



Jonathan E. Sherin, M.D., Ph.D.
Director of Mental Health

MEDI-CAL FEE-FOR-SERVICE INPATIENT HOSPITAL PROVIDER MANUAL

Third Edition
December 28, 2018

Published by:
Office of the Medical Director
Intensive Care Division, TAR Unit

Welcome

Welcome. This is the Provider Manual for Medi-Cal Fee-For-Service (FFS) acute psychiatric inpatient providers that have contracts with the Los Angeles County Department of Mental Health (LACDMH). This Provider Manual provides information explaining the processes involved in partnering with the LACDMH for the delivery of quality, cost-effective mental health care.

On January 1, 1995, under a State mandate, LACDMH began implementing Phase I of the Medi-Cal Fee-For-Service (FFS) Inpatient Services. The Phase I Consolidation resulted in significant changes to the delivery of, and reimbursement for, inpatient mental health services provided by Medi-Cal FFS acute psychiatric inpatient providers to Medi-Cal eligible beneficiaries of Los Angeles County. Information regarding the Medi-Cal Fee-For-Service inpatient reimbursement authorization procedures for Los Angeles County are described in this manual.

Thank you for your interest and participation in the Medi-Cal FFS acute psychiatric inpatient services in Los Angeles County. If you have any questions, requests or comments regarding this manual please contact the LACDMH's Intensive Care Division Treatment Authorization Unit at (213) 739-7300.

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SECTION: I

INTRODUCTION

INTRODUCTION

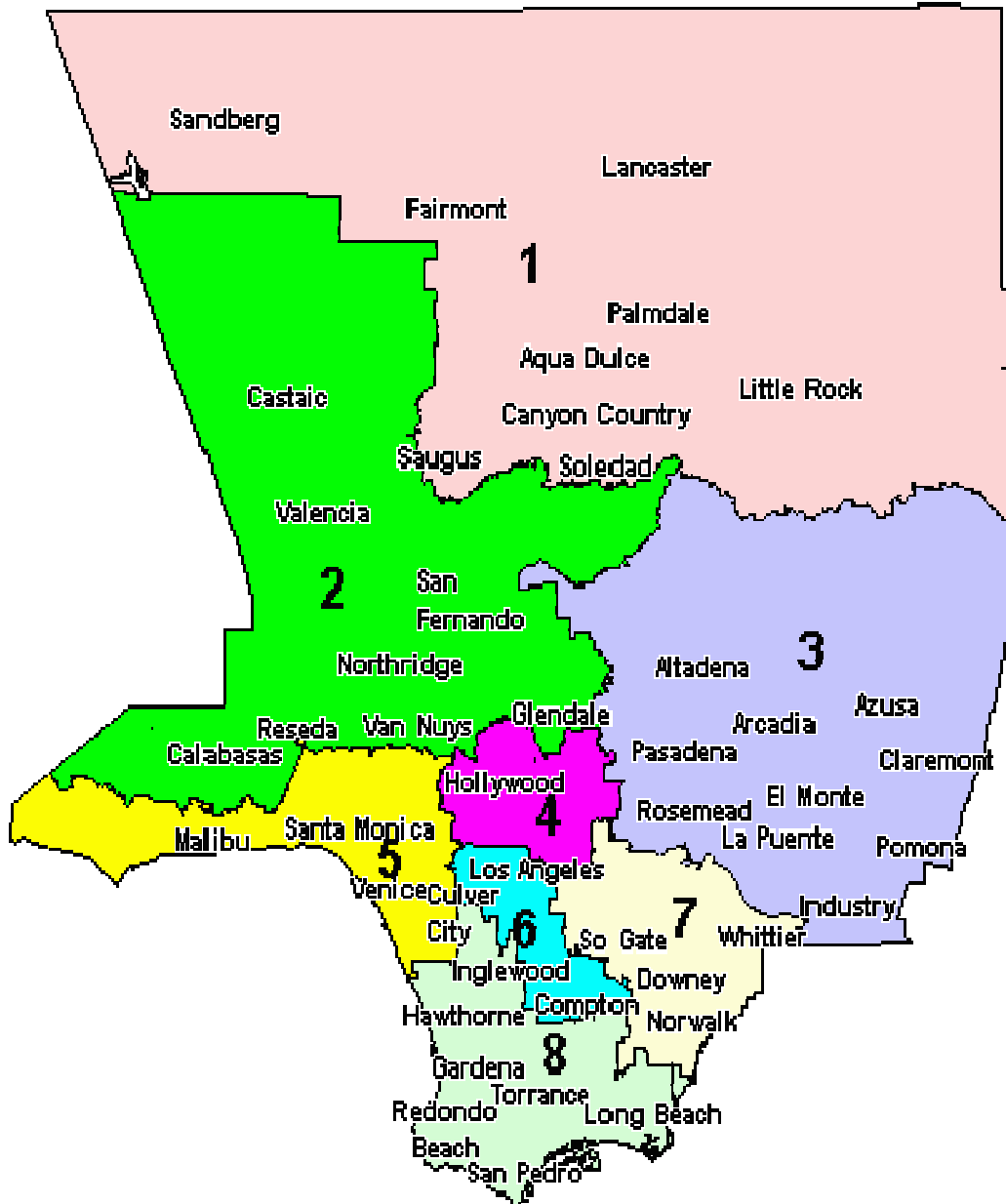
The Los Angeles County Department of Mental Health (LACDMH) is the State of California's Local Mental Health Plan (LMHP) for the County of Los Angeles. The LMHP is responsible for administering all Medicaid/Medi-Cal and State grant funds for mental health services through a well-managed system that is designed to ensure available, accessible, and quality mental health care for eligible Medi-Cal beneficiaries.

It is estimated that Los Angeles County is the county of residency to approximately one-third (1/3) of all Medi-Cal beneficiaries in the State of California. The county where Medi-Cal beneficiary eligibility is established is determined by the Department of Public Social Services. Due to the magnitude of acute psychiatric inpatient services provided to the residents of Los Angeles County, the California Department of Health Care Services (DHCS) approved the process of retrospective reviews of requests for authorizing reimbursement for Medi-Cal acute psychiatric inpatient services provided to Medi-Cal eligible beneficiaries of Los Angeles County by the Fee-for Service Network providers.

The Treatment Authorization Request Unit, within the LACDMH's Clinical Operations, Intensive Care Division, is the program responsible for implementing and operating the State Managed Care Plan, i.e., Inpatient Psychiatric Hospital Consolidation Plan. Under the State's managed care plan, the LMHP is responsible for authorizing reimbursement for Medi-Cal acute inpatient psychiatric services provided to Los Angeles County Medi-Cal beneficiaries in the Medi-Cal Fee-For-Service Network. As noted earlier, information regarding the Medi-Cal Fee-For-Service inpatient reimbursement authorization procedures for Los Angeles County is described in this manual.

LACDMH Service Planning Areas

Los Angeles County is organized into eight (8) geographic Service Planning Areas (SPAs). To identify mental health providers in your service area, go to <http://dmh.lacounty.gov/> Click Services, Click Provider and Contractor Information, and Click for an interactive map with service providers by service area.



Service Planning Area (SPA) 1 Antelope Valley

SPA 1 is the largest service area geographically, yet it has the smallest population with approximately 390,938 inhabitants. Spanish is a prominent language. SPA 1 has a younger population than the other service areas, with a reported 31% of the population between the ages of 1-15. The average for the county is 25%.

Fee for Service (FFS) hospital in the area:

Antelope Valley Hospital

Service Planning Area (SPA) 2 San Fernando Valley

SPA 2 is the most populous service area in Los Angeles County with a population of approximately 2,173,732. English and Spanish are the predominant languages. Although the number of children is within the county average, due to the overall population, there are more children in SPA 2 than in any other service area.

FFS hospitals in the area:

Encino Hospital and Medical Center
Glendale Adventist Medical Center
Glendale Memorial Hospital and Health Center
Henry Mayo Newhall Hospital
Mission Community Hospital
Motion Picture and Television Hospital
Southern California Hospital at Van Nuys
USC Verdugo Hills Hospital

Service Planning Area (SPA)3 San Gabriel Valley

The total population in the San Gabriel Valley is approximately 1,777,760 with Latinos being the largest ethnic group in the area, followed by Asians.

FFS hospitals in the area:

Aurora Charter Oak
Aurora Las Encinas Hospital
BHC Alhambra Hospital
Glendora Community Hospital
Huntington Memorial Hospital Della Martin
Intercommunity Medical Center
San Gabriel Valley Medical Center
Silver Lake Medical Center

Service Planning Area (SPA) 4 Downtown/Metro

SPA 4 has a population of 1,140,742. It has the highest number of homeless persons within its boundaries. The Metro area has the second highest poverty rate in the county.

FFS hospitals in the area

Kaiser Foundation Hospital
Silver Lake Medical Center

Service Planning Area (SPA) 5 West Los Angeles

SPA 5 has a population of 646,531. It has the largest number of individuals reporting to speak English as their primary language. Approximately 18% of its population are older adults, compared to 13% countywide. Its median household income is \$61,000 compared to \$48,000 countywide.

FFS hospital in the area:

Resnick Neuropsychiatric Hospital at UCLA
Southern California Hospital at Culver City

Service Planning Area (SPA) 6 South

SPA 6 has the most at-risk factors in the entire county. Its total population is approximately 1,030,078; however, 48% of its population is 25 years of age or less. It has the highest poverty rate in the county – 61% of its population lives below the 200% federal poverty level (FPL). Two ethnic groups account for 94% of the population- African American and Hispanic.

FFS hospital in the area:

St. Francis Medical Center

Service Planning Area (SPA) 7 East

The population within the boundaries of SPA 7 is approximately 1,309,383. It also has a young population with 43% under the age of 26. It is reported that 70% of the population is Latino with Spanish being spoken in 54% of the households.

FFS hospitals in the area:

College Hospital Cerritos
Los Angeles Community Hospital at Bellflower

Service Planning Area (SPA) 8 South Bay/Long Beach

The population of SPA 8 is 1,550,198. The service area has no overall ethnic majority. It has a household income slightly higher than the county average, and the number of individuals who graduate from college is slightly higher than the county average.

FFS hospitals in the area:

College Medical Center
Del Amo Hospital
Providence Little Company of Mary Medical Center San Pedro

SECTION: II

LACDMH CONTRACT

Contracting with the County

State of California certified and licensed Medi-Cal FFS acute psychiatric inpatient facilities located within Los Angeles County are encouraged to contract with the *County of Los Angeles Department of Mental Health* (LACDMH). Although it is not a requirement to contract with LACDMH to be reimbursed for Medi-Cal acute psychiatric inpatient mental health services, contracting promotes a seamless system of care for Medi-Cal beneficiaries residing in Los Angeles County.

This manual, and all subsequent Provider Alerts, provides specific information regarding the requirements and process for contracting with LACDMH and instructions concerning requesting reimbursement for Medi-Cal FFS Acute Psychiatric inpatient services.

Contracting Process

- Obtain from LACDMH Contracts Development and Administration Division (CDAD) the “Los Angeles County Department of Mental Health Medi-Cal FFS Acute Psychiatric Inpatient Contract Package”.
- Submit a completed Contract Package with the required documents for review and approval by the Los Angeles County Board of Supervisors. Contract providers will receive a contract for signature which must then be fully executed by LACDMH.
- Schedule orientation and training for contract providers to facilitate integration and incorporation of the contract provider into the LACDMH system of care.

Contract Required Notifications

It is essential that contract providers immediately inform the LACDMH's CDAD of the following:

- Any/all changes affecting the provider's ability to provide contracted services
- Changes in authorized signatory(ies)
- Changes in ownership
- Mergers
- Name and/or address changes
- Financial viability as evidenced by audited financial statements submitted annually during the term of the contract
- Insurance (submitted annually during the term of the contract)
- Permits
- Licenses (Submitted annually during the term of the contract)
- Other dated material and changes that are required from the contract package

Failure to inform in writing, the LACDMH's CDAD in a timely manner, of any/all conditions affecting the contract provider's ability to provide services may constitute a material breach of contract. Contract providers must submit all official correspondence and notices to the following:

**LACDMH Contract Officer
DMH Contracts Development Administrative Division
550 S. Vermont Ave. 5th floor, Room 500
Los Angeles, CA 90020**

SECTION: III

SINGLE POINT OF CONTACT

Single Point of Contact (SPOC)

All Fee-For-Service (FFS) Medi-Cal acute psychiatric inpatient providers/hospitals submitting inpatient Treatment Authorization Requests (TARs) to the LACDMH must designate a Single Point of Contact (SPOC). The SPOC is the person authorized by the provider to discuss or obtain any/all information concerning a specific TAR and/or Medi-Cal beneficiary.

This restriction on accessing information applies only to information regarding a specific Medi-Cal beneficiary to ensure compliance with laws and regulations concerning patient confidentiality. Access is not restricted regarding Medi-Cal information only if unrelated to a specific Medi-Cal beneficiary.

All official correspondence addressed to the TAR Unit must be submitted by the provider's designated SPOC and will be acted upon only if submitted in writing to the TAR Unit for matters such as, but not limited to, the following:

- TAR Inquiry, Error Corrections
- Compliance communications
- First Level Appeal
- Second Level Appeal

Change of Single Point of Contact (SPOC)

Providers may change their designated SPOC at any time by notifying the Intensive Care Division, Provider Relations Unit, in writing, on the provider's letterhead, with the full name, mailing address, email address, telephone number and fax number of the new SPOC.

Provider Alerts

The Intensive Care Division will issue LACDMH Provider Alerts to contract providers via the SPOC to disseminate information regarding clinical, administrative or financial policies and procedures. Any changes described in the Provider Alerts have the authority of policy and are binding to the LACDMH provider's contract agreement with DMH.

