

TAR Completion for Long Term Care

The *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is used to request prior authorization from the Medi-Cal field office for all Medi-Cal recipients admitted to a Nursing Facility (NF). The LTC TAR form is initiated either by the NF or the discharge planner at an acute hospital with Discharge Planning Option, depending on circumstances detailed on the following pages. If a discharge planner initiates an LTC TAR, the NF must complete it and send it to the field office.

Note: Nursing Facility Level A (NF-A) replaces Intermediate Care Facility (ICF) references, and Nursing Facility Level B (NF-B) replaces Skilled Nursing Facility (SNF) references.

The LTC TAR is a 4-part form. The first three copies are forwarded to a Medi-Cal field office consultant at one of the following Medi-Cal field offices:

Facility	Medi-Cal Field Office
NF-A and NF-B	San Bernardino
Subacute (Pediatric and Adult)	San Francisco
ICF/DD, ICF/DD-H and ICF/DD-N	Local field office

The fourth copy is retained by the NF for its records. When a Medi-Cal field office consultant approves the LTC TAR, the original and one copy are retained by the field office; and one copy is returned to the facility. After the facility receives its copy of the LTC TAR, the nine-digit TAR Control Number (TCN) is entered in the appropriate box on the *Payment Request for Long Term Care* (25-1) form. For addresses and telephone numbers of designated Medi-Cal field offices for your geographic area or specific service, refer to the *TAR Field Office Addresses* section of this manual.

Do not attach a copy of the LTC TAR to a *Payment Request for Long Term Care* (25-1) form. Enter the TCN only in the appropriate space.

Note: Verbal authorization is not available for NF admissions. For additional information on LTC TARs, refer to the *TAR for Long Term Care: 20-1 Form* section in this manual.

Glossary

The following terms apply to Nursing Facilities.

Discharge Planning Option (DPO)

Discharge Planning Option is a process where the Medi-Cal on-site review nurse at an acute care hospital with on-site review can approve a variety of medically necessary services and equipment prior to the discharge of the recipient from the acute hospital to home or to a Nursing Facility. For more information, refer to the *TAR Discharge Planning Option* section in this manual.

Preadmission Screening
Resident Review (PASRR)

Preadmission Screening Resident Review is a process that screens Medi-Cal recipients entering Nursing Facilities to determine the appropriate level of care and care needs of Mentally III and Mentally Retarded recipients. For more information, refer to the *Preadmission Screening Resident Review (PASRR)* section in this manual.

Level I PASRR
Screening

Level I is the first level of screening for PASRR. The purpose of Level I is to screen or assess those recipients who have a diagnosis or suspicion of Mental Illness or Mental Retardation. If, during the Level I screen, a recipient is identified as being possibly Mentally III or Mentally Retarded, the recipient must then be referred to Level II.

Level II PASRR
Screening

Level II screening determines the appropriateness for Nursing Facility care and if there is a need for specialized services. Level II screening is performed by the Department of Mental Health (DMH) or the Department of Developmental Services (DDS), or their designee. For more information, refer to the *Preadmission Screening Resident Review (PASRR)* section in this manual.

Minimum Data Set for Nursing Home Resident Assessment and Screening (MDS 2.0)	Federal law requires that all NFs establish a uniform system for assessing each resident's ability to perform Activities of Daily Living (ADL). The State has designated the <i>Minimum Data Set (MDS) – Version 2.0 for Nursing Home Resident Assessment and Care Screening</i> (MDS 2.0) form as the Resident Assessment Instrument (RAI) to be used by NFs certified by the State to participate in the Medicare and Medi-Cal programs. These NFs are required to conduct resident assessments on a regular basis using the MDS information. For further information on the MDS 2.0 and the <i>Quarterly Assessment Form 2.0</i> , refer to the <i>TAR for Long Term Care: MDS Form</i> section of this manual.
Delegated Acute Hospital	A delegated acute hospital is an acute hospital that has entered into an agreement with the Department of Health Care Services (DHCS) to perform the Level I PASRR screening.
Non-Delegated Acute Hospital	A non-delegated acute hospital is an acute hospital that has not entered into an agreement with DHCS to perform the Level I PASRR Screening.
On-Site Review Program	<p>On-site review is the process where a Medi-Cal nurse regularly visits an acute hospital to review acute care authorization requests for Medi-Cal recipients.</p> <p>Hospitals that do not have Medi-Cal on-site review nurses authorizing services for Medi-Cal recipients do not have "on-site review."</p>

LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

FOR FI USE ONLY

CONFIDENTIAL PATIENT INFORMATION

1
STATE USE ONLY

1A
PLEASE TYPE ALL REQUIRED INFORMATION

Elite Pica
[] [] [] []

CCN

Typewriter Alignment

1B TRANSFER [] INITIAL [] REAUTHORIZATION [] 1C SKILLED NURSING CARE [] INTERMEDIATE CARE [] I.C.F. D.D. [] SPECIAL PROGRAM FORM LIC 231 ATTACHED []

PART I FOR PROVIDER USE

18 PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED 2 APPROVED AS MODIFIED SEE COMMENTS BELOW.

3 DENIED REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW. 4 DEFERRED

5 JACKSON VS RANK PARAGRAPH CODE

18

BY: (MEDICAL CONSULTANT) 18A

X

I.D. NO. DATE REVIEW COMMENTS INDICATOR

19

COMMENTS/EXPLANATION 20

20A 20

21 22

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

15A PERIOD OF CARE REQUESTED: (FROM) DATE (TO) DATE PRIM. DX CODE 16

16A CURRENT DIAGNOSES A. (PRIMARY):

16B (SECONDARY):

16C NAME OF FORMER FACILITY:

B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY):

16D

C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

16E BEDRIDDEN TOTALLY INCONTINENT SPOON FED CONFINED TO WHEEL CHAIR AMBULATORY W/ASSISTANCE AMBULATORY

SPECIFY: 16F

D. DIET: 16G E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 16H

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS: 16I

PHYSICIAN NAME & PHONE NO. 17A

PHYSICIAN PROVIDER NUMBER 17

17B TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN DATE

PART III FOR STATE USE

21 APPROVED CARE 22 SPECIAL PROGRAM

SNF	ICF	ICF-OD	M.D. SUB	M.D. REHAB	NO SPECIAL PROGRAM
[]	[]	[]	[]	[]	[]

23 FROM (DATE) (Y/N) FOCUS REVIEW

24 FROM (DATE) (Y/N) CHART REVIEWED

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(B)

26 TAR CONTROL NUMBER OFFICE SEQUENCE

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

20-1CZ 3/07

Figure 1. Sample Long Term Care Treatment Authorization Request (Form 20-1).

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *Long Term Care Treatment Authorization Request* (Form 20-1) on a previous page in this section.

<u>Item</u>	<u>Description</u>
1.	STATE USE ONLY. Leave blank.
1A.	CLAIM CONTROL NUMBER (CCN). For FI use only. Leave blank.
1B.	<p>TRANSFER, INITIAL, REAUTHORIZATION. Enter an "X" in the appropriate box.</p> <p>TRANSFER. Indicates admission to an NF-B from another NF-B or admission to an ICF/DD-H or ICF/DD-N from another ICF/DD-N.</p> <p>INITIAL. Indicates new admission other than a transfer.</p> <p>REAUTHORIZATION. Indicates request for extension of an authorized period.</p>
1C.	<p>SKILLED NURSING CARE, INTERMEDIATE CARE, ICF-DD, SPECIAL PROGRAM CERTIFICATION FOR SPECIAL TREATMENT PROGRAM SERVICES FORM (HS 231) ATTACHED. Enter an "X" in the appropriate box. Subacute facilities annotate S/A next to the SNF box to clarify level of care requested.</p> <p>SKILLED NURSING CARE (SNF). Care given a recipient who requires skilled nursing care on a continual basis. This is now known as NF-B.</p> <p>INTERMEDIATE CARE (ICF). Care given a recipient who requires nursing care only on an occasional basis, but who cannot be cared for at home. This is now known as NF-A.</p> <p>ICF/DD-H and ICF/DD-N. Care given a recipient with chronic developmental disability. (Note: Attach Form HS 231 to the LTC TAR.)</p>

