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

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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4rd Edition

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Intensive Care Division, TAR Unit

Welcome

Welcome. This is the Provider Manual for Medi-Cal Fee-For-Service (FFS) acute psychiatric inpatient providers that submit Treatment Authorization Requests (TARs) to the Los Angeles County Department of Mental Health (LACDMH), Intensive Care Division (ICD). This Provider Manual provides information explaining the processes involved in partnering with the LACDMH for the delivery of quality, cost-effective mental health care.

The LACDMH, ICD, TAR Unit, is assigned the task of reviewing documentation submitted by contracted and non-contracted Fee-for-Service acute inpatient psychiatric hospitals and authorizing hospital stays when the submitted documentation meets medical necessity criteria for admission, continued stay and administrative day requirements.

This Manual has been revised to reflect the changes brought about by the revision of the *Federal Managed Care Regulations, Code of Federal Regulations (CFR), Title 42, Sections 438 et al.* Important changes are in the areas of medical necessity, document submission, review and authorization methodology, administrative day documentation requirements and appeals process.

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.

TABLE OF CONTENTS

SECTION I: INTRODUCTION

INTRODUCTION

The Los Angeles County Department of Mental Health (LACDMH) is the State of California's Local Mental Health Plan (MHP) for the County of Los Angeles. The MHP 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 former State of California Department of Mental Health (SDMH) previously 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.

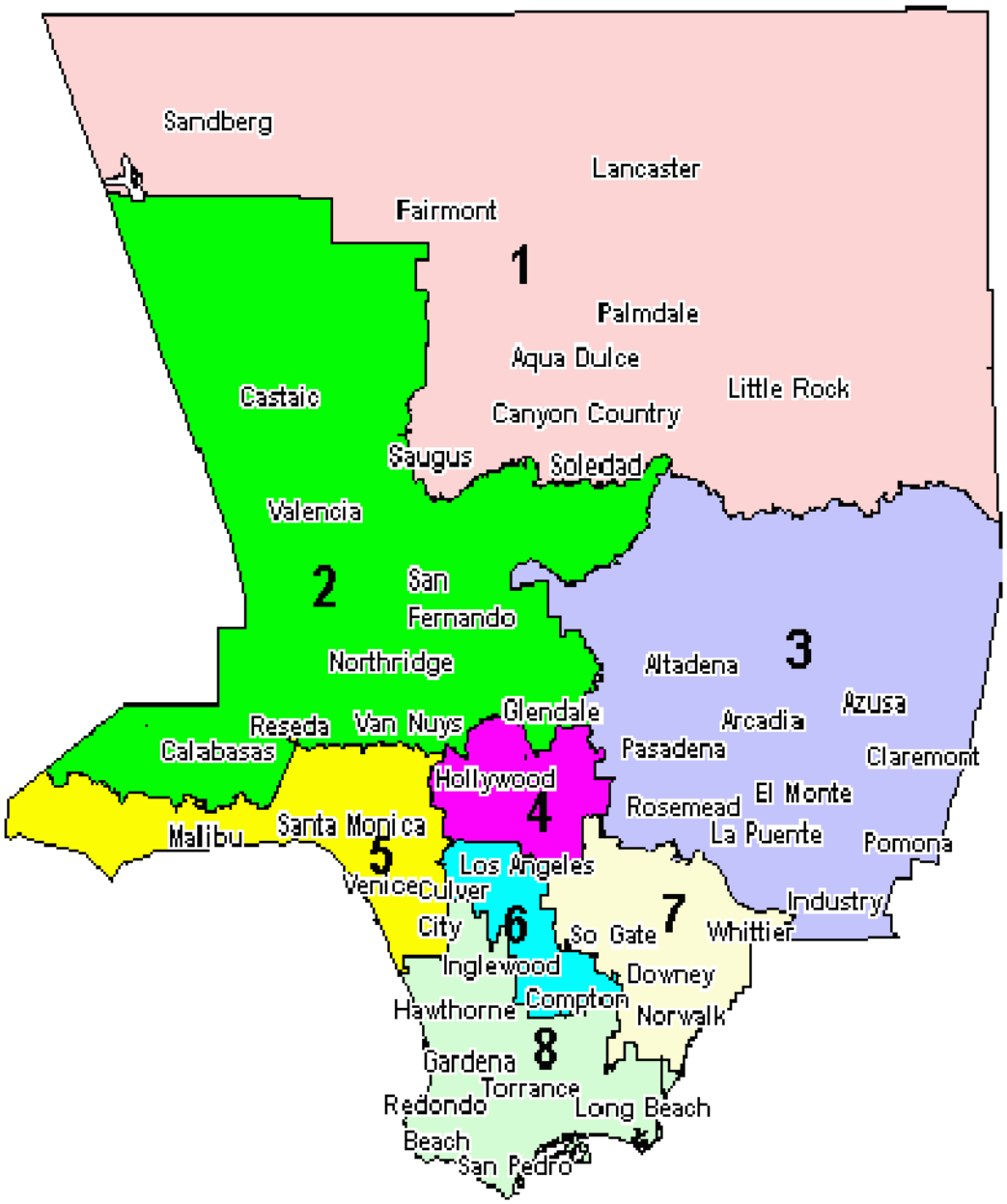
On May 6, 2016, the Center for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, aimed at aligning the Medicaid Managed Care regulations with requirements for other major sources of coverage. The Final Rule revised the regulations for Medicaid Managed Care in Part 438 of the Code of Federal Regulations (CFR). As a result of the Managed Care Final Rule changes, the Department of Health Care Services (DHCS) published *Information Notices (IN) No. 19-026, Authorization of Specialty Mental Health Services* delineating new documentation requirements applicable to authorization of all Specialty Mental Health Services including Administrative Days, and *IN 18-010E Federal Grievance and Appeal System Requirements*. The *IN No. 19-026* further mandated the MHPs to change the authorization process from retrospective to concurrent reviews. Pursuant to *Welfare and Institutions Code (W&IC) §14197.1(b)*, DHCS has the authority to implement these requirements via issuance of an IN in lieu of adopting regulations.

On April 15, 2022, DHCS published *Behavioral Health IN No. 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*. The TAR Unit staff will be using these standards when reviewing documentation for authorization of services. To the extent that these requirements conflict with the *CCR, Title 9, Chapter 11,* or other state regulations, the *IN* supersede those state regulations. Pursuant to *CCR, Title 9, Chapter 11, §1820.220*, the LACDMH, acting as the MHP has delegated the Intensive Care Division (ICD), Clinical Operations, TAR Unit, as the county's Point of Authorization (POA). The TAR Unit is the program responsible for implementing and operating the authorization and reimbursement of Medi-Cal acute inpatient psychiatric services provided to Los Angeles County Medi-Cal beneficiaries. The TAR Unit staff are currently conducting concurrent reviews and authorizations on a majority of Fee-for-Service (FFS) hospitals. Retrospective reviews and authorizations will still be conducted on limited circumstances.

SECTION II:
LACDMH SERVICE PLANNING AREAS AND HOSPITAL LOCATIONS

LACDMH Service Planning Areas and Hospital Locations

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
Emanate Health InterCommunity Hospital
San Gabriel Valley Medical Center
LA Downtown Medical Center (Ingleside Campus)

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
LA Downtown 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 hospitals 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 (3 sites)
Del Amo Hospital
Providence Little Company of Mary Medical Center San Pedro

SECTION III:
LACDMH CONTRACT

Contracting with the County

State of California certified and licensed Medi-Cal FFS acute psychiatric inpatient hospitals 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

- Access Department of Mental Health website at: https://dmh.lacounty.gov/
  For Provider/Admin Tools/ Contract Opportunity/ Open Solicitation/ Request for Application (RFA) 24-hour Residential Treatment Contract and Acute Psychiatric Inpatient Contract
- 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

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
510 South Vermont Avenue, 20th Floor
Los Angeles, CA 90020

The Provider Network

The Local Mental Health Plan (LMHP) Provider Network authorized to provide professional services in the acute psychiatric hospital is comprised of licensed mental health professionals whose scope of practice permits the practice of psychotherapy independently. Network providers may be Psychiatrists (MD/DO), Psychologists (Ph.D./Psy.D.), and Nurse Practitioners. Nurse Practitioners must be certified by the American Nurses Credentialing Center (ANCC) or the American Association of Nurse Practitioners (AANP) in Behavioral Health.

All mental health providers must be credentialed and contracted with the LMHP to receive reimbursement for specialty mental health services provided to Los Angeles County Medi-Cal beneficiaries. Credentialed providers may contract with the LMHP as an Individual provider or render services as part of the contracted group. A group is composed of two or more licensed, credentialed and contracted mental health providers. All members of the group must be credentialed by the LMHP for inpatient services. Sub-contracting is not permitted in the Professional Service Agreement.

Credentialing

Credentialing is the formal process of collecting and verifying the professional credentials and qualifications of licensed providers and evaluating them against the standards and requirements established by the LMHP to determine whether such licensed providers meet these standards and requirements. Before the LMHP network applicant can be offered a LACDMH contract, he or she must apply for enrollment in the State Medi-Cal program and be free and clear of any Medi-Cal related adverse actions.

Network providers are required to re-credential every three years in order to continue to participate in the LMHP Provider Network. It is the network provider's responsibility to maintain current credentials. A network provider's failure to maintain current credentials will result in the termination of reimbursement privileges for specialty mental health services rendered to Medi-Cal beneficiaries. Dates of service upon which a network provider has experienced a break in active credentialing status will not be subject to retroactive reimbursement. Even if a contract is in place at the time credentials lapse, the contract is considered in default and claims will not be reimbursed until the provider's credentials are renewed.

It is recommended that prospective FFS Individual and Group Providers review the *Medi-Cal Specialty Mental Health Services Fee-For-Service Network Provider Manual, 9th*

Edition, September, 2022, Section II- The Provider Network for Credentialing Application and other documentation requirements. The Medi-Cal Specialty Mental Health Services Network Provider Manual, 9th Edition, September, 2022 can be downloaded at: https://dmh.lacounty.gov/pc/cp/ffs2/ Under “Manuals and Guides”

SECTION IV:
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
- Provider Appeals

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.

Responsibility of the SPOC on Provider Alerts

The LACDMH, Intensive Care Division will issue Provider Alerts to contract providers via the SPOC. The SPOC shall be responsible in disseminating the Provider Alerts to appropriate hospital personnel. The immediate distribution of Provider Alerts upon receipt is very important because the Alert contains information regarding clinical, administrative or financial policies and procedures that will have direct impact on authorization and reimbursement of services. Any changes described in the Provider Alerts have the authority of policy and are binding to the LACDMH provider's contract agreement with LACDMH.