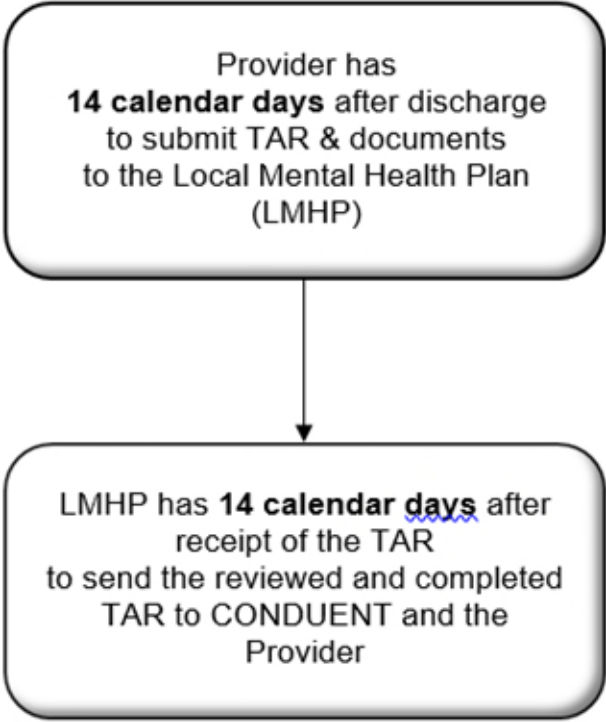
SECTION: IV

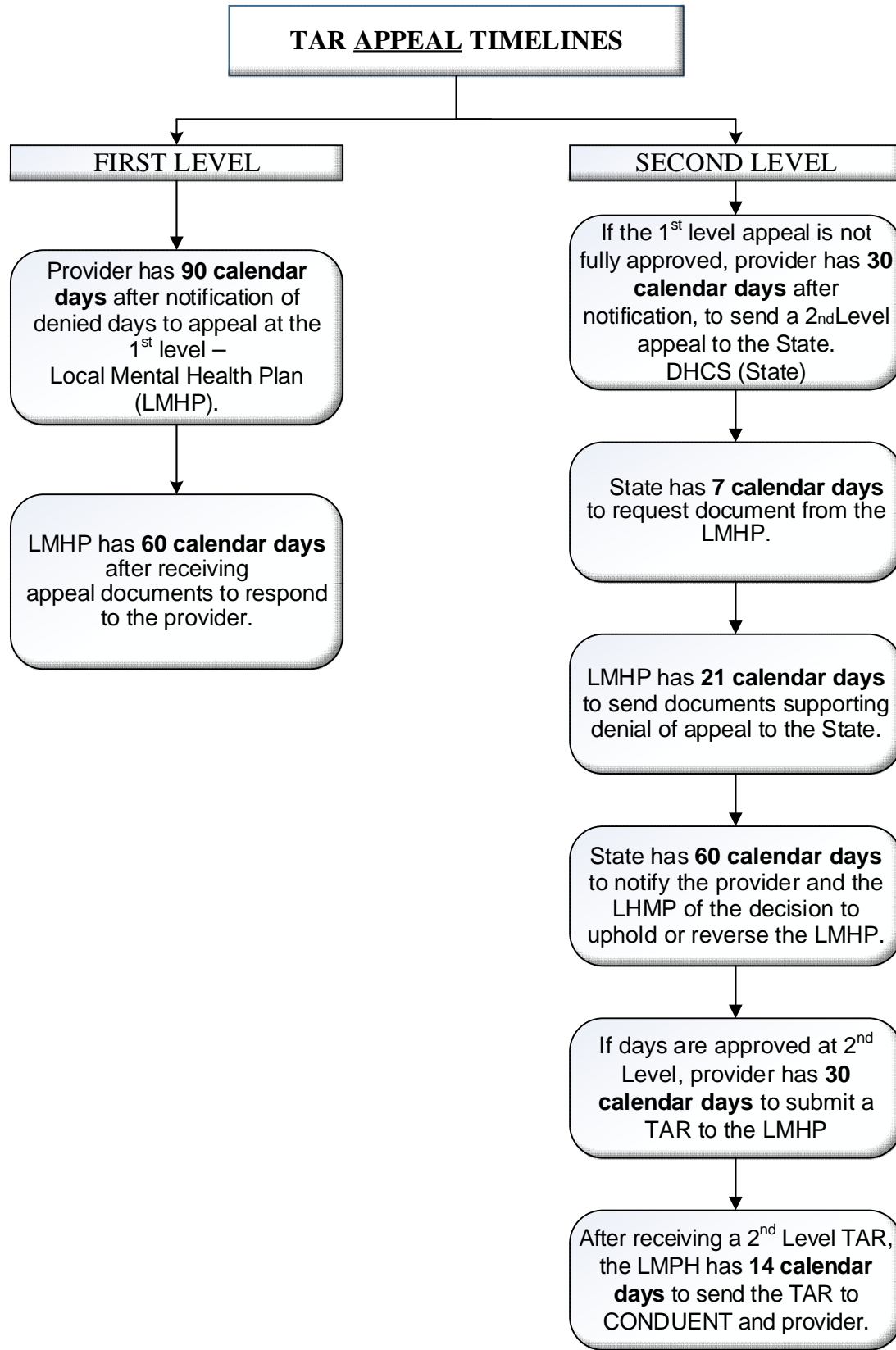
TAR PROCESS FLOW CHART

SECTION: V

TIMELINES

Timelines for Initial Submission of a TAR





SECTION: VI

INSTRUCTIONS FOR COMPLETING A TAR

Patient's Authorized Representative – If known, enter the name and address of the patient's authorized legal representative, payee or conservator - parent's name if patient is a minor.

Describe Current Condition Requiring Hospitalization – Complete this section as instructed on the TAR. Use this space to indicate specific dates requested when submitting multiple TARs, *Admin Day* TARs and Appeal TARs

Planned Procedures – Complete as instructed. On Appeal TARs, leave this section blank.

Signature of Provider & Date: To be signed and dated by hospital representative.

Signature of Physician & Date: Signed and dated by the attending physician or psychologist who has admitting privileges.

For County Use Only: Do not write in this section.

Sample Mental Health Stay in a Hospital TAR form (SDMH 18-3)

To Order: Providers can request TAR forms from Conduent by contacting its Medi-Cal Telephone Service Center at (800) 541-5555.

inpatient

4

TREATMENT AUTHORIZATION REQUEST FOR MENTAL HEALTH STAY IN HOSPITAL

F.I. USE ONLY

1. CLAIMS CONTROL NUMBER: F.I. USE ONLY

2 3
4 5
6 7

CONFIDENTIAL PATIENT INFORMATION

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) ADMIT DATE AUTH. EXP. EMER. ADMIT

PROVIDER NUMBER PROVIDER PHONE NO. VERBAL CONTROL

PROVIDER NAME

PROVIDER STREET/MAILING ADDRESS

PROVIDER CITY, STATE AND ZIP CODE

PATIENT MEDICAL ID NO. DATE OF BIRTH AGE

PATIENT NAME MEDICARE STATUS

NUMBER OF DAYS REQUESTED TYPE OF SERVICE DISCHARGE DATE ADMITTING ICD9-CM

ADMITTING DIAGNOSIS DESCRIPTION

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

CURRENT DIAGNOSIS PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS

DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION.

WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE

HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN SIGNATURE OF RESPONSIBLE PHYSICIAN DATE

COUNTY MEDICAL CONSULTANT - VALIDATING INFORMATION AND EXPLANATION

FOR COUNTY USE ONLY

28 DENIED 29 DEFERRED 30 APPROVED AS REQUESTED 31 APPROVED AS MODIFIED 32 FROM 24 FROM 25 FROM 26 FROM 27 FROM

33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 00

BASE OF THE HOSPITALIZATION (SEE COMMENTS) JACKSON VS. FRANK PARAGRAPH CODE

CHART REVIEWS REVIEW COMMENTS INDICATOR

BY COUNTY MEDICAL CONSULTANT DATE TAR CONTROL NUMBER

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

SEND TO COUNTY MENTAL HEALTH DEPT. - F.I. COPY

18-3 (8/07)

Figure 1. Sample Request for Mental Health Stay in Hospital (Form 18-3).

2 - Inpatient Mental Health Services Program

Inpatient Services 391
May 2007

SECTION: VII

SUBMISSION OF A TAR

SUBMISSION OF INITIAL TAR

A request for Medi-Cal psychiatric inpatient mental health reimbursement must be submitted on an **original TAR** (18-3 form). Providers can order TAR forms by calling DHCS fiscal intermediary (Conduent) at (800)541-5555. Address: 820 Stillwater, West Sacramento, CA 95605-1630

- All providers must adhere to the State regulatory timelines when submitting TARs. TARs (form 18-3) must be submitted within 14 calendar days of discharge from the hospital and ninety-nine calendar days of continuous service to the beneficiary, if the hospital stay exceeds that period of time.
- TARs not meeting the State timelines will be denied authorization for hospital payment. (CCR, Title 9 §1820.220).
- All providers must complete the TAR (form 18-3) accurately in order to be processed for reimbursement authorization.

LATE TAR SUBMISSION (CCR §1820.215)

- Reimbursement of late TARs will be determined by the LMHP. Providers are required to submit factual documentation of late submission within 60 calendar days of LMHP's request due to:
 1. Natural disaster that has:
 - a). Destroyed or damaged the hospital's business office or records; or
 - b). Substantially interfered with the hospital's agent's processing of requests for LMHP payment authorization or;
 2. For delays caused by other circumstances beyond the hospital control, documentation shall include evidence that the circumstance causing the delay was reported to a law enforcement agency or fire agency, if the circumstance is required to be reported.

CIRCUMSTANCES **NOT** CONSIDERED BEYOND THE CONTROL OF THE HOSPITAL INCLUDE BUT ARE NOT LIMITED TO:

- A) Negligence by employees.
- B) Misunderstanding of program requirement.
- C) Illness or absence of any employee trained to prepare the LMHP payment authorizations.
- D). Delays caused by the United States Postal Service or any private delivery service.

RETROACTIVE TARs

Retroactive TARs may be submitted for payment authorization request beyond the timelines specified by regulations for the following reasons upon verification of the LMHP:

1. Medi-Cal eligibility inquiry during hospital stay wherein initially shows no eligibility. Provider to submit a copy of current eligibility
2. Denial of payment (exhaustion of benefits) or a partial payment from a third party payer (Medi-Care or other insurance)

TARs that meet retroactive criteria must be **submitted within 60 calendar days** of the following:

- 1) Date of discovery of Medi-Cal eligibility.
- 2) Date Remittance Advice Statement (RA) showing partial payment or Notice of Exhaustion of Benefits (EOB) was received from third party.

Note: TARs are to be submitted only after having billed any other insurance carrier including Medicare. LACDMH shall not be responsible for reimbursing FFS/MC hospitals that deliver Medicare covered services to a beneficiary for any Medicare co-insurance and deductible payments due to the provider from the Medi-Cal program.

HOW TO SUBMIT A RETROACTIVE TAR:

- 1) Enter the episode into the LACDMH data system.
- 2) Mark box 19 with an "X" to indicate retroactive status.
- 3) Submit either (a) or (b) with the TAR:
 - (a) Proof of Medi-Cal eligibility
 - (b) A copy of the RA or EOB.
- 4) Follow instructions for Submitting a TAR for Payment Authorization.

Note: The run date on the proof of eligibility or date stamp on the RA or EOB (reflecting date of receipt) will determine the start of the 60 calendar-days timeline for submission of a retroactive TAR.

Note: TARs will not meet retroactive criteria **if at any time during the hospital stay (including the day of discharge) there is discovery of Medi-Cal eligibility or discovery that third party benefits expired. If this is the case, these TARs are not to be treated as retroactive.**

1. Enter the episode in the LAC data system immediately upon discovery of Medi-Cal eligibility.
2. Submit the TAR within 14 calendar days after the patient is discharged.

All contract providers must enter patient episode data into the LACDMH Data Collection and Reporting System according to established policies and procedures.

Enter the following data:

- Within 24 hours of admission, enter the episode information.
- Prior to submission of a TAR, enter:
 - Discharge information, including date of discharge and
 - Discharge diagnosis.
- Print the *episode screen* showing the correct admitting and discharge dates. Submit this printout with the TAR and chart documents as well as the open episode and closed episode forms.

Note: If there is no recorded **Medi-Cal** eligibility or pending eligibility, do not enter data into the LACDMH Integrated Behavioral Health Information System (IBHIS).

Determine Medi-Cal Eligibility



- **Verify Medi-Cal eligibility (POS, AVES or Eligibility Response).**
 - Submit proof of eligibility with the TAR.
 - Write the County and Aid Codes on the TAR, above box #11.
- Submit a TAR only if the beneficiary is eligible for L.A. County (#19) Medi-Cal during the month(s) of service.
- When there is other coverage (Medicare/private insurance) in addition to Medi-Cal, the other coverage must be billed first.
- If Medi-Cal billable days remain after receipt of a partial payment or *Notice of Exhaustion of Benefits* (EOB) from Medi-Care or other insurance carrier, submit a TAR. Please see the section on *Submission of a Retroactive TAR*.

AFTERCARE PLAN

The Los Angeles County Department of Mental Health (LACDMH) continues to develop quality assurance efforts to ensure comprehensive quality of care services for its beneficiaries. Continuity of care is essential for the successful transition of a beneficiary from inpatient hospitalization to a lower level of care. In conjunction with the discharge of a Medi-Cal beneficiary, the inpatient provider must prepare a written aftercare plan to be submitted to the appropriate LACDMH outpatient provider and a copy given to the beneficiary. A copy of the aftercare plan must also be included with the TAR documents.

Summary:

Minimum required documents to submit:

1. Original TAR
2. Proof of eligibility with the TAR (POS, AVES, or Eligibility Response)
3. Episode screen with the correct admit/discharge dates
4. Hospital admit/discharge sheets
5. Copy of the patient's medical record to support medical necessity for acute days and if applicable, Administrative Days
6. Copy of After Care Plan
 - a. Facility name where patient is referred
 - b. Name of contact person
 - c. Date/time of follow up appointment

NOTE: For patients that are admitted/transferred to different units within the hospital (e.g. medical-surgical, ICU, etc); the admit/discharge date on the TAR will be the same dates as the hospital episode. Only one TAR is needed: Indicate the dates requested (acute or administrative days) on the TAR section "Describe current condition requiring hospitalization."

Submit TARs and documents to:

TAR Unit
LAC Department of Mental Health
550 S. Vermont Avenue, 7th Floor, Room 701
Los Angeles, CA 90020

SECTION: VIII

APPEALS

APPEAL

“Appeal” means:

- (a) A request by a beneficiary or a beneficiary’s representative for review of an action as defined in-CCR, Chapter 11, §1810.200
- (b) A request by a beneficiary or a beneficiary’s representative for review of a provider’s determination to deny or modify a beneficiary’s request for a covered specialty mental health service;
- (c) A request by a beneficiary or a beneficiary’s representative for review of the timeliness of the delivery of a specialty mental health service when the beneficiary believes that services are not being delivered in time to meet the beneficiary’s needs, whether or not the mental health plan has established a timeliness standard for the delivery of the service.

Authority: Section 14680, Welfare and Institutions Code

Reference: Section 14684, Welfare and Institutions Code and Title 42, Code of Federal Regulations, Part 438, Subpart F.

FIRST LEVEL APPEAL

FIRST LEVEL APPEAL: A written request from the provider to appeal a determination from the LMHP on denial of acute and/or administrative days for inpatient hospitalization that did not establish medical necessity and/or administrative placement criteria.

TIMELINE

- All appeal documents must be submitted within 90 calendar days of the initial TAR denial notification date. This is the date the initial TAR was faxed to the provider. See Appeal Timeline Flow Chart. (Section V).

SUBMIT THE FOLLOWING:

1. Submit a written First-Level Appeal by the provider to the LACDMH TAR Unit on provider letterhead and signed by the treating physician addressing the medical necessity criteria for each day being appealed, and addressing each issue raised by the Provider.
2. Submit the Appeal to the LMHP on or before the 90th calendar day after fax notification of denied days from the LMHP. All documentation must be submitted at the same time.
3. Review of Appeal requests that fail to meet the 90 calendar day timeline will be calculated by comparing the date stamp on the Initial TAR with the date that the Provider submitted for the First- Level Appeal TAR. These dates are obtained from the Provider Transmittal Form, the FedEx, UPS Envelopes, U.S.P.S. Postmarked Dates and Certified or Regular Mail. Logs are kept on all Couriers and Delivery Services which may be used as a cross reference to verify 90 calendar day timeline.

4. Retention of envelopes and receipts documenting submission dates are retained on all Appeals that failed to meet the 90 calendar day timeline for a First-Level Appeal.
5. Fax a Notice to Provider that the Request for an Appeal did not meet the LMHP's 90 calendar day timeline. Providers that met the Timeline will complete the remaining steps listed below.
6. Submit the Request for an Appeal in narrative form or a summary that may refer to other documentation in the chart, include: Copy of Initial TAR and Appeal TAR (e.g., nurses' notes, but must definitely support the medical necessity criteria as outlined by the California Code of Regulations, Title 9, Chapter 11, Section 1820.205) to support the appeal. Clarification of illegible notes may be submitted but must be printed or typed before resubmission.
7. Complete a new TAR (Form 18-3) for the days being appealed with the Appeal request. This expedites processing an approved appeal TAR. It must be completed using the same admission and discharge dates as the initial TAR.
 - In box 17, indicate the number of acute or administrative days being appealed.
 - In box 18, indicate the type of day, using "0" for acute days and "2" for administrative days. List the actual dates being appealed in the "Describe Current Condition" section of the TAR.