<u>Item</u>	<u>Description</u>
1C.	<p>SKILLED NURSING CARE, INTERMEDIATE CARE, ICF-DD, SPECIAL PROGRAM FORM HS 231 ATTACHED. (continued)</p> <p>Facilities certified to bill for special programs (such as the Mentally Disordered Rehabilitation Program) and facilities approved for ICF-DD level of care must attach the Form HS 231 to the LTC TAR when requesting initial authorization and reauthorization from the consultant.</p> <p>Form HS 231 may be approved for up to two years, depending on the type of special program involved. Once the approved period on form HS 231 expires, a new form must be filled out and signed by the appropriate agency. Form HS 231 should be submitted with all initial and reauthorization TARs identified above. Subsequent HS 231 forms are to be maintained on file by the facility, and must be reviewed by the Medi-Cal consultant.</p> <p>Note: If the facility does not receive form HS 231 before the initial written LTC TAR is submitted, the facility should submit the LTC TAR anyway. The LTC TAR will be date-stamped on receipt in the field office and returned to the facility <u>without approval</u>. When form HS 231 <u>is</u> received, the facility should resubmit the LTC TAR for approval with form HS 231 attached.</p> <p>If you check the <i>Special Program Form 231 Attached</i> box, you must check either the <i>Skilled Nursing Care</i> box or <i>Intermediate Care</i> box.</p>

	<u>Item</u>	<u>Description</u>
PART I: FOR PROVIDER USE	1D.	VERBAL CONTROL NUMBER. Leave blank. Verbal authorization is not available.
	1E.	RETROACTIVE REQUEST. Enter an "X" in the appropriate box to indicate whether the request is retroactive. Guidelines for obtaining retroactive authorization are outlined in Title 22, Section 51003(b), (1), (2), (3), (4), (5) and (6).
	1F.	PROVIDER PHONE NO. Optional.
	1G.	PROVIDER NAME AND ADDRESS. Enter the provider name, address and nine-digit ZIP code. Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.
	2.	PROVIDER NUMBER. Enter your provider number.
	3 – 5.	F.I. USE ONLY. Leave blank.
	5A.	MEDICAL RECORD NUMBER. This is an optional field. Enter the recipient's medical record number or account number in this field (maximum of five characters – either numbers or letters).
	6.	PATIENT NAME. Enter the last name, first name, and middle initial, if known. Avoid nicknames or aliases.

<u>Item</u>	<u>Description</u>
7.	MEDI-CAL IDENTIFICATION NO. When entering the recipient identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. Do not enter any characters (dashes, hyphens, special characters, etc.) in the remaining blank positions of the Medi-Cal ID field. The county code and aid code <u>must</u> be entered just <u>above</u> the recipient <i>Medi-Cal Identification Number</i> box.

The image shows a form for entering a Medi-Cal Identification Number. At the top right, there are two small boxes labeled "County code" and "Aid code". Below these, the text "MEDI-CAL IDENTIFICATION NO." is centered. Underneath, a large rectangular box contains the number "90000000A95001". To the left of this large box is a small box containing the number "7".