SECTION V: INSTRUCTIONS FOR COMPLETING A TAR

INSTRUCTIONS FOR COMPLETING A TAR

The following section is to be completed by the hospital provider.

HOSPITAL USE:

Box 6 Leave blank

Box 7 Date of admission

Box 8 Leave blank

Box 9 Place an "X" on all TARs

Box 10 Provider NPI number *Verbal Control* – Leave Blank

Provider Phone No., Name and Address – 9-digit zip code

Box 11 Patient's Medi-Cal ID number.

Above Box #11, place the Medi-Cal *County Code* and *Aid Code* numbers

Box 12 Blank

Box 13 M or F

Box 14 Date of Birth MM/DD/YYYY and Age (check accuracy with DOB)

Box 15 Medicare Status: 0 = No Medicare 1 = Medicare, Part A only 2 = Medicare, Part B only 3 = Medicare, Part A & Part B

Box 16 Other Coverage. "X" if patient has other insurance

Box 17 Number of days requested on this TAR

- The day of admission is counted but **not** the discharge day
- If other insurance has been billed, include only the Medi-Cal billable days
- The maximum number of days is limited to 99 days per TAR

Box 18 Type of days: "0" – acute. "2" – administrative

Box 19 Enter an **"X"** ONLY if the TAR is being submitted as a **Retro TAR**, If not, leave blank

Box 20 Date of discharge

Box 21 Admitting diagnostic code. It must match the written diagnosis

Box 22 Discharge diagnostic code. It must match the written diagnosis

***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.

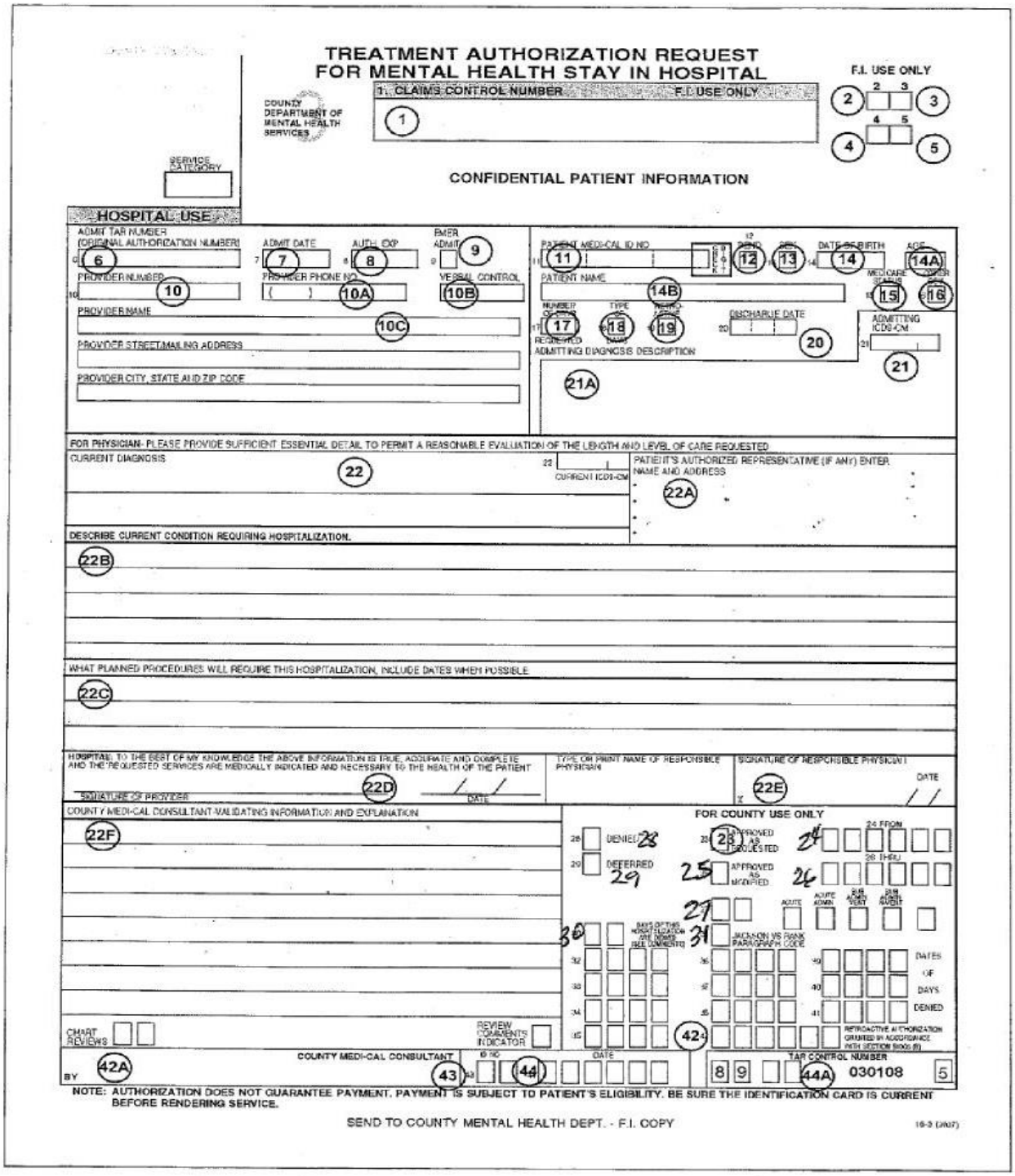
Planned Procedures: Complete as instructed. On Appeal TARs, leave this section blank.

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 sect

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



TREATMENT AUTHORIZATION REQUEST
FOR MENTAL HEALTH STAY IN HOSPITAL

F.I. USE ONLY

COUNTY DEPARTMENT OF MENTAL HEALTH SERVICES

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

SERVICE CATEGORY

CONFIDENTIAL PATIENT INFORMATION

HOSPITAL USE

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

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

PROVIDER NAME 10C

PROVIDER STREET/MAILING ADDRESS

PROVIDER CITY, STATE AND ZIP CODE

PATIENT MEDI-CAL ID NO. 11 | AID CODE 12 | SER. CODE 13 | DATE OF BIRTH 14 | AGE 14A

PATIENT NAME 14B | MEDICARE STATUS 15 | OTHER COVER 16

NUMBER OF DIAGNOSES REQUIRED 17 | TYPE OF CARE 18 | PERIOD OF CARE 19

DISCHARGE DATE 20

ADMITTING ICD9-CM 21

ADMITTING DIAGNOSIS DESCRIPTION 21A

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

CURRENT DIAGNOSIS 22 | CURRENT ICD9-CM 22

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

DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION. 22B

WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE 22C

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

SIGNATURE OF PROVIDER 22D | DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN 22E | DATE

COUNTY MEDI-CAL CONSULTANT VALIDATING INFORMATION AND EXPLANATION 22F

FOR COUNTY USE ONLY

25 DENIED 28 | 28 APPROVED AS REQUESTED 28 | 24 FROM 24

29 DEFERRED 29 | 25 APPROVED AS MODIFIED | 26 THRU 26

27 ACUTE | ACUTE ADMIN | SUB ACUTE VENT | SUB ACUTE ADMIT

30 DAYS DEFERRED HOSPITALIZATION ARE DENIED (SEE COMMENTS) | 31 JACKSON VS FRANK PARAGRAPH CODE

32 33 34 35 | 36 37 38 39 | 40 41 DATES OF DAYS DENIED

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 5008 (f)

CHART REVIEWS | REVIEW COMMENTS INDICATOR | 42

BY 42A | COUNTY MEDI-CAL CONSULTANT | ID NO. 43 | DATE 44

TAR CONTROL NUMBER 8 9 | 44A 030108 5

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 (2/07)

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

SECTION VI:
SUBMISSION OF A TAR

SUBMISSION OF INITIAL TREATMENT AUTHORIZATION REQUEST (TAR) FORM FOR RETROSPECTIVE AUTHORIZATION

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 DXC Technology at (800) 541-5555. Address: 820 Stillwater, West Sacramento, CA 95605-1630.

- 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, Chapter 11, Section 1820.220).

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

LATE TAR SUBMISSION

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: Destroyed or damaged the hospital's business office or records; 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.

CIRCUMSTANCES WHEN RETROSPECTIVE TARs CAN BE SUBMITTED

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

1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or
4. Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and shall be communicated to the provider in a manner that is consistent with state requirements.

TARs that meet retrospective 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 coinsurance and deductible payments due to the provider from the Medi-Cal program.

HOW TO SUBMIT A RETROSPECTIVE TAR FOR REVIEW:

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-day timeline for submission of a retrospective TAR.

Note: TARs will not meet retrospective review 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.**

1. Enter the episode in the LAC data system immediately upon discovery of Medi-Cal eligibility; and
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 following episode information:

- Prior to submission of a TAR enter the discharge information, including date of discharge;
- Discharge diagnosis; and
- 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).

- Determining Medi-Cal Eligibility
- Verify Medi-Cal eligibility (POS, AVES or Eligibility Response)
- Submit proof of eligibility with the TAR for each month of service.
- 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*

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 admission and discharge summaries;
5. Copy of the patient's medical record to support medical necessity for acute days and if applicable, Administrative Days;
6. Copy of beneficiary's signed and approved treatment plan; and
7. 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:

LAC Department of Mental Health TAR Unit
510 S. Vermont Avenue, 20th Floor
Los Angeles, CA 90020

SUBMISSION OF 99-DAY 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.

SECTION VII:
TAR PROCESS COMPLIANCE

TAR PROCESS 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 of receipt.**

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 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".

Note: When appropriate, the LACDMH TAR Unit will validate circumstances resulting in late claims. These claims must be submitted to the following special address:

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

SECTION VIII: 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 DXC Technology
- 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 DXC Technology 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
510 South Vermont Ave., 20th Floor
Los Angeles, CA 90020

FAX TO:

Treatment Authorization Unit
Attention: TAR Inquiry, Correction and Resubmit Desk
FAX #: (213) 947-1425
Phone number: (213) 739-7300

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

SECTION IX:
MEDICAL NECESSITY

MEDICAL NECESSITY CRITERIA

Medical Necessity Criteria for Reimbursement of Acute Psychiatric Inpatient Hospital Services Including Psychiatric Services Provided at Institutions of Mental Diseases (IMD) and Psychiatric Health Facilities (PHF).

For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services including inpatient psychiatric services at IMDs and PHFs shall meet medical necessity criteria set forth below:

(1) One of the included diagnosis found in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5,* published by the American Psychiatric Association. Please see explanation below.

