Community-Based Adult Services (CBAS): IPC and TAR Form Completion

Page updated: August 2020

Under Medi-Cal fee-for-service, most Community-Based Adult Services (CBAS) require submission of a *Treatment Authorization Request* (TAR) (either a paper TAR 50-1 to the TAR Processing Center or an eTAR submitted electronically) for each Medi-Cal beneficiary. CBAS initial assessment and transition days do not require a TAR. CBAS regular days of attendance require a TAR, except if the services are provided by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

Note: For authorization of CBAS services under Medi-Cal managed care, contact the participant's Managed Care Plan (MCP) for instructions.

When a TAR is submitted for CBAS regular days of attendance, a specified number of days of service, based upon days per calendar month, may be authorized for a period of up to six months, or for up to 12 months for the Medi-Cal managed care beneficiary when the MCP determines that such authorization is clinically appropriate. Approved CBAS services may be rendered on any day of the calendar month for which they were approved. The total number of days billed is not to exceed the total number of days authorized on the TAR for that calendar month, except for carry-over days. Claims for CBAS services in excess of the number of days per calendar month specified on an approved TAR will not be reimbursed, with the exception of carry-over days. Refer to "Carry-Over Days" on a following page for additional information.

Note: Pursuant to *California Code of Regulations* (CCR), Title 22, Section 51470 and *Welfare and Institutions Code* (W&I Code), Section 14107, it is illegal for providers to bill for services not yet provided. The Department of Health Care Services (DHCS) reserves the right to audit any CBAS center claim and will refer inappropriate claiming for investigation to the Bureau of Medi-Cal Fraud Prevention and the Department of Justice.

Important Notice: A new Individual Plan of Care (IPC) form will be implemented no earlier than the first of the second month following the publication of the IPC on the California Department of Aging website. Implementation will occur on a roll-out basis as new TARs are submitted. As each IPC comes up for review/renewal, the new IPC form must be used. All TARs submitted on or after the implementation date (initial, reauthorization and change TARs) must be accompanied by the new IPC. The California Department of Aging (CDA) will issue an All Center Letter (ACL) containing specific information related to the IPC implementation dates and process.

Settlement Agreement

The information outlined below and contained within these provider manual pages were the subject of a court settlement agreement in the Darling et al. v. Douglas et al. litigation, C09-03798 SBA, which was approved by the Court on January 24, 2012. A copy of the settlement agreement is available at: *www.dhcs.ca.gov/Documents/Darling%20v.%20Douglas%20Settlement%20Agreement.pdf.*

Per the settlement agreement, Adult Day Health Care (ADHC) was eliminated as a payable benefit under the Medi-Cal program effective March 31, 2012, and was replaced with a new program called Community-Based Adult Services (CBAS) effective April 1, 2012. The Centers for Medicare and Medicaid Services (CMS) approved the "California Bridge to Reform" and current "Medi-Cal 2020" 1115 Demonstration Waiver to include CBAS. The inclusion of CBAS provides this benefit to eligible Medi-Cal beneficiaries including those who are dually-eligible for Medicare and Medi-Cal.

See the *Community-Based Adult Services (CBAS)* section in this Provider Manual for a complete discussion of specific provider requirements and eligibility and medical necessity criteria.

IPC Form Accompanies TAR

All TARs shall be initiated by the CBAS center, and must include the participant's IPC form (DHCS 0020), pursuant to the CCR, Title 22, Section 54211. Refer to the following pages in this section for additional information. An electronic copy of this form may be found on the California Department of Aging (CDA) website.

A completed history and physical (H&P), including a request for CBAS services signed by the participant's personal health care provider (or CBAS center physician, pursuant to the W&I Code, Section 14528.1), must be maintained in the participant's health record.

Note: Separate reimbursement for provision of H&P information is not available to the personal health care provider nor to the CBAS center's staff physician. The participant's personal health care provider, however, may receive reimbursement as part of an office visit.

The CBAS center is responsible for obtaining the information necessary to medically justify the authorization of CBAS services. When reviewing CBAS TARs and IPCs, the Medi-Cal consultant will apply the eligibility criteria specified in the approved 1115 Demonstration Waiver. This criteria is provided in the *Community-Based Adult Services (CBAS)* section of this provider manual.

TAR Completion and Form Example

When preparing and submitting a TAR, refer to instructions in the TAR Completion section in this manual. For TAR form examples, see *Figure 1* on a following page in this section and the *TAR Completion* section in this manual.

Items specific to CBAS should be completed as follows:

- Submit a completed IPC, along with a TAR to the TAR Processing Center
- Enter in the *Medical Justification* area:
  - "See attached Individual Plan of Care"
  - Admission date
  - Total number of days requested in the six-month period
- Indicate the following in the *Specific Services Requested* area:
  - CBAS, month of requested service, inclusive dates (for example, "CBAS, May 14 thru 31, 2017"). Each calendar month must be specified on a separate line of the TAR.
  - The requested number of days of service for the specified calendar month. This number must reflect the fewest number of days needed to carry out the IPC.
  - The requested "From" and "To" dates of the TAR.

Note: The CBAS provider must complete the service date field and should not begin providing CBAS to the participant until the center has received an adjudication response. If the CBAS provider begins providing CBAS to the participant prior to notification of the approved TAR, it is at the risk of no reimbursement if the Medi-Cal consultant does not authorize the recommended number of days requested.

- Enter the appropriate procedure code in the *NDC/UPC Or Procedure Code* box. A procedure code (same as a service code) is required only for regular days of service. For specific service codes, refer to the *Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates* section in this manual.
- Enter the total number of days of service requested for the specified calendar month on each line of the TAR in the *Quantity* box.

Note: MCPs may not utilize a TAR or the process described above for seeking CBAS authorization. It is the responsibility of the CBAS provider to contact the participant's MCP and follow their instructions.

Transmittal Form (MC 3020)

When submitting paper TARs and IPCs to the TAR Processing Center with a TAR *Transmittal Form* (MC 3020), enclose a self-addressed stamped envelope. The envelope will be used to return a copy of the date-stamped transmittal form. MC 3020 (8/99) forms can be located on the Forms page of the Medi-Cal website at *www.medi-cal.ca.gov.*

Incomplete Submissions

With the exception of claims for assessment and transition days, claims submitted without obtaining authorization of a TAR will be denied.

Request for Increase in Days of Service (Change TAR)

A TAR and IPC must be submitted if the number of days approved on the current TAR must be increased due to a change in the participant's condition or service needs.

The TAR should be completed in full as follows:

- In the *Medical Justification* area, enter: "The number of service days per month authorized on _____ (TAR Control Number) has been increased on this TAR. See attached IPC for explanation"
- The "From" and "To" dates for additional services
- The total "Units of Service" is the total number of additional days between the "From" and "To" dates

The new IPC should be completed as follows:

- On page 1, place an “X” in the “Change TAR” box in Box 1.
- The *Need/Problem, Treatment(s)/Intervention(s), Frequency* and *Goal(s)* fields (Boxes 13 and 14) must state the need for an increase in the days of service.
- All applicable boxes must be updated to include the reason(s) for the increase in days of service.
- Signatures of the participant’s personal health care provider or CBAS center physician, registered nurse, social worker, any other discipline providing services and program director must be entered in the *Signatures of Multidisciplinary Team and Program Director* fields (Box 17) of the IPC form.

Lapsed (Expired) TARs

When the participant is away from the center (not attending on their previously scheduled days) for some period of time, a currently authorized TAR may lapse or expire. If the participant has not yet returned to the CBAS center, the CBAS center will not be able to obtain a reauthorization TAR.

Note: If the CBAS center discharges the participant, the TAR is considered “expired.”

If and when the participant returns to the CBAS center, the CBAS center must conduct all required assessments/reassessments and complete and submit a TAR and IPC according to standard instructions, with the following exceptions.

The TAR should be completed as follows:

- On page 1, the “From” date is the date the center began providing services again.

The IPC should be completed as follows:

- In Box 16, give a full explanation of the extended absence.
- On page 1, place an “X” in the “Initial” box, Box 1 (regardless of the length of, and reason for the participant’s absence and subsequent lapsed TAR; the first TAR after a previous TAR has lapsed is <u>always</u> considered an initial TAR).

The CBAS center must ensure that all of the requirements for initial admission are met, including a current TB clearance (must have been done and determined negative within one year of return to the CBAS center), a current home assessment and current Multidisciplinary Team (MDT) assessments, IPC and H&P as needed.

