TAR Deferral/Denial Policy (Frank v. Kizer)

Page updated: September 2020

The purpose of this section is to inform providers of the Memorandum of Understanding (MOU) between the Department of Health Care Services (DHCS) and the Legal Aid Society of Alameda County regarding the implementation of the Frank v. Kizer court order.

Memorandum of Understanding (MOU)

Pursuant to the court order in Frank v. Kizer, when the Department denies or reduces a request for previously approved services, the recipient has the right to receive continued Medi-Cal approval of those services pending the outcome of a timely requested administrative hearing decision concerning the Department's action. Such approval is called "aid paid pending." Pursuant to the MOU for implementing the court order, to receive such aid paid pending, the recipient must request the hearing within 10 days from the date of the Department's notice of action of the denial or reduction or prior to the expiration of the previous approval of services, whichever is later. However, the recipient must still be receiving the requested services in order for aid paid pending to be instituted.

The scope of the MOU applies only to those Medi-Cal services requiring authorization using the *Treatment Authorization Request* (TAR) form and more specifically, for those TARs determined to be requests for approval of "continuing service" TARs.

Non-Acute Continuing Care Services

Continuing service in the non-acute setting is defined as a request for reauthorization received within 10 working days after expiration of the previously approved TAR for services in the following categories:

- Long Term Care (Nursing Facility Levels 1 and 2, Subacute)
- Chronic hemodialysis (including all related services)
- Hospice Care
- In-Home Medical Care Services (and all related services such as transportation)
- Skilled Nursing Facility Waiver Services (and all related services)
- Model Community-Based Waiver Services (and all related services)
- All other non-acute care services covered under the Medi-Cal program when the treating physician substantiates on or with the TAR that the same level or frequency of services should be continued because the treatment goal approved on the previous TAR has not been achieved

"Substantiate" means that the treating physician must submit sufficient information (narrative or other evidence) in support of his or her conclusion that services must be continued because treatment goals have not been met. Information submitted is sufficient if the field office consultant determines that a reasonable, competent physician might agree, based on the information submitted, that treatment goals have not been met.

Non-Acute Continuing Care TAR Deferral

Non-acute continuing care TARs may be deferred. However, the Frank v. Kizer MOU imposes deadlines on the deferral period. The Medi-Cal program has 15 working days from the date of deferral to take action on a non-acute continuing care TAR. The Medi-Cal program must therefore expedite the receipt of medical information on deferred TARs. To assist providers in complying with the deferral deadlines, the Medi-Cal field offices will use a *TAR Information Form* for non-acute services that most often fall under the definition of continuing care and are most often deferred. ‹‹These forms are shown in Figures 1 thru 8 and may be downloaded from the Medi-Cal Web site (*www.medi-cal.ca.gov*) by clicking "Forms."›› They must be completed for all initial and reauthorization requests for the following services:

- ‹‹Durable Medical Equipment (DME) (see Figure 3, DHCS 6181)››
- ‹‹Medical Transportation (see Figure 7, DHCS 6182)››
- ‹‹Therapy Treatment Plans (see Figure 5, DHCS 6183)››
- ‹‹Apnea Monitors (see Figure 6, DHS 6184)››
- ‹‹Home Oxygen Therapy (see Figure 4, DHS 6185)››
- ‹‹Home Health Care providers should complete *Form HCFA-485*, available from a Medi-Cal field office (see Figure 8).››

‹‹DHS Form 6186 (see Figure 1) will give the provider the deadline for submitting the information to the field office in order that Medi-Cal can make its decision within the 15 working day deadline. If the information is not submitted, the TAR must be denied and notice must be sent to the Medi-Cal recipient unless additional time is granted. If the provider finds that it is impossible to submit the additional information to the field office within the deadline, the provider may fill out the request for extension at the bottom of the form and return it to the field office before the deadline for submitting the additional information. While an oral request for extension may be made, failure to submit the request for extension form will increase the likelihood of the Medi-Cal field office consultant not being aware of the request.››

Waiver Services Deferrals

The deferral deadline for all waiver services is 25 working days in recognition of the greater complexity of information and greater time required to collect the information for these services.