Regarding the provision of diagnosis, the provider shall use the criteria sets in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM -5*) as the clinical tool to make diagnostic determinations. Once a DSM-5 diagnosis is determined, the provider shall determine the corresponding mental health diagnosis in the *International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10 CM).*

The provider shall use the ICD-10 CM diagnosis Code(s) to submit a claim for specialty mental health services to receive reimbursement of Federal Financial Participation (FFP).

The Department of Health Care Services had issued an Information Notice No.18-053, published on October 26, 2018, adding a list of ICD-10 diagnosis codes that are covered for Inpatient Specialty Mental Health Services effective October 1, 2018.

(2) Pursuant to *Welfare and Institutions Code, Section 14184.402(a),* <u>for individuals 21 years of age and older</u>, a service is medically necessary or there is medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

(3) <u>For individuals under 21 years of age</u>, a service is medically necessary or there is medical necessity if the service meets the standards set forth in *Section 1396d(r)(5) of Title 42 of the United States Code*, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as EPSDT.

Physician Coverage

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 credentialed and LACDMH contracted house staff psychiatrist, or another credentialed and LACDMH contracted psychiatrist 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/behaviors are also taken into consideration, as well as any interventions rendered by other licensed professionals 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 is acceptable to assist in the determination of medical necessity of acute care. *Pursuant to CCR, Title 9, Chapter 11, Section 1810.241*, psychologist services may only be provided by licensed psychologists who are individual or group providers. In addition to being a group or individual provider, the LMHP requires that the psychologist be credentialed and contracted with the county. Visits by any other non-physician practitioners with staff privileges should be documented as well.

SECTION X: CONCURRENT REVIEW PROCESS

THE CONCURRENT REVIEW PROCESS

Pursuant to the *Welfare & Institutions Code §14680 through §14726* and under the State Department of Health Care Services (DHCS), Los Angeles County Department of Mental Health (LACDMH) operates the Local Mental Health Plan (LMHP). In accordance with the *DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) No. 19-026,* the LACDMH is required to conduct concurrent review and authorization for all psychiatric inpatient hospital services, except for some limited circumstances. If the circumstances are deemed appropriate, the medical record will be reviewed retrospectively. *DHCS, pursuant to Behavioral Health Information Notice (BHIN) No. 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*, defines medical necessity or what is a medical necessary service. The definition of medical necessity found in the *California Code of Regulations, Chapter 11, Section 1820.205* has been superseded by *BHIN 22-017*.

DEFINITIONS

Acute Psychiatric Inpatient Hospital Services: Services provided by a hospital to beneficiaries for whom the facilities, services and equipment are medically necessary for diagnosis and treatment of mental disorder.

AVATAR: LACDMH software application for electronic medical records.

Concurrent Review: Clinical review of treatment authorizations for all inpatient psychiatric services following the first day of admission.

Continued Stay Services: Psychiatric inpatient hospital services for beneficiaries that occur after admission.

Fee-For-Service Medi-Cal Hospital: A hospital providing acute inpatient psychiatric services to the LMHP's Medi-Cal beneficiaries; and submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the fiscal intermediary.

Institutions of Mental Disease (IMD): Per *Code of Federal Regulations (CFR), §435.1009(b)(2)*, defines an IMD as "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 diseases, including medical attention, nursing care, and related services.

Integrated Behavioral Health Information System (IBHIS): The Electronic Health Record System (EHRS) implemented by Los Angeles County Department of Mental Health (LACDMH).

Medical Necessity Criteria for Acute Inpatient Services: The conditions necessary for receiving inpatient acute psychiatric services following a psychiatric evaluation; and required for Medi-Cal reimbursement.

Microsoft Teams: Messaging application- a workspace for real-time collaboration and communication, meetings, files, etc. in one place, all in the open, all accessible to LACDMH TAR Unit staff.

Notice of Adverse Benefit Determination (NOABD): Notice to beneficiaries of the adverse benefit determination that LACDMH has made, and procedures for exercising beneficiary's rights.

Point of Authorization (POA): LACDMH, Clinical Operations, Intensive Care Division, Treatment Authorization Unit is the POA to authorize payment for services.

ProviderConnect: Web interface used to communicate with IBHIS. It 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.

Retrospective Review: A review of medical documentation following discharge. Retrospective reviews shall be conducted under the following conditions: Retroactive Medi-Cal Determinations; Inaccuracies in the Medi-Cal Eligibility Data System; Authorization of services for beneficiaries with other healthcare coverage pending evidence of billing, including dual-eligible beneficiaries and/or beneficiary's failure to identify payer (e.g., Inpatient Psychiatric Hospital Services).

Treatment Authorization Reviewer: A LACDMH credentialed and State of California licensed mental health employee trained and assigned to review for medical necessity criteria for acute inpatient hospital admissions, continued stays and administrative days services.

Treatment Authorization Status Form (TAS): LACDMH TAR Unit communication form between TAR Unit and the provider. This form is used to submit with documents received and sent; and to communicate authorization decisions to the provider.

ADMISSION NOTIFICATION and REQUEST FOR TREATMENT AUTHORIZATION

Within 24 hours of admission of a Medi-Cal beneficiary for psychiatric inpatient hospital services, the hospital shall provide the LACDMH ICD TAR Unit the beneficiary's admission orders, initial plan of care pursuant to *Code of Federal Regulations, Title 42, Subpart D, Section 456.180*, a request to authorize the beneficiary's treatment (partially completed TAR), and a completed face sheet that includes the following information (if available):

a) Hospital name and address
b) Patient name and DOB
c) Insurance coverage
d) Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System

e) Current address/place of residence
f) Date and time of admission
g) Working/provisional diagnosis
h) Date and time of admission
i) Name and contact information of admitting, qualified and licensed practitioner
j) Utilization review staff contact information

Note: If upon admission, a beneficiary is in an emergency medical condition, as defined in *Health and Safety Code, Section 1317.1(k)*, the time period for the hospital to request authorization shall begin when the beneficiary's condition is stabilized.

INITIAL PROCESS FOR THE SUBMISSION OF MEDICAL RECORD DOCUMENTATION FOR CONCURRENT REVIEW AND AUTHORIZATION

- The providers create their own general email box that is accessible to all staff who will send and/or receive information from LACDMH TAR Unit.

- LACDMH TAR Unit assigns each provider a Unique Identifier and the provider must use this Unique Identifier with the beneficiary's identifying information when submitting initial request for authorization for Medi-Cal reimbursement of acute inpatient psychiatric services for concurrent review. The provider's Unique Identifier consist of the following: the patient's IBHIS member number, _last name_ first name initial_date of birth__admission date_ hospital's three (3) letter acronym_admission date_submission number. Providers are required to send documents through ProviderConnect to LACDMH TAR Unit with a secure email notification. The access to ProviderConnect enables the provider to upload documents for review and authorization. All emails sent to the TAR Unit must have only the 3-letter hospital acronym on the subject line.

- Within 24 hours of admission or the next working day, providers are required to notify the TAR Unit through secure email a beneficiary admission notification and request authorization for reimbursement of acute inpatient psychiatric hospital services.

- Contents of the provider uploads are limited to the documents listed on the "List of Required Documents for Concurrent Review".

- Upon receipt of provider's notification of beneficiary admission, the TAR Clinical Reviewers will conduct concurrent review of treatment authorizations following the first day of admission and enter review notes in AVATAR. The TAR Clinical Reviewers use AVATAR to open and review documents, and authorize from admission to the next assigned review date.

EXCHANGE OF RELEVANT BENEFICIARY INFORMATION BETWEEN THE ICD TAR UNIT AND THE PROVIDERS FOR CONTINUED STAY AUTHORIZATION

The LACDMH ICD TAR Unit may request only information from the hospital and treating provider that is reasonably necessary to decide whether to grant, modify or deny the request. The exchange of information is intended to occur flexibly, with the TAR Unit and hospital exchanging relevant client and clinical information as needed to complete concurrent review procedures and for discharge planning and aftercare support. Conversely, the treating provider at the hospital may request information and records from the TAR Unit needed to determine the appropriate length of stay for the beneficiary.

Clinical information to be exchanged includes:

a) Current need for treatment to include involuntary or voluntary status, diagnosis, current symptoms and current response to treatment.

b) Progress notes or risk assessments to include any changes, inclusive of new indicators since initial intake assessment that reflect current risk. Examples may include protective and environmental factors and available supports that should be considered in discharge planning; updates regarding changes to suicidal and/or homicidal ideation since admission; aggression/self-harm since admission; behavioral observations; historical trauma.

c) Precipitating events if further identified or clarified by the treating hospital after TAR Unit admission notice.

d) Known treatment history as relates to this episode of care to include daily status (e.g., physician orders, daily progress notes, nursing notes, physician notes, social work notes, rounds sheet, lab results of the treating hospital.

e) Hospital information on prior episode history that is relevant to current stay.

f) Hospital information of relevant and clinically appropriate client history.

g) Medications to include medication administration records for this episode, changes in medication, response to current medication, or further recommendations.

h) Substance use information to include any changes, inclusive of new indicators since initial intake assessment. Examples may include SUD history, any recent changes in SUD, role of SUD in current diagnosis, SUD treatment goals, motivation to change SUD, and recommended SUD treatment post discharge.

i) Known medical history to include co-occurring factors that may be related to care of the psychiatric condition as detailed in admitting and/or ongoing history and physical, or medical treatment needs while admitted.

j) Treatment plan including any updates and changes to the initial treatment plan and evidence of progress or symptom management.

k) Discharge and aftercare plan to include follow-up care, social, and community supports, and a recommended timeline for those activities.

l) Number of continuing days requested.

Review of Continued Stay Authorization Request

The LACDMH ICD TAR Unit shall issue a decision on a hospital's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.

- On submission/upload days, the provider shall include all outstanding documents from the preceding days in one (1) pdf file. Example: When the assigned upload day is on a Monday, the TAR Unit Clinical Reviewers should be able to see progress notes from prior days like Thursday, Friday, Saturday, and Sunday. If the submission/upload day is on a Thursday, the TAR Unit Clinical Reviewers must be able to see progress notes from Monday, Tuesday, and Wednesday.

- The provider must send a separate secure email to the TAR Unit every time a pdf document has been uploaded to ProviderConnect. The secure email shall be sent to: tarunit@dmh.lacounty.gov. The email will alert the TAR Unit Clerical staff that documents were uploaded to ProviderConnect for processing. It is also necessary for the provider to create Provider Communication form for each upload. The Unique Identifier shall be documented on the form with the number of upload(s) sent.