IMPORTANT: *If the appealed days are not consecutive then a TAR (18-3) is required for each grouping of consecutive days only. For example, if appealed days are 8/4 & 8/5, and 8/9 & 8/10 then a new TAR will be needed for each group of days being appealed. In the above example, a TAR for 8/4 & 8/5 would be required, and a TAR for 8/9 & 8/10 would also be required.*

It is not necessary for the FFS inpatient psychiatric provider to send another copy of the medical record because medical records with denied days remain on file at LACDMH.

8. Distribute First Level Appeals to LMHP credentialed and licensed personnel of TAR Unit not involved in the initial denial or modification decision to determine the appeal decision. The Appeals Physician Reviewer makes the final decision on behalf of the Office of the Medical Director, Intensive Care Division.

Request for a Change in Level of Care for First Level Appeal

1. Request the option of a change in the Level of Care from days which were initially requested as acute days to appealed administrative days and conversely, administrative days may be appealed as acute days. In both

- cases, the corresponding criteria must be met for the days requested. This decision to a change in Level of Care is binding.
2. If there were no acute days approved on initial review, then the Provider may request to have these acute days appealed as administrative days at the First Level. At least one of these appealed days must be requested as an acute day.
 3. One approved acute day is required before administrative days can be approved. Should both acute and administrative days be appealed, a TAR for each type of day must be sent. However, no change from acute to administrative days or from administrative days to acute days will be accepted at Second-Level Appeal.

Submit documentation for First-Level Appeal to:

**TAR Unit/Appeals Section
Los Angeles Department of Mental Health
550 S. Vermont Avenue, 7th Floor, Room 701
Los Angeles, CA 90020**

Notice to Provider of First-Level Appeal Decision

1. Receive a submission for an inquiry to the TAR Unit from the provider to request to receive a decision before the 60 calendar day time period. The provider should immediately determine the status of the appeal, including whether or not the Appeal Request was received by the TAR Unit. It is recommended that status inquiries be sent as early as 30-calendar days after the First-Level appeal was submitted to the TAR Unit.
2. Fax the decision from the TAR Unit to the Provider, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision. This must be completed up to the 60th calendar day. It is crucial for the Provider to inquire about the appeal as soon as possible before the TAR Unit's 60 calendar day timeline ends. This date starts the 30 calendar day timeline for the provider to appeal to the State for a Second Level Appeal. (See CCR, Title 9, Chapter 11, Section 1850.305 through 1850.315).
3. Request made by Provider to request a Second-Level Appeal to DHCS must be done within 30 calendar days after a fax notification that the First-Level Appeal was not fully approved. Timeline documentation is maintained by the First-Level Appeal, TAR Unit.

Notice to LMHP of Provider's Request for Second Level Appeal to DHCS

1. Respond to DHCS encrypted email request for specific documentation supporting LMHP decision to deny authorization for payment. The LMHP has 21 calendar days to respond to DHCS request.
2. Submit to DHCS the following:
 - Cover letter from LMHP including the date the LMHP received the Appeal Notification from DHCS, Beneficiary's name, facility name and Admission Date.
 - The enclosed documentation includes: First Level Appeal TAR; LMHP Decision Letter; Provider's Appeal Letter; Initial TAR; STAR/Reviewer Notes for the original TAR; Psychiatrist/Psychologist Admission Notes and Progress Notes for Denied Days only; Nurses Progress Notes for Denied Days only; Social Worker Notes if pertinent (Administrative Days Denied); and Aftercare and Discharge Summary.
3. Submit documentation by FedEx to:

**Department of Health Care Services
Mental Health Services Division
1500 Capitol Avenue Suite 72. 442 MS 2703
Sacramento, CA 95814
(916) 324-9125**

Notice to LMHP of Provider Second Level Appeal from DHCS for Timeline

Submit to DHCS the following:

Cover letter from LMHP including the date the LMHP received the Appeal Notification from DHCS, Beneficiary's name, facility name and Admission Date. The enclosed documentation includes: Initial TAR, including date of FAX to the Provider; Provider Appeal Letter, First-Level Appeal decision letter, and AVATAR/Reviewer notes regarding timelines, including AVATAR Administrative Summary notes from First-Level Appeal.

Submit documentation via FedEx to:

**Department of Health Care Services
Mental Health Services Division
1500 Capitol Avenue, Suite 72. 442 MS 2703
Sacramento, CA 95814
(916) 324-9125**

Notices to LMHP from DHCS on Decisions Regarding Second-Level Appeals

Upheld Decisions to LMHP:

- Receive the Decision Letter from DHCS notifying the Medical Director and the TAR Second Level Appeal Unit of the DHCS findings on the Provider's Appeal.
- LMHP will not communicate any information to the Provider regarding Second Level Appeal decision. DHCS will notify the Provider directly of its decision.
- Enter the Upheld Decision in the Second Level Appeal Log, and input the decision in the AVATAR system and complete the AVATAR Summary of the findings.

Reverse and Split (Partially Approved and Partially Denied Days) Decisions:

- Receive the Decision Letter with Provider Instructions from DHCS notifying the Medical Director and the TAR Unit, Second Level Appeal Section, of DHCS decision on the Provider's Appeal.
- Enter the Reverse and Split Decision in the Second-Level Appeal Log, and input the decision in the STAR System and complete a STAR Summary of the findings.
- File the DHCS Decision Letter in Provider's Appeal file until the LMHP receives a Second Level Appeal TAR from the Provider as indicated in the DHCS instructions to the Provider. A Second Level Appeal TAR (form 18-3) must be submitted with admission and discharge dates completed by the Provider and must include the days that are reversed and requested for payment.
- Write "Approved as Requested" on the TAR (form 18-3) by the TAR staff for both Reverse Decisions and Split Decisions. Use lower left corner of the TAR (referred to as the County section.)
- Write "# days approved at Second Letter Appeal" for Reversed Decisions.
- Write "# days approved at Second Level Appeal," "# days remain denied" for Split Decisions.
- Deliver the above TAR, DHCS Decision Letter and DHCS Instructions to TAR administrative support staff for further processing.

Submit to Fiscal Intermediary and Provider Completed Second Level Reverse/Split Documents

- Fax within 14 calendar days the Completed Second-Level appealed TAR w/ cover letter to the Provider.
- FedEx within 14 calendar days the Completed Second-Level appealed TAR and TAR Run Report to Fiscal Intermediary.
- File original documents with TAR Records staff.

Process State Invoices After Second-Level Appeal Charges on Reversed Days

- Forward DHCS Invoices and a copy of the DHCS Decision Letter to the Office of the Medical Director, Administrative Services, for further processing.

AUTHORITY:

Welfare & Institutions Code Section 14680 and California Code of Regulations, Title 9, Section 1850.305,

SECTION: IX

COMPLIANCE

COMPLIANCE

Inpatient Treatment Authorization Requests (TARs) submitted for Medi-Cal payment authorization must be in compliance with State regulatory timelines. TARs not meeting State timelines will be denied authorization for hospital payment.

Providers must complete the TAR (form 18-3) accurately in order to be processed for reimbursement authorization.

TARs with errors submitted beyond the State timelines will be denied payment.

- Incomplete TARs that need provider correction will be returned as Non Compliance Denial. Providers are notified about these denials and responsible for making the corrections.
- **Return the corrected TAR to the TAR Unit within 7 business days**

Inappropriate Submission of TAR

The following TARS will be returned to the provider:

- a. Medi-Cal eligibility not with LA County.
- b. The following examples of TAR errors will be returned for provider correction:
 - Missing physician or provider signature
 - Discrepancy between the service dates and the number of days requested
 - Incomplete or incorrect information in the TAR fields/boxes
 - Information on TAR does not match IBHIS/AVATAR

Note: All correspondence from the TAR Unit to inpatient providers will be sent to the providers' designated Single Point of Contact (SPOC).

CLAIMS OVER ONE-YEAR-OLD

Per: UB-92 Submission and Timeliness Instruction – Page 2

The fiscal intermediary (Conduent) reviews all original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient's eligibility, reversal of decisions on appealed TARs, Medicare/other health coverage delays or other circumstances beyond the provider's control. Claims submitted more than 12 months from the month of service must always use late billing code "X8".

These claims must be submitted to the following special address:

**Conduent Over-one-year Claims Unit
P.O. Box 13029
Sacramento, CA 95813-4029**

Note: When appropriate, the LACDMH TAR Unit will validate circumstances resulting in late claims.

SECTION: X

INQUIRY, TUT, AND RESUBMIT

INQUIRY, TUT AND RESUBMIT

All requests regarding TARs, including inquiries, resubmissions or TAR Update Transmittal (TUTs), must be submitted in writing and mailed or faxed to the TAR Unit Inquiry Desk. Always include a copy of the TAR(s) in question.

Send to the Inquiry, Correction and Resubmit desk any of the following requests:

- Status of a TAR
- Requests for a TUT. TUTs are used to correct errors on TARs already on the Conduent Master File.
- Requests for resubmission of a TAR to Conduent.

Requests must be as follows:

- Written on hospital letterhead
- Submitted by the Single Point of Contact (SPOC)
- Include the patient's name, dates of service and the 6-digit TAR number.
- **Attach a copy of the TAR in question.**

When requesting a TUT to correct for errors on the Conduent TAR Master File, clearly state the correction to be made and include the *box number* on the TAR (e.g. "Correct box # 24 from 12-3-01 to 12-3-00" or "Correct the spelling of beneficiary's name and provide the correct spelling of the name").

A response from LACDMH TAR Unit can be expected within four weeks of receipt.

MAIL TO: Treatment Authorization Unit
Attention: TAR Inquiry, Correction and Resubmit Desk
Los Angeles County Department of Mental Health
550 South Vermont Ave., 7th Floor
Los Angeles, CA 90020

FAX TO: Treatment Authorization Unit
Attention: TAR Inquiry, Correction and Resubmit Desk
(213) 739-0128, 487-7483 or 427-6164
Phone number: (213) 739-7303

All requests for a TUT or a Resubmit of a TAR must be submitted to Conduent by the Local Mental Health Plan (LMHP). Documents are sent to Conduent via FedEx and copies of these documents are faxed to the provider.

SECTION: XI

MEDICAL NECESSITY

**MEDICAL NECESSITY CRITERIA DERIVED FROM
TITLE 9, CALIFORNIA CODE OF REGULATIONS, CHAPTER 11,
SECTION 1820.205**

Medical Necessity Criteria for Reimbursement of Acute Psychiatric Inpatient Hospital Services Including Psychiatric Services Provided at Institutions of Mental Diseases

- (a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services including inpatient psychiatric services at Institutions of Mental Diseases (IMDs), the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

- (a) One of the following “Inpatient ‘included’ ICD-10-CM Diagnoses” These updates correspond to the Department of Health Care Services (DHCS) Information Notice 18-053 as well as diagnosis code changes made by the Centers for Medicare and Medicaid Services (CMS) effective October 1, 2018 through September 30, 2019. Subsequent updates regarding included diagnoses will be published through a Provider Alert.

Removed Diagnoses:

F10.288	Alcohol Dependence with other Alcohol-Induced Disorder
F11.188	Opioid-Induced Anxiety Disorder with Opioid Use Disorder, Mild
F11.288	Opioid-Induced Anxiety Disorder with Opioid Use Disorder, Moderate or Severe
F18.188	Inhalant Abuse with other Inhalant-Induced Disorder
F18.288	Inhalant Dependence with other Inhalant-Induced Disorder
F18.988	Inhalant Use, Unspecified, with other Inhalant-Induced Disorder
F19.19	Other Psychoactive Substance Abuse with Unspecified Psychoactive Substance-Induced Disorder
F19.982	Other (or Unknown) Stimulant-Induced Sleep Disorder without other (or Unknown) Substance Use Disorder
F50.8	Other Eating Disorders
F53	(Deleted CMS Code: see F53.1)
F63.9	(Deleted CMS Code: see F63.89)

Added Diagnoses:

F18.180	Inhalant Abuse with Inhalant-Induced Anxiety Disorder
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F18.280	Inhalant Dependence with Inhalant-Induced Anxiety Disorder
F18.94	Inhalant Use, Unspecified, with Inhalant-Induced Mood Disorder
F18.980	Inhalant Use, Unspecified, with Inhalant-Induced Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.2	Dissociative Stupor
F44.89	Other Dissociative and Conversion Disorders
F45.20	Hypochondriacal Disorder, Unspecified
F45.29	Other Hypochondriacal Disorders
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F50.89	Other Specified Eating Disorder
F53.0	Postpartum Depression (New CMS Code)
F53.1	Puerperal Psychosis (New CMS Code)
F63.89	Impulse Disorder, Unspecified
F84.2	Rett's Syndrome
F95.0	Transient Tic Disorder

Diagnoses with new diagnosis descriptions:

F15.250	Other Stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F30.13	Manic episode, without psychotic symptoms
F41.0	Panic disorder (Episodic Paroxysmal Anxiety)

(b) A beneficiary must have both (A) and (B) below:

- A. Cannot be safely treated at a lower level of care; and
- B. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:
 - 1. Has symptoms or behaviors due to a mental disorder that (one of the following):
 - a. Represent a current danger to self or others, or significant property destruction.
 - b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
 - c. Present a severe risk to the beneficiary's physical health.

- d. Represent a recent, significant deterioration in ability to function.
2. Require admission for one of the following:
 - a. Further psychiatric evaluation.
 - b. Medication treatment.
 - c. Other treatment that can reasonably be provided only if the patient is hospitalized.

CONTINUED STAY SERVICES

“Continued Stay Services” means psychiatric inpatient hospital services for beneficiaries that occur after admission (CCR, § 1820.200 (b)).

DOCUMENTATION CRITERIA FOR CONTINUED STAY CCR, TITLE 9, §1820.205(b)

Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:

- (1) Continued presence of indications that meet the medical necessity criteria as specified in (a).
- (2) Serious adverse reaction to medication, procedures, or therapies requiring continued hospitalization.
- (3) Presence of new indications that meet medical necessity criteria specified in (a).
- (4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

CONTINUED STAY TARS

1. The maximum number of days that can be requested on a TAR is 99 days. When the days in an episode reach more than 99 days, a second TAR must be submitted.
 - a. On subsequent TARs beyond 99 days, specify the dates that are being requested in the TAR section “Describe current condition requiring hospitalization.” On the same TAR section, describe the circumstances of the continuous stay by writing the description of the current condition as well as explanation of extenuating circumstances regarding the need for the continuing stay.
 - b. On the days requested, indicate if the specified dates are Administrative Days or Acute Days
2. When multiple TARS are submitted, number the TARs (e.g. 1 of 3, etc.) the space to the right of the TAR form, next to the heading “Confidential Patient Information.”
3. At the top of each TAR, indicate which days are being submitted as “Continuous Stay Days”.

Examples of Continuing Stay TARs:

Continuing Stay Part 1-Day 1 Through 99

Continuing Stay Part 2-Day 100 through 198

Continuing Stay Part 3-Day 199 through 297

Continuing Stay Part 4-Day 298 through 396

Note: The Admission and Discharge Dates will be the same for all TARs in the same episode. Discharge date is NOT included in the requested days.

