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 used 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	Response
Provider Agency Name:	Enter Agency's legal name
Level of Care:	Enter ASAM Level of Care
Report month & year:	Month & Year covered in report
Number of locations reported on form:	Number of locations (maximum of three per form)
Number of forms submitted:	
Submission date:	
Submitted to:	QIC Name
Agency Contact:	Person must be able to answer questions about report.
Contact telephone number:	
Email address:	

Instructions for the report sheet:

New table here

Referrals & transfers	**Number or %**	**Comments**
# Gateway referrals (for the reporting month)	DADS 2009	
# Gateway referrals (for prior month(s))	DADS 2009	
# Referrals from other sources (e.g. courts)	No UniCare Report	Will need to be tracked separately
# Transfers-referrals from other providers	No UniCare Report	Will need to be tracked separately
Total of all referrals	**Total of all referrals**	
# of clients who **did not** meet medical necessity for substance use tx	Referral dispo-no UniCare Report	
# of clients who **did not** meet medical necessity for the agency's level(s) of care	Referral dispo-no UniCare Report	
Total of all clients not admitted to your agency	**Total of all admissions**	
Admissions		
Total number of admissions	DADS 7003	

% of referrals & transfers admitted	(Admissions/Total referrals)*100	
ALOC		
# of admissions with ALOC		
# of discharges with ALOC		
% of admissions with QI authorization	(# of authorizations/# of admissions)*100	Computed value
Cost Center discharge*		
# of all Cost Center Discharges	DADS 7001	
# of Cost Center Discharge –services – No CalOMS	DADS 7001	
Open clients & services		
# of (unduplicated) open clients	DADS 3001	
# clients with stays over **90 (adult)/30 (youth)** days	DADS 7003	
# approved extensions for stays over 90/30 days	DADS 7003	
Caseload & utilization		
# of (unduplicated) open clients	DADS 3001	
% utilization of beds	See formula below	Computed value

% utilization of beds – involves using bed days.

1. Compute total number of bed days for location – number of contracted beds X number of days in the month (For example, if you have a contract for 10 beds, the total number of bed days for June would be 10*30 days= 300 bed days). This is the denominator.
2. Compute the total number of days a bed was occupied-simplest method add up LOS of unique clients for the month. This is the numerator.