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

Page updated: September 2020

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 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 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 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 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 *Request for Extension of Stay in Hospital* (18-1 TAR) to the on-site nurse. Providers who have agreements to fax TARs should use the fax version of the *Request for Extension of Stay in Hospital* (18-2).

Ancillary and Physician Services

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.

If the Medi-Cal 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.

Adjudication Response (AR)

Authorization for Medi-Cal benefits will be valid for the number days specified by the consultant on the *Adjudication Response* (AR). Services must be rendered during the valid “From Date of Service-Thru Date of Service” period.

For additional information about ARs, providers may refer to “TAR Status on Adjudication Response (AR)” in the *TAR Overview* section of the Part 1 manual.

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.

‹‹Excluded admissions are as follows:

Acute Inpatient Intensive Rehabilitation (AIIR) Services

AIIR services require authorization with a *Treatment Authorization Request* (TAR) form 18-1 or an electronic TAR (eTAR), unless DHCS has waived the TAR requirement. A TAR for an AIIR admission is submitted by the facility providing AIIR services. The TAR should include the total number of acute inpatient intensive rehabilitation hospital days and be reflected in the Number of Days field (Box 17), as appropriate.

Unlike some general acute inpatient TARs, AIIR requires a daily TAR because reimbursement is based on a (non-APR-DRG) per-diem rate.

Authorization shall be based upon medical necessity substantiated by documents submitted with the TAR for each date of service (DOS) requested.

Refer to the *TAR Criteria for Acute Inpatient Intensive Rehabilitation (AIIR)* section in the Inpatient Services Provider Manual for additional information on AIIR document requirements and medical necessity criteria. Providers should also refer to the *Inpatient Rehabilitation Services* section of the appropriate provider manual for additional billing information regarding AIIR services.

If submitting an eTAR for AIIR services, providers should:

- Include all days of the request in the *Total Units* field
- Add a comment to the *Miscellaneous TAR* Information field, to indicate that the TAR is for AIIR services

Acute Administrative Days (AAD)

AAD requires authorization with a TAR (18-1) or an eTAR, unless DHCS has waived the TAR requirement. A TAR for AAD is submitted by the facility providing AAD services. The TAR should include the total number of acute administrative days and be reflected in the *Number of Days* field (Box 17), as appropriate.

Unlike some general acute inpatient TARs, AAD requires a daily TAR because reimbursement is based on a (non-APR-DRG) per-diem rate.

Authorization shall be based upon criteria substantiated by documents submitted with the TAR for each date of service (DOS) requested.

Refer to the *TAR Criteria for Acute Administrative Days (AAD)* section in the Inpatient Services provider manual for information on AAD criteria. Providers should also refer to the *Administrative Days* section of the Inpatient Services provider manual for billing information regarding AAD.

If submitting an eTAR for AAD services, providers should include all days of the request in the *Total Units* field.››

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

REQUEST FOR EXTENSION OF STAY IN HOSPITAL

STATE USE ONLY

SERVICE CATEGORY

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

1. CLAIMS CONTROL NUMBER (1) F.I. USE ONLY

(2) (3) F.I. USE ONLY (4) (5)

CONFIDENTIAL PATIENT INFORMATION

ELITE PICA PLEASE TYPE ALL INFORMATION TYPEWRITER ALIGNMENT ELITE PICA

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) (6) | ADMIT DATE (7) MM DD YY | AUTH. EXP. (8) MM DD YY | EMER. ADMIT (9)

PROVIDER NUMBER (10) | PROVIDER PHONE NO. (10A) ( ) | VERBAL CONTROL (10B)

PROVIDER NAME (10C)

PROVIDER STREET/MAILING ADDRESS

PROVIDER CITY, STATE AND ZIP CODE

PATIENT MEDI-CAL ID NO. (11) | PEND (12) | SEX (13) | DATE OF BIRTH (14) MM DD YY | AGE (14A)

PATIENT NAME (14B) | MEDICARE STATUS (15) | OTHER COV. (16)

NUMBER OF DAYS REQUESTED (17) | TYPE OF DAYS (18) | RETRO-ACTIVE (19) | DISCHARGE DATE (20) MM DD YY | ADMITTING ICD9-CM (21)

ADMITTING DIAGNOSIS DESCRIPTION (21A)

FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS (22) | CURRENT ICD9-CM CODE

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS (18A) (22A)

DESCRIBE CURRENT CONDITION REQUIRING EXTENSION, INCLUDE PERTINENT LAB AND X-RAY REPORTS WITH DATES.