DIAGNOSIS USING DSM-5

The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. All Health Insurance Portability and Accountability Act (HIPAA) – covered entities must implement ICD-10-CM on October 1, 2015 (<http://www.cms.gov/Medicare/Coding/icd10/>).

All providers must utilize the criteria found in DSM-5 to formulate the diagnosis and make determinations of medical necessity for specialty mental health services (SMHS). Once the diagnosis is formulated using the criteria found in DSM-5, a corresponding International Classification of Diseases (ICD-10-CM) code should be selected. DSM-5 provides a suggested ICD-10 code for each diagnosis. So long as the criteria from DSM-5 were used to formulate the diagnosis, a different ICD-10-CM code (from the one found in DSM-5) may be used. At times, there may be an ICD-10-CM code that provides greater specificity than the ICD-10-CM code found in DSM-5.

Note: The list of included diagnoses for SMHS medical necessity is provided in terms of ICD-10-CM codes. The shift to DSM-5 does not change the included diagnoses required to meet medical necessity criteria.

See the official State DHCS list of included diagnosis for inpatient services at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/InfoNotice18-053Enclosure>

State Medi-Cal Policy Statement 1-89 issued April 12, 1994 regarding required daily documentation of inpatient hospital psychiatrists

Medi-Cal statutes and regulations give the Department of Health Care Services (DHCS) authority to examine medical records to assure the level of care requested for reimbursement is substantiated. A patient undergoing acute care is expected to need the supervision of a physician each day she/he is hospitalized.

The Medi-Cal program policy regarding coverage of inpatient services is to require documentation of the medical necessity for acute level of care for each 24-hour day authorized. By definition, acute hospital services, including specific physician services, function 24 hours per day, 7 days per week, in order to meet the medical needs of the patients. Physician observation of the patient's status, along with the physician's intervention based on this observation, analysis of the medical record documentation, and interaction with the rest of the health care team is essential in order that appropriate and necessary care will be provided to the patient and to assure the earliest appropriate discharge. This does not mean that the attending physician must visit the patient every day, but when he/she is not available, it is reasonable to assume that a house staff physician, a consultant, or one covering the attending physician's service will assess the acuteness of the patient's status and document his/her assessment.

The question of the need for acute hospitalization on a day when the patient's psychiatrist elects not to see the patient is multi-factorial. It should be noted that authorization for reimbursement is not based solely on the physician's visit. The patient's symptoms are also taken into consideration, as well as any interventions rendered that would necessitate an acute level of care. For mental illness cases where the hospital bylaws permit an attending psychologist, his/her daily visits with documentation of the patient's condition are acceptable to assist in determination of medical necessity of acute care. Visits by any other non-physician practitioners with staff privileges should be documented as well.

SECTION: XII

ADMINISTRATIVE DAY DOCUMENTATION REQUIREMENTS

ADMINISTRATIVE DAY

“Administrative Day Services” means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary’s stay at the hospital must be continued beyond the beneficiary’s need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

GENERAL GUIDELINES

- Request for payment authorization for administrative day services shall be approved by Los Angeles County TAR Unit (TAR Unit) staff when the following conditions are met in addition to requirements for timelines of notification and any mandatory requirements of the contract negotiated between the hospital and the County:
 - (A) During the hospital stay, a beneficiary has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.
 - (B) There is no appropriate, non-acute residential treatment facility in a reasonable geographic area.
 - (C) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage.
 - a) **Note:** (a) Interrupted psychiatric inpatient stay, such as a temporary transfer to another facility or hospital department for treatment of a medical condition and upon return, also meets the administrative day criteria if the psychiatric inpatient stay includes an approved acute day.
 - b) While on administrative day status, a beneficiary’s condition changes to an acute level of care, a modification of the level of care is required. A beneficiary’s stay in the hospital may continue under an administrative day status if after the acute phase, a need for appropriate placement option continues to be established.

- **Administrative Day Documentation Requirements**

Label the medical record entry to identify it as a note documenting discharge planning and/or placement activity (e.g. “Discharge Planning, “Social Services,” Administrative Day”). For discharge planning purposes, the reason why administrative days are being sought must be documented in the medical record.

The hospital shall document contacts with a minimum of five appropriate, non-acute residential treatment facilities per week. The requirement of five contacts per week may be waived if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week. A statement (LMHP waiver) explaining the reason why there are fewer than five appropriate non-acute residential treatment facilities shall be included in the weekly documentation.

Note: There shall be at least one administrative day telephone contact to an appropriate lower level of care treatment facility on the first day that administrative day is ordered.

Contact requirements shall be documented to include but not limited to:

- a. Date of the contact.
- b. Name of the person and facility contacted.
- c. Facility response regarding availability of beds (status).
- d. Signature of the person making the contact.
- e. For IMD placement status prior to CRM (Countywide Resource management) placement approval, date of the contact (on a weekly basis), name of CRM staff contacted, number of client on the waiting list status and the signature of the person making the contact must be included in the documentation.

Note: For the hospital's documentation of the facility's response to bed availability, statements such as "pending", "received fax", "reviewing packets", "contacting Public Guardian" are not acceptable. There must be a follow-up documentation of the outcome of the facility's review of the packet within the identified week or 7-day period. The "week" starts on the date that administrative days was ordered.

Documentation requirements for Administrative Days using the Countywide Resource Management Program (State Waiver)

- The Los Angeles County Department of Mental Health (LAC DMH) Countywide Resource Management (CRM), informally referred to as the "Gatekeeper Program" functions as bed control for Institutions of Mental Disease and sub-acute mental health facilities. LAC DMH was granted an exemption by the State of California Department of Mental Health from the requirements under CCR, Title 9, Chapter 11, Section 1820.220(j)(B)(5)(A)(B) if the hospital refers the beneficiary for consideration under the discharge process administered by the CRM and the CRM accepts the beneficiary for placement consideration under the process. In addition to the contact documentation requirements identified below, the hospital discharge planner shall follow the following procedures when referring beneficiaries to the CRM:

1. Documentation in the medical record by the hospital staff of the hospital's referral to the CRM that is initiated within twenty-four hours of an administrative day order identifying the need of a long-term care facility.
2. Submission of any information on the beneficiary's status to the CRM by the hospital.
3. An evaluation of the beneficiary by the CRM that will assign the beneficiary to the CRM waiting list if admission criteria are met or notify the hospital that assignment to the waiting list has been denied.
4. For beneficiaries who are assigned CRM waiting list status, documentation by the hospital in the beneficiary's medical record of the results of the hospital's weekly contacts with the CRM that include information on bed availability and waiting list status as reported to the hospital by the CRM, name of the person contacted and signature of the hospital staff making the contact.
5. When the beneficiary is at the top of the waiting list, notification by the CRM to the hospital that placement has been authorized and the facilities to which the hospital may refer the beneficiary. The hospital staff shall continue to contact the identified facilities a minimum of every seven calendar days until the patient is accepted to the facility and discharged.
6. Reasonable promptness by the hospital in discharging the beneficiary to the facility that will be accepting the beneficiary.

Consistent with the exemption stated above, when the CRM determines that the beneficiary referred by the hospital does not meet CRM admission criteria, the TAR Unit shall:

Approve the hospital's TAR for administrative days from the date of the administrative day order that placement in an appropriate non-acute residential treatment facility was medically necessary for the beneficiary through the date that the CRM notified the hospital that the beneficiary did not meet the criteria for admission to the CRM. The approval is contingent upon the presence of the required weekly documentation. It shall be noted that the hospital follows the requirement that a referral be made to the CRM within twenty-four hours of the administrative day order.

After the date of the denial notification, the TAR Unit staff shall require that the hospital comply with the provisions of CCR, Title 9, Chapter 11, Section 1820.220(j)(B)(5)(A)(B)1.2.a.b.c. as a condition of continued authorization of administrative days.

Administrative Day Restriction

- 1) Before any administrative day can be authorized, there must be at least one approved acute day. (See general guidelines above)
- 2) Medi-Cal Fee-For-Service hospitals – For a Regional Center beneficiary, there is a limit of 4 administrative days per episode.
- 3) Los Angeles County Department of Health Project – limit 5 administrative days per hospital stay.

- 4) Only board and care facilities offering an array of treatment modalities provided by their own staff can be considered as placement option billable to SD/MC administrative day services. These augmented board and care facilities fall under the category of Community Residential Treatment System (CRTS) and provide rehabilitative specialty mental health services.

Administrative Days for Regional Center Beneficiaries

- Pursuant to a Memorandum of Understanding (MOU) between the State's Local Mental Health Plan (LMHP) and six (6) Regional Centers (Lanterman, Westside, South Central, San Gabriel, North Los Angeles, and East Los Angeles) located within Los Angeles County, the LMHP will be financially responsible only for the acute psychiatric inpatient days approved and the first four (4) approved administrative days for each acute psychiatric inpatient episode.
- The respective Regional Center will be financially responsible for all subsequent administrative days for their beneficiaries. Upon admission of a Regional Center Medi-Cal beneficiary to inpatient psychiatric services, the hospital is required to contact the appropriate local Regional Center to begin placement efforts and to obtain a written pre-authorization for any prospective reimbursement for administrative days.
- The Regional Center pre-authorization applies only to payment for administrative days in excess of the first four (4) approved days covered by the MOU.
- The hospital will also submit a written reimbursement claim/bill for administrative days to the respective Regional Center starting with day five (5).
- The TAR Unit will not authorize reimbursement for any administrative days when the beneficiary is a client of Los Angeles County Harbor Regional Center. This center elected not to be a party to the MOU and subsequent Addendums.

SECTION XIII

ASSESSMENT and BENEFICIARY TREATMENT PLAN

Assessment

Pursuant to the Code of Federal Regulations (CFR), Title 42, Chapter IV, Subchapter C, Part 456, Subpart D; §456.170; and the Contract between the State Department of Health Care Services, the Los Angeles County Department of Mental Health (LACDMH) has established required components of an assessment. LACDMH TAR Unit, acting as the Point of Authorization (POA) shall review the beneficiary's medical record for presence of an Initial Psychiatric Evaluation. POA shall apply all rules and regulations pertaining to initial assessment requirements.

CFR, §456.170 specifies that "before admission to a mental hospital, or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or beneficiary's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation".

Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures. The completion of an Assessment establishes the foundation for an included diagnosis and impairments in life functioning. It further documents needs, barriers and strengths which are helpful in the formulation of a treatment plan

Initial Assessment Requirements:

1. Assessor Information (name, discipline);
2. Identifying information and special service needs
 - a. Beneficiary name
 - b. Date of birth
 - c. Gender
 - d. Ethnicity
 - e. Preferred language
 - f. Other relevant information
3. For children, biological parents, caregivers and contact information;
 - a. Names
 - b. Contact information (phone or address)
 - c. Other relevant information
4. Presenting problem(s): beneficiary's chief complaint, history of presenting problem(s), including current functioning level, relevant family history and current family information;
 - a. Precipitating event/reason for admission
 - b. Current symptoms/behaviors including intensity, duration, onset and frequency
 - c. Impairments in life functioning

5. Beneficiary strengths: documentation of beneficiary's strengths in achieving client plan goals;
6. Mental Health History: previous treatment, including providers, therapeutic modality, (e.g. medications, psychosocial treatments) and response, inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
 - a. Psychiatric hospitalizations including dates, locations and reasons
 - b. Outpatient Treatment including dates, locations and reasons
 - c. Response to treatment, recommendations, satisfaction with treatment
 - d. Past suicidal/homicidal thoughts/attempts
 - e. Other relevant information
7. Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;
Examples of risks include (DHCS Information Notice No.:17-040)
 - a. History of Danger to Self (DTS), or Danger to Others (DTO)
 - b. Previous inpatient hospitalizations for DTS, DTO
 - c. Prior suicide attempts
 - d. Lack of family or other support systems;
 - e. Arrest history, if any;
 - f. Probation status;
 - g. History of alcohol/drug abuse;
 - h. History or trauma or victimization;
 - i. History of self-harm behaviors (e.g, cutting);
 - j. History of assaultive behavior;
 - k. Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others; and
 - l. Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality
8. Medications: Information about medications that the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. Documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of informed consent for medications;
 - a. Medication
 - b. Dosage/frequency
 - c. Period taken
 - d. Effectiveness, response, side effect, reactions
 - e. Other relevant information
9. Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
10. Medical History: (relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: include prenatal and perinatal

- events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- a. Doctor's name and contact information
 - b. Allergies
 - c. Relevant medical information
 - d. Developmental history (for children)
 - e. Developmental milestones and environmental stressors (for children)
11. Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history or trauma or exposure to trauma;
- a. Education/school history, status, aspirations
 - b. Employment history/Vocational information including means of financial support (for adults)
 - c. Legal/Juvenile court history and current status
 - d. Child abuse/protective service information (for children)
 - e. Dependent Care Issues (for adults)
 - f. Current and past relevant living situations including social supports
 - g. Family History/Relationships
 - h. Family Strengths (for children)
 - i. Other relevant information
12. Mental Status Examinations;
- a. Mental Status examination
13. Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data;
14. A diagnostic descriptor consistent with the clinical information
- a. Diagnostic descriptor
15. Most current ICD code set documentation consistent with the diagnostic descriptor;
- a. ICD Diagnostic Code
 - b. Specialty Mental Health Services Medical Necessity Criteria
16. Staff name and signature of the person performing a Psychiatric Diagnostic Assessment (staff person must practice within the scope of licensure).

Beneficiary Plan of Care (Treatment Plan)

An individual plan of care or treatment plan must be in place: a) before admission to a mental hospital or before authorization for payment. Attending physician or staff physician must establish the treatment plan for each applicant or beneficiary.

Required components of a Plan of Care:

1. Diagnosis, symptoms, complaints and complications indicating the need for admission;
2. Description of the beneficiary's functional level;

3. Specific, observable and/or specific, quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of a qualifying mental health diagnosis;
4. Descriptions of the types of interventions/modalities with a detailed descriptions of the proposed interventions (consistent with the qualifying diagnosis and includes the frequency and duration of each intervention);
5. Any orders for:
 - a) Medication
 - b) Treatments
 - c) Restorative and rehabilitative services
 - d) Activities
 - e) Therapies
 - f) Social services
 - g) Diet
 - h) Special procedures recommended for the health and safety of the beneficiary
6. Plans for continuing care, including review and modification of the treatment plan;
7. Discharge plans;
8. Documentation of beneficiary's degree of participation in and agreement with the plan. (Client's signature or statement describing client participation. If beneficiary refused or unavailable to sign, document explanation of refusal or unavailability); and
9. Physician signature and date on the written treatment plan indicates their establishment of the plan.

SECTION: XIV

NOTICE OF ACTION FOR ACUTE INPATIENT PSYCHIATRIC SERVICES (NOA-C)

Pursuant to the *Welfare & Institutions Code §14680 through § 14726* the Los Angeles County Department of Mental Health (LACDMH) functioning as the Local Mental Health Plan (LMHP), administers policies and procedures for the timely execution of provider and beneficiary grievances and appeals. The LMHP shall provide a beneficiary of the LMHP with a Notice of Action. A Notice of Action (NOA-C) is required when the LMHP denies or modifies a payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the LMHP that the service was not medically necessary or otherwise was not a service covered by the LMHP.

Processing the NOA-C through the Treatment Authorization Unit:

TAR Reviewers complete the retrospective review of medical records to determine medical necessity for admission and continued stay at a FFS inpatient acute psychiatric hospital, and complete the TAR with decision to approve or deny some or all days.

