

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

**Frequently Asked Questions (FAQs) for the  
Designated Public Hospital (DPH) Project**

**FAQ Organization**

This FAQ document is organized into the following sections:

- I. General Questions**
- II. DPH Requirements for Using InterQual/MCG and Case Management Documentation**
- III. Secondary Review Process**
- IV. Monthly Compliance Reviews and DPH Reporting Responsibilities**
- V. Statement of Findings Reports / Dispute Resolution Process**
- VI. Claims Adjustment / Recoupment Processes**
- VII. Restricted Aid Codes**
- VIII. OB Days with Delivery During Stay (OB Cert Days)**
- IX. Administrative Days**
- X. Other Healthcare Coverage**
- XI. Other**

**I. General Questions**

- **Why did DHCS decide to go TAR free for inpatient hospital days in Designated Public Hospitals (DPHs)?**

**Answer:** To increase efficiency and effectiveness while still ensuring hospital inpatient stays are billed appropriately, DHCS transitioned from 100% utilization review to allowing DPHs to use evidence-based standardized medical review criteria, such as InterQual or Milliman Care Guidelines (MCG) for acute inpatient days for fee-for-service (FFS) Medi-Cal beneficiaries, followed by a monthly paid claims compliance review by DHCS to ensure appropriate utilization management monitoring and oversight.

- **Where can I find information about the Public Hospital Project on-line?**

**Answer:** The Public Hospital Project has a webpage available at <https://www.dhcs.ca.gov/provgovpart/Pages/PublicHospitalProject.aspx>. The webpage can also be found by starting at the Department of Health Care Services (DHCS) Home Page, <https://www.dhcs.ca.gov>, and clicking on the “Providers & Partners” tab in the header, and then clicking on “Public Hospital Project” within the ‘Programs’ group.

- **What is the general process of the DPH TAR-Free utilization management process?**

**Answer:** The high-level process is as follows:

1. DPHs must run all acute inpatient days through standardized medical review criteria as well as review for Medi-Cal specific policies, such as delays of service, administrative day policies and aid code restrictions.
2. If all days of a stay meet criteria and Medi-Cal policies, DPHs may claim all days.
3. If a day/days do not meet criteria and the DPH wants to claim for the day/days, DPHs may perform a Secondary Review determination by a facility physician (see **Secondary Review Process** section for additional information). If the facility physician approves the Secondary Review, the DPH may claim for the day/days approved on Secondary Review. If the DPH does not perform a Secondary Review, any day that does not meet standardized medical review criteria may not be claimed. Please note, Secondary Review decisions are subject to DHCS review for medical necessity and conformance to Medi-Cal policies.
4. DHCS conducts a monthly compliance review of a statistically valid sample of claims paid during a given month, and issues a Statement of Findings report to the DPH detailing any findings (see **Statement of Findings/Dispute Resolution Process** section for additional information).
5. If a DPH chooses to dispute a clinical finding, they have 60 days from the date of the letter transmitting the Statement of Findings to submit the dispute to DHCS (see **Statement of Findings/Dispute Resolution Process** section for additional information). DHCS will issue a Dispute Report within 60 days of dispute receipt.
6. Any undisputed findings or findings upheld on dispute will be recouped (see **Recoupment Process** section for additional information).

- **Do any inpatient services still require a TAR?**

**Answer:** General acute care inpatient hospice continues to require a TAR.

- **Even though hospital days no longer require a TAR, will surgeries and medical procedures still need one?**

**Answer:** Yes, elective and emergency surgeries/procedures that previously required a TAR will continue to require one. However, the TAR should not request hospital days associated with the surgery or medical procedure.

