a Call List is not required for OB or TB administrative days.

s. Is there a three-day billing limit for TB administrative days?

Answer: No, there is no three-day limit of billing. DHCS agrees to adhere to the recommendation of the local county public health department for a safe discharge of TB-positive beneficiaries.

t. Does a delivery have to occur during an admission to be able to bill for OB administrative days?

Answer: No, a delivery is not a required outcome for the billing of OB administrative days.

XI. Acute Inpatient Intensive Rehabilitation (AIIR)

a. Can a beneficiary with a restricted aid code qualify for AIIR services?

Answer: Full aid codes are required to qualify for AIIR services. In rare instances, a pregnant beneficiary with a restricted aid code may be approved. This is handled on a case-by-case basis.

b. How often are InterQual or MCG reviews required for AIIR stays?

Answer: Reviews are required on admission and weekly thereafter. The documentation must clearly indicate which week is under review and if the week met or did not meet InterQual/MCG acute rehabilitation criteria. The week starts with the day of admission.

c. In addition to the medical record and InterQual/MCG required documents, what documentation does DHCS require for the acute rehabilitation reviews?

Answer: Required documentation includes:

- Pre-admission Screening
- Individualized Plan of Care
- CMS Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).

d. Is there a Secondary Review process?

Answer: Yes, if acute rehabilitation InterQual/MCG criteria are not met and the facility wishes to bill AIIR services for the week. The Secondary Review physician must document the medical rationale for the approval of the week and sign-off on the decision. The beneficiary's attending physician may not approve hospital days through the Secondary Review process.

e. What are the medical necessity criteria for AIIR?

Answer: The required documents listed above will be used to determine medical necessity at the time of admission, including the following concepts and criteria:

- Involvement of multiple therapy disciplines
- Active patient participation
- Rehabilitation physician supervision
- Intensive rehabilitation therapy program
- Coordinated interdisciplinary team (IDT) approach

For specifics regarding each criteria, you may refer to the *TAR Criteria for Acute Inpatient Intensive Rehabilitation (AIIR)* section of the Provider Manual.

f. How are AIIR therapy hours counted?

Answer: Therapy hours start on the day of admission and the beneficiary must have at least two therapies which must include either Physical Therapy or Occupational Therapy.

In some instances, three hours of therapy per day cannot be accomplished due to medical reasons. DHCS can allow some flexibility as long as 15 hours per week are met.

g. Will DHCS allow group therapy?

Answer: DHCS will allow no more than 25% of the required 15 hours per week of treatment time for group therapy, if deemed medically appropriate for group therapy. A minimum of 11.25 hours of individual therapy per week is required. Any additional therapy above the required minimum hours per week can be either group or individual.

h. Can we approve acute rehabilitation days when the beneficiary misses therapy sessions due to medical reasons?

Answer: Yes, in some cases for unexpected clinical events or a medical procedure that is well documented, but for no more than three consecutive days**.** After three days, if the beneficiary is unable to participate in therapy, they should be transferred from acute inpatient intensive rehabilitation to acute inpatient status requiring hospital care or discharged to a lower level of care setting (e.g., NF or home).

i. Can a beneficiary have an overnight off-site pass to evaluate the home environment prior to discharge?

Answer: No, DHCS will allow short term off-site passes but will not approve an overnight pass.

j. Are AAD allowed when a beneficiary no longer requires AIIR services and NF placement is ordered?

Answer: Yes, to claim these administrative days the beneficiary must be at a NF level of care and there must be documented placement efforts (10 calls with responses per day).

k. Do I need to use rehabilitation codes when I file a claim?

Answer: Yes, AIIR claims are identified in the claims processing system by the presence of revenue codes 118, 128, 138 and 158.

XII. Awaiting Subacute/Long-term Acute Care (LTAC) Placement

a. Are daily InterQual/MCG reviews required for beneficiaries awaiting placement to a subacute or LTAC facility?