- For continued stay authorization requests, the provider submits documents requesting a review to establish whether the beneficiary meets medical necessity criteria. Once the TAR Clinical Reviewer receives clinical documents, then the TAR Clinical Reviewer may authorize continued stay days. The continued stay authorized days will be reflected on the Treatment Authorization Status Form (TAS).

- The TAS is sent via secure mail to the provider and the beneficiary's treating physician within 24 hours of the decision.

Note: The MHP is responsible to cover the cost of each day of an inpatient hospital stay, at the applicable rate for acute psychiatric inpatient hospital services, until the requirements in paragraph 1 or 2, below, have been met:

1. The existing authorization expires and the hospital discharges the beneficiary (or the beneficiary's level of care is downgraded to administrative day level while awaiting transfer) pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider; or

2. The TAR Unit denies a hospital's continued stay authorization request and the hospital discharges the beneficiary (or the beneficiary's level of care in the hospital is downgraded to administrative day level while awaiting transfer), pursuant to a plan of care that is agreed upon by the MHP and the beneficiary's treating provider.

PHYSICIAN CONSULTATION OF DENIAL AFTER CONTINUED STAY REVIEW

- The TAR Clinical Reviewers may elect to authorize multiple days; however, documentation for each day of treatment must meet medical necessity criteria for admission and/or continued stay. The TAR Physician Reviewer may deny previously approved days done by TAR Clinical Reviewers if clinical documentation does not meet medical necessity criteria.

- The TAR Physician Reviewer uses AVATAR to open and review documents. After review, the Physician Reviewer enters a decision to deny/approve in the Certifying MD Summary section of AVATAR.

- The Physician Reviewer replies to the TAR Clinical Reviewer electronically in Microsoft Teams through MD Consults Channel messaging with the decision, “Denial” or “Approval”.

- The TAR Physician Reviewer’s reason for denial is noted in the TAS. The TAS and the Notice of Adverse Benefit Determination (NOABD) are completed, logged and sent to the provider and beneficiary’s treating physician within 24 hours of the decision.

- For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, the MHP must mail the notice to the beneficiary within two business days.

SECTION XI: ADMINISTRATIVE DAYS DOCUMENTATION REQUIREMENTS

ADMINISTRATIVE DAY

Pursuant to California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.202, "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 FOR CONCURRENT OR RETROSPECTIVE AUTHORIZATION REVIEWS FOR ADMINISTRATIVE DAYS

Request for payment authorization for administrative day services shall be approved by Los Angeles County Department of Mental Health, Intensive Care Division, 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.

Note: Interrupted psychiatric inpatient stay, such as a temporary transfer to another facility or hospital department for treatment of a medical condition and upon return, still meets the administrative day criteria, shall have at least one approved acute day.

When a beneficiary's condition changes to an acute level of care, or when the beneficiary becomes stable and return to administrative day status, the licensed and credentialed attending psychiatrist shall write an order for the modification of the level of care. 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.

Two Pathways to select from when beneficiaries meet the criteria for Administrative Day Services (Please choose only one):

A. Placement option in non-acute residential treatment facilities; or
B. Placement option through a State approved program flexibility waiver that is administered by the Intensive Care Division.

Documentation requirements when a provider chooses to select the non-acute residential treatment facilities pathway pursuant to beneficiary's needs.

A provider/acute psychiatric hospital may be authorized to provide Administrative Day Services when a beneficiary no longer meets Medical Necessity Criteria for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. Pursuant to the *Department of Health Care Services (DHCS) Information Notice (IN) No. 19-026, Authorization of Specialty Mental Health Services*, and *DHCS Behavioral Information Notice (BHIN) No. 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*, the Los Angeles County Mental Health Plan (MHP), Intensive Care Division, Treatment Authorization Unit shall conduct concurrent review and authorization of Administrative Day Service requests and the provider shall document the following:

(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.)

1. There shall be a physician's order for administrative day services. This is considered as day one (1).

2. The provider shall document having made one (1) contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status.

3. Once appropriate contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.

   A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which an appropriate contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

4. Providers may waive the requirements of five contacts per week 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. When there are less than five available and appropriate contacts per week, these contact calls shall also be done on consecutive days. The reason(s) for the lack of five (5) appropriate non-acute treatment facilities shall be documented on the progress notes or administrative day log every week.
   Contact requirements shall be documented to include but not limited to:

a. Date of the contact.

b. Name of the person contacted.
c. Facility response regarding availability of beds (status).
d. Signature of the person making the contact.
e. Name and telephone number of the facility contacted.

Note: For the hospital's documentation of the facility's response to bed availability, statements such as "pending", "received fax", "contacting Public Guardian", "facility staff did not answer my call so I left a message" 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.

Examples of appropriate placement option status include, but may not be limited to the following:

- The beneficiary's information packet is under review
- An interview with the beneficiary has been scheduled for (date)
- No bed available at the non- acute treatment facility
- The beneficiary has been put on a wait list
-
- The beneficiary has been accepted and will be discharged to a facility on (date of discharge)
- A conservator deems the facility to be inappropriate for placement
- The beneficiary has been rejected from the facility due to (reason). When the reason for rejection is due to age restriction or wheelchair access, the provider shall remove the name of the facility as a placement option.

Guidelines and Recommendations when selecting non-acute residential treatment facilities as a placement option

1. "Appropriate, non-acute residential treatment facilities" means facilities which offer Specialty Mental Health Services (SMHS) on premises to all beneficiaries in the facility. SMHS consist of Individual, Group. Collateral therapies, and Medication Support Services. Please note that a Fee-for-Service (FFS) Physician services does not qualify because he/she only provides services to beneficiaries under his/her care. In addition, the services provided by the FFS Physician will be reimbursed by LACDMH. For children and adolescents, "non-acute residential treatment facility" usually consists of a designation by LACDMH of certain Rate Classification Levels (RCL).

2. Inpatient hospital staff must contact facilities that are appropriate for the needs of the identified beneficiary that they are attempting to refer. For example, if a beneficiary has a dual diagnosis, then facilities that are licensed to treat this condition must be contacted. Beneficiaries without substance/alcohol related diagnosis or history should not be referred to the Dual Diagnosis Program. Another example: An elderly beneficiary who has extensive medical issues is referred to a facility that does not accept this age bracket and the placement is not able to provide the services needed.

3. When a beneficiary who has been on administrative days is discharged home, or back to the facility from which he/she had been admitted from, there must be documentation to

determine whether this abrupt change in the discharge plan was foreseeable. If the hospital was in good faith searching for a placement to which it fully intended to discharge the beneficiary, but unforeseeable events outside of the hospital control caused the hospital to abort its plan, then credit maybe given for those days that meet the administrative day criteria. The reason for the abrupt change shall be documented.

4. If there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement option for the beneficiary, there must be a written justification in the medical record of the reason why less than the required five (5) contacts per week was made. This justification is called the "waiver". It shall be submitted on a weekly basis if the hospital is unable to contact five (5) appropriate non-acute residential treatment facilities per week.

Non- Appropriate Facilities for Administrative Day Placements are:

Assisted Living Facilities, Guest Homes, Non-augmented Board and Care Facilities, and Skilled Nursing Facilities without a Special Treatment Program (STP) do not qualify as these facilities do not provide organized SMHS available to all beneficiaries.

Administrative Day Services for Regional Center Patients

- There is a limit of four (4) Administrative Days per episode for clients of 6 of the 7 Regional Centers in Los Angeles County.
- Pursuant to a Memorandum of Understanding (MOU) between MHP and 6 Regional Centers (Lanterman, Westside, South Central, San Gabriel, North Los Angeles, and East Los Angeles) located within Los Angeles County, the MHP will be financially responsible only for the acute psychiatric inpatient days approved, and the first four (4) Administrative Days for each acute psychiatric 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 acute inpatient psychiatric services, the hospital is required to contact the appropriate local Regional Center to begin placement efforts and to obtain pre-authorization for any prospective reimbursement for Administrative Days.
- The Regional Center pre-authorization applies only to payment for the 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 on day five (5).

Documentation Requirements for Administrative Days using the ICD Pathway

The Los Angeles County Department of Mental Health (LACDMH) Intensive Care Division (ICD) program, formerly referred to as the "CRM Gatekeeper Program", functions as bed control for subacute mental health facilities, Crisis Residential Treatment (CRTP) facilities, Adult Residential Treatment facilities (ART) and Enriched Residential Services (ERS). LACDMH was granted an exemption by the former State of California Department of Mental Health from the requirements under *CCR, Title 9, Chapter 11, § 1820.220(j)(B)(5)(A)(B)* if the hospital refers the beneficiary for consideration under the

discharge process administered by the ICD and the ICD accepts the beneficiary for placement consideration under the process. The LACDMH administrative day waiver is sanctioned under the *Contract between the Mental Health Plans with DHCS*. In addition to the contact documentation requirements identified below, the hospital discharge planner shall follow the following procedures when referring beneficiaries to ICD:

1. There must be at least one (1) day approved TAR that meets medical necessity criteria for acute psychiatric admission set forth in *DHCS BHIN No. 22-017.*

2. There must be a physician order for Administrative Day for ICD level of care. The physician order date is considered Day 1. *Reference: Code of Federal Regulations, Title 42, Public Health, Part 456, Utilization Control: Mental Hospital, §456.235, Length of Stay Modification.* No other discipline can write an order for Administrative Days. In addition, retroactive orders for Administrative Days are not acceptable.

   Within twenty-four (24) hours of a physician Administrative Day order, the hospital discharge planner or assigned staff contacts ICD for initial referral (Telephone: 213.738. 4775). Initial telephone referrals must make contact with ICD staff. If no contact, leave a voicemail and follow-up with email. ICDReferral@dmh.lacounty.gov. A copy of this email shall be included in the uploaded/submitted documents for administrative days.

   There must be documentation of contact date (within 24 hours of the physician order), staff name that was contacted, telephone number, hospital staff name and signature. Within one (1) business day, ICD staff will return the voicemail or email. If ICD determines that the referral is appropriate, the hospital must send a complete medical record to ICD within five (5) business days. If referred beneficiary is not yet Lanterman Petris Short (LPS) conserved, send copy of LPS application for conservatorship (T-Con). Medical records shall be sent through eFax at 213.947.1609.

3. Hospital staff must include *ICD Confirmation of Appropriate Referral* when submitting or uploading documents to the TAR Unit and provide documentation that the complete medical record was sent on or before the fifth (5th) business day.

