



## TAR Discharge Planning Option

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The Discharge Planning Option (DPO) was implemented to facilitate the discharge of patients from acute care hospitals to home, board and care, or a nursing facility in response to a report by the State of California's Little Hoover Commission. These discharge planning procedures do not apply to patients enrolled in Medi-Cal Managed Care plans.

### INTRODUCTION

#### Initiating Discharge Planning Option

Upon admission of a Medi-Cal patient to an acute hospital with on-site review, the Medi-Cal Consultant begins working closely with the discharge planner to determine the post discharge needs of the patient. See *Figure 3* on a following page for a sample communications log to facilitate communication between the Medi-Cal Consultant and discharge planner.

Once a patient's post discharge needs are determined, the acute care hospital must complete one of the following forms depending on the place of service where the patient is being discharged:

- *Medi-Cal Managed Care Authorization* form (55-1) for post discharge community services, including allied health, dialysis, and home health services.
- *Long Term Care Treatment Authorization Request* (20-1) for post discharge Nursing Facility services.

#### TAR Completion Instructions

Instructions for completing the *Medi-Cal Managed Care Authorization* form (55-1) are included in this section. Refer to the *TAR Discharge Planning Option Codes* section in the appropriate Part 2 manual for the listing of services that may be requested on this form.

For instructions on how to complete the *Long Term Care Treatment Request* (20-1), refer to the *TAR Discharge Option Plan for Long Term Care* section in the appropriate Part 2 manual.

## MEDI-CAL MANAGED CARE AUTHORIZATION FORM (55-1)

### Post Discharge Community Services

The *Medi-Cal Managed Care Authorization* form (55-1) is used to request Medi-Cal field office authorization for post discharge community services. See *Figures 1* and *2* on a following page for examples of the 55-1.

### Discharge Planner Review

The DPO process is initiated by the acute hospital discharge planner prior to the patient's anticipated discharge. After identifying community services for post discharge needs, the discharge planner completes a 55-1 and presents it to the Medi-Cal Consultant for approval. The Medi-Cal Consultant has the authority to approve a specified range of medically necessary post discharge services. The 55-1 is signed by a representative of the acute hospital. A physician's signature is not necessary.

**Note:** If the patient needs Long Term Care facility post discharge services, the discharge planner will fill out a *Long Term Care Treatment Authorization Request (20-1)* instead of a 55-1. Refer to the *TAR Discharge Planning Option for Long Term Care* section in the appropriate Part 2 manual.

### Medi-Cal Consultant Review

The Medi-Cal Consultant reviews the patient's chart and the items and services requested on the 55-1 to verify the presence of a physician's order for post discharge services and to determine medical necessity. The consultant may also observe or interview the patient to determine appropriate post discharge services.

The consultant then approves appropriate services and completes the 11-digit TAR Control Number by adding a two-digit prefix and one-digit suffix.

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Post Discharge Providers

The acute hospital is responsible for identifying Medi-Cal providers willing and able to provide post discharge services (post discharge providers).

The discharge planner will contact providers in the community who agree to render post discharge services and inform the providers of the 11-digit TAR Control Number. Post discharge providers use this 11-digit number to bill for services. After the field office enters the 55-1 into the TAR master file, an *Adjudication Response* (AR) will be sent to the post discharge provider.

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

Multiple Post Discharge Services

The discharge planner may list up to four post discharge services, providers or a combination of both services and providers on one *Medi-Cal Managed Care Authorization* form. If more than four post discharge services or providers are requested, additional 55-1 forms must be used.

**Note:** Community providers must use the TAR Control Number that appears on the line(s) authorizing their services.

Exceptions to Discharge Planning Option

Discharge Planning Option (DPO) is not initiated for patients pending Medi-Cal eligibility, who are eligible for California Children Services or are enrolled in Medi-Cal Managed Care health care plans (county health initiatives, Prepaid Health Plans or Primary Care Case Management plans). If the patient is eligible for both Medicare and Medi-Cal, DPO may only be initiated for services not covered by the Medicare program.

**Completing the Medi-Cal  
Managed Care  
Authorization Form (55-1)**

The discharge planner is responsible for completing item numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 18, 23, 24, 25, 26 and 27 on the *Medi-Cal Managed Care Authorization form (55-1)* for services provided by post discharge community providers. An example of a correctly completed 55-1 for post discharge community services is shown below.