Acute Continuing Care Services

The Frank v. Kizer MOU applies only to acute continuing care services in hospitals where the Medi-Cal program performs an on-site utilization review. Continuing service in acute care is defined as an on-site hospital request for an extension of stay when an 18-1 is presented because the treating physician has determined that the recipient cannot be safely discharged.

The treating physician must determine that acute care services continue to be medically necessary for one of the following reasons, and the medical record must contain documentation consistent with that determination:

1. The continuation of acute care is needed for the purpose of treating the condition or conditions for which acute care was originally approved on a 50-1;
2. Complications directly related to the original diagnosis for which acute care was originally approved have arisen and necessitate further acute care;
3. Acute care is needed for an illness that has been contracted during the course of an approved admit and the illness most likely occurred because the patient was hospitalized;
4. Further acute care is needed for the purpose of treating a diagnosed condition(s) for which a length of stay was previously approved after an emergency or urgent admit;
5. Further treatment and/or diagnostic procedures are needed after a previously approved emergency or urgent admission for which no length of stay has been approved and the acute care stay has been at least five days in duration at the time of the request for extension.

Acute Continuing Care Extension of Stay TAR Deferral

Deferral of acute care extension of stay may also occur. However, in this case, the Medi-Cal program has only three working days within which to make its decision. The additional information required will be noted in the patient's chart and the information may then be added to the medical record as quickly as possible. Once again, if the Medi-Cal on-site reviewer does not receive the information by the deadline, the request for extension of stay must be denied and the recipient must be provided with a notice of action. The three-day time limit does not include days in which the medical record is not available to review, if the reviewer has requested that the hospital make the record available.

Notice of Action Hand-delivered to Recipient

The notice of action will be hand-delivered to the recipient in the acute facility unless the treating physician specifically requests in writing that the patient should not be given the notice personally as it may result in serious harm to the patient. ‹‹The physician must complete the official form for this purpose (see Figure 2; DHS 6180) and must submit it with the request for extension of stay.›› In this case, the notice will be mailed to the patient's mailing address. Or if the patient has an authorized representative as identified in patient records submitted to the Department, the authorized representative will be mailed the notice rather than the patient. The name and address of the authorized representative, if applicable, should be noted on the TAR.

General Provisions

In all cases, the recipient has the right to request a state hearing to protest the Medi-Cal program decision. If the recipient requests the hearing within 10 calendar days of the date of the mailing of the notice, or at any time up to and including the last date on which services were authorized under the immediately preceding TAR, whichever is later, the recipient may be eligible to continued Medi-Cal authorization pending a hearing decision, as long as the same level of services continues to be prescribed by the attending physician. Continued Medi-Cal authorization pending a hearing will not be at a level of service greater in amount or frequency than approved on the immediately preceding TAR.

Only the recipient or his or her authorized representative has the right to request a hearing.

For further clarification or questions, the local Medi-Cal field office administrator should be contacted.

Page updated: December 2021

State of California—Health and Welfare Agency

Department of Health Services

Medi-Cal Field Office ____________________

Provider Name and Address:

RESULTS OF TREATMENT AUTHORIZATION REQUEST REVIEW: DEFERRAL

The additional medical information requested on this deferred TAR must be submitted to the Medi-Cal Field Office by ____________________
Please make every effort to submit this additional information within the deadline. If you are not able to do so and would like an extension of the deferral period, please indicate this to the Medi-Cal Field Office at any time up to the date specified above. You may do so by filling in the form below and mailing it to the Medi-Cal Field Office. Thank you for your cooperation.

REQUEST FOR EXTENSION OF DEADLINE TO SUBMIT MEDICAL INFORMATION ON A DEFERRED TAR

Medi-Cal Field Office ____________________

Provider Name:

Address:

Patient Name:

Address:

Medi-Cal I.D. Number:

TAR Control Number

Services for which prior authorization is being requested:

Service codes:

Reason you are requesting an extension of the deadline to submit additional information:

Estimate of the date you will submit the Information:

Date: ____________________

Provider's Signature

Date

DHS 6186 (6/90)

‹‹**Figure 1:** Results of *Treatment Authorization Request* Review: Deferral/Request for Extension of Deadline to Submit Medical Information on a Deferred TAR (DHS 6186).››

State of California—Health and Human Services Agency

Department of Health Services

PHYSICIAN CERTIFICATION REGARDING MEDI-CAL DELIVERY OF NOTICE TO PATIENT

Dear Physician:

The Medi-Cal program is required to provide notice to Medi-Cal beneficiaries whenever an adverse decision is made regarding extension of acute care services. Notice is provided in the form of a printed form delivered personally to the beneficiary in the hospital one working day after the decision is made by the Medi-Cal Medical Consultant to deny continuing acute services.