TAR Reviewers confirm that TARs received from FFS providers are signed and dated by a licensed Psychiatrist or Psychologists who has admitting privileges. Signed TARs with denied days are processed by the administrative support staff responsible for initiating and completing NOA-C decisions as soon as reasonably possible.

TAR Administrative Support staff provides data entry of the TAR into the payment authorization system process.

TAR Administrative Support is responsible for distribution of the NOA-C in the following manner: NOA-C is mailed to the Medi-Cal beneficiary with a postmarked certified notice, including a Return Receipt Requested. NOA-C is hand delivered to Patient's Rights Office located at LAC-DMH Headquarters. NOA-C is faxed to the Hospital/Provider Single Point of Contact (SPOC). NOA-C copy is maintained in the beneficiary's medical record at the LMHP, Treatment Authorization Unit, Appeals Section.

**Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Post-Service Denial of Payment)**

To _____, Medi-Cal Number _____

The mental health plan for Los Angeles County has denied changed your Provider's request for payment on the following service(s).

The request was made by: (Provider name) _____

The original request from your Provider was dated _____ and your Provider says that you received service on the following date or dates: _____

THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.

The mental health plan took action based on information from your Provider for the reason(s) checked below:

- Your mental health condition as described to us by your Provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205)
- Your mental health condition as described to us by your Provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205):

- The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- The mental health plan requested additional information from your Provider that the plan needs to approve payment of the service you received. To date, the information has not been received.
- Other

If you don't agree with the plan's decision, you may:

File an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (213) 738-4949 or write to: Patients' Rights Office, Los Angeles County, Department of Mental Health, 550 S. Vermont Ave., Los Angeles, CA 90020 or follow the directions in the information brochure the mental health plan has given to you. You must file an appeal within 90 days of the date of this notice.

If you are unhappy with the outcome of your appeal, you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your Provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.

NOA-C Post-Service (revised 6-1-05)

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days starts:

- 1. The day we personally gave you this notice, **OR**
- 2. The day after the postmark date of this notice, **OR**
- 3. If you have filed a grievance, 90 days after the postmark date of a decision denying your grievance.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date this notice was mailed or personally given to you or before the effective date of the change, whichever is later.
- Your Medi-Cal mental health services will stay the same until your hearing or until your provider says you no longer need the services, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the public Inquiry and Response Unit.

Call toll free: 1-800-952-5253
 If you are deaf and use TDD, call 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney, or anyone else you choose. You must arrange for this representative yourself.

Grievance

You may also ask about your hearing rights and your rights to file a grievance with the mental health plan at the number on the front side of the form. If you file a grievance with the mental health plan and are unhappy with the result of the grievance, you will have 90 days to request a state hearing. The 90 days begins after the date the mental health plan sends you its decision on the grievance.

Information Practices Act Notice (California Civil Code Section 1798, et.seq.) The information you are asked to write on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Department of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send this page to:

State Hearings Division
 California Department of Social Services
 P.O. Box 944243, Mail Station 19-37
 Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of _____ County.

Here's why: _____

Check here and add a page if you need more space.

My Name (print): _____
 My Social Security Number: _____
 My Address (print): _____

 My Phone Number: (____) _____
 My Signature: _____
 Date: _____

I need an interpreter at no cost to me. My language or dialect is _____

I want the named person below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____
 Address: _____

 Phone Number: _____

SECTION: XV

RESOURCE INFORMATION

Contact Information

ACCESS Center telephone number (800) 854-7771 is for public information regarding mental health services throughout Los Angeles County. ACCESS is available 24 hours 7-days, including holidays, and is capable of answering calls in languages such as English, Spanish, Mandarin (Chinese), and other languages available from translators.

- Conduent DHCS Fiscal Intermediary

820 Stillwater
West Sacramento, CA 95605-1630
Telephone No. (916) 375-3737
To request TAR Form 18-3: (800) 541-5555

- Los Angeles County Department of Mental Health Contract Development and Administration Division (CDAD):

Chief, CDAD
550 S. Vermont Avenue, 5th Floor
Los Angeles, California 90020
Telephone No. (213) 738-4684

- Treatment Authorization Unit:

550 S. Vermont Avenue, Room 701
Los Angeles, California 90020
Telephone No. (213) 739-7300
Fax No. (213) 487-7483 or (213) 427-6164
Email: TAR Unit@dmh.lacounty.gov

- LACDMH TAR Inquiry, Correction and Re-submit desk:

Telephone No. (213) 739-7303
Fax No. (213) 487-9658

1st Level TAR Appeals:

- 1st Level Appeal Section of the TAR Unit
550 S. Vermont Avenue, Room 701
Los Angeles, CA 90020
Telephone No. (213) 739-7300 or (213) 639-6344
Fax No. (213) 487-7483 or (213) 427-6164

2nd Level TAR Appeals

- State of California
Department of Health Care Services
Mental health Services Division
1500 Capitol Avenue, Suite 72-442 MS 2703
Sacramento, CA 95814
Telephone No. (916) 324-9125

SECTION: XVI

PROVIDER SITE REVIEW

PROVIDER SITE REVIEW

All hospitals shall comply with Federal requirements for utilization control pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D. These requirements include certification of need for care, evaluation and medical review, plans of care and utilization review plan. Each hospital shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care and to identify problems with quality of care. Composition of the committee shall meet the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D, §456.150 through §456.245.

In accordance with oversight authority contained in the Los Angeles County Department of Mental Health Service Agreement Contract Allowable Rate Fee-for-Service (FFS) Medi-Cal Acute Psychiatric Inpatient Hospital Services, the Intensive Care Division, Compliance Unit schedules provider reviews once every three years or more often when egregious issues are identified through TAR reviews and outcome of the system review. Findings that are not in compliance with the established rules and regulations will require a Plan of Correction from the provider.

The four major areas of review consist of the following areas:

- 1) Utilization Review including Utilization Review Plan and Medical Care Evaluation Studies;
- 2) System review consisting of review of Policies and Procedures and their practical applications;
- 3) Chart review to ensure that Policies and Procedures and Contract provisions are being followed particularly in the areas of treatment planning, discharge planning and service referrals; and
- 4) Beneficiary interviews to ensure that the providers are complying with applicable laws and regulations relating to patient's rights.

SECTION: XVII

REPORTING ADVERSE OUTCOMES

REPORTING ADVERSE OUTCOMES

All contracted providers must report adverse outcomes to the LACDMH. Such adverse outcomes include any event which threatens or causes actual damage to the health, welfare and/or safety of beneficiaries, staff or the community, including but not limited to, the following:

- Death (unknown cause, suspected or known medical cause or suspected or known suicide;
- Suicide attempt requiring emergency medical treatment;
- Client sustained intentional injury requiring emergency medical treatment;
- Injury to others caused by a client and requiring emergency medical treatment;
- Homicide by a client;
- Alleged client abuse;
- Adverse medication events including medication errors; and
- Possible malpractice.

Upon determining that an adverse outcome has occurred, inpatient contractors must submit an Adverse Outcome Report to the Lanterman Petris Short (LPS) Designation Coordinator, and include the incident(s) in the **MONTHLY DATA REPORT FOR LAC DMH LPS DESIGNATION**.

Reporting of adverse outcomes must be called in immediately to the LPS Designation Coordinator at **(213) 639-6315** during normal business hours, or the ACCESS Center at (800) 854-7771 after hours.

ALL Adverse Outcome Reports should be sent within 72 hours of the occurrence of an adverse outcome to:

Office of the Medical Director, Clinical Operations
County of Los Angeles Department of Mental Health
550 South Vermont Avenue, 12th Floor
Los Angeles, CA 90020

FAX, as well as send within **24 hours** of the adverse outcome, all Adverse Outcome reports containing time-sensitive information to:

Office of the Medical Director, Clinical Operations
FAX (213) 738-4646

Before the Adverse Outcome Report is faxed, a telephone call shall be made to the Office of the Medical Director notifying the secretary that the material will be transmitted.

Questions regarding mental health inpatient adverse outcome issues should be directed to the LACDMH LPS Designation Coordinator, 10th floor by telephone at (213) 639-6315 or email at mczubiak@dmh.lacounty.gov.

SECTION: XVIII
Integrated
Behavioral Health
Information System
(IBHIS) / DATA
COLLECTION &
REPORTING
SYSTEM
REQUIREMENTS

DATA COLLECTION & REPORTING REQUIREMENTS

The collection of beneficiary and service utilization data by Medi-Cal Fee-For-Service (FFS) network providers is a mandatory requirement of the LACDMH contract. Federal Center for Medicare and Medicaid Services, State of California (*Departments of Health Services and Mental Health*), and County (*Department of Mental Health*) all mandate reporting of beneficiary-based information regarding the individuals served by county mental health plans.

All Medi-Cal FFS network providers are required to collect beneficiary-based information and report this data to the *County of Los Angeles Department of Mental Health Local Mental Health Plan (LMHP)* when:

- ◆ Registering a beneficiary
- ◆ Submitting claims

Beneficiary-based registration data will be entered into the *LACDMH's Data Collection and Reporting system* via the ProviderConnect system (an application that interfaces with IBHIS) pursuant to all applicable requirements and procedures.

LACDMH is currently communicating ProviderConnect related issues such as system events, system outages, or policy and procedure changes to its providers via an email from Provider Relations Unit (email address FFS2@dmh.lacounty.gov). In order to receive such announcements, you must ensure that your email information is updated. If you need to update (add/remove) any contact information please complete the Contractor Address Form that can be located via the following link http://lacdmh.lacounty.gov/hipaa/documents/ATTACHMENTX-ContractorAddressForm2018-10-04NG_Rev20181106.pdf.

LACDMH Managed Care Fee-For Service End User Manual (training material for ProviderConnect)

LACDMH Managed Care Fee-For Service End User Manual is available and attached at the end of the Provider Manual or via the following link:
<https://dmh.lacounty.gov/for-providers/administrative-tools/provider-manualsdirectories/>

The link to the ProviderConnect is: <https://lapconn.netsmartcloud.com/la>

SECTION: XIX

DEFINITIONS, ABBREVIATIONS AND PROGRAM TERMS

GLOSSARY OF TERMS

- **Acute Psychiatric Inpatient Hospital Services:** Services provided by a hospital to beneficiaries for whom the facilities, service and equipment are medically necessary for diagnosis or treatment of a mental disorder.
- **Administrative Day Services:** Psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient services and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.
- **Assessment:** Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
- **Beneficiary:** The person receiving services; synonymous with consumer, or patient.
- **Chief Information Officer Bureau (CIOB):** The Los Angeles County Department of Mental Health's bureau responsible for maintaining automated data collection and reporting system, i.e., the LACDMH Data Collection and Reporting System.
- **Client Identification Number (CIN):** Medi-Cal beneficiaries are assigned the client identification number by the Department of Public Social Services (DPSS).
- **Conduent TAR Master File:** Electronic data file maintained by SDHCS fiscal intermediary recording all relevant TAR information, e.g., beneficiary identification, dates of service, number of days approved for reimbursement, etc.
- **Emergency Psychiatric Condition:** A condition that meets the criteria in CCR, Title 9, Chapter 11, Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.
- **Fee-for-Service/Medi-Cal Hospital:** "Fee-for-Service/Medi-Cal Hospital" means a hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through a fiscal intermediary.
- **Integrated Behavioral Health Information System; the LACDMH Data Collection and Reporting System,** are used interchangeably when referring to the

Los Angeles County Department of Mental Health's (LACDMH) computer system storing all client and program service information pertinent to all facets of its services and operations. All patient information stored into the LACDMH Data System and Reporting System must be in strict compliance with rules, procedures and protocols promulgated by the LACDMH's Chief Office of Information Bureau in order to protect patient confidentiality and in compliance with all Federal, State, County and professional regulations, rules, procedures and protocols.

- **Local Mental Health Plan (LMHP):** Agency designated by the State Department of Health Care Services (DHCS) responsible for implementation and management of the Medi-Cal Consolidation Program, e.g., Los Angeles County Department of Mental Health (LACDMH as the LMHP).
- **Medi-Cal Eligibility Data System (MEDS):** The data system maintained by the State DHCS that contains information on Medi-Cal eligibility including a beneficiary's county of responsibility.
- **Medicare:** A Federal Health Insurance Program for people who have attained the age of 65 or over, or have received SSD for two years or more.
- **NPI:** National Provider Identifier
- **Provider:** Hospital providing acute inpatient psychiatric services
- **Psychiatric Inpatient Hospital Services** means both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.
- **Conduent:** A fiscal intermediary which has contracted with the State Department of Health Care Services to perform services for the Medi-Cal Program pursuant to Section 14104.3 of the Welfare and Institutions Code.
- **Treatment Authorization Request (TAR):** A TAR is a State Form (18-3), each with a unique number, used statewide for authorization of inpatient psychiatric hospital days.
- **TAR Update Transmittal (TUT):** Form completed and submitted by the LMHP to correct information recorded on the Conduent TAR Master File.
- **Single Point of Contact (SPOC):** The person authorized by the provider to discuss or obtain any/all information concerning a specific TAR and/or Medi-Cal beneficiary.
- **Institution of Mental Diseases:** a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disorders, including medical attention, nursing care, and related services.

SECTION: XX

FREQUENTLY ASKED QUESTIONS

Q & A

- **Is the use of check boxes acceptable in progress notes and other documentation?**

Routine information can be captured by using check boxes; however, use of check boxes would not be adequate or descriptive enough to capture specific individualized information regarding the beneficiary's mental status, how the intervention reduced the impairments, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the treatment plan, and the beneficiary's response to the intervention. It is highly recommended that a narrative description of the beneficiary's behaviors be documented.

- **What are the biggest problems TAR Unit staff encounter when reviewing progress note entries for medical necessity?**

The most frequently encountered problems are unclear, vague and behaviorally non-specific documentation of a beneficiary's behaviors or mental health status. Providers should avoid using jargon and/or writing just the symptoms because they convey very little precise meaning.

In order to meet the criteria of **current** Danger to Self (DTS), Danger to Others (DTO), or Danger to Property (DTP), there must be documentation of suicidal, homicidal or property destruction ideation **together with either intent or a specific plan**. There are times that documentation only state, "SI but no plan or intent", "I feel safe here but if I will be discharged today, I would kill myself by overdosing on medication." Sometimes, a beneficiary expresses suicidal, homicidal ideation and intent which is purely conditional. In such a case, there should be an assessment of how the beneficiary would react or feel about being discharged to a residential treatment facility where s/he would have 24-hour access to staff. A beneficiary may fear being discharged to a place where s/he would not have adequate support and professional attention or may feel that s/he may not have access to food and shelter or the means to purchase them. If the assessment reveals that the beneficiary would feel safe in a residential treatment facility, then continued stay services would not be appropriate. In the case where there is no documentation of intent or plan for suicidal ideation, documentation shall include an assessment of the beneficiary's ability to execute or resist planning for suicide. When a beneficiary is admitted after a highly lethal suicide attempt, additional acute days maybe approved to determine if improvement is genuine. A history of suicide attempts may be taken into account if similar triggers from previous incidents are present in the current admission. However, when suicidal ideation with no plan is documented and there is no clarification whether the ideation is active or passive or no description of the content of the ideation, then medical necessity is not met.