If the participant returns before the current TAR period has ended, a new TAR is not necessary. The time remaining on the current TAR should be completed and a new TAR submitted as a reauthorization TAR when the current TAR period has ended. The participant's absence must be noted and explained in the participant's health record.

CBAS centers are encouraged to develop specific policies and procedures for their individual center regarding lapsed (expired) TARs, including when the participant is discharged. The center will be expected to maintain documentation in the health record regarding absences and follow-up done by the center.

DHCS/CDA considers a participant "discharged" when:

- They are discharged per the CBAS center's policies and procedures, or
- They are not in attendance for 60 days and the authorization has expired.

Number of Days

When determining the appropriate number of days per calendar month to authorize, a Medi-Cal consultant will consider the following five factors:

- Overall health condition of the participant, relative to the participant's ability and willingness to attend the number of days requested, specified on the TAR and IPC
- Frequency and nature of services specified on the IPC
- The extent to which other services currently being received by the participant meet the participant's needs, as specified on the TAR and IPC
- Number of days requested on the TAR
- If the personal health care provider or CBAS center physician has requested a specific number of days

When requesting the number of days per calendar month, the provider must ensure that the request is related to the participant's need(s)/problem(s) and the number of days needed to carry out the IPC.

Note: For the managed care participant, the CBAS center should contact the participant's MCP for information/directions regarding the criteria used by the plan to determine the appropriate number of days per month to be authorized.

The Medi-Cal consultant authorizes CBAS services on the basis of a specific number of days per calendar month. The CBAS center must specify the months and the number of requested days for each calendar month on separate lines of the TAR. For example, for a six-month request, there should be six lines filled in on the TAR. See the example below:

LINE NO.	AUTHORIZED Y / N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1			CBAS SERVICES 040912 THRU 043012		S5102	10	
2			CBAS SERVICES 050112 THRU 053112		S5102	12	
3			CBAS SERVICES 060112 THRU 063112		S5102	12	
4			CBAS SERVICES 070112 THRU 073012		S5102	12	
5			CBAS SERVICES 080112 THRU 083112		S5102	12	
6			CBAS SERVICES 090112 THRU 093012		S5102	12	

- The Medi-Cal consultant will authorize the total number of days per month for up to six months.
- The CBAS provider should continue to specify the number of planned days per week on the TAR in the *Medical Justification* section.

The CBAS center may schedule attendance of the participant authorized for CBAS services for any day(s) during the month, based on the participant's needs, and so long as the total number of days attended by the participant during the month does not exceed the number of days authorized on the TAR for that calendar month, except for carry-over days.

Claims for CBAS services will <u>not</u> be reimbursed for days in excess of the number of days per calendar month authorized on the TAR, except for carry-over days. Claims for any day(s) not authorized on the TAR for that calendar month will be denied, except for carry-over days.

Carry-Over Days

A carry-over day is defined as a day of attendance that was:

- Authorized on the TAR for the previous calendar month
- Not attended by the participant on the day planned nor on any other day during the previous calendar month
- Not reimbursed for the previous calendar month
- Subsequently attended as an extra day during the calendar month following the month in which it was authorized

Note: A planned day that is missed, rescheduled and subsequently attended within the same calendar month is not a carry-over day. Carry-over days cannot be reimbursed in the first month of the TAR period. For example, if the TAR runs from February 1, through August 1, carry-over days for the month of February reflecting unattended, approved days in January will not be reimbursed.

The following conditions apply for carry-over days:

- A day may only be carried over into the calendar month following the calendar month in which it was authorized.
  - Days may not be carried over from one authorized TAR period to the next authorized TAR period. Therefore, carry-over days may never be billed during the first month of an authorized TAR.
- Up to four days may be carried over. The CBAS center must specify the days being billed as carry-over days.
- Participant health records must reflect services rendered on the carry-over days. CBAS center attendance logs must reflect the participant's actual attendance on all carry-over days.
- A statement of medical necessity for each carry-over day must be submitted on or with the claim. A TAR is not required for carry-over days. If the participant needs more than four carry-over days during any calendar month, or needs additional days on an ongoing basis, then a change TAR must be submitted (see "Request for Increase in Days of Service [Change TAR]" on a previous page).
- Carry-over days may only be billed on the final claim of the month in which the carry-over day(s) was used.

Claims for carry-over days that do not meet the requirements specified above will not be paid.

Medical Necessity for Carry-Over Days

A statement of medical necessity for carry-over days must be included on or with the carry-over day claims. This statement must be specific to the participant and provide sufficient detail to explain why the carry-over day(s) should be reimbursed. Additional information justifying the medical necessity for the carry-over day(s) must be maintained in the participant's health record and available for State review upon request.

The claims statement must demonstrate one of the following:

- The participant is returning after an absence due to illness, injury or hospitalization and requires an additional day(s) of CBAS services in the current calendar month to meet goals as specified on the participant's IPC.
- The participant is returning after an absence in which the participant's physical or mental condition declined, and requires an additional day(s) to meet IPC goals.
- The participant is returning after an absence that resulted in missing a CBAS service necessary for the improvement and/or ongoing stabilization of the participant's physical or mental condition, and in the absence of an extra day during the current calendar month, the CBAS service cannot be rescheduled in a timely manner to meet the participant's needs.

DHCS may conduct random audits of CBAS claims. CBAS centers may be asked to provide additional documentation before the claim for a carry-over day is reimbursed.

Request for Additional Therapy Services

CBAS centers have the ability to obtain authorization for additional physical, occupational and speech therapy services for a specific participant if the CBAS center has or will meet its required monthly therapy hours (CCR, Title 22, Sections 54423 and 78419). A separate TAR must be submitted by the CBAS center to the TAR Processing Center for authorization. Documentation that the CBAS center has or will meet its required therapy hours, and that the additional therapy hours being requested exceed the required monthly therapy hours and that the requested additional therapy hours are medically necessary to carry out the IPC for the specific participant, must be attached to the TAR. The rendering therapist may bill the additional therapy hours separately from the CBAS center's daily rate. The CBAS center may not bill for additional therapy hours.

Documentation of medical necessity for additional therapy must accompany the TAR. The TAR must clearly state that services will be rendered at the CBAS center. If a participant is an MCP enrollee, the CBAS center must contact the MCP for plan-specific information about authorization and billing for additional therapy services.

