County of Los Angeles

Department of Health Services

LOS ANGELES GENERAL MEDICAL CENTER

UTILIZATION MANAGEMENT

PROGRAM

2023-2025

LOS ANGELES GENERAL MEDICAL CENTER

UTIIZATION MANAGEMENT PROGRAM

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LOS ANGELES GENERAL MEDICAL CENTER

INPATIENT / ER

UTILIZATION MANAGEMENT PROGRAM

I. AUTHORITY

A. The Utilization Management Committee of Los Angeles County USC Medical Center is a standing committee of the Medical Center in accordance with the bylaws of the Attending Staff Association.

B. The Medical Center's Utilization Management Plan will be applicable to all patients, including those patients whose care is paid in whole or in part by the provisions of Titles XVIII (Medicare) and XIX (Medi-Cal) of the Social Security Act (hereafter such patients referred to collectively as "Federal Patient(s)") and to those patients covered by private insurance referred to collectively as "Private Insured Patients".

C. This Utilization Management Plan will also be applicable to those patients whose care is paid in whole or part by County General Funds and County General Funds/Medi-Cal in compliance with and under the authority of the Department of Mental Health, California Code of Regulations, Title 9, and Code of Federal Regulations, Title 42, Subpart D - Utilization Control of Mental Hospitals 456.150 – 456.238.

D. This Utilization Management Plan will also be applicable to all other patients of the Medical Center (hereafter, such patients referred to collectively as "Unknown(s)").

II. PURPOSE

The Utilization Management Committee is a fact-finding, non-disciplinary instrument of the Medical Center whose purposes are:

A. The Medical Center is committed to providing the best value and the best care to individuals and organizations requesting or purchasing health care services. To ensure appropriate utilization of medical resources to maximize the effectiveness of care provided to all patients, regardless of ability to pay or source of payment for the services.

B. The Utilization Management (UM) Department will follow this UM Plan when giving consideration for preauthorization/precertification requests, admission reviews, concurrent/continued stay reviews, discharge plans, and referrals to alternate level of healthcare services as considered necessary for the wellbeing of the patient. In addition, the UM Department will oversee or assist with all retrospective requests for review of medical necessity and appropriateness of care and services, discharge planning, and for the communication of information on non-approvals. The standard for the arbitration and appeal processes are also outlined in this plan.

III. ORGANIZATION

A. The Medical Center's Utilization Management Medical Director or his/her designee, appointed by the President of the Attending Staff Association with the concurrence of the Chief Medical Officer, shall serve as the chairman, and shall serve as co-chair of the Utilization Management Committee.

B. The Utilization Management Committee shall be comprised of representatives of the major Clinical Departments of the Medical Center, as well as Nursing, Administration, Medical Records and key support services.

C. The majority of members shall be physician members of the Medical Staff.

D. The Psychiatry Utilization Management Committee is a Subcommittee of the Utilization Management Committee. As such it will report its minutes to the Utilization Management Committee and a summary of its activities on a quarterly basis.

E. The Director of Utilization Management shall supervise a staff of Utilization Management Nurses, who are registered nurses known as Utilization Management (UM) Nurses. The Utilization Management Nurses will be responsible for the performance of preadmission review and authorization, admission certification, continued stay, and discharge reviews as described in Paragraph VI below. The Medical Director of Utilization Management and Physician Advisors will be available to resolve problems identified by the Utilization Management Nurses. The physician advisors will also be directly responsible to the Chairman of the Utilization Management Committee. No person who holds financial interest in the Medical Center shall make review determinations, nor will any person make review determination on any case in which he/she is currently directly professionally involved.

F. The Director of Utilization Management shall be responsible for the training of the persons in this section and shall oversee the compliance with requirements of the

Centers of Medicare and Medicaid Services (CMS), Medi-Cal, private insurers, and other fiscal intermediaries.

G. A list of members of the Utilization Management Committee and the departments or services they represent will be up-to-date at all times and available in the Office of the Director of Utilization Management.

IV. ACCOUNTABILITY / RESPONSIBILITY

A. Utilization Management Case Management Medical Director

- The Utilization Management Medical Director shall oversee the Utilization Management Program.
- The Utilization Management Medical Director shall be an active member of the Medical Staff.
- The Utilization Management Medical Director shall chair the Utilization Management Committee.
- The Utilization Management Medical Director shall serve as the Physician Advisor to the Utilization Management Department and shall review cases brought for review by the Utilization Management.

B. Utilization Management Nursing Director

- The Director of Utilization Management shall have direct responsibility for all aspects of the Utilization Management program including ensuring adequate resources and monitoring the program's outcomes.
- The Director of Utilization Management shall have the responsibility for the Utilization Management functions. He/she may delegate responsibility to other individuals and departments as appropriate.
- The Director of Utilization Management shall participate in new physician orientation and periodically discusses the Utilization Management process with the Medical Staff to gain understanding and support.

C. Utilization Management Nursing Supervisor

- The Utilization Management Supervisor has immediate responsibility for organizing, assigning, and evaluating the work.
- The Utilization Management Supervisor provides technical and administrative direction to the Utilization Management subordinate staff.
- The Utilization Management Supervisor analyzes cases for referral to the physician advisor and serves as liaison with the physician advisor for follow up of referrals.

D. Utilization Management Nurse

- The Utilization Management Nurse shall have the responsibility to maintain and facilitate the ongoing activities of the Utilization Management Department.
- The Utilization Management Nurse shall assure that admission and continued stay reviews are performed as outlined in the Utilization Management plan and in a timely basis.
- The Utilization Management Nurse shall expedite discharge planning by early identification and appropriate referrals of cases.
- The Utilization Management Nurse shall refer to the Utilization Management Medical Director, any cases in which medical indication for admission or continued stay appears unclear.

E. Care Coordinators

- The RN Care Coordinator is a Registered Nurse II who functions and performs highly specialized duties requiring excellent clinical, organizational, managerial, and customer services skills while interacting with all departments involved in providing services to patients in the hospital.
- The MCW Care Coordinator is a Medical Case Worker II who assists with transitions of care, transfers patients to other acute care or lower level of care facility, obtains follow up appointments, coordinates the needs of patients with health plans and/or IPAs, verifies and notifies health plans and/or IPAs and obtains authorization for inpatient management and other services.

F. Community Nurse Coordinator

- The Community Nurse Coordinator shall have responsibility to screen and identify patients who are appropriate for Home Health Care.
- The Community Nurse Coordinator shall serve as a resource expert to all the Medical Center's departments and in the community.
- The Community Nurse Coordinator shall process referrals to appropriate Home Health and community agencies based on geographical area, needed services and available resources.
- The Community Nurse Coordinator shall serve as "liaison" between the Medical Center, contracted Home Health Agencies and the Public Health Department.
- The Community Nurse Coordinator shall provide in-service education on discharge planning and continuity of care to all staff.

G. UR Technicians

- UR Technicians are Intermediate Clerks or Nursing Attendants whose primary role is to verify, validate and notify the health plans and/or IPAs. He/she identifies the

Care Manager and Primary Care Provider, with faxing the clinical information to the designated third-party payer, obtaining follow up appointments, following up with status of authorization, and helps with the other needs of the Department (i.e. discharges, picking up of medical record CDs, providing Important Message Letters to patients.)

H. Attending Staff

- The attending staff as a body has the overall responsibility for the quality of the professional services provided by individuals with clinical privileges and also the responsibility of accounting to the Governing Body.
- The attending staff shall provide patients quality care meeting the professional standards of the attending staff of the Medical Center.
- The attending staff members shall abide by the Association Bylaws, rules, and regulations and department rules and regulations and therefore shall make the commitment to actively participate in the Utilization Review Program and shall be responsible utilization of hospital resources and maintenance of high quality patient care.

I. Chief Executive Officer

- The Chief Executive Officer shall assume responsibility for the effective management of the Utilization Management Program. It is to provide the staff necessary for review functions and to assure support for the program.
- The LA General Executive Team shall work with Attending Staff Executive Committee to address problems and concerns.

J. Attending Staff Association Executive Committee/Medical Executive Committee (MEC)

- The Executive Committee of the Attending Staff (MEC) shall be responsible for recommending action to the Medical Director, the CEO, the Director and the Governing Body on matters of a medico-administrative and management and recommending appropriate budgetary support to permit provision of quality patient care to assure that the Governing Body provides sufficient funds for the attending staff to render quality health care.
- The Attending Staff Association Executive Committee (MEC) shall receive and act on reports and recommendations from the Utilization Management Committee and shall evaluate the medical care rendered to patients in the Network, identify opportunities to improve patient care, monitor the activities of the Utilization Management Department and be responsible for assuring that the findings and recommendations are implemented in order to fulfill the Association's accountability to the Governing Body for the health care rendered to patients in the Medical Center.

K. Governing Body

- The Governing Body is ultimately responsible for maintaining quality patient care and providing organization management and planning, including assuring the provision of one standard of patient care within the institution.
- The Governing Body shall have the final authority and overall responsibility for a comprehensive and integrated Utilization Review Case Management Program.
- The Governing Body delegates the authority and accountability to the administrative and medical staff to implement the Utilization Management Program.
- The Governing Body shall make the commitment to provide the financial support necessary for the program so that the Administration can provide the specific resources in services, equipment and personnel required.

V. MEETING

A. The Utilization Management Committee shall hold at least ten (10) monthly meetings per year, shall maintain a permanent record of its proceedings and actions, and may submit a quarterly report to the Network Quality of Care Review Committee, The Utilization Management Committee minutes shall be submitted monthly to the Executive Committee of the Attending Staff Association.

B. A quorum will be multidisciplinary and represent a majority of the Committee (including at least three (3) attending staff). No less than a quorum shall make Utilization Management Committee determinations.

VI. FUNCTIONS

The following are functions of the Utilization Management Committee and may be carried out by the whole committee, a subcommittee, or by delegated representatives, such as a physician advisor or Utilization Management Nurse or Medical Center's Office of Utilization Management.

A. To establish and carry out a program of admission certification and continued stay review of all patients in accordance with applicable statutes, and regulations.

B. To use evidence-based, approved by a committee designated by the medical staff by-laws.

C. To supervise the review activities of non-physician reviewers.

D. To Perform Inter-Rater Reliability monitoring to evaluate the consistency and appropriateness of UR decision-making.

E. To review monthly, quarterly, and annually utilization management reports and other pertinent utilization management information, and when indicated, make

recommendations to Department Chair and the Medical Executive Committee for the most efficient use of the Medical Center's services and facilities.

F. To verify the timely implementation of discharge planning.
G. To recommend changes in the Medical Center's procedures of medical staff practices as indicated by analysis of review findings.
H. To recommend continuing education programs as indicated by the analysis of review findings.
I. To adopt norms, standards, and criteria for patient care review.
J. To establish and carry out an outpatient utilization management to assure outpatient clinical services are provided in accordance with applicable statutes regulations, procedures, and contractual obligations

VII. PROGRAM STRUCTURE

The following Committees and/or departments are involved in Utilization Management activities:

A. The Hospital Administration – Hospital Executive Leadership
B. Attending Staff Association (ASA)
C. Utilization Management Committee (UMC)
D. Committee membership and meeting schedules are set per ASA by-laws

VIII. METHODS OF REVIEW

A. Utilization Management Procedures

1. Admission, Concurrent and Discharge reviews of all patients will be performed under the direction of the Utilization Management Committee, employing Utilization Management Nurses and Physician Advisors (PA). A physician advisor is a physician representative of the Utilization Management Committee. The physician advisor will become involved with hospital admission[s] only after the Utilization Management Nurse has attempted to contact the Attending Physician of Record regarding a potential denial based on review of chart documentation, or a third-party payor denial, but is unable to reach the Attending Physician of Record or cannot obtain a response. The physician advisor will try to resolve these issues with the patient's Attending Physician of Record.
2. Utilization Management Nurses will review the admissions and continued stays of all patients using norms, standards, and criteria (IQ) approved by the Utilization Management Committee.
3. Utilization Management Nurses will review the admissions and continued stay of all admissions to the psychiatric inpatient service using norms, standards,

and criteria approved by the Department of Mental Health and in compliance with California Code of Regulations, Title 9.

