

County of Los Angeles – Department of Mental Health  
Local Mental Health Plan



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# Medi-Cal Fee-For-Service Inpatient Hospital Provider Manual

Second Edition  
February 7, 2018

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

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# Welcome

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

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

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

# TABLE OF CONTENTS

**SECTION I: INTRODUCTION**

Introduction ..... 1

LACDMH Service Areas ..... 2

**SECTION II: LACDMH CONTRACT**

Contracting with the County ..... 1

Contracting Process ..... 1

Contract Required Notification ..... 2

**SECTION III: SINGLE POINT OF CONTACT (SPOC)**

Single Point of Contact ..... 1

Change of Single Point of Contact ..... 1

Provider Alerts ..... 1

**SECTION IV: TAR PROCESS FLOW CHART**

TAR Process Flow Chart ..... 1

Key to TAR Process Flow Chart ..... 2

**SECTION V: TIMELINES**

Initial TAR Timeline ..... 1

Appeal Timelines ..... 2

**SECTION VI: INSTRUCTIONS FOR COMPLETING A TAR**

Instructions for Completing a TAR ..... 1

Sample TAR ..... 2

**SECTION VII: SUBMISSION OF A TAR**

Submission of a TAR ..... 1

Aftercare Plan ..... 2

Initial TAR ..... 3

Retroactive TAR ..... 4

Administrative Day TAR ..... 5-8

**SECTION VIII: APPEALS**

First Level Appeal ..... 1-2

Second Level Appeal ..... 3

**SECTION IX: COMPLIANCE**

Compliance ..... 1

TAR Error ..... 1

Inappropriate Submission of a TAR ..... 1

State Regulatory Timeline Compliance ..... 1-2

Claims Over One Year Old ..... 2

**SECTION X: INQUIRY, TUT AND RESUBMIT**

Inquiry, TUT and Resubmit..... 1

**SECTION XI: MEDICAL NECESSITY CRITERIA**

Title 9, California Code of Regulations..... 1-2  
 LACDMH Review of Medical Necessity Criteria..... 3  
 State Medi-Cal Policy Statement 1-89 (Issued April 12, 1994)..... 4

**SECTION XII: NOTICE OF ACTION**

TAR Denial – Notice of Action..... 1  
 DMH NOA-C Form Sample..... 2-3

**SECTION XIII: RESOURCE INFORMATION**

Contact Information..... 1-2

**SECTION XIV: PROVIDER SITE REVIEW**

Provider Site Review..... 1

**SECTION XV: REPORTING ADVERSE OUTCOMES**

Reporting Adverse Outcomes..... 1

**SECTION XVI: DATA COLLECTION & REPORTING SYSTEM REQUIREMENTS**

Data Collection & Reporting Requirements..... 1  
 Provider Connect – FFS 1 End User Manual v4.5..... 1  
 IBHIS Codes Manual & Decision Tree..... 2

**SECTION XVII: DEFINITION, ABBREVIATIONS AND PROGRAM TERMS**

Glossary of Terms..... 1

**SECTION XVIII: FREQUENTLY ASKED QUESTIONS**

Q&A..... 1

**SECTION XIX: IMPORTANT TELEPHONE NUMBERS**

Important Phone Numbers..... 1

**SECTION XX: ALERTS**

Alerts..... 1

# **SECTION: I**

# **INTRODUCTION**

## INTRODUCTION

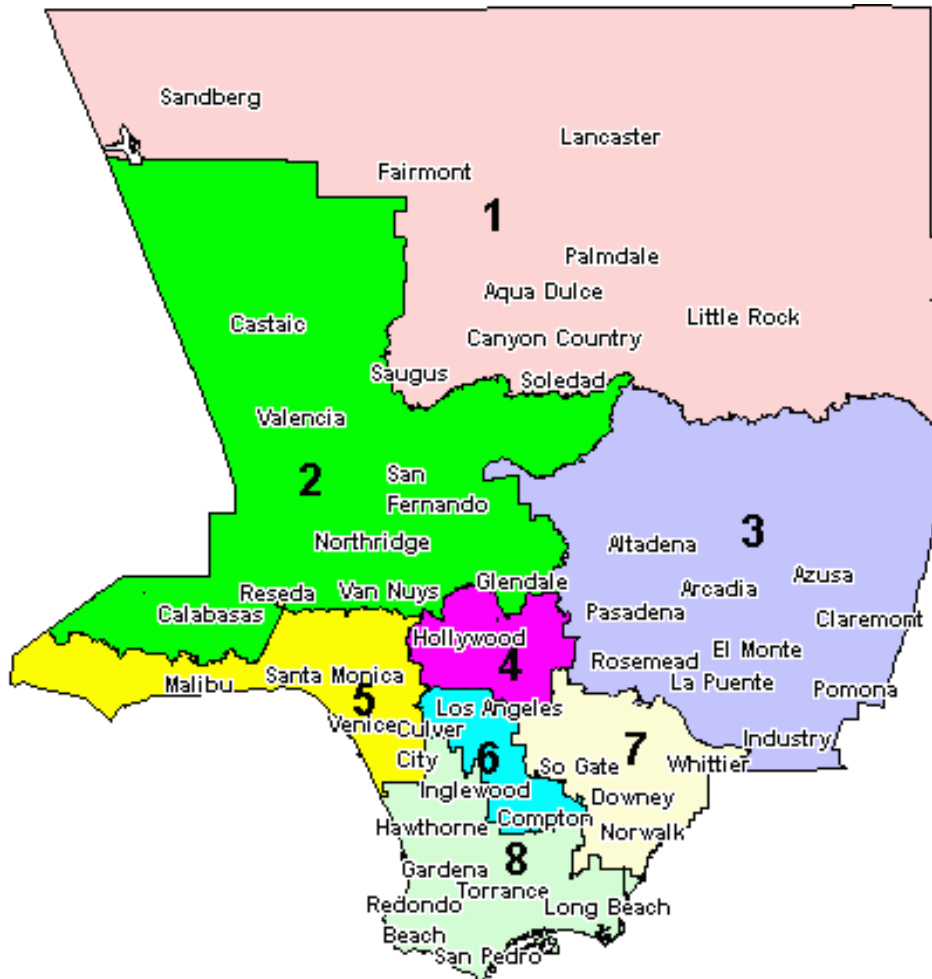
The Los Angeles County Department of Mental Health (LACDMH) is the State of California's Local Mental Health Plan (LMHP) for the County of Los Angeles. The LMHP is responsible for administering all Medicaid/Medi-Cal and State grant funds for mental health services through a well-managed system that is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

It is estimated that Los Angeles County is the county of residency to approximately one-third (1/3) of all Medi-Cal beneficiaries in the State of California. The county where Medi-Cal beneficiary eligibility is established is determined by the Department of Public Social Services. Due to the magnitude of acute psychiatric inpatient services provided to the residents of Los Angeles County, the State of California Department of Mental Health 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.

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

### LACDMH Service Areas

The Los Angeles County Department of Mental Health is organized into eight (8) geographic Service Areas. 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.



# **SECTION: II LACDMH CONTRACT**



## **Contracting with the County**

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

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

## **Contracting Process**

- Obtain from and submit a completed Los Angeles County Department of Mental Health Medi-Cal FFS Acute Psychiatric Inpatient Contract Package to, the LACDMH *Contracts Development and Administration Division* (CDAD).
- Submit a signed contract, completed Contract Package and required documents for approval/adoption by the Los Angeles County Board of Supervisors. Contingent upon the requisite approvals, contract providers will receive a fully executed contract agreement.
- Schedule orientation and training for contract providers to facilitate integration and incorporation of the contract provider into the Los Angeles County Department of Mental Health (LACDMH) system of care.