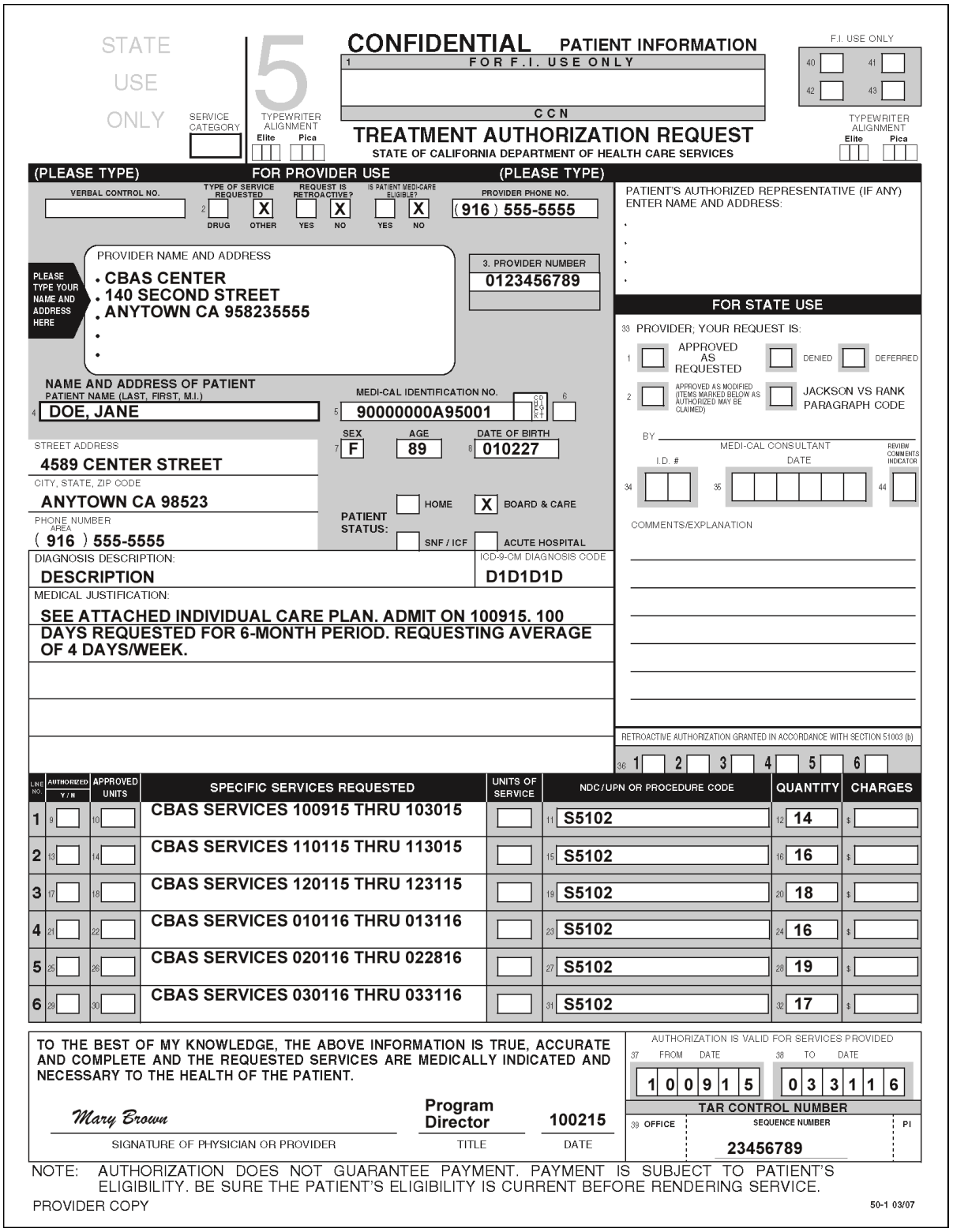
CBAS centers that provide additional physical, occupational and/or speech therapy services and meet the criteria stated above should refer to the "Appendix" of this manual for physical, occupational and speech therapy service policies and maximum reimbursement rates.

Transportation

Transportation provided by or arranged by the CBAS center between a participant's home and a CBAS center is included in the daily rate paid to a CBAS center and is not separately reimbursable. Non-emergency medical transportation (NEMT) providers enrolled in the Medi-Cal program may obtain TARs for NEMT from the CBAS center to medical appointments. NEMT must be billed separately from the CBAS center's daily rate by the Medi-Cal transportation provider. These TARs must document medical necessity for the transportation and must state clearly that the service is being provided from a CBAS center.

Note: Medical appointments should not preclude the minimum of four hours per authorized day of participant attendance at the CBAS center. Such appointments should be scheduled to allow four hours of CBAS center attendance and participation in scheduled activities.

Figure 1: CBAS Tar Example.



STATE USE ONLY

SERVICE CATEGORY

5

TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

TYPEWRITER ALIGNMENT Elite Pica

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO.

2 TYPE OF SERVICE REQUESTED: DRUG [ ] OTHER [X]

REQUEST IS RETROACTIVE? YES [ ] NO [X]

IS PATIENT MEDI-CARE ELIGIBLE? YES [ ] NO [X]

PROVIDER PHONE NO. (916) 555-5555

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS
- CBAS CENTER
- 140 SECOND STREET
- ANYTOWN CA 958235555

3. PROVIDER NUMBER 0123456789

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

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.) 4 DOE, JANE

5 MEDI-CAL IDENTIFICATION NO. 90000000A95001 CO CNTY 6

7 SEX F | 8 AGE 89 | DATE OF BIRTH 010227

STREET ADDRESS 4589 CENTER STREET

CITY, STATE, ZIP CODE ANYTOWN CA 98523

PHONE NUMBER AREA (916) 555-5555

PATIENT STATUS: HOME [ ] BOARD & CARE [X] SNF / ICF [ ] ACUTE HOSPITAL [ ]

DIAGNOSIS DESCRIPTION: DESCRIPTION

ICD-9-CM DIAGNOSIS CODE D1D1D1D

MEDICAL JUSTIFICATION:

SEE ATTACHED INDIVIDUAL CARE PLAN. ADMIT ON 100915. 100 DAYS REQUESTED FOR 6-MONTH PERIOD. REQUESTING AVERAGE OF 4 DAYS/WEEK.

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED [ ] DENIED [ ] DEFERRED [ ]

2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) [ ] JACKSON VS RANK PARAGRAPH CODE [ ]

BY _____ MEDI-CAL CONSULTANT

34 I.D. # [ ] [ ] | 35 DATE [ ] [ ] [ ] [ ] [ ] [ ] | 44 REVIEW COMMENTS INDICATOR [ ]

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

LINE NO.	9 AUTHORIZED Y / N	10 APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	11 NDC/UPN OR PROCEDURE CODE	12 QUANTITY	CHARGES
1			CBAS SERVICES 100915 THRU 103015		S5102	14	$
2			CBAS SERVICES 110115 THRU 113015		S5102	16	$
3			CBAS SERVICES 120115 THRU 123115		S5102	18	$
4			CBAS SERVICES 010116 THRU 013116		S5102	16	$
5			CBAS SERVICES 020116 THRU 022816		S5102	19	$
6			CBAS SERVICES 030116 THRU 033116		S5102	17	$

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

Mary Brown — SIGNATURE OF PHYSICIAN OR PROVIDER

Program Director — TITLE

100215 — DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE 100915 | 38 TO DATE 033116

TAR CONTROL NUMBER

39 OFFICE | SEQUENCE NUMBER 23456789 | PI

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

PROVIDER COPY

50-1 03/07

Individual Plan of Care (IPC)

Completion and Form Example

The IPC must be completed by the CBAS center and submitted with a TAR. This form is used to substantiate the medical need for CBAS services. The IPC should be developed based on the multidisciplinary team's assessment and the needs, goals and desired outcomes expressed by the participant and/or authorized representative(s) during the assessment process and signed by all appropriate team members. Refer to explanations of form items on the following pages of this section. A current copy of the IPC must always be maintained in the participant's health record.

IPC Queries

For questions about completing the TAR, IPC or adjudication of specific TARs, providers should contact the Los Angeles Medi-Cal Field Office Integrated Systems of Care at (213) 897-6774. For questions about the CBAS provider requirements, providers should call CDA at (916) 419-7545. For questions regarding the request for CBAS services, IPC or adjudication of specific requests for the Medi-Cal managed care beneficiary, contact the participant's MCP directly.

Submitting With TAR

The IPC must be submitted with the initial TAR and sent to the TAR Processing Center for review. If the IPC and/or TAR is incomplete, or there is insufficient information to determine medical necessity for CBAS services as specified in the *Community-Based Adult Services* (CBAS) section of this provider manual, the TAR will be deferred and an *Adjudication Response* notice will be sent to the CBAS center for resubmission of the TAR.

Individual Plan of Care (IPC) Instructions

Explanation of Form Items:

The following box numbers and directions for completion correspond to fields on the IPC form.

Please Note: General Information

a. Complete the participant's name, Client Identification Number (CIN) and dates of service at the top of each page of the Individual Plan of Care (IPC).

b. Definitions of all key words in the IPC can be found in the Community-Based Adult Services (CBAS) section of the Medi-Cal Provider Manual and the CBAS provisions of the current Medi-Cal 1115(a) Demonstration Waiver, entitled Medi-Cal 2020. In the event of any conflict, the provisions of the current Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020, or as modified in any successor waivers, shall be controlling.

c. Consideration for authorization under managed care: terminology used in the IPC and the IPC instructions reflect the fee-for-service method of authorization and payment of claims. Not all MCPs will use the same terminology/process. It is the responsibility of the CBAS center to be familiar with and seek guidance from the CBAS center's contracted plan(s).

d. All boxes checked, and information provided on the IPC must be supported by appropriate documentation in the participant's health record and must be consistent with and supported by information provided throughout the IPC.

e. CBAS providers shall complete an updated IPC at least every six months or when there is a change in circumstance that may require a change in benefits.

f. All information presented on the IPC must be based on multidisciplinary team (MDT) assessments completed within a person-centered care planning process at the CBAS center. In addition, as specified in paragraph 49.c. of the CBAS Special Terms and Conditions of the Medi-Cal 2020 Demonstration Waiver, the IPC must address the following: The IPC must identify each participant's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; and

    a. The IPC must allow the participant to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the participant's choosing; and
    b. The IPC must ensure that the participant has informed choices about treatment and service decisions; and
    c. The IPC must incorporate a planning process that is collaborative, recurring and involves an ongoing commitment to the participant.

