LTC TAR Form Completion Explanation

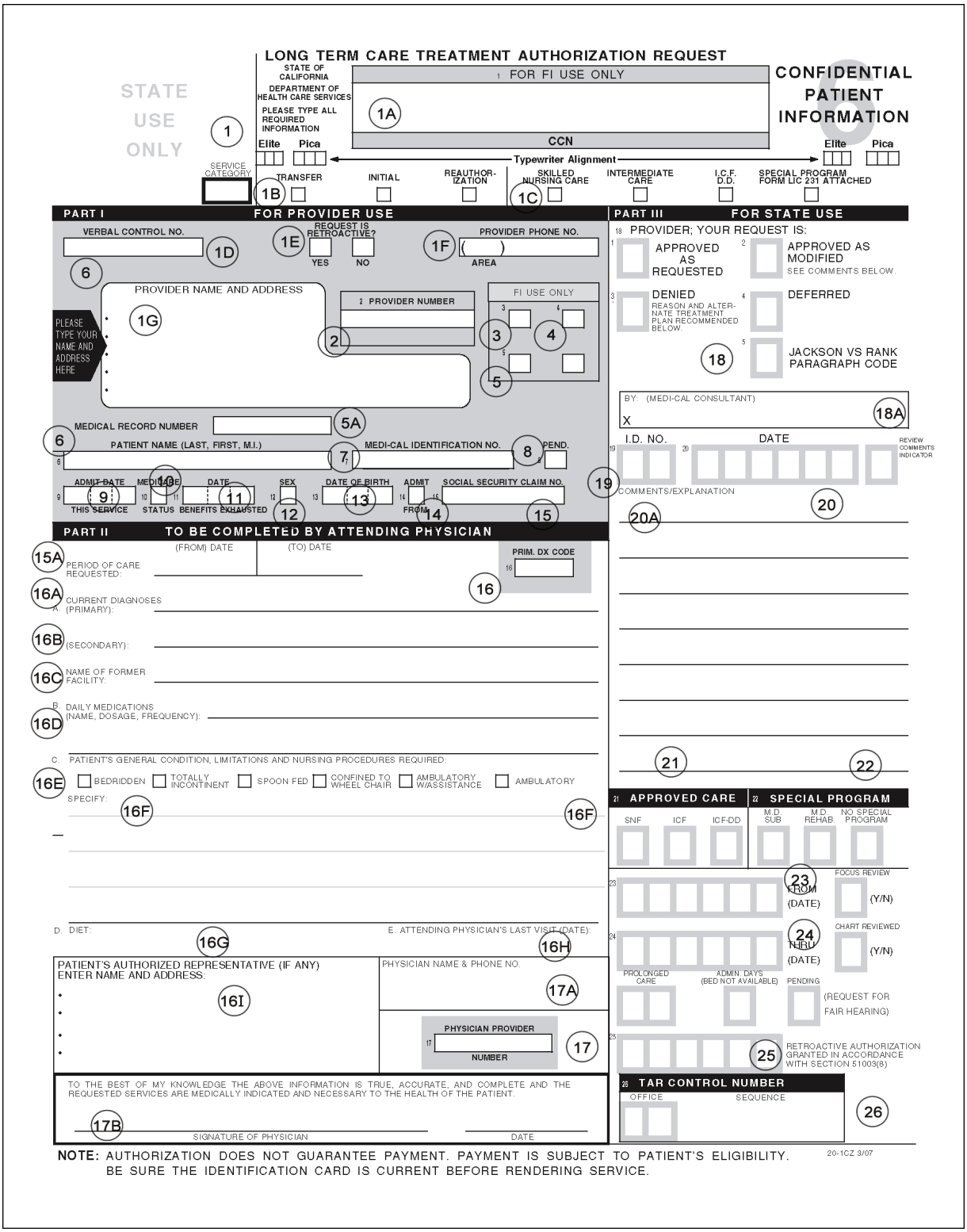


Figure 1. Sample *Long Term Care Treatment Authorization Request* (Form 20-1).

Explanation of Form Items

Item Description

1. **STATE USE ONLY.** Leave blank.

