California Department of Health Care Services
Clinical Assurance and Administrative Support Division (CAASD)

Frequently Asked Questions (FAQs) for the Public Hospital Project

General Questions

- **Why did DHCS decide to go TAR free for inpatient hospital days in Public Hospitals?**

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

- **Do any inpatient services still require a TAR?**

  Answer: Inpatient acute rehabilitation and general acute care inpatient hospice will continue to require a TAR, as will any surgical procedures. However, hospital days associated with surgical procedures will not require a TAR and can be billed using the TAR free process.

- **Why will some hospitals use diagnosis related groups (DRGs) for payment?**

  Answer: The California Legislature directed Medi-Cal to replace the current reimbursement methodology for hospital acute care inpatient services (both negotiated contract rates and non-contract cost reimbursement) with payment by DRGs, per Senate Bill 853 which added Section 14105.28 to the California Welfare and Institutions Code.

- **What are the monthly data files/data reviews?**

  Answer: Each month, approximately 60 days after the month of admission, each hospital is required to send DHCS a monthly data file of their FFS admissions. The data will be used to derive a statistically valid sample that will be reviewed by DHCS Nurse Evaluators and Medical Consultants to ensure compliance with Medi-Cal policy and the appropriate use of InterQual or MCG.

- **What additional documentation does DHCS need for the monthly reviews?**

  Answer: Required additional documentation includes:

  1. The Point of Service (POS) (eligibility verification);
  2. The face sheet;
  3. 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, aside from OB cert stays;
  4. Other health care coverage denials, if applicable, such as California Children's Services (CCS) or Medicare denials; and
  5. Nursing Facility (NF) placement call list, if applicable, for any stays that were approved for acute administrative days.

- **How often do we need to verify eligibility?**

  Answer: Eligibility must be verified on admission and for each subsequent month that the hospital stay extends into, if applicable. DHCS will need to verify that eligibility was current at the time of admission and throughout the hospital stay.

- **What is the bi-annual review?**

  Answer: It is a review of data files of FFS admissions that, for various reasons, were not submitted in the monthly admission list. These admissions could fall into one or more of the four (4) following categories:
  1. CCS;
  2. Medicare Part A Exhaustion of Benefits;
  3. Stays over 30 days and/or;
  4. Retro Eligibility Determinations. If retro eligibility has not been verified by the date the monthly data is due, the data file should be submitted in the next bi-annual review. If retro eligibility **is** verified by the date the monthly data is due, the data file should be submitted with the monthly data.

- **When is the bi-annual review documentation due?**

  Answer: The bi-annual data files are due on March 5th and September 5th. DHCS will work with the hospitals to schedule a review of the bi-annual data.

- **What kind of format does the bi-annual review need to be in?**

  Answer: The data template is the same as the one used for the monthly reviews.

- **Are all admissions involving CCS, Medicare Part A exhaustion of benefits, stays greater than 30 days and retro eligibility stays included in the monthly review data?**

  Answer: Any hospital stay that includes days billed to Medi-Cal FFS must be included in the review data. In some cases, such as when CCS eligibility is pending, the payor source may not be known at the time of the monthly review. These cases can be held until the payor source is known and submitted in the bi-annual review. It is important that all days billed to FFS Medi-Cal are captured in these data sets. It is the hospital's duty to ensure all FFS stays are submitted.

- **If a hospital denies an entire stay, do these data files need to be submitted for the monthly review?**

  Answer: Yes, all FFS admissions for the review month must be submitted. When the entire stay is denied, no medical records or supporting documentation needs to be prepared. However, all stays are subject to audit and review by DHCS.

- **What are the purpose and the requirements of the secondary review?**

  Answer: When a hospital day does not meet InterQual/MCG acute criteria and the case manager feels that acute hospital days may be warranted, he/she can request the day be reviewed by a California licensed physician, who can recommend approval of the day if acute care appears medically necessary. The physician must document the rationale for the approval and sign off on the decision. The physician's contact information must be included with the documentation. It is very important that the beneficiary's attending physician may not approve hospital days through the secondary review process.

