Riverside University HEALTH SYSTEM Behavioral Health

Attachment E

Quality Improvement Inpatient

Inpatient TAR Processing Requirements

Chart requirements for determining medical necessity (noncompliance can result in denial of days or denial of entire hospital stay):

- Consumer's Plan of Care with both MD and patient signature (Note: Must have written explanation if no patient signature) The comprehensive Plan of Care will consist of the following components: ICD-10 Diagnosis, signs & symptoms of psychiatric impairment, specific treatment interventions & services, long & short term goals, measurable objectives with time frames, estimated duration of treatment, prognosis, professional discipline responsible for each element of care, tentative discharge plan, any specified medication regimen, and dated legible physician signature. Signatures are to be obtained at the beginning of treatment
- Legal Paperwork ***(if applicable***)
  - Request for Voluntary Admission ***–or-***
  - 72-Hour Hold Application/5150
  - 14-Day Hold Notice of Certification/5250 and all additional Hold Notices
  - 14-Day Certification Probable Cause Review Hearing
  - Temporary Conservatorship Investigations/paperwork
  - Riese Hearing paperwork/ Decision
- Psychiatrist's Initial History and Evaluation (**Must be completed within 24 hours of admission**)
- Daily M.D. Progress Notes (**Notes must be written or dictated on day of service**)
- M.D. Orders
- History & Physical Exam (**Must be completed within 24 hours of admission**)
- Nursing Progress Notes (**for all shifts per each day of hospitalization**)
- Social Work Psychosocial Evaluation (**Must be completed within 48 hours of admission**)
- Administrative Days: Social Work/Case Management notes, or log, showing a minimum of five appropriate, non-acute treatment facilities per week being contacted for placement options during Administrative Day Services with at least one contact being made on the first day. Calls left on an answer machine or calls not answered do NOT count. RCDMH may waive the requirements of 5 (five) contacts per week if there are fewer than 5 (five) appropriate, non-acute residential treatment facilities available. In no case shall there be less than one contact per week
- Medication Administrative Records
- Any flow charts used by the hospital, all lab results, any seclusion & restraint paperwork and any separate progress notes in the record
- All group/therapy/activity notes
- Notification of client's admission within the first 24-hours of the admission (or TAR/chart received by RCMH within 10 days of admission if not notified within 24 hours)

Correctly completed TAR and complete chart received by RUHS-BH within 14 days of patient discharge