*Per California Code of Regulations (CCR) § 51501 (e): (e) Fees shall not be paid to any provider for professional services rendered in a hospital or other facility when such provider is compensated on a salary or contract basis, for performing the same*

*or similar services, by that hospital or facility if the funds used to pay such salary or to discharge the obligation of such contract are subject to reimbursement in whole or in part from the General Fund of the State of California or from taxes or assessments paid to any of its subdivisions.*

## II. DPH Requirements for Using InterQual/MCG and Case Management Documentation

- **Are daily InterQual/MCG reviews required?**

**Answer:** Yes, each acute day that will be billed to Medi-Cal FFS must meet acute InterQual/MCG criteria or be approved on Secondary Review. Acute administrative days and inpatient hospital services for deliveries and well babies (OB cert days) as specified in Title 22 Section 51327(a)(1)(A) are exempt from this requirement.

- **If a beneficiary is admitted with an order indicating an admission to observation, does the admission need to meet InterQual/MCG acute criteria?**

**Answer:** Yes. If there are Medi-Cal FFS billed days associated with an admission to observation, 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/MCG acute criteria. Observation is not a status that Medi-Cal recognizes and, therefore, Medi-Cal does not honor InterQual/MCG observation criteria.

- **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/MCG 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/MCG Case Management Summary (summary notes that capture decisions for the length of stay, level of care, approved or denied days and Secondary Reviews).

- **If InterQual /MCG indicated that a beneficiary qualified for multiple consecutive acute days based on their diagnosis, am I still required to perform a daily review?**

**Answer:** Yes, all acute days billed to Medi-Cal must be individually evaluated using InterQual/MCG acute criteria along with Medi-Cal policies. Any acute days billed to Medi-Cal which have not been evaluated will be cited as variances, with potential referral to A&I for recoupment.

- **Are hospital stays for dual eligible patients (Medicare and Medi-Cal) required to meet InterQual/MCG acute criteria?**

**Answer:** Only the days that will be billed to Medi-Cal as the primary payer are required to meet the acute criteria. Once Medicare benefits have exhausted, any remaining days

in the stay that will be billed to Medi-Cal must meet acute criteria or be approved on Secondary Review, unless acute administrative days are being requested.

- **If a beneficiary exhausts Medicare Part A coverage in the middle of the stay and Medi-Cal becomes responsible for coverage, does the Case Manager start using InterQual admission review criteria or do they start with the Continued Stay review?**

**Answer:** The Case Manager would not use the Admission Review criteria. They would go to the appropriate Episode Day for the hospitalization and the condition-specific subset. Once the episode days within a subset have been exhausted and continued stay is necessary, the Extended Stay subset should be used.

- **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 are 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/MCG criteria are used to review all observation days or a Secondary Review is performed. Medi-Cal does not recognize observation status and, therefore, does not honor the InterQual/MCG observation criteria. Those orders with additional documentation establishing that the beneficiary was admitted under observation status and did in fact meet the InterQual/MCG acute criteria would allow a facility, in most cases, to bill for the appropriate acute hospital day(s). Also, if the day did not meet InterQual/MCG 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 available, and the physician has signed off on this approval.

- **If a beneficiary is admitted for an outpatient procedure but later must be admitted as an inpatient, does the stay need to meet InterQual/MCG criteria?**

**Answer:** Yes, all acute inpatient days (except OB cert stays) that were paid under FFS Medi-Cal must meet InterQual/MCG acute criteria. Please note that outpatient billing within 24 hours of an inpatient admission paid by Medi-Cal is not allowable.

- **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 that clearly indicate the date of care being reviewed. 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 acute days requested, include the date and time of the Secondary Review, 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.

### III. Secondary Review Process

- **What are the purpose and the requirements of the Secondary Review?**

**Answer:** When a hospital day does not meet InterQual/MCG 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 is medically necessary. The physician must document the rationale for the approval and sign off on the decision. The physician's contact information must be included with the documentation. It is very important that the beneficiary's attending physician may not approve hospital days through the Secondary Review process.

- **If a hospital stay does not meet InterQual/MCG 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. However, the requirements for acute administrative days must be met including call lists for NF acute administrative days and the beneficiary must qualify for NF level of care.

