DESIGNATED PUBLIC HOSPITAL (DPH) TREATMENT AUTHORIZATION REQUEST (TAR)-FREE PROCESS

Variance Descriptions and Authorities

Category 1: Hospital Utilization Review (UR) Process

1.1 Utilization Process

The Designated Public Hospital (DPH) Treatment Authorization Request (TAR)-Free Process allows for the use of standardized medical review tools based on nationally recognized peer-reviewed medical standards to determine medical necessity.

The decision to admit, retain, or discharge a member is a physician decision. When a member is admitted to an acute inpatient hospital and the standardized medical review criteria tool has determined that the primary review did not meet criteria, the utilization review nurse must request a secondary review by a physician. The secondary review may be completed by a physician adviser, physician on the UR Committee or any other California licensed physician that is not the attending/ordering physician.

If the DPH chooses to perform a secondary review and to authorize additional days, then this secondary review determination must be performed and signed off by a Doctor of Medicine or Osteopathy with a current active license in the State of California. The secondary review should include the physician review date, signature, physician name and contact information (phone number) and a written discussion outlining the medical rationale for authorization of each day of the stay.

Authority

- California Code of Regulations, Title 22, Section 51476 – *Keeping and Availability of Records*
- Code of Federal Regulations, Title 42, Section 482.24 – *Condition of participation: Medical record services*
- Code of Federal Regulations, Title 42, Section 482.30 – *Condition of participation: Utilization review*

- United States Code, Title 42, Section 1396a(a)(30)(A) – *Utilization plan*

1.2 Medical Necessity

Medical necessity for an acute inpatient day is met if approved by the standardized utilization review tool criteria. If an acute day falls out of the criteria of the UR tool a secondary review is required. The Department of Health Care Services (DHCS) will review secondary review decisions to determine if Medi-Cal acute inpatient level of care criteria is met. Approval of acute inpatient hospital days requires that the care rendered is medically necessary and the Medi-Cal member remains at the acute level of care as documented in the medical record. Acute hospital services, including specific physician services, procedures and consultations are to be available 24 hours per day, 7 days per week, to meet the medical needs of the member.

Authority

- Manual of Criteria for Medi-Cal Authorization Chapter 5.1, I
- Welfare and Institutions Code, Section 14059.5 – *Medical necessity*
- Welfare and Institutions Code, Section 14133.25(a) – *Inpatient versus outpatient*
- Welfare and Institutions Code, Section 14133.3(a) – *Medical justification*

Category 1 Variance(s) (Appendix)

Category 2: Limited/Restricted Aid Codes

2.1 Aid Code Discrepancy

Aid Codes are meant to assist providers in identifying the types of services for which Medi-Cal and County Medical Services Program (CMSP) members are eligible. Aid Codes were developed for use inconjunction with the Medi-Cal Eligibility Verification System (EVS). Providers must verify eligibility every month as a member's eligibility can change anytime. Providers must verify eligibility on the date of service even if eligibility was previously verified for the month. They must submit an inquiry to the EVS to verify a member's eligibility for services. A Point of Service (POS) printout or internet eligibility response may be kept as proof of

eligibility for the month. When a provider verifies that an individual is eligible to receive Medi-Cal benefits; the provider accepts the individual as a Medi-Cal member.

Authority

- Code of Federal Regulations, Title 42, Section 482.30 – *Condition of participation: Utilization review*
- United States Code, Title 42, Section 1396a(a)(30)(A) – *Utilization plan*
- Welfare and Institutions Code, Section 14018.2 – *Medi-Cal eligibility*

2.2 Restricted Aid Code

Medi-Cal funds can be paid only for services that the member qualifies for under their assigned aid code. Some aid codes have limited or restricted eligibility. These aid codes limit reimbursement to medical care that is directly related to the emergent condition for which they were admitted or for services that are medically necessary services related to a pregnancy.

A member with a restricted aid code has coverage for services that are medically necessary and related to the emergent condition. (Examples of some of these aid codes are 3V, 58).

