

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

**Frequently Asked Questions (FAQs) for the  
TAR free Inpatient Acute Rehabilitation Admissions at the Public Hospitals**

**General Questions**

- **Why did DHCS decide to go TAR free for acute inpatient rehabilitation stays in Public Hospitals?**

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

- **Is there a training period after we start the TAR-free process?**

**Answer:** Yes. The training period lasts for 6 months after the transition start date. During the training period, DHCS will work with hospitals to ensure understanding and compliance with Medi-Cal requirements.

- **In addition to the medical record and IQ/MCG required documents what documentation does DHCS require for the acute rehabilitation reviews?**

**Answer:** Required documentation includes:

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

- **How often are IQ or MCG reviews required?**

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

- **How are the 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.

- **Is there a secondary review process?**

**Answer:** Yes, if acute rehabilitation IQ/MCG criteria are not met and the facility wishes to bill for an acute rehabilitation day. 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.

- **Can a beneficiary with a restricted aid code qualify for acute inpatient rehabilitation services?**

**Answer:** Full aid codes are required to qualify for acute inpatient rehabilitation. In rare instances, a pregnant beneficiary with a restricted aid code may be approved. This is handled on a case-by-case basis. The appropriate Medi-Cal Field Office should be contacted prior to admission.

- **Will DHCS allow group therapy?**

**Answer:** DHCS will allow no more than 25% of the required 15 hours per week (per IQ) 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.

- **Can we approve an acute day 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, he/she should be discharged from acute rehabilitation to acute inpatient status requiring hospital care or to a lower level of care setting (NF or home).

- **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

### **Administrative Days**

- **Are acute administrative days allowed when a beneficiary no longer requires acute rehabilitation services and NF placement is ordered?**

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

- **Are acute administrative days required to be evaluated with IQ/MCG criteria?**

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

- **Is the hospital required to make 10 daily calls for NF placement?**

**Answer:** Yes, if they are seeking NF placement. They are required to make 10 daily placement calls with corresponding responses. The exception is no calls are required on weekends or holidays. Calls must be made on Fridays to cover the weekends.

### **Monthly Data File Requirements**

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

**Answer:** 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 IQ/MCG.

- **How should the hospital submit monthly data for acute rehabilitation admissions to DHCS?**

**Answer:** Data should be submitted with the monthly acute admissions using the current format utilized for acute inpatient reviews. Please reference FAQs on the current weblink: <http://www.dhcs.ca.gov/provgovpart/Pages/PublicHospitalProject.aspx>.

A new column labeled “rehab” has been added to the data spreadsheet. Acute rehabilitation stays should be designated with a “Y” in this column.

- **What is the sampling size for the data requirements?**

**Answer:** DHCS will select all Medi-Cal Fee-For-Service (FFS) acute rehabilitation admissions during the first 90 days. Once the 90 day period is over, DHCS will analyze the variance patterns and determine the sampling methodology which would be a statistically valid sample of acute rehabilitation admissions.

- **Do we include beneficiaries with OHC such as California Children's Services (CCS) or Medicare Part A benefits in the monthly review data?**

**Answer:** Any hospital stays with at least one day billed to Medi-Cal FFS must be included in the review data.

- **Will there be biannual reviews?**

**Answer:** Since the volume of acute rehabilitation admissions is lower than acute admissions, annual reviews rather than biannual reviews will be conducted for those records that were not included in the monthly reviews.

- **When should the hospital submit annual data to DHCS?**

**Answer:** The data is due annually starting with the month/year following the hospital's transition to TAR-free acute inpatient rehabilitation. For example, if the first TAR-free month for acute inpatient rehabilitation was September 2015, the first year's annual data would be due with the September 2016 monthly data.

- **Will the Statement of Findings (SOF) report for acute rehabilitation be separate from the acute inpatient SOF report?**

**Answer:** Yes, the findings for acute inpatient hospitalizations and acute inpatient rehabilitation admissions will be on separate reports and distributed to the hospital following the monthly review.

## Claims

- **When will the hospital be able to submit claims?**

**Answer:** The hospital may claim after the IQ process is completed and all days to be billed have been adjudicated.

- **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.

- **Do I need to use rehabilitation codes when I file a claim?**

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

- **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. Based on their investigation, A&I may request recoupment of payment.

## **Dispute Resolution**

- **Can the hospital initiate the Dispute Resolution Process when the hospital does not agree with the SOF report?**

**Answer:** The provider may initiate the Dispute Resolution Process within 60 days of receipt of the Statement of Findings report. The provider must submit a dispute resolution form for each variance and any additional documentation supporting the facility's determination. The dispute form must clearly identify what variance and dates of service are being disputed. Please note that the medical review conducted for the dispute is independent of the medical review completed by field office staff; therefore the provider may need to submit all relevant clinical documentation with the dispute to ensure a thorough medical review can be completed by the DHCS Medical Consultant. A 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. 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 must be submitted to the dispute resolution secure website at <https://etransfer.dhcs.ca.gov/>. You must submit the dispute within 60 days of receipt of the Statement of Findings 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](mailto:phpdispute@dhcs.ca.gov) to request a username and password.

- **Some of the IQ 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 Statement of Findings report. Can I submit the missing IQ 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 the complete medical record, IQ/MCG reviews and any secondary reviews, NF call list and the POS document that identifies eligibility. 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 a Statement of Findings report.

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.