- **When the physician approves (or denies) a day(s) on Secondary Review, where should the physician document his/her decision?**

**Answer:** The physician should document the decision in the case management InterQual/ MCG notes. If the physician does not have access to the InterQual/MCG notes, the decision can be documented in an email or other note sent to the Case Manager. The documentation should be presented at the PHP review along with the case management notes.

- **If a beneficiary does not meet InterQual/MCG acute criteria and the attending feels that acute care is warranted but the physician disagrees on Secondary Review, do we have to deny the day?**

**Answer:** Yes, if acute criteria are not met and the day is denied on Secondary Review, the day should be denied and not billed to FFS Medi-Cal.

#### IV. Monthly Compliance Reviews and DPH Data Reporting Responsibilities

- **What are the monthly paid claims compliance reviews?**

**Answer:** As of early 2016, DPHs are longer required to submit monthly or bi-annual hospital admission data to DHCS for use in creating a sample list of cases. Instead, DHCS now derives a statistically valid sample from paid claims data that will be reviewed by DHCS Nurse Evaluators and Medical Consultants in a monthly compliance review to ensure that DPHs are in compliance with Medi-Cal policy and the appropriate use of InterQual or MCG.

- **Does DHCS eliminate any paid claims prior to creating the monthly statistically valid sample?**

**Answer:** Yes, similar to the process that occurred when hospitals submitted monthly data, DHCS removes from the sample well baby stays and any obstetric claims that fall under the obstetric cert days per Title 22 Section 51327 (a)(1)(A).

- **What documentation does DHCS need for the monthly paid claims compliance reviews?**

**Answer:** Required additional documentation in addition to the medical record includes:

1. The InterQual/MCG Case Management Summary (summary notes that capture decisions for the length of stay, level of care, approved or denied days and Secondary Reviews) for each day the hospital plans to bill as an acute hospital day, aside from OB cert stays; and
2. Nursing Facility (NF) placement call list, if applicable, for any stays that were approved for acute administrative days.

- **What data reporting requirements must DPHs follow?**

**Answer:** DPHs are no longer required to submit monthly or bi-annual admission data to DHCS. Instead, DPHs are required to submit, on a quarterly basis, limited data for any denied days. In this context, denied days are any acute or administrative days where a fee-for-service Medi-Cal beneficiary was an inpatient and the DPH did not approve the day. The migration to using paid claims data does not allow DHCS to capture this information, therefore, it must be sent by the DPHs.

The following is a link to the ***DPH Denied Medi-Cal Days Template*** Excel spreadsheet. This spreadsheet shall be used for this data submission.

<https://www.dhcs.ca.gov/provgovpart/Pages/DPH-Denied-Medi-Cal-Days-Template.aspx>

Please begin using this spreadsheet to capture cases with any denied days for admissions on or after July 1, 2016. Denied days must be reported no later than the last day of the following calendar quarter, i.e.:

<b>Calendar Quarter</b>	<b>Dates</b>	<b>Submit Data by:</b>
<b>Summer</b>	July 1 - September 30	December 31
<b>Fall</b>	October 1 - December 31	March 31
<b>Winter</b>	January 1 – March 31	June 30
<b>Spring</b>	April 1 – June 30	September 30

- **Where do DPHs submit the denied Medi-Cal days template?**

**Answer:** The denied Medi-Cal days template should be submitted through the secure file transfer website at <https://etransfer.dhcs.ca.gov/>.

- **Now that DPHs no longer submit monthly and bi-annual case data to DHCS, what can DPHs do to ensure that the medical record number associated with cases selected for monthly compliance reviews appears on the master list?**

**Answer:** In the past, DPHs supplied DHCS with admission data that included the medical record number. In order for DHCS to have access to the medical record number to provide to DPHs in association with compliance reviews, DPHs should indicate the medical record number in box 3A of the UB04 claim form.

## V. Statement of Findings Reports / Dispute Resolution Process

- **When do DPHs receive Statement of Findings reports?**

**Answer:** DPHs should receive a Statement of Findings report approximately 60 days after DHCS conducts a compliance review. The Statement of Findings report will detail any variances identified during the compliance review, and instructions will be provided on those variances where recoupment may occur.

