

# ADHC Update

November 2007

Implementation of SB 1755



# Course Outline

- What's new (SB 1755)
- Program requirements (statutes and regulations)
- TAR Process
  - TAR submission
  - Supporting documentation
    - Individual Plan of Care (IPC)
  - Adjudication Process
  - Appeal Process

# Senate Bill 1755 - Enacted 9/29/06

## ■ Changes to Welfare and Institutions Code

### □ Section amended:

- 14571, 14571.1, 14571.2, 14571.5 (rate methodology)

### □ Sections added:

- 14521.1, 14522, 14522.3 (clarification/definitions),
- 14526.1 (authorization and medical necessity),  
14528.1 (personal health care provider and conflict of interest language),
- 14550.5 (daily core service requirements),

### □ Section repealed and added:

- 14525 (eligibility)



## SB 1755

### Provisions to be Implemented on or about February 1, 2008 (W&I Code Citation)

- *New definitions (14522.3)*
- New eligibility criteria (14525)
- New authorization and medical necessity criteria (14526.1)
- New requirements for participant's personal health care provider (14528.1)
- New ownership conflict of interest language (14528.1)
- New daily core service requirements (14550.5)

| TAR Receipt Date and Dates of Service   | SB 1755 Requirements Implemented |
|---|----------------------------------|
| TAR received on or after February 1, 2008<br>AND<br>Dates of services on or after February 1, 2008.   | YES                              |
| TAR received prior to February 1, 2008<br>AND<br>Dates of services prior to February 1, 2008.   | NO                               |
| TAR received prior to February 1, 2008<br>AND<br>Dates of services on or after February 1, 2008.  | NO                               |
| TAR received on or after February 1, 2008<br>AND<br>Dates of services prior to February 1, 2008.  | NO                               |
| TAR received prior to February 1, 2008<br>AND<br>Dates of services starting before February 1, 2008 and ending on or after February 1, 2008.    | NO                               |
| TAR received on or after February 1, 2008<br>AND<br>Dates of services starting before February 1, 2008 and ending on or after February 1, 2008. | NO                               |

**Note:** Dates of service shall not be split between the period before February 1, 2008 and the period after February 1, 2008. TARs should continue to be submitted for six-month intervals based on the end date of the previous TAR without regard to the February 1, 2008 implementation.

## SB 1755

### Provisions to be Implemented on or about August 1, 2010 [14571 & 14571.2]

- “. . . the department shall establish . . . A reimbursement methodology and a reimbursement limit . . . on a prospective cost basis for services that are provided to each participant, pursuant to his or her IPC.”
- Reimbursement methodology includes:
  - “Daily core services”\* and
  - “Separately billable services”\*

\*See next slide for definitions



## *Definitions Relevant to Reimbursement Methodology [14571.2]*

- (1) “Daily core services”: the services described in Section 14550.5*
- (2) “Separately billable services” shall include, but not be limited to:*
  - (A) Physical therapy services*
  - (B) Occupational therapy services*
  - (C) Speech and language pathology services*
  - (D) Mental health services*
  - (E) Registered dietitian services*
  - (F) Transportation services*



# New Eligibility Criteria

## SB 1755 [14525] (1 of 5)

Any adult eligible for benefits under Chapter 7 (commencing with Section 14400) shall be eligible for ADHC services if that person meets all of the following criteria:

- (a) The person is 18 years of age or older and has one or more chronic or postacute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested ADHC services for the person



# New Eligibility Criteria

## SB 1755 [14525] (2 of 5)

Any adult eligible for benefits under Chapter 7 (commencing with Section 14400) shall be eligible for ADHC services if that person meets all of the following criteria:

- (b)...has functional impairments in two or more activities of daily living, instrumental activities of daily living, or one or more of each, and requires assistance or supervision in performing these activities.



# New Eligibility Criteria

## SB 1755 [14525] (3 of 5)

Any adult eligible for benefits under Chapter 7 (commencing with Section 14400) shall be eligible for ADHC services if that person meets all of the following criteria:

- (c) The person requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.



# New Eligibility Criteria

## SB 1755 [14525] (4 of 5)

Any adult eligible for benefits under Chapter 7 (commencing with Section 14400) shall be eligible for ADHC services if that person meets all of the following criteria:

- (d) The person requires ADHC services as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the ADHC program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services...



# New Eligibility Criteria

## SB 1755 [14525] (5 of 5)

Any adult eligible for benefits under Chapter 7 (commencing with Section 14400) shall be eligible for ADHC services if that person meets all of the following criteria:

- (e) Notwithstanding the criteria...(a) to (d), inclusive, of this section, any person who is a resident of an ICF/DD-H shall be eligible for ADHC services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through ADHC, placement to a more costly institutional level of care would be likely to occur.



## Authorization Under SB 1755 [14526.1]

- (a) Initial and subsequent TARs may be granted for up to six calendar months
- (b) TARs shall be initiated by the ADHC center and shall include all of the following:
  - (1) The signature page of the H&P form that shall serve to document the request for ADHC services. A complete H&P form\*, including a request for ADHC services signed by the participant's personal health care provider, shall be maintained in the participant's health record . . . .
  - (2) The participant's Individualized Plan of Care (IPC) pursuant to CCR, Title 22, §54211

*\* See next slide for status of H&P form*

# *History and Physical form* Implementation

Implementation of the *History and Physical* form will be delayed until after the February 1, 2008 implementation of the other provisions of SB 1755. More information will be available to providers at a later date.

*-adu tar ipc 1*

# Medical Necessity Criteria Under SB 1755 [14526.1 (d)] (1 of 5)


- (d) Authorization or reauthorization of an ADHC TAR shall be granted only if the participant meets all of the medical necessity criteria:
  - (1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's *personal health care provider*\* as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:
    - (A) Monitoring
    - (B) Treatment
    - (C) Intervention

\*Definition on next slide



## *Definition [14522.3]*

- *“Personal health care provider”: the participant’s personal physician, physician’s assistant, or nurse practitioner, operating within his or her scope of practice*



# Medical Necessity Criteria Under SB 1755 [14526.1 (d)] (2 of 5)


- (d) Authorization or reauthorization of an ADHC TAR shall be granted only if the participant meets all of the medical necessity criteria:
  - (2) The participant has a condition or conditions resulting in both of the following:
    - (A) Limitations in the performance of 2 or more ADLs\* or IADLs\* or one or more from each category
    - (B) A need for assistance or supervision in performing the activities identified in (A) as related to the condition or conditions specified in (d)(1). That assistance or supervision shall be in addition to any other non-ADHC support the participant is currently receiving in his or her place of residence.

\*See next slide for definitions




## *Definitions [14522.3]*

- *“Activities of daily living”*: activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation, and transferring
- *“Instrumental activities of daily living”*: functions or tasks of independent living, including hygiene, medication management, transportation, money management, shopping, meal preparation, laundry, accessing resources, and housework



# Medical Necessity Criteria Under SB 1755 [14526.1 (d)] (3 of 5)

- (d) Authorization or reauthorization of an ADHC TAR shall be granted only if the participant meets all of the medical necessity criteria:
- (3) The participant's network of non-ADHC supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
- (A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
  - (B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.
  - (C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.



# Medical Necessity Criteria Under SB 1755 [14526.1 (d)] (4 of 5)


- (d) Authorization or reauthorization of an ADHC TAR shall be granted only if the participant meets all of the medical necessity criteria:
  - (4) A *high potential*\* exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if ADHC services are not provided.

\*See next slide for description

# *Description of “High Potential”*


- *“High potential” is described as the outcome having at least a 50 percent probability of occurring within the time frame covered by the applicable TAR for ADHC services.*

*-Provider Manual, ‘adu tar ipc 33’*



# Medical Necessity Criteria Under SB 1755 [14526.1 (d)] (5 of 5)

- (d) Authorization or reauthorization of an ADHC TAR shall be granted only if the participant meets all of the medical necessity criteria:
- (5) The participant's condition or conditions require ADHC services specified in ...(a) to (d), inclusive, of Section 14550.5, on each day of attendance, that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.



## Reauthorization Under SB 1755 [14526.1 (e)]

Reauthorization of an ADHC TAR shall be granted when the criteria specified in subdivision (d) have been met and the participant's condition would likely deteriorate if the ADHC services were denied.