    Note: "Person-centered plan" and "person-centered planning process" refer to the process outlined by Federal requirements specified in the *Code of Federal Regulations* (CFR), Title 42, section 441.301(c)(1) through (3).

g. “Personal health care provider” means the participant’s personal physician, physician assistant or nurse practitioner, operating within their scope of practice.

h. For providers NOT completing the IPC through customized software, if more space is needed for Boxes 12, 13 and 14, additional templates are available along with the IPC Form on the CDA CBAS webpage. (*www.aging.ca.gov*)

‹‹Completion Instructions for Top of Page One››

‹‹General Instructions››

a. Center Name: Enter the CBAS center’s name.

b. Provider Number (NPI): Enter the CBAS center’s Medi-Cal Identification (ID) number or National Provider Identifier (NPI).

c. Participant Name: Enter the participant’s name.

d. Gender: Check the appropriate box for the participant’s gender.

e. Date of Birth (MM/DD/YY): Enter the participant’s date of birth in the format indicated.

f. CIN: Enter the participant’s CIN, also known as the participant’s Medi-Cal ID number.

g. Managed Care Plan Name: Enter the name of the MCP in which the participant is enrolled. If the participant is not enrolled in a plan or is ineligible to enroll in managed care, enter N/A and explain in the *Additional Information* field (Box 16).

h. Dates of Service: Enter the dates of service (DOS) requested on the TAR. The start date is the first requested date of service after the assessment days are completed and the *Participation Agreement* is signed. If there was an extended break in service (the previous TAR lapsed [expired]), the new start date is the first requested date of service after the participant’s return to the center. Authorization for CBAS services is typically limited to a period of six months’ duration, but in no case longer than 12 months. If the contracting MCP authorizes services for longer than six months, the CBAS center is still required by the Medi-Cal 2020 Waiver and regulation to complete a new IPC every six months.

i. Tar Control Number (TCN): Enter the eight-digit TAR Control Number from the attached TAR (paper TAR) or the 10-digit number from the eTAR. If the MCP has to issue the number and has not yet done so, leave this space blank at the time of submission and enter once the number has been issued.

j. Planned Days/Week: Enter the planned number of days of attendance per week. This number must support what is planned at the time of the MDT assessment.

Note: The number of days of attendance should be initially proposed by the MDT based on the participant assessment and collaborative agreement with the participant.

‹‹Completion Instructions for Box (1) Treatment Authorization Request (TAR) and Eligibility››

‹‹General Instructions››

a. Check the appropriate box regarding TAR type.

1. **Initial TAR** – the TAR for the first admission to this CBAS center or return to this CBAS center after a break in service (previously lapsed [expired] TAR).
2. **Reauthorization TAR** – a TAR for continuing services at the CBAS center for which the immediately preceding TAR was authorized.
3. **Change TAR** – the TAR for additional day(s) that is submitted within the current TAR cycle. The IPC must be revised to support medical necessity for the increased number of days requested.

b. Enter the tuberculosis (TB) clearance date. This date is the date the participant's TB test was determined to be negative. This date must be within one year prior to the participant's admission to the CBAS center. The TB clearance date applies to initial TARs only.

c. If this is a reauthorization TAR, state whether or not the participant's condition would likely deteriorate if the CBAS services were denied by checking the appropriate box.

Note: If this is NOT a reauthorization TAR, check *N/A*.

d. Certify that the individual meets all CBAS eligibility and medical necessity criteria and one or more of the five required CBAS medical criteria categories, pursuant to the Medi-Cal 2020 Demonstration Waiver, para. 48.d, by checking all the boxes that apply.
    1. If the individual does not meet any of the specified categories, authorization for CBAS services may be denied.
    2. If the category(ies) under which the participant qualified for CBAS has changed since the last IPC, note in the *Changes since Previous IPC* field (Box 15).

    Note: A description of the five medical criteria categories of CBAS eligibility can be found in the *Community-Based Adult Services (CBAS)* section of the Medi-Cal Provider Manual.

‹‹Completion Instructions for Box (2) Diagnoses and ICD Codes››

‹‹General Instructions››

a. Enter the list of diagnoses and the corresponding ICD-CM code(s) applicable to the participant in the format indicated. The most current codes must always be used.
b. These diagnoses codes must be the same diagnoses and ICD-CM codes as entered on the TAR and the *UB-04* claim form; they must be the same codes as provided or confirmed by the participant's personal health care provider(s).

‹‹Completion Instructions for Box (3) Medications››

‹‹General Instructions››

a. In the *Active Prescriptions* section, list all active prescription medications and supplements (such as Vitamin D) prescribed by the participant's personal health care provider, even if the medication or supplement can be purchased over-the-counter (OTC) and whether or not the medication or supplement is taken at the center.
b. In the *Over-the-Counter Medications and/or Supplements* section, list all other medications and supplements that the participant takes regularly for which they do not have a prescription from their personal health care provider.

c. If the participant is not taking any prescription medications, OTC medications and/or supplements, check *No Medications or Supplements.*

Notes:

1. An active prescription is a current, non-expired prescription by a participant's personal health care provider.
2. Frequency and dosage are not required.

d. Check "yes" or "no" indicating whether the CBAS center or the participant administers the prescribed medications at the center. If the center administers any of the participant's prescribed medications, the participant is not considered able to self-administer.

Notes:

1. Questions regarding administration of prescribed medications at the center should conform with the Participant Characteristics Report (CDA CBAS 293) definitions:
    - "Prescribed Medications Administered at the Center" means medications administered by the center nursing staff during the center's hours of service that are prescribed by a participant's personal health care provider on a routine medication order, not PRN (as needed). This could include OTC medications, so long as they are prescribed by the personal health care provider on a routine order and are administered by the center's nurse.
    - "Self-Administers Medication(s) at the Center" means that the participant meets the following criteria: (a) administers own medications at the center (including OTC medications) that are prescribed by the participant's personal health care provider on a routine medication order, not PRN; (b) does not need monitoring, supervision, physical assistance or verbal cues; and (c) meets the criteria for medication self-administration per Title 22, CCR, Sections 54319(e) and 78317(f)(1) through (3).

2. Title 22, CCR, Section 54319(e): The Community-Based Adult Services center may allow participants who are independently responsible for taking their own medication at home, if authorized by the participant's personal health care provider, to continue to be responsible for taking their own medication during the hours spent in the adult day health care program.
3. Title 22, CCR, Section 78317(f)(1) through (3): The self-administration of medications at the center shall be permitted only under the following conditions: (a) the center shall have approved policies permitting self-administration of medication when approved by the MDT; (b) training in self-administration of medication shall be provided to all participants based on the recommendation of the MDT; and (c) the health record of each participant who is capable of self-medication shall name all drugs which are to be self-administered.

‹‹Completion Instructions for Box (4) Active Personal Medical/Mental Health Provider(s)››

‹‹General Instructions››

List all active personal medical and mental health care providers for the participant, if known, including their names, provider specialty, addresses and phone numbers.

If none or not known, leave blank and explain in the *Additional Information* field (Box 16).

‹‹Completion Instructions for Box (5) ADL/IADL››

‹‹General Instructions››

a. For each Activity of Daily Living (ADL) and Instrumental ADL (IADL) listed, check the appropriate column, *Independent, Needs Supervision, Needs Assistance or Dependent.* Descriptions of these terms are printed at the top of the box on the IPC form. There must be one check in each row, for each ADL and for each IADL.
    1. "ADL/IADL Status" means the participant's abilities to perform all of the components and steps of the activity.
    2. "Medication Management" includes self-administration of the medication(s), refilling and picking up/arranging for pick-up/delivery of prescriptions, opening containers, ability to read/see information on bottles, etc. If the participant requires assistance or supervision in any aspect of medication management, the participant's functional status for medication management would not be considered "independent."

b. The CBAS center's assessment should reflect the participant's ADLs/IADLs as they are on the participant's worst or lowest functioning day. In addition to the MDT assessment, this information may be obtained through discussions with the participant and/or the participant's family/caregiver(s)/ authorized representative.

c. The participant must have ADL/IADL limitations as specified under the category in which the participant qualifies for CBAS, as applicable:

   1. These limitations must be related to the participant's chronic or post-acute medical, cognitive or mental health condition(s).