4. Utilization Management Nurses will employ the review procedures set forth in this Section. Cases referred to the Utilization Management Committee because of their high costs, excessive services, suspected lack of appropriate services, or classes of admission wherein patterns of care are frequently found to be questionable, will be subjected to closer professional scrutiny. When deemed necessary, the Utilization Management Committee will subject cases to in-depth peer review in order to focus attention on problem areas, to correct deficiencies and to assure high quality care for all inpatients.
5. If prior authorization is denied by a third-party payer, the UM Medical or Physician Advisor (PA) can override the denial and approve the admission of the patient as deemed appropriate.
6. The chart review abstract and review date shall be documented and entered electronically into the Utilization Management application in Care Management (CM) Module in ORCHID reflecting days meeting and not meeting criteria, including days that were reviewed at the secondary review level (done by the Physician Advisor(s) shall be completed, printed and sent to billing office, Consolidated Billing Office, (CBO), no later than 30 days after the review is completed.
7. Such review will constitute perusal of the medical records progress notes, nursing notes, ancillary services notes, laboratory reports, flow sheets, etc., for documentation pertaining to the level of care required.

B. Pre-Admission Certification

1. All UM determinations are based on medical necessity. UM Nurse Screens for medical necessity using UM Committee (UMC) approved criteria sources. All cases that do not meet the screening criteria for medical necessity will require secondary review by a Physician Advisor (PA).
2. The need for a prior Authorization or pre-certification request is determined by the payer – i.e. Medi-Cal, Medicare, insurance or third party payer, or other payer source. Prior authorization is required for elective admissions.

C. Admission Certification – All Patients (Except Psychiatric Patients)

1. All UM determinations are based on medical necessity and appropriateness of admission, regardless of the patient's financial resource. UM Nurses screen for medical necessity using UMC approved criteria sources which is InterQual criteria. To determine medical necessity of an admission, an Emergency Department Utilization Management (ED UM) nurse will review patient's medical records where an order for admission is written by a physician. Admitting physicians may be an Emergency Department Physicians, clinic

physicians, or service attending physicians. If the patient is in the emergency department, the review using IQ criteria should be performed as soon as possible after the order for admission is written or a determination is expected that the patient will be admitted. If there is any question regarding the medical necessity of the admission the emergency room physician or attending physician should be contacted to determine if there is more information that may be documented and that would assist in making a final medical necessity decision.

2. If the physician elects to proceed with the admission and IQ criteria for medical necessity are not met, the case will be verbally referred for secondary medical review by the ED UM Nurse to the Attending physician advisor for an override**.** After review of the case, the Physician Advisor or ED Attending physician will document the medical justification; "override" notes, in the ED progress notes. The ED UM Nurse will be notified through First Net and will copy and paste the notes into the Care Management Note application in ORCHID. In some cases, the director of UM may perform a secondary peer/clinical review prior to requesting a review by a physician advisor.
3. If the physician advisor believes the admission was not necessary or was inappropriate, he/she shall confer with the Attending Physician of Record and the judgment of the Attending Physician of Record will be given great weight. Only a licensed physician can make an adverse determination.
4. If it is not possible to perform an admission review before or at the time of the admission, the review should be completed as soon as possible after the admission. When completing an admission review on a patient already admitted (retrospective review) the reviewer will only use information available at the time of admission. Acceptable reasons for the delay in admission review completion are: Life-threatening emergency cases, holidays, weekends, or admission times when UM services are not available.
5. For Medicare patients, an "Important Message from Medicare" [IM] letter (Attachment I) is issued, explained and the patient or his/her representative's signature is obtained by the Registration staff, during the full registration process. The IM letter informs the Medicare patients of their Discharge and Appeal Rights. The patient or his/her representative's signature is obtained. The original is placed in patient's chart and a copy of the IM letter is given to the patient. If the beneficiary and/or his/her representative refused to sign the original or follow up IM letter, document in the patient's admission packet and note on the signature portion of the form "patient refused to sign and form is dated."
6. For third party payers, if the patient is determined to be *stable* for transfer to the capitated facility by the ED attending physician, the ED UM nurse will notify the Health Plan and transfer process is coordinated with the Health

Plan's Case Manager. If the patient is determined to be *unstable* for transfer, the UM nurse will call the Case Manager of the Health Plan and obtain authorization to admit. The decision of the third-party payer is documented in Care Management module in ORCHID. If the Attending Physician of Record is not in agreement with the Health Plan's denial, he/she can appeal the decision either telephonically (while the patient is still in ED), or by appeal letter (after the patient's discharge). Written denial notices to the patient are the responsibility of the third-party payor. However, if the Attending Physician of Record is in agreement with the denial, but the patient refuses to comply with the Attending Physician of Record's plan to expedite care or discharge the patient, a letter entitled: "Notice of Hospital Bill Responsibility" will then be issued to the patient/patient's family explaining the reason for the denial and their possible responsibility for the hospital bill if they choose to stay (Attachment II).

D. Continued Stay Review – All Patients (Excluding Psychiatric Patients)

1. All UM determinations are based on medical necessity. UM Nurse screens for medical necessity using UMC approved criteria sources, InterQual (IQ). The chart review abstract and review date shall be documented and entered electronically into the Utilization Management application in Care Management Module, in ORCHID. The cases that did not meet the IQ criteria for continued stay are referred to the PA for medical secondary review and determination. The request for medical secondary review is accessed by the PA via the Message Center in ORCHID. PA's dispositions are entered in the InterQual Review ORCHID**.** In some cases, a supervisor or director of UM may perform a secondary peer/clinical review prior to requesting a review by a physician advisor.
2. If the physician advisor believes the continued stay is not medically necessary or is inappropriate and he/she agrees with the IQ criteria not met, he/she shall confer with the Attending Physician of Record and the judgment of the Attending Physician of Record will be given great weight. Only a licensed physician can make an adverse determination. Provision of ongoing services and discharge will be based on the care required by or the identified needs of the patient as determined by the Attending Physician of Record.
3. For third party payers, the Utilization Management Nurse will supply the additional information needed by the third-party payer in order for them to make a decision concerning authorization of the continued stay. Patients must be notified of a potential financial responsibility determined by their payer. Providers and billing areas are notified of all non-approval/not met, or denial determinations. Patients and providers may assume continued

approval unless notified. Only a medical reviewer/physician review may make a denial decision.

4. If review of the patient's record fails to demonstrate medical necessity for the continued stay, or the third-party payor questions or denies the continued stay, the UM Nurse shall refer the case, on the same day, to the Attending Physician of Record for additional information and documentation, or for consideration of an alteration in the treatment plan for the patient. If the additional documentation does not appear to substantiate the need for the continued stay, no change in the treatment plan is made, or the Attending Physician of Record cannot be contacted, the case will then be referred to a physician advisor of the Utilization Management Committee, via Message Center in ORCHID. If the physician advisor finds the continued stay as medically necessary, he/she will certify the continued stay and will document clinical justification in ORCHID and assign an additional length of stay.
5. Patients should be notified of any denial decisions that may result in the patient being responsible for all or part of the bill for services rendered, whether it is the admission or continued stay being denied. In the case of a third-party payer this notification will often be made by the payer directly to the patient.
6. The patient can take one or more of the following actions in the case of a payer denial:
    a. Appeal to their insurer or third-party payer.
    b. Discuss alternate levels of care with their attending physician.
    c. While it is never recommended and should be strongly discouraged, the patient may request discharge or leave the facility against medical advice.
7. For Medicare patients, if a decision is made by the Attending Physician to discharge the patient, the Utilization Management Nurse will hand deliver and explain a follow up copy of the original signed “Important Message from Medicare” (IM-Attachment I) to the beneficiary or his/her representative for second signature and current date, prior or on the day of discharge. The follow up letter may be delivered to the beneficiary at least four (4) hours before the patient is discharged from the hospital. If the Attending Physician of Record determines the patient is not capable of receiving it then every effort will be made to deliver the notice to a family member or patient representative. If no such person can be identified, then this will be noted in the patient’s chart.
8. If beneficiary and or his/her representative refuse to sign the original or follow up IM letter, document in the patient’s medical record and note on the signature portion of the form “patient refused to sign” the Medicare beneficiary, who indicates dissatisfaction with the decision of his/her

discharge, will receive a completed "Detailed Notice of Discharge" (Attachment IV). This notice will be given to the patient or his/her representative and will be completed by the Attending Physician who makes a determination that acute care is no longer medically necessary. Once Medicare provides with the appeal process outcome, the URM Nurse, will in term provide the information to the patient and the team.

E. Discharge Review

A review performed to determine the safety of discharge or transfer from one level of care to another. Discharge planning should start as soon as after admission as possible, but the review is done when a discharge is planned or when a patient is no longer meeting medical necessity criteria.

F. Retrospective Review

A review performed after the patient has received inpatient services or been discharged from the facility in order to determine the medical necessity of the admission to and continued stay in the facility. A retrospective review may also be performed if the patient's payer source changes.

1. All hospital admissions to Los Angeles General Medical Center may not be financial identified until after discharge of the patient. A retrospective review shall be completed when, for any reason, the Utilization Management Nurse is not notified of the admission of a third-party payor patient on or before the second working day following admission or is notified after the discharge date.
2. When the Utilization Management Nurse is notified of a financial resource for a patient after the discharge date, he/she shall immediately complete the review of the patient's chart (if this has not been done yet) for compliance with Centers of Medicare and Medicaid Services (CMS) approved screening guidelines, Title XXII guidelines, and guidelines/criteria approved by the Utilization Management Committee. ALL admissions are reviewed concurrently. Except for a small percentage of cases that are admitted/discharged before they can be reviewed, the documentation justifying medical necessity for the admission is already present on the review form.
3. All actions with respect to review will be documented electronically into the Utilization Management application in Care Management Module in ORCHID

G. Medicare Criteria for Authorization of Acute Hospital Stay

1. Admission Criteria: Urgent/Emergent Admissions

   The level of care must be of such severity that it can only be given in an acute inpatient hospital setting. Medical necessity shall be reviewed via lnterQual®

Level of Care Criteria Guidelines. If admission criteria are not met, a physician secondary review will be completed to determine appropriate level of care. A physician's review and opinion that the admission is medically necessary despite criteria not being met will result in admission being approved.

2. Admission Criteria: Elective Admissions
   Elective/scheduled admissions require prior authorization from Utilization Management team to ensure appropriate level of care. Medical necessity shall be reviewed via lnterQual® Level of Care Criteria Guidelines. If admission criteria are not met, a secondary medical review will be completed to determine appropriate level of care, i.e. inpatient vs. outpatient setting for procedure.