- **If a hospital stay does not meet InterQual/MCG acute criteria and acute administrative days are requested, is a secondary review required?**

  Answer: No, secondary reviews are only required when acute criteria is not met but the case manager still feels acute hospitalization is medically necessary and claims will be submitted for those acute inpatient days which did not meet criteria. However, the requirements for acute administrative days must be met including call lists for NF acute administrative days.

- **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 Manager. The documentation should be presented at the PHP review along with the case management notes.

- **If a beneficiary does not meet InterQual/MCG acute criteria and the attending feels that acute care is warranted but the physician disagrees on secondary review, 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.

- **We use the "read only" version of InterQual. Do we need to use the interactive version for the project?**

  Answer: No. DHCS encourages use of the interactive version of InterQual as it facilitates case management documentation and the monthly hospital data review. However, you can use the "read only version" but you must use the current version of InterQual/MCG and use the criteria for every inpatient acute day for which you are seeking acute reimbursement. DHCS requires case management notes that capture 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). Please note that Medi-Cal does not recognize observation level of care and therefore observation criteria must not be used for authorization of days.

- **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 is an admission to observation that is submitted as part of the DPH data, 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**. Observation is not a status that Medi-Cal recognizes and, therefore, Medi-Cal does not honor observation criteria.

- **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. 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 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 was performed by a CA licensed physician (not the attending) with a written discussion of the medical

necessity, physician contact name and phone number are provided, and the physician has signed off on this approval.

- **If a beneficiary is admitted for observation only and the intent is to bill as an outpatient, do we need to include the admission on the monthly data list?**

  Answer: No, any acute inpatient or acute administrative days for FFS Medi-Cal beneficiaries need to be included but not outpatient care.

- **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, all days that the facility intends to bill as acute inpatient days must meet InterQual/MCG acute criteria (except OB cert stays) and be included in the monthly data list.

- **Can hospital stays greater than 30 days be included in the monthly data?**

  Answer: Yes, all admissions that began in the review month, regardless of the discharge date, should be submitted as long as the beneficiary has been discharged before the data is due, all the days have been reviewed and a decision has been made. If all the days have not been reviewed and adjudicated, that admission should go into the bi-annual report.

- **Are daily InterQual/MCG reviews required?**

  Answer: Yes, each acute day that will be billed to Medi-Cal FFS must meet acute InterQual/MCG criteria or be approved on secondary review. Acute administrative days and inpatient hospital services for deliveries and newborns (OB cert days) as specified in Title 22 Section 51327(a)(1)(A) are exempt from this requirement.

- **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. Any acute days billed to Medi-Cal which have not been evaluated are subject to referral to A&I and possible recoupment.

- **Are hospital stays for dual eligible patients (Medicare and Medi-Cal) required to meet InterQual/MCG acute criteria?**

  Answer: Only the days that will be billed to Medi-Cal as the primary payer are required to meet the acute criteria. Once Medicare benefits have exhausted, any remaining days in the stay that will be billed to Medi-Cal must meet acute criteria or be approved on secondary review, unless acute administrative days are being requested.

- **If a beneficiary exhausts Medicare Part A coverage in the middle of the stay and Medi-Cal becomes responsible for coverage, does the Case Manager start using InterQual admission review criteria or do they start with the Continued Stay review?**

  Answer: The Case Manager would not use the Admission Review criteria. They would go to the appropriate Episode Day for beneficiary 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.

- **What documentation is required from Case Management?**

  Answer: Case management notes should include the following information:
  - Header, to include hospital name and address
  - Discharge diagnosis(es)
  - Beneficiary name, date of birth, Medi-Cal number and hospital medical record number.
  - Type and version of the standardized UR tool used.
  - Dates of service including admission and discharge dates, total length of stay and indication of the specific days that will be billed to Medi-Cal FFS.
  - Case Management summaries for each day of the UR review that clearly indicate the date of care being reviewed. These should contain the case manager'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 there were additional acute days requested, include the date and time of the secondary review, the physician's name, telephone number and a summary of the medical decision to approve the extended stay. The physician is not required to write the secondary review decision but must sign off on the decision with a written or electronic signature. The signature must be kept on file and is subject to review and/or audit.
  - If the beneficiary is at a lower level of care and NF placement is sought in order to approve acute administrative days, include the dates when administrative days started and stopped.
  - Document the disposition of all beneficiaries, including transfers to another acute hospital, subacute facilities or acute rehabilitation and discharges to home, an NF, shelter, respite care, etc.

