Retrospective Process Beginning August 1, 2011:

Establish an average length of stay for retrospective cases. Retrospective requests that are less than or equal to the average length of stay will not be subject to a medical necessity review and those days will be authorized after the FI verifies that the case meets the definition of a retrospective case. If the length of stay for the retrospective request exceeds the established average length of stay, then the provider is required to submit daily abstracted clinical for each day that exceeds the established average length of stay. These days that exceed the average length of stay will be subject to a medical necessity review before they can be authorized. InterQual will be applied by the nurses at the FI. Any case that does not meet InterQual Criteria will be referred to the physician consultant. If the physician consultant determines that the documentation supports inpatient hospitalization he/she will approve the case. The physician can approve up to 5 Variance Days (VD's) if there are days that do not require an acute inpatient level of care. VD's can be paid to the hospital if they have documented "due diligence" to place a patient to a lower level of care. The Fiscal Intermediary (FI) physician consultants may approve more variance days depending on the clinical situation after approval by the FI Medical Director.

Variance Day = day of a hospital stay in which an acute inpatient level of care is no longer necessary and non-inpatient hospital placement is appropriate.

Retrospective Authorization = approval of a service for a recipient who became Medicaid eligible after the service was provided.

Average Retrospective Length of Stay (ARLOS) = 6 days

PROCESS If ARLOS < or = to 6 days (Excludes NICU):

- If the ARLOS is less than or equal to 6 days the provider must submit a completed PCF01 Form. The PCF01 must be populated with the admission date and the discharge date. The case must be indicated as a retrospective case by marking the retrospective box. The paper form must be used as ePrecert cannot currently process retrospective requests.
- Providers must include codes for outpatient procedures performed on the first or second day of an inpatient admission on all PCF01 forms that are submitted. Clinical documentation that supports the outpatient procedure being performed as inpatient does NOT need to be submitted. If these codes are not included on the PCF01 they cannot be added to the file. If the codes are not on file and the provider includes the outpatient surgical procedure on the claim then the claim will deny.
- The FI will use the MMIS system to confirm that the request qualifies as a retrospective review per processes currently in place at the FI.
- If the case qualifies as a retrospective case then Molina will assign a precertification number and authorize the entire length of stay requested.
- If the MMIS system indicates that the patient had active Medicaid coverage for the dates of service submitted then the request for retrospective approval will be denied.

PROCESS If ARLOS is > 6 days:

- If the ARLOS is greater than 6 days the provider must submit a completed PCF01 Form. The PCF01 must be populated with the admission date and the discharge date. The case must be indicated as a retrospective case by marking the retrospective box. The paper form must be used as ePrecert cannot currently process retrospective requests.

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- The provider must include daily abstracted clinical starting with the 7th day of the hospitalization. This information should be on the PCF0A form.
- The FI will use the MMIS system to confirm that the request qualifies as a retrospective review per processes currently in place at the FI.
- If the case qualifies as a retrospective case then the precert nurses will apply InterQual Criteria beginning with the 7th day of the hospitalization. If InterQual Criteria is met all days will be authorized by the nurse. If InterQual Criteria is not met the case will be sent to the physician consultant for secondary medical review.
- The physician consultant can approve up to 5 variance days. These days are defined as hospital days in which an acute inpatient level of care is no longer necessary and non-inpatient hospital placement is appropriate. The provider must submit documentation of "due diligence" to transition the patient to an alternate care setting.

PROCESS FOR TRAUMA CASES:

Trauma inclusion definition:

1. A patient with injury or suspected injury who is triaged from a scene to a trauma center or ED based upon the responding EMS provider's trauma triage protocol; or a patient with injury who is transported via EMS transport from one acute care hospital to another acute care hospital; **OR**
2. A patient with injury or suspected injury for whom a trauma team activation occurs; **OR**
3. A patient with injury who:
   - Is admitted as a result of the injury **OR** who dies as a result of the injury **AND**
   - Has an ICD-9-CM diagnosis code within categories 800 through 959

If the LOS for the retrospective case is greater than **6** days **and** the case qualifies as a trauma then the hospital can submit the retrospective request in the following manner:

- Submit the PCF01 in the same manner as all other retrospective cases. Write "Trauma" in the upper right hand corner of the PCF01. You must submit either the history and physical or the discharge summary with all trauma cases. The discharge summary is the preferred document.
- You cannot use ePrecert to submit these requests. You must use the paper PCF01.
- The Injury Severity Score (ISS) must be submitted along with the hospital ISS form.
- LOS will be based on the ISS as follows:

ISS Score	Severity	LOS
1-9	Minor	4
10-15	Moderate	9
16-24	Moderate/Severe	20
>or=25	Severe/Critical	15

- Daily abstracted clinical in required for each hospital day that exceeds the number of days assigned to each ISS severity category.
- For hospitals that do not use an ISS score, 6 days will be authorized and daily abstracted clinical will be required from hospital day 7 until discharge.

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PROCESS FOR NICU CASES:

- Providers must submit a PCF01 on all NICU cases. The retro box must be marked, NICU LOC indicated in the appropriate place on the form, and the admission and discharge dates completed.
- For NICU or Newborn babies a case is only considered retrospective when the baby obtains eligibility after discharged from an inpatient hospital.
- The FI will approve all the days requested ONLY if the recipient became Medicaid eligible AFTER the discharge date identified on the PCF01. The reason for only considering the case a retro if eligibility is obtained after discharge is to discourage providers from circumventing the process currently in place that allows newborn babies to be pre-approved with all zero's and then UPDATING the case when the Medicaid number is issued. This process currently reduces the number of retrospective cases that are submitted for newborn babies.
- If the MMIS system indicates that the Medicaid number was issued while the baby was still inpatient in the hospital then the request will be accepted as a retrospective case but the hospital will be expected to submit daily abstracted clinical that will be reviewed for medical necessity in order to obtain payment.

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