HOSPITAL NAME & ADDRESS. <b>Community Acute Hospital 123 Health Road Anytown, CA 95814</b>		<b>CONFIDENTIAL Patient Information</b>			PATIENT'S AUTHORIZED REPRESENTATIVE. <b>Raquel Conrad</b>		
		<b>MEDI-CAL MANAGED CARE AUTHORIZATION</b>			NAME <b>789 River Road</b>		
					ADDRESS <b>Anytown, CA 95814</b>		
<b>PATIENT INFORMATION</b>							
PATIENT NAME. <b>Conrad, Jose M</b>		AGE. SEX. <b>58</b> <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MEDI-CAL NUMBER		TRANSFER TO:	
PATIENT ADDRESS. <b>789 River Road Anytown, CA 95814</b>		DATE OF BIRTH. <b>06 / 30 / 42</b> MM DD YY		COUNTY CODE <b>3 4</b>		AID CODE <b>6 0</b>	
		SOCIAL SECURITY NO. <b>1 1 1 - 2 2 - 3 3 3 3</b>				HOME BOARD & CARE <input checked="" type="checkbox"/> NF/CF <input type="checkbox"/>	
MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		ICD-9-CM <b>897.2</b>		DIAGNOSIS <b>S/P traumatic amputation, above knee, left leg</b>			
<b>SPECIFIC SERVICES REQUESTED</b>							
DCN.		SERV. CAT.		DRUG <b>(OTHER)</b>		PROVIDER NO. <b>HHA666660</b>	
						PROVIDER NAME: <b>Caring Home Health Agency (916) 555-1111</b>	
<b>1</b>		FROM [ ] TO [ ]		COMMENTS <b>Open draining stump wound requires daily dressing changes for one week 3x week for 2 weeks, 2x week for one week.</b>			
PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED	PROCEDURE	SERVICE DESCRIPTION:
	<b>50012821</b>				Y N UNITS	<b>Z6900</b>	<b>Skilled Nursing Services</b>
						QTY. <b>15</b>	
DCN.		SERV. CAT.		DRUG <b>(OTHER)</b>		PROVIDER NO. <b>HHA666660</b>	
						PROVIDER NAME: <b>Caring Home Health Agency (916) 555-1111</b>	
<b>2</b>		FROM [ ] TO [ ]		COMMENTS <b>To continue range of motion – transfer – ambulation with assistive device 3x week for 3 weeks.</b>			
PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED	PROCEDURE	SERVICE DESCRIPTION:
	<b>50012821</b>				Y N UNITS	<b>Z6904</b>	<b>Physical Therapy Services</b>
						QTY. <b>9</b>	
DCN.		SERV. CAT.		DRUG <b>(OTHER)</b>		PROVIDER NO. <b>HHA666660</b>	
						PROVIDER NAME: <b>Caring Home Health Agency (916) 555-1111</b>	
<b>3</b>		FROM [ ] TO [ ]		COMMENTS <b>To continue goal of independent wheelchair transfer from bed to commode 3x week for 3 weeks.</b>			
PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED	PROCEDURE	SERVICE DESCRIPTION:
	<b>50012821</b>				Y N UNITS	<b>Z6906</b>	<b>Occupational Therapy Services</b>
						QTY. <b>9</b>	
DCN.		SERV. CAT.		DRUG <b>(OTHER)</b>		PROVIDER NO. <b>DME234560</b>	
						PROVIDER NAME: <b>Hospital Equipment Inc. (916) 555-2222</b>	
<b>4</b>		FROM [ ] TO [ ]		COMMENTS <b>Requires varying bed height to facilitate patient transfers and personal care.</b>			
PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED	PROCEDURE	SERVICE DESCRIPTION:
	<b>50012821</b>				Y N UNITS	<b>E0295</b>	<b>1 month rental of semi-electric hospital bed.</b>
						QTY. <b>1</b>	
<b>NOTE: Approval does not guarantee payment! Patient's eligibility must be current and claims properly submitted</b>							
To the best of my knowledge the above information is true, accurate and complete, and the requested services are medically necessary for the patient.				MEDI-CAL CONSULTANT COMMENTS:			
SIGNATURE OF PHYSICIAN OR PROVIDER <b>. J. J. Jones RN.</b>				MEDI-CAL CONSULTANT I.D.#			
DATE <b>11/18/04</b>				DATE			

Figure 1. Sample Completed Medi-Cal Managed Care Authorization Form (55-1).