   2. These limitations must require that at least assistance or supervision is necessary when performing the relevant ADL(s)/IADL(s).

      Notes:

      - Assistance with ADLs or IADLs (e.g., the IHSS worker does the housework for the participant) does not automatically indicate that the participant is "dependent."
      - If the participant does not have limitations as specified under the category in which the participant qualifies for CBAS, the TAR will, at a minimum, be deferred.

3. Any limitation in ADLs and/or IADLs due solely to culture, language, or any condition other than the participant's medical, cognitive, or mental health condition(s) will not be considered for eligibility/medical necessity determination.

‹‹Completion Instructions for Box (6) Current Assistive/Adaptive Devices››

‹‹General Instructions››

a. Check the appropriate box(es) to indicate the assistive/adaptive device(s) currently being utilized by the participant, regardless of setting.

b. If no device is currently being utilized, check *None.*

c. If *Respiratory Equipment* is checked, specify the equipment being used by the participant.

d. If *Other* is checked, specify the device(s)/equipment.

‹‹Completion Instructions for Box (7) Continence Information››

‹‹General Instructions››

a. Check the appropriate box(es) to indicate any continence conditions currently present. The evaluation of continence should be based on the participant's status "if no intervention is provided."

b. Check *continent* if the participant needs no intervention to remain continent.

Note: If the participant is independent with self-initiated timed voiding and maintains continence, then the participant is considered continent. If the timed voiding requires cueing or assistance, then the participant would not be considered continent.

c. *If Incontinent of bladder* and/or *Incontinent of bowel* is checked, specify if *occasionally, frequently,* or *always.*

Notes:

1. *"Occasionally"* is defined as occurring at irregular and/or infrequent intervals or has occurred but rarely.
2. *"Frequently"* is defined as occurring multiple times in a week or a month; can be regular or irregular.
3. *"Always"* is defined as occurring all of the time; continually.

d. If Other is checked, specify.

‹‹Completion Instructions for Box (8) Nutritional Information

‹‹General Instructions››

a. Check the appropriate box(es) to indicate nutritional information.

b. Enter the body mass index (BMI) for all participants.

   1. The BMI is a useful measure to determine if someone is “underweight,” “overweight” and/or suffers from “obesity” and is potentially at risk for diseases that can occur with too little or too much body fat.

   2. BMI is calculated using a participant’s height and weight (in pounds and inches) as follows:

      - Formula: weight (lb)/[height (in)]^2 x 703
      - Calculate BMI by dividing weight in pounds by height in inches squared and multiplying by a conversion factor of 703.
      - Example:
        Weight = 150 pounds, Height = 5'5" (65 inches)
        Calculation: [150 ÷ (65)^2] x 703 = 24.96 or
        [150 ÷ 4225] x 703 = 24.96

   3. The BMI score is interpreted as follows – these categories are the same for men and women of all body types and age 20 and older:

      - Underweight (Below 18.5)
      - Normal (18.5-24.9)
      - Overweight (25.0-29.9)
      - Obese (30.0 and above)

Notes:

1. BMI must be calculated if the participant's weight and height are known.
2. The BMI results will enable the provider to determine if the participant is underweight, overweight or obese.
3. Check *BMI Not Known* only if the provider is not able to determine the weight and/or height of the participant due to their condition. Explain in the *Additional Information* field (Box 16).
4. If BMI results indicate the participant is underweight, overweight or obese, the MDT may want to consider referring the participant to the Registered Dietician.

c. A "special/therapeutic diet" means a diet prescribed by the participant's personal health care provider and provided at the CBAS center to help manage a chronic illness or other medical condition(s). A special/therapeutic diet includes portion control, high/low calorie, low sodium, low cholesterol/low fat, no concentrated sweets, diabetic, and renal; also includes modified textures when the modified texture alters the nutritional content of the food such as mechanical soft, pureed, or tube feeding diets.

   A "special/therapeutic diet" does not include diets to prevent chronic disease such as a "heart healthy" diet (no added salt, no added fat), cut up, chopped with no alteration of the nutritional content, tube feeding that is not formulated for a specific medical condition, enteral nutrition (tube feeding) or parenteral nutrition (intravenous).

d. If *Other* is checked, specify. *Other* may include those diets not prescribed for a medical condition(s), such as participant preferences, including vegetarian or diets for religious purposes.

e. Any services provided directly by the Registered Dietician should be placed in the *Additional Services* field (Box 14) under *Registered Dietician Services.*

f. Any services provided directly by the Registered Nurse or Licensed Vocational Nurse should be placed in the *Core Services* field (Box 13) *under Professional Nursing Services*.

Note: If the participant is receiving tube feedings or intravenous feedings at home and will not be receiving food at the CBAS center, check *Other* and explain.

‹‹Completion Instructions for Box (9) Living Arrangement/Household Composition and Non-CBAS Long Term Support Services (if known)››

Type of Residence:

Check the appropriate box(es) to indicate type of participant residence.

a. *Personal Residence* is defined as a house, apartment, mobile home or other type of residence (owned or rented) that is not a licensed facility, other congregate living setting or temporary shelter.
b. *Community Care Licensed Facility* means a non-medical facility licensed by the Department of Social Services, such as a Residential Care Facility.
c. *Other Congregate Living* means a non-medical, unlicensed congregate living arrangement/setting such as room and board where persons live together and may share a common dining room, recreation areas and other services/amenities.
d. *ICF/DD-H* means an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) licensed by the Department of Public Health, Licensing and Certification Division. An ICF/DD-H is a medical and social facility specifically for persons with developmental disabilities.
e. *Homeless/Temporary Shelter* means no permanent place of residence; living in shelters/on the street.
f. If the participant resides in a residence not listed here, check *Other* and specify.

Household Composition

a. Check the appropriate box to indicate whether the participant lives alone or with others.
b. If *Relative* or *Non-relative* is checked, note the relationship of the person to the participant (for example, husband, wife, child, etc. for *relative* and neighbor, friend, etc. for *non-relative*). Do not list the person's name.

Support Services(in addition to CBAS):
Check the appropriate box(es) to indicate the non-CBAS support services currently being utilized by the participant.

a. If not known, check *Not Known*.

b. If no service(s) other than CBAS is being utilized, check *None*.

c. If *IHSS (In-Home Supportive Services*) is checked, specify the number of hours/month being utilized by the participant, if known.

d. If a care management program is being utilized, check *Care Management Program*. If the participant is receiving services from a specific care management program, such as the Multipurpose Senior Services Program (MSSP) or Regional Center services (for persons with developmental disabilities), check the specific program. *Care Management Program* as used here does not include IHSS coordination through the county or care coordination through the MCPs. If a care management program, other than MSSP, regional center services or care coordination through managed care is being used, check *Othe*r and specify the program and/or services.

e. If Veteran services are being utilized by the participant, check *Veterans Administration* Services and specify the services being provided.

f. *Telephone Reassurance program* is defined as a volunteer program with trained volunteers who make supportive or "check-in" calls to individuals who are alone/lonely, depressed/at risk for depression, etc. Similar programs may have different names.

g. *Transportation* as used here means transportation support (paid or unpaid) to medical appointments, grocery shopping, church and other community activities. <u>It does not refer</u> to transportation to/from the CBAS center and the participant's place of residence, which is the center's responsibility and is included in the center's daily rate.

h. If a support service(s) other than those listed is being utilized, check *Other* and specify the service(s). Such services may include the Home Energy Assistance Program (HEAP) or Lifeline Services.

Notes:

1. Any required legal documents and/or names of persons involved with the participant should be in the participant's health record; do not include names in the IPC (for example, for *Representative Payee* or *Conservatorship*).
2. Centers are encouraged to describe in detail in the *Additional Information* field (Box 16) any support service insufficiencies and additional support services needed to maintain the individual in the community.
3. Any of the above listed types of residence and household compositions and utilization of any of the above listed support services will NOT automatically disqualify the participant for CBAS services. If the participant requires services in addition to those services checked to remain in the community, such as CBAS services in the quantity documented on the TAR and IPC to be medically necessary, such services will be authorized.
4. The information requested in this box may be obtained through documentation in the participant's health record, MDT assessments, other medical records and through discussions with the participant and/or any other person authorized by the participant to provide health and life information.