Answer: For days while awaiting placement to a subacute/LTAC facility, daily UR documentation (InterQual/MCG) is not required, however, an initial Secondary Review approving subacute/LTAC status must be present if InterQual/MCG acute criteria is either not met or not submitted. No further Secondary Reviews are required if the beneficiary remains at the subacute/LTAC level of care prior to transfer.

Documentation substantiating subacute/LTAC level of care and subacute/LTAC placement efforts are required for all days while awaiting placement to a subacute/LTAC facility.

b. Are Call Lists required while awaiting subacute/LTAC placement for a beneficiary?

Answer: No, since days while awaiting placement to a subacute/LTAC facility are billed as acute days, Call Lists are not required. Call Lists are only required if billing for AAD while awaiting placement to a NF.

XIII. Other Healthcare Coverage

a. **If some days of a hospital stay were paid for by the other health coverage, does the part of the stay covered by Medi-Cal FFS need to meet InterQual/MCG criteria?**

   Answer: If Medi-Cal FFS is the primary payer for one or more days then InterQual/MCG criteria must be met for those days only.

b. **If a Medi-Cal beneficiary who has elected hospice has a hospital stay for a medical condition not related to their hospice related illness, such as a fractured hip, does the stay need to meet InterQual/MCG criteria?**

   Answer: Yes, treatment of other medical conditions unrelated to the hospice condition that will be billed to Medi-Cal FFS must meet InterQual/MCG acute criteria. Only hospice related conditions can be billed to the hospice and are not part of the TAR-free process.

c. **Do admissions for psychiatric conditions need to meet InterQual/MCG criteria? What if the beneficiary also has an acute medical condition?**

   Answer: A hospital stay for a psychiatric condition without an acute medical condition is not covered by Medi-Cal FFS. The hospital stay would only be covered if it met InterQual/MCG criteria for an acute medical condition, not for a psychiatric condition. Once the medical condition has resolved, FFS Medi-Cal coverage through the TAR-free process ends. The local county mental health agency is responsible for coverage of psychiatric conditions.

d. **Some Medi-Cal beneficiaries are enrolled in Medi-Cal Managed Health Care Plans (HCPs). Are their stays required to meet InterQual MCG criteria?**

   Answer: DHCS will not review stays of beneficiaries enrolled in a Medi-Cal HCP and does not require the use of InterQual/MCG, although the HCP may have such a requirement. However, if a beneficiary was partial coverage of a stay through an HCP and part under FFS Medi-Cal, any days paid for by FFS Medi-Cal must meet the requirements outlined in this document related to the use of InterQual/MCG and adherence to Medi-Cal policies.

e. If Medicare coverage exhausts during the stay and the beneficiary is eligible for FFS Medi-Cal, what days will DHCS review?

Answer: DHCS will only be review those days for which there is a paid FFS Medi-Cal claim as a result of an exhaustion of Medicare benefits. However, DHCS needs access to the applicable medical record for the entire stay in order to conduct a review of the FFS paid days.

f. If a Medi-Cal beneficiary is also covered by Medicare and inpatient benefits have exhausted, is the beneficiary required to use the 60 day "lifetime reserve" provided by Medicare before Medi-Cal coverage begins?

Answer: No, the beneficiary may elect to save the reserve days for a later time.

XIV. Other

a. Under the Affordable Care Act (ACA), what is the process for reporting Provider Preventable Conditions (PPCs) for Medi-Cal beneficiaries?

Answer: As of July 1, 2012, providers must identify PPCs and report them to A&I, even if the provider does not intend to bill Medi-Cal. Any DHCS staff aware of potential PPCs may also refer them to A&I starting on July 1, 2012. CMS has directed that state Medicaid agencies prohibit payment for specified PPCs. Providers can access the PPC Reporting Form through the following link: https://www.dhcs.ca.gov/individuals/Pages/PPC_Reporting.aspx.