4. Hospital staff contacts ICD at least once a week (except weekends and holidays) for status of referral. Required documentation of the weekly call includes but not limited to:
   a. Date of ICD contact;
   b. ICD staff name that was contacted;
   c. Telephone number contacted;
   d. Status of referral (in triage, referral being reviewed); and
   e. Hospital staff name and signature of the person making the contact.

   Note: ICD is no longer assigning wait list numbers.

5. Hospital must follow the ICD screening and review process until the beneficiary is placed on the appropriate facility and/or facilities referral list (Sub acute, CRTP, ARTs or ERS).

6. Within two (2) business days of receipt of the *ICD Referral Approval Form,* hospital must contact the facilities checked off on the form and forward medical records to these

facilities. **Copy of the *ICD Referral Approval Form* shall accompany all medical records to be submitted for authorization.** Please note that only the checked off facilities listed on the *ICD Referral Approval Form* shall be called. No facilities shall be called prior to the receipt of the ICD Referral Form. If ICD checked only one (1) facility that is appropriate for the beneficiary, only that facility shall be called. Please do not call ICD.

7. Hospital shall contact the identified provider at least once a week or as often as necessary to check the beneficiary's referral status. This weekly contact shall be done until the beneficiary is accepted/denied to the facility and discharged. Required documentation includes but not limited to:

a. Date of facility contact;
b. Facility staff name contacted;
c. Name of facility and telephone number;
d. Status of referral; and
e. Provider staff name and signature of the person making the contact. Leaving voicemails are not acceptable and will lead to a denial.

8. Reasonable promptness of the hospital in discharging the beneficiary to the accepting facility is anticipated.

9. If the beneficiary is denied from all identified placements, hospital staff may contact ICD for alternative discharge consultation. If there is a delay in the ICD staff returning the call, you may call the ICD Supervisor.
   Although not required, it is recommended that the hospital maintain an Administrative Day Log so that the required elements of contact documentation are captured and met.
   Note: If a hospital discharge planner or case manager independently calls ICD placement options without going through the ICD process and mixes these facilities with non-ICD contracted facilities and/or Board and Care facilities, the entire week will run the risk of being denied.

ICD Initial Referral Denial

When ICD determines that the hospital's initial referral is not appropriate and does not meet ICD admission criteria, the TAR Unit will approve the hospital's TAR for Administrative Day, from the date of the physician order through the date the ICD notified the hospital that the beneficiary did not meet ICD admission criteria. The hospital staff shall start to document required contact pursuant to DHCS IN No. 19-026 and DHCS BHIN No. 22-017 the day after the beneficiary was denied by ICD.

The TAR Unit wishes to emphasize the importance of clear and accurate documentation in the medical records as required. Lack of required and accurate documentation will create problems at all phases of Administrative Day requests and could potentially put the hospital at risk of unanticipated denials.

ICD Levels of Care
Sub-acute Facilities including State Hospitals

Sub-acute facilities provide long-term care for individuals wo no longer meet criteria for acute care but are not clinically ready to live independently or be discharged to a board and care facility. Sub-acute facilities provide 24/7 psychiatric care, nursing care, and psychosocial rehabilitation services geared to the needs of individuals with serious mental illness who are placed under Lanterman-Petris-Short (LPS) conservatorship. Sub-acute facilities are in a locked setting level of care. Providers may submit a referral for this level of care as soon as LPS application is filed.

Crisis Residential Treatment Program (CRTP)

CRTP is an intensive short-term and structured residential program that serves as an alternative to hospitalization for clients experiencing an acute psychiatric crisis or episode and who do not have medical complications requiring nursing care. Length of stay ranges from 14 days up to a maximum of 90 days. Services are provided in a non-institutional residential setting with the purpose of restoring, improving and/or preserving client's prior living arrangements with independent skills, and access to support systems within the community.

Enriched Residential Services (ERS)

ERS program is designed to provide comprehensive mental health and rehabilitative services in a non-institutional residential setting for individuals 18 years and older, who would be at risk of hospitalization, re-hospitalization or other institutional placement if they were not in the ERS program. ERS program accommodates persons discharged from a locked sub-acute facility, acute psychiatric inpatient units, jails or intensive residential facilities. ERS program targets individuals in higher levels of care who require on-site mental health and supportive services. ERS is an open setting lower level of care. Services focuses on life skills training, linkage and community engagement activities that support individuals in their effort to restore, maintain and apply interpersonal skills and independent living skills and to access community support system. ERS program aims to stabilize, prepare, and transition individuals to a stable, independent community living environment.

SECTION XII: 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 (DHCS), the Los Angeles County Department of Mental Health (LACDMH) has established required components of an assessment. LACDMH ICD 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".
California Code of Regulations, CCR, Title 22, Section 71517, Admission, Transfer and Discharge Policies, (c) Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination and psychiatric evaluation performed by persons lawfully authorized by their respective practice acts to perform such examinations providing the condition of the patient permits. Each patient shall have a complete psychological evaluation performed by a physician and surgeon or clinical psychologist consistent with the medical bylaws and providing the condition of the patient permits.

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.

Assessment Domain Requirements:

Documentation requirements for Specialty Mental Health Services pursuant to *DHCS Behavioral Information Notice No. 22-019.*

The Assessment shall include the following seven (7) required domains. Providers shall document the domains in the Assessment and keep the Assessment in the beneficiary's medical record. Providers shall complete the Assessment within a reasonable time, and in accord with generally accepted standards of practice. Pursuant to California Code of Regulations, *Title 22, Section 71517, Admission, Transfer and Discharge,* the Assessment shall be written immediately before admission or within 24-hours after admission. Every patient shall have a complete history and physical examinations, and psychiatric evaluation performed by persons lawfully authorized by their respective practice acts to perform such examinations providing the condition of the patient permits. Each patient shall have a complete psychological evaluation performed by a physician and surgeon or clinical

psychologist consistent with the medical bylaws and providing the condition of the patient permits.

Domain 1
•Presenting problem(s)
•Current Mental Status
•History of presenting problems
•Beneficiary-identified improvements

Domain 2
•Trauma

Domain 3
•Behavioral Health History
•Comorbidity

Domain 4
•Medical History
•Current medications
•Comorbidity with Behavioral Health

Domain 5
•Social and life circumstances
•Culture/Religion/Spirituality

Domain 6
•Strength, Risk behavior(s), and safety factors
•Clinical Summary and recommendations

Domain 7
•Clinical summary and recommendations
•Diagnostic Impression
•Medical Necessity Determination/level of care/Assessment Criteria

Staff name and signature of the person performing a Psychiatric Diagnostic Assessment (staff person must practice within the scope of licensure).

Initial Beneficiary Plan of Care

Pursuant to *Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D, Section 456.170* and referenced on *California Department of Health Care Services, Behavioral Health Information Notice No. 22-017 under "Admission and Authorization", an individual plan of care or treatment plan must be in place: a) 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 an appropriate professional personnel must make a psychiatric and social evaluation.*

Required components of an Initial Plan of Care:

1. Diagnosis;
2. Summary of present medical findings;
3. Mental and physical functional capacity;
4. Prognoses; and
5. A recommendation by a physician concerning:

a) Admission to the mental hospital, or
b) Continued care in the mental hospital for individuals who apply for Medi-Cal while in the mental hospital.

Individual Written Plan of Care

Pursuant to *Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D, Section 456.180* and referenced on *California Department of Health Care Services, Behavioral Health Information Notice No. 22-017 under "Admission and Authorization",* the Individual written Plan of Care must include:

(1) Diagnosis, symptoms, complaints, and complications indicating the need for admission;
(2) A description of the functional level of the individual;
(3) Objectives;
(4) Any orders for-
(i) Medications;
(ii)Treatments;
(iii)Restorative and rehabilitative services;
(iv)Activities
(v)Therapies
(vi)Social services
(vii)Diet; and
(viii)Special procedures recommended for the health and safety of the patient
(5) Plans for continuing care, including review and modification of the plan of care; and
(6) Plans for discharge.

The Plan of Care shall be updated on an on-going basis to reflect the current presentation of the beneficiary. Care plan updates every 5-7 days is the accepted practice in the inpatient psychiatric hospitals.

The provider shall add or remove problems from the plan of care when there is a relevant change to the beneficiary's condition. The name and title of the provider that identified, added, or removed the problem shall be add his/her signature. In addition, the dated signature of the physician of record shall be in place.

When a signature is required on a client plan, and the beneficiary is unable to sign the plan, the reason for the missing signature shall be documented in the client pan. *(Reference: BHIN 21-046)*

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.

SECTION XIII: APPEALS

Effective July 1, 2017, the Los Angeles County Department of Mental Health, Intensive Care Division, Treatment Authorization Unit, (LACDMH/ICD, TAR Unit), will comply and operate with all applicable federal managed care requirements, state regulations and will implement its policies in processing adverse benefit determinations. The Policy and Procedures for the Intensive Care Division NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD), NOTICE OF APPEAL RESOLUTION (NAR) AND THE RIGHT TO A STATE FAIR HEARING will be discussed in this Chapter.

APPEAL

The Appeal described below will only be followed after the LMHP has denied services following a Concurrent or Retrospective Reviews and after the beneficiary or provider's receipt of an NOABD.

An Appeal is a written request from the beneficiary to appeal a determination from the TAR Unit on denial of acute and/or administrative days for inpatient hospitalization that did not establish medical necessity and/or meet administrative day placement criteria. Appeal is further defined by *DHCS MHSUDS Information Notice No. 18-010E* that under new federal regulations, an "Appeal" is a review by the Plan of an Adverse Benefit Determination.

The Los Angeles County Department of Mental Health, Intensive Care Division, TAR Unit, acting as the Point of Authorization and handling of standard and expedited appeals shall only have one level of appeal for beneficiaries.

TIMELINE FOR FILLING STANDARD APPEALS

- All Standard Appeal documents must be submitted by the beneficiary, authorized representative or provider within 60 calendar days of the initial TAR denial date and receipt of the Notice of Adverse Benefit Determination (NOABD) letter. This is the date the initial TAR and NOABD were faxed to the provider.