# *SB 1755 on the Personal Health Care Provider (1 of 3)*

## *[14528.1]*

- (a) The personal health care provider... shall have and retain responsibility for the participant's care.*
- (b) If the participant does not have a personal health care provider during the initial assessment process to determine eligibility for ADHC, the ADHC center staff physician may conduct the initial H&P for the participant.*
- (c) The ADHC center shall make all reasonable efforts to assist the participant in establishing a relationship with a personal health care provider.*

# *SB 1755 on the Personal Health Care Provider (2 of 3)*


## *[14528.1]*

- (d) If the ADHC center is unable to locate a personal health care provider for the participant, or if the participant refuses to establish a relationship with a personal health care provider, the ADHC center shall do both of the following:*
- (1) Document the lack of a personal health care provider relationship in the participant's health record.*
  - (2) Continue to document all efforts taken to assist the participant in establishing a relationship with a personal health care provider.*

# *SB 1755 on the Personal Health Care Provider (3 of 3)*

## *[14528.1]*

- (e)(1) A personal physician for one or more of an ADHC center's enrolled participants may serve as the ADHC staff physician.*
- (2) When a personal physician serves as the staff physician, the physician shall have a personal care services arrangement with the ADHC center that meets the criteria set forth in ... (federal law).*
- (3) A personal care physician, an ADHC staff physician, or an immediate family member of the personal care physician or ADHC staff physician, shall comply with ownership interest restrictions as provided under ... (state law).*



# Required ADHC Core Services

## SB 1755 [14550.5]

ADHC centers shall offer, and provide directly on the premises, in accordance with the participant's IPC, ... the following core services to each participant during each day of the participant's attendance at the center.

- (a) One or more of (five) professional nursing services\*
- (b) One or both of the (specified) core personal care\* services or social services
- (c) At least one of (two) therapeutic activities provided by the ADHC center activity coordinator or other trained ADHC center personnel\*
- (d) One meal per day of attendance

\*Additional detail given in slides on IPC



## *Additional ADHC Responsibility Every Six Months [14526.1 (c)]*

*Every six months, the ADHC center shall initiate a request for an updated H&P form from the participant's personal health care provider using a standard update form that shall be maintained in the participant's health record...*

# *History and Physical form* Implementation

Implementation of the *History and Physical* form will be delayed until after the February 1, 2008 implementation of the other provisions of SB 1755. More information will be available to providers at a later date.

-adu tar ipc 1



# The New IPC

- Revised because SB 1755 changed the medical necessity criteria
- Medical necessity criteria from SB 1755 integrated into the form
- Clinical, functional, and psychosocial data gathered in logical relationships to the medical necessity criteria

State of California  
Health and Human Services (9/2007)

**ADULT DAY HEALTH CARE  
INDIVIDUAL PLAN OF CARE (IPC)**

Department of Health Care Services  
Page 1 of 9

Participant Name: \_\_\_\_\_

TAR Control Number (TCN): \_\_\_\_\_

Center Name: \_\_\_\_\_

Provider Number (NPI): \_\_\_\_\_

Dates of Service (DOS): From: \_\_\_\_\_ To: \_\_\_\_\_

| Box #  | Instructions for Completion  |
|--|--|
| <p align="center"><b>Top of Page<br/>One</b></p> | <p>a. <b><u>PARTICIPANT NAME:</u></b><br/>Enter the participant's name.</p> <p>b. <b><u>TAR CONTROL NUMBER (TCN):</u></b><br/>Enter the eight-digit TAR Control Number from the attached TAR (paper TAR) or the 10-digit number from the eTAR (SURGE TAR).</p> <p>c. <b><u>CENTER NAME:</u></b><br/>Enter the ADHC center's name.</p> <p>d. <b><u>PROVIDER NUMBER (NPI):</u></b><br/>Enter the ADHC center's Medi-Cal ID number or National Provider Identifier (NPI).</p> |

| Box #   | Instructions for Completion  |
|---|--|
| <p><b>Top of Page One<br/>(Continued)</b></p> | <p><b>e. <u>DATES OF SERVICE:</u></b><br/> Enter the dates of service requested on the TAR. The start date is the first requested date of service after the assessment days are completed and the Participant Agreement is signed.</p> <p>If there was an extended break in service (the previous TAR lapsed), the new start date is the first requested date of service after the participant's return to the center.</p> <p>Authorization of a TAR for ADHC services is limited to a period of not more than six months duration.</p> <p><b><u>Note:</u></b> If you are using this IPC as a fill-in form, this information (a. through e. above) will fill in automatically on all subsequent pages. If you are using this IPC as a paper form in which you are typing or handwriting this information, please complete this information on each page.</p> |

NOTE: Definitions of all key words in this IPC can be found in the Medi-Cal Inpatient/Outpatient Provider Manual.

**(1)** Check box that applies to this IPC:  Initial TAR  Reauthorization TAR  Change TAR

(#) \_\_\_\_\_ Planned Days/Week      Date of last attendance at the ADHC center: \_\_\_\_\_

What were the date(s) of the most recent multidisciplinary team assessment? \_\_\_\_\_

TB Clearance Date (initial TAR only): \_\_\_\_\_

The signature page of the *History and Physical* form accompanies this IPC and documents the request for ADHC services (initial TARs only).  Yes  No

| Box #  | Instructions for Completion   |
|--|---|
| <p align="center"><b>(1)<br/>Information Box</b></p> | <p><b>a. <u>Check the Appropriate Box Regarding TAR Type.</u></b></p> <ul style="list-style-type: none"> <li>• <b><u>INITIAL TAR</u></b> – the TAR for the first admission to this ADHC center or readmission after a break in service (lapsed TAR).</li> <li>• <b><u>REAUTHORIZATION TAR</u></b> – a TAR for continuing services at the ADHC center for which the immediately preceding TAR was authorized.</li> <li>• <b><u>CHANGE TAR</u></b> – the TAR for additional day(s) that is submitted within the current six-month TAR cycle. The IPC must be revised to support medical necessity for the increased number of days requested.</li> </ul> <p><b>b. Enter planned number of days of attendance per week. This number must support what is planned at the time of the multidisciplinary team assessment.</b></p> |

| Box #  | Instructions for Completion  |
|--|--|
| <p align="center"><b>(1)</b><br/> <b>Information Box</b><br/> <b>(Continued)</b></p> | <p><b>c. Enter the date of last attendance at the ADHC center.</b></p> <p><b>d. Enter the date(s) of the most recent multidisciplinary team (MDT) assessment.</b></p> <p><b>e. Enter the tuberculosis (TB) clearance date. This date is the date the person's TB test was determined to be negative. This date must be within one year of the participant's admission to the ADHC center.</b></p> <p><b>f. For initial TARs check Yes or No to indicate whether the signature page of the <i>History and Physical</i> form is attached to this TAR and IPC. If not attached, the TAR will be deferred.</b></p> |

| <b>(2) DIAGNOSES AND ICD CODES</b>   |  |                 |  |  |                 |
|--|--|-----------------|--|--|-----------------|
| <b>Diagnoses</b><br>Include diagnoses as provided or confirmed by the personal health care provider(s) |  | <b>ICD Code</b> | <b>Diagnoses</b><br>Include diagnoses as provided or confirmed by the personal health care provider(s) |  | <b>ICD Code</b> |
| 1  |  |                 | 7  |  |                 |
| 2  |  |                 | 8  |  |                 |
| 3  |  |                 | 9  |  |                 |
| 4  |  |                 | 10   |  |                 |
| 5  |  |                 | 11   |  |                 |
| 6  |  |                 | 12   |  |                 |

| <b>Box #</b>                               | <b>Instructions for Completion</b>   |
|--|--|
| <b>(2)<br/>Diagnoses and<br/>ICD Codes</b> | <p><b>Enter the list of diagnoses and the corresponding ICD-9-CM codes applicable to the participant. The most current codes must always be used. Enter all diagnoses and codes that have been provided or confirmed by the participant's personal health care provider(s).</b></p> <p><b>These diagnoses codes must be the same diagnoses and ICD-9-CM codes as entered on the TAR and the <i>UB-04</i> claim form; they must be the same codes as provided or confirmed by the participant's personal health care provider(s).</b></p> |

|  |  |    |
|--|--|----|
| <b>(3)<br/>MEDICATIONS</b>   | <b>Active Prescriptions</b>                                  | 12 |
|  | 1  | 13 |
|  | 2  | 14 |
|  | 3  | 15 |
|  | 4  | 16 |
| <input type="checkbox"/><br><b>No Medications<br/>or Supplements</b> | <b>Over-The-Counter Medications &amp;/or<br/>Supplements</b> |    |
|  | 5  | 1  |
|  | 6  | 2  |
|  | 7  | 3  |
|  | 8  | 4  |
|  | 9  | 5  |
|  | 10   | 6  |
| 11   |  |    |

| <b>Box #</b>               | <b>Instructions for Completion</b>  |
|----------------------------|---|
| <b>(3)<br/>Medications</b> | <p><b>List all active prescription medications and/or over-the-counter medications and supplements being taken by the participant. If the participant is not taking any medications or supplements, please check <i>No Medications or Supplements</i> box.</b></p> <p><b>An “active prescription” is described as a current and non-expired prescription.</b></p> |

| <b>(4)<br/>Active Personal<br/>Medical/Mental<br/>Health Care<br/>Provider(s)<br/>(if known)</b> | <b>Name</b> | <b>Address</b> | <b>Phone</b> |
|--|-------------|----------------|--------------|
|  |             |                |              |
|  |             |                |              |
|  |             |                |              |

| <b>Box #</b>  | <b>Instructions for Completion</b>  |
|---|---|
| <b>(4)<br/>Active Personal<br/>Medical/<br/>Mental Health<br/>Provider(s)</b> | <b>List all active personal medical and mental health care providers for the participant, if known, including their names, addresses and phone numbers.</b> |