If you believe that personal delivery of this notice may result in serious harm to the beneficiary, please certify that below. In the event that the Medi-Cal program denies continuing acute care to this beneficiary, the notice will be mailed to the beneficiary's mailing address.

Thank you for your cooperation.

Patient name

Address

Medi-Cal I.D. number

Authorized representative's name

Address

Social Security number

I hereby certify that delivery of any notice regarding an adverse decision on continuing acute care may result in serious harm to the patient named above. I therefore request that any such notice be mailed to the patient or to his/her authorized representative whose name is reflected in the medical record.

Attending physician signature

Date

Facility name

Address

Note to Facility: Please attach this signed form to the Treatment Authorization Request (TAR) when initially presented to the on-site Medi-Cal reviewer. Thank you.

DHS 6180 (8/99)

‹‹**Figure 2:** Physician Certification Regarding Medi-Cal Delivery of Notice to Patient (DHS 6180).››

State of California - Health and Human Services Agency | Department of Health Care Services

CERTIFICATE OF MEDICAL NECESSITY
FOR ALL DURABLE MEDICAL EQUIPMENT (DME)
(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)* Last	First	Phone Number ( )	License Number

Address Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: __________

SECTION 2—Patient's Information: New Rx ***(For Rx Renewal, please also complete 2A below)***

Patient Name *(Print)* Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number

Address Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: __________

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ☐ No ☐ Explain "Yes" answer: __________

Equipment required for:
- ☐ Less than 10 months *(code the TAR for a rental)*
- ☐ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

a) __________

b) STANDARD: __________ BARIATRIC: __________

c) Replacing existing equiment? Yes ☐ No ☐ If yes, explain why: __________

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: __________

f) How many hours per day of usage? __________

g) Accessories requested and why: __________

h) Custom features requested and why: __________

i) Other equipment currently in the home: Cane ☐ Walker ☐ Crutches ☐ Prosthesis ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Hospital Bed ☐ Oxygen ☐ POV (scooter) ☐ Other: __________

j) Patient currently using the following equipment: __________

k) When/How often: __________

l) State specific reason for accessories requested: __________

DHCS 6181 (08/09)

‹‹**Figure 3:** Durable Medical Equipment (DHCS 6181).››

SECTION 4—Diagnosis Information

Diagnoses: ______ Date of onset: ______

Prognosis: ______

SECTION 5—Pertinent History:

______

______

SECTION 6—Functional Status:

Beneficiary's height: ______ Beneficiary's weight: ______

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted ❒ Unable ❒ Bed confined ❒
Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination ❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒
Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):
Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): ______ Sitting Posture/Deformity: ______

Cognitive status: ______ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒
Other: ______

Living Assistance: Lives alone ❒ With other person(s) ❒ Alone most of the day ❒ Alone at night ❒

Attendant care: Live in attendant ❒ or ______ Hours/day Homemaker ❒ Hours ______

Transportation:

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed: ______

______

Is frequent repositioning required throughout the day? Yes ❒ No ❒ Explain: ______
Is frequent repositioning required throughout the night? Yes ❒ No ❒
Can the beneficiary or caretaker use a "manual" bed? Yes ❒ No ❒
If no, explain why: ______

______

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: ______ *(Please print)* Title: ______ *(OT, PT, RESNA, etc.)* DME Provider Name: ______ *(Please print)*

______ *(Use Ink - A signature stamp is not acceptable)* Date: ______ ______ *(Use Ink - A signature stamp is not acceptable)*

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician's Signature:

______ *(Use Ink - A signature stamp is not acceptable)* Date: ______

‹‹**Figure 3 (continued):** Durable Medical Equipment (DHCS 6181).››

State of California–Health and Human Services Agency

Department of Health Services

Medi-Cal Field Office ____________________

CERTIFICATION OF MEDICAL NECESSITY FOR HOME OXYGEN THERAPY

The oxygen therapy you are requesting for this Medi-Cal beneficiary cannot be evaluated until we have sufficient medical information. In order to appropriately evaluate your request, all of the following items must be completed including physician signature and date of signature.