METHOD OF FILING

- In accordance with the *Code of Federal Regulations (CFR), Title 42, Section 438.402(c)(3)(iii)* and *California Code of Regulations (CCR), Title 28, Section 1300.68(a)(1)*, Appeals may be filed by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing.
    - Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. The provider is expected to obtain this consent and file it in the beneficiary's medical records.
    - An oral appeal (excluding expedited Appeals) shall be followed by a written, signed appeal by the beneficiary. The date of the oral Appeal establishes the filing date for the Appeal.
- The Patient's Rights Office (PRO) of the Los Angeles County Department of Mental Health has staff assigned to area hospitals. The PRO staff are responsible in assisting

beneficiaries in completing appeal forms and other procedural steps to file an appeal and informing beneficiaries of the location of the forms on the Plan's website or providing the form to the beneficiaries without having to make verbal or written requests to anyone. The FFS inpatient hospital providers have a dedicated space that contains the Beneficiary Rights, Appeal and Grievance Forms and envelops that are readily available to beneficiaries and hospital staff. The presence of posted forms is also monitored during the triennial Inpatient System Review by the Intensive Care Division, Compliance Unit.

STANDARD APPEAL PROCESS

(Appeals may be submitted electronically through Provider Connect)

1. Submit a written Appeal/Internal Appeal by the provider/beneficiary 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. A written, signed Appeal by the beneficiary is also required; however, in the event that the TAR Unit does not receive a written, signed Appeal from the beneficiary, the TAR Unit shall neither dismiss nor delay resolution of the Appeal.

   An oral appeal may be submitted by calling the TAR Unit's dedicated line at (213)- 739-7300. This oral submission of a standard appeal shall be followed by a written request to include the consent and signature of the beneficiary.

2. The provider/beneficiary/authorized representative shall submit the Appeal to the LACDMH ICD TAR Unit within 60 calendar days from the date on the NOABD. All documentation must be submitted at the same time.

3. Retention of envelopes, receipts and emails documenting submission dates are retained on all Appeals that failed to meet the 60-calendar day timeline for an Appeal.

4. The TAR Unit shall Fax a written acknowledgment to provider and beneficiary within five (5) calendar days of receipt of the Appeal. The acknowledgment letter shall include the date of receipt as well as name, telephone number, and address of the TAR Unit representative who the beneficiary may contact about the appeal.

5. 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 in the *DHCS BHIN No. 22-017* to support the Appeal. Clarification of illegible notes may be submitted but must be printed or typed before resubmission.

6. TAR Unit shall distribute Appeals of adverse benefit determination to the TAR Unit credentialed and licensed personnel not involved in the initial denial, modification or any previous level of decision-making and were not subordinates of any individual who was involved in a previous level of review to determine the appeal decision. Decision makers of the submitted appeal will take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse

benefit determination. The Appeal Physician Reviewer makes the final decision on behalf of the Program Manager III, Intensive Care Division.

7. The TAR Unit may extend the timeframe for processing an appeal by up to 14 calendar days, if the beneficiary requests an extension or the TAR Unit determines that there is a need for additional information and that the delay is in the beneficiary's benefit.

8. If the TAR Unit extends the timeframes, the TAR Unit shall, for any extension not requested by the beneficiary, make reasonable efforts to give the beneficiary reasonable efforts to give the beneficiary prompt oral notice of the delay and notify the beneficiary of the extension and reasons for the extension in writing within two (2) calendar days of the decision to extend the timeframe. The TAR Unit's written notice of extension shall inform the beneficiary of the right to file a grievance if he/she disagrees with the TAR Unit's decision. The TAR Unit shall resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires. *(42 CFR, Section 438.408(c)(2)(i)-(iii)*. The written notice of the extension is not a Notice of Adverse Benefit Determination.

9. Allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person or in writing.

10. Provide the beneficiary or his/her representative the beneficiary's case file including medical records, and any other documents and records, and any new and additional evidence considered, relied upon, or generated by the TAR Unit in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the beneficiary. *42 CFR, Section 438.406(b)(5).*

11. Provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe. The TAR Unit shall resolve the standard appeal by sending a Notice of Appeal Resolution (NAR) within 30 days from the day of the receipt of the appeal.

12. The TAR Unit shall notify the beneficiary, and/or her representative, of the resolution of the appeal in writing using the attachment to *DHCS MHSUDS Information Notice No.:18-010E, Notice of Appeal Resolution.*

13. In the event that the TAR Unit fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the mental health plan's appeal process and may initiate a State Hearing.

14. Allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties of the appeal.

15. Provider shall 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 <u>number</u> 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.

EXPEDITED APPEALS

“Expedited Appeal” is an appeal used when the mental health plan determines that taking the time for a standard resolution could seriously jeopardize the beneficiary’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Expedited Appeal Process

1. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

2. The beneficiary may file the request for expedited appeal orally without requiring the beneficiary to submit a subsequent written, signed appeal. It should be noted that there will be no punitive action taken by the mental health plan against a provider who requests an expedited resolution or supports the beneficiary’s expedited appeal.

3. The TAR Unit shall acknowledge written receipt of the Expedited Appeal request. The acknowledgment letter shall include the name, address, telephone number of the staff handling the appeal. The letter shall be sent as expeditiously as possible considering the timeframe for resolution.

   The TAR Unit shall log the time and date of the appeal receipt when expedited resolution is requested as this specific time of receipt of the request drives and begins the timeframe for resolution.

4. The TAR Unit shall inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. This information shall be included in the TAR Unit’s acknowledgement letter to the beneficiary

5. The TAR Unit must resolve and provide oral and written notice no longer than 72 hours after receipt of the Expedited Appeal request. The decision shall be communicated in the Notice of Appeal Resolution (NAR), and the NAR shall either be Overturned or Upheld based on the initial decision made in the NOABD. The TAR Unit shall provide prompt oral notice to the beneficiary of the resolution. The TAR Unit shall log the hospital staff’s name receiving the oral notice of the resolution.

6. The TAR Unit may extend the timeframe up to 14 calendar days if the beneficiary requests an extension, or the TAR Unit determines that there is need for additional information and that the delay is in the beneficiary's interest.

7. If the TAR Unit extends the timeline for processing an expedited appeal not at the request of the beneficiary, the TAR Unit shall make reasonable efforts to give the beneficiary prompt oral notice of the delay and notify the beneficiary of the extension and the reason(s) for the extension, in writing, within two (2) calendar days of the determination to extend the timeframe. The written notice of the extension is not an NOABD.

8. The TAR Unit shall resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

9. The TAR Unit shall send the beneficiary *Notice of Appeal Resolution* using the attachment found in *DHCS MHSUDS Information Notice No. 18-010E*. There must be a clear and concise explanation of the reason(s) for the decision. For determination based on medical necessity criteria, the notice must include the clinical reasons for the decision and a description of the criteria used.

   If the TAR Unit denies the request for an expedited appeal resolution, the TAR Unit shall:

a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the TAR Unit receives the appeal.

b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal. The TAR Unit shall provide written notice of the decision and reason for the decision within two (2) calendar days from the date of the denial and inform the beneficiary of the right to file a grievance if he or she disagrees with the decision. It shall be noted that the written notice of denial of the request for appeal is not an NOABD.

NOTICE OF APPEAL RESOLUTION (NAR)

The NAR is a formal letter informing a beneficiary that the Adverse Benefit Determination (NOABD) has been overturned or upheld.

Adverse Benefit Determination Upheld

For appeals not resolved wholly in favor of the beneficiary, the TAR Unit shall utilize the DHCS template included in the *DHCS MHSUDS Information Notice No. 18-010E*, for upheld decisions, which is comprised of two (2) components:

1) Notice of Appeal Resolution; and
2) "Your Rights" attachments. These documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR. The NAR shall contain the following:

a) The results of the resolution and the date it was completed;

b) The reasons for the determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
c) For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;
d) For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and
e) Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the TAR Unit's adverse benefit determination.

NAR "Your Rights" attachment provides beneficiaries with the following required information pertaining to NAR:

a) The beneficiary's right to request a State Hearing no later than 120 calendar days from the date of the TAR Unit's written appeal resolution and instructions on how to request a State hearing; and
b) The beneficiary's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten (10) days from the date the letter was post-marked or delivered to the beneficiary) in accordance with *Title 42, CFR, Section 438.420.*

Adverse Benefit Determination Overturned

For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. TAR Unit shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. The TAR Unit shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions.

The TAR Unit must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the TAR Unit reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. TAR Unit shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

Should the beneficiary file a grievance related to the denied Expedited Appeal Request then the TAR Unit shall:

- Notify the beneficiary with a written acknowledgment of Receipt of the grievance postmarked within (five) calendar days of the receipt of the grievance. The timeframe for resolving a grievance related to a denied Expedited Appeal Request shall not exceed 30 calendar days.

- The TAR Unit shall send a Notice of Grievance Resolution (NGR) letter to the beneficiary providing a summary of the grievance filed, steps taken to resolve the grievance, a clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the beneficiary, and the reasons for the decision. A copy of the NGR shall be transmitted to the Patient's Rights Office. If the beneficiary is dissatisfied with the resolution of the grievance, the beneficiary may file another grievance with the Mental

Health Plan. In accordance with *CFR, Title 42, Section 438.402*, a beneficiary may file a grievance with the MHP at any time.

Where to Submit documentation for Appeal/Internal Appeal:

Los Angeles County Department of Mental Health
Intensive Care Division, TAR Unit/Appeals Section
510 S. Vermont Avenue, 20th Floor
Los Angeles, CA 90020

Telephone number is: (213) 739-7300. This phone number is answered by staff during regular office hours of 8:00 AM to 5:00 PM Monday through Friday. Office is closed on Saturday, Sunday, and holidays.

STATE HEARING

The *California Code of Regulations, Title 22, Section 50951* refers to State Hearing as the Right of beneficiaries if they are dissatisfied with any action or inaction of the county department, the Department of Health Care Services (DHCS) or any person or organization acting on behalf of the county or the Department relating to Medi-Cal eligibility or benefits.

A beneficiary has the right to request a State Hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness. Beneficiaries must exhaust the Los Angeles County Department of Mental Health, Intensive Care Division, Treatment Authorization Request Unit's (LACDMH ICD TAR) appeal process prior to requesting a State Hearing.

The beneficiary's right to file for a State Hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary shall be indicated in the NAR. The TAR Unit's communication with the provider shall also include information of the beneficiary's right to request and receive benefits while the State Hearing is pending, and how the beneficiary makes this request. Included in the beneficiary and provider communication letters, as appropriate, are updated attachments to *DHCS Information Notice No. 18-010E 'Your Rights", Language Assistance taglines, Notice of Adverse Benefit Determination (NOABD) "Denial", Nondiscrimination Notice, NOABD Financial Liability, and NOABD "Upheld".*

Timeframe for Filing

Pursuant to the *Federal Code of Regulations, Title 42, §438.408(f)(1) and (2)*, beneficiaries are allowed to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary that the Adverse Benefit Decision has been upheld by the TAR Unit.

