



DEPARTMENT OF HEALTH CARE SERVICES  
**FACILITY RESPONSIBILITIES FOR PARTICIPATION IN THE  
 PUBLIC HOSPITAL PROJECT**

### I. Facility Primary Contact

Provide facility name and address. Also provide a single facility contact person's name, phone number, and e-mail address. This person will be the primary contact for the Department of Health Care Services' (DHCS) Public Hospital Project (PHP).

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street Address

Suite/Unit #

City

State

ZIP Code

Primary Contact Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Provide NPI Number for Participating Hospital Facility:** \_\_\_\_\_

### II. Organizational Chart

Please attach the UR/Case Management Department's organizational chart along with primary contacts of the hospital's UR/Case Management, Medical Records and Billing departments.

**To ensure the participating hospital receives the appropriate DHCS documentation, it is the responsibility of the hospital to notify DHCS within ten (10) business days of any modifications.**

To verify current hospital representatives receiving correspondence/documentation related to the Public Hospital Project for your facility, please contact DHCS at [PublicHospitalProject@dhcs.ca.gov](mailto:PublicHospitalProject@dhcs.ca.gov).

### III. Utilization Review Process

As the single state Medicaid agency, DHCS is required to provide technical assistance, oversight and monitoring of state and federal funds. In the Superior Systems Waiver's (SSW) PHP, DHCS' role changed from direct-100 percent review and authorization of inpatient hospital stays to monitoring and oversight of the facility's evidence-based standardized medical review criteria processes and outcomes.

The participating hospital must submit evidence that each hospital day was individually adjudicated through the utilization review process, including daily decisions and daily case management notes. Grouping of a range of days is not permitted. No claims can be submitted until the utilization review

process is completed for each hospital day billed. The Clinical Assurance Division (CAD) may ask the participating hospital to amend claims that do not fulfill these requirements.

For acute inpatient claims associated with Medi-Cal beneficiaries with restricted aid codes, one of the following phrases must be indicated in the "Comments" field of the claim form:

**"Hospital certifies providing emer svcs to unverified citizen"**

OR

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

Use of a current evidence-based standardized medical review criteria tool is required for participation in the SSW's PHP. **Please indicate below which system your facility uses:**

- InterQual; Version:
- MCG – formerly Milliman Care Guidelines; Version:
- Other (Please Specify):

If your facility changes its evidence-based standardized medical review criteria system, please notify DHCS at least 30 calendar days prior to the planned implementation date of the change via email or by telephone:

Public Hospital Project

[PublicHospitalProject@dhcs.ca.gov](mailto:PublicHospitalProject@dhcs.ca.gov)

(916) 552-9100

#### **IV. Utilization Review Committee**

As Medi-Cal providers, facilities are required to have a utilization review (UR) committee.

Code of Federal Regulations Title 42, section 482.30(b) requires a facility's UR committee to be composed of two or more practitioners who carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in section 482.12(c)(1).

For further information, please refer to Code of Federal Regulations Title 42, sections 456.1 through 456.51, 482.12, and 482.30.

#### **V. Requirements**

As a participant in the SSW's PHP the facility is required to:

- Use the current version of evidence-based standardized medical review criteria for acute inpatient care. (Please note – your facility determines which product it will use.)
- Include all DHCS submission criteria requirements in your facilities evidence-based standardized medical review criteria documentation.
- Ensure UR staff is trained on the use of evidence-based standardized medical review criteria.

- Receive training by DHCS staff for applicable facility UR staff on the new UR process, requirements, and relevant Medi-Cal policies prior to beginning the new UR process, and ongoing training as needed.
- Provide a process for resolving Beneficiary grievances including recording of all grievances received, date of receipt, nature of problem, date and resolution or disposition of the grievance.
- Allow DHCS staff electronic access to fee-for-service Medi-Cal beneficiary medical records, evidence-based standardized medical review criteria determinations, call lists for Administrative days, and secondary review decisions at least five (5) business days prior to scheduled review.
- Submit requested missing documentation within 24 hours of notification.
- Notify DHCS of anticipated system changes (i.e. firewalls, updates, etc.).
- Notify DHCS within ten (10) business days of any organization personnel changes.
- Report within 30 calendar days after the end of each calendar quarter, in an electronic format identified by DHCS, all Medi-Cal fee-for-service days that did not meet standardized medical review criteria and were not authorized on secondary review, including any grievance actions requested by the beneficiary.

## VI. Secondary Review Process

If an acute hospital day does not meet evidence-based standardized medical review criteria, and the facility wants to be reimbursed by Medi-Cal, the facility must perform a secondary review and include:

- A written discussion of the medical necessity,
- Physician contact name and phone number,
- Date of review, and
- The physician must also sign off on the approval

This secondary review determination must be performed by a doctor of medicine or osteopathy with a current active medical license in the State of California. This physician may be a member of the UR committee, but may not be one of the attending physicians for the case under review.

Hospital days approved through the secondary review process must be individually justified by the physician. Grouping approval of a range of days is not permitted.

## VII. TAR-Free Claiming

TARs will no longer be required for most acute inpatient stays prior to claim submission with participation in the PHP. This excludes the following:

- Hospice General Inpatient Care
- Surgical Procedures (Hospital days associated with surgical procedures will not require a TAR and can be billed using the TAR-free process.)