## **Contract Required Notifications**

It is essential that contract providers immediately inform the LACDMH's Contracts Development Administration Division (CDAD) of the following:

- Any/all changes affecting the provider's ability to provide contracted services
- Changes in ownership
- Mergers
- Financial viability
- Insurance
- Permits
- Licenses
- Staffing Pattern
- Other dated material and changes that are required from the contract package

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

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

# **SECTION: III SINGLE POINT OF CONTACT**

**Single Point of Contact (SPOC)**

All Fee-For-Service (FFS) Medi-Cal acute psychiatric inpatient providers/hospitals submitting inpatient Treatment Authorization Requests (TARs) to the Los Angeles County Department of Mental Health 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, Corrections and Resubmissions
- Compliance Unit
- First Level Appeal
- Second Level Appeal

**Change of Single Point of Contact (SPOC)**

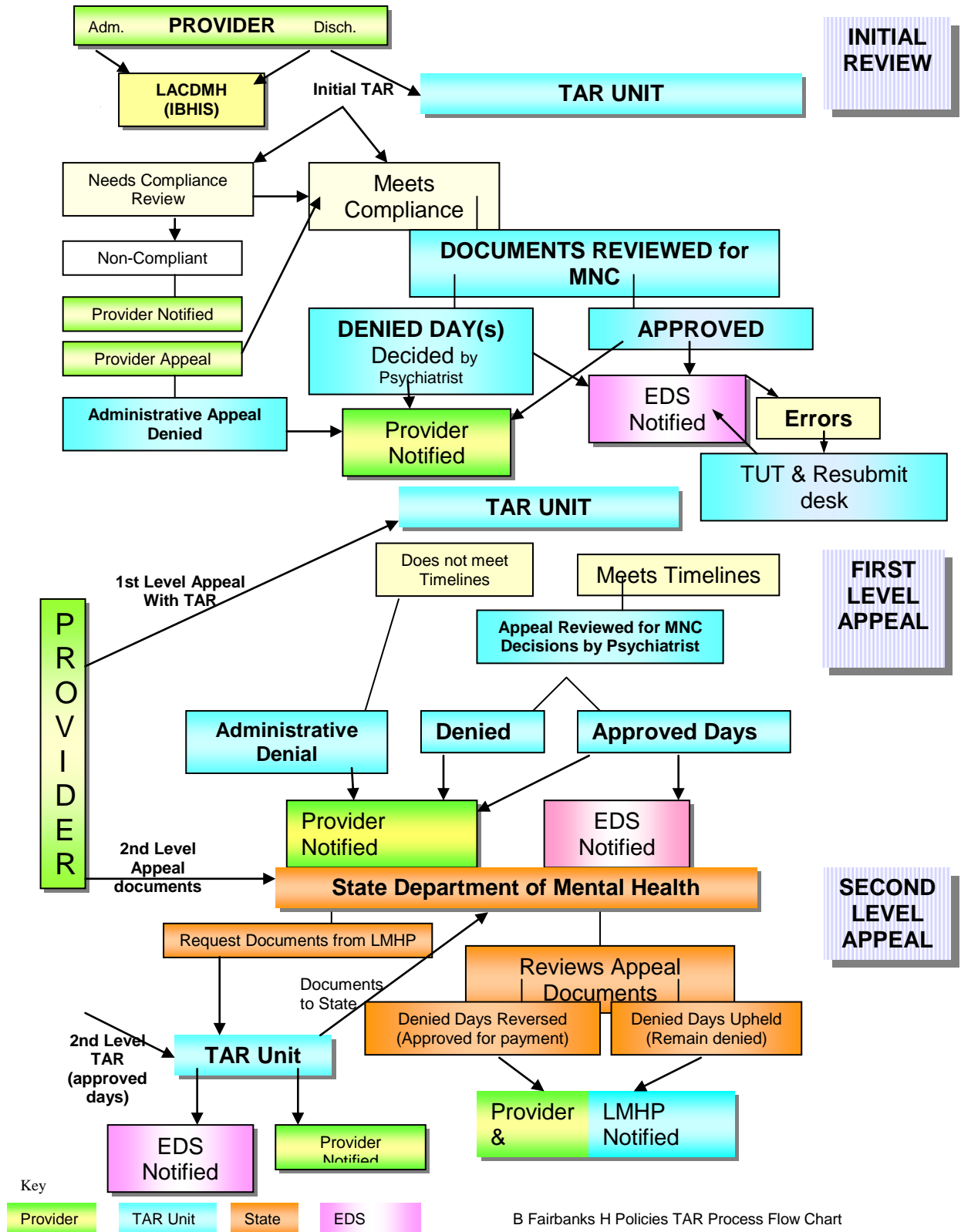
Providers may change their designated SPOC at any time by notifying the TAR Unit in writing, on the provider's letterhead, with the full name, mailing address, email address, telephone number and fax number of the new SPOC.

**Provider Alerts**

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

# **SECTION: IV TAR PROCESS FLOW CHART**

**TAR PROCESS FLOW CHART**



B Fairbanks H Policies TAR Process Flow Chart

## KEY TO TAR PROCESS FLOW CHART

**TAR:** Treatment Authorization Request. A TAR is a State Form (18-3), each with a unique number, used statewide for authorization of inpatient psychiatric hospital days.

**PROVIDER:** Hospital providing acute inpatient psychiatric services.

**IBHIS:** *Integrated Behavioral Health Information System* – the LAC/DMH Integrated Behavioral Health Information System (IBHIS). Charts not entered in the Information System (IBHIS) cannot be processed in the DMH TAR Unit’s unique electronic data collection system, previously known as STAR.

- Contract providers have access to the LAC/DMH Integrated Behavioral Health Information System (IBHIS) and are responsible for entering data on their clients into the system.
- Since *non-contract providers* cannot access the Integrated Behavioral Health Information System (IBHIS), the TAR unit staff enters the episode data into the Integrated Behavioral Health Information System (IBHIS) when the TAR & chart arrive to be reviewed.

**COMPLIANCE:** Compliance with 1) State timeline regulations and/or 2) County contract agreements as specified below.

- **State:** 14-day timeline for submission of an initial TAR or 60-day timeline (from date of discovery of Medi-Cal eligibility) for submission of a *retroactive* TAR.
- **County contract:** Specified data to be entered into the Data Collection and Reporting System.

**MNC:** Medical Necessity Criteria as specified in State regulations – Title 9, Chapter 11 of the California Welfare and Institutions Code.

**LMHP/TAR UNIT:** Local Mental Health Plan is the term used by the State to refer to the counties or other entities responsible for authorization of payment for Medi-Cal psychiatric inpatient services. In this instance LMHP is LACDMH and referred to in the chart as the *TAR Unit*.

**APPEALS:** The provider sends a letter requesting a first or second level appeal of TARs denied for failure to meet MNC or State timelines. *Note: At the second level, chart documents are sent to the State with the appeal letter but not a new TAR. A State decision letter is sent to the provider. If the State reverses denied days (approves those days), the provider submits a TAR, with a copy of the State letter, to the TAR Unit.*

**EDS:** Electronic Data Systems in Sacramento, CA acts as the State’s financial intermediary. This agency is contracted by the State to process payment of the approved days. Payment can only be issued for those TARs in the EDS Master File. *Note: The initial review TAR is always sent to EDS (approved days and denied days) – this establishes the episode in EDS. However, first and second level appeal TARs are only sent to EDS if there are approved days. Approved days, on appeal, are previously denied days that have been reversed by the LMHP or the State.*

# **SECTION: V**

# **TIMELINES**



**Timelines for Initial Submission of a TAR**

Provider has  
**14 days** after discharge  
to submit TAR & documents  
to the LMHP



LMHP has **14 days** after  
receipt of the TAR  
to send the reviewed and completed  
TAR to EDS and the provider

**Timelines for a Retroactive TAR**

- Submit a retroactive TAR within  
**60 days of:**
- Discovery of Medi-Cal eligibility  
or from a third party Payer -
  - Notice of Partial Payment or
  - Exhaustion of Benefits (EOB)