When there is a conflicting documentation from different licensed disciplines, credibility and weight is towards documentation which is more behaviorally specific. In addition, issues arise when documentation for continued stay service days are actually those which were observed on the day of admission but which were repeated in documentation for subsequent hospital days by staff from one discipline, even though the documentation by other disciplines contradicts it. Medical necessity determinations are based upon an evaluation of the beneficiary's **current** symptoms and behaviors.

Beneficiary is unable to provide for or utilize food, clothing or shelter. The correct standard to apply when evaluating for this criterion is whether the beneficiary is able to utilize (rather than formulate/carry out a plan for obtaining) the food, clothing and shelter which is provided. The reason this is the correct standard is that in the step-down levels of care to which the beneficiary could be discharged, food, clothing and shelter are provided.

Another criterion which the TAR reviewers encounter a paucity of documentation is "the beneficiary has behaviors that represent a recent, significant deterioration in ability to function". Even if there is a "recent, significant deterioration in ability to function," when the beneficiary could be evaluated and treated at a lower level of care, admission and continued stay services may not be reimbursable. Documentation should include a description of the beneficiary's previous level of functioning as well as an explanation of why the beneficiary could not be safely and effectively treated at a lower level of care. If there is only a medical (as opposed to psychiatric) basis for the recent, significant deterioration in ability to function, the hospital stay would not be reimbursable.

- **Regarding Administrative days, if the first contact with a potential placement is documented on administrative day #3, may that contact be counted for administrative days #1 and #2?**

No. There must be at least one documented placement contact which meets all requirements on the first administrative day for which reimbursement is approved.

- **How does a hospital determine the "MHP of the Beneficiary" if the beneficiary has adopted a nomadic lifestyle or is conserved?**

Pursuant to CCR, Title 9, Chapter 11, Section 1850.405, the decision in determining the MHP of the beneficiary is based on the following criteria:

- (A) If a beneficiary has moved to a county or acts to establish residency in a county and has a clear intent to reside in the county, the MHP for that county shall be considered the MHP of the beneficiary.
- (B) If a beneficiary is a Lanterman-Petris-Short or Probate Conservatee, the MHP for the county in which the beneficiary is conserved shall be considered the MHP of the beneficiary.

- (C) If a beneficiary has been placed in legal custody by a county, the MHP for the county that initiated the legal proceeding shall be considered the MHP of the beneficiary. If a beneficiary is on parole or in a conditional release program and is restricted to a particular area, the MHP for the county that includes the area to which the beneficiary is restricted shall be the county of the beneficiary.
- (D) If a beneficiary has adopted a transient, nomadic lifestyle and has a clear intent to continue this lifestyle, the MHP for the county in which the beneficiary presents for services shall be considered the MHP of the beneficiary.
- (E) If a beneficiary, because of the beneficiary's mental status, is unable to form or express a clear intent to reside anywhere, the following may be considered evidence that the MHP for the county involved would be the MHP of the beneficiary:
1. The county that originated residential, medical, or psychiatric placement.
 2. The county in which the beneficiary has current housing.
 3. The county that has paid general assistance to the beneficiary
 4. The county in which the beneficiary has received ongoing community mental health clinical care during the last six months.
- **What is the address, telephone and fax numbers for the Los Angeles County Department of Mental Health's Treatment Authorization Unit? The TAR Unit contact information is as follows:**

550 S. Vermont Avenue, Room 701
Los Angeles, California 90020
Telephone No. (213) 739-7300
Fax No. (213) 487-7483/ (213) 427-6164
Email: TARUnit@dmh.lacounty.gov
 - **How does a provider get information about a specific TAR?**

Any inquiry regarding a specific TAR must be submitted only by the provider's designated Single Point of Contact (SPOC) in writing; then mailed, delivered or faxed to the TAR Unit.
 - **How does a provider change their designated Single Point of Contact (SPOC)?**

At any time, and as often as necessary, a provider may change their SPOC by submitting a written notification to the Provider Relation's Unit on the provider's letterhead stationery, providing the name, mailing address, telephone and fax number of their SPOC. Please allow at least one (1) business day for the Provider Relation's Unit to update their files.

- **Where can someone get information about mental health outpatient and inpatient services in Los Angeles County?**
Phone the Los Angeles County Department of Mental Health ACCESS Center Hotline at (800) 854-7771. The ACCESS Center is staffed 7-days a week-24hours per day.
- **Does the Local Mental Health Plan (LMHP), i.e., the Los Angeles County Department of Mental Health (LACDMH), arrange and reimburse for transporting (e.g., via ambulance) a Medi-Cal beneficiary?**
No.
- **What can be done about a TAR not included in the Conduent TAR Master File?**
Refer to Section X, page 1-1.
- **What can be done to correct erroneous TAR information on the Conduent TAR Master File?**
Refer to Section X, page 1-1.
- **Where do providers get TAR (SDMH 18-3 3/07) forms?**
SDHCS fiscal intermediary, i.e., Conduent provides Mental Health Stay in a Hospital TAR forms. Each TAR is uniquely numbered and must not be duplicated. Copies of TARs cannot be processed by the TAR Unit. Request Mental Health Stay in a Hospital TAR forms by calling Conduent at (800) 541-5555.
- **What is the SDHCS website for Medi-Cal provider enrollment information and application forms?** SDHCS's website for provider enrollment information and application forms is www.medi-cal.ca.gov.

SECTION: XXI

IMPORTANT TELEPHONE NUMBERS

Treatment Authorization Unit	LACDMH	(213) 739-7300 (Voice) (213) 487-7483 (Fax) (213) 427-6164 (Fax)
TUT and Re-submit Desk	LACDMH	(213) 739-7303
1 st Level TAR Appeals Section	LACDMH	(213) 351-8913 (213) 639-6344
2nd Level TAR Appeals	State DHCS	(916) 324-9125
Conduent Medi-Cal Processing Service Center	State DHCS Contract	(800) 541-5555
California Department of Health Care Services	State DHCS	(916) 319-0985
Access Center	LACDMH	(800) 854-7771
Patient's Rights Bureau	LACDMH	(213) 738-4673
Lanterman-Petris-Short (LPS) Designation Coordinator	LACDMH	(213) 639-6315
Contract Development and Administration Division	LACDMH	(213) 738-4684
Chief Information Office Bureau Helpdesk	LACDMH	(213) 351-1335
Provider Relations	LACDMH	(213) 738-3311

SECTION: XXII

ALERTS

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH/TAR UNIT



Provider Alert



NOVEMBER 2018 Alert No: 2018-1

FFS Medi-Cal Inpatient Hospital

A Publication of the Local Mental Health Plan (LMPH) of the County of Los Angeles Department of Mental Health

IN THIS ISSUE

The purpose of this Provider Alert is to notify Fee-for-Service Hospital Providers about the annual update revisions from the Centers for Medicare and Medicaid Services to the International Classification of Diseases, Tenth Revision (ICD-10) diagnoses codes effective October 1, 2018 through September 30, 2019 that are covered for inpatient and outpatient specialty mental health services (SMHS).

Department of Health Care Services (DHCS) Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No: 18-053 is effective for service dates on and after October 1, 2018 and supersedes MHSUDS IN 17-004E.

LACDMH Quality Assurance Bulletin No. 18-11 issued November 5, 2018 also updated the Organizational Provider’s Manual to reflect additions to the “Outpatient and Day Services “Included” ICD-10 CM Diagnoses and “Inpatient “Included ICD-10-CM Diagnoses” to correspond the DHCS Information Notice 18-053 and the diagnosis code changes made by the Centers for Medicare and Medicaid Services.

⊕ **Outpatient Included Diagnosis List Modifications Effective October 1, 2018**

Added

Diagnoses:

- F40.9 Phobic Anxiety Disorder, Unspecified
- F43.8 Other Reactions to Severe Stress
- F43.9 Reaction to Severe Stress, Unspecified
- F44.2 Dissociative Stupor
- F44.89 Other Dissociative and Conversion Disorders
- F45.20 ~~Hypochondriacal~~ Disorder, Unspecified
- F45.21 Hypochondriasis
- F45.29 Other ~~Hypochondriacal~~ Disorders
- F45.9 Somatoform Disorder, Unspecified
- F50.8 Other Eating Disorders
- F50.89 Other Specified Eating Disorder
- F53.0 Postpartum Depression (*New CMS Code*)
- F53.1 Puerperal Psychosis (*New CMS Code*)
- F63.89 Other Impulse Disorders
- F64.8 Other Gender Identity Disorders
- F65.89 Other ~~Paraphilias~~
- F91.0 Conduct Disorder Confined to Family Context
- F94.2 Disinhibited social engagement disorder
- F94.8 Other Childhood Disorders of Social Functioning

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F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.8	Other Specified Behavioral and Emotional Disorders With Onset Usually Occurring in Childhood and Adolescence
F98.9	Unspecified Behavioral and Emotional Disorders With Onset Usually Occurring in Childhood and Adolescence

Removed Diagnoses:

F53 (Deleted CMS Code: see F53.1)

Diagnoses with new diagnosis descriptions:

F41.0	Panic disorder [Episodic Paroxysmal Anxiety]
F68.10	Factitious disorder imposed on self, unspecified
F68.11	Factitious disorder imposed on self, with predominantly psychological signs and symptoms
F68.12	Factitious disorder imposed on self, with predominantly physical signs and symptoms
F68.13	Factitious disorder imposed on self, with combined psychological and physical signs and symptoms

⊞ Inpatient Included Diagnosis List Modifications Effective October 1, 2018Removed

<u>Diagnoses:</u>	Alcohol Dependence With Other Alcohol-Induced Disorder
F10.288	
F11.188	Opioid-Induced Anxiety Disorder With Opioid Use Disorder, Mild
F11.288	Opioid-Induced Anxiety Disorder With Opioid Use Disorder, Moderate or Severe
F18.188	Inhalant Abuse With Other Inhalant-Induced Disorder
F18.288	Inhalant Dependence With Other Inhalant-Induced Disorder
F18.988	Inhalant Use, Unspecified, With Other Inhalant-Induced Disorder
F19.19	Other Psychoactive Substance Abuse With Unspecified Psychoactive Substance-Induced Disorder
F19.982	Other (or Unknown) Stimulant-Induced Sleep Disorder Without Other (or Unknown) Substance Use Disorder
F50.8	Other Eating Disorders
F53	(Deleted CMS Code: see F53.1)
F63.9	(Deleted CMS Code: see F63.89)

Added

Diagnoses:	Inhalant Abuse With Inhalant-Induced Anxiety Disorder
F18.180	
F18.280	Inhalant Dependence With Inhalant-Induced Anxiety Disorder
F18.94	Inhalant Use, Unspecified, With Inhalant-Induced Mood Disorder
F18.980	Inhalant Use, Unspecified, With Inhalant-Induced Anxiety Disorder
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders

F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.2	Dissociative Stupor
F44.89	Other Dissociative and Conversion Disorders
F45.20	Hypochondriacal Disorder, Unspecified
F45.29	Other Hypochondriacal Disorders
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F50.89	Other Specified Eating Disorder
F53.0	Postpartum Depression (<i>New CMS Code</i>)
F53.1	Puerperal Psychosis (<i>New CMS Code</i>)
F63.89	Impulse Disorder, Unspecified
F84.2	Rett's Syndrome
F95.0	Transient Tic Disorder

Diagnoses with new diagnosis descriptions:

F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F30.13	Manic episode, severe, without psychotic symptoms
F41.0	Panic disorder [Episodic Paroxysmal Anxiety]

The updated Organizational Provider's Manual is available on the DMH Internet:
http://file.lacounty.gov/SDSInter/dmh/1047808_2018-10OrgManual_1_.pdf

LACDMH Managed Care Fee-For-Service 1 End User Manual

ProviderConnect



August 16, 2017

v. 4.5

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Introduction to IBHIS for Fee-for-Service Providers

Overview

Integrated Behavioral Health Information System (IBHIS) is the Electronic Health Record System (EHRS) that was implemented by Los Angeles County Department of Mental Health (LACDMH). ProviderConnect is a web interface used to communicate with IBHIS. ProviderConnect is a standard browser based application and can be launched from any web browsing application such as Internet Explorer, Chrome, or Firefox, and has real time communication with IBHIS. Any information submitted via ProviderConnect is directly entered and updated into the IBHIS system immediately.

Fee-For-Service 1 (FFS1) L.A County Medi-Cal inpatient providers will use this system to:

1. Search for a client:
 - A. If client *is* found, either in your hospital or in any other hospital, add admission record.
 - B. If client is *not* found, either in your hospital or in any other hospital, create admission for new client.
2. Enter client demographic information or update existing client demographic information.
3. Enter admission diagnosis

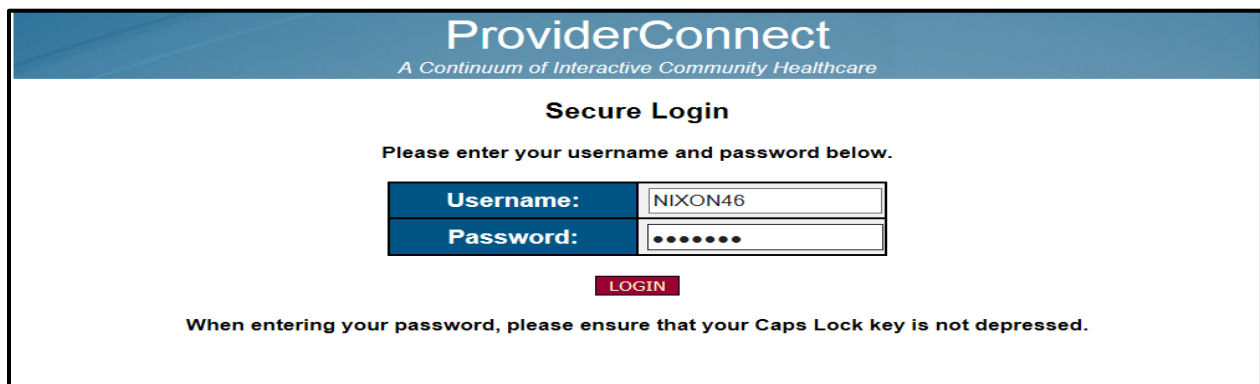
Note: Enter admission record and admission diagnosis within 24 hours of admission, to facilitate care coordination.
4. Upon discharge: First, enter discharge diagnosis and finally, create discharge.
5. Print (using your desktop print functions/Right-Click) the following screens to accompany paper TAR and clinical records to be submitted to DMH TAR Unit:
 - A. Admission screen.
 - B. Admission/Discharge Diagnosis screen.
 - C. Discharge screen.

ProviderConnect Log In

1. Start the web browser (IE, Chrome) in your system. Type the following web address in the address line:
<https://lapconn.netsmartcloud.com/la>

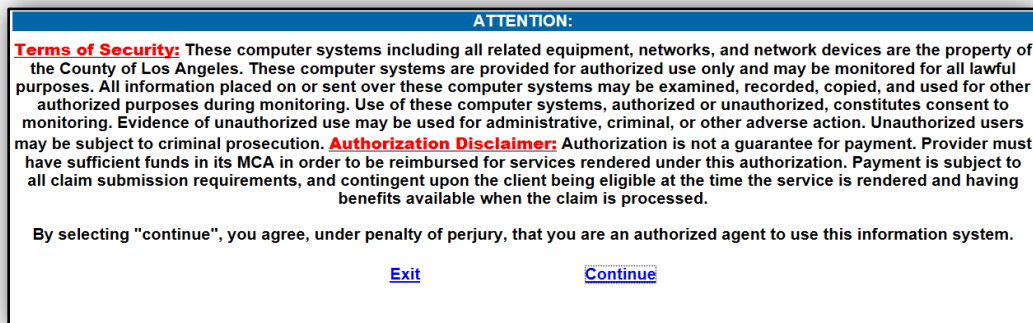
Note: For *training* purposes only, type the following web address in the address line:
<https://lapconn.netsmartcloud.com/lastaging> This link will take you to the ProviderConnect training environment where you may practice using the ProviderConnect system, prior to using the system live.