Deadline for submitting the information, if any: ____________________.

Patient's

Address

Medi-Cal I.D. number

Diagnosis (Include any secondary diagnosis that relate to oxygen need.)

Type of oxygen
- ☐ Portable
- ☐ Stationary

Oxygen Delivery System: Type of equipment and why?

Medical Need:
- ☐ Date oxygen prescribed ____________________
- ☐ Date patient evaluated ____________________
- ☐ Oxygen flow rate ____________________
- ☐ Frequency of use ____________________
- ☐ Duration ____________________
- ☐ Other ____________________

Arterial Blood Gas on room air and patient stable and/or Oxygen Saturation test results (appropriate for children only.)

Date of test: ____________________ Test results: ____________________

Name and address of testing facility

Any additional medical findings supporting need for oxygen?

If a portable system is requested, describe activities requiring the portable system that cannot be met by a stationary system.

If equipment is not to be used in home, indicate facility name and address.

Other

Attending Physician's signature

Date

Physician's name and address

DHS 6185 (8/99)

‹‹**Figure 4:** Certification of Medical Necessity for Home Oxygen Therapy (DHS 6185).››

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal Field Office ______________________

MEDICAL JUSTIFICATION FOR THERAPY TREATMENT PLAN

Your request for prior authorization for Medi-Cal payment for therapy services to the patient named below must include the following information in order to be appropriately evaluated by the Medi-Cal Field Office. Please provide this information to the Medi-Cal Field Office.

Deadline for submitting the information, if any: ______________________ .

Patient name

Address

Medi-Cal I.D. number

Diagnosis and date of onset

Date: ______________________

Date of surgery (if applicable): ______________________

Significant associated diagnoses

Current medical status of patient and/or functional limitations

Findings on initial evaluation

Specific services prescribed, including amount, frequency, duration

Therapeutic goals to be achieved by therapies and anticipated time for achievement of goals

Anticipated medical outcome as a result of therapy

The extent to which physical therapy, occupational therapy, speech therapy, or audiology services have been previously provided, and benefits or improvements demonstrated by such prior care.

Other

Physician's name	Address
Therapy provider's name	Address

Physician's signature	Date

DHCS 6183 (9/09)

‹‹**Figure 5:** Medical Justification for Therapy Treatment Plan (DHCS 6183).››

State of California-Health and Human Services Agency

Department of Health Services
Medi-Cal Field Office

JUSTIFICATION REQUIRED FOR APPROVAL OF APNEA MONITOR

Your request for prior authorization for an apnea monitor must include all of the following information in order to be appropriately evaluated by the Medi-Cal Field Office. Please complete all of the following items including physician signature

Deadline for submitting information, if

Patient name and address

Medi-Cal I.D. number

Date of birth

Reason for prescribing apnea monitor

Any secondary diagnoses related to the need for an apnea monitor

Gestational age at birth

Is this a SIDS sibling? Yes ☐ No ☐ If yes, age of sibling at death: ____________

Documentation of apneic episodes

Polysomnography test results (if performed)

Facility where test was administered

FOR RENEWAL REQUESTS

Documentation of instrument alarms or observed apneic episodes of more than 15 seconds
(Include dates, who observed, what interventions were made, and any follow-up.)

Was resuscitation required?

Other

Physician's signature

Date

Physician's name and address

DHS 6184 (8/99)

‹‹**Figure 6:** Justification Required for Approval of Apnea Monitor (DHS 6184).››

State of California—Health and Human Services Agency

Department of Health Care Services

NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) REQUIRED JUSTIFICATION

In order to appropriately evaluate your request, **complete all form fields** below including **physician signature** and **date of signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323 and the Medi-Cal Provider Manual]

1. Patient's name
2. Medi-Cal I.D. number

3. The current Skilled Nursing Facility (SNF) face sheet is:
   ☐ attached, since this patient currently resides in a SNF.
   ☐ not applicable, since this patient resides at home.