IX. APPEALS

A. The patient Appeal Process will be initiated if the patient does not agree with the Physician's decision regarding the Utilization Management aspects of the case.
   1. Medi-Cal beneficiaries have the right to a fair hearing if dissatisfied with any action of DHCS with respect to the scope and duration of health care services. The code of Federal Regulations Title 42, section 482.13 requires a hospital to protect and promote each patient's rights by, among other things, establishing a grievance process allowing for prompt resolution of a patient grievance.
   2. For Medicare patients, the Utilization Management Nurse staff will facilitate and assist the patient in pursuing an appeal with the Medicare Quality Improvement Organization (QIO), Health Services Advisory Group (HSAG) through established mechanisms, should the patient disagree with the decision or request an appeal.

B. Medi-Cal Appeal Procedures
   An appeal is initiated due to a denial by Medi-Cal for medical necessity of acute hospitalization. The Utilization Management Director and Physician Advisor review all denials and initiates a formal written appeal/dispute of any case believed to have been medically inappropriately denied by Medi-Cal.
   1. A dispute to DHCS will be sent within 60 days of the date of the On-Site Detail Report of the medical record findings from the Department of Health Care Services (DHCS), Utilization Management Division (UMD) review before they are finalized.
   2. Disputes will be submitted to: phpdisputes@dhcs.ca.gov
   3. All documentation must be attached to support the dispute.
   4. A decision will be based upon the supporting documentation.
   5. Finalization of these findings will be postponed until resolution of the dispute.

X. NON APPROVAL NOTICE PROCESS

When evidence based criteria is not met for pre-admission/certification, admission, or continued stay, the case must be referred to a physician for final medical necessity determination.

In the case of a not met decision notifications should be made to the attending physician so that additional data, if available, can be added to the medical record. If the medical record information still does not meet criteria a secondary peer/clinical review may be performed by a UM supervisor or UM director prior to submitting to a physician advisor for a medical review.

The attending / Admitting physician can take one or more of the following actions if the medical necessity criteria are not met:

a. Provide additional medical information and request the UM nurse to review the case again.
b. Request to discuss the case with the physician reviewer.
c. Add documentation or orders to the medical record that were not previously documented so that the medical record may now comply with the physician advisor recommendations (Except for retrospective reviews).
d. Continue with the existing plan.

Patients should be notified of any denial decisions that may result in the patient being responsible for all or part of the bill for services rendered. In the case of a third-party payer this notification will often be made by the payer directly to the patient.

The patient can take one or more of the following actions in the case of a payer denial:

a. Appeal to their insurer or third-party payer.
b. Discuss alternate levels of care with their attending physician.
c. While it is never recommended and should be strongly discouraged, the patient may request discharge or leave the facility against medical advice.

XI. DISCHARGE PLANNING

a. Discharge planning is an integral part of Utilization Management and must be initiated as early as possible after admission in order to facilitate timely discharge.
b. Discharge planning does not require a physician order and can be initiated by any non-physician health care provider.
c. Utilization Management Nurse will participate in the discharge planning process with other involved disciplines.
d. The patient, patient's family and attending physician will be involved in the discharge planning process.

e. Documentation in the patient's medical record is used to identify patients whose diagnosis, therapy and psychosocial or other health related circumstances usually requires discharge planning.
f. The discharge planning activity shall include, but not be limited to, placement in alternative care facilities and arrangement for appropriate equipment and/or community resources available to improve or maintain patient's health status on an outpatient basis.
g. Discharge planning interventions must be documented in the patient's medical record.

XII. UTILIZATION MONITORING

Any cases in which a physician insists on an admission or refuses to discharge a patient after a secondary medical reviewer/physician reviewer recommends an alternative level of care or discharge, should be considered for review by the UM Medical Director. He/she may then recommend interventions if necessary.

XIII. MEDICAL RECORDS REQUIREMENTS

A. Each patient's electronic medical record must include at least the following:
    1. Identification data, i.e., name, age, date of birth, address, telephone number, date of admission, etc.).
    2. Evaluation / Assessment.
    3. For Psychiatric Admissions, ICD 10 codes in the diagnosis; description of the functional level of the beneficiary.
    4. Treatment Plan.
    5. Daily Progress notes by appropriate disciplines.
    6. Name of patient's medical staff member responsible for care
    7. Continued stay documentation (specific reason justifying medical necessity for the continued stay);
    8. Discharge Summary; and
    9. All other pertinent record information.

B. Each record entry shall be timed, dated and signed electronically in ORCHID.

XIV. UTILIZATION MANAGEMENT REPORTS AND RECORDS AND COMMITTEE MINUTES

The Medical Center's Office of Utilization Management will be responsible for maintaining individual and aggregate patient data with respect to Pre-admission review, Admission Review and Continued Stay Review. The Patient List, UM List and Care Management Assignment List can all be found in ORCHID. Each patient will contain information regarding

daily admissions/discharges and admissions reviews, physician comments (when appropriate), and physician decisions when referrals are made. An Allocation of Days (AOD) form contains the total numbers of days certified and denied, which are also on the admission worksheet. Denial letters and reconsideration decisions are appended to the worksheets as deemed appropriate.

The Office of the Chairman and Co-Chair of the Utilization Management Committee will maintain complete minutes of all Utilization Management Committee meetings. These minutes will include the following:

1. Name, date and convening and adjourning times of meetings.
2. Names of members present and absent, by discipline.
3. Description of activities.
4. Reports for Denied Days, any cases reviewed, including recommendations and follow-up as appropriate.
5. Appeals and Outcomes.
6. Minutes of any subcommittee of the Utilization Management Committee or any ad hoc groups discussing Utilization Management cases.
7. Signature of chairperson indicating that the minutes have been reviewed and approved.

The chairperson / co-chairperson will provide monthly reports of the Denied Days, Appeal Statistics, Psychiatric Administrative Cases and Days, and results of MCE studies to the Hospital's Professional Staff Executive Committee, through the Governing Body Reports. The Executive Committee consists of the Hospital Administrator, the Chair of each Department, Director of QI and Risk Management, Medical Center's Director of Nursing, and Medical Center's Associate Medical Director of Ambulatory Care. The monthly reports are presented to the members and all information and data included in reports will be done to assure confidentiality in compliance with all applicable laws, regulations, guidelines and directives. All such records and reports will be kept for at least 2 years in the Office of the Chairman of the Utilization Management Committee.

XV. SECURITY OF DATA

Security measures have been implemented that address the maintenance of privacy for information included in internal reports and for individual or summary data that may be included in external reports. Information is considered proprietary and confidential and is handled in accordance with hospital Utilization Management Departmental and corporate confidentiality policies.

XVI. STATEMENT OF CONFIDENTIALITY

The Medical Center has developed and implemented a confidentiality Policy that requires employees to sign an Acknowledgment of Understanding of the Department of Health Services' Confidentiality Policy as a condition for employment. It states the Medical Center has developed and the employees have a responsibility to ensure all personal patient, practitioner, provider, and employee information remain confidential. This statement is reviewed at each performance evaluation and an updated signature, indicating understanding, is obtained. Security measures have been implemented to address the maintenance of privacy of information at the workstation, in the computer, and/or over phone/fax/e-mail communications. The UM Department will adhere to all hospital and corporate policies and procedures regarding privacy and confidentiality.

XVII. STATEMENT OF CONFLICT OF INTEREST

No person in the UM process will review cases in which they are/were actively or personally involved. If potential for conflict of interest is identified, another qualified reviewer is designated. No compensation, incentives, or anything of value is provided to employees or agents. No conditions on employment or evaluations, and no performance standards, are set based on the number of non-approvals, reductions/limitations on lengths of stay, benefits, services, charges, or on the number/frequency of telephone calls or other contacts with health care practitioners, providers, or members.

XVIII. RELATIONSHIPS TO THIRD-PARTY PAYORS

The Utilization Management Committee's administrative files shall be kept confidential and disclosed only in accordance with applicable State laws. It shall be made available for DMH and DHS inspection. In addition, copies of reports and records must be available, consistent with State and Federal laws, to Committee members, State and Federal surveyors. Information and data will be maintained to assure confidentiality in compliance with HIPAA regulations and all applicable laws, regulations, guidelines and directives. Medical Records shall be removed from the jurisdiction and safe keeping of the hospital only under court order, subpoena or statute. Patient's identifiable information shall not be disclosed or released without the written consent of the patient or the patient's surrogate decision maker to any person not directly concerned with the care of the patient, except when disclose if authorized by law. Information shall be released only by the appointed Custodian of Records, unless otherwise authorized in writing by the Chief Executive Officer.

Admission and continued stay reviews for all third-party payor patients will be communicated to the appropriate review organization within twenty-four (24) hours of receiving the request for information or the first workday following the admission. The

Director of Utilization Management will assist in providing records and space for private insurance audits.

XIX. RESPONSIBILITIES OF MEDICAL CENTER ADMINISTRATION

Medical Center Administration will provide assistance to the Utilization Management Committee directly by participation in the review process and by acting as liaison with all Medical Center departments. Administration will also assure that appropriate personnel will be assigned to provide discharge planning. Administration will indirectly be responsible for notifying the Utilization Management Committee and Utilization Management Nurses of all patient admissions, providing access to medical records through Electronic Health Records (EHR), which is ORCHID, for continued stay review, and for considering and acting upon decisions and recommendations made by the committee with respect to Medical Center policy, procedures and staffing.

PSYCHIATRIC

Utilization Management Plan

Psychiatric Utilization Management Plan

I. ORGANIZATION

The Psychiatric Utilization Review Subcommittee is a multidisciplinary team that consist of two or more physicians, of whom one is knowledgeable in the diagnosis and treatment of mental disease and assisted by other professional personnel such as the Utilization Review (UR) Nurse who is responsible for reviewing the Psychiatric inpatient cases.

- **A.** Psychiatric Clinical Director
- **B.** Physician Advisor (PA)
- **C.** Psychiatrist
- **D.** Nurse Manager
- **E.** Director of Utilization Review Department or designee
- **F.** Director of Psychiatric Social Worker or designee

II. CONFLICT OF INTEREST

The Utilization Management Committee may not include any individual who has financial interest in any mental hospital such as patient referrals to their own personal private practice.

III. MEETING

The Utilization Management (UM) Psychiatric Subcommittee will meet quarterly or more frequently, if deemed necessary by the Chairman. Complete accurate minutes of all UR Committee meetings are maintained in the office of the Chairman. The committee chairperson or his/her designee reports to the Utilization Management Committee on a monthly basis.

IV. FUNCTIONS AND RESPONSIBILITIES

A. Ensure that the Psychiatric UM review process is in compliance with the requirements of The Joint Commission (TJC), Department of Health Services/Department of Mental Health, CCR Title 9 Chapter 11, Title 22 Medi-Cal of California, Administration Code, the Centers for Medicare and Medicaid Services (CMS), and Code of Federal Regulations, Title 42, Subchapter C, Subchapter D.

B. Establish and implement a program of admission, continued stay and discharge reviews for all patients in accordance with applicable statutes, regulations and procedures.

C. Perform patient quality care reviews in accordance with the standards and criteria implemented by the State of California.
D. Review of the monthly Psychiatric Administrative Days Report by the UM Committee at designated meetings.
E. Provide recommendations on all clinical issues related to:
    a. Admission, concurrent and discharge reviews
    b. Ongoing care planning
    c. Appeals for reconsideration of denied authorization
F. Control certification of inpatient stays and authorization of payment.

V. CONFIDENTIALITY

All worksheets, minutes of meetings, findings, recommendations, reports and medical care evaluation studies shall be considered confidential in compliance with HIPAA regulations and all applicable laws, regulations and guidelines.