# Participants Must Meet 5 Medical Necessity Criteria

## Criteria Verification

- **Yes/No/NA must be checked for all criteria.**
- **All boxes checked must be supported by appropriate documentation in the participant's health record.**
- **All information presented must be based on multidisciplinary team assessments completed at the center.**

# Medical Necessity Criterion # 1

| <b>(5) MEDICAL NECESSITY CRITERION #1</b> |                                |   |
|---|--------------------------------|---|
| <b>Criterion Met</b>                      |                                | The participant has <u>one or more chronic or post acute</u> medical, cognitive or mental health condition(s) identified by the participant's personal health care provider as requiring monitoring, treatment or intervention, without which the participant's condition(s) will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization. |
| Yes<br><input type="checkbox"/>           | No<br><input type="checkbox"/> |   |

| <b>Box #</b>  | <b>Instructions for Completion</b>   |
|---|--|
| <b>(5)<br/>Medical<br/>Necessity<br/>Criterion #1</b> | <p><b>Check <i>Yes</i> or <i>No</i> to indicate whether the participant meets criterion #1.</b></p> <p><b>Note: If the participant does not meet this criterion, the TAR will be denied.</b></p> |

**(6) PARTICIPANTS WITH MENTAL ILLNESS**

All participants with a primary or secondary diagnosis of mental illness, pursuant to the California Code of Regulations, title 9, section 1830.205, as an included diagnosis for County Mental Health shall be provided information regarding availability of referral unless the center believes that a referral is not appropriate or referral has occurred prior to this TAR period. The ADHC center shall refer those participants that give consent for such referral. Check all that apply:

- Excluded Diagnosis
- Referral Made
- Participant/Family Declined Referral
- Currently Being Served by County Mental Health
- Referral not Made (state reason):

| Box #  | Instructions for Completion   |
|--|---|
| <p><b>(6)<br/>Participants<br/>with Mental<br/>Illness</b></p> | <p><b>This box is specific to the participant with one or more mental illness diagnoses pursuant to CCR, Title 9, Section 1830.205. The participant and/or family/caregiver must be informed of the availability of a referral to County Mental Health at the time of the initial TAR (unless another agency has made the referral) and at any time the participant is given a new mental illness diagnosis.</b></p> <p><b>a. Check the appropriate box(es) as they apply to the specific participant.</b></p> <p><b>b. If <i>Referral Not Made</i> is checked, please state reason why not.</b></p> <p><b><u>Note:</u> If this information is not completed, the TAR will be deferred.</b></p> |

| Box #  | Instructions for Completion  |
|--|--|
| <p><b>(6)</b><br/> <b>Participants with Mental Illness</b><br/> <b>(continued)</b></p> | <p>c. <b><u>“Included” mental health diagnoses</u></b></p> <p>Participants with one or more of the following diagnoses must be informed of the availability of a referral to County Mental Health:</p> <ul style="list-style-type: none"> <li>• Pervasive developmental disorders, except autistic disorders</li> <li>• Disruptive behavior and attention deficit disorders</li> <li>• Feeding and eating disorders of infancy and early childhood</li> <li>• Elimination disorders</li> <li>• Other disorders of infancy, childhood or adolescence</li> <li>• Schizophrenia and other psychotic disorders</li> <li>• Mood disorders</li> <li>• Anxiety disorders</li> <li>• Somatoform disorders</li> <li>• Factitious disorders</li> <li>• Dissociative disorders</li> <li>• Paraphilias</li> <li>• Gender identity disorder</li> <li>• Eating disorders</li> <li>• Impulse control disorders not elsewhere classified</li> <li>• Adjustment disorders</li> <li>• Personality disorders, excluding antisocial personality disorder</li> <li>• Medication-induced movement disorders related to other included diagnoses</li> </ul> |

| Box #  | Instructions for Completion   |
|--|---|
| <p><b>(6)<br/>Participants<br/>with Mental<br/>Illness<br/>(continued)</b></p> | <p><b>d. <u>“Excluded” mental health diagnoses</u></b></p> <p><b>Participants with diagnoses other than the diagnoses listed above in c, are not included in the mental health consolidation agreement with the Department of Mental Health and do not need to be referred to County Mental Health. These include:</b></p> <ul style="list-style-type: none"> <li>• <b>Mental retardation</b></li> <li>• <b>Learning disorder</b></li> <li>• <b>Motor skills disorder</b></li> <li>• <b>Communication disorders</b></li> <li>• <b>Autistic disorder/other pervasive</b></li> <li>• <b>Tic disorder</b></li> <li>• <b>Delirium, dementia, amnesic and other cognitive disorders</b></li> <li>• <b>Mental disorders due to a general medical condition</b></li> <li>• <b>Substance-related disorders</b></li> <li>• <b>Sexual dysfunction</b></li> <li>• <b>Sleep disorders</b></li> <li>• <b>Antisocial personality disorder</b></li> <li>• <b>Other conditions that may be a focus of clinical attention, except medication-induced movement disorders</b></li> </ul> |

**(7) TAR FOR PARTICIPANT RESIDING IN AN ICF/DD-H**

Yes

No

NA

If this is a TAR for a participant residing in an ICF/DD-H, the level of functioning is such that without supplemental intervention through ADHC, placement to a more costly institutional level of care would be likely to occur.

| Box #   | Instructions for Completion   |
|---|---|
| <p><b>(7)<br/>TAR for<br/>Participant<br/>Residing in an<br/>ICF/DD-H</b></p> | <p><b>Check <i>Yes</i>, <i>No</i>, or <i>NA</i> to indicate whether or not the participant is residing in an ICF/DD-H AND meets the condition specified in Box 7 on the IPC.</b></p> <ul style="list-style-type: none"><li>• <b>“Yes” means the participant is residing in an ICF/DD-H AND meets the condition specified in Box 7 on the IPC.</b></li><li>• <b>“No” means the participant is residing in an ICF/DD-H AND does NOT meet the condition specified in Box 7 on the IPC.</b></li><li>• <b>“NA” means the participant is NOT residing in an ICF/DD-H.</b></li></ul> <p><b><u>Note:</u> If the person is residing in an ICF/DD-H and does not meet the criterion as specified in Box 7 on the IPC, the TAR will be denied.</b></p> |

# Medical Necessity Criterion # 2

| <b>(8) MEDICAL NECESSITY CRITERION #2</b>  |  |
|--|--|
| <p><b>Criterion Met</b></p> <p>The participant has a condition or conditions resulting in <u>both</u> of the following:</p> <ul style="list-style-type: none"> <li>• Limitations in the performance of <u>two or more</u> ADLs and/or IADLs.</li> </ul> <p style="text-align: center;"><b><u>AND</u></b></p> <ul style="list-style-type: none"> <li>• A need for assistance or supervision in performing ADLs or IADLs as related to the participant's medical, cognitive or mental health condition or conditions. This assistance or supervision is in addition to any other non-ADHC support the participant is currently receiving in place of residence.</li> </ul> |  |
| <p><b>Yes</b></p> <p><input type="checkbox"/></p>  | <p><b>No</b></p> <p><input type="checkbox"/></p> |

| <b>Box #</b>  | <b>Instructions for Completion</b>  |
|---|---|
| <b>(8)<br/>Medical<br/>Necessity<br/>Criterion #2</b> | <p><b>Check <i>Yes</i> or <i>No</i> to indicate whether the participant meets criterion #2.</b></p> <p><b><u>Note:</u> If the participant does not meet this criterion, the TAR will be denied.</b></p> |



## Definitions [14522.3]

- *“Activities of daily living”*: activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation, and transferring
- *“Instrumental activities of daily living”*: functions or tasks of independent living, including hygiene, medication management, transportation, money management, shopping, meal preparation, laundry, accessing resources, and housework

| <b>(9) ADL/IADL LIMITATIONS (Check only one box per row):</b> |  |  |  |  |
|---|--|--|--|--|
| See Criterion 2<br><br><b>ADLs</b>                            | <b>Independent</b><br>(able to perform for self<br>with or without device) | <b>Needs Supervision</b><br>(no physical help or cueing required but<br>needs to be monitored, even with device) | <b>Needs Assistance</b><br>(physical help or cueing<br>required, even with device) | <b>Dependent</b><br>(unable to do for self, even<br>with physical help, cueing<br>or device) |
| Ambulation  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Bathing   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Dressing  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Self-Feeding  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Toileting   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Transferring  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| <b>IADLs</b>  | -----  | -----  | -----  | -----  |
| Access Resources  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Housework   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Hygiene   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Laundry   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Meal Preparation  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Medication Mgmt   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Money Management  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Shopping  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |
| Transportation  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>   |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(9)</b><br/><b>ADL/IADL</b><br/><b>Limitations</b></p> | <p>a. For each ADL and IADL listed, check the appropriate column, <i>Independent, Needs Supervision, Needs Assistance or Dependent</i>. Descriptions of these terms are printed under the word. There must be a check in each row, for each ADL and for each IADL.</p> <ul style="list-style-type: none"> <li>• The participant must have limitations in two or more of the listed ADLs, IADLs, or one or more of both AND (pursuant to criterion #2): <ul style="list-style-type: none"> <li>✓ These limitations must be related to the participant's chronic or post acute medical, cognitive or mental health condition(s) that qualified the participant for ADHC services under criterion number one (Box 5).</li> <li>✓ These limitations must require that at least assistance or supervision is necessary when performing the relevant ADLs/IADLs.</li> <li>✓ The assistance or supervision required must be in addition to any non-ADHC support(s) currently being received in the participant's place of residence.</li> </ul> </li> </ul> <p><b>Note:</b> If the participant does not have limitations in two or more of the listed ADLs and/or IADLs that meet the criteria stated above, the TAR will, at a minimum, be deferred.</p> |