Authority

- California Code of Regulations, Title 22, Section 51056 – *Emergency services*
- Welfare and Institutions Code, Section 14007.5 – *Service limitations due to immigration status*

Category 2 Variance(s) (Appendix)

Category 3: Delay

3.1 Delay of Services

- **Delay in Rendering Acute Care:** A delay in rendering acute care occurs when a service or procedure has not been supplied or performed in a timely manner, the member's hospital discharge is delayed, and there is no documented medical reason for the delay.
- **Slow Progression of Acute Care:** Slow progression of acute care occurs when progress in reaching therapeutic goals is delayed beyond generally accepted standards of medical practice that causes a delay in the member's hospital discharge, and there is no documented medical reason for the delay.

Authority

- United States Code, Title 42, Section 1396a(a)(30)(A) – *Utilization plan*
- Welfare and Institutions Code, Section 14133.3(a) – *Medical justification*
- Welfare and Institutions Code, Section 14133.3(b) – *Utilization control*

Category 3 Variance(s) (Appendix)

Category 4: Acute Administrative Days (AAD)

4.1 Acute Administrative Days

Medi-Cal funds cannot be paid at an acute level of care rate when the member is receiving a lower level of care. There are instances when a member's level of care is not at the acute level, but they must remain in an acute setting due to:

- An inability to find nursing facility placement (NF AAD)
  - Documentation of attempts at placement is required for payment of acute administrative days for nursing facility placement
- Members with tuberculosis (TB) in isolation awaiting negative TB sputum tests following initiation of treatment (TB AAD)

- Monitoring of an at-risk obstetrical patient (OB AAD)

Authority

- California Code of Regulations, Title 22, Section 51173 – *Acute administrative days*
- California Code of Regulations, Title 22, Section 51342 – *Acute administrative days*
- Manual of Criteria for Medi-Cal Authorization, Chapter 5.3, III. (A)

Category 4 Variance(s) (Appendix)

Category 6: Length of Stay

6.1 Day of Admission

The day of admission is determined by the time and date the physician writes the order in the medical record to admit the member to the hospital. This order can be written in the MD orders, progress notes or Emergency Department notes. There must also be the intent to admit with the expectation of an overnight hospital stay.

Authority

- California Code of Regulations, Title 22, Section 51108 – *Inpatient*

6.2 The Physician's Discharge Order Date

The day of discharge is determined by the time and date the physician writes the order in the medical record to discharge the member from the hospital. Members shall be discharged from the hospital only upon the order of the credentialed practitioner.

To determine the length of the hospitalization, the reviewer will verify the admission and discharge order dates on the medical record.

Each hospital should have policies that ensure uniformity of both content and format of the member's record based on all applicable accreditation standards, federal and state regulations, payer requirements, and professional practice standards.

Authority

- Code of Federal Regulations, Title 42, Section 482.24 – *Condition of participation: Medical record services*

Category 6 Variance(s) (Appendix)

Category 7: Hospice

7.1 Hospice

Once a member elects hospice, the hospice organization is responsible for paying for hospice-related care, including inpatient care. Hospice related conditions must be billed to the hospice organization. Inpatient treatment of other medical conditions unrelated to the hospice condition that will be billed to Medi-Cal Fee-for-Service must meet standardized medical review criteria.

Authority

- California Code of Regulations, Title 22, Section 51349 - *Hospice Care*

Category 7 Variance(s) (Appendix)

Category 8: Mental Health

8.1 Psychiatric Inpatient Hospital Services

Mental Health Plans (MHP) are responsible for the authorization and payment of all medically necessary specialty mental health services for Medi-Cal members of that county in accordance with federal and state Medicaid requirements.

Each MHP is financially responsible for payment of emergency psychiatric services provided to its members within California and specified border communities. MHPs may not restrict member access to emergency services. Emergency psychiatric services are covered by the MHP when the member has been admitted to a hospital or a psychiatric health facility.

Psychiatric inpatient hospital services are covered by the County Mental Health Departments. If a member with a psychiatric diagnosis is admitted to a medical unit as an emergency admission, the stay is evaluated for medical necessity for their medical condition. If the member's condition is medically stable, then the provider will refer the member to the local MHP. Medi-Cal members are enrolled automatically in the MHP in each of the 58 counties. In most cases, the MHP is the county mental health department.