The UM Committee's administrative files shall be kept confidential and disclosed only in accordance with applicable state laws and shall be made available for Department of Mental Health and Department of Health Services inspection.

UM Committee members, consultants and guests must agree to maintain confidentiality of the issues and patients discussed.

VI. RECORD KEEPING

A. The Psychiatric Utilization Management Subcommittee maintains the following records;
    - Monthly Minutes from the Psychiatric UR Subcommittee (maintained by the Psychiatry Department)
    - Monthly Psychiatric Administrative Cases/Days Report (distributed to: DHS Revenue Management; UR Administrative Director, Psychiatric UR Chair, Hospital UR Chair & Psychiatric Program Manager)
    - Medical Case Evaluation Studies
    - Medical Utilization Management Psychiatric Subcommittee Notes (kept attached to the Psychiatric UM minutes and being maintained by Psychiatry Department).

B. The Utilization Management Department maintains an electronic file for each patient that is admitted to the psychiatric inpatient service.

C. Psychiatric Hospital Utilization Management Subcommittee maintains the following records that are emailed to the different departments on a monthly basis:

- Psychiatric Utilization Management Subcommittee Minutes (being maintained by the Psychiatric UR Chair)
- Psychiatric Denied Days Report (distributed to: Revenue Management-DHS , Psychiatric UR Chair, Psychiatric UR Subcommittee members through the UR Psychiatric Subcommittee monthly meeting)
- Monthly Psychiatric Acute & Administrative Days Report (distributed to: Revenue Management-DHS , Psychiatric UR Chair, Psychiatric UM Subcommittee members through the Psychiatric UM Subcommittee monthly meeting)

VII. PSYCHIATRIC ADMISSION CERTIFICATION

A. For Psychiatric Inpatients, admission certification will be performed within one (working) day of admission, or the next working day following admission (if the admission occurs on a weekend or holiday). Clinical chart reviews shall be documented and entered electronically into the Utilization Review Module, in ORCHID's Care Management application. Admission review is based on all notes from the day of admission which includes Psychiatric ER notes, ER nursing notes, Medicine notes, etc. History and Physical (H&P)/Psychiatric Initial Evaluation and must be completed by MD within 24 hours of admission. In addition, Initial Treatment Plan must be completed prior to any authorization of payment by a UR representative.

Acute inpatient mental health services are covered benefits of the County General Funds/Medi-Cal Program. For reimbursement consideration of Medi-Cal eligible beneficiaries admitted to a psychiatric inpatient hospital, the beneficiary shall meet the medical necessity criteria set forth in CCR Title 9 section 1820.205 as stated below:

1. One of the following INPATIENT SERVICE: MEDI-CAL INCLUDED ICD CODE 10-CM DIAGNOSES: (Attachment VII)
2. A beneficiary must have both a and b:
    a. Cannot be safely treated at a lower level of care except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and
    b. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 1 or 2 below:
        (1) Has symptoms or behaviors due to a mental disorder that (one of the following):
            a) Represent a current danger to self or others, or significant property destruction.
            b) Prevent the beneficiary from providing for, or utilizing food, clothing or shelter.

c) Present a severe risk to the beneficiary's physical health.
d) Represent a recent, significant deterioration in ability to function.

(2) Requires admission for one of the following:
a) Further psychiatric evaluation.
b) Medication treatment.
c) Other treatment that can reasonably be provided only if the patient is hospitalized.

B. The UM Nurse completes 2 sections of the BH UR admission review form in ORCHID accurately and timely:
   a. Admission Requirements 1:
      i. patient's level of functioning
      ii. appropriate ICD-10 diagnosis
      iii. Behavioral Risk Factors
      iv. Date and source of admission
   b. Admission Requirements 2:
      i. Date and time of H&P completion
      ii. Date and time of Initial Treatment Plan completion
      iii. Date of Attending Physician's signature on the Initial Treatment Plan
      iv. Client's signature and/or reason if patient is unable to sign
      v. Criteria for admission: met or not met
      vi. Legal status I and II
      vii. Anticipated Discharge disposition

   The UM Nurse must also complete a clinical manual review which is submitted electronically to the Physician Advisor for final decision and approval. If an admission is denied by the PA, the UM Nurse will complete the PA Referral Form (PDF fillable form - Attachment V) & the Notice of Denial Form (PDF fillable form - Attachment VI) to be given to the Attending physician indicating the reason/s for denial. If the Attending physician disagrees with the PA decision, an appeal can be filed in writing within 48 hours of notification. The appeal must contain justification supported by documentation in the medical record as to why decision must be overturned. The UM Nurse will follow procedure based on the final outcome (approval process vs. denial process).

   Admission is timed from the moment when the beneficiary is physically brought onto the inpatient unit and begins to receive care, which is usually documented in a nursing progress note or assessment. For purposes of Medi-Cal reimbursement, the admission is **NOT** considered to be the exact date and time of the physician's admitting order.

For **Medicare Inpatient Admission**, admission certification will be performed, using InterQual criteria, within one working day of admission, or the next business day following admission, if the admission occurs on a weekend or holiday. Only one InterQual (initial review) is needed for patients with MEDICARE. Complete IQ Initial Review for BH: Adult Psychiatry with the appropriate subset. Submit the review electronically to PA for final decision and approval.

C. A letter "Important Message from Medicare" (IM - Attachments I and III) is issued, explained and a signature is obtained from the beneficiary or his/her representative, by PFS/Admitting Staff or Utilization Management Representative **ONLY** if the Attending Physician of Record determines that the patient is physically, mentally, and emotionally capable of receiving such a notice. The IM letter contains the Medicare Beneficiary's Discharge and Appeal Rights, the original copy is placed in patient's chart and a copy of the IM letter is given to the patient. If the beneficiary and/or his/her representative refuses to sign the IM letter, document on the signature portion of the form that "patient refused to sign." The UM representative will sign and date the form and provide the patient with a signed copy.

D. Initial Treatment Plan
    1. The UM Nurse will verify completion of the Initial Treatment Plan within 3 days of admission. The Initial Treatment plan must be done by all Behavioral Health disciplines involved with the patient's care of a physician-approved treatment plan within three working days which includes the following:
        a. Diagnoses
        b. Problem formulation
        c. A description of the functional level of the individual
        d. Short- and long-term treatment goals
        e. Orders for necessary drug therapy, social therapy, behavior modification, psychotherapy, other appropriate intervention, and attention to any medical/surgical problems. Orders for diet and special procedures recommended for the health and safety of the patient
        f. Plans for continuing care, including review and modification to the plan of care
        g. Plans of discharge upon the day of admission
        h. Documentation of the beneficiary's degree of participation in and agreement with the treatment plan.
        i. Documentation of the physician establishment of the treatment plan.

E. All actions taken during admission review will be documented electronically in the Utilization Management application in Care Management Module, in ORCHID.

VIII. CONTINUED STAY REVIEW

A. Continued Stay Review is based on the Physician's Progress Notes, Nursing Notes and/or the Medical Case Worker (MCW) Progress notes. Reviews for each patient are completed on a daily basis. All acute and administrative clinical manual reviews are completed and submitted electronically to PA for final decision and approval.

Documentation on continued stay service days should reflect symptoms and behaviors **exhibited on that day and not on previous days, including the day of admission or days on which the patient was in Psychiatric ER to justify medical necessity.**

Essential services involved in diagnosis and treatment include:

1. Standard psychiatric work-up (including mental status examination) and initial physical examination.
2. Initial assessment of patient's social and family functioning, psychological strengths and assets, and available support systems, including community agencies. Identification of possible barriers to the patient's discharge.
3. Ongoing progress notes reflective of the client's social and familial functioning, psychological strengths and assets, and available support systems, including community agencies.

B. Acute Days: Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

1. Continued presence of indications that meet the medical necessity criteria.
2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
3. Presence of new indications that meet medical necessity criteria.
4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

The Utilization Management Nurse will not authorize continued stay in the absence of appropriate documentation of medical necessity, reflecting descriptive behaviors. The Utilization Management Nurse will notify the Attending Physician regarding the lack of documentation of the justification of medical necessity. The UM Nurse will follow procedure based on the final outcome (approval process vs. denial process).

All actions with respect to continued stay reviews will be documented electronically in to the Utilization Management application in Care Management Module, in ORCHID.

C. Denied Continued Stay Days: If the physician advisor finds that a continued stay is not justified due to lack of documentation, the UM Nurse submits an electronic clinical review to the PA for secondary review. Once the patient has been referred for

administrative day and the reviewer finds that a continued stay is not justified due to a delay in placement to non-billable disposition/facilities, the UR nurse will complete clinical manual reviews on a weekly basis. No secondary reviews necessary except when a client's condition changes to acute level of care or denial is due to an otherwise approved administrative day.

D. If the attending physician disagrees with the PA decision, an appeal can be filed in writing within 48 hours of notification. The appeal must contain justification supported by documentation in the medical record as to why decision must be overturned. The UR Nurse will follow procedure based on the final outcome (approval process vs. denial process).

IX. AUTHORIZATION FOR ADMINISTRATIVE DAYS

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

B. The UM nurse will notify the attending physician if the patient no longer meets medical necessity for acute level of care. The attending physician will place an order for administrative day referral.

   To meet this reimbursement criteria:

   i. Documentation must establish that the client previously met medical necessity for acute psychiatric hospital service during the current hospital stay.
   ii. For referrals to non-waivered facilities, documentation must state the lack of placement options and the contacts made with a minimum of 5 appropriate non-acute residential treatment facilities per week except if it is documented that there are fewer than 5 facilities available as placement options.
   iii. For referrals to waivered facilities through the Intensive Care Division-Countywide Resource Management (ICD-CRM) Program, ICD must be contacted within 24 hours of the administrative day order with documentation of status updates a minimum of every seven days.
   iv. Documentation requirements must include name of ICD/facility staff contacted, status of the placement option, date of contact and signature of the person making the contact.

C. Administrative Day approval process [see list of approved placement facilities]: (Attachment VIII)
    I. Waivered facilities (CRM):
        i. Authorization for administrative day will begin on the day of Physician's order for referral and will continue provided the reimbursement criteria is met except when a client's condition changes to acute level of care.
        ii. There must be MCW referral documentation within 24 hours of MD order for which administrative day is authorized.
        iii. When a client's condition changes to acute status during the referral period, acute day/s will be authorized with presence of documentation justifying acute level of care.
        iv. When a client no longer meets criteria for acute status, resume authorization of administrative days so long as the reimbursement criteria is met with documentation of ICD/facility staff name, status of the placement option, date of contact and signature of the person making the contact.

    II. Non-Waivered facilities: Residential Facilities with Mental Health Treatment Components (formerly known as Dual Diagnosis):
        i. Authorization for administrative day will begin on the day of Physician's order for referral when the reimbursement criteria is met.
        ii. There must be MCW referral documentation within 24 hours of MD order for which administrative day is authorized.
        iii. For each week, the number of successful contacts must be summed and multiplied by 1.4 which yields the number of reimbursable days in that particular week. The rule of multiplying the number of qualifying contacts X 1.4 days works for "weeks" with fewer than seven days.
        iv. A minimum number of 5 contacts must be made every 7 days except when except if it is documented that there are fewer than 5 facilities available as placement options.

D. Administrative Day Denial: See Denial Codes 50 series (Attachment IV)
    I. The patient does not meet administrative criteria due to:
        i. No acute day initially authorized
        ii. No clear and specific discharge plan
        iii. Patient or family refusal of placement
        iv. Lack of calls or successful referrals made by MCW/Waiver procedure not followed by MCW

v. Other reasons for denial not mentioned above will require a written comment (e.g., lack of status, court related delay, unreasonable delay in referral/acceptance, unsuccessful contact with 3 attempts, etc.)