Note: The parties to State Hearing include the LAC DMH, as well as the beneficiary and his/her authorized representative or the representative of a deceased beneficiary's estate.

State Fair Hearing/State Hearing Decision Timeframes Standard Hearings
The TAR Unit shall notify beneficiaries that the State must reach its decision within 90 calendar days of the date of the request.

Expedited Hearings
If the beneficiary thinks that waiting for 90 days for the resolution of the hearing will affect his/her health, an **"expedited appeal"** may be filed. The reason for the expedited appeal request shall be stated. An expedited state hearing will be resolved within three (3) working days.

The TAR Unit shall notify beneficiaries that the State must reach its decision within three (3) working days of the date of the request.

Overturned Decisions
The TAR Unit shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

HOW DO BENEFICIARIES FILE FOR A STATE FAIR HEARING?
A State Fair Hearing must be filed within 120 days from the date of the NAR letter. A beneficiary can ask for a State Fair Hearing by phone, electronically, or in writing:

By phone: Call **1-800-952-5253**. If the beneficiary has a hearing or speech impairment, he/she can call **TTY/TDD 1-800-952-8349.**

Electronically: A beneficiary may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

In writing: A beneficiary shall fill out a State Hearing form or send a letter to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

To complete the application, the beneficiary shall ensure that he/she includes the following: name, address, telephone number, date of birth, and the reason why a State Hearing is being pursued.

If someone is helping the beneficiary to request for a State Hearing, it is important to add their name, address, and telephone number to the form or letter.

The need for an interpreter and in what language must be requested at the time of filing. Interpreter service will be provided for free.

A beneficiary may also get legal help by calling the local Legal Aid program of Los Angeles County at **1-888-804-3536.**

All of the above information can be found in an attachment sent with the NOABD. This attachment is called, "NOABD Your Rights".

Notices to LMHP on Decisions Regarding State Hearing Appeals

Upheld Decisions to LMHP:

The California Department of Social Services, State Hearings Division will notify the LACDMH ICD TAR Unit on its decision on the Provider's Appeal.

- LMHP will not communicate any information to the beneficiary regarding Appeal decision. California Department of Social Services, State Hearings Division will notify the beneficiary directly of its decision.
- Enter the Upheld Decision in the State Hearing 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:

- The LACDMH TAR Unit shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the MHP's adverse benefits determination.

After receipt of the State Hearing Division decision, The TAR Unit's Appeal staff will:

- Enter the Reverse and Split Decision in the Appeal Log and input the decision in the AVATAR System and complete AVATAR Summary of the findings.
- File the State Decision Letter in Provider's Appeal file until the LMHP receives a State Hearing Appeal TAR from the Provider as indicated in the DSS instructions to the Provider. A 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 State Hearing Appeal" for Reversed Decisions.

- Write "# days approved at State Hearing Appeal," "# days remain denied" for Split Decisions.
- Deliver the above TAR, DSS Decision Letter and Instructions to TAR administrative support staff for further processing.

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

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

AUTHORITY: *Welfare & Institutions Code Section 14680 and California Code of Regulations, Title 9, Chapter 11, Section 1850.305.*

GRIEVANCE

Pursuant to *Title 42, Code of Federal Regulations, §438.400(b)*, the term "grievance" has been redefined to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The definition specifies that grievances may include, but not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's rights to dispute an extension of time proposed by the Plan to make an authorization decision. There is no distinction between an informal and formal grievance. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination".

Note: The Local Mental Health Plan (LMHP) shall not discourage the filing of Grievances. The beneficiary need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry. The complaint shall still be aggregated for tracking and trending purposes as with other Grievances.

Timeframes for Filing Grievances

In accordance with *Title 42, Federal Code of Regulations (CCR), §438.402*, a beneficiary may file a grievance at anytime.

Method of Filing

A beneficiary, or a provider and/or authorized representative, may file a grievance either orally or in writing.

Standard Grievances

Acknowledgement

The LMHP shall provide the beneficiary a written acknowledgment of receipt of the grievance postmarked within five (5) calendar days of receipt of the grievance. The acknowledgement letter shall include the date of receipt, as well as the name, telephone number, and address of the LMHP representative who the beneficiary may contact. The Los Angeles County Department of Mental Health, Intensive Care Division, Treatment Authorization Unit (TAR) under the Appeals Section is responsible for completing this task when grievances are received from the Fee For Service (FFS) hospitals when representing a beneficiary or from beneficiaries or their authorized representatives.

Resolution

The TAR Unit shall resolve the standard grievance and notice to affected parties not to exceed 90 calendar days from the day it receives the grievance.

The following steps shall be taken into consideration when formulating a resolution for the standard grievance:

a. "Resolved" means that the TAR Unit has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
b. The resolution of the grievance shall be completed within 90 calendar days of the receipt of the grievance. The TAR Unit shall enter on the Grievance Log the following:
    - Date and time of receipt of the grievance;
    - The name of the beneficiary filing the grievance;
    - The name of the representative (TAR Unit staff) recording the grievance;
    - A description of the complaint or problem;
    - A description of the action taken by the TAR Unit or provider to investigate and resolve the grievance;
    - The proposed resolution by the TAR Unit or provider;
    - The name of the TAR Unit staff responsible for resolving the grievance; and
    - The date of notification of the resolution.
c. The timeframe for resolving grievances related to disputes of the TAR Unit's decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days.
d. The TAR Unit shall use the *Department of Health Care Services' (DHCS) Information Notice No.:18-010E Enclosure* of written Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the TAR Unit's decision.
e. Pursuant to *Title 42, CFR, §438.408(b)and(c*), the TAR Unit is allowed to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or

the TAR Unit identify that there is a need for additional information and how the delay is in the beneficiary's interest. In the event that the resolution of a standard grievance is not reached within 90 calendar days as required, the TAR Unit shall provide the beneficiary with the applicable Notice of Adverse Benefit Determination (NOABD) and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.

If the TAR Unit extends the timeframe, not at the request of the beneficiary, it must complete all of the following:

- Give the beneficiary prompt oral notice of the delay;
- Within two calendar days of making the decision, give the beneficiary written notice of the reason of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision; and
- Resolve the grievance no later than the date the extension expires.

Grievance Process Exemptions

1. Grievances received over the telephone or in-person by the TAR Unit or a network provider of the LMHP, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt of the grievance are exempt from the requirement to send a written acknowledgement and disposition letter.

2. Grievances received via mail by the TAR Unit, or a network provider of the LMHP, are not exempt from the requirement to send an acknowledgement and disposition letter in writing.

   If the TAR Unit or a network provider of the LMHP receives a complaint pertaining to an Adverse Benefit Determination, as defined under *42 CFR §438.400,* the complaint is not considered a grievance and the exemption does not apply.

3. The TAR Unit must transmit issues identified as a result of the grievance to the LACDMH Quality Improvement Committee, the Quality Assurance Division, the LACDMH administration or another appropriate body within Los Angeles County's operations. The TAR Unit currently enters all pertinent information regarding Grievances and Appeals in a Log that is located in the IBHIS. The information that are entered into the IBHIS are available to the LACDMH Quality Improvement Division for analyses and submission. The LMHP shall ensure exempt grievances are included in its Beneficiary Grievance and Appeal Report that is submitted.

SECTION XIV:

NOTICE OF ADVERSE BENEFIT DETERMINATIONSN (NOABD)

Adverse Benefit Determination

The Final Rule replaced the term “Action” with “Adverse Benefit Determination”. An Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary’s request to dispute financial liability.

Written Notice of Adverse Benefit Determination (NOABD) Requirements

Beneficiaries must receive a written NOABD when the LAC DMH TAR Unit (TAR Unit) takes any of the actions described above. The TAR Unit must give beneficiaries timely and adequate notice of an adverse benefit determination in writing consistent with the requirements of *42 CFR Section 438.10*. The federal regulations delineate the requirements for content of the NOABDs. The NOABD must explain all of the following:

1. The adverse benefit determination the TAR Unit has made or intends to make;

2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The TAR Unit shall explicitly state why the beneficiary’s condition does not meet medical necessity criteria.

3. A description of the criteria used. This includes medical necessity criteria, and any processes strategies, or evidentiary standards used in making such determinations.

4. The beneficiary’s right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary’s adverse benefit determination.

Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, the TAR Unit must also include the name of the decision maker.

If the TAR Unit can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision maker through means other than a direct phone number, (e.g., telephone number of the specific unit of the Utilization Management Department that handles provider appeals directly), a direct telephone number or extension is not required.

Timing of the Notice

The TAR Unit must mail the notice to the beneficiary within the following timeframes:

1. For termination, suspension, or reduction of previously authorized specialty mental health service, at least 10 days before the date of the action;

2. For denial of payment, at the time of any action denying the provider's claim; or,

3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two (2) business days of the decision.

   The TAR Unit must also communicate the decision to the affected provider within 24-hours of making the decision.

Written NOABD Templates and Your Rights Attachment

The TAR Unit shall utilize the NOABD templates corresponding "Your Rights" attachments included in *DHCS MHSUDS Information Notice No.: 18-010E.*

The "NOABD Your Rights" attachment provides beneficiaries with the following information pertaining to NOABD:

1. The beneficiary's or provider's rights to request an internal appeal with the TAR Unit within 60 calendar days from the date on the NOABD;

2. The beneficiary's right to request a State Hearing only after filing an appeal with the TAR Unit and receiving a notice that the Adverse Benefit Determination has been upheld;

3. The beneficiary's right to request a State Hearing if the TAR Unit fails to send a resolution notice in response to the appeal within the required timeframe;

4. Procedures for exercising the beneficiary's rights to request an appeal;

5. Circumstances under which an expedited review is available and how to request it; and

6. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with *Title 42, CFR, Section 438.420.*

SECTION XV:
NURSE PRACTITIONER

A Nurse Practitioner is a Registered Nurse who possesses additional preparation and skill in physical diagnosis, psycho-social assessment and management of health illness needs in primary health care, and who has been prepared in a program conforming to the Board Standards as specified in the California Code of Regulations (CCR), 1484 (Standards of Education).

Pursuant to Business and Professional Code, Division 2, Healing Arts, Chapter 6, Nursing, Article 8, Nurse Practitioners, on or before January 1, 2008, an applicant for qualification as a Nurse Practitioner shall meet the following:

a) Hold a valid and active registered nursing license;
b) Possess a Master's Degree in Nursing, Master's Degree in a clinical field related to nursing, or a graduate degree in nursing; and
c) Satisfactorily complete a Nurse Practitioner Program approved by the Board.
In addition, the Nurse Practitioner must have a furnishing number issued by the Board of Registered Nursing.

