Instructions for Providers: Revised

General instructions:

The Provider Monthly Report (PMR) has been revised to make reporting requirements clearer to analysts (Revision – Version July 2020). Please note the changes in the PMR. Changes are noted in purple font.

- ✓ In the revised PMR, numbers need only be reported for each level of care at the **agency**. It will not be necessary to report by LCode (locations where treatment is provided). For instance, if your agency provides OP services at two different locations, you are asked to roll up the figures for both locations for this report.
- ✓ The monthly report must cover the entire month, from the 1st to the last day of the month. For example, the report for April 2020, must cover the dates 1 through 30th day of the month including both dates.
- ✓ Monthly figures should be reported for all the elements shown in the PMR. There should be no blanks in the report.
- ✓ **Please note the changes in reporting of Referrals & Transfers:**
  - Report the initial referrals from Gateway for the reporting month (Eg June referrals for June report)
  - Report referrals from Gateway for the previous month (if there were no pending referrals from the previous month, enter 0. If there were pending referrals, enter the number).
  - Report referrals from other sources (Probation, DWC, walk-ins, etc.) for the reporting month
  - For transfers from another provider, submit numbers for the report month. So, if there were 10 referrals from other providers (transfers within levels of care) during the report month (say April), the number of transfers would be 10.
- ➢ Not meeting medical necessity – is based on the GRS section called 'Referral Disposition.' Count the number of clients who do not meet medical necessity for a level of care available at the referred to provider, and clients who do not meet medical necessity for substance use treatment (do not have a diagnosis for a Substance Use Disorder).
- ✓ Some providers offer multiple levels of care. A **separate report** must be submitted for **each level of care** in which county funded services are provided. For instance, if a provider offers IOP and OP services, a separate form must be used unless the following criteria are met:
  - If the same counselors provide both levels of care, and their caseload consists of a combination of OP & IOP clients, this should be noted in the report.
- ✓ Please note that caseload should be reported by FTE (Full-time equivalent-40 hours per week). For instance, if your agency has 2 counselors each of whom works 20 hours a week, then both combined equal 1 FTE. (Required only for OP treatment providers).
- ✓ If the submitting provider has an explanation for the figures, an analysis and narrative may be attached. If additional documents are attached, they must indicate the name of the section to which the data refer.
- ✓ Alternatively, comments may be noted in the PMR form.

Instructions for face page:

Item	Instructions
Provider Agency Name:	Enter Agency's legal name
Level of Care:	Enter ASAM Level of Care (e.g, ASAM 1.0)
Report month & year:	Month & Year covered in report
Locations	Enter the number of locations included in this report. List the locations in the space provided
Submission date:	
Submitted to:	QIC Name
Agency Contact:	Person must be able to answer questions about report.
Contact telephone number:	
Email address:	

Instructions for PMR

Referrals & transfers	**Number or %**	**Comments**
# Gateway referrals (for reporting month)	DADS 2009	
# Gateway referrals (not for reporting month)	DADS 2009	Enter only if there were pending referrals from previous month
# Referrals from other sources (e.g. courts) (for reporting month)	Not available in UniCare	Needs to be tracked separately
# Transfers-referrals from other providers (for reporting month)	Not available in UniCare	Needs to be tracked separately
Total of all referrals	Add all referrals	
# of clients who **did not** meet medical necessity for substance use tx	Referral disposition (no report)	Needs to be tracked separately
# of clients who **did not** meet medical necessity for the agency's level(s) of care	Referral disposition (no report)	Needs to be tracked separately
Total of all clients not admitted to your agency	Add all clients not admitted to tx	
Admissions		
Total number of admissions	DADS 7003	
% of referrals & transfers admitted	Calculate percentage	

	(Admissions/ Total of all referrals)*100	
ALOC		
# of admissions with ALOC	BHS0700	
# of discharges with ALOC	BHS0700	
Cost Center discharge *		
# of all Cost Center Discharges	DADS 7001	
# of Cost Center Discharge –services – No CalOMS	DADS 7001	

Open clients & services	All of these can be tracked in UniCare or in agency EHRs	Comments
# of (unduplicated) open clients	DADS 3005	The data elements are provided but need to be calculated
# of clients without a service in **30** days	DADS 3005	
# clients with stays over **90** days	DADS 3005	
# assessments -medical necessity for stays over **180** days	DADS 3005	
Caseload & utilization		
# of counselors (FTE)	FTE is Full-Time Equivalent. Add FTEs together to get total FTEs (may not be equal to the number of counselors)	
# of (unduplicated) open clients	DADS 3005	Will need to be counted
Average caseload per FTE	DADS 3005	Will need to be counted
# of counselors with caseload below contracted level		Will need to be counted
% utilization of slots	=(Open clients for month/contracted capacity) *100	Need to calculate

*Please note: This section requires a count of the new **cost center discharge codes**.

Example – using DADS 3005 to complete the form

The notation in red indicates the source of the figure that is placed in each box. Summary values are available in some of the DADS reports in Profiler. For instance, DADS 3005 provides by cost center and counselor:

- ✓ Counselor caseload (total for provider at the UCode)
- ✓ Total open clients at the Cost Center
- ✓ Last day of service
- ✓ Length of stay (the interval between admission date and date of report)
- ✓ The number of days since the last service will need to be calculated