- **What is the Audits and Investigations (A&I) Division and what is their role in the project?**

  Answer: A&I is a division of DHCS that may investigate a provider if a trend of non-compliance to the UR process is identified during onsite reviews. For example, there may be a

trend of beneficiaries with restricted aid codes admitted for elective procedures and the days being billed to Medi-Cal. Based on their investigation, A&I may request recoupment of payment.

- **If a hospital is referred to A&I, is there a penalty at that point?**

  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.

- **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 for possible recoupment.

- **What changes must I make on my claims after we go TAR free?**

  Answer: First, there will be no TAR number to reference. Also, in the case of a beneficiary with a restricted aid code receiving emergency or pregnancy related services, the Remarks Section (Box 80) on the claim form must include one of the following statements:

  "Hospital certifies providing emer svcs to unverified citizen"

  or

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

- **Will Medi-Cal be reviewing paid claims?**

  Answer: Yes, Medi-Cal will review paid claims and ensure there was a corresponding hospital stay and that days reported on the data file and UR notes correspond to billed days. Claims are subject to referral to A&I on an individual basis. Medi-Cal will also be reviewing paid claims to ensure that all admissions have been submitted on the hospital admission files.

- **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 the A&I division of DHCS, 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 link below.

http://files.medi-cal.ca.gov/pubsdoco/Forms/dhcs_7107.pdf

- **Even though hospital days no longer require a TAR, will surgeries and procedure still need one?**

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

- **Where can I find information about the Public Hospital Project on-line?**

  Answer: The Public Hospital Project has a webpage available at http://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, http://www.dhcs.ca.gov, and clicking on the "Providers & Partners" tab in the header, and then clicking on "Public Hospital Project" within the 'Programs' group.

Restricted Aid Codes

- **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".

  Beneficiaries with restricted aid codes are not eligible for acute administrative days.

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

  Answer: Per the definition in the California Welfare and Institutions Code 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.

- **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 perform reviews with a beneficiary's specific aid code taken into consideration.

- **How do we handle beneficiaries that are admitted with a restricted aid code and during the stay are converted to a full aid code?**

  Answer: Aid codes are valid for the entire month of eligibility, regardless of the day of the month the beneficiary became eligible. For example, if a beneficiary is admitted on October 30 with a restricted aid code and received full eligibility on November 5, the restricted aid code would be in effect through October 31 and the full 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 current aid codes are known for the TAR free process to ensure correct determinations are made.

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

  Answer: Yes, OB administrative days may be available.

- **Can patients who are restricted to pregnancy 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.

- **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 stay is approved it must be related to an emergency and be authorized using InterQual/MCG criteria or upon secondary review.

- **Are beneficiaries with restricted aid codes eligible for acute, TB or OB administrative days?**

Answer: OB admin days are available to beneficiaries with restricted aid codes that cover pregnancy related services. Pregnant beneficiaries may be eligible for TB admin days if TB is suspected and treatment/isolation is required. Beneficiaries with restricted aid codes otherwise are not eligible for acute administrative days.

OB Days with Delivery During Stay (OB Cert Days)

- **Why do we need to add cases that previously qualified as TAR free OB days into the data file if DHCS isn't going to review them?**

  Answer: Hospitals are required to submit all admission types in their monthly admissions data. The data is then used to generate a statistically valid sampling. DHCS does review previously TAR free OB cases to ensure they fall within guidelines for hospital care for newborns and hospitalization for delivery services as set in Title 22 Section 51327(a)(1)(A).

- **Do OB cert days need to meet InterQual/MCG criteria?**

  Answer: No, as long as the beneficiary is admitted and delivers within the normal OB cert days per Title 22 Section 51327 (a)(1)(A). These OB stays 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.