| <b>Box #</b>  | <b>Instructions for Completion</b>  |
|---|---|
| <b>(9)<br/>ADL/IADL<br/>Limitations<br/>(continued)</b> | <ul style="list-style-type: none"><li data-bbox="764 444 1835 792">• <b>Any limitation in ADLs and/or IADLs due solely to culture, language, or any condition other than the medical, cognitive, or mental health condition(s) will not be considered for medical necessity determination.</b></li></ul> <p data-bbox="674 834 1871 1182"><b>b. If <i>Dependent</i> is checked for any ADL/IADL, please describe the participant's status and any related services the ADHC will provide or arrange to have provided in <b>Box 27, <i>Additional Information</i></b>, if not explained elsewhere in this IPC.</b></p> |

| <b>(10) CURRENT ASSISTIVE/ADAPTIVE DEVICES</b> (Check all that apply): |                     |                          |                                     |
|--|---------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/>   | None                | <input type="checkbox"/> | Gait Belt                           |
| <input type="checkbox"/>   | Wheelchair          | <input type="checkbox"/> | Hoyer Lift                          |
| <input type="checkbox"/>   | Walker              | <input type="checkbox"/> | Hearing Device                      |
| <input type="checkbox"/>   | Crutches            | <input type="checkbox"/> | Glasses or Other Vision Aid         |
| <input type="checkbox"/>   | Cane                | <input type="checkbox"/> | Dentures                            |
| <input type="checkbox"/>   | AAC Device          | <input type="checkbox"/> | Respiratory Equipment<br>(specify): |
| <input type="checkbox"/>   | Orthosis/Prosthesis | <input type="checkbox"/> | Other (specify):                    |

| <b>Box #</b>  | <b>Instructions for Completion</b>   |
|---|--|
| <b>(10)<br/>Current<br/>Assistive/<br/>Adaptive<br/>Devices</b> | <p><b>a. Check the appropriate box(es) to indicate the assistive/adaptive devices currently being utilized by the participant.</b></p> <p><b>b. If no devices are currently being utilized, please check <i>None</i>.</b></p> <p><b>c. If <i>Other</i> is checked, please specify device(s).</b></p> |

**(11) CONTINENCE INFORMATION** (Check all that apply):

- Incontinent of bladder    Incontinent of bowel    External/internal catheter    Ostomy  
 None    Other (specify):

| <b>Box #</b>                               | <b>Instructions for Completion</b>  |
|--|---|
| <b>(11)<br/>Continence<br/>Information</b> | <b>a. Check the appropriate box(es) to indicate any continence conditions currently present.</b><br><b>b. If no special continence conditions are present, please check <i>None</i>.</b><br><b>c. If <i>Other</i> is checked, please specify.</b> |

**(12) SELF-FEEDING INFORMATION** (Check all that apply):

- Overweight  Underweight  Feeding tube  Therapeutic/special diet  Difficulty chewing and/or swallowing  
 None  Other (specify):

| <b>Box #</b>                                 | <b>Instructions for Completion</b>  |
|--|---|
| <b>(12)<br/>Self-Feeding<br/>Information</b> | <p><b>a. Check the appropriate box(es) to indicate any self feeding conditions currently present.</b></p> <p><b>b. If no special self-feeding conditions are present, please check <i>None</i>.</b></p> <p><b>c. A therapeutic or special diet means a diet ordered by the personal health care provider and modified from a regular diet in a manner essential to the treatment or control of a particular condition, disease or illness, including texture-modified diets.</b></p> <p><b>d. If <i>Other</i> is checked, please specify.</b></p> |

# Medical Necessity Criterion # 3

| <b>(13) MEDICAL NECESSITY CRITERION #3</b> |                                |   |
|--|--------------------------------|---|
| <b>Criterion Met</b>                       |                                | The participant's <u>network of non-ADHC center supports</u> is insufficient to maintain the individual in the community, demonstrated by <u>at least one</u> of the following ( <u>check all that apply</u> ):   |
| Yes<br><input type="checkbox"/>            | No<br><input type="checkbox"/> |   |
|  |                                | <input type="checkbox"/> The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.<br><input type="checkbox"/> The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.<br><input type="checkbox"/> The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant. |

| <b>Box #</b>   | <b>Instructions for Completion</b>  |
|--|---|
| <b>(13)<br/>Medical<br/>Necessity<br/>Criterion #3</b> | <p><b>a. Check Yes or No to indicate whether or not the participant meets criterion #3.</b></p> <p><b>b. Check the appropriate box(es) relative to the participant's living arrangements within Box 13.</b></p> <p><b><u>Note:</u> If the participant does not meet this criterion, the TAR will be denied.</b></p> |

**(14) NON-ADHC CENTER SUPPORT/SERVICES – PART A (if known).** Check all that apply:

| <b>SUPPORT SERVICE</b>   |  | <b>DESCRIBE</b><br><b>(how or why the support service is insufficient)</b> |
|--------------------------|--|--|
| <input type="checkbox"/> | Not Known  |  |
| <input type="checkbox"/> | NONE   | -----  |
| <input type="checkbox"/> | IHSS/PCSP Services   | Hours authorized per week/month: _____                                     |
| <input type="checkbox"/> | Case Management (e.g., TCM, MSSP waiver)                           | Frequency: _____   |
| <input type="checkbox"/> | Other Paid Caregiver(s)  | Frequency: _____   |
| <input type="checkbox"/> | ICF/DD-H   | _____  |
| <input type="checkbox"/> | Lives in a Community Care Licensed Facility (e.g., Board and Care) | _____  |

| Box #   | Instructions for Completion   |
|---|---|
| <p align="center"><b>(14)<br/>Non-ADHC<br/>Center<br/>Supports/<br/>Services –<br/>Part A</b></p> | <p>a. If this information is unknown to the ADHC center, please check <i>Not Known</i> and explain.</p> <p>b. Check the appropriate box(es) to indicate non-ADHC center support(s)/service(s) currently being utilized by the participant.</p> <p>c. If no support(s) is currently being utilized, please check <i>None</i>.</p> <p>d. Provide the information as requested under the <i>Describe</i> column, specific to how or why the support service is insufficient to maintain the individual in the community.</p> <ul style="list-style-type: none"> <li>• If <i>IHSS/PCSP Services</i> is checked, please specify the hours per week or month that are authorized for the participant.</li> <li>• If <i>Case Management</i> is checked, please specify type and frequency.</li> <li>• If <i>Other Paid Caregiver(s)</i> is checked, please specify frequency.</li> </ul> |

| Box #   | Instructions for Completion   |
|---|---|
| <p>(14)<br/>Non-ADHC<br/>Center<br/>Supports/<br/>Services –<br/>Part A<br/>(Continued)</p> | <ul style="list-style-type: none"> <li>• If <i>ICF/DD-H</i> is checked, please provide information as relevant to the participant.</li> <li>• If <i>Lives in Community Care Licensed Facility</i> is checked, please describe how or why the service(s) provided in the community care licensed facility is insufficient.</li> </ul> <p><b><u>Note:</u></b> Utilization of any of the above supports/services shall NOT automatically disqualify the participant for ADHC services. If, in addition to the above specified supports/services, the participant requires ADHC services to remain in the community, such ADHC services, in the quantity documented on the TAR and IPC to be medically necessary shall be authorized.</p> |

**(15) NON-ADHC CENTER SUPPORT/SERVICES – PART B (if known).** Check all that apply:

Within the last 6 months, the participant received the following non-institutional services:

Not Known. Explain: \_\_\_\_\_

None.