For administrative days, the UR Nurse will complete the clinical manual review, and submit electronically to PA for final decision and signing. Once finalized, the UR nurse will allocate the days appropriately.

E. Non-Billable Days: See the denial codes 70s (Attachment IV). This applies when the disposition plan is to a lower level of care facility that are not approved for administrative day reimbursement criteria:
   I. Home
   II. Shelter
   III. Medical Skilled Nursing Facility
   IV. Board and Care Facility
   V. Independent/Assisted Living
   VI. Parole Placement
   VII. Regional Center placement
   VIII. Recuperative care (except Percy Village)
   IX. Full Service Partnership (FSP)
   X. Other discharge destinations that are not on the Gatekeeper List

F. Discharge Planning
   1. Discharge planning must be initiated at the time of admission in order to facilitate a timely discharge.
   2. Discharge planning does not require a physician's order and can be initiated by any non-physician health care provider. Discharge planning should not be confused with discharge order of which requires an MD order.
   3. The Utilization Management Nurse will review the discharge planning process and make recommendations.
   4. Documentation in the patient's medical record consisting of patient's diagnoses, therapy and psychosocial or other health related circumstances will be used as guide for discharge planning.
   5. Discharge planning shall include but not be limited to placement in alternative care facilities and arrangement for appropriate equipment and/or community resources available to improve or maintain a patient's health status on an outpatient basis.
   6. The patient, patient's family (if appropriate) and treating Physician of Record will be included in the discharge planning process.
   7. Discharge planning interventions must be documented in the patient's medical record.

X. MEDICAL CASE EVALUATION (MCE) STUDIES

The purpose of MCE studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

The Department of Psychiatry has two ongoing committees responsible for reviewing and monitoring quality of care within the department:

- Psychiatry Clinical Council Committee
- Utilization Management Psychiatric Subcommittee

The Psychiatry Clinical Council Committee:

- Identifies specific criteria that indicate possible issues related to the quality of care based on chart review, audit results, internal and external statistical data
- Reviews performance measures yearly and revises as necessary
- Maintains on-going quarterly statistical data related to the use of restraints and seclusion
- Monitors medication errors
- Maintains statistical data on average length of stay, census, admissions, discharged and readmissions within 30 days.
- Reports quarterly to the Quality Improvement Committee

The Utilization Management Psychiatric Subcommittee:

- Maintains monthly statistical data for all denied acute and administrative days with denial reasons
- Reports quarterly (or more frequently, if necessary) to the Psychiatry Clinical Council Committee.
- Reports monthly to the Medical Center Utilization Management Committee.

Any member of the Psychiatry Clinical Council Committee or the Utilization Management Psychiatric Subcommittee can draft a proposal for a Medical Care Evaluation Study. All draft proposals are reviewed by the Utilization Management Psychiatric Subcommittee. The Utilization Management Psychiatric Subcommittee, based on consensus, selects the draft study proposal to be conducted for the annual Medical Care Evaluation Study for the upcoming calendar year. The selected draft study proposal is submitted to the Medical Center Utilization Management Committee for final approval (Title 42).

MCE Study overall selection is based on the perceived impact of the study to promote the most efficient and effective use of health facilities and services as well as to improve the quality of patient care in comparison to the other draft proposals that were submitted to the Utilization Management Psychiatric Subcommittee.

Each annual study contains a description of the methods used to identify the study design and explain how data collection occurs. Study results are identified and used to improve the quality of care and promote more effective use of facilities and services. Findings are analyzed for each study and corrective actions taken, if needed.

Results are documented, including recommendations, if indicated, which improve quality of care and promote more effective and efficient use of services and facilities. Repeat monitoring identifies improvement or lack thereof. The results of the MCE studies will be used as a basis for continuing medical education, process improvement and upgrading the quality of patient care.

The hospital must have one MCE study in progress at any time and one completed study per calendar year.

XI. PAYMENT AUTHORIZATION

The Utilization Management Committee, through the Utilization Management Nurse and Utilization Management Physician Advisor will authorize initial payment for Short Doyle/Medi-Cal (SD/MC) inpatient psychiatric hospital stay. Payment for authorization process is as follows:

1. The Utilization Management Nurse performs an admission certification within one working day of admission and tracks psychiatric hospital stay on the Los Angeles General Medical Center Utilization Management Form.
2. The Utilization Management Nurse completes all required documentation on all admissions following the UM admission procedure.
3. The Utilization Management Nurse reviews each patient's hospital day from admission to discharge and follows the established reimbursement criteria.
4. Upon discharge, the Utilization Management Nurse completes all documentation for discharges following the UM discharge procedure.
5. The Utilization Management Nurse completes the Utilization Management Application in the Care Management Module in ORCHID. The AOD must accurately reflect the payer source, acute dates of service, administrative dates of service (Medi-Cal or Short Doyle), denied days, denial category, type and reason, including comments as applicable (example: for 50F, 70J and 13F Denial Codes).
6. At the beginning week of each month, clerical/administrative staff will review all discharges from the previous month for accuracy and completion of allocation of days. Monthly data reports will be discussed during the Psychiatric UM Subcommittee meeting and will be submitted to Fiscal Programs and Consolidated Business Office (CBO).
7. Consolidated Business Office (CBO) follows the Inpatient Mental Health Billing Procedures to ensure compliance in the billing of Inpatient Psychiatry Services to the Department of Mental Health (CGF) and Medi-Cal.

LOS ANGELES GENERAL MEDICAL CENTER
HEALTHCARE NETWORK
UTIIZATION MANAGEMENT PLAN

APPENDIX: UTILIZATION MANAGEMENT FORMS

Important Message from Medicare

Patient name: **Patient number:**

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: **LIVANTA LLC Tel: 1(877)588-1123.** The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO **LIVANTA LLC Tel: 1(877)588-1123** to appeal, or if you have questions.

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO **[LIVANTA LLC Tel: 1(877)588-1123]**.
- If you belong to a Medicare health plan: Call your plan.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

Signature of Patient or Representative

Date / Time

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Los Angeles General
Medical Center

Exceptional Care. Healthy Communities.

2051 Marengo Street
Inpatient Tower (IPT)
2nd Floor, Room C2K100
Los Angeles, CA 90033

Tel: (323) 409-2800
Fax: (323) 441-8030

"To provide world-class care and education for all in our community."

Los Angeles General Medical Center
Utilization Review Department
1100 N. State St, CT Bldg. Rm. 7B303
Los Angeles CA 90033

Patient Name:

MRUN#:

Admit Date:

NOTICE OF HOSPITAL BILL RESPONSIBILITY or CONTINUED STAY DENIAL NOTICE

You have received emergency care/continued hospitalization at Los Angeles General Medical Center. Los Angeles General Medical Center is not a part of your health plan's provider network. Under State law, emergency care must be paid by your health plan, no matter where you received Care.
Your Los Angeles General Medical Center physician has determined that you no longer require emergency care or continued hospitalization at this hospital, and you are stable to be safely transferred to another hospital or other facility [ ] for additional care. Therefore, your health plan has not authorized further care at Los Angeles General Medical Center. Los Angeles General Medical Center has arranged for you to be moved to a hospital or other facility that is in your health plan's provider network.

If you agree to be moved, your health plan will pay for your care at the contracted, receiving hospital. You will not have to pay a deductible, co-payment, or co-insurance for transportation to the contracted, receiving hospital. You will only be responsible for your deductible, co-payments, or co-insurance for the care you have received at Los Angeles General Medical Center up to the time of this notice.

If you choose to stay at Los Angeles General Medical Center, you will have to pay the full cost of care from [ ] until you are discharged.

If you do not think you can be safely moved, talk to your Los Angeles General Medical Center physician about your concerns. If you would like additional help, you may contact your health plan member services department. Look on your plan member card for that phone number. You can file a grievance or complaint with your health plan.

Patient Name:

Date:

If you have LA Care Health Plan, you may file your grievance with:

L.A. Care Health Plan Member Services Department
1055 West 7th Street
Los Angeles, CA 90017
1-888-839-9909 (phone) 1-213-438-5748 (fax)
www.lacare.org

If you have Health Net Health Plan, you may file your grievance with: Health Net Appeals & Grievances
P.O. Box 10348
Van Nuys, CA 91410-0348
1-800-675-6110 (phone) 1-877-713-6189 (fax)
www.healthnet.com

State Fair Hearing is another way that you can file your grievance or appeal.
California Department of Social Services
State Hearings Division
P.O. Box 944243 MS 09-17-37
Sacramento, CA 94244-2430

Medical Managed Health Care
Department of Managed Health Care California Help Center
980 9th Street, Suite 500 Sacramento, CA 95814-2725
Online: Complaint / Independent Medical Review (IMR) Application Form

A copy of this written notice will be given to you, your spouse or legal guardian for signature and a copy will be retained in your medical record.

Your health care service plan or its contracting medical provider will receive confirmation of this written notice.

If you, your spouse, or legal guardian refuse to sign this notice, it will be documented in your medical record that the notice was provided, and signature was refused. Upon your, your spouse or legal guardian refusal to sign, the patient shall assume financial responsibility for any further non-emergency care provided by Los Angeles General Medical Center.

Patient/Parent/Conservator/Guardian_____

Date _____ Time _____

If signed by other than patient, indicate

relationship_____

Witness_____

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Medical Center

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Tel: (323) 409-2800
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"To provide world-class care and education for all in our community."

Los Angeles General Medical Center
Utilization Review Department
1100 N. State St, CT Bldg. Rm. 7B303
Los Angeles CA 90033

Patient Name:
MRUN#:
Admit Date:

NOTICE OF HOSPITAL BILL RESPONSIBILITY or DENIAL NOTICE DUE TO REFUSAL TO BE DISCHARGE

You have received continued hospitalization at Los Angeles General Medical Center. Please be informed that effective [ ], your attending physician [ ], has determined that you are stable to be discharged to [a lower level of care or your home]. Los Angeles General Medical Center Department of Utilization Management agrees with this decision.

Since you and/or your representative refused to be discharged and you want to remain at Los Angeles General Medical Center, you or your representative will be financially responsible for all services rendered beginning [ ], as your primary health insurance coverage will cease covering the continued hospitalization. The minimum all-inclusive daily rate for a [ ] is [ ] per day.

If you leave on [ ], you will not be liable for the costs for the care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by your insurance. If you choose to stay at Los Angeles General Medical Center, you will have to pay the full cost of care from [ ] until you are discharged. If you require assistance to make discharge arrangements or need to discuss further health related concerns or issues, please talk with your Physician.

Patient/Parent/Conservator/Guardian_____
Date _____ Time _____
If signed by other than patient, indicate relationship_____
Witness_____

Sincerely,

Los Angeles General Medical Center
UM Medical Director

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

Los Angeles General Medical Center
Exceptional Care. Healthy Communities.

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  _____ Medicare Managed Care policies, if applicable: _____ _____ {insert specific managed care policies}

  _____ Other _____ {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _____{insert hospital and/or plan telephone number}.

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CMS 10066 (approved xx/2016)

Instructions for Completing the Detailed Notice of Discharge
CMS 10066

This is a standardized notice. Hospitals may not deviate from the content of the form except where indicated. Please note that the OMB control number must be displayed on the notice. Insertions must be typed or legibly hand-written in 12-point font or the equivalent.