‹‹Completion Instructions for Box (10) Other Health Services (if known)››

‹‹General Instructions››

Check the appropriate box(es) to indicate the other health service(s) the participant received within the last six months, and/or is currently receiving and provide the information requested.

a. If the participant has not received any of the other health service(s) listed within the past six months, check *None*.
b. If this information is unknown to the CBAS center, check *Not Known*.

Note: Provider responsibilities include liaison with the participant's personal health care provider(s)/caregivers to be informed about the participant's health status/needs and to coordinate care.

c. If *Emergency Department Visit(s)* is checked, provide the number of visits and explain.

d. If *Medical Hospitalization(s)* is checked, provide the number of times the participant was admitted and explain.

e. If *Psychiatric Hospitalization(s)* is checked, provide the number of times the participant was admitted and explain. This refers to a hospitalization primarily for an acute psychiatric episode which may or may not be in a psychiatric facility.

f. If *Nursing Facility* is checked, explain.

g. If *Home Health Services* is checked, explain and specify whether or not the participant is currently receiving home health services.

h. If *Hospice Care* is checked, explain and specify whether or not the participant is currently receiving hospice services.

i. If *Mental Health Outpatient Services* is checked, explain and specify whether or not the participant is currently receiving mental health outpatient services. Indicate if the mental health services have been or currently are being provided by county mental health.

j. If services other than those listed were utilized within the past six months, check Other and explain. Other may include urgent care or other possible places where health services have been utilized (for example, places of health care in lieu of the participant's personal health care provider's office or the emergency department).

Notes:

1. If known, any additional information (such as relevant history, reason for current use of the service and dates, number of visits and an explanation that could include the reason for and type of services utilized, frequency/length of stay, outcome, etc.) may be added on the Explain lines in this box.
2. “Currently receiving” means the participant is actively receiving services at the time of the MDT assessment and IPC development.
3. Current and continuing utilization of home health, mental health or emergency department services will NOT automatically disqualify the participant for CBAS services. If the participant requires services in addition to those services checked to remain in the community, such as CBAS services in the quantity documented on the TAR and IPC to be medically necessary, such services will be authorized.
4. While utilization of Hospice Care services will not automatically disqualify the participant for CBAS services, any care for the Hospice-related condition(s) that the participant’s personal health care provider has certified as likely to result in a life expectancy of six months or less is the responsibility of the Hospice provider. Such services are not reimbursable to the CBAS center and the need for these services will not be considered when determining eligibility/medical necessity for CBAS services.
5. The information requested in this box may be obtained through documentation in the participant’s health record, MDT assessments, other medical records and through discussions with the participant and/or any other person authorized by the participant to provide health and life information.‹‹Completion Instructions for Box (11) Risk Factors

‹‹Completion Instructions for Box (11) Risk Factors

General Instructions

Check all risk factors that apply to the participant based on information resulting from the center's MDT assessment process including information expressed by the participant, family/caregiver and/or authorized representative. Checked risk factors support the participant's need for CBAS. Such risk factors may need to be addressed in the IPC in the *Core Services* field (Box 13) and the *Additional Services* field (Box 14), but it is not a requirement.

Notes:

1. Risk factors (one or in combination) may place the CBAS participant at risk for an adverse event such as an emergency department visit, hospitalization, long term care facility admission, eviction from one's place of residence, significant disability and/or death. Addressing these risk factors may prevent an adverse event and enable the participant to continue living in the community as safely and independently as possible.
2. Use the *Additional Information* field (Box 16) if necessary to provide more information about the risk factor(s) and to support authorization of CBAS.
3. If the center uses a screening/assessment tool to evaluate certain conditions such as a cognitive impairment, depression, fall risk, etc. then the name of the screening tool and results should be documented in the participant's health record.

Definitions/Guidance:

Internal/Clinical Risk Factors

a. If none of the listed risk factors apply to the participant, check *None*.
b. Mental Illness means a diagnosed mental disorder.
c. Substance Use/Abuse means recurrent use/misuse of alcohol or other substances resulting in functional impairment; it does not require a diagnosis.

d. Cognitive Impairment means the loss or deterioration of intellectual capacity characterized by impairments in short- or long-term memory; language; concentration and attention; orientation to people, place or time; visual-spatial abilities or executive functions or both; including, but not limited to, judgment, reasoning or the ability to inhibit behaviors that interfere with social, occupational or everyday functioning due to conditions, including, but not limited to, mild cognitive impairment, Alzheimer's disease or other form of dementia or brain injury.

e. *Polypharmacy (6+)* refers to six or more prescribed medications; does not include OTC medications. If prescribed medication(s) numbering less than six are considered a risk factor(s), check *Other* and specify.

f. *Medication Mismanagement* means not taking medications accurately as prescribed. This may be the result of any or all of the following: the participant is not safe to self-administer medications due to cognitive impairment or other condition/reason and does not have the assistance of someone capable of safely administering medications to the participant; has a history of medication compliance issues or errors (for example, does not medication(s) as prescribed, stops medication(s) without knowledge of the participant's personal health care provider), is unable to afford medication(s), is unable to pick up medication(s) at the pharmacy, is physically unable to open pill containers or other reasons.

g. *ADL Functional Limitations* (3+) means limitations in three or more ADLs listed in the *ADL/IADL Status* field (Box 5). Referring to definitions in Box 5, "limitations" would include ADL's checked in the following categories: *Needs Supervision, Needs Assistance* and *Dependent.*

h. *High Fall Risk* means the participant's fall risk has been measured by the center's MDT using an industry standard tool; includes participants with a history of falls and/or recent falls. The provider may refer to the *Participant Characteristics Report* (PCR) instructions on the California Department of Aging (CDA) website at *(www.aging.ca.gov).*

i. *Chronic Pain* means ongoing or long-term pain that is self-described or diagnosed by the participant's personal health care provider. The participant may or not be taking pain medication(s).

j. *Frailty* means a clinical syndrome or state of decline and vulnerability in later life characterized by weakness, fatigue, low energy, slowed walking, decreased physical activity and weight loss; a chronic progressive condition that results in a heightened vulnerability to adverse outcomes that may occur in the face of stressors. Frail older adults are likely to have delayed recovery from illness, may be likely to fall, to develop greater functional impairment including becoming disabled or dependent, or to die.

k. *Wandering/Exit-Seeking Behavior* means walking away from the immediate area without informing others; not able to express where they are going or for what purpose; behavior is typically exhibited by persons with a dementia or cognitive impairment who without supervision, are at-risk for getting lost.

l. *Significant Sensory Impairment* means deficit(s) in hearing (hearing loss, deaf), vision (diminished/low vision, blind), and/or speech (difficulty speaking and being understood); excludes language barriers identified in *External Risk Factors* section.

m. *Other* may include IADL limitations listed in the *ADL/IADL Status* field (Box 5) that place the participant at risk for an adverse event; uncontrolled/unstable medical condition(s) such as diabetes, COPD, asthma, etc. that have resulted in emergency department visits or hospitalizations; terminal condition/diagnosis; polypharmacy of fewer than six prescribed medications that puts the participant at risk; medications considered high risk such as blood thinners, seizure medications, pain medications/opioids, tranquillizers, etc., that have resulted in past emergency department utilization and hospitalizations. The provider may use the *Additional Information* field (Box 16) if necessary to support authorization of CBAS.