- **How are OB deliveries that fall outside the cert days handled?**

  Answer: If the stay is longer than permitted by Title 22 Section 51327 (a)(1)(A), InterQual/MCG criteria must be used for all days that exceed the guidelines. Days that fall within the OB cert guidelines do not require the use of IQ/MCG criteria.

- **If there is a fetal demise, is it covered under OB cert days or must InterQual/MCG be used?**

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

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

Answer: Yes, if the infant is sick and goes to the NICU for 1 or more days and is not covered by CCS, then all NICU days must be evaluated using the InterQual/MCG acute criteria.

- **If a pregnant, diabetic patient restricted to pregnancy 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 would be covered, as long as InterQual/MCG acute criteria are met or the day(s) is approved on secondary review.

Administrative Days

- **Do stays that only include acute administrative days need to be evaluated with InterQual/MCG criteria?**

  Answer: No, only acute days that will be billed to FFS Medi-Cal must be evaluated with InterQual/MCG criteria. However, acute administrative days must meet Medi-Cal criteria for administrative days.

- **Ten calls daily are required to document efforts to place a beneficiary in a NF in order to qualify for acute administrative days. 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. However, the response from each NF must be documented for every call. No calls are required on weekends or holidays.

- **There are only 8 NFs in our hospital's immediate area. Are we still required to contact 10 NFs daily?**

  Answer: No, the number of calls should equal the number of NFs in the immediate area, as long as they are inclusive of all the NFs in the area.

- **If NF placement is found but the beneficiary or family refuse transfer, do they continue to qualify for acute administrative days?**

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

- **Can a hospital request acute administrative days while attempting to find placement in an acute psychiatric hospital or a board and care?**

Answer: No, acute administrative days can only be approved through Medi-Cal while awaiting placement in an NF-A or NF-B. Acute administrative days for psychiatric patients may be available through the county. The local county mental health agency should be contacted for information.

- **Can we request acute administrative days for beneficiaries admitted for NF placement only and who have no acute issues?**

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

- **I have a beneficiary that requires NF placement for 6-8 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 make10 NF calls every day to qualify for acute administrative days?**

  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.

- **Our hospital has two holiday days for Thanksgiving, Christmas and New Year's. 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: Thanksgiving Day, 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 but not the Friday or weekend afterwards. Ten calls must be made on Friday to cover the weekend.

- **Can I consolidate calls to NFs for placement? For example, if I have 5 patients needing placement, can I make 1 call to each of 10 NFs, tell them I have 5 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.

- **If a beneficiary is pending NF placement and the days are denied by the hospital or meet administrative day criteria, is any secondary review required?**

  Answer: No. Any days that are denied or will be billed as administrative days do not require the use of InterQual/MCG acute criteria or a secondary review.

- **If a beneficiary is admitted from a NF and is stable for discharge while the 7 day NF bed hold is still in effect, can acute administrative days 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 acute administrative days should be claimed.

Other Healthcare Coverage

- **When a beneficiary is admitted to the hospital and has other healthcare coverage such as CCS or Medicare Part A, does the hospital stay need to be included in the data file?**

  Answer: Only stays that would be billed to Medi-Cal FFS should be included in the data files. If the entire stay is paid for through other health coverage it need not be submitted in the data file.

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

  Answer: If FFS Medi-Cal is the primary payor for 1 or more days then InterQual/MCG criteria must be met for those days only. The entire stay should still be included in the data set. Please be sure that the data clearly shows there was OHC and how many days were authorized and denied for FFS Medi-Cal.

- **If there is CCS/Medi-Cal coverage and CCS has authorized 10 days of a 12 days stay and the remaining 2 days were approved as meeting acute InterQual/MCG criteria, are all 12 days considered as "Facility Acute Days Approved" in the data file?**

  Answer: No, only the 2 days that will be billed to Medi-Cal would be considered "approved". However, the length of the stay would still be 12 days. The Case Management notes should clearly indicate which days were covered by CCS and which days were covered by Medi-Cal.

- **If 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.

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

Answer: Psychiatric conditions are not covered under this project. However, a hospital stay for an acute medical condition would be covered if it met InterQual/MCG criteria for acute hospitalization. Once the medical condition has resolved, FFS Medi-Cal coverage through the TAR-free process ends. County Mental Health is responsible for coverage of psychiatric conditions.