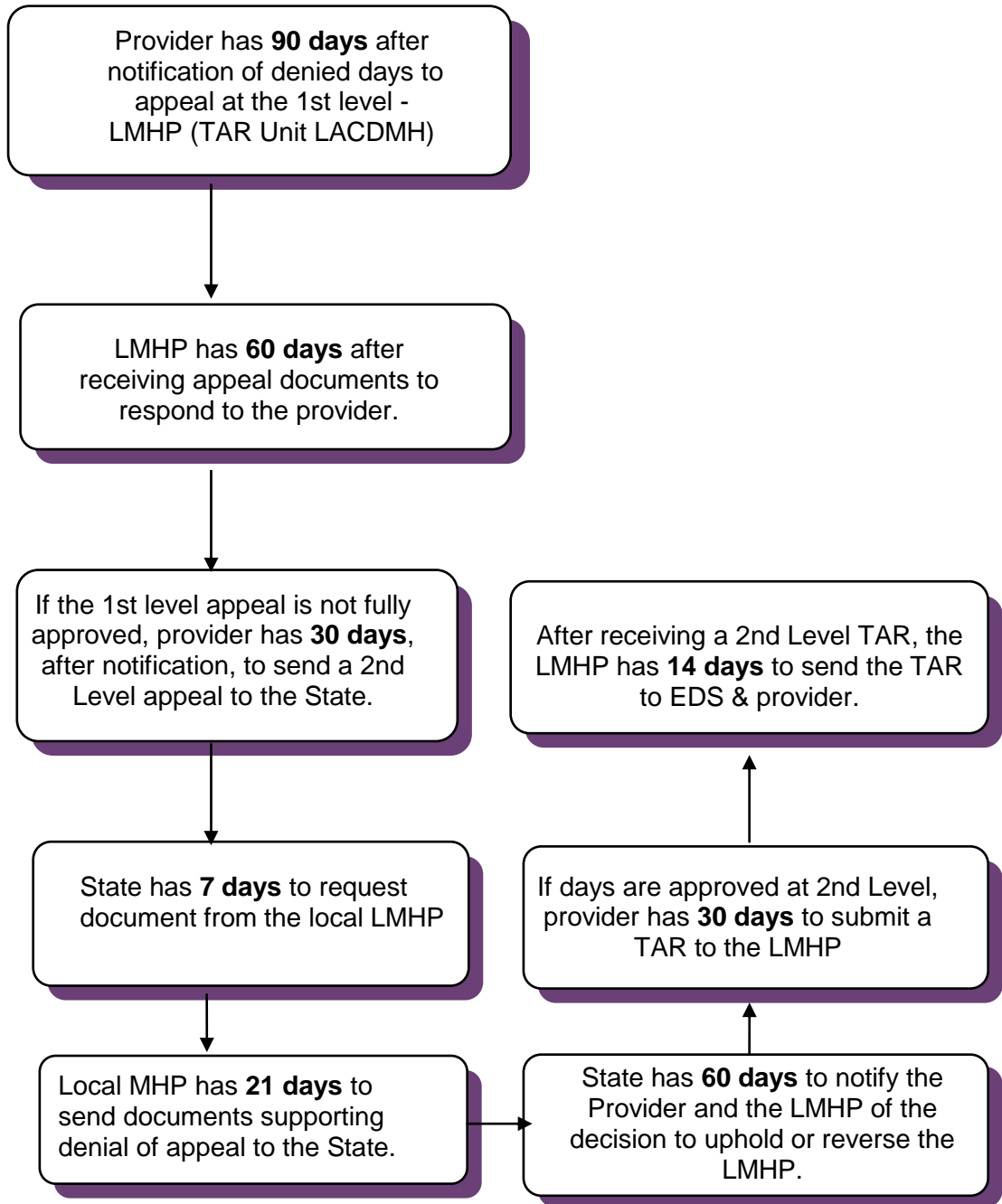
**TAR APPEAL TIMELINES**

F  
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appltm1n.ppt

# **SECTION: VI 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 Social Security Number or 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 & 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 section.

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

**To Order:** Providers can request TAR forms from Electronic Data Systems' (EDS), by contacting its Medi-Cal Telephone Service Center at (800) 541-5555.

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

**COUNTY USE ONLY**

**COUNTY OF CALIFORNIA DEPARTMENT OF MENTAL HEALTH SERVICES**

1. CLAIMS CONTROL NUMBER

F.I. USE ONLY

2 3

4 5

**CONFIDENTIAL PATIENT INFORMATION**  
County Code and Aid Code go here

HOSPITAL USE				CONFIDENTIAL PATIENT INFORMATION					
ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER)	ADMIT DATE	AUTH. EXP.	EMER. ADMIT	PATIENT MED-CAL ID NO.	PEND.	SEX	DATE OF BIRTH	AGE	
PROVIDER NUMBER	PROVIDER PHONE NO.	VERBAL CONTROL		FULL NAME			MEDICARE STATUS	OTHER COV.	
PROVIDER NAME	PROVIDER STREET/MAILING ADDRESS			ADMITTING DIAGNOSIS DESCRIPTION					
PROVIDER CITY, STATE AND ZIP CODE				DISCHARGE DATE					
FOR PHYSICIAN: PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.				CURRENT ICD-9-CM					
CURRENT DIAGNOSIS				PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY), ENTER NAME AND ADDRESS					
DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION									
WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE									
SIGNATURE OF PROVIDER				TYPE OF PRINT NAME OF RESPONSIBLE PHYSICIAN		SIGNATURE OF RESPONSIBLE PHYSICIAN			
DATE						DATE			
COUNTY MEDICAL CONSULTANT - VALIDATING INFORMATION AND EXPLANATION				FOR COUNTY USE ONLY					
SIGNATURE OF COUNTY MEDICAL CONSULTANT _____ DATE _____ REVIEW COMMENTS INDICATOR <input type="checkbox"/>				28 DENIED	29 APPROVED AS REQUESTED	31 FROM			
				29 DEFERRED	30 APPROVED & MODIFIED	32 THRU			
				30 DAYS OF THIS STAY SUBJECT TO COUNTY REVIEW	31	32			
				32	33	34			
				33	35	36			
				34	37	38			
COUNTY MEDICAL CONSULTANT				43	44	TAR CONTROL NUMBER			

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

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

# **SECTION: VII SUBMISSION OF A TAR**

## SUBMISSION OF A TAR

A request for Medi-Cal psychiatric inpatient mental health reimbursement must be submitted on an **original** State Department of Mental Health (SDMH form 18-3 form). That form is commonly referred to as the TAR. Providers can order TAR forms by calling SDMH's fiscal intermediary – Electronic Data Systems (EDS) at (800) 541-5555.

LACDMH conducts **retrospective reviews**. A TAR is to be submitted only after a Medi-Cal beneficiary is discharged from the hospital. When the authorization review is complete, the provider and EDS will be notified of the decision within 14 days following the date of the TAR submission to the LMHP.

### Authorization of Medi-Cal reimbursement is conditional on the following:

- The beneficiary was Medi-Cal eligible for Los Angeles County during the month(s) of service.
- The service was provided by a State approved FFS Medi-Cal inpatient provider.
- A timely submission of a *Treatment Authorization Request* (TAR) with an accompanying documentation of Medical Necessity Criteria (MNC). See timeline flow chart.
- Contract providers have entered the episode data into the LACDMH Information System.

### Determine Medi-Cal Eligibility

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

### Los Angeles County Department of Mental Health Information System

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

Enter the following data:

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

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

## **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 plan 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 in-patient provider must prepare a written aftercare plan to be submitted to the appropriate LACDMH Single Fixed Point of Responsibility. A copy of the aftercare plan must also be included with the TAR documents.



## INITIAL TAR

**Within 14 days from the date of discharge, submit the following:**

**A) Original TAR – (see Instructions for completing TAR form 18-3)**

- 1) **If requesting both acute and admin days**, submit separate TARs.
  - (a) Code box #18 with an ‘0’ for *acute days* and a ‘2’ for *admin days*.
  - (b) Request the correct number of days (box #17) for each TAR.
  - (c) Specify which dates are being requested (in *Current Condition* section).

**Note:** The *admission* and *discharge* dates will be the same for all TARs in an episode. See *Administrative Day TAR*.
- 2) The maximum number of days that can be requested on a TAR is 99. When the days in an episode reach 100, a second TAR must be submitted. See #1c above.
- 3) **A TAR must be correct and complete in order to be processed.** Check the TAR for missing or incorrect data (e.g. number of days requested, admit and discharge dates, type of days, DSM-IV codes, and signatures and dates).
- 4) When **multiple TARs** are submitted, number the TARs (e.g.1 of 3 etc.). in the space to the right of the heading *Confidential Patient Information*.

**B) Aftercare Plan, with the TAR (but not stapled to it), shall include the following:**

- 1) Date & time of follow-up appointment (or reason why one could not be scheduled).
- 2) Name of contact person.
- 3) Name of facilities where the Aftercare Plan was faxed.

**C) Proof of Medi-Cal eligibility.** – POS, AVES or Eligibility Response

**D) Print-out** of the LACDMH data system *Episode Screen*.

**E) Chart documents/notes to support:**

- 1) Medical necessity criteria for *acute days* requested.
- 2) Placement activity for *administrative days* requested.

**Submit TARs and documents to:**

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

## RETROACTIVE TAR

### A retroactive TAR may be submitted for the following reasons:

- 1) In case of a natural disaster or circumstances beyond the control of the provider, which has been reported to an appropriate law enforcement or fire agency. (See Title 9, Chapter 11, 1820.215).
- 2) Medi-Cal eligibility inquiry during hospital stay shows *no eligibility*. The finding may be: *No matching records found*. Print inquiry
- 3) Denial of payment (exhaustion of benefits) or a partial payment from a third party payer (Medi-Care or other insurance).

### TARs that meet retroactive criteria must be submitted within 60 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.**

**Please note:** TARs are to be submitted only after having billed any other insurance carrier including Medicare. This includes those situations where it is apparent that some days will have to be billed to Medi-Cal.