Home Health Agency Services. Explain: \_\_\_\_\_

Is the participant currently receiving **Home Health Agency Services**?  Yes  No

Hospice Care. Explain: \_\_\_\_\_

Is the participant currently receiving **Hospice Services**?  Yes  No

If the participant is currently receiving either home health agency or hospice services, please specify:

| Service | Frequency |
|---------|-----------|
|         |           |
|         |           |
|         |           |

Urgent Care. Explain: \_\_\_\_\_

Mental Health Services. Explain: \_\_\_\_\_

Emergency Department. Explain: \_\_\_\_\_

Other. Explain: \_\_\_\_\_

| Box #  | Instructions for Completion   |
|--|---|
| <p>(15)<br/> Non-ADHC<br/> Center<br/> Supports/<br/> Services –<br/> Part B</p> | <p>Check the appropriate box(es) next to any of the non-ADHC center support(s)/service(s) the participant received within the last six months. <i>For Home Health Agency Services and Hospice Services</i>, specify if these supports/services are currently being received.</p> <p>a. If this information is unknown to the ADHC center, please check <i>Not Known</i> and explain.</p> <p>b. If the participant has not received any non-ADHC center supports/services listed, please check <i>None</i>.</p> <p>c. If <i>Home Health Agency Services</i> is checked, please also specify whether or not the participant is currently receiving home health agency services. If so, please list the specific services and their frequencies (for example, three times per week) in the table provided.</p> |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(15)<br/>Non-ADHC<br/>Center<br/>Supports/<br/>Services –<br/>Part B<br/>(Continued)</b></p> | <p><b>d. If <i>Hospice Care</i> is checked, please explain the nature of the services received and also specify whether or not the participant is currently receiving hospice services. If so, please list the specific services and their frequencies (for example, three times per week) in the table provided.</b></p> <p><b>e. If <i>Urgent Care</i> is checked, please explain the nature of the services received.</b></p> <p><b>f. If <i>Mental Health Services</i> is checked, please explain the nature of the services received.</b></p> <p><b>g. If <i>Emergency Department</i> is checked, please explain the nature of the services received.</b></p> <p><b>h. If the participant received other non-ADHC center supports/services, please check <i>Other</i> and specify the type and nature of the services received.</b></p> |

| Box #   | Instructions for Completion  |
|---|--|
| <p>(15)<br/>Non-ADHC<br/>Center<br/>Supports/<br/>Services –<br/>Part B<br/>(continued)</p> | <p><b><u>Note:</u></b> Current and continuing utilization of home health agency, urgent care, mental health or emergency department services shall NOT automatically disqualify the participant for ADHC services. If, in addition to these support/services, the participant continues to require ADHC services to remain in the community, such ADHC services, in the quantity documented on the TAR and IPC to be medically necessary shall be authorized.</p> <p>While utilization of Hospice Care services shall NOT automatically disqualify the participant for ADHC services, any care for the Hospice related condition(s) that a physician has certified as likely to result in a life expectancy of six months or less is the responsibility of the Hospice provider. Such services are not reimbursable to the ADHC center provider and the need for these services cannot be considered when determining medical necessity for ADHC services.</p> |

# Medical Necessity Criterion # 4

| <b>(16) MEDICAL NECESSITY CRITERION #4</b> |                                |  |
|--|--------------------------------|--|
| <b>Criterion Met</b>                       |                                | A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if ADHC services are not provided. |
| Yes<br><input type="checkbox"/>            | No<br><input type="checkbox"/> |  |

| <b>Box #</b>   | <b>Instructions for Completion</b>   |
|--|--|
| <b>(16)<br/>Medical<br/>Necessity<br/>Criterion #4</b> | <p><b>Check <i>Yes</i> or <i>No</i> to indicate whether or not the participant meets criterion #4.</b></p> <p><b><u>Note:</u> If the participant does not meet this criterion, the TAR will be denied.</b></p> <p><b>“High potential” is described as the outcome having at least a 50 percent probability of occurring within the time frame covered by the applicable TAR for ADHC services.</b></p> |

**(17) RISK FACTORS (check all conditions that are demonstrated at the time of IPC completion)**

- |   |   |
|---|---|
| <input type="checkbox"/> Inappropriate Affect, Appearance or Behavior | <input type="checkbox"/> Dementia Related Behavioral Problems |
| <input type="checkbox"/> Poor Judgment                                | <input type="checkbox"/> Fall Risk                            |
| <input type="checkbox"/> Medication Mismanagement                     | <input type="checkbox"/> Isolation                            |
| <input type="checkbox"/> Self Neglect                                 | <input type="checkbox"/> Frailty                              |
| <input type="checkbox"/> Two or More Chronic Conditions               | <input type="checkbox"/> Other (specify):                     |

| <b>Box #</b>                 | <b>Instructions for Completion</b>  |
|------------------------------|---|
| <b>(17)<br/>Risk Factors</b> | <b>a. Check the appropriate box(es) that applies to this participant at the time of IPC completion.</b><br><br><b>b. If <i>Other</i> is checked, please specify the risk factor(s).</b> |

**(18) AT RISK FOR ADMISSION TO INSTITUTIONAL CARE (if known).** Check all that apply:

Within the last 6 months, the participant was admitted to the following level(s) of institutional care:

- Not Known. Explain: \_\_\_\_\_
- None.
- Acute Care Hospital. Explain: \_\_\_\_\_
- Nursing Facility. Explain: \_\_\_\_\_
- ICF/DD or ICF/DD-N. Explain: \_\_\_\_\_
- Other. Explain: \_\_\_\_\_

Last Known Discharge Date from an Institutional Level of Care:

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(18)</b><br/> <b>At Risk for Admission to Institutional Care</b></p> | <p>a. Check the appropriate box(es) next to the level of institutional care to which the participant has been admitted within the last six months.</p> <ul style="list-style-type: none"> <li>• If this information is unknown to the ADHC center, please check <i>Not Known</i> and explain.</li> <li>• If the participant has not been admitted to any institutional care, please check <i>None</i>.</li> <li>• If <i>Acute Care Hospital</i> is checked, please explain the nature of the admission.</li> <li>• If <i>Nursing Facility</i> is checked, please explain the nature of the admission.</li> <li>• If <i>ICF/DD</i> or <i>ICF/DD-N</i> is checked, please explain the nature of the admission.</li> <li>• If the participant has been admitted to another level of institutional care, please check <i>Other</i> and specify the institutional care and explain the nature of the admission.</li> </ul> <p>b. State the last known discharge date from institutional care.</p> |

# Medical Necessity Criterion # 5

| <b>(19) MEDICAL NECESSITY CRITERION #5</b>  |                                |
|---|--------------------------------|
| <b>Criterion Met</b>  |                                |
| Yes<br><input type="checkbox"/>   | No<br><input type="checkbox"/> |
| The participant's condition or conditions require <u>all</u> of the ADHC services set forth in boxes 20-23 <u>on each day</u> of attendance that are <u>individualized</u> and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization. |                                |

| <b>Box #</b>   | <b>Instructions for Completion</b>  |
|--|---|
| <b>(19)<br/>Medical<br/>Necessity<br/>Criterion #5</b> | <p><b>Check <i>Yes</i> or <i>No</i> to indicate whether the participant meets criterion #5.</b></p> <p><b><u>Note:</u> If the participant does not meet this criterion, the TAR will be denied.</b></p> |

|  |                                |  |
|--|--------------------------------|--|
| <b>(20)</b><br><br>Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> | <b>A. Professional Nursing Services</b><br><u>One or more of the following professional nursing services on each day of attendance:</u><br>N1 <u>Observation, assessment, and monitoring</u> of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions upon which admission to the ADHC center was based.<br>N2 <u>Monitoring and assessment</u> of the participant's medication regimen, administration and recording of the participant's prescribed medication, and intervention, as needed, based upon the assessment and participant's reactions to his/her medications.<br>N3 <u>Oral or written communication with the participant's personal health care provider</u> , other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms.<br>N4 <u>Supervision of the provision of personal care services</u> for the participant, and assistance, as needed.<br>N5 <u>Provision of skilled nursing care and intervention</u> , within scope of practice, to participants, as needed, based upon an assessment of the participant, his/her ability to provide self-care while at the ADHC center, and any health care provider orders. |
|--|--------------------------------|--|

| Box #   | Instructions for Completion  |
|---|--|
| <b>(20)</b><br><b>Required (Daily Core) Services:</b><br><b>Professional Nursing Services</b> | <p><b>a. Check Yes or No to indicate whether the participant will be receiving professional nursing services as specified, in this TAR period.</b></p> <p><b><u>Note:</u> If the participant will not be receiving professional nursing services, the TAR will be denied.</b></p> <p><b>b. The "N1" through "N5" designation found in this box is intended to enable coding of the ADHC center health record for documentation of core services.</b></p> |



## *Definition [14522.3]*

- *“Professional nursing”: services provide by a registered nurse or licensed vocational nurse functioning within his or her scope of practice*

|  |                                |  |
|--|--------------------------------|--|
| <b>(21)</b><br><br>Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> | <b>A. Personal Care Services/Social Services</b><br><u>One or both</u> of the following core <u>personal care services</u> or <u>social services</u> on each day of attendance:<br>P1 <u>One or both</u> of the following <u>personal care services</u> :<br>P1a Supervision of, or assistance with, ADLs or IADLs.<br>P1b Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.<br>P2 <u>One or more</u> of the following <u>social services</u> provided by the ADHC center social worker or social worker assistant:<br>P2a Observation, assessment, and monitoring of the participant's psychosocial status.<br>P2b Group work to address psychosocial issues.<br>P2c Care coordination. |
|  |                                |  |

| Box #  | Instructions for Completion   |
|--|---|
| <b>(21)</b><br><b>Required (Daily Core) Services: Personal Care Services/Social Services</b> | <p><b>a. Check Yes or No to indicate whether the participant will be receiving personal care services/social services as specified, in this TAR period.</b></p> <p><b><u>Note:</u> If the participant will not be receiving personal care and/or social services, the TAR will be denied.</b></p> <p><b>b. The "P1," "P1a," "P1b," "P2," "P2a," "P2b" and "P2c" designation found in this box is intended to enable coding of the ADHC center health record for documentation of core services.</b></p> |