WHAT PLANNED PROCEDURES WILL REQUIRE THIS EXTENSION, INCLUDE DATES WHEN POSSIBLE.

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 PROVIDER DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN X (22B) DATE

MEDI-CAL CONSULTANT- VALIDATING INFORMATION AND EXPLANATION (22C)

FOR STATE USE ONLY

DENIED | DEFERRED | (23) APPROVED AS REQUESTED | 24 FROM MM DD YY | APPROVED AS MODIFIED | 26 THRU MM DD YY

DAYS DD | ACUTE | ACUTE ADMIN. | SUB ADMIN VENT | SUB ADMIN N-VENT

DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS) | JACKSON VS RANK PARAGRAPH CODE (42A)

DATES OF DAYS DENIED: MM DD

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (B) (42) 1 2 3 4 5 6

CHART REVIEWS | REVIEW COMMENTS INDICATOR

BY (42B) MEDI-CAL CONSULTANT (43) | ID. NO. (44) | DATE MM DD YY | TAR CONTROL NUMBER (45)

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

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).*

Explanation of Form Items Table

Item	Description
1	**Claims Control Number**. Leave blank. For California MMIS Fiscal Intermediary use only
2 thru 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 *Emergency Admit* field (Box 9) must be left blank when the *Admit TAR Number* 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.

Explanation of Form Items Table (continued)

Item	Description
	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 ‹‹Medi-Cal Benefits Identification Card (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, 10th Revision, Clinical Modification* **Note:** This form has not been updated to reflect an ICD-10-CM field label name. • 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
10C	**Provider Name and Address**. Enter the name of the hospital, street address, city, state and nine-digit ZIP code

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Explanation of Form Items Table (continued)

Item	Description
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 *Patient Medi-Cal ID No.* field). Enter the county code and aid code below Box 11.
12	**Pend**. Leave blank.
13	**Sex.** Enter the patient's sex: • "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 *UB-04 Completion: Inpatient Services* 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.

Explanation of Form Items Table (continued)

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>16</td><td>Other Coverage. Enter an “X” if the recipient has other insurance or Other Health Coverage (OHC).

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.

Note, however, that providers should refer recipients with PHP/HMO coverage to their PHP/HMOs for treatment, except for emergencies. Refer to the Other Health Coverage (OHC) Guidelines for Billing section of the Part 1 manual for billing instructions for claims for emergency services rendered by non-plan providers to recipients in PHPs/HMOs.

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.

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 Other Health Coverage (OHC) section in this manual for additional information on submitting denial letters.

Note: Eligibility under Medicare is not considered other coverage. Refer to the Other Health Coverage (OHC) Guidelines for Billing 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.</td></tr>
<tr><td>17</td><td>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.</td></tr>
<tr><td>18</td><td>Type of Days. Enter the code indicating type of days requested:
0 Acute
2 Administrative
3 Subacute administrative ventilator dependent
4 Subacute administrative non-ventilator dependent</td></tr>
</table>

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Explanation of Form Items Table (continued)

Item	Description
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-10-CM book. **Note:** This form has not been updated to reflect an ICD-10-CM field label name.
21A	**Admitting Diagnosis Description and ICD-9-CM Diagnosis Code**. Always enter the English description of the diagnosis from the ICD-10-CM book. **Note**: This form has not been updated to reflect an ICD-10-CM field label name.
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-10-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.
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 consultant use only.

Explanation of Form Items Table (continued)

Item	Description
23 thru 42	**For State Use Only**. Leave blank; (This section will contain the decision of the Medi-Cal consultant.)
42A	**Sub. Admin. Vent/Sub Admin N-Vent**. The Medi-Cal 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 thru 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.

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.