### Submission of a retroactive TAR:

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

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

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

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

## ADMINISTRATIVE DAY

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

### GENERAL GUIDELINES

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

- **Administrative Day Documentation Requirements**

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

The hospital shall document contacts with a minimum of five appropriate, non-acute residential treatment facilities per week. The requirement of five contacts per week may be waived if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

Note: The reason why there are fewer than five appropriate non-acute residential treatment facilities available for the beneficiary as placement option shall be documented.

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

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

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

- a. Approve the hospital's TAR for administrative days from the date of the administrative day order that placement in an appropriate non-acute residential treatment facility was medically necessary for the beneficiary through the date that the CRMP notified the hospital that the beneficiary did not meet the criteria for admission to the CRMP. It shall be noted that the hospital follow the requirement that a referral be made to the CRMP within twenty four hours of the administrative day order.
  - b. After the date of the denial notification, the TAR Unit staff shall require that the hospital comply with the provisions of CCR, Title 9, Chapter 11, Section 1820.220(j)(B)(5)(A)(B)1.2.a.b.c. as a condition of continued authorization of administrative days.
- ◆ Contact requirements shall be documented to include but not limited to:
- a. Date of the contact.
  - b. Name of the person and facility contacted.
  - c. Facility response regarding availability of beds (status).
  - d. Signature of the person making the contact.
  - e. For IMD placement status prior to CRMP's placement approval, date of the contact (on a weekly basis), name of CRMP staff contacted, number of client on the waiting list status and the signature of the person making the contact must be included in the documentation.

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

● **Administrative Day Restriction**

- 1) Before any administrative day can be authorized, there must be at least one approved acute day. (See general guidelines above)
- 2) Medi-Cal Fee-For-Service hospitals – For a Regional Center beneficiary, there is a limit of 4 administrative days per episode.
- 3) Los Angeles County Department of Health Project – limit 5 administrative days per hospital stay.
- 4) Only board and care facilities offering an array of treatment modalities can be considered as placement option billable to SD/MC administrative day services. These augmented board and care facilities fall under the category of Community Residential Treatment System (CRTS) and provide rehabilitative specialty mental health services.

- **Administrative Days for Regional Center Beneficiaries**

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

References:

*CCR, Title 9, Chapter 11, Section 1810.202; 1820.220(j)(B)(5)(A)(B)*

*CFR, Title 42, Part 456 Subpart D, §456.235(b)*

*LACDMH, Countywide Resource Management Program, Intake Procedure for IMD or IMD*

*Step-down Referrals*

*Title 9, Article 3.5 Community Residential Treatment System*

# **SECTION: VIII**

# **APPEALS**

## FIRST LEVEL APPEAL

### Guidelines for First Level Appeal

A First Level Appeal may be submitted to LACDMH TAR Unit when requested days on the Initial Review TAR are denied. Information in this section applies to appeals based on medical necessity criteria (MNC) only. Appeals pertaining to timeline denials are to be submitted to the Compliance Unit, (see Compliance Section II).

#### TIMELINE

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

#### SUBMIT THE FOLLOWING:

- **An Appeal letter**
  - To justify MNC, send a letter signed by the treating physician addressing the medical necessity criteria for each day being appealed. This letter can be in narrative form or it can be a summary. It may refer to other documentation in the chart (e.g., nurses' notes) but must definitively support the medical necessity criteria as outlined by the State Department of Mental Health.
- **The appeal documents can also include:**
  - Chart pages which were missing from the chart sent for initial review
  - Clarification of illegible notes. Print or type the exact notes before resubmitting.
  - Chart pages on which the missing patient identification has been added.
- **A copy of the initial TAR containing the denied days.**
- **A new TAR for the days being appealed.**
  - This expedites processing an approved appeal TAR.
  - This TAR should have the same admission and discharge dates as the initial TAR. In box 17, indicate the number of acute or administrative days being appealed. In box 18, indicate the type of day, using "0" for acute days and "2" for administrative days. List the actual dates being appealed in the "*Describe Current Condition*" section of the TAR.  
**IMPORTANT:** If the appealed days are not consecutive (e.g., days appealed are: 8/4 & 8/5, and 8/9 & 8/10, a new TAR will be needed for each group of days being appealed). In the example given, two new TARs would be needed. The TAR (18-3) is designed for a request of consecutive days only.



**Please Note:** It is not necessary to send another copy of the chart with the first level appeal. All charts with denied days remain on file at LACDMH.

- **Change in level of care.** At the filing of the first-level appeal with the Los Angeles County Department of Mental Health, the provider has the option of requesting a change in the level of care. Days which were requested as acute days initially may be appealed as administrative days and conversely, administrative days may be appealed as acute days. In both cases, the corresponding criteria must be met for the days requested. However, this level of care is binding – no change will be accepted at Second Level Appeal.
- **Reminder:** If there were no acute days approved on initial review, at least one of the appealed days must be requested as an acute day. One approved acute day is required before administrative days can be approved. Should both *acute* and *admin* days be appealed, a TAR for each type of day must be sent

Send appeal documents to:

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

## INQUIRY

The TAR Unit has 60 days to respond to a first level appeal. If the provider has not received a decision within the 60-day time period, we recommend that the provider immediately send an inquiry to determine the status of the appeal including whether or not it was received. This inquiry could be sent as early as 30 days after the first-level appeal was sent, as frequently the appeals are completed significantly earlier than the 60 days allowed. It is crucial to inquire about the appeal as soon as possible after the TAR Unit's 60-day timeline ends because that date starts the 30 day timeline for the provider to appeal to the State. (see Chapter 11, Section 1850.305 (3) (e) (2) ).

## SECOND LEVEL APPEAL

Appeals to the State must be sent within 30 days after notification of the 1<sup>st</sup> level appeal decision. See the flow chart for appeal timelines.

State address to submit 2nd Level Appeals:

**Department of Mental Health  
Medi-Cal Oversight  
1600 9<sup>th</sup> Street, Room 410  
Sacramento, CA 95814  
Attn: Bobbie Chevis  
TAR 2<sup>nd</sup> Level Appeals**

State contact for 2nd Level Inquiries:

**2nd Level TAR Appeals  
Phone: (916) 651-3838  
Fax: (916) 651-3921**

# **SECTION: IX COMPLIANCE**

## COMPLIANCE

Inpatient Treatment Authorization Requests (TARs) submitted for Medi-Cal payment authorization must be in compliance with State regulatory timelines as well as State instructions for completing the TAR (State form 18-3-07). Incomplete or incorrect TARs cannot be processed for reimbursement authorization. TARs not meeting State timelines will be denied authorization for hospital payment.

### 1) TAR Error (provider correction needed)

#### Incomplete TARs include the following:

- a. Missing physician or provider signature and/or date.
- b. Incomplete or incorrect information in the TAR fields.
- c. Discrepancy between dates of service and days requested.  
Note: the day of discharge is not counted.
- d. Incomplete or incorrect diagnostic code.

Provider will be notified of the error by a *Regular Return Letter*.

#### Provider Response

- a. Corrections are to be made by the provider.
- b. Return all documents to the TAR Unit Compliance Section of LACDMH within 30 days.

After all corrections have been completed the TAR and chart will be processed for payment authorization review.

### 2) Inappropriate Submission of TAR

- a. Medi-Cal eligibility not with LA County.
- b. Patient remains hospitalized (not discharged).
- c. Duplicate TAR (TAR for this episode previously submitted to LACDMH).

These TARs and documents will be returned to the inpatient provider.

### 3) State Regulatory Timeline Compliance

#### 1. Timeline Criteria:

- a. The State 14-day timeline not met for Initial Review. Documents must be sent to the LMHP within 14 days of discharge.
- b. The State 60-day timeline for retroactive TAR not met. The 60-day timeline starts with discovery of Medi-Cal eligibility, or notification from Medicare or other insurance carrier of partial payment and/or exhaustion of benefits.

**2. Timeline Denial**

- a. Authorization for payment to the hospital is denied when State timelines are not met.
- b. A denial letter, for failure to meet State Timelines, will be sent to the provider from the Compliance Section of the TAR Unit.

**3. Appeal for Timeline Denial**

- a. Within 90 days, the provider can appeal the *State Timeline* denial.
- b. Submit an explanation for failure to meet State timelines and provide documents to verify the reason for lateness (e.g. proof of mailing within the timelines and/or courier records.)
- c. If it is a retroactive TAR, include notification from other insurance carriers. A retroactive TAR requires proof of Medi-Cal eligibility and/or Medi-Cal remittance statements including dates of discovery. (See *RETROACTIVE TAR*.)

Send the timeline appeal to:

TAR Unit  
Attention: Compliance Section  
Los Angeles County Department of Mental Health  
550 South Vermont Ave., 7<sup>th</sup> Floor  
Los Angeles, CA 90020

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 – Pg 2 .