The following login screen will appear:



2. Type in a user ID and password then click the **LOGIN** button.

A screen will be displayed with a Confidentiality/Security statement. **You must accept and agree** before continuing.



Once “continue” has been selected, the system will display **ProviderConnect-News** alerts.

The **News** screen will provide the user with alerts and updates regarding the system.

3. Click **Skip to Main Menu** to continue to the **Main Menu**.

ProviderConnect Main Menu

You are logged in as:	NIXON46	
Your last login was:	6/2/2017 12:59:00 PM	
Main Menu - Provider		
<u>L</u> ookup Client	Add New Client/Client Search	Change Password
Documentation	News	
Logout / Exit		

- **News:** Is used to provide you with communication regarding updates and enhancements associated to ProviderConnect. If the News message displays “THIS IS A NON-PRODUCTION ENVIRONMENT”, this means you are in the testing environment. Logout and connect to the LIVE environment at <https://lapconn.netsmartcloud.com/la>
- **Documentation:** Provides help on ProviderConnect
- **Change password:** Allows users to change password

Note: When changing password, the following rules will apply:

Password Tips:

- Password cannot be "password".
- Passwords must be between 6 and 30 characters.
- Passwords are case-sensitive.
- Passwords cannot be the same as your username, or your username backwards.
- Passwords cannot be common English words or commonly used (guessable) passwords.
- Try substituting numbers or punctuation for letters. For example, instead of "provider" use "pr0v1d3r".

Client Search

The **Main Menu** is used to search for existing clients.

There are two steps to search for clients:

- **“Lookup Client”:** Allows you to search clients by **First and Last Name, SSN, DOB, and your agency name** for an existing admission created by *your* agency. Please note: Records cannot be accessed by existing TAR numbers.

ProviderConnect

Client Search with Lookup Client

The **Lookup Client** option is used to search for clients with an existing admission created by your Hospital.

You may search for clients using the following parameters:

- **Member ID** (only)
- **Social Security Number** (only)
- Or a combination of **First Name, Last Name** and **D.O.B.**

Note: You must use **Capital Letters** for the first letter in both the “Last Name” and “First Name” fields.

Search Criteria	
Member ID:	<input type="text"/>
SSN:	<input type="text"/>
Last Name:	Client <input type="text"/>
First Name:	Test <input type="text"/>
Date of Birth:	05/27/1954 <input type="text"/>
Agency:	BHC ALHAMBRA HOSPITAL

Note: Only clients with authorization requests, pending or approved authorizations, and/or provider-initiated Admissions will display.

[Search by Criteria](#)

Results of the search will list the client information as follows based on the parameters provided.

Search Results				
Client ID	Last Name	First Name	Date of Birth	Agency
3170994	Client	Test	5/27/1954	BHC ALHAMBRA HOSPITAL

Search Criteria

[Back](#)

About ProviderConnect 2017.4.1

1. Click on the **Client ID** to view client information.

ProviderConnect Lookup Client (Cont'd)

2. The following screen will appear:

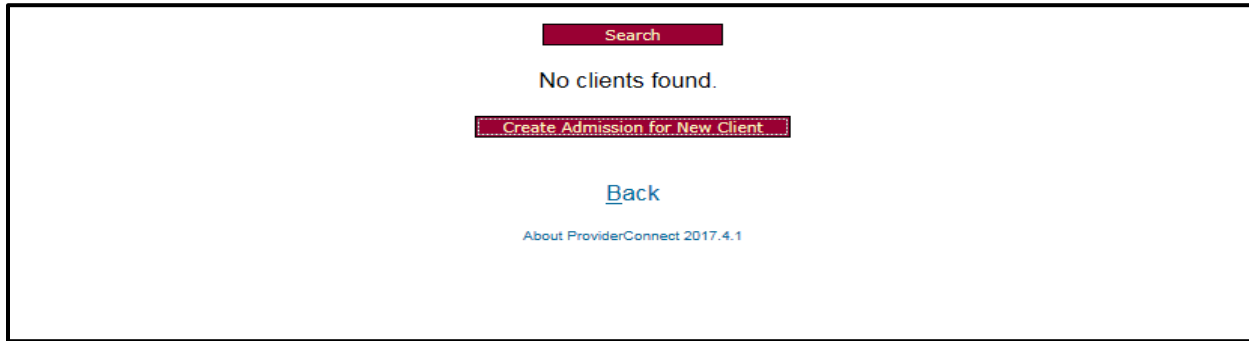
Member ID	ProviderConnect - Demographic		
3170994	BHC ALHAMBRA HOSPITAL 6/7/2017 10:42:17 AM Lookup Client Main Menu Log Out		
Demographic	Client Name: Client, Test		
CSI Admission	Member ID: 3170994		
Financial Eligibility	SSN: 765-43-2100		
Authorizations	Member Demographics		
Provider Admission	Social Security Number 765-43-2100	Date of Birth 5/27/1954	Facility Chart Number
Provider Diagnosis	Member Street 1 1234 Anywhere Street	Member Street 2	Member City
Day Treatment / MHS Authorization Details	Member County Please Choose One	Member State CA - CALIFORNIA	Member Work Number
Over Threshold Authorization Request	Member Zip Code 90202	Member Phone Number	Ethnicity Please Choose One
Plan Communication	Member Language English - 7	Sex Male - M	Client Maiden Name
Systemwide Annual Liability	Race White - 1	Race African-American - 2 American Indian/Alaska Native - 4 Armenian - 31 Asian Indian - 15	Citizenship Status Please Choose One
Exit to Main Menu	Veteran	Education Level At Admission Unknown - 99	Pre-Admission Disposition
	Employment Status Unemployed - UE	Client's Cell Phone	Client Declined to Provide Information Ethnic Origin - 8 Language - 149 Race - 116
	Marital Status Single / Never Married - 1	Smoker Please Choose One	
	Communication Preference Please Choose One		
	Save Record		
	<small>About ProviderConnect 2017.4.1</small>		

If client is not found within by “**Lookup Client**” function, go to the next step:

ProviderConnect Client Search with Add New Client/Client Search

- “**Add New Client/Client Search**”: Allows you to search clients by **First and Last Name, SSN, DOB** and **Sex** for clients who may have an existing admission within the system from other providers.
- To edit records for a client admitted under *your* facility, the “Lookup Client” function must be used.

ProviderConnect - Add New Client/Client Search		BHC ALHAMBRA HOSPITAL 6/2/2017 1:20:12 PM Lookup Client Main Menu Log Out	
Search Criteria			
Social Security Number:	765-43-2100		
Last Name:	Client		
First Name:	Test		
Sex:	<input type="radio"/> Female - F <input checked="" type="radio"/> Male - M <input type="radio"/> Unknown - U		
Date of Birth:	05/27/1954		
Search			
Back			
<small>About ProviderConnect 2017.4.1</small>			



If no client found in client search: “Create Admission for New Client.”

Note: When adding a new client, always make sure you have already performed a thorough search to ensure that the client does not already have an existing admission in the system.

If the client has not been found, using the steps above, the **Main Menu** is used to add new clients not previously in the system:

1. Click **Create Admission for New Client** to add an admission for your facility.

Admission Information	
Sex <input type="radio"/> Female - F <input checked="" type="radio"/> Male - M <input type="radio"/> Unknown - U	
Date of Birth 05/27/1954	Age 63
Admission Date <input type="text"/>	Admission Time <input type="text"/> HH:MM AM/PM
Program [-Please Choose One-]	Admitting Practitioner [-Please Choose One-]
Attending Practitioner [-Please Choose One-]	Treatment Service [-Please Choose One-]
Type of Admission [-Please Choose One-]	Social Security Number 765-43-2100

Note: All fields highlighted in **red** are required. Because the Provider Admission form *can* be submitted with missing and inaccurate data in the **red** fields, and once submitted, it cannot be changed by you, you *must* verify that all **red** field data is entered and is accurate.

2. Click **Save Admission** to submit admission record.
3. If the client has an existing admission a list will display search results matching the parameters you provided.

Search Results							
ID	Name	Date Of Birth	Client's Address City	Client's Address Zipcode	Alias	Admitting Practitioner	Score
5170994	CLIENT_TEST	05/27/1954	LOS ANGELES	90020		056575	231

[Create Admission for New Client](#)

[Back](#)

About ProviderConnect 2017.4.1

- Verify the information for accuracy before proceeding.
- Click on the Client ID number. The **Provider Admission Form** will appear with prepopulated information that you entered in the search screen.
- Complete admission data and client demographic data as follows:

Admission Information	
Sex <input type="radio"/> Female - F <input checked="" type="radio"/> Male - M <input type="radio"/> Unknown - U	
Date of Birth 05/27/1954	Age 63
Admission Date	Admission Time HH:MM AMPM
Program [Please Choose One]	Admitting Practitioner [Please Choose One]
Attending Practitioner [Please Choose One]	Treatment Service [Please Choose One]
Type of Admission [Please Choose One]	Social Security Number 765-43-2100

Demographics	
Client Last Name Client	Client Home Phone Number
Client First Name Test	Client Work Number
Client Address Line 1	Client Address Line 2
Client Address - City	Client Address - State [Please Choose One]
Client Address - Zip Code	Client Address - County [Please Choose One]
Marital Status [Please Choose One]	Race/Ethnicity
Education [Please Choose One]	Religion [Please Choose One]
Other Ethnic Origin Field not yet supported	Place of Birth
Citizenship [Please Choose One]	Country of Origin [Please Choose One]
Maiden Name	Occupation [Please Choose One]
Client's Primary Language [Please Choose One]	Informed of Smoking Policy <input type="radio"/> No - N <input type="radio"/> Yes - Y
Employment Status [Please Choose One]	
Alias	Alias 2
Alias 3	Alias 4
Alias 5	Alias 6

Note: All fields highlighted in red are required. The Provider Admission form cannot be submitted without completing all the required fields. Once the admission has been saved, data cannot be changed. Verify all data for accuracy before submitting.

- Click [Save Admission](#) to submit admission record.

ProviderConnect

Editing Demographic Information

The **Demographic** form is used to maintain and update clients' demographic information (i.e. name, social security number, date of birth, address, sex, etc.).

Demographic information is prepopulated from the previous episode. However, the user may update any necessary changes (e.g. address, telephone number, etc.).

For the zip code field on all addresses across all DMH systems, the 9-digit (Zip+4) zip code is **REQUIRED**. If the 4 digit code is unknown, use **'9998'** as a default.

1. To edit client's demographic information, click **Demographic** on the **Navigation Tool Bar** to open the Member's demographic form.

The **Navigation Tool Bar** on the left side column allows you the ability to access different forms.

Member ID: 3170994

Client Name: Client, Test
Member ID: 3170994
SSN: 785-43-2100

View and update

View client admissions/episodes

Save Record

Note: Please verify that the correct client record has been selected before making any changes. Client's name, date of birth, and social security number **CANNOT** be edited.

Remember, all fields highlighted in **red** are required. The form cannot be submitted without completing the required fields.

2. Complete the admission data and update any client demographic data if necessary.
3. Click **Save Record** to save the changes.

ProviderConnect Admission Diagnosis

The **Diagnosis** form is used to create and update clients' diagnosis record.

Note: Both an Admission diagnosis and a Discharge diagnosis are required for all admissions and should be entered before creating a discharge.

1. To create/edit client's diagnosis information, click "**Provider Diagnosis (ICD10)**" on the task bar to open the "**Provider Diagnosis (ICD10)**" form.

Member ID
3170994

Demographic

CSI Admission

Financial Eligibility

Authorizations

Provider Admission

Provider Diagnosis

Provider Diagnosis (ICD-10)

Day Treatment / MHS Authorization Details

Over Threshold Authorization Request

Plan Communication

Systemwide Annual Liability

Exit to Main Menu

ProviderConnect - Provider Admissions FFS1 HOSPITAL TRAINING

Client Name: Client, Test
Member ID: 3170994
SSN: 765-43-2100

Episode Information			
Episode	Admission Date	Discharge Date	Program
1	5/15/2017		5007I BHC ALHAMBRA HOSPITAL
Unassigned	10/10/2016		1234I FFS1 HOSPITAL TRAINING

Add Admission Record

2. Click **Add Diagnosis Record** to open form.
3. Complete all **red** required fields and select.
4. The **Provider Diagnosis** pre display screen will populate.
5. Click **Add Diagnosis Record** to add the diagnosis.

https://lapconn.netsmartcloud.com/last ProviderConnect : Login Client Data

Member ID: 3170994

Client Name: Client, Test
Member ID: 3170994
SSN: 765-43-2100

Diagnosis Information (ICD-10)

Episode Number: 2
Type of Diagnosis: Please Choose One

Date of Diagnosis: 10/10/2016
Time of Diagnosis: 10:00 AM

Prognosis:
Estimated Discharge Date:
Trauma (CSI): No - N
General Medical Condition Summary Code (CSI) (Select Up to Three):
Allergies - 17
Anemia - 16
Arterial Sclerotic Disease - 01
Arthritis - 19
Substance Abuse / Dependence (CSI): No - N

Ranking	Diagnosis	Classification	Onset Date	Diagnosing Practitioner	Billing Order	Present On Adm Indicator
Primary - 1	Chronic schizophrenia	Mental Health - 4		MEDICAL_DOCTOR,FFS	1	Yes - Y
...Please Choose One...	...Please Choose One...	...Please Choose One...		...Please Choose One...	2	...Please Choose C

Save Diagnosis Return To List

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Diagnosis				
Date of Diagnosis	Type of Diagnosis	Principal Diagnosis	Diagnosing Practitioner	Episode Number
4/1/2017	Admission	296.00	ACEVEDO,MARIA	1
Add Diagnosis Record ←				

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6. Complete all red required fields and select **Save Diagnosis**.

ProviderConnect Discharge

- To discharge client from current hospital episode, *first* you must enter the discharge diagnosis.

Member ID: 3170994

Client Name: Client, Test
Member ID: 3170994
SSN: 765-43-2100

Diagnosis Information (ICD-10)

Episode Number: 2	Type of Diagnosis: Discharge - D
Date of Diagnosis: 10/15/2016	Time of Diagnosis: 10:30 AM
Prognosis:	Estimated Discharge Date:
Trauma (CSI):	General Medical Condition Summary Code (CSI) (Select Up to Three): Allergies - 17 Anemia - 16 Arterial Sclerotic Disease - 01 Arthritis - 19
Substance Abuse / Dependence (CSI):	Substance Abuse / Dependence Diagnosis (CSI):

Ranking	Diagnosis	Classification	Onset Date	Diagnosing Practitioner	Billing Order	Present On Adm Indicator
Primary - 1	Chronic schizophrenia	Mental Health - 4		MEDICAL_DOCTOR,FFS	1	Yes - Y

Buttons: Save Diagnosis, Return To List

- Click on "Provider Admission," Select [Create Discharge](#) link.

Member ID: 3170994

Client Name: Client, Test
Member ID: 3170994
SSN: 765-43-2100

Episode Information

Episode	Admission Date	Discharge Date	Program
1	5/15/2017	Create Discharge	5007I BHC ALHAMBRA HOSPITAL

Enter all red required fields. Ensure that all current demographic information is completed/updated.