Hospitals or plans may modify the following sections to incorporate use of a sticker or label that includes this information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in the patient's ID number. This should not be, nor should it contain, the patient's social security or HICN number.

Physician: Fill in the name of the patient's physician.

Date Issued: Fill in the date the notice is delivered to the patient by the hospital/plan.

Insert logo here: Hospitals/plans may elect to place their logo in this space. However, the name, address, and telephone number of the hospital/plan must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number (including TTY) of the hospital/plan must appear above the title of the form.

BLANK 1: "**This notice gives you a detailed explanation of why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on** _____. In the space provided, fill in planned date of discharge.

First Bullet: **"Medicare Coverage Policies:"** Place a check next to the applicable Medicare and/or managed care policies. If necessary, hospitals may also use the selection "Other" to list other applicable policies, guidelines or instructions. Hospitals or plans may also preprint frequently used coverage policies or add more space below this line, if necessary. Policies should be written in full sentences and in plain language. In addition, the hospital or plan may attach additional pages or specific policies or discharge criteria to the notice. Any attachments must be included with the copy sent to the QIO as well.

Second Bullet: **"Specific information about your current medical condition"** Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. Use full sentences and plain language.

Third Bullet: **"If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call** _____." The hospital/plan should also supply a telephone number for patients to call to get a copy of the relevant documents sent to the QIO. If the hospital/plan has not attached the Medicare policies and/or the Medicare managed care plan policies used to decide the discharge date, the hospital should supply a telephone number for patients to call to obtain copies of this information.

Hospitals or plans may add space below this section to insert a signature line and date, if they so choose.

DENIAL CODES

Acute Inpatient Admission Criteria Not Met Per Medical Record Documentation

13-A No DSM-IV Diagnosis Present for Admission to an Acute Inpatient Care Facility
13-B Use of Abbreviations for Admission Diagnosis
13-C Patient No Longer a Danger to Self/Danger to Others/Gravely Disabled at time Admission
13-D InterQual Criteria Not Met for Admission to an Acute Inpatient Care Facility (For Medicare Patients Only)
13-E Admission for Placement to Lower Level of Care Facility Only
13-F Other regarding Admission Denial - Written Comment Needed

Missing Treatment Plan/Psychiatric H&P/Psychiatric Inpatient Evaluation/Discharge Plan/Psychosocial Assessment within Mandated Timeframe of Admission

20-A No Treatment plan within 72 Hours of Admission
20-B No Psychiatric H&P/Psychiatric Inpatient Evaluation within 24 hours of Admission
20-C No Discharge Plan Documented within 72 Hours of Admission
20-D No Psychosocial Assessment within 72 Hours of Admission

Incomplete Treatment Plan/Medical Evaluation/Psychiatric Evaluation within Mandated Timeframe of Admission Incomplete Treatment Plan within 72 hours of Admission

21-A Missing Patient Signature
21-B Missing Documentation if Patient Refused/Unable to Sign
21-C Missing Current GAF
21-D Missing Past GAF (if known)
21-E Missing MD Signature
21-F Missing Symptoms, Complaints, and/or Complications Indicating Need for Admission
21-G Missing Description of Functional Level of the Beneficiary
21-H Missing Objectives
21-I Missing Orders for Medications, Treatments, Activities, Therapy, Restorative Rehabilitative Services, Social Services, Diet, Special Procedures Recommended for the Health and Safety of the Beneficiary.
21-J Missing Plans for Continuing Care, Including Review and Modification of the Plan of Care
21-K Missing Plans for Discharge
21-L Missing Nursing Signature
21-M Missing Social Work/Caseworker Signature
21-N Missing Occupational/Recreational Therapy Signature
21-O Missing Resident Signature
21-P Missing Psychologist Signature
21-Q Missing Patient's Primary Language/Language Needs

Incomplete Medical Evaluation/Psychiatric Evaluation within 24 hours of Admission

21-R Incomplete Medical Evaluation
21-S Incomplete Psychiatric Evaluation

**** DENOTES CHANGES**
REVISED JULY 2015

Treatment Plan Not Updated Weekly/Missing Multidisciplinary Staff Initials/Signatures

22-A Treatment Plan Not Updated Weekly
22-B Missing Multidisciplinary Staff Initials/Signatures
22-C Missing Documentation of Patient's Degree of Participation and Agreement of the Treatment Plan

****Medical Record Documentation Does Not Meet Criteria for Continued Acute Inpatient Stay**

30-A Documentation Does Not Justify Continued Stay/Not Descriptive for an Acute Inpatient Facility
30-B No Documentation of Interpreter being used when Primary Language is not English (As indicated on the Multidisciplinary Assessment Form)
30-C Missing Daily Team Progress Note
30-D Documentation Does Not Meet InterQual Criteria for Continued Inpatient Stay (For Medicare Patients Only)

Delay in Services/Discharge/Transfer

40-A Delay in Patient Discharge or Transfer d/t Delay in Ancillary (includes lab results, radiological scans/procedures)
40-B Delay in Patient Discharge or Transfer d/t Delay in Medicine/Surgical/Specialty Physician Consult
40-C Other regarding Delays-Written Comment Needed

****Administrative Day Denial**

50-A Patient Does Not Meet Administrative Criteria - Discharge to Facility NOT on Gatekeeper List
50-B Patient Does Not Meet Administrative Criteria - **NO Acute** Day Initially Authorized
50-C Patient Does Not Meet Administrative Criteria - NO Clear and Specific Discharge Plan
50-D Patient/Family Refuse Placement
50-E Denial Due to Lack of Calls/Referral to Gate Keeper by Social Work/Waiver Procedure Not Followed by Social Work
50-F Other Regarding Administrative Day Denial - Written Comment Needed
Patient Does Not Meet Administrative Criteria—Discharge to Recuperative Care Facility

Acute Inpatient Discharge Criteria Not Met Per Medical Record Documentation

60-A No DSM-IV Discharge Dx
60-B Use of Abbreviations for Discharge

****Lower Level of Care – Non Billable Days**

70-A Lower Level of Care – Discharge to Home
70-B Lower Level of Care – Discharge to Shelter
70-C Lower Level of Care – Discharge to Street
70-D Lower Level of Care – Discharge to Medical SNF
70-E Lower Level of Care – Discharge to Board & Care/Independent/Assisted Living
70-F Lower Level of Care – Discharge Arranged by Parole Officer
70-G Lower Level of Care – Discharge Arranged by Regional Center Case Manager
70-H Lower Level of Care – Discharge to Recuperative Care (if not Percy Village)
70-I Lower Level of Care – Discharged Arranged by Full Service Partnership (FSP)
70-J Lower Level of Care – Others

ATTACHMENT VI

LOS ANGELES GENERAL MEDICAL CENTER
HEALTHCARE NETWORK
UTILIZATION MANAGEMENT

PHYSICIAN ADVISOR REFERRAL

Date: _____

PATIENT: _____ MRUN#: _____ ADMIT DATE: _____

WARD CHIEF: _____ WARD: _____ DX: _____

☐ M-CAL#: _____ ☐ M-CARE#: _____ ☐ OTHER: _____ UNK: _____

TO BE COMPLETED BY UR COORDINATOR:

After review of this patient's medical record, I am referring the case for review of:

☐ ADMISSION _____

_____

☐ CONTINUED STAY _____

PLACEMENT: ☐ LOCKED SNF ☐ ENRICHED B&C ☐ DUAL DIAGNOSIS ☐ IMD ☐ METRO

☐ FULL SERVICE PROGRAM OTHER _____

COMMENTS: _____

_____

****

TO PHYSICIAN ADVISOR:

Dr. Keshishian:

Please review this case and advise as to the action you feel is appropriate.

Thank you.

TO BE COMPLETED BY PHYSICIAN ADVISOR:

Chart review done ☐

After review of this case, I advised:

ACUTE STATUS from _____ to _____

DENIED STATUS from _____ to _____

ADMINISTRATIVE DAYS from _____ to _____

The decision is based on the following rationale:

_____

_____

_____

PA Signature _____ Date: _____

LAC+USC MEDICAL CENTER
AUGUSTUS F. HAWKINS MENTAL HEALTH FACILITY
UTILIZATION REVIEW DEPARTMENT

NOTICE OF DENIAL

TO: Ward Chief _____

FROM: UR Case Manager _____ PHONE: _____

SUBJUECT: Patient _____ Admit Date _____

MRUN# _____ Ward _____

Based upon current medical information, it has been determined by the physician consultant, Dr. Keshishian, that payment can no longer be certified at the acute level of care as of _____.

Denial Reasons

_____ Does not meet criteria for admission
_____ No Treatment Plan within 72 hrs or Incomplete Treatment Plan (Plan of Care)
_____ Insufficient documentation for need of further acute care
_____ Delay in service: _____
_____ Patient at lower level of care: not eligible for administrative days
_____ Eligible for administrative days: placement attempts are not documented

NOTE:
IF YOU DISAGREE with the above decision, you must appeal to the physician advisor in writing no later than _____.
The appeal must contain justification supported by documentation in the record as to why decision should be reversed.
If no response is received by the above date, the decision will stand.
IF YOU AGREE with the decision, please sign below. Direct all responses to:
UTILIZATION REVIEW
UR Mail @ Medical Records *or*
UR Mail Box @ Dr. Keshishian's Office

_____ Agree with Decision

_____ _____
Date Physician

_____ I wish to appeal the above decision based on:

_____

_____ _____
Date Physician

UR Response received _____ No response received by _____

4-28-11
6/12/2019

INPATIENT
“INCLUDED” ICD-10-CM DIAGNOSES

Updated: May 6, 2022

INPATIENT SERVICE: MEDI-CAL INCLUDED ICD-10-CM DIAGNOSIS	
ICD 10	**Diagnosis Description**
F01.51	Vascular dementia with behavioral disturbance (aggressive, combative, violent behavior)
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F11.14	Opioid abuse with opioid-induced mood disorder
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.24	Opioid dependence with opioid-induced mood disorder
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.94	Opioid use, unspecified with opioid-induced mood disorder
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.988	Opioid use, unspecified with other opioid-induced disorder
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations

F12.980	Cannabis use, unspecified with anxiety disorder
F13.14	Sedative, hypnotic or anxiolytic abuse with mood disorder
F13.150	Sedative, hypnotic or anxiolytic abuse with psychotic disorder with delusions
F13.151	Sedative, hypnotic or anxiolytic abuse with psychotic disorder with hallucinations
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.250	Sedative, hypnotic or anxiolytic dependence with psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with psychotic disorder with hallucinations
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations

F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.94	Inhalant use, unspecified, with inhalant-induced mood disorder
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.94	Inhalant use, unspecified, with inhalant-induced mood disorder

F18.980	Inhalant use, unspecified, with inhalant-induced anxiety disorder
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.180	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F30.9	Manic episode, unspecified

F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, mod
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depress, mild or mod severe, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate

F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.41	Major depressive disorder, recurrent, in partial remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorder
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F40.00	Agoraphobia, unspecified
F40.01	Agoraphobia with panic disorder
F40.02	Agoraphobia without panic disorder
F40.10	Social phobia, unspecified
F40.11	Social phobia, generalized
F40.210	Arachnophobia
F40.218	Other animal type phobia
F40.220	Fear of thunderstorms
F40.228	Other natural environment type phobia
F40.230	Fear of blood
F40.231	Fear of injections and transfusions
F40.232	Fear of other medical care
F40.233	Fear of injury
F40.240	Claustrophobia
F40.241	Acrophobia