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

These claims must be submitted to the following special address:

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

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

# **SECTION: X INQUIRY, TUT, AND RESUBMIT**

## INQUIRY, TUT AND RESUBMIT

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

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

- ◆ Status of a TAR
- ◆ Requests for a TAR Update Transmittal (TUT). TUTs are used to correct errors on TARs already on the EDS Master File.
- ◆ Requests for resubmission of a TAR to EDS

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

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

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

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

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

# **SECTION: XI MEDICAL NECESSITY CRITERIA**



## TITLE 9, CALIFORNIA CODE OF REGULATIONS

### CHAPTER 11. Medi-Cal Specialty Mental Health Services

#### 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

- (a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:
- (1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
- (A) Pervasive Developmental Disorders
  - (B) Disruptive Behavior and Attention Deficit Disorders
  - (C) Feeding and Eating Disorders of Infancy or Early Childhood
  - (D) Tic Disorders
  - (E) Elimination Disorders
  - (F) Other Disorders of Infancy, Childhood, or Adolescence
  - (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
  - (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
  - (I) Schizophrenia and Other Psychotic Disorders
  - (J) Mood Disorders
  - (K) Anxiety Disorders
  - (L) Somatoform Disorders
  - (M) Dissociative Disorders
  - (N) Eating Disorders
  - (O) Intermittent Explosive Disorder
  - (P) Pyromania
  - (Q) Adjustment Disorders
  - (R) Personality Disorders
- (2) A beneficiary must have both (A) and (B)
- (A) Cannot be safely treated at a lower level of care; and
  - (B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:
    - 1. Has symptoms or behaviors due to a mental disorder that (one of the following):
      - a. Represent a current danger to self or others, or significant property destruction.

- b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
    - c. Present a severe risk to the beneficiary's physical health.
    - d. Represent a recent, significant deterioration in ability to function.
  2. Require admission for one of the following:
    - a. Further psychiatric evaluation.
    - b. Medication treatment.
    - c. Other treatment that can reasonably be provided only if the patient is hospitalized.
- (b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:
  - (1) Continued presence of indications which meet the medical necessity criteria as specified in (a).
  - (2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
  - (3) Presence of new indications which meet medical necessity criteria specified in (a).
  - (4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

### **LACDMH Review of Medical Necessity Criteria (MNC)**

The Medi-Cal Fee for Service Acute Mental Health Inpatient Consolidation Program defines reimbursable acute inpatient psychiatric services in Title 9, California Code of Regulations (CCR), Chapter 11, Section 1820.205. To qualify as reimbursable, each day of service must be appropriately provided and adequately documented when provided to a Medi-Cal beneficiary who, as a result of mental illness is a danger to himself, others, gravely disabled and inappropriate to treat at a lower level of care.

The TAR Unit functions to review psychiatric inpatient provider requests for Medi-Cal reimbursement by determining whether such criteria have been satisfied by the documentation submitted with the TAR.

The basic issue is whether or not hospitalization is required for each day of the hospital stay or whether less restrictive care would suffice. Medi-Cal will only pay for inpatient care when the necessity for that level of care is documented in the chart. There is also a specific listing of diagnoses qualifying for payment.

Specifically excluded are mental states that are the direct effect of a medical illness.

The Los Angeles County Department of Mental Health conducts a retrospective review of requests for Medi-Cal reimbursement for acute psychiatric hospitalizations. We do not provide pre-admission nor concurrent authorizations.

Charts sent to LACDMH TAR Unit are initially assigned on a random basis for review by our review staff. No staff reviewer is assigned to a specific provider or group of providers. Reviewers examine a chart to determine whether, for each day of hospitalization, documentation exists to justify inpatient care per State regulations (Title IX CCR Chap. 11, Sect 1820.205). Reviewers do not interpret documentation, choice of therapeutic modality, efficiency of treatment or even the optimal nature of inpatient care. They only determine documentation of medical necessity. State regulations, Title IX CCR, Chapter 11, stipulate that while approval of an application for payment may be rendered by a licensed mental health professional other than a physician, a decision to reject a request for payment, in part or whole, must be made by a psychiatric physician.

## **State Medi-Cal Policy Statement 1-89 issued April 12, 1994**

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

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

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

# **SECTION: XII**

# **NOTICE OF**

# **ACTION**

## TAR DENIAL – NOTICE OF ACTION (NOA-C)

In the event inpatient TAR reimbursement is denied, entirely or partially, both the Medi-Cal beneficiary and the provider requesting reimbursement will be notified of such denial via a timely Notice of Action-C (NOA-C) will provide information regarding the State-mandated procedures for appealing the decision to deny reimbursement.

A *Notice of Action* is a required document that is given to Medi-Cal beneficiaries informing them of denials, terminations, reductions or modifications of requested mental health services from the LMHP and their right to appeal (See document at end of this section). The Notice of Action begins the ninety (90) day period that beneficiaries have to file for State Fair Hearings regarding the decisions indicated on the *Notice of Action*.

The Notice of Action-C issuance is the responsibility of the LMHP

LMHP will do the following:

1. Send the original NOA-C to the beneficiary at his/her last known mailing address as noted in the service provider's documents accompanying the Treatment Authorization Request.
2. Send a copy of the NOA-C to the service provider/UR contact person requesting reimbursement for the inpatient acute psychiatric services.
3. Send a copy of the NOA-C to the Practitioner requesting reimbursement for inpatient acute psychiatric services.
4. Send a copy of the NOA-C to: Los Angeles County  
Department of Mental Health  
Patients' Rights Unit
5. Retain a copy of the NOA-C

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

Date: \_\_\_\_\_

To: \_\_\_\_\_, Medi-Cal Number \_\_\_\_\_

The mental health plan \_\_\_\_\_ County has  denied \_\_\_\_\_ changed your Provider's request for \_\_\_\_\_  
for \_\_\_\_\_ Los Angeles \_\_\_\_\_  
payment of the following service(s): \_\_\_\_\_

The request was made by: (Provider name) \_\_\_\_\_

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

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

The mental health plan took action based on information from your Provider for the reason check below:

- Your mental health condition as described to us by your Provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).
- Your mental health condition as described to us by your Provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): \_\_\_\_\_
- The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- The mental health plan requested additional information from your Provider that the plan needs to approve payment of the service you received. To date, the information has not been received.
- Other

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

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

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

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

**YOUR HEARING RIGHTS**

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

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

**To Keep Your Same Services While You Wait for A Hearing**

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

**State Regulations Available**

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

**To Get Help**

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

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

**Authorized Representative**

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

**Grievance**

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

**Information Practices Act Notice (California Civil Code Section 1798, et. seq.)** The information you are asked to write in on this form is needed to process your hearing request.

Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

DMH NOA-BACK (7-3-98)

**HOW TO ASK FOR A STATE HEARING**

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

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

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

**HEARING REQUEST**

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

Here's why: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

My name: (print) \_\_\_\_\_

My Social Security Number: \_\_\_\_\_

My Address:(print) \_\_\_\_\_  
 \_\_\_\_\_

My phone number: (\_\_\_\_\_) \_\_\_\_\_

My signature: \_\_\_\_\_

Date: \_\_\_\_\_

I need an interpreter at no cost to me. My language or dialect is: \_\_\_\_\_

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

Name \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Phone number \_\_\_\_\_



# **SECTION: XIII RESOURCE INFORMATION**

## Contact Information

- ACCESS Center, telephone number (800) 854-7771, is for public information regarding mental health services throughout Los Angeles County. ACCESS is available 24 hrs, 7-days, including holidays, and is capable of answering calls in languages such as English, Spanish, Mandarin (Chinese), and other languages available from translators.
- California State Department of Mental Health:
  - Medi-Cal Mental Health Branch
  - 1600 9<sup>th</sup> Street
  - Sacramento, CA 95814
  - Phone: (916) 651-9370
  - Fax: (916) 654-5591
- Los Angeles County Department of Mental Health Contract Development and Administration Division (CDAD):
  - Chief, CDAD
  - 550 S. Vermont Avenue, 5<sup>th</sup> Floor
  - Los Angeles, California 90020
  - Phone: (213) 738-4684
- Treatment Authorization Unit:
  - 550 S. Vermont Avenue, Room 701**
  - Los Angeles, California 90020**
  - Tel: (213) 739-7300**
  - Fax: (213) 487-7483/ (213) 427-6164**
  - Email: [TAR\\_Unit@dmh.lacounty.gov](mailto:TAR_Unit@dmh.lacounty.gov)**
- California State Department of Mental Health's fiscal intermediary, EDS's Medi-Cal Telephone Service Center for requesting Mental Health Stay in a Hospital TAR forms (SDMH 18-3) is (800) 541-5555.
- California State Department of Mental Health's website for Medi-Cal provider enrollment information and application forms is as follows: [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

- 1st Level TAR Appeals:
  - 1st Level Appeal Section of the TAR Unit  
550 S. Vermont Avenue, Room 701  
Los Angeles, CA 90020  
Fax # (213) 487-7483 or (213) 427-6164  
Telephone # (213) 739-7300 or (213) 639-6344.
  