Authority

- Welfare and Institutions Code, Section 14680 through 14684.1 – *Mental health services*
- California Code of Regulations, Title 9, 1820.20 - *Medical necessity criteria for reimbursement of psychiatric inpatient hospital services*
- California Code of Regulations, Title 9, 1820.225(b) – *Emergency psychiatric inpatient hospital services*

Category 8 Variance(s) (Appendix)

Category 10: Potential Outpatient

10.1 Potential Outpatient

Outpatient services refer to non-emergency health care services provided to members whose hospital stay is less than 24 hours and there is no intent by the physician for the member to remain in the hospital overnight.

Authority

- California Code of Regulations, Title 22, 70525 – *Outpatient Service Definition*
- Welfare and Institutions Code, Section 14133.25(a) – *Inpatient versus outpatient*

Category 10 Variance(s) (Appendix)

Category 13 - 17: Acute Inpatient Intensive Rehabilitation (AIIR) – Admission Documentation, Active Participation, IDT Conferences, Face-to-Face Visits, and Therapy Documentation

13-17 Acute Inpatient Intensive Rehabilitation Services

Acute Inpatient Intensive Rehabilitation (AIIR) is a service intended to help the physically or cognitively impaired patient achieve or regain his/her maximum potential for mobility, self-care, and independent living by restoring maximum independent function, resulting in a sustained higher level of self-care to be able to discharge home/other community setting/lower level of care, in the shortest possible time.

It is designed to provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. Requirements for intensive rehabilitation therapy include specific admission documentation such as the pre-admission screening, individualized overall plan of care, and the CMS Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). These requirements consist of the following medical necessity criteria: multiple therapy disciplines, active patient participation, rehabilitation physician supervision, intense therapy program, and interdisciplinary team conferences.

Authority

- California Code of Regulations, Title 22, Section 70595 through 70603 – *Rehabilitation center*
- CMS Medicare Benefit Policy Manual, Chapter 1, Section 110
- Welfare and Institutions Code, Section 14064 – *Inpatient intensive rehabilitation hospital services*
- Welfare and Institutions Code, Section 14132.8 – *Rehabilitative services*

Category 13-17 Variance(s) (Appendix)

Appendix

Designated Public Hospital (DPH) TAR-Free Process Variances

Category 1: Hospital Utilization Review Process	
Variance Code	**Description**
1A	No documentation of secondary review by hospital physician, but DHCS agrees with approval
1B	No documentation of secondary review by hospital physician and DHCS disagrees with approval **(R)**
1C	Secondary review with documentation by hospital physician and DHCS disagrees with approval **(R)**
1D-1	No documentation of daily standardized medical criteria review decision, but DHCS agrees with approval
1D-2	No documentation of daily standardized medical criteria review decision and DHCS disagrees with approval **(R)**
1F-1	Observation criteria used but DHCS agrees with approval
1F-2	Observation criteria used and DHCS disagrees with approval **(R)**
1G-1	No documentation of standardized medical criteria review decision and/or secondary review prior to submitting claim, but DHCS agrees with approval
1G-2	No documentation of standardized medical criteria review decision and/or secondary review prior to submitting claim and DHCS disagrees with approval **(R)**
1H-1	Insufficient documentation (missing medical records and/or documents) but DHCS agrees with approval
1H-2	Insufficient documentation (missing medical records and/or documents) and DHCS disagrees with approval **(R)**
1J	Standardized medical criteria review was not met and a secondary review by hospital physician denied the day, but hospital billed **(R)**

Category 1: Hospital Utilization Review Process*	
Variance Code	**Description**
1K-1	No documentation of weekly acute inpatient rehabilitation standardized medical criteria review decision, but DHCS agrees with approval
1K-2	No documentation of weekly acute inpatient rehabilitation standardized medical criteria review decision and DHCS disagrees with approval **(R)**
1L-1	No documentation of secondary review by hospital physician, but DHCS agrees with approval
1L-2	No documentation of secondary review by hospital physician and DHCS disagrees with approval **(R)**
1M	Secondary review with documentation by hospital physician and DHCS disagrees with approval **(R)**
1N	Acute inpatient rehabilitation standardized medical criteria review criteria was not met and secondary review by hospital physician denied the day, but hospital billed **(R)**