F40.242	Fear of bridges
F40.243	Fear of flying
F40.248	Other situational type phobia
F40.290	Androphobia
F40.291	Gynephobia
F40.298	Other specified phobia
F40.8	Other phobic anxiety disorders
F41.0	Panic disorder [episodic paroxysmal anxiety]
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42.2	Mixed obsessional thoughts and acts
F42.3	Hoarding disorder
F42.4	Excoriation disorder
F42.8	Other obsessive-compulsive disorder
F42.9	Obsessive-compulsive disorder, unspecified
F43.0	Acute stress reaction
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F43.20	Adjustment disorder, unspecified
F43.21	Adjustment disorder with depressed mood
F43.22	Adjustment disorder with anxiety
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F43.24	Adjustment disorder with disturbance of conduct
F43.25	Adjustment disorder with mixed disturbance of emotions and conduct
F43.29	Adjustment disorder with other symptoms
F43.8	Other reactions to severe stress
F43.9	Reactions to severe stress, unspecified
F44.0	Dissociative amnesia
F44.1	Dissociative fugue

F44.2	Dissociative stupor
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F44.81	Dissociative identity disorder
F44.89	Other dissociative and conversion disorders
F45.0	Somatization disorder
F45.1	Undifferentiated somatoform disorder
F45.20	Hypochondriacal disorder, unspecified
F45.21	Hypochondriasis
F45.22	Body dysmorphic disorder
F45.29	Other hypochondriacal disorders
F45.41	Pain disorder exclusively related to psychological factors
F45.42	Pain disorder with related psychological factors
F45.8	Other somatoform disorders
F45.9	Somatoform disorder, unspecified
F48.1	Depersonalization-derealization syndrome
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F53.0	Postpartum depression
F53.1	Puerperal psychosis
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder

F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.9	Personality disorder, unspecified
F63.1	Pyromania
F63.81	Intermittent explosive disorder
F63.89	Impulse disorder, unspecified
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other conduct disorders
F91.9	Conduct disorder, unspecified
F93.0	Separation anxiety disorder of childhood
F93.8	Other childhood emotional disorders
F93.9	Childhood emotional disorder, unspecified
F94.0	Selective mutism
F94.1	Reactive attachment disorder of childhood
F94.2	Disinhibited attachment disorder of childhood
F95.0	Transient tic disorder

F95.1	Chronic motor or vocal tic disorder
F95.2	Tourette's disorder
F95.8	Other tic disorders
F95.9	Tic disorder, unspecified
F98.0	Enuresis not due to a substance or known physiological condition
F98.1	Encopresis not due to a substance or known physiological condition
F98.21	Rumination disorder of infancy
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood
F98.4	Stereotyped movement disorders
R15.0	Incomplete defecation
R15.9	Full incontinence of feces

DEPARTMENT OF MENTAL HEALTH
RESIDENTIAL FACILITIES WITH MENTAL HEALTH TREATMENT COMPONENTS

These facilities do not fall under the LAC DMH gatekeeping waiver with the State. Clinical record documentation must reflect required elements necessary for Short-Doyle/Medi-Cal administrative day reimbursement pursuant to the California Code of Regulations, Title 9, Chapter 11, Section 1820.230(d)(2)(A)&(B) and 1820.220(j)(5)(A)&(B).

Antelope Valley Rehabilitation Center
30500 Arrastre Canyon Road
Acton, CA 93510
661-223-8700

BRIDGES FACILITIES
Casitas Esperanza
Casitas Tranquilas
11927 Elliot Avenue
El Monte, CA 91732
626-350-5304

Hacienda Retirada
8514 Topanga Canyon Blvd.
Canoga Park, CA 91306
818-999-0143

Primer Paso
20401 Roscoe Blvd.
Canoga Park, CA 91306
818-998-1565

***California Hispanic Commision on Alcohol And Drug Abuse, Inc.**
2309 Daly St.
Los Angeles, CA 95816
323-222-4591

Eden Dual Diagnosis Program/Shield for Family
11601 S. Western Ave.
Los Angeles, CA 90047
323-242-5000 Ext. 234

Phoenix Houses of Los Angeles, Inc.
503 Ocean Front Walk
Venice, CA 91342
310-392-3070

River Community
23701 East Fork Road
Azusa, CA 91702
626-332-3145

***SOUTHERN CALIFORNIA ALCOHOL AND DRUG**
Corporate Office – Heidi Hobart
DMH Residential Contract
11500 Paramount Blvd.
Downey, CA 90241
562- 923-4545 Ext. 2233

Folley House
10511 Mills Avenue
Whittier, CA 90604
562-944-7953

Positive Steps (HIV & S/A&MI)
11501 Dolan Street
Downey, CA 90241
562-923-7894

Tarzana Treatment Center
Main Office
18646 Oxard St.
Tarzana, CA 91356
818-996-1051

*Please note: These residential alcohol and drug sites have a separate mental health treatment component.

U:S&QA:DHS:Admin Days Res Facilities

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION
24-HOUR RESIDENTIAL FACILITY LIST

STATE HOSPITAL:

Atascadero State Hospital (no direct LPS admission) 10333 El Camino Real Atascadero, CA 93422-5808 Ph: (805) 468-2000	**Metropolitan State Hospital** 11401 S. Bloomfield Ave. Norwalk, CA 90650-2015 Ph: (562) 863-7011	**Napa: State Hospital** 2100 Napa Vallejo Hwy Napa, CA 94558-6293 Ph: (707) 253-5000	**Patton State Hospital** (no direct LPS admission) 3102 E. Highland Ave. Patton, CA 92369-7813 Ph: (909) 425-7000
Coalinga State Hospital (no direct LPS admission) 24511 W. Jayne Avenue Coalinga, CA 93210 Ph: (559) 935-4300			

IMD SUBACUTE:

Crestwood Fallbrook Healing Center MHRC 624 E. Elder Avenue Fallbrook CA, 92028 Ph: 760-451-4165 Fax: 760-731-1377	**La Paz** 8835 Vans Street Paramount, CA 90723-4656 Ph: (562) 633-5111 Fax: (562) 408-1120	**Olive Vista Center** 2335 S. Towne Pomona, CA 91766-6227 Ph: (909) 628-6024 Fax: (909) 628-1839/(610) 612-3495
Shandin Hills 4164 N. Fourth Ave. San Bernardino, CA 92407-2908 Ph: (909) 886-6786 Fax: (909) 886-2953	**Sierra Vista** 3455 E. Highland Ave. Highland, CA 92346-2214 Ph: (909) 862-6454 Fax: (909) 864-1337	**California Psychiatric Transition MHRC** 9226 N. Hinton Ave. Delhi, CA 95315 Ph: (209) 667-9304 x201 Fax: (209) 425-4701

Alpine Special Treatment Center MHRC 2120 Alpine Blvd. Alpine, CA 91901-2113 Ph: (619) 445-2644 Fax: (619) 445-0444	**Community Care Center** 2335 S. Mountain Ave. Duarte, CA 91010-3559 Ph: (626) 357-3207 Fax: (626) 303-1116	**Harborview Center MHRC** 490 West 14th Street Long Beach, CA 90813-2943 Ph: (562) 591-8701 Fax: (562) 591-0235
La Casa MHRC 6060 Paramount Blvd. Long Beach, CA 90805-3711 Ph: (562) 634-9534 Fax: (562) 531-4567	**Landmark Medical Center** 2030 No. Garey Ave. Pomona, CA 91767-2722 Ph: (909) 593-2585 Fax: (909) 593-4120	**Laurel Park Center** 1425 West Laurel Ave. Pomona, CA 91768-2837 Ph: (909) 622-1069 Fax: (909) 622-4319
Meadowbrook Manor 3951 East Blvd. Los Angeles, CA 90066-4605 Ph: (310) 391-8266 Fax: (310) 390-9878	**View Heights Convalescent** 12619 South Avalon Blvd. Los Angeles, CA 90061-2727 Ph: (323) 757-1881 Fax: (323) 757-0601	**Stoney Point SNF** 21820 Craggyview St. Chatsworth, CA 91311 Ph: (818) 882-8233

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION
24-HOUR RESIDENTIAL FACILITY LIST

ENRICHED RESIDENTIAL SERVICES (ERS):
(Affiliated B&Cs not included)

Anne Sippi Clinic 5335 Craner Ave. North Hollywood, CA 91601 Ph: (818) 927-4045 Fax: (818) 927-4016	**Bridges – Casitas Esperanza** 11927 Elliott Ave. El Monte, CA 91732-3740 Ph: (626) 350-5304	**Cedar Street Homes** 11401 Bloomfield St. Bldg. 305 Norwalk, CA 90650-2015 Ph: (562) 207-9660 Fax: (562) 207-9680
Percy Village 4063 Whittier Blvd., Suite #202 Los Angeles, CA 90023 (323) 268-2100 ext. 234 Fax (323) 263-3393 eFax 323-983-7530	**Telecare 7** 4335 Atlantic Blvd. Long Beach, CA 90807-2803 Ph: (562) 216-4900 Fax: (562) 484-3039	**Normandie Village East–** 1338 S. Grand Ave Los Angeles, CA 90015 Ph: (213) 389-5820 Fax: (213) 389-5802
Special Services for Groups (SSG) 11100 Artesia Blvd. Ste. A Cerritos, CA 90703-2547 Ph: (562) 865-1733 Fax: (213) 389-7993		

CRISIS RESIDENTIAL TREATMENT PROGRAM (CRTP):

Hillview Crisis Residential 12408 Van Nuys Blvd., Bldg. C Pacoima, CA 91331 Ph: (818) 896-1161 x 401	**Didi Hirsch Excelsior House** DiDi Hirsch Comm. MH 1007 Myrtle Ave. Inglewood, CA 90301 Ph: (310) 412-4191 Fax: (310) 412-3942	**Didi Hirsch Jump Street CRTP** DiDi Hirsch Comm. MH 1233 S. La Cienega Blvd. Los Angeles, CA 90035 Ph: (310) 895-2343 Fax: (310) 855-0138
Exodus CRTP 3754-3756 Overland Avenue Los Angeles, CA 90034 Ph: (424) 384-6130 Fax: (213) 265-3290	**Freehab (Teen Project) CRTP** 8142 Sunland Blvd., Sun Valley, CA 91352 Phone: (818) 582-8832 Fax: (818) 582-8836	**Gateways CRTP** 423 N. Hoover Street Los Angeles, CA 90004 Ph: (323) 300-1830 Fax: (323) 664-0064
Safe Haven CRTP – 12580 Lakeland Rd. Santa Fe Springs, CA 90670 Phone: (562) 210-5751	**SSG Florence House CRTP** 8627 Juniper Street Los Angeles, CA 90002 Phone: (323) 537-8979	**Valley Star MLK CRTP** 12021 Wilmington Ave. Los Angeles, CA 90059 Phone: (213) 222-1681
Telecare Olive House CRTP 14149 Bucher Ave. Sylmar, CA 91342 Phone: (747) 999-4232	**Telecare Citrus House CRTP** 7725 Leeds Street Bldg. D Downey, CA 90242 Phone: (562) 445-3001	**Telecare Magnolia House CRTP** 1774 Zonal Ave RTP, Bldg. D Los Angeles, CA 90033 Phone: (323) 992-4323

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION
24-HOUR RESIDENTIAL FACILITY LIST

Central Star Rancho Los Amigos CRTP 7745 Leeds St. Downey, Ca 90242 Phone: (562) 719-2866		