- 2nd Level TAR Appeals:
  - 2nd Level TAR Appeals  
Phone: (916) 651-3838  
FAX: (916) 651-3921

# **SECTION: XIV PROVIDER SITE REVIEW**

## PROVIDER SITE REVIEW

The *Local Mental Health Plan* requires that each Contract provider maintains:

- ◆ Compliance with the contract between the provider and the DMH.
- ◆ A safe facility, and when applicable, store and dispense medications in compliance with state and federal laws and regulations.
- ◆ Compliance with documentation standards, maintenance of records, and ability standards as required by the DMH.

The services of providers will be reviewed on a regular basis to determine compliance with various regulatory standards.

# **SECTION: XV REPORTING ADVERSE OUTCOMES**

## REPORTING ADVERSE OUTCOMES

### Section XV

### Provider Manual 2015

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

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

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

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

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

LPS Designation Coordinator  
Office of the Medical Director  
County of Los Angeles Department of Mental Health  
550 South Vermont Avenue, 6th Floor  
Los Angeles, CA 90020

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

LPS Designation Coordinator  
Office of the Medical Director  
FAX (213) 738-4646

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

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

Section XV

Provider Manual 2015  
2<sup>nd</sup> Edition

Page 1 – 1

Section XVII

Provider Manual 2015  
2<sup>nd</sup> Edition

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Page 1 – 1



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

## DATA COLLECTION & REPORTING REQUIREMENTS

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

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

- ◆ Registering a beneficiary
- ◆ Submitting claims

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

The Department is currently communicating Integrated Behavioral Health Information System (IBHIS, the current name of the LACDMH's Data Collection and Reporting System) related issues such as system events, system outages, or policy and procedure changes to its providers via LACDMH's Data Collection and Reporting System (IBHIS) Alerts.

### **Integrated Behavioral Health Information System (IBHIS) Provider Connect-FFS 1 End User Manual**

Provider Connect Training Manual is available and attached at the end of the Provider Manual and below. <https://lapconn.netsmartcloud.com/la>

This link will take you to the Provider Connect training environment. Please read the IBHIS Provider Connect-FFS 1 End User Manual to print required admission date, discharge date, admission diagnosis and discharge diagnosis information. The Provider Connect printed information should be submitted with the TAR form. If you have any questions, please contact (213) 739-7300.

# **SECTION: XVII DEFINITIONS, ABBREVIATIONS AND PROGRAM TERMS**

## GLOSSARY OF TERMS

- **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).
- **Integrated Behavioral Health Information System, or ProviderConnect; the LACDMH Data Collection and Reporting System, and the LACDMH Information System (IBHIS)** 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 Mental Health (SDMH) responsible for implementation and management of the Medi-Cal Consolidation Program, e.g., Los Angeles County Department of Mental Health (LACDMH)..
- **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
- **EDS TAR Master File:** Electronic data file maintained by SDMH's fiscal intermediary recording all relevant TAR information, e.g., beneficiary identification, dates of service, number of days approved for reimbursement, etc.
- **TAR Update Transmittal (TUT):** Form completed and submitted by the LMHP to correct information recorded on the EDS TAR Master File.
- **Single Point of Contact (SPOC):** See Section III

# **SECTION: XVIII FREQUENTLY ASKED QUESTIONS**

- What is the address, telephone and fax numbers for the Los Angeles County Department of Mental Health's Treatment Authorization Unit? **The TAR Unit contact information is as follows:**

**550 S. Vermont Avenue, Room 701  
Los Angeles, California 90020  
Tel: (213) 739-7300  
Fax: (213) 487-7483/ (213) 427-6164  
Email: TARUnit@dmh.lacounty.gov**

- How does a provider get information about a specific TAR? **Any inquiry regarding a specific TAR must be submitted only by the provider's designated Single Point of Contact (SPOC) in writing; then mailed, delivered or faxed to the TAR Unit.**
- How does a provider change their designated Single Point of Contact (SPOC)? **At any time, and as often as necessary, a provider may change their SPOC by submitting a written notification to the TAR Unit on the provider's letterhead stationary, providing the name, mailing address, telephone and fax number of their SPOC. Please allow at least one (1) business day for the TAR Unit to update their files.**
- Where can someone get information about mental health outpatient and inpatient services in Los Angeles County? **Phone the Los Angeles County Department of Mental Health ACCESS Center Hotline at (800) 854-7771. The ACCESS Center is staffed 7-days a week-24hours per day.**
- Does the Local Mental Health Plan (LMHP), i.e., the Los Angeles County Department of Mental Health (LACDMH), arrange and reimburse for transporting (e.g., via ambulance) a Medi-Cal beneficiary? **No.**
- What can be done about a TAR not included in the EDS TAR Master File? **Refer to Section X, page 1-1.**
- What can be done to correct erroneous TAR information on the EDS TAR Master File? **Refer to Section X, page 1-1.**
- Where do providers get TAR (SDMH 18-3 3/07) forms? **SDMH fiscal intermediary, i.e., Electronic Data Systems (EDS), provides Mental Health Stay in a Hospital TAR forms. Each TAR is uniquely numbered and must not be duplicated. Copies of TARs cannot be processed by the TAR Unit. Request Mental Health Stay in a Hospital TAR forms by telephoning EDS at (800) 541-5555.**

- What is the SDMH website for Medi-Cal provider enrollment information and application forms? **SDMH's website for provider enrollment information and application forms is [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).**

# **SECTION: XIX IMPORTANT TELEPHONE NUMBERS**



## Section XIX

<b>IMPORTANT PHONE NUMBERS</b>
--------------------------------

Treatment Authorization Unit	LACDMH	(213) 739-7300 (Voice) (213) 487-7483 (Fax) (213) 427-6164 (Fax)
1 <sup>st</sup> Level TAR Appeals Section	LACDMH	(213) 739-7300 (213) 639-6344
2nd Level TAR Appeals	State DMH	(916) 651-3838 Fax (916) 651-3921
EDS Medi-Cal Processing Service Center	State DMH	(800) 541-5555
California State Dept. of Mental Health	State DMH	(916) 651-9370
Access Center	LACDMH	(800) 854-7771
Patient's Rights Bureau	LACDMH	(213) 738-4673
Lanterman-Petris-Short (LPS) Designation Coordinator	LACDMH	(213) 639-6315
Contract Development and Administration Division	LACDMH	(213) 738-4684
Chief Information Office Bureau Helpdesk	LACDMH	(213) 351-1335

# **SECTION: XX**

# **ALERTS**

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

**ProviderConnect**



**February 9, 2018**

**v. 4.5**

# Table of Contents

Introduction to IBHIS for Fee-for-Service Providers.....	2
Overview.....	2
ProviderConnect Log In .....	3
ProviderConnect Main Menu.....	4
ProviderConnect Client Search With Lookup Client .....	5
ProviderConnect Client Search With Add New Client/Client Search.....	6
ProviderConnect Create Admission for New Client .....	7
ProviderConnect Editing Demographic Information .....	9
ProviderConnect Admission Diagnosis.....	10
ProviderConnect Discharge .....	12
ProviderConnect Printing Admission, Diagnosis and Discharge Screens.....	14
ProviderConnect Accessing LACDMH Service Information .....	16
Coordinating ProviderConnect and TAR Form Data.....	18
Common Errors Made on TAR(s).....	18
ProviderConnect Correcting Data Input Errors .....	20
TAR Medical Record Submission Content and Organization for Determination of Medical Necessity.....	21