Box 7 of TAR (20-1):

This example also shows placement of the county code and aid code on the form above Box 7.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 8. | PEND. If the recipient's Medi-Cal eligibility is not yet established and the Medi-Cal number is not known, insert the letter "P" in Box 12 to indicate "Pending." |
| 9. | ADMIT DATE THIS SERVICE. Enter the recipient's admission date to the facility in six-digit format (for example, November 1, 2006 = 110106). |
| 10. | MEDICARE STATUS. Leave blank if recipient is Medicare eligible. If not, enter one of the following codes: |

<u>Code</u>	<u>Explanation</u>
0	Under 65, does not have Medicare coverage
* 1	Benefits exhausted
* 2	Utilization committee denial or physician non-certification
3	No prior hospital stay
* 4	Facility denial
* 5	Non-eligible provider
* 6	Non-eligible recipient
* 7	Medicare benefits denied or cut short by Medicare intermediary
8	Non-covered services
* 9	PSRO denial

* Documentation required

Continue to submit documentation of Medicare denial for the appropriate status codes to the Medi-Cal field office.

- | <u>Item</u> | <u>Description</u> | | | | | | | | | | | | | | |
|-------------|---|-------------|--------------------|---|---------------------|---|-------------------------------|---|---------------|---|---|---|---------------------|---|------|
| 11. | DATE BENEFITS EXHAUSTED. If Medicare Status Code "1" (Benefits Exhausted) is indicated in Box 10, and you are billing for NF-B or Subacute Care, enter the date that Medicare benefits were exhausted. Documentation supporting benefit exhaustion must be submitted with TAR. | | | | | | | | | | | | | | |
| 12. | SEX. Use the capital "M" for male, or "F" for female. Obtain from the BIC. | | | | | | | | | | | | | | |
| 13. | DATE OF BIRTH. Enter the recipient's date of birth in a six-digit format. | | | | | | | | | | | | | | |
| 14. | ADMIT FROM. Enter the code number from the following list:
<table><thead><tr><th><u>Code</u></th><th><u>Description</u></th></tr></thead><tbody><tr><td>1</td><td>Acute Hospital Care</td></tr><tr><td>2</td><td>Hospital Skilled Nursing Care</td></tr><tr><td>3</td><td>NF-B Facility</td></tr><tr><td>4</td><td>NF-A, ICF/DD, ICF/DD-H, ICF/DD-N Facility</td></tr><tr><td>5</td><td>Board and Care Home</td></tr><tr><td>6</td><td>Home</td></tr></tbody></table> | <u>Code</u> | <u>Description</u> | 1 | Acute Hospital Care | 2 | Hospital Skilled Nursing Care | 3 | NF-B Facility | 4 | NF-A, ICF/DD, ICF/DD-H, ICF/DD-N Facility | 5 | Board and Care Home | 6 | Home |
| <u>Code</u> | <u>Description</u> | | | | | | | | | | | | | | |
| 1 | Acute Hospital Care | | | | | | | | | | | | | | |
| 2 | Hospital Skilled Nursing Care | | | | | | | | | | | | | | |
| 3 | NF-B Facility | | | | | | | | | | | | | | |
| 4 | NF-A, ICF/DD, ICF/DD-H, ICF/DD-N Facility | | | | | | | | | | | | | | |
| 5 | Board and Care Home | | | | | | | | | | | | | | |
| 6 | Home | | | | | | | | | | | | | | |
| 15. | SOCIAL SECURITY CLAIM NUMBER. Not required by Medi-Cal. | | | | | | | | | | | | | | |

	<u>Item</u>	<u>Description</u>
PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN	15A.	PERIOD OF CARE REQUESTED. Enter the "From Date" and the "Thru Date" requested for authorization.
	16.	PRIMARY DX (DIAGNOSIS) CODE. Enter the appropriate primary ICD-9-CM diagnosis code.
	16A.	CURRENT DIAGNOSES (PRIMARY). Always enter the English description of the primary diagnosis corresponding to the ICD-9-CM diagnosis code entered in Box 16.
	16B.	CURRENT DIAGNOSES (SECONDARY). If necessary, provide the description of the secondary diagnosis.
	16C.	NAME OF FORMER FACILITY. Enter the name of the facility where the recipient previously resided. Enter "Home" if the recipient is being admitted from home.
	16D.	DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY). Enter the name, dosage and frequency of medications given to the recipient on a daily basis.
	16E.	PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED. Enter an "X" in the appropriate boxes to show BEDRIDDEN, TOTALLY INCONTINENT, SPOON FED, CONFINED TO WHEEL CHAIR, AMBULATORY W/ASSISTANCE, or AMBULATORY conditions.