Category 2: Limited/Restricted Aid Codes	
Variance Code	**Description**
2A	Elective procedure/non-emergent condition **(R)**
2B	Services are not related to the emergent condition **(R)**
2C	Does not qualify for acute administrative days **(R)**
2D	Services not covered under aid code **(R)**

(R) Recoupment
*Applies only to AIIR stays

Category 3: Delay	
Variance Code	**Description**
3A	Delay of service **(R)**
3B	Delay of discharge/transfer **(R)**

Category 4: Acute Administrative Days (AAD)	
Variance Code	**Description**
4A	Documented skilled nursing level of care - not eligible for acute days. **(R)**
4B	TB Admin Days - member in isolation with probable TB, requires lower level of care **(R)**
4C	OB Admin Days – no longer at acute level of care but remains in hospital for monitoring **(R)**
4D-1	No call list for NF placement **(R)**
4D-2	Incomplete call list for NF placement (< 10 NF calls with responses per day) **(R)**
4F	No documentation of intent to discharge to NF but acute administrative days billed **(R)**
4G	Enrolled in Hospice - not eligible for acute administrative days **(R)**
4H	Documented bed hold day - not eligible for acute administrative days **(R)**
4J	Delay of transfer to NF **(R)**

Category 6: Length of Stay	
Variance Code	**Description**
6B	Discrepancy with date of admission - additional days billed **(R)**
6D	Discrepancy with date of discharge - additional days billed **(R)**

Category 7: Hospice	
Variance Code	**Description**
7F	Care was related to the hospice qualifying condition, and no disenrollment documentation was presented for the review **(R)**

Category 8: Mental Health	
Variance Code	**Description**
8	Psychiatric days - paid by county Mental Health Plan (MHP) **(R)**

Category 10: Potential Outpatient	
Variance Code	**Description**
10	No intent for inpatient overnight stay: Member may have had an admission order, but documentation did not support intent to admit overnight. Hospital may bill as outpatient **(R)**

Category 11: Miscellaneous	
Variance Code	**Description**
11	Miscellaneous **(potential recoupment)**

Category 13: Admission Documentation*	
Variance Code	**Description**
13A	Documentation of a pre-admission screening was not presented
13D	Documentation of a Plan of Care was not presented
13E	Documentation of an Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) was not presented

(R) Recoupment
*Applies only to AIIR stays

Category 14: Active Participation*	
Variance Code	**Description**
14C	The member was not expected to actively participate in intensive rehab therapy and DHCS disagrees with approval **(R)**

Category 15: IDT Conferences*	
Variance Code	**Description**
15A-1	Weekly Interdisciplinary Team Conferences were not documented but DHCS agrees with approval
15A-2	Weekly Interdisciplinary Team Conferences were not documented and DHCS disagrees with approval **(R)**

Category 16: Face-to-Face Visits*	
Variance Code	**Description**
16A-1	Face-to-face physician visits were documented less than 3 times per week, but DHCS agrees with approval
16A-2	Face-to-face physician visits were documented less than 3 times per week and DHCS disagrees with approval **(R)**

(R) Recoupment
*Applies only to AIIR stays

Category 17: Therapy Documentation*	
Variance Code	**Description**
17A	Documentation of active and ongoing therapeutic intervention of multiple therapy disciplines (one therapy must be PT or OT) **(R)**
17C-1	The total therapy hours were less than 15 hours per week (7 days) without medical justification **(R)**
17D	The individual and group therapy hours were not separately documented
17E-1	The individual therapy hours were less than 11.25 hours per week (7 days) without medical justification **(R)**
17F	The member was non-compliant with therapy for more than 3 consecutive days **(R)**
17G	The member plateaued for more than 3 consecutive days **(R)**

(R) Recoupment
*Applies only to AIIR stays