

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

tar req ext

1

TAR Request for Extension of Stay in Hospital (Form 18-1)

Authorization for hospital emergency admissions is always requested by the hospital on a *Request for Extension of Stay in Hospital* (18-1) for the number of days of the stay. This TAR is only authorized for inpatient hospital use and not for the physician or outpatient hospital in billing specific TAR-required procedures. Physicians must submit TARs (50-1) for surgical procedures that require authorization performed in a hospital.

Diagnosis-Related Groups (DRG) Impact

Important information for using the *Request for Extension of Stay in Hospitals* form (18-1) is included in the *Diagnosis-Related Groups (DRG): Inpatient Services* section in this manual. Hospitals reimbursed according to the DRG model will generally not need to submit the 18-1 to request a longer hospital stay, if an admit TAR was previously approved.

Day of Admission Definition

A Medi-Cal recipient's day of admission for acute care is based on the written or ordered date of admission by the admitting physician.

TARs for inpatient admissions are submitted to the local Medi-Cal field office, accompanied by documentation supporting the medical necessity of the service(s). The TAR must include a signed admission order by the admitting physician.

Note: Medi-Cal's day of admission definition shall not be construed as contrary to the meaning of the *California Code of Regulations*, Title 22, Section 51108.

Emergency Admissions (18-1 TAR)

Authorization for hospital emergency admissions is always requested by the hospital on a *Request for Extension of Stay in Hospital* (18-1). All non-emergency, non-obstetrical admissions require authorization on a 50-1 TAR.

Day of Emergency Admission

If the emergency admission does not meet the definition of emergency services as set forth in *California Code of Regulations* (CCR), Title 22, Section 51056(a), the Medi-Cal field office consultant will deny the day of admission. (See CCR, Title 22, Section 51056[b].) The denial of the day of admission will apply to all types of admissions (medical, surgical, psychiatric, etc.).

Emergency Ancillary and Physician Services

When the day of admission or any other day is denied, all other physician or ancillary services rendered that day will also be denied or recouped, including any emergency room, diagnostic, therapeutic, surgical and recovery services.

Medical Admissions	If a medical admission does not meet the definition of emergency services and the inpatient hospital services provided to the recipient are not documented as medically necessary, the Medi-Cal field office consultant will deny the entire length of stay for both medical and psychiatric admissions.
Surgical Admissions	If a surgical admission does not meet the definition of emergency services and the surgery performed was not documented as medically necessary, the Medi-Cal field office consultant will deny the day of admission and all other hospital days.
Authorization Extensions	If the recipient requires inpatient hospitalization beyond previously authorized days, the provider must submit a <i>Request for Extension of Stay in Hospital</i> (18-1 TAR) to the on-site nurse or local Medi-Cal field office. Providers who have agreements with the field offices to fax TARs should use the fax version of the <i>Request for Extension of Stay in Hospital</i> (18-2).
Ancillary and Physician Services	<p>Denial of any day of hospitalization will also result in denial or recoupment of payment for all physician or ancillary services rendered that day including any emergency room, diagnostic and therapeutic, or surgical and recovery services.</p> <p>If the Medi-Cal field office consultant has previously approved the recipient's hospitalization, but considers continuation of the patient's stay not to be medically necessary, the consultant will deny an extension of hospital stay.</p>
Adjudication Response (AR)	<p>Authorization for Medi-Cal benefits will be valid for the number days specified by the consultant on the <i>Adjudication Response (AR)</i>. Services must be rendered during the valid "From Date of Service -Thru Date of Service" period.</p> <p>For additional information about ARs, providers may refer to "TAR Status on Adjudication Response (AR)" in the <i>TAR Overview</i> section of the Part 1 manual.</p>
Elective Acute Admissions	All elective acute inpatient admissions, except for certain excluded admissions, are reviewed for medical necessity and authorized, as appropriate, using a 50-1 TAR.