1A. **CLAIM CONTROL NUMBER (CCN).** For FI use only. Leave blank.

1B. **TRANSFER, INITIAL, REAUTHORIZATION.** Enter an "X" in the appropriate box.

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.

INITIAL. Indicates new admission other than a transfer.

REAUTHORIZATION. Indicates request for extension of an authorized period.

1C. **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.

SKILLED NURSING CARE (SNF). Care given a recipient who does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who requires skilled nursing care on a continual basis. This is now known as NF-B.

INTERMEDIATE CARE (ICF). Care given to a recipient whose medical condition requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of their ability. This is now known as NF-A.

ICF/DD-H and ICF/DD-N. Care given a recipient with chronic developmental disability. (**Note:** Attach Form HS 231 to the LTC TAR.)

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.

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.

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 and returned to the facility without approval. When form HS 231 is received, the facility should resubmit the LTC TAR for approval with form HS 231 attached.

If you check the *Special Program Form 231 Attached* box, you must check either the *Skilled Nursing Care* box or *Intermediate Care* box.

PART I: FOR PROVIDER USE

Item	Description

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.

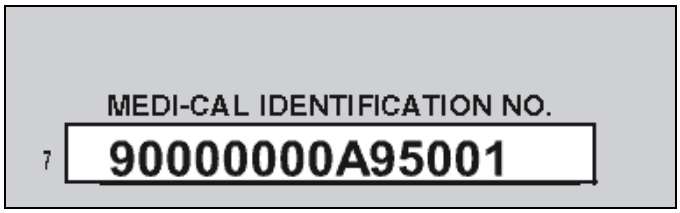
2. **PROVIDER NUMBER.** Enter your provider number.

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.

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 must be entered just above the recipient *Medi-Cal Identification Number* box.



County code | Aid code

Box 7 of TAR (20-1):

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

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).

Item	Description

10. **MEDICARE STATUS.** Leave blank if recipient is Medicare eligible. If not, enter one of the following codes:

Code	Explanation
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

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:

Code	Description
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.

PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN

Item	Description

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-10-CM diagnosis code.

16A. **CURRENT DIAGNOSES (PRIMARY).** Always enter the English description of the primary diagnosis corresponding to the ICD-10-CM diagnosis code entered in Box 16.

Item	Description

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.

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. This information is only required for recipients being admitted to a Nursing Facility.

Initial LTC TARs When completing an initial LTC TAR, fill out the following information on lines 2 through 4:

Community options available: _____ Yes _____ No
Check one.
PAS/PASRR completed on: (date) By: _____
Fill in the date and enter who completed the PAS/PASRR (NF, Acute or DHCS).
Referred to DMH/DDS for Level II screen on: (date)
Fill in the date.

Note: For bed hold requests, specify: BED HOLD REQUEST

Reauthorization LTC TARs

When completing a reauthorization LTC TAR, fill out the following information on lines 2 and 3:

Level II/ARR completed on: (date) _____N/A
Fill in the date or check Not Applicable.
Community options available: _____Yes _____ No
Check one.

PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN

Item	Description

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.

Item	Description

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. **FOR STATE USE:** Leave this area blank. Consultant's or on-site nurse's determination is entered in this section.

18. Only submit your claim if Box 1 (Approved as Requested) or Box 2 (Approved as Modified) is marked. The *Denied* and *Deferred* boxes indicate that the provider's request has not been approved.

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.

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.