HOSPITAL NAME & ADDRESS. ①	<b>CONFIDENTIAL Patient Information</b>  <b>MEDI-CAL</b> <b>MANAGED CARE AUTHORIZATION</b>	PATIENT'S AUTHORIZED REPRESENTATIVE. ⑨ NAME _____ ADDRESS _____
<b>PATIENT INFORMATION</b>		
PATIENT NAME. ②  PATIENT ADDRESS. ③	AGE. SEX. ⑤ ④ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE DATE OF BIRTH. ⑥ ____ / ____ / ____ MM DD YY	MEDI-CAL NUMBER COUNTY CODE ⑦ SOCIAL SECURITY NO. ⑧ _____ - ____ - ____ TRANSFER TO: HOME BOARD & CARE <input type="checkbox"/> NF/ICF <input type="checkbox"/>
MEDICARE ⑩ <input type="checkbox"/> YES <input type="checkbox"/> NO ICD-9-CM ⑪ DIAGNOSIS _____		
<b>SPECIFIC SERVICES REQUESTED</b>		
DCN. ⑫  <b>1</b> FROM _____ TO _____ COMMENTS ⑮ PREFIX TAR CONTROL NO. P.I. JVR ACTION AUTHORIZED PROCEDURE SERVICE DESCRIPTION: QTY. 50012821 _____ Y N UNITS ⑳ ㉑ ㉒ ㉓ ㉔ ㉕	SERV. CAT. ⑬ DRUG /OTHER ⑭ PROVIDER NO. ⑮ PROVIDER NAME: ⑯	
DCN. ⑱  <b>2</b> FROM _____ TO _____ COMMENTS PREFIX TAR CONTROL NO. P.I. JVR ACTION AUTHORIZED PROCEDURE SERVICE DESCRIPTION: QTY. 50012821 _____ Y N UNITS	SERV. CAT. DRUG /OTHER PROVIDER NO. PROVIDER NAME:	
DCN. ⑲  <b>3</b> FROM _____ TO _____ COMMENTS PREFIX TAR CONTROL NO. P.I. JVR ACTION AUTHORIZED PROCEDURE SERVICE DESCRIPTION: QTY. 50012821 _____ Y N UNITS	SERV. CAT. DRUG /OTHER PROVIDER NO. PROVIDER NAME:	
DCN. ⑲  <b>4</b> FROM _____ TO _____ COMMENTS PREFIX TAR CONTROL NO. P.I. JVR ACTION AUTHORIZED PROCEDURE SERVICE DESCRIPTION: QTY. 50012821 _____ Y N UNITS	SERV. CAT. DRUG /OTHER PROVIDER NO. PROVIDER NAME:	
<b>NOTE: Approval does not guarantee payment! Patient's eligibility must be current and claims properly submitted</b>		
To the best of my knowledge the above information is true, accurate and complete, and the requested services are medically necessary for the patient. ⑳ SIGNATURE OF PHYSICIAN OR PROVIDER _____ ㉑ DATE _____	MEDI-CAL CONSULTANT COMMENTS: ㉒ _____ _____ _____ ㉓	MEDI-CAL CONSULTANT I.D.# ㉔ DATE ㉕ _____ _____

Figure 2. Sample Medi-Cal Managed Care Authorization Form (55-1).

**Explanation of Form Items**

The following item numbers and descriptions correspond to the sample *Medi-Cal Managed Care Authorization* shown on a previous page. All items must be completed unless otherwise noted in these instructions.

**Note:** Authorization does not guarantee payment. Be sure the patient's eligibility is current and that the patient is not enrolled in a Medi-Cal Managed Care Plan. To receive payment, the patient must be eligible for the date of service and all claims submitted properly.

<u>Item</u>	<u>Description</u>
1.	<b>HOSPITAL NAME &amp; ADDRESS.</b> Enter the name and address of the discharging acute hospital. If the patient is transferring or being admitted to an acute hospital (for example, acute rehabilitation), enter the name and address of the admitting hospital. If the patient is not in an acute hospital, leave blank.
2.	<b>PATIENT NAME.</b> Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.

Newborn Infant

When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name, sex and date of birth in the appropriate spaces. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (for example, Jones, Baby Girl). If newborn infants from a multiple birth are being authorized, each newborn must also be designated by number or letter (for example, Jones, Baby Girl, Twin A). Services to an infant may be authorized and billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.

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|----|---|
| 3. | <b>PATIENT ADDRESS.</b> Enter the patient's residence address.  |
| 4. | <b>AGE.</b> Enter the patient's current age.  |
| 5. | <b>SEX.</b> Enter an "X" in the <i>Male</i> box if the patient is male. Enter an "X" in the <i>Female</i> box if the patient is female.   |
| 6. | <b>DATE OF BIRTH.</b> Enter the month of birth in the "MM" area, the day of birth in the "DD" area and the year of birth in the "YY" area. For example, June 30, 1942 would be entered as 06 30 42. |