# Introduction to IBHIS for Fee-for-Service Providers

## Overview

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

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

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

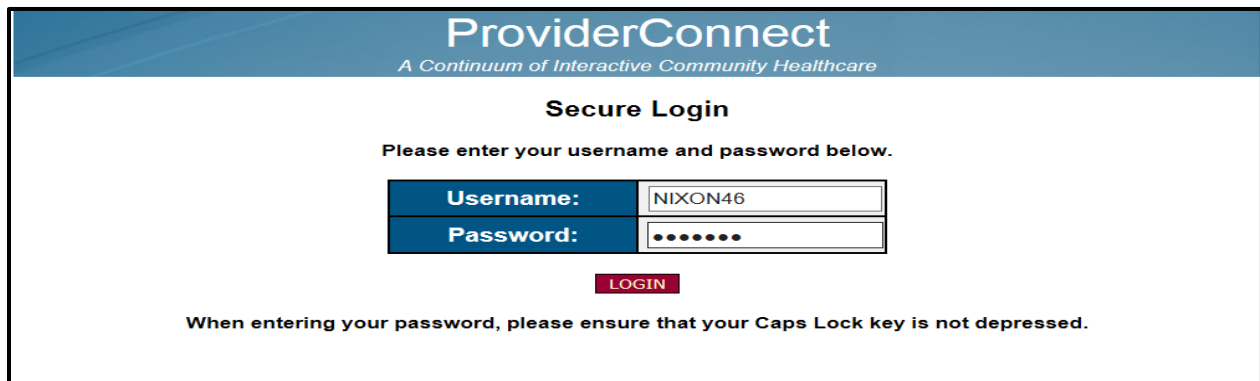
Note: Enter admission record and admission diagnosis within 24 hours of admission, to facilitate care coordination.
4. Upon discharge: First, enter discharge diagnosis and finally, create discharge.
5. Print (using your desktop print functions/Right-Click) the following screens to accompany paper TAR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

# ProviderConnect Log In

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

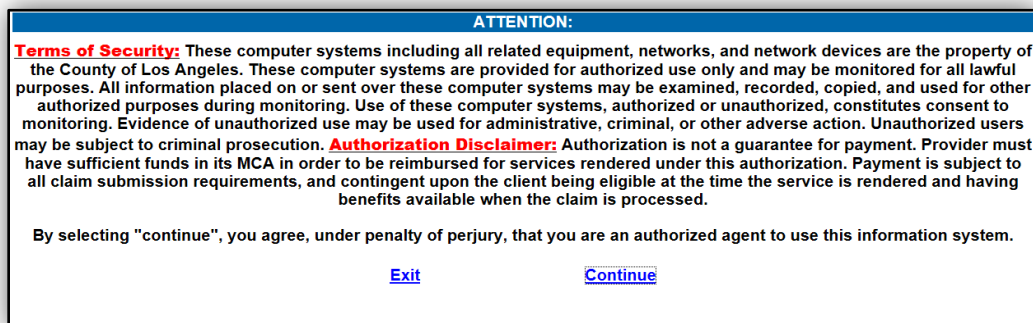
**Note:** For *training* purposes only, type the following web address in the address line:  
<https://lapconn.netsmartcloud.com/lastaging> This link will take you to the ProviderConnect training environment where you may practice using the ProviderConnect system, prior to using the system live.

The following login screen will appear:



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

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



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

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

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

# ProviderConnect Main Menu

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

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

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

#### Password Tips:

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

## Client Search

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

There are two steps to search for clients:

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

# ProviderConnect

## Client Search with Lookup Client

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

You may search for clients using the following parameters:

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

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

Search Criteria	
Member ID:	<input type="text"/>
SSN:	<input type="text"/>
Last Name:	Client <input type="text"/>
First Name:	Test <input type="text"/>
Date of Birth:	05/27/1954 <input type="text"/>
Agency:	BHC ALHAMBRA HOSPITAL
Note: Only clients with authorization requests, pending or approved authorizations, and/or provider-initiated Admissions will display.	
<input style="background-color: #800040; color: white; padding: 5px 20px;" type="button" value="Search by Criteria"/>	

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

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

Search Criteria

Back

About ProviderConnect 2017.4.1

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



# ProviderConnect Lookup Client (Cont'd)

2. The following screen will appear:

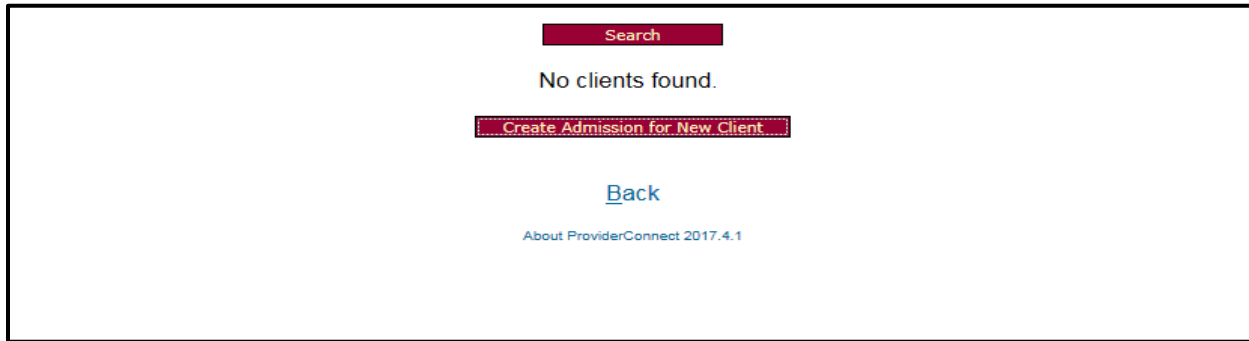
Member ID	ProviderConnect - Demographic		BHC ALHAMBRA HOSPITAL 6/7/2017 10:42:17 AM	Lookup Client   Main Menu   Log Out
3170994	Client Name: Client, Test			
Demographic	Member ID: 3170994			
CSJ Admission	SSN: 765-43-2100			
Financial Eligibility				
Authorizations				
Provider Admission				
Provider Diagnosis				
Day Treatment / MHS Authorization Details				
Over Threshold Authorization Request				
Plan Communication				
Systemwide Annual Liability				
Exit to Main Menu				
Member Demographics				
Social Security Number	Date of Birth	Facility Chart Number		
765-43-2100	5/27/1954			
Member Street 1	Member Street 2	Member City		
1234 Anywhere Street				
Member County	Member Phone Number	Member State		
[Please Choose One]		CA - CALIFORNIA		
Member Zip Code	Member Work Number	Ethnicity		
90020		[Please Choose One]		
Member Language	Sex	Client Maiden Name		
English - 7	Male - M			
Race	Race	Citizenship Status		
White - 1	African-American - 2 American Indian/Alaska Native - 4 Armenian - 31 Asian Indian - 15	[Please Choose One]		
Veteran	Education Level At Admission	Client Declined to Provide Information		
	Unknown - 99	Ethnic Origin - 0 Language - 149 Race - 116		
Pre-Admission Disposition	Employment Status	Client's Cell Phone		
	Unemployed - UE			
Marital Status	Client's Email Address	Smoker		
Single / Never Married - 1		[Please Choose One]		
Communication Preference				
[Please Choose One]				
<div style="background-color: #c00; color: white; padding: 5px; display: inline-block;">Save Record</div>				
About ProviderConnect 2017.4.1				

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

## ProviderConnect Client Search with Add New Client/Client Search

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

ProviderConnect - Add New Client/Client Search		BHC ALHAMBRA HOSPITAL 6/2/2017 1:20:12 PM	Lookup Client   Main Menu   Log Out
Search Criteria			
Social Security Number:	765-43-2100		
Last Name:	Client		
First Name:	Test		
Sex:	<input type="radio"/> Female - F <input checked="" type="radio"/> Male - M <input type="radio"/> Unknown - U		
Date of Birth:	05/27/1954 x		
<div style="background-color: #c00; color: white; padding: 5px; display: inline-block;">Search</div>			
<a href="#" style="color: #0056b3; text-decoration: none;">Back</a>			
About ProviderConnect 2017.4.1			



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

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

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

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

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

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

**Note:** If you find out after submission that any of the admission data input is entered incorrectly, for example (admission date), and the system does not allow you to make the correction, please create a heat ticket immediately for DMH to make that correction. **“Do not create a new “DUPLICATE” admission under the same client or create a “DUPLICATE” client ID to create the admission.”**

<https://dmh.sslvpn.lacounty.gov/dmh/contractor>

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

Search Results							
ID	Name	Date Of Birth	Client's Address City	Client's Address Zipcode	Alias	Admitting Practitioner	Score
8170994	CLIENT, TEST	05/27/1954	LOS ANGELES	90020		056575	231

[Create Admission for New Client](#)

[Back](#)

About ProviderConnect 2017.4.1

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

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

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

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

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

# ProviderConnect

## Editing Demographic Information

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

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

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

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

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

The screenshot displays the 'ProviderConnect - Demographic' form for client 'Client\_Test' (Member ID: 3170994, SSN: 785-43-2100). The form is divided into several sections: 'Member Demographics' (Social Security Number, Date of Birth, Facility Chart Number, Member Street 1 & 2, Member City, Member State, Member Work Number, Ethnicity, Client Maiden Name, Citizenship Status), 'Employment Status' (Pre-Admission Disposition, Employment Status), 'Marital Status' (Marital Status), 'Communication Preference' (Communication Preference), and 'Smoker' (Smoker). A 'Save Record' button is located at the bottom left of the form. Two red callout boxes are present: one pointing to the 'View and update' button and another pointing to the 'View client admissions/episodes' button. The navigation bar on the left shows 'Member ID' 3170994 and a 'Demographic' tab selected.