## Definitions [14522.3]

- *“Psychosocial”*: a participant’s psychological status in relation to the participant’s social and physical environment
- *“Group work”*: a social work service in which a variety of therapeutic methods are applied within a small group setting to promote participant’s self-expression and positive adaptation to their environment



## *Definitions [14522.3]*

- *“Care coordination”:* the process of obtaining information from, or providing information to, the participant, the participant’s family, the participant’s primary health care provider, or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as identified by one or more members of the multidisciplinary team

|                                 |                                |  |
|---------------------------------|--------------------------------|--|
| <b>(22)</b>                     |                                | <p><b>A. Therapeutic Activities</b></p> <p><u>One or both</u> of the following <u>therapeutic activities</u> provided by the ADHC center activity coordinator or other trained ADHC center personnel on each day of attendance:</p> <p>A1 Group or individual activities to enhance the social, physical, or cognitive functioning of the participant.</p> <p>A2 Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.</p> |
| Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |  |

| Box #  | Instructions for Completion   |
|--|---|
| <b>(22)</b><br><b>Required (Daily Core) Services:</b><br><b>Therapeutic Activities</b> | <p><b>a. Check <i>Yes</i> or <i>No</i> whether or not the participant will be receiving therapeutic activities as specified, in this TAR period.</b></p> <p><b><u>Note:</u> If the participant will not be receiving therapeutic activities, the TAR will be denied.</b></p> <p><b>b. The “A1” and “A2” designation found in this box is intended to enable coding of the ADHC center health record for documentation of core services.</b></p> |



## *Definition [14522.3]*

- *“Facilitated participation”*: an interaction to support a participant’s involvement in a group or individual activity, whether or not the participant takes an active part in the activity itself

|                                 |                                |   |
|---------------------------------|--------------------------------|---|
| <b>(23)</b>                     |                                | <b>D. Meal Service</b><br>M <u>At least one</u> meal per day of attendance. |
| Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |   |

| Box #  | Instructions for Completion   |
|--|---|
| <b>(23)</b><br><b>Required (Daily Core) Services:</b><br><b>Meal Service</b> | <p><b>a. Check <i>Yes</i> or <i>No</i> to indicate whether or not the participant will be receiving meal services as specified, in this TAR period.</b></p> <p><b><u>Note:</u> If the participant will not be receiving meal services, the TAR will be denied.</b></p> <p><b>b. The “M” designation found in this box is intended to enable coding of the ADHC center health record for documentation of core services.</b></p> |

**(24) TAR FOR REAUTHORIZATION OF ADHC SERVICES**

|                                 |                                |                                |  |
|---------------------------------|--------------------------------|--------------------------------|--|
| Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> | Na<br><input type="checkbox"/> | If <u>this is a reauthorization TAR</u> , the participant's condition would likely deteriorate if the ADHC services were denied. |
|---------------------------------|--------------------------------|--------------------------------|--|

| Box #   | Instructions for Completion   |
|---|---|
| <p><b>(24)<br/>TAR for<br/>Reauthorization<br/>of ADHC<br/>Services</b></p> | <p><b>Check <i>Yes</i>, <i>No</i> or <i>NA</i> to indicate whether this is a reauthorization TAR AND the participant's condition would likely deteriorate if the ADHC services were denied, as specified.</b></p> <ul style="list-style-type: none"> <li>• <b>“Yes” means the TAR is a reauthorization TAR AND the participant meets the condition specified.</b></li> <li>• <b>“No” means the TAR is a reauthorization TAR AND the participant does NOT meet the condition specified.</b></li> <li>• <b>“NA” means the TAR is NOT a reauthorization TAR.</b></li> </ul> <p><b><u>Note:</u> If the participant does not meet this criterion on a reauthorization TAR, the TAR will be denied.</b></p> |

# C O R E

**(25) Participant's Individual Plan of Care (Core Services) (must be consistent with information provided in this IPC)**

| <b>ADHC CORE SERVICES</b>                | <b>Participant Problem<br/>(must include a measurable starting point)</b> | <b>Treatments/<br/>Interventions<br/>(Include whether individual and/or group intervention, and any out-of-center activities)</b> | <b>Frequency of Treatment/<br/>Intervention<br/>(e.g., 2x per week)</b> | <b>Discipline Specific Objective/Goal of Treatment/<br/>Intervention<br/>(must include <u>measurable</u> objectives/goals)</b> |
|--|---|---|---|--|
| Professional Nursing Services            |   |   |   |  |
| Personal Care Services                   |   |   |   |  |
| Social Services                          |   |   |   |  |
| Therapeutic Activities                   |   |   |   |  |
| Physical Therapy Maintenance Program     |   |   |   |  |
| Occupational Therapy Maintenance Program |   |   |   |  |
| Nutrition/Diet                           |   |   |   |  |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(25)<br/>Participant<br/>Individual Plan<br/>of Care<br/>(Core Services)<br/>(Continued)</b></p> | <p>Pursuant to W&amp;I Code, Section 14550.5, each participant must receive each of the core services on each day of attendance at the ADHC center. Indicate that these core services will be provided by completing each column for each of the core services.</p> <p>a. Description of terms (left-hand column, ADHC Core Services):</p> <ul style="list-style-type: none"> <li>• <u>Professional Nursing Services</u> – those services specified in W&amp;I Code, Section 14550.5(a).</li> <li>• <u>Personal Care Services</u> – those services specified in W&amp;I Code, Section 14550.5(b)(1).</li> <li>• <u>Social Services</u> – those services specified in W&amp;I Code, Section 14550.5(b)(2).</li> </ul> |

| Box #   | Instructions for Completion   |
|---|---|
| <p align="center"><b>(25)</b><br/> <b>Participant Individual Plan of Care (Core Services) (Continued)</b></p> | <ul style="list-style-type: none"> <li>• <b><u>Therapeutic Activities</u></b> – those services specified in W&amp;I Code, Section 14550.5(c).</li> <li>• <b><u>Physical Therapy Maintenance Program</u></b> – procedures and exercises that are provided to a participant, pursuant to Section 1580 of the <i>Health and Safety Code</i>, in order to generally maintain existing function. These procedures and exercises are planned by a licensed or certified therapist and are provided by a person who has been trained by a licensed or certified therapist and who is directly supervised by a nurse or by a licensed or certified therapist (pursuant to Section 1570.7(h) of the <i>Health and Safety Code</i>).</li> </ul> |

| <b>Box #</b>  | <b>Instructions for Completion</b>  |
|---|---|
| <b>(25)<br/>Participant<br/>Individual Plan<br/>of Care<br/>(Core Services)<br/>(continued)</b> | <ul style="list-style-type: none"><li>• <b><u>Occupational Therapy Maintenance Program</u></b> – procedures and exercises that are provided to a participant, pursuant to Section 1580 of the <i>Health and Safety Code</i>, in order to generally maintain existing function. These procedures and exercises are planned by a licensed or certified therapist and are provided by a person who has been trained by a licensed or certified therapist and who is directly supervised by a nurse or by a licensed or certified therapist (pursuant to Section 1570.7(h) of the <i>Health and Safety Code</i>).</li></ul> |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(25)</b><br/> <b>Participant<br/> Individual Plan<br/> of Care<br/> (Core Services)<br/> (continued)</b></p> | <ul style="list-style-type: none"> <li>• <b><u>Meal Services</u></b> – those services specified in W&amp;I Code, Section 14550.5(d). Please specify whether the participant will be receiving a regular or special diet; if a special diet, please be specific as to the type of special diet (such as low salt, diabetic, etc.).</li> </ul> <p><b><u>Note:</u></b> Services provided directly to the participant by the Registered Dietitian should be placed on the IPC under <i>Registered Dietitian Services</i> (see Box 26, Participant Plan of Care <i>Specialized Services</i>).</p> |