REQUEST FOR EXTENSION OF STAY IN HOSPITAL

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

STATE USE ONLY

SERVICE CATEGORY

1. CLAIMS CONTROL NUMBER F.I. USE ONLY

CONFIDENTIAL PATIENT INFORMATION

PLEASE TYPE ALL INFORMATION
TYPEWRITER ALIGNMENT

F.I. USE ONLY

HOSPITAL USE		ELITE <input type="checkbox"/> PICA <input type="checkbox"/>	ELITE <input type="checkbox"/> PICA <input type="checkbox"/>
ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) 6	ADMIT DATE 7 MM/DD/YY	ADMIT EXP. DATE 8 MM/DD/YY	EMER. ADMIT. 9
PROVIDER NUMBER 10	PROVIDER PHONE NO. 10A	VERBAL CONTROL 10B	PATIENT MEDICAL ID NO. 11
PROVIDER NAME 10C	PATIENT NAME 14B		SEX 12
PROVIDER STREET/MAILING ADDRESS	DISCHARGE DATE 20 MM/DD/YY		DATE OF BIRTH 14 MM/YY
PROVIDER CITY, STATE AND ZIP CODE	ADMITTING DIAGNOSIS DESCRIPTION 21A		AGE 14A
FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.			
CURRENT DIAGNOSIS 22		PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS 18A	
DESCRIBE CURRENT CONDITION REQUIRING EXTENSION, INCLUDE PERTINENT LAB AND X-RAY REPORTS WITH DATES.		SIGNATURE OF RESPONSIBLE PHYSICIAN 22B	
WHAT PLANNED PROCEDURES WILL REQUIRE THIS EXTENSION, INCLUDE DATES WHEN POSSIBLE.		DATE	
HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.		SIGNATURE OF RESPONSIBLE PHYSICIAN 22B	
SIGNATURE OF PROVIDER		DATE	
MEDI-CAL CONSULTANT- VALIDATING INFORMATION AND EXPLANATION		FOR STATE USE ONLY	
22C		<input checked="" type="checkbox"/> DENIED 23	
		<input checked="" type="checkbox"/> APPROVED AS REQUESTED 24 FROM MM/DD/YY TO MM/DD/YY	
		<input checked="" type="checkbox"/> APPROVED AS MODIFIED 25 FROM MM/DD/YY TO MM/DD/YY	
		<input type="checkbox"/> DEFERRED 29	
		DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS) 30	
		JACKSON VS RANK PARAGRAPH CODE 42A	
		RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51062 (B) 42	
CHART REVIEWS <input type="checkbox"/>		REVIEW COMMENTS INDICATOR <input type="checkbox"/>	
BY 42B		TAR CONTROL NUMBER 45	
MEDI-CAL CONSULTANT 43		ID NO. 44	
		DATE	

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

18-1 3/07

Figure 1. Sample Request for Extension of Stay in Hospital (18-1).

Explanation of Form Items

The following item numbers correspond to a circled number on the *Request for Extension of Stay in Hospital (18-1) (Figure 1)*.

<u>Item</u>	<u>Description</u>
1.	CLAIMS CONTROL NUMBER. Leave blank. For DHCS Fiscal Intermediary (FI) use only.
2. – 5.	F.I. USE ONLY. Leave blank.
6.	ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER). Enter the 11-digit TAR Control Number from the original admitting TAR when additional hospital days are requested. The <i>Emergency Admit</i> field (Box 9) must be left blank when the <i>Admit TAR Number</i> field is completed. For emergency admits, refer to Item 9.
7.	ADMIT DATE. Enter the date of admission.
8.	AUTHORIZATION EXPIRES. Enter the date the current TAR expires.
9.	EMER. ADMIT. Enter an “X” if the patient was admitted to the hospital on an emergency basis and this is the initial authorization. Leave blank on subsequent extension TARs for the recipient. Refer to a previous page for detailed information about emergency admissions.

<u>Item</u>	<u>Description</u>
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Providers requesting an approval of emergency admission, transfer or extension of hospital stay on the 18-1 form must complete the following fields accurately:

- The *Patient Medi-Cal ID No.* (Box 11) should be copied from the patient's current BIC and must match the ID number on the claim form. This recipient identifier is either the 14-digit recipient ID, the nine-digit CIN from the BIC, or the nine-digit SSN. When using the SSN, enter the county code and aid code below Box 11.
- The *Provider Number* (Box 10) should be the complete and correct provider number of the hospital (nine digits).
- The *Number of Days Requested* (Box 17) is the total number of days requested on this extension.
- *Admitting ICD-9-CM* (Box 21) and *Current ICD-9-CM* (Box 22) should be completed using the *International Classification of Diseases, 9th Revision, Clinical Modification*.
- The *Admit TAR Number (Original Authorization Number)* (Box 6) should contain the TAR Control Number (TCN) from the *Treatment Authorization Request (50-1)* for elective and urgent admissions. On emergency admissions, the TCN from the original or first 18-1 is placed in the *Admit TAR Number* box. The Admit TAR Number is used to link subsequent extensions to the original admitting TAR for the purpose of claims submittal.

10. **PROVIDER NUMBER.** Enter your provider number.

10A. **PROVIDER PHONE NO.** Enter the provider's telephone number, including area code.

10B. **VERBAL CONTROL.** Leave blank. Verbal authorization is not available.

Note: Verbal requests are no longer available.