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

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

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

# ProviderConnect Admission Diagnosis

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

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

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

ProviderConnect - Provider Admissions FFS1 HOSPITAL TRAINING			
Client Information			
Client Name:	Client, Test		
Member ID:	3170994		
SSN:	765-43-2100		
Episode Information			
Episode	Admission Date	Discharge Date	Program
1	5/15/2017		5007I BHC ALHAMBRA HOSPITAL
Unassigned	10/10/2016		1234I FFS1 HOSPITAL TRAINING

[Add Admission Record](#)

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

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

File Edit View Favorites Tools Help

<b>Member ID</b>	<b>Client Name:</b> Client, Test
<b>3170994</b>	<b>Member ID:</b> 3170994
	<b>SSN:</b> 765-43-2100

**Demographic**

CSI Admission  
Financial Eligibility  
Authorizations  
Provider Admission  
Provider Diagnosis  
Provider Diagnosis (ICD-10)

Day Treatment / MHS Authorization Details  
Over Threshold Authorization Request  
Plan Communication  
Systemwide Annual Liability

Exit to Main Menu

**Diagnosis Information (ICD-10)**

<b>Episode Number</b> 2	<b>Type of Diagnosis</b> Please Choose One
<b>Date of Diagnosis</b> 10/10/2016	<b>Time of Diagnosis</b> 10:00 AM HH:MM AM/PM
<b>Prognosis</b>	<b>Estimated Discharge Date</b>
<b>Trauma (CSI)</b> No - N	<b>General Medical Condition Summary Code (CSI) (Select Up to Three)</b> Allergies - 17 Anemia - 16 Arterial Sclerotic Disease - 01 Arthritis - 19 <small>Ctrl+click to choose multiple items (1 currently selected)</small>
<b>Substance Abuse / Dependence (CSI)</b> No - N	<b>Substance Abuse / Dependence Diagnosis (CSI)</b>

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

**Add Diagnosis Entry**

**Save Diagnosis** **Return To List**

ProviderConnect 2017.5.1 © 2017 Netsmart Technologies, Inc.

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

About ProviderConnect v2.217

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

# ProviderConnect Discharge

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

Member ID: 3170994

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

**Diagnosis Information (ICD-10)**

Episode Number: 2	Type of Diagnosis: Discharge - D
Date of Diagnosis: 10/15/2016	Time of Diagnosis: 10:30 AM
Prognosis:	Estimated Discharge Date:
Trauma (CSI):	General Medical Condition Summary Code (CSI):
Substance Abuse / Dependence (CSI):	Substance Abuse / Dependence Diagnosis (CSI):

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

Buttons: Save Diagnosis, Return To List

- You must Click on **“Provider Admission,”** then Select [Create Discharge](#) link.

Member ID: 3170994

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

Episode Information			
Episode	Admission Date	Discharge Date	Program
1	5/15/2017	Create Discharge	50071 BHC ALHAMBRA HOSPITAL

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

**Member ID**  
3170994

**Demographic**  
CSI Admission  
Financial Eligibility  
Authorizations  
Provider Admission  
Provider Diagnosis  
Provider Diagnosis (ICD-10)

**Day Treatment / MHS Authorization Details**  
Over Threshold Authorization Request  
Plan Communication  
Systemwide Annual Liability

**Exit to Main Menu**

**Discharge Information**

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

**Demographics**

Client Home Phone Number	Client Work Number
Client Address Line 1 1234 Anywhere Street	Client Address Line 2
Client Address - City	Client Address - State CA - CALIFORNIA
Client Address - Zip Code 94720	Client Address - County

3. Click **Save Discharge**

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

<b>Financial Eligibility</b>	<b>Episode Information</b>			
Authorizations	Episode	Admission Date	Discharge Date	Program
Provider Admission	2	10/10/2016	Queued	1234I FFS1 HOSPITAL TRAINING
Provider Diagnosis	1	5/15/2017		5007I BHC ALHAMBRA HOSPITAL
Provider Diagnosis (ICD-10)				

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

**Member ID**  
3170994

**Demographic**  
CSI Admission  
Financial Eligibility  
Authorizations  
Provider Admission  
Provider Diagnosis  
Provider Diagnosis (ICD-10)

**ProviderConnect - Provider Admissions** FFS1 HOSPITAL TRAINING 6/28/2017 1:50:05 PM [Lookup Client](#) | [Main Menu](#) | [Log Out](#)

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

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



# ProviderConnect

## Printing Admission, Diagnosis and Discharge Screens

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

Print Preview of Admission screen:

Client Data
Page 1 of 1

**Member ID**

**3170994**

**ProviderConnect -**  
**Provider Admission**  
**Form**

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

<b>Demographic</b>	<b>Client Name:</b> Client, Test
<b>CSI Admission</b>	<b>Member ID:</b> 3170994
	<b>SSN:</b> 765-43-2100

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

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

Print Preview of Admission/Discharge Diagnosis screen:

Member ID: 3171132

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

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

Add Diagnosis Record

About ProviderConnect 2017.5.1

Print Preview of Discharge screen:

Member ID: 3170994

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

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

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

# Accessing LACDMH Service History Information through ProviderConnect

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

Main Menu - Provider		
Lookup Client	<b>Reports</b>	Add New Client/Client Search
Change Password	Documentation	News

**Step 2:** Click on [LACDMH Client Service History]

Reports
LACDMH Client Service History

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

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

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

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

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

## Looking up IBHIS episodes

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

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

Main Menu - Provider		
<u>Lookup Client</u> Documentation	Add New Client/Client Search News	Change Password
Logout / Exit		

About ProviderConnect 2017.4.1

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

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

**Step 3:** Select the ‘Provider Admission’ option.

Member ID
<input type="text"/>
Demographic
CSI Admission
Financial Eligibility
Authorizations
<u>Provider Admission</u>
Attachments
Provider Diagnosis (ICD-10)

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

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

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

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

## Coordinating ProviderConnect and TAR form data

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

**Note:** If you find out after submission that any of the admission data input is entered incorrectly, for example (admission date), and the system does not allow you to make the correction, please create a heat ticket immediately for DMH to make that correction. **“Do not create a new “DUPLICATE” admission under the same client or create a “DUPLICATE” client ID to create the admission.”**

<https://dmh.sslvpn.lacounty.gov/dmh/contractor>

## Common Errors Made on TAR(s)

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

1. Box #7 (admission date.)
2. Box #14 (date of birth.)
3. Patient’s name- Provider forgets to give a.k.a. or misspells the patient’s name.

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

4. Box #17- Number of days does not coincide with the admission date and/or discharge date.
5. Box #20 (discharge date.)
6. Providers forget to indicate how many days apply to each TAR when there are multiple TAR(s) i.e., acute and administrative. Example: 6/30-7/15 TAR#1.

**COUNTY  
USE  
ONLY**

SERVICE  
CATEGORY

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

1. CLAIMS CONTROL NUMBER
F.I. USE ONLY

2 3

4 5

**CONFIDENTIAL PATIENT INFORMATION**  
County Code and Aid Code go here

**HOSPITAL USE**

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) 6

ADMIT DATE 7

PROVIDER NUMBER 10

PROVIDER NAME

PROVIDER STREET/MAILING ADDRESS

PROVIDER CITY, STATE AND ZIP CODE

EMER. ADMIT 9

AUTH. EXP. 8

PROVIDER PHONE NO.

VERBAL CONTROL

NUMBER OF DAYS REQUESTED 17

ADMITTING DIAGNOSIS DESCRIPTION

PATIENT MEDICAL ID NO. 11  e.g. 1960

PATIENT NAME 12

DATE OF BIRTH 14

DISCHARGE DATE 20

ADMITTING ICD9-CM 21

# To Correct Data Input Errors Post Submission:

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

<https://dmh.sslvpn.lacounty.gov/dmh/contractor>



Los Angeles County

## Mental Health SSLVPN

c+ContractorID   
Hosted Password

By logging on using this interface, I acknowledge that I have read, understood, and accepted the Los Angeles County's Agreement for Acceptable Use And Confidentiality of County IT Resources; I further understand that I must obtain prior authorization from my management to perform County business functions during off hours.

Home · My Items · Knowledge Center · More... Self Service (MH) Help

Home Report an Issue

Need help? Search for  in All

Announcements  
No records

ID	Summary	Progress	Created on

Report an Issue using Template Go to the Knowledge Center

Cannot open Outlook-DMH-Self Service

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

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

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

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

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