<u>Item</u>	<u>Description</u>
PART II, SECTION C: TO BE COMPLETED BY THE NURSING FACILITY	16F. SPECIFY. Specify the reason for the recipient's limitation(s) on the first line. Fill out the following three lines as indicated below. <u>This information is only required for recipients being admitted to a Nursing Facility.</u>
Initial LTC TARs	<p>When completing an <u>initial</u> LTC TAR, fill out the following information on lines 2 through 4:</p> <p>Community options available: <input type="checkbox"/> Yes <input type="checkbox"/> No Check one.</p> <p>PAS/PASRR completed on: <u>(date)</u> By: _____ Fill in the date and enter who completed the PAS/PASRR (NF, Acute or DHCS).</p> <p>Referred to DMH/DDS for Level II screen on: <u>(date)</u> Fill in the date.</p> <p>Note: This information does not have to be completed if the recipient is being admitted from an acute hospital <u>with Discharge Planning Option</u> to NF-A, NF-B, or Subacute Facility. In this case, the on-site review nurse will provide the required information in <i>Part III (Comments/Explanation)</i> section) of the TAR form.</p> <p>Note: For bed hold requests, specify: BED HOLD REQUEST</p>
Reauthorization LTC TARs	<p>When completing a <u>reauthorization</u> LTC TAR, fill out the following information on lines 2 and 3:</p> <p>Level II/ARR completed on: <u>(date)</u> _____ N/A Fill in the date or check Not Applicable.</p> <p>Community options available: <input type="checkbox"/> Yes <input type="checkbox"/> No Check one.</p>

	<u>Item</u>	<u>Description</u>
PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN	16G.	DIET. Enter the type of diet prescribed.
	16H.	ATTENDING PHYSICIAN'S LAST VISIT (DATE). Enter the attending physician's last visit in six-digit format.
	16I.	PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS. If applicable, enter the name and address of the recipient's authorized representative, representative payee, conservator over the person, legal representative or other representative handling the recipient's medical and personal affairs.
	17.	PHYSICIAN PROVIDER NUMBER. Enter the rendering provider number in this area.
	17A.	PHYSICIAN NAME AND PHONE NUMBER. Enter the physician name and telephone number.
	17B.	SIGNATURE OF PHYSICIAN. Must be signed and dated by the admitting or primary physician. An original signature is required.
	PART III: FOR STATE USE	18. – 26.
18.		Only submit your claim if Box 1 (Approved as Requested) or Box 2 (Approved as Modified) is marked. The <i>Denied</i> and <i>Deferred</i> boxes indicate that the provider's request has not been approved.
18A.		The LTC TAR must show the consultant's signature. If not, contact the Medi-Cal field office.
19.		The consultant will write his or her ID number in this box.
20.		The consultant will write the date the LTC TAR was reviewed in this box.

<u>Item</u>	<u>Description</u>
20A.	The consultant may use this section to list the approved procedures or any further information the provider must submit with the claim or resubmit with the LTC TAR. The on-site nurse uses this area to indicate the length of stay and level of care approved.
21. & 22.	The consultant will indicate the approved care and special program in these boxes.
23. & 24.	The consultant will indicate the valid dates of authorization for this LTC TAR.
25.	The consultant will enter a retroactive authorization code in this box, if applicable.
26.	The consultant will enter a two-digit prefix to the pre-imprinted seven-digit number. This entire nine-digit number must be added on the claim form when this service is billed. <u>Do not attach a copy of the LTC TAR to the claim form.</u>

LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

1 FOR FI USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

PLEASE TYPE ALL REQUIRED INFORMATION

Elite Pica

TRANSFER INITIAL REAUTHORIZATION SKILLED NURSING CARE INTERMEDIATE CARE I.C.F. D.D. SPECIAL PROGRAM FORM LIC 231 ATTACHED

TYPEWRITER ALIGNMENT

Elite Pica

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES NO

PROVIDER PHONE NO. (213) 555-5555

PROVIDER NAME AND ADDRESS
 ABC NURSING HOME
 1234 MAIN STREET
 ANYTOWN CA 958235555

PROVIDER NUMBER 0123456789

FI USE ONLY

MEDICAL RECORD NUMBER 7654321

PATIENT NAME (LAST, FIRST, M.I.) DOE, JOHN

MEDI-CAL IDENTIFICATION NO. 90000000A95001

ADMIT DATE 11:06:07

MEDICARE STATUS 1

DATE 11:06:07

SEX M

DATE OF BIRTH 07:25:15

ADMIT FROM 1

SOCIAL SECURITY CLAIM NO.

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE 11 06 07 (TO) DATE 10 06 08

PRIM. DX CODE 25001

CURRENT DIAGNOSES (PRIMARY): DIABETES

(SECONDARY): COPD

NAME OF FORMER FACILITY: ACUTE

DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY): REGULAR INSULIN 10 UNITS Q AM. VITAMINS, MOM.

PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:
 BEDRIDDEN TOTALLY INCONTINENT SPOON FED CONFINED TO WHEEL CHAIR AMBULATORY W/ASSISTANCE AMBULATORY

SPECIFY: COMMUNITY OPTIONS AVAILABLE YES NO

PASRR COMPLETED ON 110207 BY NF

REFERRED TO DMH/DDS FOR LEVEL II SCREEN (DATE) NA

D. DIET: DIABETIC DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 110607

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

PHYSICIAN NAME & PHONE NO: K. BROWN, MD 213-555-5555

PHYSICIAN PROVIDER NUMBER: 1234567890

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

K. Brown SIGNATURE OF PHYSICIAN 122507 DATE

PART III FOR STATE USE

PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED

2 APPROVED AS MODIFIED SEE COMMENTS BELOW.

3 DENIED REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW.

4 DEFERRED

5 JACKSON VS RANK PARAGRAPH CODE

BY: (MEDI-CAL CONSULTANT)

I.D. NO. DATE

REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

MEDICARE DENIAL ATTACHED

MDS WITH ASTERISKED AREAS COMPLETED ATTACHED

21 APPROVED CARE

SNF ICF ICF-DD 4

M/D SUB M/D REHAB. NO SPECIAL PROGRAM

22 FOCUS REVIEW

23 FROM (DATE) (Y/N)

24 THRU (DATE) (Y/N)

PROLONGED CARE ADMIN. DAYS (BED NOT AVAILABLE) PENDING (REQUEST FOR FAIR HEARING)

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(b)

26 TAR CONTROL NUMBER

OFFICE SEQUENCE

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

20-1CZ 3/07

Figure 2. Sample Initial LTC TAR.

LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

PLEASE TYPE ALL REQUIRED INFORMATION

1 FOR FI USE ONLY

CCN

Elite Pica

Elite Pica

Typewriter Alignment

TRANSFER INITIAL REAUTHORIZATION SKILLED NURSING CARE INTERMEDIATE CARE I.C.F. D.D. SPECIAL PROGRAM FORM LIC 231 ATTACHED