4. Dates of Service (DOS) From: ____________ To: ______________
5. Appointment time Start: ______ ☐ am ☐ pm End: ______ ☐ am ☐ pm

6. Days(s) of the week transported to above appointment(s)
   ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

7. Documentation is attached
   ☐ attached, since transport *is not to the nearest* facility that can meet the patient's medical needs.
   ☐ not applicable, as transport is to the nearest facility that can meet the patient's medical needs.

8. Diagnosis specific to visit(s)

9. Medical purpose/justification for visit(s)

10. The prescribed treatment plan including problems, interventions, and goals (along with why original goals were not met, if this is a reauthorization TAR)
    ☐ is attached, since request is for *multiple* transports that are *ongoing to same provider* for *same chronic diagnosis*.
    ☐ is not applicable, since request is for a single transport for a routine visit or one-time medical event.

11. Patient mobilizes via:
    ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other (describe):

12. Functional limitations, (specific *physical* or *mental*), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: *(If more space is needed, please attach another page.)*

13. Based on 11 and 12, above, the required mode of transport is:
    ☐ Wheelchair van ☐ Gurney or litter van ☐ Ambulance

14. Physician signature (Physician's personal signature only. No proxy. No stamps.)
15. Date
16. Physician specialty (print or type)
17. License number
18. Physician name (print or type)
19. Telephone number (Area code and number) (   )
20. Physician address (number, street, city, zip code)

DHCS 6182 (rev. 9/09)

‹‹**Figure 7:** Justification Required for Non-Emergency Medical Transportation (DHCS 6182).››

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's HI Claim No. | 2. SOC Date | 3. Certification Period From: To: | 4. Medical Record No. | 5. Provider No.

6. Patient's Name and Address

7. Provider's Name and Address.

8. Date of Birth: | 9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM | Principal Diagnosis | Date

12. ICD-9-CM | Surgical Procedure | Date

13. ICD-9-CM | Other Pertinent Diagnoses | Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation; 2 ☐ Bowel/Bladder; 3 ☐ Contracture; 4 ☐ Hearing; 5 ☐ Paralysis; 6 ☐ Endurance; 7 ☐ Ambulation; 8 ☐ Speech; 9 ☐ Legally Blind; A ☐ Dyspnea With Minimal Exertion; B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest; 2 ☐ Bedrest BRP; 3 ☐ Up As Tolerated; 4 ☐ Transfer Bed/Chair; 5 ☐ Exercises Prescribed; 6 ☐ Partial Weight Bearing; 7 ☐ Independent At Home; 8 ☐ Crutches; 9 ☐ Cane; ☐; A ☐ Wheelchair; B ☐ Walker; C ☐ No Restrictions; D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented; 2 ☐ Comatose; 3 ☐ Forgetful; 4 ☐ Depressed; 5 ☐ Disoriented; 6 ☐ Lethargic; 7 ☐ Agitated; 8 ☐ Other

20. Prognosis: 1 ☐ Poor; 2 ☐ Guarded; 3 ☐ Fair; 4 ☐ Good; 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Verbal Start of Care and Nurse's Signature and Date Where Applicable:

24. Physician's Name and Address

25. Date HHA Received Signed POT

26. I ☐ certify ☐ recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care, is confined to his home, and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need and no longer has a need for such care or therapy, but continues to need occupational therapy.

27. Attending Physician's Signature (Required on File in Medical Records of HHA) | Date Signed

PROVIDER

‹‹**Figure 8:** Home Health Certification and Plan of Treatment (HCFA-485).››

ADDENDUM TO: ☐ **PLAN OF TREATMENT** ☐ **MEDICAL UPDATE**

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name	7. Provider Name

8. Item No.

9. Signature of Physician	10. Date
11. Optional Name/Signature of Nurse/Therapist	12. Date

PROVIDER

‹‹**Figure 9:** Plan of Treatment/Medical Update and Patient Information Addendum.››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.