After the facility's own UR process is completed, and a secondary review has been performed if necessary, the participating facility may then submit a claim form directly to the DHCS fiscal intermediary.

Evidence-based standardized medical review criteria must be utilized before submitting a claim for acute inpatient days. Evidence based-decisions, access to the evidence-based standardized review acute criteria system, and secondary reviews should be available to DHCS upon request; if these requirements are not met, DHCS will instruct the participating facility to adjust claims.

### **VIII. Acute Inpatient Rehabilitation [as applicable]**

***This section only applies to hospitals that provide Acute Inpatient Rehabilitation (acute rehab) services.***

For acute rehab services, DPHs will also perform their own utilization review using evidence-based standardized medical review criteria, such as InterQual or MCG. Medi-Cal Fee-For-Service acute rehab criteria for DPHs in the PHP are as follows:

- DHCS will perform a 100% review of acute rehab stays for the first 90 days from the date the DPH transitioned their acute rehab stays into the PHP. Once the 90-day period has passed, the sampling modality will take effect.
- The participating hospital is required to document InterQual or MCG outcomes on a weekly basis.
- All acute rehab services for Medi-Cal Fee-For-Service beneficiaries must be provided in an acute care bed (certified pursuant to 42 CFR Part 482) in a rehabilitation center (licensed in accordance with Title 22, CCR, sections 70595-70603).
- Only the identified acute rehab revenue codes shall be used when billing for acute rehab stays, i.e. 118, 128, and/or 138.
- DHCS requires patients to be in an Intensive Rehab Program, consisting of 15 hours per week of treatment therapies as directed in the standardized medical review criteria (except in circumstances where temporary changes in the patient's condition preclude administration of this level of therapy) and this can consist of individual and group therapy if the beneficiary is deemed medically appropriate for group therapy. Of the provided hours, no less than 75% of the 15 hours per week (11.25 hours) shall be individual therapy. Any additional therapy may consist of group or individual based upon the clinical determination of the treating physician.
- Care/treatment must be supervised by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation.

### **IX. DHCS Oversight**

DHCS will review statistically valid samples of medical records as well as perform, as applicable, focused reviews to validate the facility's UR process and adherence to Medi-Cal specific admission and service authorization policies. If DHCS determines there was erroneous billing, the facility will be instructed to correct the claim through the Claims Inquiry Form (CIF) process. The CIF process is a two-step process (CIF and claim appeal through the DHCS fiscal intermediary) that results in a correction of the claim for proper payment history. This process includes the coding of the claim as instructed in the CIF links below:

## CIF Overview -

[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/cif\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/cif_z01.doc)

and

## CIF Completion -

[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/cifco\\_z02.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/cifco_z02.doc)

A dispute process is available to facilities. Claims must be corrected through the CIF process within 60 days of notification by DHCS or if disputed, within 30 days following the final resolution of any applicable dispute. The appeal form overview and completion process is identified in the links below:

## Appeal Overview -

[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/appeal\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/appeal_z01.doc)

and

## Appeal Completion -

[https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/appealform\\_z02.doc](https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/appealform_z02.doc)

One purpose of the DHCS monitoring and oversight process is to provide information and additional training in order to correct variances in the facility's UR process. The facility is also required to provide ongoing training on the TAR-Free UR process to current and new staff. If information sharing and training does not correct a facility's variances, a referral to DHCS Audits and Investigations (A&I) may occur for further follow up. This referral to A&I would only occur after the DHCS Clinical Assurance Division (CAD) provided training and technical assistance and worked with a facility to correct issues to meet a measurable level of, and timeframe to come into, compliance, determined by DHCS and communicated to the facility in writing. If a facility is deemed non-compliant with the requirements that govern the utilization management process, DHCS may require another method of utilization review, such as the TAR process, until such time that the facility can demonstrate compliance.

If after 60 days, or within 30 days following the final resolution of any applicable disputes, the identified claims were not corrected through the CIF and appeal processes, this information will be submitted to Audits and Investigations for monthly recoupments of overpayments to the provider that are subject to recovery pursuant to Section 51458.1, Article 6 of Division 3, Title 22, California Code of Regulations.

The DHCS oversight and monitoring/audit process may lead to recoupment from the facility and/or civil money penalties. Civil money penalties may be imposed as permitted by Welfare and Institutions Code, Section 14123.25. These penalties range from \$100 to \$1,000 per adjustment to reported costs, up to three times the amount for each item or service improperly claimed, whichever is greater.

## X. Acknowledgement

I have read and understand the facility responsibilities outlined above. This document is intended to provide general information about facility responsibilities for participation in the PHP. It is not a complete or exhaustive list of all facility responsibilities. This agreement shall be updated annually from the date signed. By signing, the authorized representative acknowledges his/her authority to enter into this agreement.

Facility Representative [Print Name]:	Facility Representative Signature:	Title	Date
Facility Representative Email:	Facility Representative Phone:	<i>This section intentionally left blank.</i>	
DHCS Representative:	DHCS Representative Signature:	Title	Date
<b>Doug Robins</b>		<b>Chief, Clinical Assurance Division</b>	