- **Is there a way to identify if a hospital has any outstanding Statement of Findings reports?**

**Answer:** Yes. Please send an email request to the Public Project Unit (PHP) mailbox at [PublicHospitalProject@dhcs.ca.gov](mailto:PublicHospitalProject@dhcs.ca.gov). PHP staff will identify any outstanding reports.

- **What if the hospital does not agree with the findings of the DHCS Statement of Findings report?**

**Answer:** The provider may initiate the Dispute Resolution Process within 60 days of the date of the letter transmitting the Statement of Findings report. The provider must submit a dispute resolution form for each variance, and all disputed findings from a Statement of Findings report must be submitted together. 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.

- **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 the 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 does not 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.

- **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 the date of the letter transmitting 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.

- **Is there only one level of the Dispute Resolution Process?**

**Answer:** Yes, the Dispute Resolution Process has only one level.

- **What are the Dispute Resolution Process timelines?**

**Answer:** DPHs have 60 days from the date of the letter transmitting the Statement of Findings report, or if any Statement of Findings report variances are disputed, within 30 days following the date of notification of the final resolution of the dispute(s).

- **Some of the InterQual 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 Onsite Review Summary Detail. Can I submit the missing InterQual reviews through the dispute resolution process?**

**Answer:** The dispute resolution process is designed to resolve only disputes involving **clinical** issues for which recoupment language is identified on the Statement of Findings report, 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 IQ/MCG reviews, applicable NF call lists, etc. If documentation is missing, DHCS staff will ask the DPH to provide it at the time of the review.

- **Where can I find additional information on the Dispute Process?**

**Answer:** Please see the document entitled *Process for Disputes, Claim Adjustments and Recoupment* at [https://www.dhcs.ca.gov/provgovpart/Documents/Public%20Hospital%20Project/Process\\_for\\_Disputes\\_Claim\\_Adjustments\\_and\\_Recoupment.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/Public%20Hospital%20Project/Process_for_Disputes_Claim_Adjustments_and_Recoupment.pdf).

## VI. Claims Adjustment / Recoupment Processes

- **Why would a DPH need to initiate a Claims Adjustment?**

**Answer:** If a DPH does not dispute findings listed on the Statement of Findings, or if findings are upheld through the dispute process, DPHs must use the Claims Inquiry Form (CIF) process to resubmit the claims that have been paid.

- **How many steps are there to the CIF process?**

**Answer:** There are two (2) steps to the CIF process – 1) voiding the original claim; and 2) an appeal for the corrected payment. These processes are outlined in the two links below:

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)

CIF Submission and Timeline Instructions

[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/cifsub\\_z02.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/cifsub_z02.doc)

- **What happens if DPHs do not use the Claims Adjustment process?**

**Answer:** All findings that do not follow the Claims Adjustment process will be recouped on a quarterly basis directly by the DHCS Audits and Investigations (A&I) Division.

- **What is the two-step recoupment process?**

**Answer:** Please see the document entitled ***Process for Disputes, Claim Adjustments and Recoupment*** at

[https://www.dhcs.ca.gov/provgovpart/Documents/Public%20Hospital%20Project/Process\\_for\\_Disputes\\_Claim\\_Adjustments\\_and\\_Recoupment.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/Public%20Hospital%20Project/Process_for_Disputes_Claim_Adjustments_and_Recoupment.pdf) for information on the two-step recoupment process.

- **How can a DPH find a final recoupment amount?**

**Answer:** DPHs will be notified by A&I of the final recoupment amount via the ***Notice of Proposed Adjustment to Designated Public Hospital Project Review of Medical Necessity and Recovery*** letter.

- **What is the A&I Division and what is their role in the project?**

**Answer:** A&I is a division of DHCS that is responsible for ensuring the fiscal integrity of the health programs administered by DHCS as well as ensuring quality of care provided to the beneficiaries of these programs. For the DPH project, A&I is responsible for recouping identified variances on Statement of Findings reports that were not disputed or were upheld on dispute. In addition, A&I may investigate a provider if a trend of non-compliance to the UR process is identified during compliance reviews.

