

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
UTILIZATION MANAGEMENT DIVISION
PUBLIC HOSPITAL PROJECT**

**External Stakeholders Workgroup Teleconference
July 22, 2013 Teleconference Minutes**

Handouts

Each participant was e-mailed an agenda and minutes from the previous meeting as well as an updated list of hospital transition dates and the first version of a Participants Contact Information list.

Agenda Item II: Transition Status

Discussion: All but two designated public hospitals have transitioned into the Public Hospital Project by June 1, 2013. DHCS will continue to work with the two remaining hospitals on their transition.

Agenda Item III: Superior Systems Waiver (SSW) Renewal Update

Discussion: An interim SSW extension was submitted to CMS on June 1, 2013 to be effective from July 1, 2013 through September 30, 2013. The interim SSW has no impact on Designated Public Hospitals. The purpose of this version was to establish authority for private hospitals that use the Diagnosis Related Groups payment methodology (DRG) to submit admission TARs starting July 1, 2013. A draft of the comprehensive SSW renewal, effective date October 1, 2013 through September 30, 2015 will be forwarded to all Public Hospital Project participants today. This draft is primarily to establish a transition phase for Non-Designated Public Hospitals to move from admission TARS to using InterQual (IQ) or Milliman Care Guidelines (MCG). Doug Robins asked that any feedback on the draft of the comprehensive SSW be forwarded to DHCS by close of business, this Friday, July 26, 2013.

Agenda Item IV: Completion of Training Phase

Discussion: Once DHCS completes six months of reviews and sends the corresponding Summary Statement of Findings reports to a facility, it will send a

letter confirming that the facility has completed its training phase. At that time, DHCS will begin trending the variances.

Agenda Item V: Common Compliance Review Findings

Discussion: General Issues

- Standardized utilization review tool (IQ or MCG) notes are required for each hospital day, as is a final decision for approval or denial by the hospital.
- Each day should have brief case management notes documenting the reason for the admission and days, as well as interventions and discharge planning.
- Days approved as acute admin days do not require a standardized review.
- OB stays with deliveries that extend beyond the OB certification guidelines must have an InterQual (IQ) or Milliman Care Guidelines (MCG) review for the entire stay, including the certification days. OB certification guidelines allow for 2 days post-delivery for a vaginal birth and 4 days post-delivery for a cesarean birth without Medi-Cal authorization.
- DHCS accepts medical necessity determinations made by IQ or MCG, except when decisions conflict with existing Medi-Cal policy, such as when beneficiaries with restricted aid codes receive elective surgeries/procedures.
- When acute care in an ICU or NICU remains essentially the same over the course of several days, block reviews are acceptable. A block review is when several days are reviewed at one time. For example, stays where the beneficiary is on a ventilator and receiving multiple continuous IV medication infusions could be block reviewed. With the block case management reviews, please note, IQ acute criteria must still be used every day.

Discussion: Secondary Reviews

- A secondary review physician must be a California licensed physician, but is not required to be a member of the hospital's Utilization Review committee. The physician cannot have been an attending physician on the case at any time.
- A secondary review is required for all days that do not meet acute criteria and the hospital wants to bill Medi-Cal for acute inpatient days.

- Case managers should refer any day that does not meet acute criteria to a secondary review physician if the case manager/attending physician decides acute care is warranted.
- The secondary review physician's review should include a brief note with the rationale for any decision to approve the day, and include the physician's name and contact information.
- That secondary review physician is not required to write the note, but must sign off on the decision. The physician signature should be auditable and available upon DHCS request.
- An electronic note by the secondary reviewer is acceptable if all the other requirements above are met.
- If the secondary review physician does not feel that acute care is warranted, the case manager may discharge the beneficiary to a lower level of care and document the denied days in the case management notes. Secondary reviews must be completed prior to billing.

Agenda Item VI: New Process for Handling Charts Not Available for Review

Discussion: If an entire chart or the IQ/MCG notes are unavailable for the scheduled DHCS review, the hospital must ensure that the chart and notes are available at the next scheduled monthly review.

Rare instances when a chart will never be available will be handled on a case-by-case basis.

Agenda Item VII: Exit Conference Process

Discussion: For the past few months, DHCS Nurse Reviewers have not provided hospitals with exact numbers of variances during exit conferences. DHCS review staff asked the participants on the call how the exit conferences could be improved.

Suggestion: A representative from Santa Clara Valley Medical Center suggested that it would be helpful for DHCS Nurse Reviewers to provide the exact number of each variance at the exit conferences. This would allow the hospital to review specific records and take action to correct or change hospital procedure in a timely manner.

Suggestion: A representative from Los Angeles County said that the hospital physicians should be able to communicate directly with DHCS Field Office and Headquarters staff.

The most common variances DHCS have identified are:

- Elective admissions for beneficiaries with restricted aid codes.
- Cases in which the emergency condition has resolved, but the patient remains in the hospital.
- Delays of service.
- Incorrect use of acute administrative days
- Incomplete call lists for acute administrative days

Agenda Item VIII: Dispute Resolution Process

Discussion: DHCS Headquarters continues to build a comprehensive list of Public Hospital Project participant contacts. A follow-up email will go out to all participants for general contacts and specifically for contacts that will likely submit dispute documentation in the future.

Discussion: If a clinical variance is disputed, the hospital should submit progress notes and/or doctor's orders for that day to support the dispute. Case Management notes will not be sufficient documentation to overturn a decision.

Agenda Item IX: Clinical Issues Submitted by Stakeholders

Example: If a patient is transitioning from Intravenous pain meds to oral pain meds, and there is a day that falls out of acute criteria, DHCS would need the secondary review physician to explain any days that did not meet InterQual acute criteria on a case by case basis.

Other: DHCS may begin collecting specific numbers of days that are billed by other health care coverage. Currently, there is a column on the monthly admissions data Excel template that asks for a "Y" or "N" for other health care coverage. DHCS is currently assessing the impact of this proposed change.

Agenda Item X: Next Meeting Date – September 23, 2013