Member ID: 3170994

Discharge Information

Client Last Name Client	Client First Name Test
Client Middle Name	Social Security Number 765-43-2100
Sex () Female - F (X) Male - M () Unknown - U	Date of Birth 5/27/1954
Episode Number	Program 1234I FFS1 HOSPITAL TRAINING
Date of Discharge	Discharge Time HH:MM AM/PM
Type of Discharge Please Choose One *	Reason for Death Please Choose One *
Date of Death	Discharge Practitioner Please Choose One *
Discharge Remarks/Comments	
Hospital Discharge Instructions	

Demographics

Client Home Phone Number	Client Work Number
Client Address Line 1 1234 Anywhere Street	Client Address Line 2
Client Address - City	Client Address - State CA - CALIFORNIA
Client Address - Zip Code 90000	Client Address - County

3. Click **Save Discharge**

4. Initially, "Discharge Date" will read as "Queued."

Episode Information			
Episode	Admission Date	Discharge Date	Program
2	10/10/2016	Queued	1234I FFS1 HOSPITAL TRAINING
1	5/15/2017		5007I BHC ALHAMBRA HOSPITAL

5. After approximately 30 seconds, you may click "Refresh" on your computer to confirm discharge date.

Member ID: 3170994

ProviderConnect - Provider Admissions FFS1 HOSPITAL TRAINING 6/28/2017 1:50:05 PM

Client Name: Client, Test
Member ID: 3170994
SSN: 765-43-2100

Episode Information			
Episode	Admission Date	Discharge Date	Program
2	10/10/2016	10/15/2016	1234I FFS1 HOSPITAL TRAINING
1	5/15/2017		5007I BHC ALHAMBRA HOSPITAL

ProviderConnect

Printing Admission, Diagnosis and Discharge Screens

6. Print (using your desktop print functions/Right-Click) the following screens to accompany paper TAR and clinical records to be submitted to DMH TAR Unit:
 - A. Admission screen.
 - B. Admission/Discharge Diagnosis screen.
 - C. Discharge screen.

Print Preview of Admission screen:

Client Data
Page 1 of 1

Member ID

3170994

**ProviderConnect -
Provider Admission
Form**

FFS1 HOSPITAL
TRAINING 6/28/2017 3:34:38
PM [Lookup Client](#) | [Main Menu](#)
| [Log Out](#)

Demographic	Client Name: Client, Test
CSI Admission	Member ID: 3170994
Financial Eligibility	SSN: 765-43-2100

Authorization	Admission Information	
Provider Admission	Episode Number 2	Client Name Client, Test
Provider Diagnosis	Sex () Female - F (X) Male - M () Unknown - U	
Provider Diagnosis (ICD-10)	Date of Birth 5/27/1954	Age 63
Day Treatment MHS Authorization Details	Admission Date 10/10/2016	Admission Time 10:00 PM
Over Threshc Authorization Request	Program 1234I FFS1 HOSPITAL TRAINING	Admitting Practitioner MEDICAL_DOCTOR,FFS
Plan Communicati	Attending Practitioner	Treatment Service SA2 - 2
Systemwide Annual Liabil	Type of Admission Elective - 5	Social Security Number 765-43-2100

Exit to Main Menu	Demographics	
	Client Home Phone Number	Client Work Number
	Client Address Line 1 1234 Anywhere Street	Client Address Line 2
	Client Address - City	Client Address - State CA - CALIFORNIA
	Client Address - Zip Code 90020	Client Address - County
	Marital Status Single / Never Married - 1	Race White - 1
	Race/Ethnicity	Education Unknown - 99

Print Preview of Admission/Discharge Diagnosis screen:

Member ID: 3171132

ProviderConnect - Provider Diagnosis

FFS1 HOSPITAL TRAINING 6/28/2017 2:09:58 PM

Client Name: Day, Doris
Member ID: 3171132
SSN: 999-99-9999

Diagnosis				
Date of Diagnosis	Type of Diagnosis	Principal Diagnosis	Episode Number	
1/1/2013	Admission	Major depressive disorder, recurrent	1	Edit
1/2/2013	Discharge	Major depressive disorder, recurrent	1	Edit

Add Diagnosis Record

About ProviderConnect 2017.5.1

Print Preview of Discharge screen:

Member ID: 3170994

ProviderConnect - Provider Discharge Form

FFS1 HOSPITAL TRAINING 6/28/2017 3:34:07 PM

Client Name: Client, Test
Member ID: 3170994
SSN: 765-43-2100

Discharge Information	
Client Last Name Client	Client First Name Test
Client Middle Name	Social Security Number 765-43-2100
Sex () Female - F (X) Male - M () Unknown - U	Date of Birth 5/27/1954
Episode Number 2	Program 1234 FFS1 HOSPITAL TRAINING
Date of Discharge 10/15/2016	Discharge Time 10:30 AM
Type of Discharge Discharged to Home or Self-Care - 3	Reason for Death
Date of Death	Discharge Practitioner MEDICAL_DOCTOR,FFS
Discharge Remarks/Comments	
Hospital Discharge Instructions	

Demographics	
Client Home Phone Number	Client Work Number
Client Address Line 1 1234 Anywhere Street	Client Address Line 2
Client Address - City	Client Address - State CA - CALIFORNIA
Client Address - Zip Code 90020	Client Address - County
Marital Status Single / Never Married - 1	Race White - 1

Accessing LACDMH Service History Information through ProviderConnect

Step 1: From the Main Menu, Select the 'Reports' section which will display a menu of available reports.

Main Menu - Provider		
<u>L</u> ookup Client	<u>R</u> eports	Add New Client/Client Search
Change Password	Documentation	News

Step 2: Click on [LACDMH Client Service History]

Reports
LACDMH Client Service History

Step 3: Enter the DMH Client ID and click the Generate Report button

Report Criteria	
Client	<input type="text"/>
Generate Report	

This will generate a report similar to the one shown below:

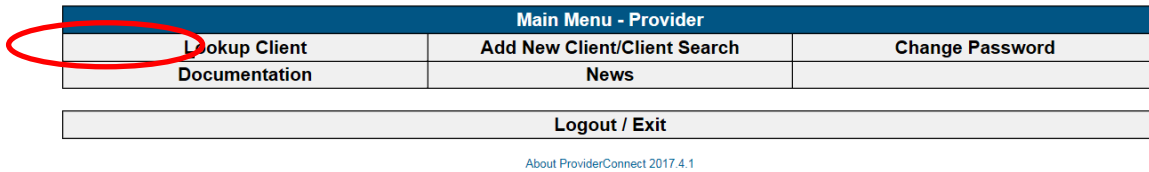
Client Service History						
Client Name (PATID): [REDACTED]						
Legacy IDs:						
Source	Program Name	Program Type	Admit / First Service Date	Discharge / Last Service Date	Practitioner	Diagnosis
Avatar	LA County DMH PreAdmit	Pre-Admit	9/16/2014	10/8/2014	SA	
Avatar	1906A EDMUND D EDELMAN WESTSIDE MHC	Admit	9/25/2015	6/2/2016	BR	F31.9 - Bipolar 1 disorder
Avatar	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	F31.9 - Bipolar disorder unspecified
Avatar	6841A WEST VALLEY MH/WELLNESS CENTER	Admit	4/25/2016	4/27/2016	SU	F31.9 - Bipolar 1 disorder
Avatar	7216E SMART	Admit	5/2/2016	5/2/2016	BA	F31.9 - Bipolar 1 disorder
History	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	799.9-Diagnosis Deferred
History	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	300.00-Anxiety Disorder NOS
History	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	311-Depressive Disorder NOS
History	1906A EDMUND D. EDELMAN-OUTPT	Outpatient	3/4/2008	6/1/2009	GR	296.34-Major Depressive Disorder, Rec., Severe
History	6859A DMH/HARBOR UCLA-ADULT OUTPT	Outpatient	5/1/2008	5/5/2008	MI	296.90-Mood Disorder NOS
History	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	296.80-Bipolar Disorder NOS
History	7797S EXODUS RECOVERY INC WESTSIDE CS	Psychiatric ER/UCC Crisis Stab	11/30/2013	12/1/2013	DI	298.9-Psychotic Disorder NOS
History	5804I PDP BHC ALHAMBRA HOSPITAL	Psych Acute Inpatient	12/1/2013	12/3/2013	DI	296.20-Major Depressive Disorder, Single Episodi

Accessing LACDMH Service History Information thru ProviderConnect (Cont'd)

Looking up IBHIS episodes

To see encounters with service providers where those services are not claimed through IBHIS (like admissions to FFS hospitals) in ProviderConnect, use the **Provider Admission** link. You will also see the “higher level” outpatient episodes that exist for this client in IBHIS.

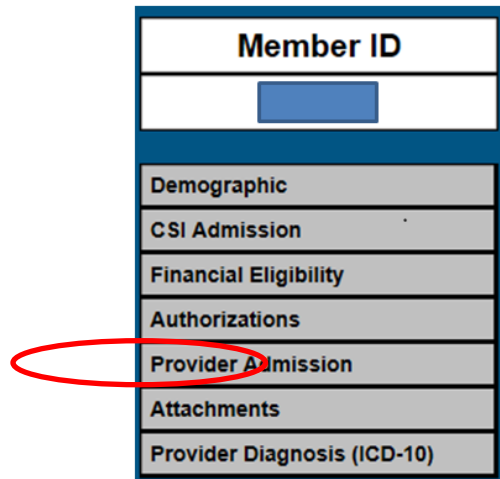
Step 1: From the Main Menu, Select the ‘Lookup Client’ section



Step 2: Enter the DMH Client ID or other search criteria to find the client record of interest. *Note: you will only be able to see the detailed episode records if your facility has a past or current admission for this client.*

Search Criteria	
Member ID:	<input type="text"/>
SSN:	<input type="text"/>
Last Name:	<input type="text"/>
First Name:	<input type="text"/>
Date of Birth:	<input type="text"/>

Step 3: Select the ‘Provider Admission’ option.



You will see a list of all IBHIS episodes that exist for the client in question.

Accessing LACDMH Service History Information thru ProviderConnect (Cont'd)

Episode Information			
Episode	Admission Date	Discharge Date	Program
5	6/30/2017	7/5/2017	5046I SOUTHERN CA HOSPITAL AT CULVER CIT
4	7/12/2017	Create Discharge	5012I HUNTINGTON MEMORIAL HOSPITAL
3	6/8/2017	6/10/2017	5570I LA COMM HOSP AT BELLFLOWER
2	6/10/2016		LE00019 LA County DMH
1	5/14/2015		LA County DMH PreAdmit

In the example above, this “client” has had 3 admissions created in IBHIS to FFS inpatient facilities, including one which is still open at Huntington Memorial. You also see that the client was “Pre-Admitted” by LACDMH at one point (e.g., for initial appointment scheduling), and formally admitted for outpatient services under the DMH Directly Operated admission program (LE00019) in 2016. You would review the ProviderConnect Service History report described earlier to see the specific outpatient service programs/sites where those services were delivered under that LE00019 episode.

Coordinating ProviderConnect and TAR form data

Please ensure that all data is entered into ProviderConnect accurately and corresponds to information entered onto the TAR form.

Common Errors Made on TAR(s)

NOTE: The following are errors that are most consistently made on TAR(s):

1. Box #7 (admission date.)
2. Box #14 (date of birth.)
3. Patient’s name- Provider forgets to give a.k.a. or misspells the patient’s name.
4. Box #17- Number of days does not coincide with the admission date and/or discharge date.
5. Box #20 (discharge date.)

Common Errors Made on TAR(s) (Cont'd)

6. Providers forget to indicate how many days apply to each TAR when there are multiple TAR(s) i.e., acute and administrative. Example: 6/30-7/15 TAR#1.

**COUNTY
USE
ONLY**

SERVICE
CATEGORY

REQUEST FOR MENTAL HEALTH STAY IN HOSPITAL F.I. USE ONLY

1. CLAIMS CONTROL NUMBER
F.I. USE ONLY

CONFIDENTIAL PATIENT INFORMATION
County Code and Aid Code go here

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) 7 8 9

PROVIDER NUMBER 10 11 12

PROVIDER NAME 13

PROVIDER STREET/MAILING ADDRESS 14

PROVIDER CITY, STATE AND ZIP CODE 15

e.g. 1960

PATIENT MEDI-CAL ID NO. 16 17 18 19 20 21

PATIENT NAME 22 23 24 25 26

NUMBER OF DAYS REQUESTED 27 28 29 30 31

ADMITTING ICD9-CM 32

To Correct Data Input Errors Post Submission:

Submit your issues by accessing the online Self Service Support application at:

<https://extra.dmh.lacounty.gov/SelfServiceSupport/Pages/SelfService.aspx>

The screenshot shows the 'Self Service Support' application interface. At the top left is the LAC DMH logo with the text '100 ANGELO COUNTY MENTAL HEALTH'. The main header is 'Self Service Support' with a 'User Manual' link on the right. Below the header is a welcome message: 'Welcome to the DMH Self Service Support Application. Please fill out the below information if you wish to submit issues, incidents, or questions pertaining to Integration.' The form is divided into two sections: 'Ticket Contact Information' and 'Ticket Details'. The 'Ticket Contact Information' section includes fields for First Name, Last Name, Phone, Phone Extension, and Email, with a red asterisk indicating required fields. The 'Ticket Details' section includes dropdown menus for Provider Type, EHR Vendor/Biller, Category, Environment, Legal Entity/FFS, and Cause. A 'Description' field is a large text area. A note states: 'Note: Please do not submit any PII and/or PHI information through this system.' At the bottom, there is a checkbox for a HIPAA certification statement and a link for more information.

LAC DMH
100 ANGELO COUNTY
MENTAL HEALTH

Self Service Support

User Manual

Welcome to the DMH Self Service Support Application. Please fill out the below information if you wish to submit issues, incidents, or questions pertaining to Integration.

Ticket Contact Information *Indicates Required Field

First Name: * Last Name: *
Phone: * Phone Extension:
Email: *

Ticket Details

Provider Type: * Legal Entity/FFS: *
EHR Vendor/Biller:
Category: * Cause: *
Environment: *

Note: Please do not submit any PII and/or PHI information through this system.

Description: *

By checking this box, I hereby certify that I have knowledge of the requirements of Federal and State confidentiality laws and will comply with all applicable provisions of same. I have verified and confirmed that the provided information and/or any uploaded attachments including but not limited to pictures and screen captures, do not include any Personally Identifiable Information (PII) and/or confidential Protected Health Information (PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that one can be held personally accountable for failing to comply with HIPAA regulations and can face disciplinary action up to and including termination of contractual agreements, denial of access to County IT resources, as well as civil and criminal penalties per 42 USC § 1320d-5. [Click Here for Information Pertaining to HIPAA](#)

For TAR business related questions, please contact your hospital's Single Point of Contact who will coordinate communication with TAR Unit.

TAR Medical Record Submission Content and Organization For Determination of Medical Necessity

Please ensure that medical records being submitted with TAR are organized, tabbed or sectioned to include the following:

1. Source of admission.
2. 5150.
3. Discharge plan.
4. Psychiatric evaluation.
5. History & Physical per Internal Medicine.
5. Physician notes.
6. Physician orders if Seclusion & Restraint or orders for STAT medications.
7. Nursing narrative notes.
8. Initial suicide assessment, including subsequent suicide assessments if patient is suicidal.
9. Placement contacts for administrative days.

Note: It is not necessary to include the entire medical record, as long as the above information is provided.