- **If a hospital is referred to A&I, is there a penalty at that point? Are there additional penalties that can be invoked?**

**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. However, 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.

- **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 may to be referred to A&I once the provider has had the opportunity to follow the direction from DHCS to void and resubmit claims or file a dispute for clinical variances.

## VII. 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/MCG acute criteria or be authorized on Secondary Review. Claims for beneficiaries with restricted aid codes must include one of the following statements in the Remarks Section (Box 80) of the claim form:

**“Hospital certifies providing emer svcs to unverified citizen”**

or

**“Hospital certifies providing emer or pregnancy related svcs to unverified citizen”.**

Beneficiaries with restricted aid codes are not generally eligible for acute administrative days.

- **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 re-evaluated for a full aid code?**

**Answer:** Yes, the beneficiary can contact the Medi-Cal eligibility office in their county and request re-evaluation. Aid code determination in general is made at the county level. The name of the eligibility office varies from county to county. The DHCS staff performs reviews with a beneficiary’s specific aid code taken into consideration.

- **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 generally valid for the entire month of eligibility. 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. It is important that hospital staff are aware of current aid codes to ensure correct determinations are made for the TAR free process.

- **If a beneficiary with a restricted aid 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 60<sup>th</sup> 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/MCG criteria?**

**Answer:** No, denied stays do not need to be run through InterQual/MCG. However, if a restricted aid code stay is approved it must be related to an emergency and be authorized using InterQual/MCG criteria or upon Secondary 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 otherwise are not eligible for acute administrative days.

## VIII. OB Days with Delivery During Stay (OB Cert Days)

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

**Answer:** No, as long as the beneficiary is admitted and delivers within the normal OB cert days per Title 22 Section 51327 (a)(1)(A). These OB stays are covered without the use of InterQual/MCG criteria up to a maximum of two consecutive days prior to delivery, beginning at midnight at the beginning of the day the mother is admitted, if delivery occurs within that two-day period, and up to a maximum of two consecutive days following vaginal delivery, or four consecutive days following delivery by Cesarean section, beginning at midnight at the end of the day the mother delivers.

- **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/MCG criteria must be used for all days that exceed the guidelines. Days that fall within the OB cert guidelines do not require the use of IQ/MCG criteria.

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

- **If a newborn infant is admitted to the NICU for 2 days but is discharged home within the OB cert period, would the days need to meet InterQual/MCG acute criteria?**

**Answer:** Yes, if the infant is sick and goes to the NICU for 1 or more days, then all NICU days must be evaluated using the InterQual/MCG acute criteria.

- **If a pregnant, diabetic patient restricted to pregnancy services only is admitted for out of control, non-gestational diabetes, could this admission be covered?**

**Answer:** Yes, any condition that could adversely affect the fetus may be covered, as long as InterQual/MCG acute criteria are met or the day(s) is approved on Secondary Review.

## IX. Administrative Days

- **Do stays that only include acute administrative days need to be evaluated with InterQual/MCG criteria?**

**Answer:** No, only acute days that will be billed to FFS Medi-Cal must be evaluated with InterQual/MCG criteria. However, acute administrative days must meet Medi-Cal criteria for administrative days.

- **Ten calls daily are required to document efforts to place a beneficiary in a NF or for NF Waiver services 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. No calls are required on weekends or holidays.

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

**Answer:** No, the number of calls should equal the number of NFs in the immediate area if there are less than 10, as long as they are inclusive of all the NFs in the area.

- **If NF placement is found but the beneficiary or family refuses 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 through Medi-Cal while awaiting placement in an NF **or for NF Waiver services**. Acute administrative days for psychiatric patients may be available through the county. The local county mental health agency should be contacted for information.

- **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 there were appropriate 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.