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

  Answer: DCHS 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, the stay should be submitted and the FFS Medi-Cal days would fall under the TAR-free process.

- **If a beneficiary is Medi-Cal FFS for part of the stay and Medi-Cal Managed Care for other days, how are those days reported in the data file? Is Medi-Cal Managed Care considered as "Other Healthcare Coverage" (OHC)?**

  Answer: All admissions that include approved days that will be billed to Medi-Cal FFS should be reported on the data file. If a Medi-Cal beneficiary converts to Medi-Cal Managed Care during the stay, only the approved days during the FFS eligibility should be reported as approved days in the data file. Medi-Cal Managed Care is considered to be OHC.

- **If a beneficiary has Medicare Part A or B and exhausts benefits during the admission, do we indicate "Y" under OHC?**

  Answer: Yes, because Medicare A is considered OHC. However, Medicare B is for outpatient care and outpatient should not be included in the data file. No Medicare B denial is necessary.

- **If Medicare coverage exhausts during the stay, are we to report only days being billed to Medi-Cal FFS as approved or denied but include the total number of days in the stay, including the Medicare days?**

  Answer: Yes, the entire stay should be included in the data set but DHCS will only be reviewing those days for which there is an exhaustion of benefits.

- **If a Medi-Cal beneficiary is also covered by Medicare and inpatient benefits have exhausted, is he/she 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.

Monthly Data File Requirements

- **How do I list approved/denied acute days on the data file?**

  Answer: Any approved acute days that will be billed to FFS Medi-Cal should be listed in the Facility Acute Days Approved column. This would include any acute days that met InterQual/MCG acute criteria or did not meet acute criteria but were approved on secondary review. Any denied acute days should be listed in the Facility Acute Days Denied column. This would include any days that did not meet InterQual/MCG acute criteria and were not referred for secondary review or were referred but denied on secondary review.

- **How do I list approved/denied acute administrative days on the data file?**

  Answer: Any approved acute administrative days should be listed in the Facility Admin Days Approved column. This would include any days where the beneficiary was at a NF level of care, NF placement was being sought and placement efforts were documented per Medi-Cal policy. Any denied acute administrative days should be listed in the Facility Admin Days Denied column. This would include any days where the beneficiary was at a NF level of care, NF placement was being sought but placement efforts were **not** documented per Medi-Cal policy. Please note, acute administrative days can only be authorized when NF placement is being sought. Days cannot be authorized while seeking outpatient dialysis placement, subacute placement or for any other reason.

- **How do I list TB or OB administrative days on the data file?**

  Answer: Any approved TB or OB administrative days should be listed in the Facility Admin Days Approved column. The days must meet Medi-Cal criteria for TB or OB administrative days but no call lists are required. Any denied TB or OB administrative days should be listed in the Facility Admin Days Denied column.

- **When do I indicate "Y" in the Other Healthcare Coverage (OHC) column of the data file?**

  Answer: Whenever the POS (eligibility verification) indicates OHC, regardless if the OHC actually covered any of the hospital days. For example, the POS may indicate that a beneficiary is CCS eligible but CCS denied the requested days. The CCS denial should be submitted with the medical record at the PHP review. Also, if the POS does not indicate OHC but it is known that the beneficiary has OHC, a "Y" should be listed in the OHC column of the data file.

- **If the beneficiary has OHC such as CCS or Medicare Part A that paid for a portion of the hospital stay, how do I list the approved days on the data file?**

Answer: Any days covered by OHC should not be listed as approved days on the data file, but they should be included in the length of stay (LOS). For example, if Medicare Part A covered 5 days of a 10 day stay and Medi-Cal was responsible for the other 5 days, only the Medi-Cal days would be listed as approved or denied on the data file. However, the LOS would be listed as 10 days.

- **If all of the hospital days are covered by OHC, should that medical record be submitted in the data file?**

  Answer: No, only those medical records that have 1 or more days billed to Medi-Cal should be submitted in the data file. The days billed to Medi-Cal could be acute and/or administrative days.

