

## REASON CODE DESCRIPTIONS AND AUTHORITY

Day of Admission	
<b>Description</b>	The day of admission is determined by the time and date the physician writes the order in the medical record to admit the patient 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.
<b>Authority</b>	<ul style="list-style-type: none"> <li>California Code of Regulations(CCR), Title 22 , Section 51108</li> </ul>

Delay of Services	
<b>Description</b>	<p><u>Delay in Rendering Acute Care:</u> A delay in rendering acute care occurs when a service or procedure has not been supplied or performed in a timely manner, the patient's hospital discharge is delayed, and there is no documented medical reason for the delay.</p> <p><u>Slow Progression of Acute Care:</u> 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 patient's hospital discharge, and there is no documented medical reason for the delay.</p>
<b>Authority</b>	<ul style="list-style-type: none"> <li>Social Security Act Section 1902[42 U.S.C. 1396a(a)(30)(A)]</li> <li>Welfare &amp; Institutions Code (W&amp;I), Section 14133.3</li> </ul>

Medical Necessity	
<b>Description</b>	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. 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 beneficiary 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, in order to meet the medical needs of the beneficiary.
<b>Authority</b>	<ul style="list-style-type: none"> <li>W&amp;I Code, Section 14133.25(a)</li> <li>W&amp;I Code, Section 14133.3(a)</li> <li>Manual of Criteria For Medi-Cal Authorization Chapter 5.1, I</li> </ul>

## Acute Administrative Days

<b>Description</b>	<p>Medi-Cal funds cannot be paid at an acute level of care rate when the patient is receiving a lower level of care. There are instances when a patient's level of care is not at the acute level, but they must remain in an acute setting due to:</p> <ul style="list-style-type: none"><li>• An inability to find nursing facility placement (Acute Administrative Days)<ul style="list-style-type: none"><li>➢ Documentation of attempts at placement is required for payment of acute administrative days for nursing facility placement.</li></ul></li><li>• Patients with tuberculosis (TB) in isolation awaiting negative TB sputum tests following initiation of treatment (TB Administrative Days)</li><li>• Monitoring of an at-risk obstetrical patient. (OB Administrative Days)</li></ul>
<b>Authority</b>	<ul style="list-style-type: none"><li>• CCR, Title 22, Section 51173</li><li>• CCR, Title 22, Section 51342</li><li>• Manual of Criteria for Medi-Cal Authorization, Chapter 5.3, III.(A)</li></ul>

## Other Health Care Coverage

<b>Description</b>	<p>Medi-Cal is the payer of last resort. Some Medi-Cal beneficiaries are also eligible for services under other State, Federal or medical care programs. The aid code under which the beneficiary qualifies for Medi-Cal also identifies the services for which they are eligible to receive as well as the funding source for those services.</p>
<b>Authority</b>	<ul style="list-style-type: none"><li>• CCR, Title 22, Section 51005</li></ul>

## Medicare Part (A) Exhaustion of Benefits

<b>Description</b>	<p>Beneficiaries who are entitled to Medicare Part A (Inpatient Hospital services) and are eligible for some form of Medicaid benefit are considered to have dual eligibility.</p> <p>Services that are covered by both programs will be paid first by Medicare and the difference by Medi-Cal up to the State's payment limit. Medi-Cal is the payer of last resort.</p> <p>The hospital provider must indicate when Medicare Part (A) coverage (to include lifetime benefits) has been exhausted with a printed verification document explaining exclusion of benefits.</p>
<b>Authority</b>	<ul style="list-style-type: none"><li>• The Medicare Program (Title XVII of the Social Security Act) provides hospital insurance, also known as Part A coverage.</li><li>• CCR, Title 22, Section 51005</li></ul>

## Restricted Aid Code

<b>Description</b>	<p>Medi-Cal funds can be paid only for services that the beneficiary 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.</p> <p>A beneficiary 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).</p>
<b>Authority</b>	<ul style="list-style-type: none"><li>• W&amp;I Code 14007.5</li><li>• Title 22, CCR, Section 51056</li></ul>

<b>The Physician's Discharge Order Date</b>	
<b>Description</b>	<p>The day of discharge is determined by the time and date the physician writes the order in the medical record to discharge the patient from the hospital. Patients shall be discharged from the hospital only upon the order of the credentialed practitioner.</p> <p>To determine the length of the hospitalization, the reviewer will verify the admission and discharge order dates on the medical record.</p> <p>Each hospital should have policies that ensure uniformity of both content and format of the patient record based on all applicable accreditation standards, federal and state regulations, payer requirements, and professional practice standards.</p>
<b>Authority</b>	<ul style="list-style-type: none"> <li>• Title 42 Code of Federal Regulations (CFR), Section 482.24</li> </ul>