| Box #   | Instructions for Completion  |
|---|--|
| <p>(25)<br/>Participant Individual Plan of Care (Core Services) (continued)</p> | <p>b. Description of terms (across the top, header row):</p> <ul style="list-style-type: none"> <li>• <b><u>Participant Problem</u></b> – the symptom or demonstrated behavior (not diagnosis) that is identified or validated by the assessment done by both the participant’s personal health care provider (or the ADHC staff physician) and the ADHC center’s multidisciplinary team. The problem must: <ul style="list-style-type: none"> <li>✓ Be related to the diagnosis or condition,</li> <li>✓ Be amenable to interventions available in the ADHC center,</li> <li>✓ Be specific to the individual participant, and</li> <li>✓ Provide a measurable starting point such as a beginning grade or strength, a percentage, degree, level or range.</li> </ul> </li> </ul> <p>Enter those participant problems for which the ADHC center staff will provide treatments or interventions during this TAR period.</p> |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(25)</b><br/> <b>Participant Individual Plan of Care (Core Services) (continued)</b></p> | <ul style="list-style-type: none"> <li>• <b><u>Treatments/Interventions</u></b> – the prescribed, proposed and/or recommended means of resolving or mitigating the participant problem that must: <ul style="list-style-type: none"> <li>✓ Reflect both the assessment done by the participant’s personal health care provider (or the ADHC staff physician) and the assessment done by the ADHC center’s multidisciplinary team,</li> <li>✓ Be related to the problem,</li> <li>✓ Be practical for implementation in the ADHC center setting,<br/>and</li> <li>✓ Be specific to the individual participant.</li> </ul> </li> </ul> <p>Please include whether the treatment/intervention is individual or group and any out-of-center activities.</p> <ul style="list-style-type: none"> <li>• <b><u>Frequency</u></b> of Treatment/Intervention – how often the treatment/intervention is provided; for example, two times per week.</li> </ul> |

| Box #  | Instructions for Completion  |
|--|--|
| <p align="center"><b>(25)</b></p> <p align="center"><b>Participant<br/>Individual Plan<br/>of Care<br/>(Core Services)<br/>(continued)</b></p> | <ul style="list-style-type: none"> <li>• <b><u>Discipline Specific Objective/Goal of Treatment/Intervention</u> – expected outcome recommended by the specific discipline that will be providing the treatment/intervention that must:</b> <ul style="list-style-type: none"> <li>✓ <b>Reflect both the assessment done by the participant’s personal health care provider (or the ADHC staff physician) and the assessment done by the ADHC center’s multidisciplinary team.</b></li> <li>✓ <b>Be related to the intervention,</b></li> <li>✓ <b>Be attainable by the individual participant,</b></li> <li>✓ <b>Be measurable, and</b></li> <li>✓ <b>Include timelines for achievement if the time frame is other than six months (or length of TAR period).</b></li> </ul> </li> </ul> |

| Box #  | Instructions for Completion   |
|--|---|
| <p align="center"><b>(25)</b></p> <p align="center"><b>Participant<br/>Individual Plan<br/>of Care<br/>(Core Services)<br/>(continued)</b></p> | <p><b><u>Note:</u> The participant's plan of care, as summarized in Boxes 25 and 26, MUST support the number of days being requested on the TAR. The medical necessity for and the frequency and duration of ADHC services are used to determine the number of days authorized and therefore MUST be clearly and succinctly described in each column of the plan of care. Boxes 25 and 26 will be used by the field offices as the primary information to determine the appropriate number of days to authorize for each participant.</b></p> |

# SPECIALIZED

(26) Participant's Individual Plan of Care (Specialized Services) (must be consistent with information provided in this IPC)

| ADHC SPECIALIZED SERVICES              | Participant Problem (must include a measurable starting point) | Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities) | Frequency of Treatment/ Intervention (e.g., 2x per week) | Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals) |
|--|--|---|--|---|
| Physical Therapy                       |  |   |  |   |
| Occupational Therapy                   |  |   |  |   |
| Speech and Language Pathology Services |  |   |  |   |
| Registered Dietitian Services          |  |   |  |   |
| Mental Health Services                 |  |   |  |   |
| Other (please specify)                 |  |   |  |   |

| Box #   | Instructions for Completion   |
|---|---|
| <p align="center"> <b>(26)</b><br/> <b>Participant</b><br/> <b>Individual Plan</b><br/> <b>of Care</b><br/> <b>(Specialized</b><br/> <b>Services)</b><br/>           (Continued)         </p> | <p> <b>Complete each column for each row. For those services that the participant will not be receiving this TAR period, please write <i>NA</i> across the row to indicate that the specified service will not be provided.</b> </p> <p> <b>a. Description of terms (left-hand column, ADHC <u>Specialized Services</u>) (for purposes of the bundled ADHC per diem rate of reimbursement):</b> </p> <ul style="list-style-type: none"> <li> <b>• <u>Physical Therapy</u> – services provided by a California licensed physical therapist within his/her scope of practice. Pursuant to Section 1570.7(i) of the <i>Health and Safety Code</i>, physical therapy “may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed</b> </li> </ul> |

| Box #  | Instructions for Completion  |
|--|--|
| <p>(26)<br/>Participant<br/>Individual Plan<br/>of Care<br/>(Specialized<br/>Services)<br/>(Continued)</p> | <p>therapist. The therapy and services are provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.”</p> <ul style="list-style-type: none"> <li>• <u>Occupational Therapy</u> – services provided by a California licensed occupational therapist within his/her scope of practice. Pursuant to Section 1570.7(i) of the <i>Health and Safety Code</i>, occupational therapy “may also be proved by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.”</li> </ul> |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(26)</b><br/> <b>Participant Individual Plan of Care (Specialized Services)</b><br/>           (continued)</p> | <ul style="list-style-type: none"> <li>• <b><u>Speech and Language Pathology Services</u></b> – services provided by a California licensed speech and language pathologist within his/her scope of practice.</li> <li>• <b><u>Registered Dietitian Services</u></b> – services such as nutrition assessment, counseling or education provided directly to the participant and/or family/caregivers by a California registered dietitian within his/her scope of practice.</li> </ul> |

| Box #  | Instructions for Completion   |
|--|---|
| <p>(26)<br/>Participant Individual Plan of Care (Specialized Services) (continued)</p> | <ul style="list-style-type: none"> <li>• <b><u>Mental Health Services</u></b> – services provided by a mental health professional, pursuant to CCR, Title 22, Sections 54325 and 78337 as listed who are practicing within his/her scope of practice: <ul style="list-style-type: none"> <li>✓ licensed psychiatrist,</li> <li>✓ licensed psychologist,</li> <li>✓ licensed clinical social worker, <u>or</u> an</li> <li>✓ advanced practice mental health registered nurse;</li> </ul> <p><b><u>or services provided by one of the following when in consultation with one of the above specified mental health professionals as listed who are practicing within his/her scope of practice :</u></b></p> <ul style="list-style-type: none"> <li>✓ recognized psychiatric/psychological assistant;</li> <li>✓ licensed marriage, family and child counselor;</li> <li>✓ licensed marriage and family therapist;</li> <li>✓ certified rehabilitation counselor; or recognized associate</li> <li>✓ clinical social worker</li> </ul> </li> <li>• <b><u>Other</u></b> – any service not specified above that the participant will receive during this TAR period (other Medi-Cal services must be billed separately by the rendering provider). Indicate the specific service.</li> </ul> |

| Box #   | Instructions for Completion  |
|---|--|
| <p align="center"><b>(26)</b><br/> <b>Participant<br/> Individual Plan<br/> of Care<br/> (Specialized<br/> Services)<br/> (continued)</b></p> | <p><b>b. Description of terms (across the top, header row): See above, Box #25. Under <i>Treatments/Interventions</i>, please also include the amount of the treatment/intervention (for example, 15 minutes) and the duration of the treatment/intervention (for example, for two weeks).</b></p> <p><b><u>Note:</u> The participant's plan of care, as summarized in Boxes 25 and 26, MUST support the number of days being requested on the TAR. The medical necessity for and the frequency and duration of ADHC services are used to determine the number of days authorized and therefore MUST be clearly and succinctly described in each column of the plan of care. Boxes 25 and 26 will be used by the field offices as the primary information to determine the appropriate number of days to authorize for each participant.</b></p> |

(27) Text Box (Optional)

This text box is available for the ADHC Center's use in providing information not explained elsewhere in this IPC that is relevant to the authorization of this TAR.

Please do not repeat information previously explained.