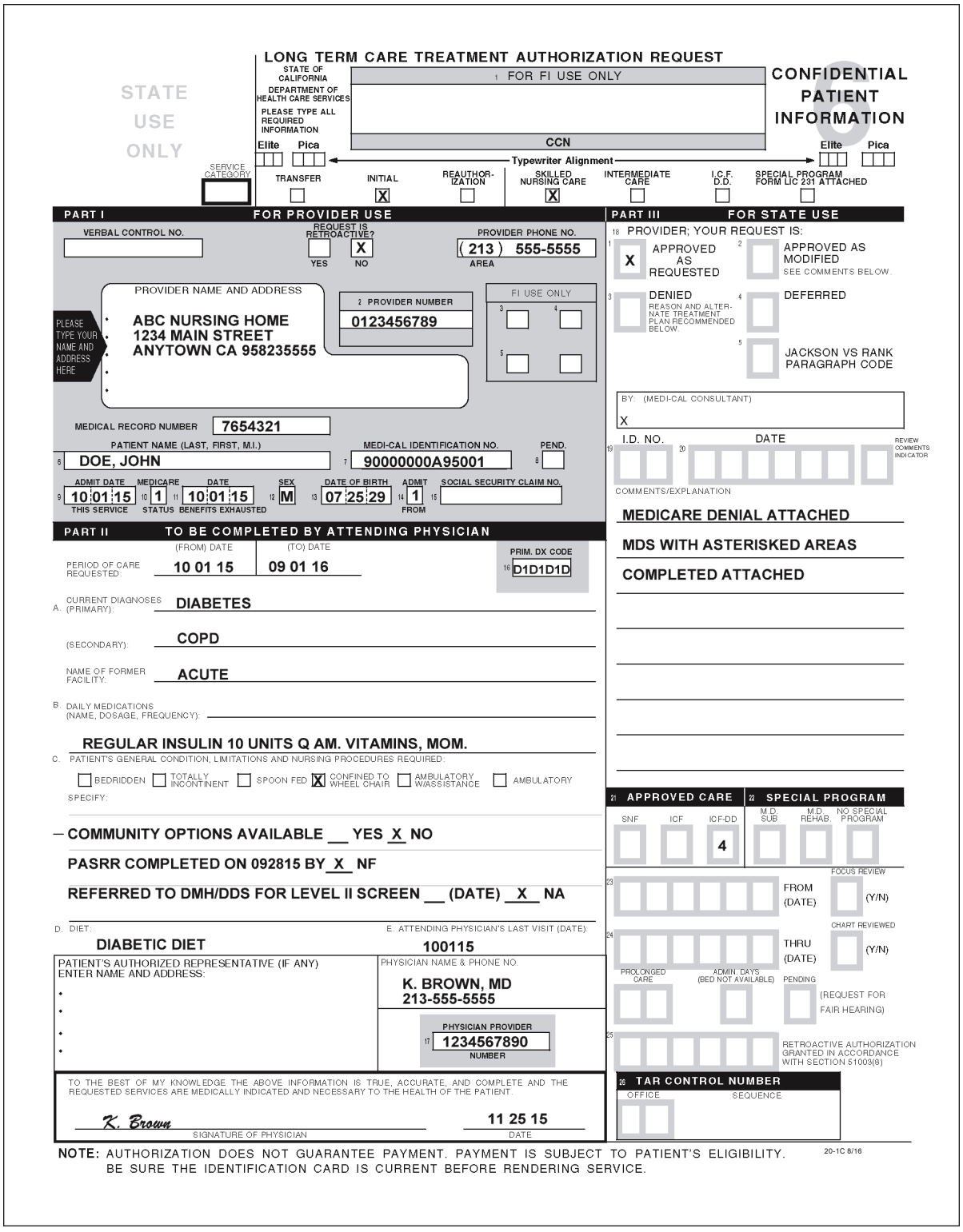
21. & 22. The consultant will indicate the approved care and special program in these boxes.

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. Do not attach a copy of the LTC TAR to the claim form.

Sample Initial LTC TAR



LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE USE ONLY

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
PLEASE TYPE ALL REQUIRED INFORMATION

1 FOR FI USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

Elite Pica

Typewriter Alignment

Elite Pica

SERVICE CATEGORY

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

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES [ ] NO [X]

PROVIDER PHONE NO. (213) 555-5555 (AREA)

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

ABC NURSING HOME
1234 MAIN STREET
ANYTOWN CA 958235555

2 PROVIDER NUMBER 0123456789

FI USE ONLY 3 4 5

MEDICAL RECORD NUMBER 7654321

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

7 MEDI-CAL IDENTIFICATION NO. 90000000A95001

8 PEND.

9 ADMIT DATE THIS SERVICE	10 MEDICARE STATUS	11 DATE BENEFITS EXHAUSTED	12 SEX	13 DATE OF BIRTH	14 ADMIT FROM	15 SOCIAL SECURITY CLAIM NO.
10 01 15	1	10 01 15	M	07 25 29	1	

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE 10 01 15 (TO) DATE 09 01 16

16 PRIM. DX CODE D1D1D1D

A. CURRENT DIAGNOSES (PRIMARY): DIABETES

(SECONDARY): COPD

NAME OF FORMER FACILITY: ACUTE

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

REGULAR INSULIN 10 UNITS Q AM. VITAMINS, MOM.