SCOPE OF MEDICAL PRACTICE

The Medical Practice Act authorizes physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissues of human beings and to use other methods in the treatment of diseases, injuries, deformities, or other physical or mental conditions. As a general guide, the performances of any of these functions by a nurse practitioner requires Specialized Procedures.

SPECIALIZED PROCEDURES

Section 2835.7 of the Business and Professions Code sets the inclusion of Specialized Procedures developed through collaboration among administrators, health professionals including the supervising physicians, surgeons and nurses in the organizational health system and medical group administrator where they will be utilized. They must be reviewed annually.

Standardized Procedures are policies and protocols formulated by organized health care system for the performance of standardized procedure functions. Specialized Procedures are authorized in the Business and Professions Code, Nursing Practice Act Section 2725, and further clarified in CCR 1480. Specialized Procedures are legal mechanisms for registered nurses and nurse practitioners to perform functions which would otherwise be considered the practice of medicine.

The organized health care system including clinics and physician's offices must develop Specialized Procedures permitting Nurse Practitioners to perform Standardized Procedure functions. A Nurse Practitioner may perform Standardized Procedure functions only under the conditions specified in a health care system's Standardized Procedures and must provide the system with satisfactory evidence that the nurse meets the experience, training, and/or education requirements to perform the functions.

The Board of Registered Nursing (BRN) and Medical Board of California jointly promulgated guidelines for Standardized Procedures. These guidelines can be found in

CCR, Title 16, Section 1474 for the BRN and CCR, Title 16, Section 1379 for the Medical Board of California.

Note: The presence of a Standardized Procedures (SP) shall be submitted for review to the Intensive Care Division, Compliance Unit Reviewers during scheduled reviews. A Plan of Correction will be issued if no SP is available for review.

Note: California Assembly Bill No.890 which was ratified by the California Senate on August 31, 2020 is an act to amend Chapter 6 of Division 2 of the Business and Professions Code, relating to healing arts. Included in the Assembly Bill is the clause that beginning January 1, 2023, the nurse practitioner who meets education, experience, and certification requirements by the Board is authorized to perform, in certain settings, specified functions without Standardized Procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing administering, dispensing, and furnishing controlled substances. For additional information, please read the entire text of the Assembly Bill No. 890.

A Nurse Practitioner must consult the Supervising Physician under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.
2. Acute decompensation of patient situation.
3. Problem which is not resolving as anticipated.
4. History, physical, or laboratory findings inconsistent with the clinical picture.
5. Upon request of the patient, nurse, or physician.

An Intensive Care Division Provider Alert concerning Psychiatric Mental Health Nurse Practitioner was issued in June, 2021. In this issue, the Los Angeles County Department of Mental Health (LACDMH) has authorized Mental Health Nurse Practitioners who are nationally certified through the American Nurses Association, ANCC Division and have met the LACDMH Credentialing and Contract requirements for the Fee For Service Network are permitted to render Specialty Mental Health Services to Medi-Cal beneficiaries in an Inpatient setting. LACDMH conferred with the State Department of Health Care Services and confirmed that the Mental Health Nurse Practitioners or Psychiatric Nurse Practitioners are allowed to provide and independently claim for professional services rendered in an acute psychiatric hospital setting. The Mental Health Nurse Practitioners may complete the intake, or initial psychiatric admission evaluation provided they are operating within their scope of practice and under the direction of a psychiatrist. The admitting evaluation must be co-signed by the hospital's credentialed and contracted attending psychiatrist.

CCR, Title 9, Chapter 11, Section 1830.230 and CCR, Title 22, Section 51003 only allow for one professional service claim per day for a patient, notwithstanding receiving services from more than one professional provider in a day.

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, including Medical Care Evaluation Studies. 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. ICD Compliance staff may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS. For example, the Compliance Unit staff may disallow claims and recoup funds if it determines a service, while authorized was not furnished to the beneficiary, or in other instances where there is evidence of fraud, waste, or abuse.

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.

Note: Included in the System Review will be monitoring of the presence of Beneficiary Consent Form to be used when the Beneficiary, Hospital or Beneficiary Representative files a grievance or appeal. A Plan of Correction will be issued if the hospital fails to submit the document. In addition, evidence of a Specialized Procedures shall be submitted by a Nurse Practitioner during a scheduled provider review that covers provider reimbursement up December 31, 2022. Pursuant to California Assembly Bill No. 890, beginning January 1, 2023, the Nurse practitioner who meets education, experience and certification requirements by the Board of Registered Nursing is authorized to perform, in certain settings, specified functions without the use of Standardized Procedures.

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;
- Physical and emotional abuse;
- Sexual assault;
- Physical assault;
- Allegation of abuse/neglect
- Taser use;
- Homicide by a client;
- Serious injury involving a psychiatric patient;
- Privacy breach; and
- Elopement.

Within 24-hours that an adverse outcome has occurred, or by the next business day if event occurs on a weekend or holiday, inpatient contractors must submit an Adverse Outcome Report to the Lanterman Petris Short (LPS) Designation Coordinator**,** by eFax (213) 652-0851 or send the Los Angeles County Report of Adverse Event/Unusual Occurrence to:

County of Los Angeles Department of Mental Health
510 South Vermont Avenue, 21st Floor
Los Angeles, CA 90020

Questions regarding mental health inpatient adverse outcome issues should be directed to the LACDMH LPS Designation Coordinator, by telephone at (213) 947-6673.

SECTION XVIII: INSTITUTIONS OF MENTAL DISEASES (IMD)

FEE-for-SERVICE FREE-STANDING MEDI-CAL INPATIENT ACUTE PSYCHIATRIC HOSPITALS, IMD EXCLUSIONS

The *Department of Health Care Services (DHCS), MHSUDS Information Notice No.18-008* clarified that under the Bronzan-McCorquodale Act, counties must pay for acute psychiatric inpatient hospital services for their eligible residents, including Medi-Cal beneficiaries between the ages of 21 and 65 years old. Due to the Institution for Mental Diseases (IMD) exclusion, federal financial participation is not available for acute psychiatric inpatient hospital services provided in an IMD.

Therefore, the implementation of *MHSUDS Information Notice No. 18-008* and the 1991 Realignment- County Responsibility through the Bronzan-McCorquodale Act, realigned the provision of community mental health services to counties and dedicated a funding source of sales tax and vehicle license fee revenues for this population. Subsequently, the county and its Mental Health Plan (MHP) is expected to use this funding source to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in IMDs, unless the county can demonstrate to DHCS' satisfaction that it does not have adequate funding.

Medical records and Treatment Authorization Requests (TARs) received from the free-standing psychiatric hospitals will be reviewed retrospectively, unless otherwise instructed to submit the records concurrently for authorization. Therefore, records shall not be uploaded for review via ProviderConnect. Instead, these records and clinical documentation to support initial and continued stay shall be delivered after discharge of the beneficiary to the Point of Authorization to:

LACDMH TAR Unit,
510 South Vermont Avenue, 20th Floor,
Los Angeles, CA 90020

The TAR Unit's working days and hours are Monday through Friday, excluding weekends and holidays, between 8 AM – 5:30 PM. Records may be delivered to the TAR Unit not later than 4:45 PM.

Eligible beneficiaries are those that have both Medi-Cal eligibility based in Los Angeles County and are residing in Los Angeles County. If the beneficiary has Los Angeles County Medi-Cal eligibility but is a resident and receiving services in a County other than Los Angeles, then steps shall be taken to change the eligibility to the County of residence, and thus that County is responsible for the payment of services.

The Free-standing hospitals will provide a ten (10) day notice of admission to the LACDMH Intensive Care Division (ICD) TAR Unit by secure email: TAR Unit@dmh.lacounty.gov; by telephone 213-739-7300 or by Fax 213-402-2009. The IMD Exclusion FFS Inpatient Psychiatric Hospitalization services require that all documentation and timelines are met as established by federal, state, and contractual obligations between the Mental Health Plan and the Free-Standing Hospitals.

The IMD Exclusion population TARs are processed by the local mental health plan and are not sent to the State for payment. The Los Angeles County Department of Mental Health, acting as the local mental health plan, provides the hospital a log of TARs received and decisions rendered on whether the day(s) have been approved or denied. This log is provided monthly to a contact person designated by the hospital. In turn, the hospital submits a financial summary form provided by the TAR Unit that confirms the authorization details. The form allows the hospital to add whether partial payment has been received from other funding sources. Once the signed financial summary form has been received by the TAR Unit, it will be submitted to the Finance department for payment.

The documents listed below must be received by the LACDMH ICDTAR Unit within 14 days of beneficiary discharge:

- IBHIS Provider Connect Demographics Admit (print out and upload)
- Face Sheet with Demographics
- Medi-Cal Eligibility (DHCS) required for every new month
- Assessment, Evaluation, and Crisis Intervention forms or Placement for Evaluation and Treatment (5159/5585/Voluntary Status Form/Conservatorship Papers/T-Con Papers)
- Full Initial Psychiatric Evaluation (IPE required upon admission or, within 24 hours of admission)
- Doctor's Orders
- History and Physical Examination (Completed within 24 hours of admission)
- Q 15 minutes aka Patient Monitoring Round Sheets
- RN Admission Note
- Daily Psychiatric Progress Notes written by credentialed and contracted Psychiatrists and Nurse Practitioners. Medical Necessity Criteria must be met upon admission and for each day of continued acute care
- Daily Narrative Nurses Notes. Medical Necessity Criteria must be met upon admission and for each day of continued acute care
- Emergency Department (ED) Consult Notes. (Applicable on transfer from ED to Inpatient Psychiatric Hospital)
- History and Physical Examination (Completed within 24-hours of admission)
- Social Services assessment (Completed within 72 hours of admission)
- Multidisciplinary Treatment Plan (Completed within 72 hours of admission)
- Weight, Intake and Output sheets
- Laboratory Results
- Record(s) of Seclusion and Restraints
- Medication Administration Record

The entire medical record, including the above-mentioned documents must be delivered and date-stamped within 14 days after beneficiary discharge for a retrospective review and reimbursement from 1991 Realignment Funds.

SECTION XIX: GLOSSARY OF 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).

- **DXC Technology 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.

- **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.

- **DXC Technology:** A fiscal intermediary which has contracted with the State Department of Health Care Services to perform services for the Medi-Cal Program pursuant to Section14104.3 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 DXC Technology 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.