<u>Item</u>	<u>Description</u>
10C.	PROVIDER NAME AND ADDRESS. Enter the name of the hospital, street address, city, state and nine-digit ZIP code.
11.	PATIENT MEDI-CAL ID NO. and CHECK DIGIT. Enter either the recipient's 14-digit Medi-Cal ID number, the nine-digit CIN from the BIC, or the nine-digit SSN (without the check digit placed in this <i>Patient Medi-Cal ID No.</i> field). Enter the county code and aid code below Box 11.
12.	PEND. Leave blank.
13.	SEX. Enter the patient's sex: <ul style="list-style-type: none">• "F" for female• "M" for male
14.	DATE OF BIRTH. Enter the patient's date of birth (month, day, year).
14A.	AGE. Enter the age of the patient.
14B.	PATIENT NAME. Enter the patient's last name, first name, and middle initial.
15.	MEDICARE STATUS. If Medicare is not billed, enter the appropriate Medicare status code number. Refer to the <i>UB-04 Completion: Inpatient Services</i> section in this manual for a listing of Medicare status codes. Note: If a patient's EVC label shows a "2" indicating Medicare coverage, and Medicare is not billed, the Medicare status code must be other than "0" regardless of the age of the patient.

<u>Item</u>	<u>Description</u>
16.	<p>OTHER COVERAGE. Enter an “X” if the recipient has other insurance or Other Health Coverage (OHC).</p> <p>Other health coverage includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) which provide all or most of the recipient’s health care needs.</p> <p>Note, however, that providers should refer recipients with PHP/HMO coverage to their PHP/HMOs for treatment, except for emergencies. Refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section of the Part 1 manual for billing instructions for emergency services rendered by non-plan providers to recipients in PHPs/HMOs.</p> <p>In all cases, when recipients have “other coverage,” providers must bill the insurance carrier or PHP/HMO <u>prior</u> to billing Medi-Cal. This also applies to recipients with Medicare coverage.</p> <p>Claims for recipients with other coverage will be denied unless proof of “other coverage denial” in the form of a denial letter from the carrier or PHP/HMO is submitted with the Medi-Cal claim. Refer to the <i>Other Health Coverage (OHC)</i> section in this manual for additional information on submitting denial letters.</p> <p>Note: Eligibility under Medicare is not considered other coverage. Refer to the <i>Other Health Coverage (OHC) Codes Chart</i> section in the Part 1 manual for information on OHC and the coding system used in connection with billing OHC carriers and/or Medi-Cal.</p>
17.	<p>NUMBER OF DAYS. Enter the number of days requested on this TAR (for example, 3). This requirement applies to hospitals, regardless of diagnosis-related groups’ (DRG) reimbursement, billing for restricted aid codes as well as administrative and rehabilitation services.</p>
18.	<p>TYPE OF DAYS. Enter the code indicating type of days requested:</p> <ul style="list-style-type: none"> 0 Acute 2 Administrative 3 Subacute administrative ventilator dependent 4 Subacute administrative non-ventilator dependent

<u>Item</u>	<u>Description</u>
19.	RETROACTIVE. Enter a capital “X” if this request is retroactive.
20.	DISCHARGE DATE. Enter the date the patient was discharged from the facility.
21.	ADMITTING ICD-9-CM. Enter the numeric code for the admitting diagnoses using the ICD-9-CM book.
21A.	ADMITTING DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE. Always enter the English description of the diagnosis from the ICD-9-CM book.
22.	CURRENT DIAGNOSIS. Current diagnosis and medical justification – provide sufficient medical justification for the Medi-Cal consultant to determine whether the service is medically justified. If necessary, attach additional information. If the patient is admitted from a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B), enter the name of the facility in the description of condition block. On requests submitted by a non-medical provider, the full name of the prescriber and office telephone number must appear in the lower left hand corner of this section, for example, John J. Smith, M.D., (916) 100-0000. Enter the current ICD-9-CM code in Box 22.
22A.	PATIENT’S AUTHORIZED REPRESENTATIVE. Enter the name and address (if known) of the patient’s authorized representative, representative payee, conservator over the person, legal representative, or other representative handling the recipient’s medical and personal affairs.

<u>Item</u>	<u>Description</u>
22B.	SIGNATURE OF RESPONSIBLE PHYSICIAN. Must be signed and dated by the admitting physician or other licensed personnel with admitting privileges. The provider assumes full legal responsibility to the Department of Health Care Services (DHCS) for the information provided by the representative. Original signatures are required.
22C.	MEDI-CAL CONSULTANT – VALIDATING INFORMATION AND EXPLANATION. Leave blank; for Medi-Cal field office use only.
23. – 42.	FOR STATE USE ONLY. Leave blank; for Medi-Cal field office use. (This section will contain the decision of the Medi-Cal consultant.)
42A.	SUB. ADMIN. VENT/SUB ADMIN N-VENT. The Medi-Cal field office consultant will mark the appropriate box. If billing for subacute care, enter the accommodation code on the claim that corresponds to the checked box on the TAR.
42B.	MEDI-CAL CONSULTANT. Leave blank. Signature block for State use.
43. – 44.	ID. NO./DATE. Medi-Cal consultant completes.
45.	TAR CONTROL NUMBER. This number is imprinted on the form and will have a prefix and suffix added to it by the Medi-Cal consultant.