External Risk Factors/Social Determinants of Health

a. If none of the risk factors apply to the participant, check *None*.
b. *At Risk When Home Alone* means the participant may live alone or with others but is alone for part of the day and is at risk for an adverse event when alone at home.
c. *Limited or No Social Supports/Family* means the participant has limited or no social or family supports to provide physical or emotional assistance if needed.
d. *Caregiver Stress/Inconsistency* means the caregiver(s) reports feeling overwhelmed, burned out, depressed, isolated, tired, worried, needing help or a break from caregiving; care receiver describes the caregiver as needing help, looking tired, irritable, not able to provide needed assistance.
e. *IHSS Inconsistency* means unreliable, inconsistent and/or frequent change of IHSS caregiver/services; excludes non-IHSS caregivers.
f. *Social Isolation/Loneliness* means limited or no social contact (outside the CBAS center); verbalizes feeling isolated, lonely, wanting more friends/social connections (versus someone who is satisfied with being alone/solitude).
g. *Emergency Department (ED)* visit within 30 days means a visit for evaluation in the emergency department within the preceding 30 days of the assessment but not admitted to the hospital.
h. *Hospitalization (unplanned) within 60 days* means an unplanned (unscheduled) hospitalization for any reason within the preceding 60 days of the assessment.
i. *Unstable or Unsafe Housing* means one or more of the following: frequent evictions, unsafe neighborhood (afraid to leave the home), home in physical disrepair, home requires adaptive equipment to be functionally safe, etc.; does not refer to being unsafe at home due to a cognitive impairment or other clinical risk factor.
j. *Homeless/history of homelessness* means no permanent place of residence; living in shelters/on the street.
k. *Financial Insecurity/Poverty/Lack of Resources* means not having (or perceiving to not have) sufficient money to pay bills to meet basic necessities such as housing, medications, clothing, etc.

l. *Food Insecurity* means not having (or perceiving to not have) sufficient food to prevent hunger, malnutrition, nutritional risk (for any reason).

m. *Lack of Transportation to Medical Visits* means the participant does not have any mode of transportation (paid/unpaid) to medical appointments; may miss medical appointments due to lack of transportation.

n. *Limited Health Literacy* means the participant has difficulty understanding their medical condition and/or medications including side effects, is not able to understand the personal health care provider instructions/recommendations, is unable to recognize when there is a medical need to contact their personal health care provider, etc. Limited health literacy may cause the participant to need assistance when going to medical appointments.

o. *Language/Communication Barriers* means the participant is unable to communicate needs/preferences to others as a result of language barriers (for example, monolingual/non-English speaking with no translator assistance); excludes speech impairments included in *Internal Risk Factors* under *Significant Sensory Impairment*.

p. *Other (specify)* may include any external risk factor(s) not addressed previously such as lack of transportation to pharmacy, grocery shopping; recent loss of spouse/significant other, friend, pet; may use the *Additional Information* field (Box 16) if necessary to support authorization of CBAS.

Sources of Information

The information requested in this box may be obtained through documentation in the participant's health record, MDT assessment, other medical records and through discussions with the participant and/or any other person authorized by the participant to provide health and life information.

‹‹Completion Instructions for Box (12) Needs/Goals/Desired Outcomes Expressed by Participant or Authorized Representative During Assessment Process

‹‹General Instructions››

a. List the needs/goals/desired outcomes expressed or otherwise indicated by the participant during the assessment process. Include the participant's own words, using direct quotes, or in cases where the participant is unable to verbalize or communicate their needs/goals/desired outcomes, paraphrase or describe as necessary. The needs/goals/desired outcomes should reflect the participant's concern or desired change in ability or behavior, such as "I would like to be able to walk without a walker in my home," and/or other aspects of the participant's experience or interests.

   1. The "authorized representative" or anyone the participant chooses may participate in this process and may speak for the participant if the participant is unable to articulate/provide information requested.
   2. This process should be guided by engaging the participant in a person-centered manner to express their desires, concerns, needs, etc.

   Note: Questions that may be asked that may elicit input from the participant regarding their needs/goals/desired outcomes include:

   - What do you need or want that the center staff can help you with?
   - What changes might you want to make about your life right now?
   - What changes might you want to make about your health?
   - What would improve the quality of your life?
   - What would you enjoy doing at home or at the center?
   - Discipline-specific questions such as health-related needs from nursing or activity coordinator-directed questions regarding activities, exercises and socialization.

   3. Box 12 includes space for five participant-expressed needs/goals/desired outcomes. It is not necessary to complete all five, however the center must complete at least one. If the provider is NOT completing the IPC through customized software and the participant expresses more than five, document additional needs/goals/desired outcomes using the Box 12 template available on the CDA website.

Notes:

1. The participant's needs/goals/desired outcomes should help to guide the development of the IPC.
2. In the case where the participant's expressed needs/goals/desired outcomes place their health, safety and wellbeing at risk, the MDT should work collaboratively with the participant to resolve issues. In the case where the participant's personal health care provider orders conflict with the participant's expressed need/goal/desired outcome, the participant's personal health care provider must be involved, as necessary.
3. In the case where the participant expresses no needs/goals/desired outcomes, the center should seek input from the authorized representative, family/caregiver(s), the participant's personal health care provider and/or anyone else involved in the participant's care.
4. Any ongoing conflicts or concerns regarding the participant's expressed needs/goals/desired outcomes must be documented in the participant's health record.

b. After listing the needs/goals/desired outcomes, check the appropriate box to indicate the discipline assessment during which the participant expressed the needs/goals/desired outcomes. The discipline identifying the participant's expressed needs/goals/desired outcomes may or may not be the discipline that develops a treatment(s) or intervention(s) in the *Core Services* field (Box 13) and/or the *Additional Services* field (Box 14). The participant's needs/goals/desired outcomes identified in Box 12 should be addressed in Boxes 13 and/or 14 by the appropriate discipline. In addition, each discipline should develop a care plan based on their assessment.

c. *Additional Information:* this box must include the participant's strengths and abilities, and may also be used to further explain and add "context" to the needs/goals/desired outcomes listed, including the following:

   1. The role of the authorized representative and/or caregivers in helping the participant and/or staff in identifying/addressing the listed needs/goals/desired outcomes.

2. Any relevant history that bears on whether or not and how the listed needs/goals/desired outcomes will be addressed (for example, history of understanding of the participant's personal health care provider orders, such as medications; or recommended health care, such as consistent use of assistive devices).
3. Any known information regarding the participant's motivation and ability (or the caregiver[s] willingness to assist the participant) to work toward addressing the listed needs/goals/desired outcomes (for example, the person has a history of choosing not to take medication as prescribed but is determined to remain at home and appears highly motivated to resolve issues).

‹‹Completion Instructions for Box (13) Core Services››

‹‹General Instructions››

Box 13 specifies the following CBAS core services: professional nursing, personal care services, social services and therapeutic activities which includes the physical therapy maintenance program and occupational therapy maintenance program and provides a space for centers to provide specified information.

Note: Although CBAS providers are required to offer a meal to participants on each day of attendance, "meal services" is not included in the *Core Services* field (Box 13) and providers are not required to care plan for meal services on the IPC.

Core services include all of the following:

a. Professional Nursing Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under "Professional Nursing Services".
b. Personal Care Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under "Personal Care Services".
c. Social Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under "Social Services".

d. Therapeutic Activities: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Therapeutic Activities”.

Note: The Physical Therapy Maintenance Program and Occupational Therapy Maintenance Program are considered therapeutic activities and are those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Maintenance Program”.

e. Meal Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Meal Services”.

Note: A meal is to be offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or hydration. Special meals are to be provided when prescribed by the participant’s personal health care provider.

For each discipline-identified need/problem that is associated with or connects in any way with a specific participant-expressed need/goal/desired outcome in the *Needs/Goals/Desired Outcomes* field (Box 12), document the number of that participant-expressed need/goal/desired outcome in the designated area in each of the core services boxes.

IPC requested information regarding core services:

a. Participant need/problem identified by one or more CBAS disciplines in collaboration with the participant.

   1. The participant need/problem describes the symptom or demonstrated behavior but is not the diagnosis.
   2. The need/problem is related to the medical or mental health diagnosis or condition.
   3. The need/problem must be amenable to intervention(s) available at the CBAS center.

4. The need/problem must be specific to the individual participant (not a group or classification of participants; e.g., participants with a history of falls or all participants with diabetes).

Note: The IPC must be individualized and person-centered, reflecting how the participant's condition affects their life situation and how the needs, interventions, and goals address the participant's needs and preferences to avoid a "cookie cutter" approach to care planning. To the extent possible, the IPC should be written in plain language, understandable to the participant/authorized representative.

5. The need/problem provides a measurable starting point such as a beginning grade or strength, a percentage, degree, level or range.
6. When addressing the participant's needs/problems, specify only those needs/problems for which the CBAS center staff will provide treatments or interventions during the authorization period.
7. "At risk for" if used to describe a participant need/problem requires more detailed specification of the risk and what the CBAS center will be doing to prevent the actual risk event.
8. Specify only one need/problem per box.

b. Treatment(s)/Intervention(s) to address the need/problem.