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

[ ] BEDRIDDEN [ ] TOTALLY INCONTINENT [ ] SPOON FED [X] CONFINED TO WHEEL CHAIR [ ] AMBULATORY W/ASSISTANCE [ ] AMBULATORY

SPECIFY:

COMMUNITY OPTIONS AVAILABLE __ YES _X_ NO

PASRR COMPLETED ON 092815 BY _X_ NF

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

D. DIET: DIABETIC DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 100115

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

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

17 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) 11 25 15 (DATE)

PART III FOR STATE USE

18 PROVIDER; YOUR REQUEST IS:

1 [X] 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) X

19 I.D. NO. 20 DATE REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

MEDICARE DENIAL ATTACHED
MDS WITH ASTERISKED AREAS
COMPLETED ATTACHED

21 APPROVED CARE			22 SPECIAL PROGRAM		
SNF	ICF	ICF-DD	M.D. SUB	M.D. REHAB.	NO SPECIAL PROGRAM
		4			

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

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

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

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

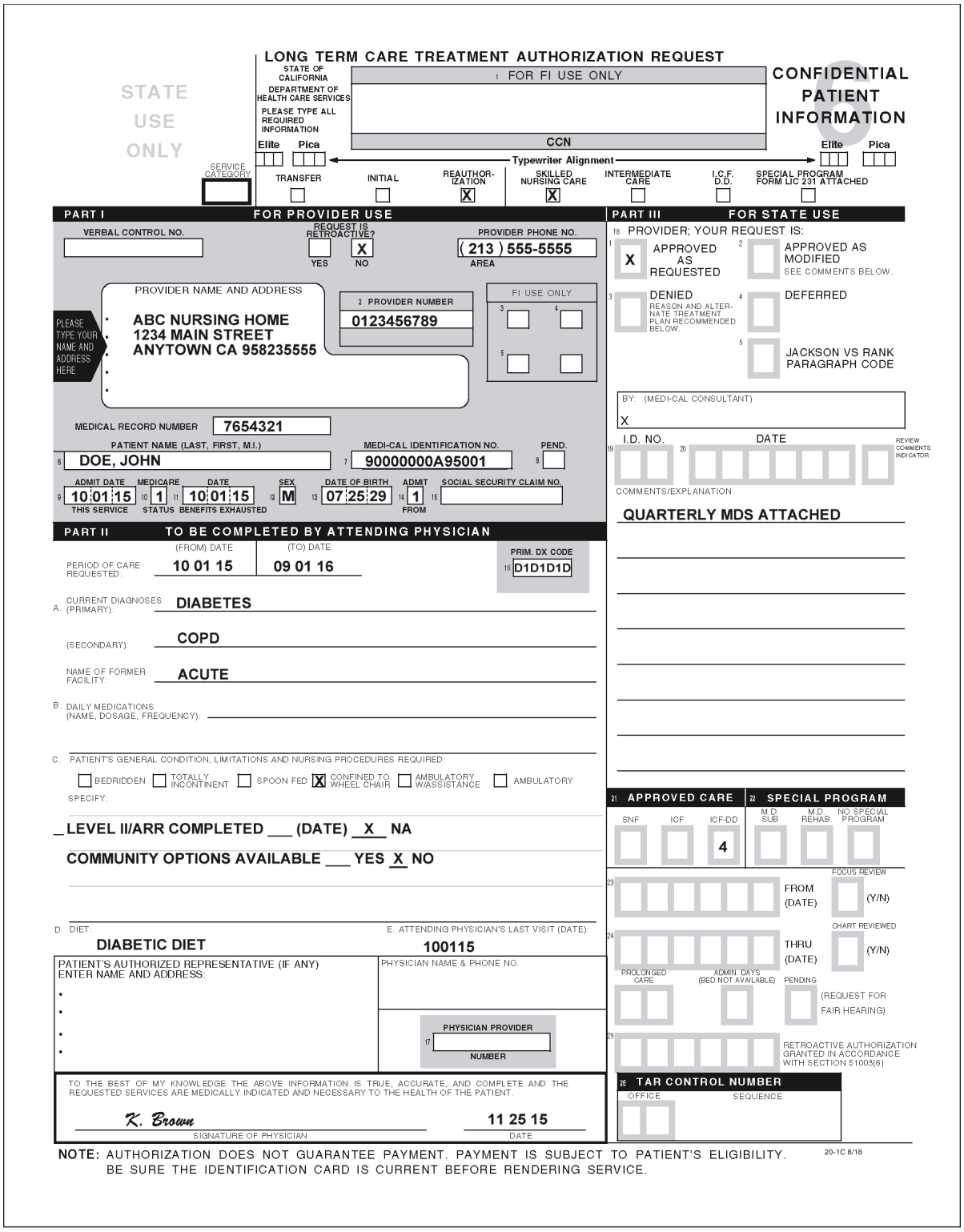
26 TAR CONTROL NUMBER OFFICE SEQUENCE

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

20-1C 8/16

Figure 2. Sample Initial LTC TAR.

Sample Reauthorization LTC TAR



LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE USE ONLY

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
PLEASE TYPE ALL REQUIRED INFORMATION

1 FOR FI USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

Elite Pica — Typewriter Alignment — Elite Pica

SERVICE CATEGORY

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

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES ☐ NO ☒

PROVIDER PHONE NO. (213) 555-5555 (AREA)

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