23-HOUR ADULT URGENT CARE CENTERS:

SERVICE AREA 1 – Lancaster, Palmdale Starview High Desert UCC 415 East Avenue I Lancaster, CA 93535 Ph: (661) 522-6770 Fax: (661) 723-9079	SERVICE AREA 2 – SAN FERNANDO VALLEY Behavioral Health UCC 14228 Saranac Lane Sylmar, CA 91342 Ph: (747) 315-6108 Office, (747) 315-6100 Main
SERVICE AREA 3 – EAST (City of Industry/East San Gabriel Valley 18501 Gale Ave. Ste. 100 City of Industry, CA 91748 Ph: (626) 626-4997	SERVICE AREA 4 – DOWNTOWN (EASTSIDE) EXODUS URGENT CARE CENTER 1920 Marengo Street Los Angeles, CA 90033 Ph: (323) 276-6400 Fax: (323) 276-6498
SERVICE AREA 5 – WEST LOS ANGELES (WESTSIDE) EXODUS URGENT CARE CENTER 11444 W. Washington Blvd. STE D Los Angeles, CA 90066-6024 Ph: (310) 253-9494 Fax: (310) 253-9495	SERVICE AREA 6 – SOUTH LOS ANGELES MLK URGENT CARE CENTER by Exodus 12021 S. Wilmington Ave. Los Angeles, CA 90059 Ph: (562) 295-4617
SERVICE AREA 8 – SOUTH LA CASA MENTAL HEALTH URGENT CARE CENTER 6060 Paramount Blvd. Long Beach, CA 90805 Ph: (562) 790-1860 Fax: (562) 529-2463	SERVICE AREA 8 - SOUTH HARBOR EXODUS URGENT CARE CENTER 1000 W Carson Street, Bldg 2 South Torrance, CA 90502 Ph: (424) 405-5888
SERVICE AREA 8 – SOUTH STARS BEHAVIORAL HEALTH URGENT CARE CENTER 3210 Long Beach Blvd. Long Beach, CA 90807 Ph: (562) 548-6565	SERVICE AREA 8 – SOUTH PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER SAN PEDRO 1300 W. 7th Street San Pedro, CA 90732 Ph: (310) 832-3311

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
Psychiatric Social Worker/Medical Casework Referral Note

_____ requires placement into a(n)_____facility.
Patient Name

Check all the facilities in a category you consider appropriate for placement.

State Hospital, Subacute, Enriched Residential Services, and Intensive Residential (only available facilities for this level of care)

Check all appropriate facilities:

State Hospital ____

Subacute
Alpine STC I,II, III _____
California Psychiatric Transitions _____
Community Care Center ____
Crestwood – Fallbrook I, II, III _____
Harborview Ctr LLC I, II, III _____
La Casa MHRC _____
La Paz Geropsychiatric Ctr _____
Landmark Medical Ctr ____
Las Encinas (Transitional IMD)____
Laurel Park _____
Meadowbrook Manor ____
Olive Vista _____
Penn Mar (Transitional IMD)____
Shandin Hills _____
Sierra Vista _____
View Heights ___

Enriched Residential Services
Anne Sippi _____
Bridges - Casitas Esperanza _____
Cedar Street _____
Normandie Village _____
Percy Village _____
SMR River Community _____
SSG _____
Telecare 7____

Intensive Residential
Excelsior House _____
Exodus CRTP _____
Freehab CRTP _____
Gateways CRTP _____
Hillview Residential Center _____
Jump Street _____

Referral to: Intensive Care Division (ICD)
510 S. Vermont Ave. 20th Floor
Los Angeles, CA 90020
Office: (213) 738-4775
Fax: (213) 947-1609

ICD Officer of the Day: _____

Bed Available: Yes _____ No _____ Wait List # _____

Hospital Staff Signature: _____

Date: _____

Date	Notes

Psychiatric Social Worker/Medical Casework Referral Note

Patient Identification

File in Medical Record
Form Revised 3/16/2022

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Intensive Care Division Referral Packet Cover Letter

Send To: Intensive Care Division
510 S. Vermont Ave., 20th Floor
Los Angeles, CA 90020
O: (213) 738-4775
F: (213) 947-1609

FACILITY NAME: _____

CLIENT NAME: _____ IBHIS#: _____

On_____, a telephone referral was made to LACDMH Intensive Care Division.
Date

On_____, the following information was mailed to LACDMH Intensive Care
Date
Division for the purpose of placement.

Hospital Staff Signature: _____ Date: _____

DIRECTIONS: Check in the right-hand column for each document included or indicate NA if not applicable. Explain in the right-hand column, next to the document name, why a required document is not included.	
Hospital face sheet	
Conservatorship Letters and Orders (Powers and Detain and Treat). Mark NA if not LPS conserved.	
If privately LPS conserved, a written consent letter from the private conservator stating that "the client can be evaluated for placement."	
Comprehensive Medical History and Physical	
Psychosocial Assessment	
Admitting Psychiatric Evaluation (complete with 5 Axis diagnosis)	
Medication Administration Sheets (at least 2 weeks)	
PRN Medication Sheets (all notes); Note: See above if included with Med Administration	
Lab and X-ray results (all reports)	
Drug Screen (mark NA if not Ordered/Obtained)	
PPD or Chest x-ray results (within 30 days)	
VDRL results (STD screen or RPR panel)	
COVID-19 Vaccination Records	
All restraints & seclusions records (mark NA if patient was never restrained or secluded)	
Interdisciplinary Progress Notes (Nursing & Social Work Notes) preferred last 2 weeks	
Psychiatrist's Progress Notes (preferred last 2 weeks); If integrated with Nursing & Social Work Notes, mark "see IPN"	

NOTES: _____
_____

LACDMH Intensive Care Division Referral Packet

Cover Letter FILE IN MEDICAL RECORD

Patient Identification

Rev. 5.25.2022

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION

COUNTY HOSPITAL WAITING LIST STATUS

***THIS IS NOT A PRE-AUTHORIZATION FOR ADMISSION TO ANY FACILITY.**

DATE: _____

Reply: Intensive Care Division
510 S. Vermont Ave. 20th FL
Los Angeles, CA 90020
Office: 213-738-4775
Fax: 213-947-1609

CLIENT NAME: _____ IBHIS#: _____

TO: _____ (HOSPITAL)

ATTN: _____ (DISCHARGE PLANNER)

At your request, your client was evaluated by _____ to determine his/her appropriateness for placement in one of the facilities listed below. The Department of Mental Health has determined the facilities identified below meet your client's needs.

Officer-of-the-Day's Signature: _____

DMH DETERMINATION OF APPROPRIATE FACILITIES	**DHS FOLLOW-UP CONTACTS WITH ICD OFFICER-OF-THE-DAY** (at least every 7 days but whenever there is a change in the status of patient)				
State Hospital, Subacute, Enriched Residential Services, & Intensive Residential (only available facilities for these levels of care)	Date of Call to Care Coordinator	Bed Available		Wait-List Number	Staff Signature
		Yes	No		
State Hospital: ☐					
Subacute:					
Alpine STC I,II, III ☐					
Crestwood – Fallbrook I, II, III ☐					
Harborview Ctr LLC I, II, III ☐					
California Psychiatric Transitions ☐					
Community Care Center ☐					
La Casa MHRC ☐					
Landmark Medical Ctr ☐					
La Paz Geropsychiatric Ctr ☐					
Laurel Park ☐					
Meadowbrook Manor ☐ Olive Vista ☐					
Shandin Hills ☐ View Heights ☐					
Sierra Vista ☐					
Enriched Residential Services:					
Anne Sippi ☐					
Bridges – Casitas Esperanza ☐					
Cedar Street ☐ Normandie Village ☐					
Percy Village ☐ SMR River Community ☐					
SSG ☐ Telecare 7 ☐					
Intensive Residential:					
Hillview Residential Center ☐					
Excelsior House ☐ Jump Street ☐					
Exodus CRTP ☐ Gateways CRTP ☐					
Freehab CRTP ☐					
Waiting List # _____					

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

FILE IN MEDICAL RECORD

Patient Identification Number

DMH Form #
Form Revised 3/16/2022

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

DEPARTMENT OF MENTAL HEALTH
INTENSIVE CARE DIVISION (ICD)
Referral Approval for State Hospital

Date: _____

Reply To: Intensive Care Division
510 s. Vermont Ave., 20th Floor
Los Angeles, CA 90020
(213) 738-4775

CLIENT NAME: _____ **IBHIS #:** _____

TO: _____ (Referring Facility/Hospital)

ATTN: _____ (Discharge Planner/ICD Liaison)

Contact Number: _____

☐ AB109

The above-named client was referred on _____ to the following facilities:

☐ Metropolitan State Hospital ☐ Napa State Hospital

COMMENTS:

Please note: A copy of this form must accompany all packets send to State Hospital Facilities. Please do not send a packet unless we have identified the facilities as indicated above. It will let the facility know we have approved this referral. If you have any questions, please contact ICD at (213) 738-4775.

ICD Care Coordinator: _____
Revised 4.20.2022

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

Reply To: Intensive Care Division
510 S. Vermont Ave., 20th Floor
Los Angeles, CA 90020
Phone: (213) 738-4775
eFax: (213) 947-1609

INTENSIVE CARE DIVISION (ICD)
Referral Approval for Subacute

Date: _____

Client's Name _____ AKA _____ IBHIS # _____

Referring Facility/Hospital _____

Discharge Planner _____ Contact Info (Email/Phone) _____

Assigned ICD Clinical Reviewer (if applicable) _____ Contact Info (Email/Phone) _____

The above-named client was referred on_____ to the following facilities:

☐ Alpine Treatment Center	☐ Level 1	☐ Level 2	☐ Level 3
☐ Crestwood - Fallbrook	☐ Level 1	☐ Level 2	☐ Level 3
☐ Harborview Center LLC	☐ Level 1	☐ Level 2	☐ Level 3
☐ Community Care Center	☐ La Casa MHRC	☐ Landmark	
☐ La Paz	☐ Laurel Park	☐ Meadowbrook Manor	
☐ Olive Vista - Forensic	☐ Sierra Vista - Forensic	☐ Shandin Hills – Forensic	
☐ California Psychiatric Transitions	☐ View Heights		

APPROVED PATCHES (select all that apply):

☐ Category I – Access to Care: _____
☐ Category II – Physical Health: _____
☐ Category III – Behavioral: _____
☐ Category IV – Other: _____

COMMENTS:

Please note: A copy of this form must accompany all packets sent to Subacute Facilities. Please do not send a packet unless we have identified the facilities as indicated above. It will let the facility know we have approved this referral. If you have any questions, please contact ICD at (213) 738-4775.

ICD Care Coordinators _____

Revised 7/1/22

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

INTENSIVE CARE DIVISION (ICD)
Referral Approval for CRTP

Date: _____

Reply To: Intensive Care Division
510 s. Vermont Ave., 20th Floor
Los Angeles, CA 90020
(213) 738-4775

CLIENT NAME: _____ **IBHIS #:** _____

TO: _____ (Referring Facility/Hospital)

ATTN: _____ (Discharge Planner/ICD Liaison)

Contact Number: _____

The above-named client was referred on _____ to the following facilities:

☐ Gateways CRTP	☐ Exodus CRTP	☐ Freehab (females only)	☐ Hillview
☐ Excelsior House	☐ Jump Street	☐ Safe Haven	☐ SSG

COMMENTS:

ICD CRTP Care Coordinator: _____
Revised 4.20.2022