1. The treatment/intervention is the prescribed, proposed and/or recommended means of resolving or mitigating the participant need/problem. The intervention may reflect how the participant, family and/or caregiver(s) will be engaged in the participant's care.
2. The treatment/intervention reflects both the assessment completed by the participant's personal health care provider(s) (or the CBAS center physician) and the assessment completed by the MDT.
3. The treatment/intervention is related to the need/problem.
4. The treatment/intervention must be practical for implementation in the CBAS center setting.
5. The treatment/intervention must be specific to the individual participant (not a group or classification of participants).
6. Include whether the treatment/intervention is individual or taking place within a group and any out-of-center activities. Identify participation in specific groups as applicable.

7. Indicate the specific type and frequency of the treatment/intervention.
8. Include the planned amount of the treatment/intervention (for example, 15 minutes) and the duration of the treatment/ intervention (for example, for two weeks).
9. There may be more than one treatment/intervention for each need/problem.

c. Goal(s) of the treatment/intervention that provides a description of the recommended/expected outcome(s) by the specific discipline that will be providing the treatment/intervention.

1. The goal(s) of the treatment/intervention reflects the assessment done by the participant's personal health care provider(s) (or the CBAS center physician), the assessment done by the MDT and the desired outcome(s) expressed by the participant, family and/or caregiver(s) or authorized representative.
2. The goal(s) of the treatment/intervention is related to the intervention.
3. The goal(s) of the treatment/intervention must be attainable by the individual participant.
4. The goal(s) of the treatment/intervention must be measurable.
5. The goal(s) of the treatment/intervention includes timelines for achievement if the time frame is other than the length of the authorization period.
6. There may be more than one goal for each treatment/ intervention.

Note: The participant's plan of care as summarized in the *Core Services* field (Box 13) and the *Additional Services* field (Box 14), must support the number of days being requested. The medical necessity for and the frequency and duration of CBAS services (in relation to the participant assessment) are used to determine the number of days authorized and therefore MUST be clearly and succinctly described when specifying participant need(s)/problem(s), intervention(s) and goal(s).

‹‹Completion Instructions for Box (14) Additional Services››

‹‹General Instructions››

Box 14 specifies CBAS additional services (physical therapy, occupational therapy, speech therapy services, registered dietician services, behavioral health services and transportation services) and provides a space for centers to provide specified information.

Additional Services include all of the following:

a. Physical Therapy: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Physical Therapy”.

b. Occupational Therapy: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Occupational Therapy”.

Note: If there is no expectation that the participant’s condition will improve significantly in a reasonable period of time and physical and occupational therapy will not be provided, the CBAS center is encouraged to utilize physical and/or occupational therapy maintenance program services, which can benefit most CBAS participants.

c. Speech Therapy: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Speech Therapy”.

d. Registered Dietician Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Registered Dietitian Services”.

e. Behavioral Health Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Behavioral Health Services”.

f. Transportation Services: those services specified in the W&I Code and described and defined in the *Community-Based Adult Services (CBAS)* section of this provider manual under “Transportation”.

Note: CBAS centers are required to provide or arrange transportation to and from the CBAS participant's place of residence and the CBAS center, when needed, and to identify transportation needs, including special transportation.

Providers shall indicate in Box 14 the participant's transportation needs to and from the participant's place of residence and the center, if any. If transportation is provided or arranged by the center (for example, center van, paratransit), document the frequency (for example, 3x/week), and the goal (for example, the participant's transportation needs to and from the center will be met.) Transportation provided by a family caregiver or authorized representative (or other mode of transportation not provided or arranged by the center) would not be care planned in Box 14.

The provider shall determine who completes Box 14 for *Transportation Services*. The participant's transportation needs shall be re-evaluated during the assessment/reassessment process every six months.

Documentation of participant's attendance and transit times to and from the participant's place of residence and the center shall be used to verify the provision of any transportation services specified in the *Additional Services* field (Box 14).

For each discipline-identified need/problem that is associated with or connects in any way with a specific participant-expressed need/goal/desired outcome in the *Needs/Goals/Desired Outcomes* field (Box 12), document the number of that participant-expressed need/goal/desired outcome in the designated area in each of the additional services boxes.

IPC requested information regarding Additional Services [participant need(s)/problem(s), treatment(s)/intervention(s) and goals of treatment/intervention]: refer to instructions for the *Core Services* field (Box 13).

Note: The participant's plan of care as summarized the *Core Services* field (Box 13) and the *Additional Services* field (Box 14), must support the number of days being requested. The medical necessity for and the frequency and duration of CBAS services (in relation to the participant assessment) are used to determine the number of days authorized and therefore MUST be clearly and succinctly described when specifying participant need(s)/problem(s), intervention(s) and goal(s).

‹‹Completion Instructions for Box (15) Significant Changes Since Previous IPC ››

‹‹General Instructions››
Box 15 provides a free-text space to describe significant changes in the participant's condition and/or care plan since the last IPC. These may include deletions, additions or modifications made to the IPC.

a. "Significant Change" means a change that may have or likely have a considerable influence or effect on the participant's quality/quantity of life or participation at the CBAS center. Significant changes may come from any area of the participant's care (for example, physical, psychosocial, cognitive, etc.).
b. At the time of readmission to the center in the case of an extended absence, the provider may use this box to explain the absence and its effect on the participant's condition and/or participation at the center (for example, institutionalization or a jail term).
c. A significant change(s) may necessitate a new IPC (e.g., the participant is hospitalized and requires changes in their treatment plan) and submission of a new TAR (for example, the participant requires an increase in the number of days of CBAS).

Note: This box is for reauthorization TARs only. If this is not a reauthorization TAR, write *N/A* in the box.

‹‹Completion Instructions for Box (16) Additional Information ››

‹‹General Instructions››

Box 16 provides a free-text space to describe or provide any critical history/information not included elsewhere in the IPC that is relevant to the authorization of CBAS services, such as medical, psychosocial history/information, or if the participant is not enrolled in a plan or is ineligible to enroll in managed care. Indicate any box numbers of the IPC that are being discussed or referenced.

If the center has referred the participant for other services (for example, county mental health, podiatry, etc.), note and briefly explain, indicating the date(s) of referral(s).

Note: Information in this box may remain throughout each TAR period if still relevant to the participant's care.

‹‹Completion Instructions for Box (17) Signatures of Multidisciplinary Team and Program Director ››

‹‹General Instructions››

a. Pursuant to Section 14529 of the W&I Code, signing on the IPC in Box 17 certifies agreement with the IPC, consistent with the signer's scope of practice.

Note: Electronic signatures are allowed. A hard copy of the signed IPC shall be available upon request. It is the CBAS center and the signee's responsibility to conform to the Health Insurance Portability and Accountability Act (HIPAA) rules for safeguarding/protecting participant health records and passwords. For more information regarding HIPAA, refer to the information on the following website: *(http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/default.aspx)*

b. The registered nurse, social worker, physical therapist, occupational therapist and activity coordinator must sign and date all initial IPCs. The registered nurse, social worker and activity coordinator must sign and date all reauthorization IPCs. The remainder of the MDT must sign and date the IPC if their particular service will be rendered to the participant during the authorization period.

Note: Participants and/or their authorized representative may sign the IPC if they choose but are not required to do so. Participant signature to indicate agreement with the IPC is required on the *Participation Agreement* form.

1. MDT: provide the signer's printed name, signature, and date of signature as requested.
2. The CBAS center must maintain all assessments completed by the individual disciplines of the MDT in the participant's health record, including the date the assessment was done and signature of the person who did the assessment.
3. All assessments must be completed prior to the start of services on the first day of authorized CBAS services (CCR, Title 22, Section 54209).

c. The participant's personal health care provider or the CBAS center's physician must sign and date all IPCs.

1. Provide the signer's printed name, signature, and date of signature as requested.
2. Signature of the designated health care provider certifies review and concurrence with the IPC.

d. The Program Director must sign and date all IPCs.
    1. Provide the signer's printed name, signature and date of signature as requested.
    2. Signature of the program director certifies that all assessments have been completed and the participant meets all CBAS eligibility and medical necessity criteria as specified in the IPC effective on the date indicated; information contained in the IPC is the result of a MDT person-centered planning process and is documented in center records; and services scheduled in the IPC will be provided, unless otherwise noted in the participant's health record, after approval of the participant's eligibility and TAR, and after the participant or authorized representative has signed the *CBAS Participation Agreement* (Form CDA 7000), no later than the first day of enrollment, consenting to services.
e. By signing this IPC, it is understood by all signees that the services scheduled on the IPC will be provided unless otherwise noted in the participant's health record.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.