<b>Provider Preventable Conditions</b>	
<b>Description</b>	<p>The Affordable Care Act, under section 2702 prohibits federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for Provider Preventable Conditions (PPCs) specified in regulation that developed during the hospital stay. PPCs are divided with two distinct categories: Health Care-Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). HCACs apply only to Medicaid inpatient hospital settings and OPPCs apply to Medicaid inpatient and outpatient health care settings. OPPCs are defined to include, at minimum, the three identified national coverage determinations for “never events”, i.e., surgery on the wrong patient, surgery on the wrong body part, and performing the wrong surgery.</p> <p>The regulations mandate the States to implement provider self-reporting regardless of the provider's intent to bill. Once data is collected at the State level, States will submit that data to CMS as part of their standard procedure for collecting and sharing Medicaid provider claims data.</p> <p>Using criteria mandated by the Deficit Reduction Act (DRA) of 2005, CMS collaborated with the Centers for Disease Control (CDC) to identify a list of HACs. The State and CMS has the option to expand the list at any time.</p>
<b>Authority</b>	<ul style="list-style-type: none"> <li>• Title 42 CFR, Section 482.24(c)(2)</li> <li>• Social Security Act, Section 1902(a)(4)</li> <li>• Social Security Act, Section 1903</li> </ul>

<b>Psychiatric Inpatient Hospital Services</b>	
<b>Description</b>	<p>Mental Health Plans ( MHP) are responsible for the authorization and payment of all medically necessary specialty mental health services for Medi-Cal recipient of that county in accordance with federal and state Medicaid requirements.</p> <p>Each MHP is financially responsible for payment of emergency psychiatric services provided to it recipients within California and specified border communities. MHPs may not restrict recipient access to emergency services. Emergency psychiatric services are covered by the MHP when the recipient has been admitted to a hospital or a psychiatric health facility.</p> <p>Psychiatric inpatient hospital services are covered by the County Mental Health Departments. If a beneficiary with a psychiatric diagnosis is admitted to a medical unit as an emergency admission, the stay is evaluated for medical necessity for his/her medical condition. If the beneficiary's condition is medically stable, then the provider will refer the beneficiary to the local managed mental health care plan. Medi-Cal recipients are enrolled automatically in the Mental Health Plans (MHP) in each of the 58 counties. In most cases, the MHP is the county mental health department.</p>
<b>Authority</b>	<ul style="list-style-type: none"> <li>• Welfare and Institutions Code, Sections 14680 through 14685</li> <li>• CCR, Title 9, Sections 1820.205 and 1820.225(b)</li> </ul>

<b>Aid Code Discrepancy</b>	
<b>Description</b>	<p>Aid Codes are meant to assist providers in identifying the types of services for which Medi-Cal and Public Health Program recipients are eligible. Aid Codes were developed for use in conjunction with the Medi-Cal Eligibility Verification System (EVS). Providers must verify eligibility every month. They must submit an inquiry to the EVS to verify a recipient's eligibility for services. Eligibility verified at the first of the month is valid for the entire month of service. A Point of Service (POS) printout or Internet eligibility response may be kept as evidence of proof of eligibility for the month. When a provider verifies that an individual is eligible to receive Medi-Cal benefits; the provider is accepting the individual as a Medi-Cal recipient.</p> <p>The Designated Public Hospital Project (DPHP) instructs the provider to submit a monthly inpatient admission list for Medi-Cal fee-for-service beneficiaries. One of the mandatory data requirements for this list includes a valid Aid Code for each beneficiary. The Aid Code provided in the monthly admissions data should match DHCS verification of the recipient's Aid Code.</p>
<b>Authority</b>	<ul style="list-style-type: none"> <li>• W &amp; I Code, section 14018.2</li> </ul>

<b>Institutional Inmate Status</b>	
<b>Description</b>	<p>An individual who becomes an inmate of a public institution is not eligible for Medi-Cal until the date of release from prison or jail on permanent release, bail, own recognizance, probation or parole.</p> <p>County Jail Inmate: The provider is instructed to submit a claim to the county.</p> <p>State Prison Inmate: The provider is instructed to submit a claim to the California Department of Corrections and Rehabilitation (CDCR).</p>
<b>Authority</b>	<ul style="list-style-type: none"> <li>• CCR, Title 22, section 50273</li> </ul>

## DPH Utilization Process

<b>Description</b>	<p>The DPHP allows for the use of a standardized screening tool to determine medical necessity.</p> <p>The decision to admit, retain, or discharge a beneficiary is a physician decision.</p> <p>When a beneficiary is admitted to an acute inpatient facility and the standardized review criteria has determined that the primary review did not meet criteria, a secondary review may be performed by the utilization review nurse and 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.</p> <p>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, contact information (phone number) and a summary outlining the medical rationale for authorization of each day of the stay through secondary review (reason for decision/outcome).</p>
<b>Authority</b>	<ul style="list-style-type: none"><li>• Title 42,4 CFR, section 482.30</li></ul>