ABC NURSING HOME
1234 MAIN STREET
ANYTOWN CA 958235555

2 PROVIDER NUMBER 0123456789

FI USE ONLY 3 4 5

MEDICAL RECORD NUMBER 7654321

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

7 MEDI-CAL IDENTIFICATION NO. 90000000A95001

8 PEND.

9 ADMIT DATE THIS SERVICE	10 MEDICARE STATUS	11 DATE BENEFITS EXHAUSTED	12 SEX	13 DATE OF BIRTH	14 ADMIT FROM	15 SOCIAL SECURITY CLAIM NO.
10 01 15	1	10 01 15	M	07 25 29	1	

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED: (FROM) DATE 10 01 15 (TO) DATE 09 01 16

16 PRIM. DX CODE D1D1D1D

A. CURRENT DIAGNOSES (PRIMARY): DIABETES

(SECONDARY): COPD

NAME OF FORMER FACILITY: ACUTE

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

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

☐ BEDRIDDEN ☐ TOTALLY INCONTINENT ☐ SPOON FED ☒ CONFINED TO WHEEL CHAIR ☐ AMBULATORY W/ASSISTANCE ☐ AMBULATORY

SPECIFY:

_LEVEL II/ARR COMPLETED ___ (DATE) _X_ NA

COMMUNITY OPTIONS AVAILABLE ___ YES _X_ NO

D. DIET: DIABETIC DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE): 100115

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

PHYSICIAN NAME & PHONE NO.

17 PHYSICIAN PROVIDER NUMBER

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

11 25 15 — DATE

PART III FOR STATE 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

BY: (MEDI-CAL CONSULTANT) X

19 I.D. NO. 20 DATE REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

QUARTERLY MDS ATTACHED

21 APPROVED CARE			22 SPECIAL PROGRAM		
SNF	ICF	ICF-DD	M.D. SUB	M.D. REHAB.	NO SPECIAL PROGRAM
		4			

23 FROM (DATE) — FOCUS REVIEW (Y/N)

24 THRU (DATE) — CHART REVIEWED (Y/N)

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

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

26 TAR CONTROL NUMBER — OFFICE — SEQUENCE

20-1C 8/16

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

Figure 3. Sample Reauthorization LTC TAR.