- **I have a beneficiary that requires NF placement for 6-8 weeks of IV antibiotics for endocarditis. No NF will accept him because he is a known IV drug abuser with drug seeking behavior. Do I still need to continue to make 10 NF calls every day to qualify for acute administrative days?**

**Answer:** Yes, 10 daily calls are still required. In situations where a beneficiary is difficult to place, hospitals are expected to broaden their search radius to include additional NFs.

- **Our hospital has two holiday days for Thanksgiving, Christmas and New Year's Day. Do I need to make NF placement calls on the second day? Will calls made on the Wednesday before Thanksgiving cover the Friday and weekend after Thanksgiving?**

**Answer:** Thanksgiving Day, Christmas Day and New Year's Day are exempt from NF calls but any other days that the hospital chooses to designate as a holiday would still require the calls. NF calls made on the Wednesday before Thanksgiving would cover Thanksgiving but not the Friday or weekend afterwards. Ten calls must be made on Friday to cover the weekend.

- **Can I consolidate calls to NFs for placement? For example, if I have 5 patients needing placement, can I make 1 call to each of 10 NFs, tell them I have 5 patients for placement and ask if any beds are available?**

**Answer:** Yes, as long as the calls are documented individually on a call list for each patient.

- **If a beneficiary is pending NF placement and the days are denied by the hospital or meet administrative day criteria, is any Secondary Review required?**

**Answer:** No. Any days that are denied or will be billed as administrative days do not require the use of InterQual/MCG acute criteria or a Secondary Review.

- **If a beneficiary is admitted from a NF and is stable for discharge while the 7 day NF bed hold is still in effect, can acute administrative days be claimed?**

**Answer:** No. If the beneficiary is stable for a lower level of care and a NF bed is available, the beneficiary should be transferred to the NF and no acute administrative days should be claimed.

- **Can a hospital request acute administrative days once the beneficiary has elected Hospice?**
- **Answer:** No. Once a beneficiary elects Hospice, the Hospice organization is responsible for paying for care and acute admin days are not approvable and Medi-Cal would not pay for acute admin days.

## X. Other Healthcare Coverage

- **If some days of a hospital stay were paid for by the other health coverage, does the FFS Medi-Cal covered part of the stay need to meet InterQual/MCG criteria?**

**Answer:** If FFS Medi-Cal is the primary payor for one (1) or more days then InterQual/MCG criteria must be met for those days only.

- **If a 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/MCG criteria?**

**Answer:** Yes, treatment of other medical conditions unrelated to the hospice condition that will be billed to Medi-Cal FFS must meet InterQual/MCG acute criteria. Only hospice related conditions can be billed to the hospice and are not part of the TAR-free process.

- **Do admissions for psychiatric conditions need to meet InterQual/MCG criteria? What if the beneficiary also has an acute medical condition?**

**Answer:** Psychiatric conditions are not a Medi-Cal FFS stay and are county claims. However, a hospital stay for an acute medical condition would be covered if it met InterQual/MCG criteria for acute hospitalization. Once the medical condition has resolved, FFS Medi-Cal coverage through the TAR-free process 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 MCG criteria?**

**Answer:** DHCS will not review stays of beneficiaries enrolled in a Medi-Cal HCP and does not require the use of InterQual/MCG, although the HCP may have such a requirement. However, if a beneficiary was partial coverage of a stay through an HCP and part under FFS Medi-Cal, any days paid for by FFS Medi-Cal must meet the requirements outlined in this document related to the use of InterQual/MCG and adherence to Medi-Cal policies.

- **If Medicare coverage exhausts during the stay and the beneficiary is eligible for FFS Medi-Cal, what days will DHCS review?**

**Answer:** DHCS will only be review those days for which there is a paid FFS Medi-Cal claim as a result of an exhaustion of Medicare benefits. However, DHCS needs access to the applicable medical record for the entire stay in order to conduct a review of the FFS paid days.

- **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.

## XI. Other

- **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 A&I, 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.

[https://www.dhcs.ca.gov/individuals/Pages/PPC\\_Reporting.aspx](https://www.dhcs.ca.gov/individuals/Pages/PPC_Reporting.aspx)