<u>Item</u>	<u>Description</u>
7.	<p><b>MEDI-CAL NUMBER/COUNTY CODE/AID CODE/ SOCIAL SECURITY NO.</b> Enter either the patient's 14-character Medi-Cal ID number or 9-character Social Security Number in the appropriate space.</p> <p><b>Note:</b> The two-digit county and aid codes <u>must</u> be entered in the appropriate boxes when using the Social Security Number.</p>
8.	<p><b>TRANSFER TO.</b> Enter an "X" in the box indicating where the patient will be transferred or discharged to. If the patient is transferred, enter the name of the admitting hospital in the <i>Comments</i> box in <i>Section 1</i> (Item 18).</p>
9.	<p><b>PATIENT'S AUTHORIZED REPRESENTATIVE.</b> If applicable, enter the name and mailing address of the patient's authorized representative, representative payee, conservator, legal representative or other representative handling the patient's medical and personal affairs.</p>
10.	<p><b>MEDICARE?</b> Enter an "X" in the <i>Yes</i> box if the patient has Medicare. Enter an "X" in the <i>No</i> box if the patient does not have Medicare.</p>
11.	<p><b>ICD-9-CM/DIAGNOSIS.</b> Enter the patient's primary discharge diagnosis code on the <i>ICD-9-CM</i> line and the primary discharge diagnosis description in the <i>Diagnosis</i> box.</p>
12.	<p><b>DCN.</b> Leave blank. For DHCS Fiscal Intermediary (FI) use only.</p>
13.	<p><b>SERV. CAT.</b> Leave blank. For FI use only.</p>
14.	<p><b>DRUG/OTHER.</b> Circle <i>Drug</i> if requesting prior approval for drugs for the patient. Circle <i>Other</i> if requesting <u>any</u> other service for the patient.</p>
15.	<p><b>PROVIDER NO.</b> Enter the rendering provider number.</p>

<u>Item</u>	<u>Description</u>
16.	<b>PROVIDER NAME.</b> Enter the name of the rendering provider. If space allows, enter the area code and telephone number of the rendering provider as well.
17.	<b>FROM/TO.</b> Leave blank. The Medi-Cal Consultant will fill in the valid dates of authorization in this area.  <b>Note:</b> TAR-authorized services billed for dates of service outside the authorized "From/To" dates will not be paid.
18.	<b>COMMENTS.</b> Enter sufficient justification for the Medi-Cal Consultant to determine if the services are medically necessary. If necessary, attach additional information. Justification includes medical reasons why specific services are required by the patient and the frequency of required services. If the services requested will be provided in an acute hospital or Nursing Facility, enter the name of the facility in this box.
19.	<b>PREFIX/TAR CONTROL NO./P.I.</b> Leave blank. The Medi-Cal Consultant will add a two-digit prefix and one-digit suffix to the pre-imprinted eight-digit number. <u>The two-digit prefix will be different for each provider listed on the Medi-Cal Managed Care Authorization form.</u>  Enter the <u>entire 11-digit TAR Control Number</u> on your claim form when billing. This TAR Control Number serves as the initial admit TAR number when admitting a patient to an acute hospital (for example, acute rehabilitation). <u>Do not attach a copy of the TAR to the claim form.</u>
20.	<b>JVR.</b> <u>Jackson v. Rank.</u> Leave blank. For State use only.
21.	<b>ACTION.</b> Leave blank. The Medi-Cal Consultant will enter a "1" if the service is approved, a "2" if the service is modified or a "3" if the service is denied.
22.	<b>AUTHORIZED UNITS.</b> Leave blank. The Medi-Cal Consultant will indicate if the service is authorized and the quantity authorized.
23.	<b>PROCEDURE.</b> Enter the five-character CPT-4, HCPCS level II or III procedure code, Drug NDC or the Medical Supply code, followed by a two-character modifier, if necessary.

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<u>Item</u>	<u>Description</u>
24.	<b>SERVICE DESCRIPTION.</b> Enter the name of the procedure, item or service requested. If requesting hospital days, enter "Hospital Day(s)."
25.	<b>QTY.</b> Enter the quantity of procedures, items, services or hospital days requested. If requesting monthly rental of a DME item, enter the number of months the rental will be required.
12 – 25.	Repeat the instructions for Items 12 through 25 for lines two through four if more than one post-discharge community service is requested, even if the different services will be rendered by the same provider.
26.	<b>SIGNATURE OF PHYSICIAN OR PROVIDER.</b> A representative of either the discharging acute hospital or the post-discharge community provider must sign on this line. A physician's signature is not necessary.
27.	<b>DATE.</b> Enter the date the representative of the discharging acute hospital or the post-discharge community provider signed the form.
28.	<b>MEDI-CAL CONSULTANT COMMENTS.</b> Leave blank. The Medi-Cal Consultant will enter any pertinent comments in this box.
29.	<b>MEDI-CAL CONSULTANT I.D.#.</b> Leave blank. The Medi-Cal Consultant will enter his or her identification number or initials in this box.
30.	<b>DATE.</b> Leave blank. The Medi-Cal Consultant will enter the date he or she signed the form in this box.
31.	<b>MEDI-CAL CONSULTANT SIGNATURE.</b> The Medi-Cal Consultant will sign the form next to or under the <i>Medi-Cal Consultant I.D.#</i> and <i>Date</i> boxes.