DEPARTMENT OF HEALTH CARE SERVICES
Public Hospital Project
Frequently Asked Questions – January 2013

General Questions

- Why did DHCS decide to go TAR free for certain 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 an evidence-based standardized review criteria, such as InterQual or Milliman Care Guidelines for acute inpatient days and acute administrative days.

- 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.

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

  Answer: The California Legislature directed DHCS to replace the current reimbursement methodology for private hospital acute care inpatient services (both negotiated contract rates and non-contract cost reimbursement) with payment by DRGs for Medi-Cal beneficiary stays, 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 fee for service (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 appropriate use of Interqual or Milliman.

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

Answer: Required additional documentation includes:

1. The POS (eligibility verification);
2. The face sheet;
3. The InterQual/Milliman Case Management Summary (summary notes that capture decisions for the length of stay, level of care, approved or denied days and secondary reviews);
4. Other health care coverage denials, if available (such as CCS or Medicare denials); and
5. 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 five (5) following categories:
  1. California Children's Services (CCS);
  2. Medicare Part A Exhaustion of Benefits;
  3. Stays over 30 days;
  4. Retro Eligibility Determinations; and/or
  5. Other (This is the category to use for those admission that do not fall into the categories described above but were not included in the monthly admissions.)

- 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?

  Answer: Any hospital stay that includes days billed to Medi-Cal FFS must be included in the review. 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.

- 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. However, when the entire stay is denied, no medical records or supporting documentation need to be prepared. These will not be reviewed, since no claim for payment from Medi-Cal will be submitted.

- What is the purpose and the requirements of the secondary review?

  Answer: When a hospital day does not meet InterQual/Milliman 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 beneficiary's attending physician may not approve hospital days through the secondary review process.

- If a hospital stay does not meet InterQual/Milliman 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 stays. However, the requirements for acute administrative days must be met.

- 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 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/Milliman Case Management Summary (summary notes that capture decisions for the length of stay, level of care, approved or denied days and secondary reviews)

- If a beneficiary is admitted with an order indicating an admission to observation, does the admission need to meet InterQual/Milliman 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/Milliman **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 is 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/Milliman criteria are used to review all observation days. Medi-Cal does not recognize observation status and therefore does not honor the InterQual/Milliman observation criteria. Those orders with additional documentation establishing that the beneficiary was admitted under observation status and did in fact meet the InterQual/Milliman **acute** criteria would allow a facility to bill for the appropriate acute hospital day(s). Also if the day did not meet InterQual/Milliman **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 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/Milliman acute criteria?

  Answer: Yes, all days that the facility intends to bill as acute inpatient days must meet InterQual/Milliman acute criteria 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 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.

- 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 have potential to be referred to Audits and Investigations (A&I) for possible recoupment.

- Are daily InterQual/Milliman reviews required?

  Answer: Yes, each acute day that will be billed to Medi-Cal FFS must meet acute InterQual/Milliman criteria. 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.

- 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. 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 days acute requested you should include the date and time of the secondary review, evidence that the physician signed off on the decision along with 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.

- 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 the following statement: **"Hospital certifies providing emer 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 claims have corresponding admissions that 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.

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/Milliman acute criteria. Claims for beneficiaries with restricted aid codes must include the following statement in the Remarks Section (Box 80) of the claim form: "**Hospital certifies providing emer svcs to unverified citizen**".

- 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 reevaluated for a full aid code?

  Answer: Yes, the beneficiary can contact the Medi-Cal eligibility office in their county and request reevaluation. Aid code determination in general is made at the county level. The name of the eligibility office varies from county to county.

- 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.

- 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 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/Milliman criteria?

  Answer: No, denied stays do not need to be run though InterQual/Milliman. However, if a stay is approved it must be related to an emergency and be authorized by meeting InterQual/Milliman acute criteria or upon second level 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 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). Also, OB cases that fall outside the guidelines will require a full InterQual/Milliman review of all days.

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

  Answer: No. If the beneficiary is admitted and delivers within the normal OB cert days per Title 22 Section 51327(a)(1)(A), InterQual/Milliman criteria is not needed to determine medical necessity for the stay.

- 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/Milliman criteria must be used for all days from admission to discharge, not just those days that exceed the guidelines.

- If there is a fetal demise, is it covered under OB cert days or must InterQual/Milliman 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).

Administrative Days

- Do stays that only include acute administrative days need to be evaluated with InterQual/Milliman crtiteria?

  Answer: No, only acute inpatient days that will be billed to Medi-Cal must be evaluated.

- 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.

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

  Answer: No, in this case, the number of calls should equal to 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 while awaiting placement in an NF-A or NF-B.

- 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.

Other Health Coverage

- When a beneficiary is admitted to the hospital and has other health care 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 Medi-Cal covered part of the stay need to meet InterQual/Milliman criteria?

  Answer: If Medi-Cal is the primary payor for 1 or more days then InterQual/Milliman criteria must be met for those days only. The entire stay should still be included in the data set.

- 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/Milliman 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/Milliman criteria?

  Answer: Yes, treatment of other medical conditions unrelated to the hospice condition that will be billed to Medi-Cal FFS must meet InterQual/Milliman acute criteria. Only hospice related conditions can be billed to the hospice.

- Do admissions for psychiatric conditions need to meet InterQual/Milliman 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/Milliman criteria for acute hospitalization. Once the medical condition has resolved, Medi-Cal coverage 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 Milliman criteria?

  Answer: DCHS will not review stays of beneficiaries enrolled in a Medi-Cal HCP and does not require the use of InterQual/Milliman. However, the HCP may have such a requirement.

- 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 billed to Medi-Cal. Medi-Cal Managed Care is not considered OHC. The entire stay should be included in the data set.

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

  Answer: No, Medicare is not considered OHC. Additionally, Medicare B is for outpatient care and shouldn't 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 DCHS 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.

Dispute Resolution

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

  Answer: The hospital can initiate the Dispute Resolution Process within 60 days of receipt of the Onsite Review Summary Detail. The hospital must submit a

dispute resolution request, a copy of the onsite review summary and any additional documentation supporting the facility's determination. A DCHS 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. Instructions on the Dispute Resolution Process will be posted on the Extranet when finalized.

- 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.