- **When do I indicate "Y" in the secondary review column of the data file?**

  Answer: If any days of a hospital stay that did not meet InterQual/MCG acute criteria are approved on secondary review, the data file should include a "Y" in the secondary review column of the data file. If there is a secondary review but no days are approved, the secondary review column should include an "N" or can be left blank.

- **If a beneficiary is admitted and discharged on the same day, should that medical record be submitted in the data file?**

  Answer: Yes, but only if the hospital plans to bill Medi-Cal for an acute day **and** the medical record documents intent to admit for an overnight stay. If there is no intent to admit for an overnight stay, the medical record should not be submitted in the data file and the hospital can bill for outpatient treatment.

- **If a beneficiary was in the hospital for less than 24 hours and there is a documented intent to admit, should that day be reported on the data file in the length of stay (LOS) column as 0 or 1?**

  Answer: If a beneficiary is in the hospital for less than 24 hours, and there is a documented intent to admit, that day should be reported as 1 on the data file in the LOS column, even if the stay did not go beyond midnight from one day to the next. There should never be a LOS of 0 reported on the data file.

- **Can a hospital create its own format for the admissions data file for submission to DHCS, as long as it contains the required data elements?**

  Answer: No. The data must be submitted in the template format provided by DHCS. The file must be an Excel document and the column order must mirror the template format. Data elements must follow the guidelines provided by DHCS. For example, days approved must be a number rather than a data range and the admit date must be in the mm/dd/yyyy format. The data file should contain no hidden columns or extra header rows.

- **Can the facility submit admission data for more than one month on the same data file?**

  Answer: No. Monthly admissions data files must contain only admit dates that fall within a single month. The discharge dates can fall within that month or subsequent months. Only the Bi-annual data files can contain admit dates from more than one month.

- **How do I list days on the data file that are covered as OB cert days under AB 1397?**

  Answer: Any days covered as OB cert days should be submitted like any other Medi-Cal FFS admission with the OB cert days listed as approved.

Dispute Resolution

- **What if the hospital does not agree with the findings of the DHCS onsite review summary?**

  Answer: The provider can initiate the Dispute Resolution Process within 60 days of receipt of the Onsite Review Summary Detail report. The provider must submit a dispute resolution form for each variance, a copy of the onsite review summary and any additional documentation supporting the facility's determination. The dispute form must clearly identify what variance and dates of service are being disputed. A DHCS Medical Consultant will review the documentation and make an independent determination to either uphold the determination or reverse it. All disputed findings from an onsite review must be submitted together and DHCS will respond to all disputed findings together.

- **How do I submit a dispute?**

  Answer: Disputes can be submitted to the dispute resolution secure website at https://eft.dhcs.ca.gov. You must submit the dispute within 60 days of receipt of the Onsite Review Summary Detail report. Please submit all disputes for a given month's report together.

  If you do not have access to the website, please send an email to phpdispute@dhcs.ca.gov to request a username and password.

- **Some of the InterQual reviews could not be located at the time of the Medi-Cal review but have since been found. The missing reviews were a variance in the Onsite Review Summary Detail. Can I submit the missing InterQual reviews through the dispute resolution process?**

  Answer: The dispute resolution process is designed to resolve disputes involving **clinical** issues only, including level of care, emergency conditions and delays of service/discharge. DHCS discourages the use of the dispute process for administrative findings. The expectation

is that all requested documentation be available at the time of the review. This includes IQ/MCG reviews, SNF call lists, the Face Sheet and the POS. If documentation is missing, DHCS staff will ask the DPH to provide it at the time of the review.

- **If a beneficiary disagrees with the number of hospital days granted by the provider, can he/she use the Dispute Resolution Process?**

  Answer: The Dispute Resolution Process can be utilized by the hospital when the hospital disagrees with any DHCS decision which is communicated through an Onsite Review Summary Detail.

  In the case where a beneficiary disagrees with the hospital about days granted, the grievance process is the one established by the hospital. If the beneficiary's primary care physician doesn't believe their condition warrants additional hospital days, then the beneficiary should take the issue up with the hospital's Ombudsman's office.

  If the beneficiary disagrees with any DHCS decision regarding hospital days granted, he/she can initiate the Fair Hearing process.