STATE USE ONLY

CONFIDENTIAL PATIENT INFORMATION

PART I FOR PROVIDER USE	PART III FOR STATE USE
<p>VERBAL CONTROL NO. <input type="text"/></p> <p>REQUEST IS RETROACTIVE? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>PROVIDER PHONE NO. (213) 555-5555</p> <p>PROVIDER NAME AND ADDRESS: ABC NURSING HOME, 1234 MAIN STREET, ANYTOWN CA 958235555</p> <p>2 PROVIDER NUMBER: 0123456789</p> <p>FI USE ONLY</p> <p>MEDICAL RECORD NUMBER: 7654321</p> <p>PATIENT NAME (LAST, FIRST, M.I.): DOE, JOHN</p> <p>MEDI-CAL IDENTIFICATION NO.: 90000000A95001</p> <p>ADMIT DATE: 11:06:07</p> <p>MEDICARE STATUS: 1</p> <p>DATE BENEFITS EXHAUSTED: 11:06:07</p> <p>SEX: M</p> <p>DATE OF BIRTH: 07:25:15</p> <p>ADMIT FROM: 1</p> <p>SOCIAL SECURITY CLAIM NO.:</p>	<p>18 PROVIDER; YOUR REQUEST IS:</p> <p>1 <input checked="" type="checkbox"/> APPROVED AS REQUESTED</p> <p>2 <input type="checkbox"/> APPROVED AS MODIFIED (SEE COMMENTS BELOW)</p> <p>3 <input type="checkbox"/> DENIED (REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW)</p> <p>4 <input type="checkbox"/> DEFERRED</p> <p>5 <input type="checkbox"/> JACKSON VS RANK PARAGRAPH CODE</p> <p>BY: (MEDI-CAL CONSULTANT) X</p> <p>I.D. NO. DATE REVIEW COMMENTS INDICATOR</p> <p>COMMENTS/EXPLANATION</p> <p>QUARTERLY MDS ATTACHED</p>
<p>PART II TO BE COMPLETED BY ATTENDING PHYSICIAN</p> <p>PERIOD OF CARE REQUESTED: (FROM) DATE 11 06 07 (TO) DATE 10 06 08</p> <p>PRIM. DX CODE: 25001</p> <p>A. CURRENT DIAGNOSES (PRIMARY): DIABETES</p> <p>(SECONDARY): COPD</p> <p>NAME OF FORMER FACILITY: ACUTE</p> <p>B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY):</p> <p>C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:</p> <p><input type="checkbox"/> BEDRIDDEN <input type="checkbox"/> TOTALLY INCONTINENT <input type="checkbox"/> SPOON FED <input checked="" type="checkbox"/> CONFINED TO WHEEL CHAIR <input type="checkbox"/> AMBULATORY W/ASSISTANCE <input type="checkbox"/> AMBULATORY</p> <p>SPECIFY: LEVEL III/ARR COMPLETED (DATE) X NA</p> <p>COMMUNITY OPTIONS AVAILABLE YES X NO</p> <p>D. DIET: DIABETIC DIET</p> <p>E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 110607</p> <p>PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:</p> <p>PHYSICIAN NAME & PHONE NO.:</p> <p>PHYSICIAN PROVIDER NUMBER: 122507</p> <p>SIGNATURE OF PHYSICIAN: K. Brown DATE: 122507</p>	<p>21 APPROVED CARE</p> <p>SNF <input type="checkbox"/> ICF <input type="checkbox"/> ICF-DD <input checked="" type="checkbox"/> M.D. SUB <input type="checkbox"/> M.D. REHAB <input type="checkbox"/> NO SPECIAL PROGRAM <input type="checkbox"/></p> <p>22 SPECIAL PROGRAM</p> <p>FOCUS REVIEW</p> <p>23 FROM (DATE) (Y/N)</p> <p>24 THRU (DATE) (Y/N)</p> <p>PROLONGED CARE ADMIN. DAYS (BED NOT AVAILABLE) PENDING (REQUEST FOR FAIR HEARING)</p> <p>25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(B)</p> <p>26 TAR CONTROL NUMBER</p> <p>OFFICE SEQUENCE</p>

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

20-1CZ 3/07

Figure 3. Sample Reauthorization LTC TAR.