Please Reference Box Number Being Discussed.

| <u>Box #</u>             | <u>Instructions for Completion</u>   |
|--------------------------|--|
| <b>(27)<br/>Text Box</b> | <b>This is an open text box for communication of any additional information that may assist in justifying medical necessity for the requested ADHC services. Do not repeat information previously explained. Indicate the box number of the IPC that is being discussed.</b> |

**(28) Signatures of Multidisciplinary Team and Program Director**

| <b>Signatures of the Multidisciplinary Team</b><br>Pursuant to section 14529 of the Welfare and Institutions Code<br>Signing below certifies agreement with the treatments<br>designated in the IPC that are consistent with the signer's scope of practice                         |                        |                 |
|---|------------------------|-----------------|
| Printed Name  | Signature              | Date of Signing |
|   | RN                     |                 |
|   | SW                     |                 |
|   | PT                     |                 |
|   | OT                     |                 |
|   |                        |                 |
|   |                        |                 |
|   |                        |                 |
|   |                        |                 |
| By signing below I certify that I have reviewed and concur with this IPC  |                        |                 |
| Printed Name  | Signature of Physician | Date of Signing |
|   |                        |                 |
| By signing below, I certify that <u>all assessments have been completed</u> and that <u>the participant meets the medical necessity criteria</u> as set forth in section 14526.1(d) of the Welfare and Institutions Code and specified in this IPC, effective on this date*: _____. |                        |                 |
| I further certify that services will be provided as scheduled on this IPC unless otherwise noted in the participant's health record.  |                        |                 |
| Printed Name  | Signature              | Date of Signing |
|   | Program Director       |                 |

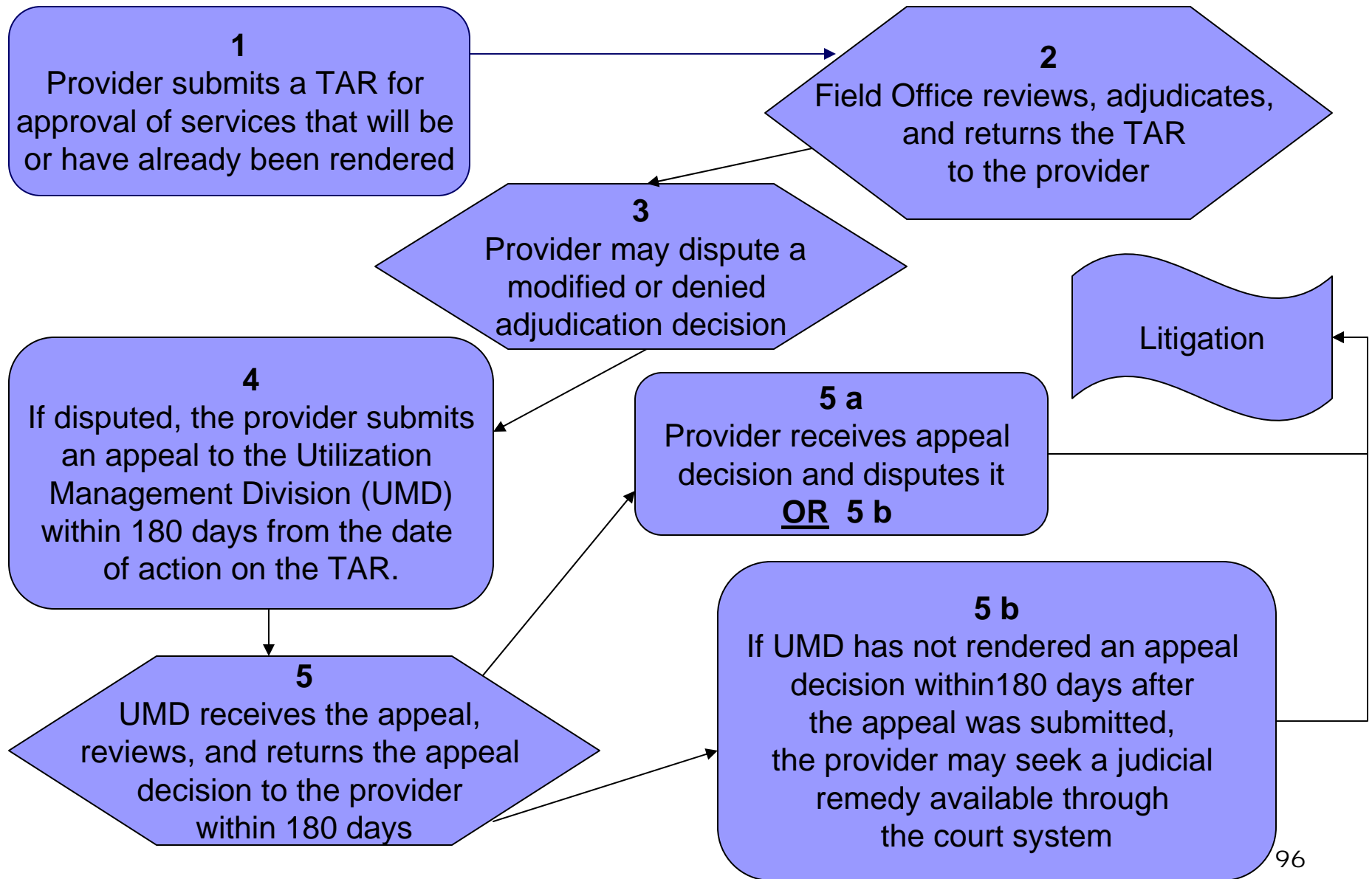
\* The TAR will NOT be approved for ADHC services provided prior to this date.

| Box #  | Instructions for Completion  |
|--|--|
| <p align="center"><b>(28)</b><br/> <b>Signatures of<br/> Multidisciplinary<br/> Team and<br/> Program<br/> Director</b><br/> (Continued)</p> | <p><b>a. The registered nurse, social worker, physical therapist and occupational therapist must sign and date all INITIAL IPCs. The registered nurse and social worker must sign and date all REATHORIZATION IPCs. The remainder of the multidisciplinary team must sign and date the IPC if their particular service will be rendered to the participant during this TAR period.</b></p> <p><b><u>Note:</u> The ADHC center MUST maintain all assessments completed by the individual disciplines of the multidisciplinary team in the participant's health record, including the date the assessment was done and the signature of the person who did the assessment.</b></p> |

| Box #  | Instructions for Completion  |
|--|--|
| <p align="center"><b>(28)</b><br/> <b>Signatures of<br/> Multidisciplinary<br/> Team and<br/> Program<br/> Director<br/> (Continued)</b></p> | <p><b>b. The participant’s personal health care provider or ADHC center physician must sign and date all IPCs.</b></p> <p><b>c. The program director must sign and date all IPCs. The TAR will be authorized only back to the date on which the program director certifies that assessments were completed and that the participant meets the medical necessity for ADHC services.</b></p> <ul style="list-style-type: none"> <li><b>• All assessments must be completed prior to the first day of authorized ADHC service (CCR, Title 22, Section 54309).</b></li> <li><b>• The program director’s signature shall serve as verification that all assessments have been completed.</b></li> </ul> |

| Box #  | Instructions for Completion  |
|--|--|
| <p data-bbox="415 388 506 435"><b>(28)</b></p> <p data-bbox="262 475 659 813"><b>Signatures of Multidisciplinary Team and Program Director (continued)</b></p> | <p data-bbox="711 388 1871 829"><b>d. If, at the time the TAR and IPC are submitted to the field office, one or more of the required multidisciplinary team signatures (excluding the personal health care provider or the ADHC center physician, and program director) are missing, please explain why and when these signatures will be obtained in Box 27, <i>Additional Information</i>.</b></p> <ul data-bbox="800 889 1871 1365" style="list-style-type: none"> <li data-bbox="800 889 1871 1052">• <b>The field office may ask for the signature page of the IPC at a later date to confirm all signatures.</b></li> <li data-bbox="800 1094 1871 1365">• <b>An IPC received without the participant's personal health care provider or the ADHC center physician, or program director's (or his/her designee) signature will be deferred.</b></li> </ul> |

# Flow of Treatment Authorization Request (TAR)





# APPEAL PROCESS

- Provider submits a written appeal within 180 calendar days from the date of the original TAR decision (TAR action date)
  - See provider manual details: *Inpatient/Outpatient, Part 2, Adult Day Health Care Centers, TAR: Submitting Appeals tar submit*
- All appeals must be sent to:
  - Department of Health Care Services
  - Utilization Management Division
  - TAR Administrative Remedy Section
  - MS 4505
  - 1501 Capitol Avenue
  - P.O. Box 997419
  - Sacramento, CA 95899-7419

# TAR & IPC Resources

## ■ Provider Manual

Go to the Department of Health Care Services website:

<http://www.dhcs.ca.gov>

Find & Click: “Providers & Partners” file tab

Find & Click: “Bulletins and Manuals”

Find: “Manuals” column

Find & Click: “Inpatient/Outpatient (Medi-Cal Provider)”

Find & Click: “Adult Day Health Care Centers (ADU)”

Find, Click, Download, & Open:

**“Adult Day Health Care (ADHC) Centers (adu)”**

Find, Click, Download, & Open:

**“Adult Day Health Care (ADHC) Centers: TAR and Individual Plan of Care (IPC) Completion [adu tar ipc]”**

## ■ Your local Medi-Cal Field Office


Go to **Adult Day Health Care Centers [ADU]** as above.

Scroll to: **the bottom of the page**

Find, Click, Download, & Open:

**TAR Field Office Addresses [tar field]**

“Where to submit TARs” begins on page 2



**On or after 11-27-2007, Submit  
ADHC questions to:**

**[http://www.dhcs.ca.gov/ProvGov  
Part/Pages/ProviderTraining.aspx](http://www.dhcs.ca.gov/ProvGovPart/Pages/ProviderTraining.aspx)**

- Questions will be researched and responses will be posted on the ADHC Frequently Asked Questions (FAQ) website
- Check for ADHC FAQs updates on Thursdays at 12:00 p.m.



Thank you!

